Dean's Corner e-Newsletter

Texas College of Osteopathic Medicine

November 4, 2004

As a Medical School dean, there is compulsory strategic planning, relationship building, resource management, and personnel management. But there is also the part of the job that involves crisis management on an as needed basis. That, along with the hard work of faculty, students and staff is what has gotten the Texas College of Osteopathic Medicine (TCOM), through the challenges related to the closing of our longest affiliated teaching hospital, Osteopathic Medical Center of Texas (OMCT).

Physicians in private practice at OMCT had a dream to start a small osteopathic medical school in the late 1960s. With less than 20 students in the first class, TCOM began in the fifth floor of OMCT, and later spread to its current site across Montgomery Street. In the mid-1970s the school became a part of what is now, the University of North Texas, in Denton. The medical school and the university continued to grow and evolve, with the infusion of state funds. The medical school now serves as the foundation for the ever growing University of North Texas Health Science Center campus here in Fort Worth. The campus has an operating budget of more than $110 million dollars a year, has 3 other schools (Graduate School of Biomedical Science, School of Public Health, and School of Health Professions), conducts more than $25 million dollars of funded research (NIH, CDC, etc.), and contributes more than a third of a billion dollars a year to the Fort Worth economy.

Over the years OMCT has been a close and integral hospital partner for the education of our medical students. But despite this close relationship, OMCT was in a difficult situation, as a small, unaffiliated community hospital, beginning to feel the pressures of market forces by the end of the 1990s. Their continued operation was dependent upon becoming part of a larger hospital chain that could provide the needed capital to operate in this heavily penetrated managed care market. But as TCOM grew, so did our need for relationship with other hospital partners. At the time of OMCT's closing, TCOM also had strong affiliations with John Peter Smith Hospital, Plaza Medical Center, Cook Children's Medical Center, Harris Methodist Medical Center Fort Worth, Baylor All Saints Medical Center, Texas Tech University Hospital-Odessa, University of Texas Health Center-Tyler, to name a few.

Although the medical school recognized the financial problems at OMCT for some time, the abrupt closing did place pressure on the medical school. Many of our physicians practiced primarily at that hospital, we had students being mentored there, and we were the university partner for the internship and residency (post-graduate specialty training) programs. Although plans had been ongoing to address our school's needs in the event of a closing, that preparation is

rarely sufficient when such an abrupt closure occurs. With over 500 students, almost 400 employees, more than 100 faculty, 55 interns/residents, and countless patients, our focus was on the people. Our priority became (in this order): 1. stabilizing our physician practice to assure NO lapse in patient care; 2. re-assignment of students with as minimal an impact as possible on their education; 3. find alternate training sites for interns and residents as quickly as possible; 4. re-establish any clinical research trials that were on-going. To allay concerns, communication became imperative so that all personnel knew the status of our initiatives, and the impacts we anticipated in our programs and services. In addition, listening to the concerns and receiving insight from all affected parties was part of that communication. I held frequent face-to-face meetings with our department chairs. Our leadership team had meetings with all groups impacted by this change, in addition to multiple email messages. All mission specific areas will now monitor these changes over the next 4-8 weeks, we will reassess the changes that we made in some of our programs, and we will act upon that information.

So in this time of health care competition in the marketplace we are personally feeling the effect of the closure of our oldest and closest hospital partner. But the small medical school that was founded by physicians from OMCT has now grown into a program with more than 500 students, a large multi-specialty physician practice, a leader in biomedical research, and the foundation of a Health Science Center campus that is part of the University of North Texas system. I personally appreciate the hard work and countless hours spent by each of our associate deans, our department chairs, our hospital partners (new and old), students, residents, and staff for making this transition as smooth and straightforward as possible. Once again, transitioning through this painful loss is part of the process of managing Fort Worth's Medical School in today's fast paced health care marketplace.

Please supply any pertinent information to my office (deantcom@hsc.unt.edu) by the third Thursday of the month, for inclusion in this Newsletter.

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Student Affairs:

Thomas Moorman, Ed.D.
Associate Vice President for Student Affairs

Division of Student Affairs

- Over 100 students, faculty, and staff attended the first ever International Student Association meeting at the UNT Health Science Center in October 2004.

- An RFP is about to be released soliciting bids to provide textbook services to our campus.

- The Office of the Registrar is in the post-implementation process of the new student information system (Enterprise Information System). Implementation activities and on-going maintenance will continue for the next three to four years. The Office of the Registrar has also been conducting several (EIS) training classes to help users across the campus develop the skills necessary to use the new software effectively.

- The Financial Aid Office continued working with the Fort Worth Independent School District this year to supply, free of charge, tutors to help elementary school children learn reading and mathematics. UNTHSC work-study students are hired to provide these services to local schools throughout the year as a requirement of the federal program.

Clinical Affairs / Faculty Practice:

Robert Adams, D.O.
Senior Associate Dean for Clinical Affairs/Chief Medical Officer

The past several weeks have been like a roller coaster. The ups and downs of trying to keep up with what's rumor, what's fact, and what needs to happen next have been stressful for all of us. As the dust clears and we begin to settle into new environments, it would probably help to reflect on where we've been, what we've accomplished and where we want to go.

