Dean's Corner e-Newsletter

Texas College of Osteopathic Medicine

April 1, 2008

March has been an exciting month for the Health Science Center and your Texas College of Osteopathic Medicine. Our window to the world, the web site has received a new make over and the feedback has been great! Thanks to the Information Systems and Marketing departments for their hard work and efforts making this transition a reality.

An unbelievable number of our faculty were recognized as *Top Doctors* by **Fort Worth, Texas** Magazine in their April edition. Those physicians were:

Ralph Anderson, MD
Barbara Atkinson, DO
Sam Buchanan, DO
Brian Carpenter, DPM
Thomas Dayberry, DO
Gary Etter, MD
Arnold Fikkert, DO
John Fling, MD
Alan Garrett, DPM
Long Hoang, DO
Janice Knebl, DO
Marianne Levine, DO
David Lichtman, MD
Salvatore LoCoco, MD
R.L. Marshall, MD
Sarah Matches, DO
Alvin Mathe, DO
William McIntosh, DO
Arvind Nana, MD
Carol Nati, MD
Alan Podawiltz, DO
Bernard Rubin, DO
Brent Sanderlin, DO
Mark Sanders, DO
Phillip Saperstein, DO
Lynn Speaks, DO
Brian Tobias, DO
Monte Troutman, DO
Martin Weiss, DO

Congratulations to each of the award winners! This recognition by their peers is a great statement of the quality of all of our clinical faculty at the Texas College of Osteopathic Medicine. I appreciate what each of our faculty do to make TCOM a superb academic and clinical program.

In addition, the 15th Annual Research Appreciation Day was held on April 6. I am going to add to the suspense by having you go to the Clinical Research and PA Studies section to see the winners' names! But I will tell you that I am proud of the ever increasing quality of the scientific projects presented at our annual event. In fact, many of the abstracts are of a quality to be published in a peer-reviewed journal. This year there were a total of 194 poster presentations, with 53 coming from students, residents, and faculty from the Texas College of Osteopathic Medicine.

And finally, TCOM has been recognized for the seventh consecutive year as a Top Medical School in Primary Care by **US News and World Report**. This recognition

comes from our commitment to primary care education, research and service. However, we could not achieve this level of recognition without our world class faculty and staff; our excellent students and residents; and our accomplished alumni, for without our "family" TCOM would not garner national recognition.
I am proud and thankful to be your Dean!

Marc B. Hahn, Do
Senior Vice President for Health Affairs & Dean

Please supply any pertinent information to my office (deantcom@hsc.unt.edu) for inclusion in future newsletters.

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Student Affairs

Thomas Moorman, EdD
Associate Vice President for Student Affairs

Student Health Clinic

CBH 113
Hours of Operation
Monday, Thursday, Friday: 8:00 – 11:00 am
Tuesdays and Wednesdays: 8:00 am – 5:00 pm
Closed for lunch daily from Noon – 1:00 pm.
817-735-5051

Appointments can be made by contacting the clinic receptionist directly at (817) 735-5051. Students will be seen by appointment only in the Student Health Clinic. All students will be seen in the CBH unless referred to the Central Clinic by the doctor. Students' office visits are free; additional out-of-pocket expenses will be incurred for services such as testing, lab fees and ex-rays. Payment can be made in the form of cash, check, or major credit cards. Tuberculosis testing is free and immunizations are administered at a discount rate for students. Female students may request their well-woman exams be administered by a female physician or

Nurse Practitioner when available. Please be prompt to appointments as clinic doors are electronically operated on a time schedule.

The Common Scholarship Application
The Financial Aid Office is happy to announce the new interactive University of North Texas Health Science Center General Scholarship application. By completing this one application, students' eligibility for all university administered scholarships will be considered. The application may be found online at http://www.hsc.unt.edu/departments/financialaid/ScholarshipApplications1.htm and must be submitted no later than April 5, 2008. For additional information, please contact the Financial Aid Office at scholarships@hsc.unt.edu or 817-735-2505.

DO Class of 2008 Awards Banquet
The annual TCOM Senior Awards Banquet is scheduled for Wednesday, May 14, 2008 from 6:00 – 10:00 p.m. at the Fort Worth Club. Faculty and staff are encouraged to come and celebrate the accomplishments of this year's graduating D.O. class. Tickets will go on sale in the near future. Watch the daily news for more information.