For the duration of TCOM's existence, we have had OMCT as a hospital partner. All of our students and many of our faculty have trained and provided patient care within its walls. While it's inconceivable that OMCT is no longer a part our lives, the fact is that TCOM remains strong and has needs far greater than what any one hospital partner can provide. Many of you have lamented at TCOM's inability to create its own identity due to the close ties with OMCT. The confusion created in the community by OMCT's closing relative to our own activities has confirmed this. The closing of OMCT has created a forced opportunity to address all of our needs and our identity. We have found community partners who have been willing to help us out during this trying time. These efforts to help have not been extended as only a quick fix for the crisis, but have been offered as a foundation for the future.

Most of our faculty have moved their clinical activities to Medical Plaza. While many of our faculty already worked at Plaza, we increased our presence dramatically within the course of 1-2 weeks. Their administration and medical staff worked diligently to accommodate our every need. They have granted emergency privileges and provided assistance in getting our physicians the right staff appointments. They have explored all opportunities to assist us, and our patient care transition has gone very smoothly. Others have found them equally helpful in meeting the

needs of our students and residents. Baylor All Saints was equally supportive in processing the credentialing packets of our OBGYN physicians. Each was processed and given privileges to practice within a week of OMCT closing, evading a significant patient care issue had our physicians not had anywhere to practice. JPS has been less involved in clinical patient care issues through this transition, but certainly demonstrated their willingness to be our partner by their involvement in solving student and resident issues. These hospitals along with Cook Children's provide our playing field for the future.

Many of our faculty are wondering what the future holds now that residents are gone and students are more scattered. This past summer, Dr. Hahn held a leadership meeting to discuss the future for each of our key areas (education, research, patient care). With Education as our primary focus, the question of what model is preferred for clinical education of our students was discussed. The resounding answer was that our students should be taught by our clinical faculty if the students are in a hospital setting within Tarrant County. The obvious implications of this response is that our clinicians need to provide patient care at hospitals where the students are receiving their education. In our current situation, the students are primarily located at Medical Plaza, JPS, and Cook Children's. With this being the case, we will be focusing on developing our hospital clinical practice activities at these hospitals in order to support our teaching mission. This also seems aligned with the opportunities available for resident education now and in the future.

We are facing a time of intense change and change is uncomfortable. However, the opportunities that may develop because of this change are significant and potentially very exciting. Please seek out answers to your questions and comfort to your concerns through active communication with your department and institutional leadership. The future of TCOM is bright and we will be a stronger institution going forward. With your patience and commitment, our clinical practice will also move forward and evolve into an entity that enjoys continued success along with a much stronger identity in the community. Thanks to everyone for their efforts during these past two weeks.

Educational Programs:

Don Peska, D.O.
Associate Dean for Educational Programs

The carnage that was the closure of “The O” is almost over. In its wake, 57 interns and residents were displaced. In the end, 57 interns and residents will be in new homes. The office of the Texas OPTI received an outpouring of well wishes, advice and, most important, training slots from around the state and around the country. Some programs were left entirely in tact as they were transferred to either Plaza Medical Center or John Peter Smith Hospital. Others closed as their participants were absorbed into training programs in the metroplex. While not all options were local, every resident received multiple offers and all but a few will be resuming their training within a short time. The cooperation and compassion of Chief Executive Officers, leadership personnel at numerous hospitals, directors of medical education, state licensing boards and the several accrediting bodies, both osteopathic and allopathic, were needed to bring closure to the process and the University provided the central coordination needed for the task. While it

has interrupted our activities for a time, the graduate medical education office will continue to pursue the growth and development of new opportunities to replace those lost.

Academic Affairs:

Bruce Dubin, D.O., J.D.
Associate Dean for Academic Affairs

This academic period, the first year medical students have subscribed to, and been trained in, the use of MDCONSULT. This is a new component of their first year clinical course work. The results have been quite exciting. With their laptops readily available in Luibel auditorium, the first year students have demonstrated their abilities to research and deal with medical concepts and conditions far beyond what has normally been expected in the first year classroom. Many thanks to Dr. Gwirtz, Dr. Cole, Dr. Jennifer Alexander, Dr. Putthoff, and the library staff in creating an exciting learning atmosphere in the classroom.

2) Clinical Rotations

With the strong collaboration and assistance among our Departments, Administration, our medical students, and local area hospitals, the problems dealing with the student closure of OMCT were handled successfully. New relationships and expanding sites also bring new opportunities to improve and expand medical education throughout the curriculum. We are excited about this opportunity to enhance and improve the education of our students. These new and exciting sites also require increased credentialing and oversight. None of us like increased "paperwork", but it is something that is important and must be dealt with. Through the hard work of Dr. Michael Budd and the rest of his staff, scheduling and credentialing of students has progressed rapidly and efficiently. If you have any questions about student rotations or credentialing, please contact Dr. Budd.

Clinical Research:

Michael Clearfield, D.O.
Associate Dean for Clinical Research

The first two months of the fiscal year have been unprecedented for clinical research. However before reviewing the success in September and October, first a very brief review of last year's totals. Research at TCOM increased overall 168% over the 2002-2003. We received a total of $5,872,803 last year which clearly exceeded our goal of $5,000,000. WAY TO GO!

In September, we were notified of several large grants to be initiated this year. The first study is the NIH Developmental Center for Research on OMM under the direction of PI Michael Smith, Ph.D. and Scott Stoll, D.O., Ph.D. Director of the Osteopathic Research Center. This is a three year grant for $1,883,216 and is the first time our profession has been funded by the NIH (NCCAM) to study OMM. This developmental grant has four key elements which will study

basic science and clinical applications of OMM. The grant is multi-discipline involving 19 investigators from all three schools and will allow the Osteopathic Research Center to continue its incredible evolution in OMM related research for our profession.

The second study is the Diabetes Research Education and Metabolic Studies (DREAMS) has been funded for the first year by the CDC for $1,433,636 under the direction of Craig Spellman, DO Ph.D. This study has three major projects associated with it which will include a family based prevention program to curtail the development of diabetes, obesity and metabolic syndrome in Tarrant County, the determination of existing and emerging risk factors for cardiovascular disease in individuals with diabetes and metabolic syndrome and the development of a database for statistical and epidemiologic assessments. As with the NIH Developmental Award for OMM, this grant is also multi- disciplinary involving 16 faculty representing all three schools at UNTHSC.

The third major grant was awarded to Stephen Weis, D.O. from the CDC for a Regional Training and Medical Consultation Center. This award will be added to Dr. Weis' current funding from the CDC which last year totaled an amazing $1,800,302. Dr. Weis has established himself as the most consistently productive researcher at TCOM and is acclaimed internationally as one of the top researchers in the world in Tuberculosis.

The fourth funded initiative awarded was to Arthur Eisenberg, Ph.D. in the DNA lab. Dr. Eisenberg was awarded five grants from the National Institute of Justice totaling $1,992,964. Just as with Dr. Weis, Dr. Eisenberg has ascended to international prominence in the field of DNA identification and these awards attest to this high acclaim as a world renowned researcher.

I think it is abundantly clear that research is alive and thriving at TCOM and it is because of the efforts of all those listed above and many more that we continued to excel in this area. I want to again congratulate the entire TCOM/UNTHSC community for a great last year and an ever greater year to come. As JFK said in his inaugural address "One person can make a difference and every person should try." I believe we are making a difference one person, one grant and one focused vision at a time.

PA Studies:

Hank Lemke, P.A.

No contribution this month

Science and Health News:

Is Kaiser the Future of American Health Care?

New York Times
[October 31, 2004]

By STEVE LOHR

OAKLAND, Calif.

AFTER 18 years in private practice, Dr. Victor Silvestre was exhausted from his lonely battle, day after day, with a health care system that seemed to be working against him. A general practitioner, Dr. Silvestre found it increasingly difficult to get his patients appointments with specialists, who tended to focus on lucrative procedures instead of routine care. Paperwork and haggling with insurance companies, he said, took more and more time. "There just had to be a better way," he recalled. For Dr. Silvestre, the better way was not across the border in Canada, or in some affluent nearby suburb, but in his own backyard, in Oakland. Two years ago, he joined Kaiser Permanente, the huge health maintenance organization based here. "So many of the solutions, the ingredients of a more rational system for delivering health care, were there," he said.

It may seem unlikely, given Kaiser's past image as a ham-handed H.M.O., but plenty of others are reaching the same conclusion. High-level visitors from across the political spectrum - the Bush administration and National Health Service of Britain, for example - are coming to California these days to look at Kaiser as an institution that is actually doing some of the things needed to improve health care.

Obviously, there is no single model for revamping the nation's costly, disjointed health care system, and Kaiser certainly has its share of problems. But according to economists and medical experts, Kaiser is a leader in the drive both to increase the quality of care and to spend health dollars more wisely, using technology and incentives tailored to those goals. "Quality health care in America will never be cheap, but Kaiser probably does it better than anywhere else," said Uwe E. Reinhardt, an economist at Princeton who specializes in health issues.

Health care systems in most industrialized countries are in crises of one form or another. But the American system is characterized by both feast and famine: it leads the world in delivering high-tech medical miracles but leaves 45 million people uninsured. The United States spends more on health care than any other country - $6,167 a person a year - yet it is a laggard among wealthy nations under basic health measures like life expectancy. In a nutshell, America's health care system, according to many experts, is a nonsystem. "It's like the worst market system you could devise, just a mess," said Neelam Sekhri, a health policy specialist at the World Health Organization in Geneva.

In this political season, the health care debate has been mostly about who will pay the bill. President Bush talks about tax credits and health savings accounts that are intended to give people more control over their care but would also mean that they would pay more out of their own pockets. Senator John Kerry wants the government to pay more, and he has proposed a major, and costly, program to cover the uninsured.

The favored solution of many liberals - and of no small number of health care experts - is a single-payer system of health insurance, covering the entire population and underwritten by the government. For the foreseeable future, that is considered politically off-limits, which was the

message Washington absorbed from the abandoned effort to fashion a national health program in the Clinton administration.

How to finance health care is only one side of the problem. The other is how to deliver the care more intelligently, and that is where the Kaiser experience holds lessons. Given the demands of an aging population and steady advances in medical technology, national health spending will continue to climb. Yet by all accounts, there is plenty of waste - estimates range up to 30 percent or more of total spending - from unnecessary clinical tests, hospital stays and prescriptions, and the bedeviling sea of paper used to handle bills, claims and patient records.

"We're not going to spend less, but figuring out how to get the most value out of our health spending is going to be the big issue of the future," said David Cutler, a health care economist at Harvard.