Field Day
"Field Day 2008" is scheduled for Saturday, May 10 at the Lockheed Martin Recreation Association (LMRA) on Bryant Irvin in Fort Worth. The purpose of this event is to bring students, faculty, and staff together to get know each other better and to encourage friendly competition. Many activities are planned including a volleyball tournament, kickball, human foosball, tug-o-war, three-legged races, jousting, and many more. The day will conclude with a celebration/awards picnic at a pavilion. Everyone at UNTHSC is welcome and encouraged to come and admission is free! Children's activities will also be available. More information will be coming out soon!

Boot Party: DO Class of 2010
The Texas College of Osteopathic Medicine's Class of 2010 is nearing the end of their second year. Holding with TCOM tradition, they will be celebrating with their very own Boot Party. The tradition of Boot Party developed as the second year class is "booted" from the classroom to the clinics for their third year. The Class of 2010 will be holding their Boot Party at The Ashton Depot in downtown Fort Worth. The historic Aston Depot is a Recorded Texas Historic Landmark that previously served as the Santa Fe railroad depot for Fort Worth. It was restored in the 1990's to be used as an event venue and it is a true example of Fort Worth flair. The event will be held May 23, 2008 on the last day of class. It will be a night to remember before the Class of 2010 embarks on the next stage of their journey on the road to becoming physicians.

Boot Party: PA Class of 2009
On March 28, 2008, the PA class of 2009 will hold their boot party at Joe T. Garcia's. This is the final gathering of the PA class before they are "booted" out and into clinical rotations. The PA boot party tradition was adopted from the DO program. This party marks the ending of their didactic training and the beginning

of their clinical experience. This is the last time for the class to have a fun evening before they embark on their final year at the UNTHSC PA program.

Commencement 2008
The Commencement Ceremony for the University of North Texas Health Science Center will be at 2:00 pm on Saturday, May 17, 2008 at the Fort Worth Convention Center, 1201 Houston Street, Fort Worth, Texas. Our Commencement speaker will be Rear Admiral (Ret.) Kenneth P. Moritsugu, M.D., MPH, FACPM. Dr. Moritsugu is Former Deputy Surgeon General, Former Acting Surgeon General, and is currently serving as Chairman of the Johnson & Johnson Diabetes Institute. All graduates need to attend rehearsal at 9:00 am on Saturday, May 17. Class pictures will be taken at the Fort Worth Water Gardens, so bring your regalia.

Clinical Affairs/Faculty Practice

Robert Adams, DO
Senior Associate Dean for Clinical Affairs/Chief Medical Officer

No articles for April 2008

Educational Programs

Don Peska, DO
Associate Dean for Educational Programs

We recently traveled to Driscoll Children's Hospital in Corpus Christi, Texas to present a faculty development workshop to our Texas OPTI faculty in south Texas. Our guest speakers included *Hershey Bell, M.D.,* Clinical Professor of Family Medicine and Associate Dean of Faculty Development and Evaluation at Lake Erie College of Osteopathic Medicine (LECOM), and *Roy Martin, D.Min*., Assistant Professor of Clinical Ethics at the University of North Texas Health Science Center. Dr. Bell's presentation was titled, "The Best of 'For the Office-Based Teacher' Series". He focused on myths regarding teaching medical students, priming students for effective clinical teaching, and evidence-based office teaching. Dr. Martin's presentation was titled, "Ethics: A Teachable Perspective." He spoke about the student's interpretation of what is considered ethical in clinical situations, as well as effective methods of teaching ethics to our students and residents. The faculty development workshop was well attended and we anticipate repeating this topic for our Texas OPTI associates in the DFW and Houston/ Galveston areas by the end of the year.

We are extremely proud of the Class of 2008 and their academic achievements. Several members of the class matched at our Texas OPTI affiliate institutions. We look forward to working with them in the future as they embrace their new positions as residents and interns. Approximately 95 percent of the class who applied for the National Residency Matching Program matched to the specialties which they selected. We wish them all the very best in their future endeavors!