But Kaiser as a model? Wasn't Kaiser, an H.M.O., part of the "managed care" movement that faltered in the 1990's amid protests from doctors and patients? In fact, Kaiser, with its origins in the 1930's and 1940's, when the industrialist Henry J. Kaiser provided health care for his construction and shipyard workers, has always been a hybrid. The managed care concept of the 1990's was about having an outside bean counter, usually an insurance company, looking over the shoulder of the doctor – managing costs instead of managing care.

Kaiser has a different setup with different incentives. It emphasizes preventive care and managing chronic diseases like heart disease and diabetes to keep people healthier. And that saves money because healthier people require less costly care like hospitalization.

The country's largest private-sector provider of health care, Kaiser employs more than 11,000 physicians and 135,000 other workers, owns 30 hospitals and hundreds of clinics and serves more than eight million members in nine states and the District of Columbia. Seventy percent are in California. Kaiser is both insurer and provider; employers typically pay fixed yearly fees for each member, no matter how much care is provided.

Clearly, Kaiser has its limits as a model for others. It is unlike many mainstream health plans in that it is a not-for-profit company - though one with annual revenue of more than $25 billion and operating margins of 5 percent. Its facilities tend to be large, and it has a lingering reputation for practicing an impersonal, regimented style of medicine that limits patient choice, despite recent efforts like the creation of physicians' personal Web pages and e-mail communication with patients.

Still, most health care experts who have studied Kaiser are impressed. "Kaiser has a model that consciously manages both quality and costs in a way that has been very effective," said Margaret O'Kane, president of the National Committee for Quality Assurance, an independent group that monitors health plans.

Kaiser's approach is best illustrated in two ways: its management of chronic illnesses like heart disease and diabetes, and its $3 billion initiative to use information technology to improve clinical care and streamline operations.

Across the country, health costs are skewed. In any given year, 90 percent of spending provides care for 30 percent of the population, and more than half of total spending goes to 5 percent of the population. Much of it is spent on people with chronic illnesses like heart disease and diabetes. So helping people with those ailments stay as healthy as possible offers much opportunity for cutting costs - and for improving lives.

In Northern California, Kaiser has sharply reduced the death rate for its three million members there in recent years by monitoring and controlling blood pressure and cholesterol levels and by promoting the use of aspirin and beta blockers (to reduce the risk of heart attacks) and statins (to lower cholesterol). The death rate from heart disease among the Kaiser members is 30 percent lower than it is in the rest of the Northern California population, adjusted for age and gender.

Four months ago, Jose Flores, 44, a postal worker in San Francisco, had double-bypass heart surgery. While still in the hospital, he was enrolled in a program of education and treatment, which is run by nurses and lasts a year. Patients receive instruction on diet, exercise and cholesterol management; smokers are placed in a course to help them quit.

Mr. Flores says he is on a drug regimen that includes beta blockers and Lovastatin, a generic cholesterol-lowering statin. He takes large doses of niacin, a vitamin that raises the level of high-density lipoprotein, the "good" cholesterol that protects against heart attacks. He walks for an hour, five days a week. His eating habits have been transformed, too: fried foods were once a staple of his diet, but no more. Blacklisted, too, are sour cream, cheese and corn chips. "Now, I try to avoid all that," Mr. Flores said.

In Northern California alone, Kaiser spends $55 million a year on chronic-care management programs. "But what's really expensive is if we don't take care of these people and manage their chronic conditions," said Dr. Robert Mithun, chief of internal medicine at Kaiser's medical center in San Francisco.

Dr. Mithun's comment may seem like no more than common sense, but it does not reflect the typical logic of the dominant fee-for-service model of health care. Most doctors and hospitals get a fee from insurers for each patient visit, clinical test, surgical procedure or day a patient spends in a hospital. In practice, the fee-for-service system is often an invitation to do more of everything - more visits, more tests, more surgery. What gets done is what gets paid for, and insurers usually do not pay for preventive care or chronic care management provided by nurses or in group classes, like the ones at Kaiser.

In the fee-for-service medical economy, doctors and hospitals routinely strike different deals at different fees with many different insurers. The results are complexity, inefficiency and a constant bureaucratic tug-of-war between health care providers and insurers over claims.

The Kaiser economy seems a world apart. "What works at Kaiser is the integration of the financing and delivery of care, and the aligned incentives that allow you to make more rational decisions about health care for members," said Ms. Sekhri, the policy expert at the World Health Organization, who has studied Kaiser.

Ms. Sekhri was a co-author of a 2002 report that compared Kaiser in California with the National Health Service of Britain. The report found that for comparable spending, the Kaiser system in California did a better job of keeping people with chronic conditions out of hospitals. And when Kaiser patients were admitted to hospitals, their stays were generally shorter. Recently, Britain sent groups of primary care physicians and hospital administrators to California to learn from Kaiser.

The Labor government in Britain may look to Kaiser as an efficient model for its health service, which is run by the government. But the Bush administration is more interested in Kaiser as a model for the efficiencies and integration that can be achieved through information technology.

In May, the Bush administration appointed Dr. David J. Brailer to the new post of national coordinator of health information technology. His mandate is to prod the nation's health care system into the computer age. Bringing patient records and prescriptions out of the pen-and-ink era promises to save both dollars and lives. The automation of an electronic system could sharply reduce medical errors, which are estimated to be responsible for 45,000 to 98,000 deaths a year, according to the Institute of Medicine of the National Academy of Sciences.

Kaiser has been investing heavily in information technology for years. Its clinical information system includes electronic records with a patient's history, prescriptions and preventive health recommendations. A doctor can call up a patient's X-ray or magnetic resonance image on a desktop personal computer. Electronic prescribing - a goal in the government plan - is routine at Kaiser.

Yet Kaiser is in the midst of a several-year, $3 billion program, called KP HealthConnect, to drastically improve and integrate its clinical and administrative systems and Web-based services for members. Once it is in place, Kaiser clinicians will be able to tap into a vast but flexible storehouse of data that uses intelligent software to automatically flag potentially harmful drug combinations for a patient or to suggest what treatments have been most effective for other people who are of the same sex, age group and - eventually - genetic profile.

DR. Brailer, for one, checks in regularly on the progress of HealthConnect. George Halvorson, Kaiser's chief executive, said, "Policy makers are looking to us as the cutting edge of how health care can be supported electronically."

Kaiser has had setbacks in the program. Last year, it abandoned I.B.M. as its main partner on the project and chose to go with specialized health care software provided by Epic Systems, a private company in Madison, Wis. Despite the switch, HealthConnect is scheduled to be rolled out during the next couple of years across Kaiser's operations.

The conversion of inefficient paperwork to a digital network also opens the door to fostering more efficient markets in health care. Markets rely on information, yet the health care economy is one in which information on patients, treatments and outcomes is trapped on paper and isolated in clinics, hospitals and insurance offices - instead of being shared, analyzed and compared, while still insuring privacy.

The fee-for-service model exists because patient visits, clinical tests and surgical procedures can be measured. They are inputs, in economic terms. Whether those inputs are effective is another matter.

In recent years, there have been efforts to focus on the quality of health care. The National Committee for Quality Assurance conducts annual reports based on a health plan's use of practices shown to improve patients' health, from timely prenatal care to cholesterol management. Kaiser plans consistently earn excellent ratings in the group's reports, and, this year, it had four of the five top-rated plans in the Pacific region, its stronghold.

Dr. Francis J. Crosson, the executive director of the physicians' side of Kaiser, said, "Our future has to be to compete on quality, offering people demonstrably better care and better value."

And the Kaiser system delivers quality while controlling total costs. A recent survey of health care costs in 15 metropolitan areas by Hewitt Associates, the human resources consulting firm, found that the cost for care per employee last year was lowest in the San Francisco area, where Kaiser members were about 35 percent of the insured population, at $5,515, and was highest in regions where Kaiser did not operate - led by New York, at $6,818 a worker.

Quality yardsticks are helpful, but they still measure inputs - ones associated with better health - instead of tracking how patients fare. The longer-term goal is for health plans to use technology more, as leading companies in the rest of the economy do. For the health plans, that may mean constantly tracking patients, treatments and results. "To have a real market for quality in health care, you need a product," Mr. Halvorson said. "And that means reliable, timely information about outcomes, clinical-trial sorts of databases that show things like, for example, 50-year-olds in our system have fewer heart attacks.

"With the right information and the right incentives," he added, "capitalism creates very good solutions."
http://www.nytimes.com/2004/10/31/business/yourmoney/31hmo.html?ex=1100314481&ei=1&en=a720d916f41f770c

As Hospitals Scramble to Meet New Workday Limits for Residents, Studies Highlight Risks of Fatigue

The Wall Street Journal
[October 28, 2004]
By LAURA LANDRO

After two decades of efforts to reduce medical errors made by sleep-deprived doctors-in-training, the problem persists, and new research is providing compelling evidence of the risks involved.

Two studies being published today show that first-year residents in hospital intensive-care and coronary-care units who worked longer than the mandatory limit of 80 hours a week made significantly more serious medical errors, had more lapses in attention, and were more fatigued than those who worked fewer hours and got more sleep.

The errors, which ranged from prescribing dangerously high doses of medication to incorrect diagnoses to difficulty inserting catheters, were mostly intercepted by other medical staffers, and no patient came to harm. But the results are likely to give a powerful boost to the movement to scale back the marathon work schedules that have been a time-honored tradition of medical training.

While numerous studies have tied sleep deprivation to medical mistakes by doctors and nurses, this research conducted at Boston's Brigham and Women's Hospital from July 2002 to June 2003 and published in the New England Journal of Medicine, is the first rigorously designed trial to compare the traditional long work schedules of first-year residents with a less demanding program that is significantly shorter than current guidelines. The shorter schedule is the focus of the Harvard Work Hours, Health and Safety Study group, which conducted the research.

The issue of residents' work hours first bubbled up in the 1980s, when New York state imposed strict work hours following the highly publicized hospital death of a young woman in New York City, Libby Zion. Ms. Zion's family contended that her death was caused at least in part by overtired residents who treated her in the ER. The Accreditation Council for Graduate Medical Education, which oversees residency programs, subsequently developed hours standards for some specialties, but they were never strictly imposed; residents often continued to work 100 or more hours per week.

In recent years, residents and medical students began clamoring for stricter standards, advocating legislation to limit resident hours and support whistle-blowers. ACGME moved last July to impose hour rules for all medical residency programs, including an 80-hour weekly limit, averaged over four weeks, and a 24-hour limit on continuous duty -- with up to six extra hours for "continuity of care and education." A bill is pending in Congress that would legally restrict hours.

Hospitals have been scrambling to meet the new ACGME rules without compromising training. But some hospitals continue to circumvent them. The issue remains one of intense emotional debate in the medical profession, where many doctors who themselves were trained under more intense hours worry that new doctors won't be adequately educated.

A "cowboy mentality" in the medical profession regarding the need for punishing work hours is the "Achilles heel of the U.S. medical system," says Charles A. Czeisler, chief of the Division of Sleep Medicine, Brigham and Women's Hospital, who led the studies. "The practice of working 30-hour shifts, when residents are hanging on to wakefulness by their fingernails," is unsafe.

The primary study looked at interns (as first-year residents are commonly known) in intensive-care and cardiac-care units. Researchers compared the error rates of interns working more than 80 hours weekly on extended work shifts of 24 hours or more every third night, to those working

on the Harvard study group's reduced schedule that eliminated extended shifts and reduced the number of scheduled hours weekly to 63. On the longer schedule, the interns made 36% more serious errors, including 21% more serious medication errors, and 5.6 times the number of diagnostic errors.

In most cases, errors identified by observers were promptly addressed by medical staff, the study says. In one case, for instance, an intern prepared to use a needle to remove fluid in a patient's chest cavity on left side when it should have been on the right. A senior resident intercepted, averting a problem.

In the second study, ICU and cardiac-care interns wore special electrodes while working to track "attentional failures" -- measuring eye movements that indicate a level of fatigue so profound that it leads to errors or missteps in performance, such as not completing a physical exam, according to Christopher Landrigan, a co-author of the study. During night work, the number of "attentional failures" occurred at more than double the rate on the traditional schedule than on the reduced schedule, researchers found.

Interns on the reduced schedule were also less sleep-deprived and took shorter sleep breaks during work hours, and were able to sleep longer during nonwork hours.

Some medical specialists still maintain that limiting residents to an 80-hour workweek can actually hurt patient care by cutting short hands-on training. "Eighty hours a week is too short a time for surgery residents to provide excellent care or provide continuity of care," says Josef E. Fischer, chairman of the Department of Surgery at Boston's Beth Israel Deaconess Medical Center. Dr. Fischer maintains that a 90- to 92-hour workweek is essential for complete surgical training.

Peter Carmel, head of the department of neurosurgery at the New Jersey Medical School in Newark and a member of the American Medical Association board of trustees, says, "The AMA supports the work rules and it is important that the patient be safe. But it is important for the public to realize that for every change you make there is a cost." He notes that his department has had to lengthen the training program for neurosurgeons to six years from five to ensure doctors get the necessary training.

Many students, however, support shorter hours. Less-exhausting schedules will create better doctors, instead of "turning out bitter and jaded people less able to connect with patients," says Brian Palmer, a Mayo Medical School graduate and president of the American Medical Students' Association.

David Leach, executive director of the ACGME, says the group is continuing to refine standards for resident care and look at other factors that affect training, such as teamwork. He suggests that patients ask if doctors caring for them are first-year residents, and if so, how closely they are supervised by chief residents and faculty. Patients can also ask residents directly how much sleep they've had and what their call schedule is for the month.

According to the ACGME, which accredits 8,000 programs, just 5% of the 2,027 programs it reviewed during the 2003-2004 academic year received one or more citations for noncompliance with the duty hours program. But the group says a recent survey of residents found a few programs where the majority of residents worked significantly beyond duty limits.

Last year, ACGME revoked the accreditation of several programs, but restored them after violations were corrected. (Physicians can't be board certified unless they have completed an accredited program.)

Health Policy News:

Congress Adjourns for Election; Leaves Spending Bills in Limbo

Congress has adjourned until after the election, putting off final decisions on domestic spending for FY 2005 until at least mid-November when the House and Senate return to Washington for a lame duck session. Prior to adjourning, Congress completed action on only four of the 13 regular appropriations bills. The chairmen of both the House and Senate Appropriations Committees have been predicting for months that the combination of tight spending limits and a congressional schedule compressed by primaries and the conventions would make it difficult to pass any spending bill other than those covering essential defense and homeland security efforts before the election. As a result, non-defense federal programs are currently operating under a continuing resolution (CR) that provides funding at FY 2004 levels through Nov. 20.

New GAO Report Analyzes Proposed Changes to Medicare Physician Payment Formula

The Government Accountability Office (GAO) Oct. 8 issued a report that concludes that any of the recently proposed changes to the Sustainable Growth Rate (SGR) system used to calculate Medicare physician payments "could be implemented in a way that would likely generate positive fee updates." The report, entitled "Medicare Physician Payments: Concerns About Spending Target System Prompt Interest in Considering Reforms" (GAO-05-85), was required under the Medicare Modernization Act (MMA) and delivered to the House and Senate Cmmittees that oversee the Medicare program, also advises that any change to the SGR system "will be very expensive" and would increase Medicare spending on physician services from 4 to 23 percent during CY 2005 - CY 2012, depending on the type of change.

Clinical Trials Database Proposed

Legislation to establish a database for all clinical trials and their results was introduced Oct. 7 in both the House and Senate. The Fair Access to Clinical Trials (FACT) Act (S. 2933/H.R. 5252) would apply to clinical trials for drugs, biological products and medical devices, and would require researchers to report all results as well as information for patients seeking to enroll in studies.

Malpractice on the national level

Med mal rate increases slow down a little.

Modern Healthcare
[October 22, 2004]
By MICHAEL ROMANO

While rates for medical malpractice insurance appear to be leveling off slightly, triple-digit increases continue, and many physicians are paying more than ever before for their coverage, according to the 2004 national survey from the Chicago-based Medical Liability Monitor. The publication, an independent newsletter that has surveyed providers of medical liability since 1991, found that the majority of rate increases were between about 7% and 25% -- lower than the range of approximately 10% to 49% in the 2003 survey.

Still, physicians, especially those in high-risk specialties, are paying more than ever before for insurance, according to the survey. While obstetricians in Dade County, Fla., experienced an 11% rate hike, their annual premiums reached $277,241, one insurer reported. Illinois obstetricians are paying as much as $230,428, the report said.

"This year, we're seeing increases leveling off in the 7% to 25% range, but at historically high amounts," said Monitor editor Barbara Dillard.

The publication, which reports rates from 45 companies -- or about 75% of the physician malpractice- insurance market -- also noted that many companies are continuing restrictive underwriting practices, imposing moratoriums on new business or declining to renew physicians in some areas.

The survey included rates for internists, OB/GYNs and general surgeons. Of the 788 rate changes listed in the survey, only 34 were decreases, while 104 rates remained unchanged.

Texas D.O.'s and leading roles in AOA

Louis Pincus, DO, of Dallas, TX, and the ACOI is representing the AOA today and tomorrow at the American Medical Association's National Summit on Obesity being held in Chicago.

Objectives for the Summit

Meeting include outlining a strategic plan for the prevention, assessment, and management of obesity; identifying partnerships for strategic plan implementation; and ideas to draw national attention to the urgency for action. Meanwhile in Savannah, GA, Royce Keilers, DO, will be

representing the AOA at the American Diabetes Association Meeting that was rescheduled following September's hurricanes in the region.

TOP HEALTH OFFICIALS SIGNED AN AGREEMENT WITH A TEXAS NONPROFIT GROUP TO EDUCATE MIGRANTS ABOUT DISEASE PREVENTION AND FREE HEALTH CARE PROVIDERS IN THE UNITED STATES, TO LESSEN THEIR RELIANCE ON OVERTAXED HOSPITAL EMERGENCY ROOMS.

The agreement between the Mexican Social Security Institute and the National Center for Farmworker Health, based in the Austin area, aims to familiarize migrants with a network of community clinics in the United States, reported the San Antonio Express-News. The plan includes exchanging bilingual health education materials and distributing a pocket directory that lists about 500 community clinics throughout the
United States, the Express-News added.

San Antonio Express-News, October 12, 2004
<http://www.mysanantonio.com/news/medical/stories/MYSA101204.08A.mexico_u>
s_health.10dedd12a.html

THE NATION'S FEDERAL HEALTH CENTERS ARE EXPERIENCING A SURGE IN UNINSURED PATIENT VOLUME.
The centers saw an 11 percent increase in uninsured patients last year, while 40 percent of the 12.4 million people treated in such centers in 2003 had no health insurance, reported the Inquirer. Congress has been increasing funding for the nation's 3,600 clinics with a goal of 1,200 new or expanded centers by 2006 – an expansion that would serve about six million more people, reaching a 16 million total when it is complete, the Inquirer added.

Philadelphia Inquirer, October 25, 2004
<http://www.philly.com/mld/inquirer/news/front/10008208.htm>

Study questions safety of expanding angioplasty
Patients who underwent coronary angioplasty in hospitals without an on-site cardiac surgery program had a 29% increased risk of mortality compared with patients who underwent the procedure in hospitals with an on-site program, according to a study led by Dartmouth Medical School researchers. The study examined the outcomes of coronary angioplasty for more than 600,000 Medicare patients from 1999 to 2001. "Our findings suggest that the current 'wave' to move (angioplasty) into hospitals that don't have coronary artery bypass surgery programs should be questioned," said David Wennberg, the study's lead author and an adjunct associate professor at Dartmouth. The study was published in this week's Journal of the American Medical Association.

Texas State Health Plan released

The Statewide Health Coordinating Council has just released its State Health Plan for the coming 5 years. Below are links to the Executive Summary and Parts 1 and 2. The general recommendations are in the summary and contain some recommendations of interest to our members.

10/28 Texas State Health Plan Executive Summary
<http://209.99.68.131/library/2004102801.PDF>
10/28 Texas State Health Plan Part 1
<http://209.99.68.131/library/2004102802.PDF>
10/28 Texas State Health Plan Part 2
<http://209.99.68.131/library/2004102803.PDF>

Research and Funding Opportunities:

NIH Guide for Grants and Contracts - Week of October 29, 2004
http://grants.nih.gov/grants/guide/WeeklyIndex.cfm?WeekEnding=10-29-04

Notices

Review of Ranking Data
(NOT-OD-05-008)
National Institutes of Health
http://grants.nih.gov/grants/guide/notice-files/NOT-OD-05-008.html

HLA Region Genetics in Immune-Mediated Diseases - Addendum to
RFA-AI-04-039
(NOT-AI-05-005)
National Institute of Allergy and Infectious Diseases
http://grants.nih.gov/grants/guide/notice-files/NOT-AI-05-005.html

Request for Information (RFI): Live Organ Donor Outcomes and Medical Needs
(NOT-AI-05-006)
National Institute of Allergy and Infectious Diseases
Health Resources and Services Administration
National Heart, Lung, and Blood Institute
National Institute of Diabetes and Digestive and Kidney Diseases
http://grants.nih.gov/grants/guide/notice-files/NOT-AI-05-006.html

Request for Information (RFI) Therapeutics to Treat Neutropenia and Thrombocytopenia Associated with the Acute Radiation Syndrome (ARS)
(NOT-AI-05-007)
Department of Health and Human Services
http://grants.nih.gov/grants/guide/notice-files/NOT-AI-05-007.html

Rapid Access to Intervention Development (RAID)
(NOT-CA-05-003)
National Cancer Institute
http://grants.nih.gov/grants/guide/notice-files/NOT-CA-05-003.html

NIDA Policy Update for Career Development Awards (K Awards)
(NOT-DA-05-001)
National Institute on Drug Abuse
http://grants.nih.gov/grants/guide/notice-files/NOT-DA-05-001.html

Notice of Limited Competition for Competing Applications: Continuation of the Family Investigation of Nephropathy and Diabetes (FIND) Study
(NOT-DK-05-001)
National Institute of Diabetes and Digestive and Kidney Diseases
http://grants.nih.gov/grants/guide/notice-files/NOT-DK-05-001.html

Planning Grants for Regional Translational Research Centers
Pre-Application Meeting
(NOT-RM-05-001)
NIH Roadmap Initiatives
http://grants.nih.gov/grants/guide/notice-files/NOT-RM-05-001.html

Requests for Applications

Typical/Disordered Language: Phenotype Assessment Tools
(RFA-DC-05-001)
National Institute on Deafness and Other Communication Disorders
National Institute of Child Health and Human Development
Application Receipt Date(s): February 24, 2005
http://grants.nih.gov/grants/guide/rfa-files/RFA-DC-05-001.html

Site Specific Approaches to Prevention or Management of Pediatric Obesity
(RFA-DK-04-013)
National Institute of Diabetes and Digestive and Kidney Diseases
National Cancer Institute
Office of Behavioral and Social Science Research
Office of Disease Prevention
Application Receipt Date(s): January 24, 2005
http://grants.nih.gov/grants/guide/rfa-files/RFA-DK-04-013.html

Specialized Cooperative Centers Program in Reproduction Research
(RFA-HD-04-030)
National Institute of Child Health and Human Development
Application Receipt Date(s): June 13, 2005
http://grants.nih.gov/grants/guide/rfa-files/RFA-HD-04-030.html

Small Research Grants for Primary Care Practice-Based Research Networks (PBRNs)
(RFA-HS-05-011)
Agency for Healthcare Research and Quality
Application Receipt Date(s): January 19, 2005
http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-05-011.html

The Centers for Education and Research on Therapeutics (CERTs)
(RFA-HS-05-014)
Agency for Healthcare Research and Quality
Application Receipt Date(s): March 11, 2005
http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-05-014.html

Strengthening Behavioral and Social Science in Medical Schools
(RFA-OD-05-001)
Office of the Director, NIH
National Center for Complementary and Alternative Medicine
National Cancer Institute
National Heart, Lung, and Blood Institute
National Institute of Arthritis and Musculoskeletal and Skin Diseases
National Institute of Child Health and Human Development
Office of Behavioral and Social Science Research
Application Receipt Date(s): January 19, 2005
http://grants.nih.gov/grants/guide/rfa-files/RFA-OD-05-001.html

Novel Preclinical Tools for Predictive ADME-Toxicology
(RFA-RM-04-023)
NIH Roadmap Initiatives
Application Receipt Date(s): January 21, 2005
http://grants.nih.gov/grants/guide/rfa-files/RFA-RM-04-023.html

INTERNATIONAL COOPERATIVE BIODIVERSITY GROUPS (ICBG)
(RFA-TW-04-004)
John E. Fogarty International Center
National Center for Complementary and Alternative Medicine
National Cancer Institute
National Heart, Lung, and Blood Institute
National Institute of Allergy and Infectious Diseases
National Institute on Drug Abuse
National Institute of General Medical Sciences
National Institute of Mental Health
National Science Foundation
Office of Dietary Supplements
Application Receipt Date(s): February 15, 2005
http://grants.nih.gov/grants/guide/rfa-files/RFA-TW-04-004.html

Program Announcements

Research on the Economics of Diet, Activity, and Energy Balance
(PA-05-009)
National Cancer Institute
National Institute on Aging
National Institute of Biomedical Imaging and Engineering
National Institute of Diabetes and Digestive and Kidney Diseases
Office of Behavioral and Social Science Research
Application Receipt Date(s): Multiple dates, see announcement.
http://grants.nih.gov/grants/guide/pa-files/PA-05-009.html

Cooperative Drug Development Group (CDDG) for the Treatment of
Mental Illness
(PAR-05-010)
National Institute of Mental Health
Application Receipt Date(s): Multiple receipt dates: April 15, 2005,
2006, 2007
http://grants.nih.gov/grants/guide/pa-files/PAR-05-010.html

Quotes:

Only the wisest and stupidest of men never change.
Confucius

It may be hard for an egg to turn into a bird: it would be a jolly sight harder for it to learn to fly while remaining an egg. We are like eggs at present. And you cannot go on indefinitely being just an ordinary, decent egg. We must be hatched or go bad.
C. S. Lewis

You must be the change you wish to see in the world.
Mohandas Gandhi

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