Eryn Loney, M.L.A.
Director of Program Development

Academic Affairs

Bruce Dubin, DO, JD
Associate Dean for Academic Affairs

This year we have piloted new “honors elective” courses for second year medical students. These programs have been greatly received and we are planning on increasing the number and type of offerings during the next academic year.

First year student grand rounds are a tremendous success. Approximately every two weeks a panel of first year medical students are presenting case reports from the New England Journal of Medicine. The students present and in depth review of the case and the pathophysiology surrounding the article. These are open to everyone. Please join the class of 2011 for their next presentation.

PA Studies

Hank Lemke, PA
Chair of PA Studies

New Positions Created In PA Studies

Two new positions have been announced in the Department of PA Studies to facilitate growth of the PA program and to offer career progression opportunities for faculty in the department. **PA Patti Pagels** has been appointed Vice Chair of Clinical Affairs and **PA Christopher Cooper** has been appointed Vice Chair of Academic Affairs. These two positions report directly to the chairman. As their titles imply, they share responsibilities for program expansion, maintenance, and curriculum supervision in their respective arenas with the chairman. PA Pagels is actively working with other clinical departments to expand opportunities for PA faculty there, while simultaneously providing oversight of PA clinical rotations in her role as clinical education coordinator. PA Cooper intensifies his role in providing oversight to the nearly 19-months of didactic studies in the MPAS curriculum.

PA Program Faculty Search

The Department of PA Studies continues its recruiting efforts for more PA faculty. PA faculty must hold NCCPA certification and Texas PA licensure. We are interested in partnering with clinical departments to create positions that allow PA faculty to provide clinical services for much of the week and provide teaching support during other times.

Student News

Nineteen (19) PA students presented 10 posters at the UNTHSCs 16th Annual Research Appreciation Day in March - congratulations to them and their faculty advisors. UNTHSC PA students recently competed in the Texas Academy of Physician Assistants Regional Challenge Bowl, taking second place. Three UNTHSC teams competed with teams from other PA programs in Texas.

Members of this second-placing team will go on to compete at the American Academy of Physician Assistants National PA Challenge Bowl, scheduled in May of this year in San Antonio. We just know you'll do a great job representing our school there!

Clinical Research

John Licciardone, DO, MS, MBA
Acting Associate Dean for Clinical Research

Congratulations to all TCOM faculty, fellows, residents, students, and staff who submitted posters and participated in the annual Research Appreciation Day (RAD) on March 28, 2008. Particular acknowledgments go to the following for their poster presentation awards:

First Place: Devin Flaherty
Title: Improved Fluid Resuscitation With Pyruvate-Fortified Ringer's for Hemorrhagic Shock and Hindlimb Ischemia

Second Place: Alan Lewis
Title: Texas Rural Automated External Defibrillator (Aed) Placement: Making A Difference

Third Place: Darcie Weilbacher and Laura Barratt
Title: Do Texas Physician Assistants Interpret Plain-Film Radiographs In Clinical Practice?

The American Osteopathic Association's Council on Research is now accepting abstracts for poster presentations at its 52nd Annual **AOA Research Conference** in Las Vegas, Nevada, in conjunction with its Annual Convention and Scientific Seminar. The conference's poster session is scheduled for Sunday, October 26, from 1-5 pm at the Las Vegas Sands Convention Center. Information is available at: www.do-online.org, "Research and Grants." The deadline date for receipt of abstracts is April 30, 2008.

Admissions

Russell Gamber, DO, MPH
Assistant Dean of TCOM Admissions & Outreach

Update on TCOM Entering Class of 2008
We continue to finalize the acceptances of the Entering Class of 2008 and anticipate seating a very competitive group of 175 freshmen students, based on the current number of acceptance letters returned to us. Admissions staff is working with Student Affairs as we prepare to turn over the entering students' records to the Registrar.

File Reviews
TCOM Admissions counselors are currently conducting file reviews for applicants who did not match in medical school this year. The advisors read each file to

determine strengths and weaknesses and make written suggestions for specific actions that would strengthen the applicants' next attempt to enter medical school. Each spring dozens of files are reviewed as a service to our applicants.

Outreach Update

College and University Recruiting Activities: The office has been actively recruiting around the state, visiting colleges and universities to increase TCOM's presence and attract talented students to both our D.O. and P.A. programs. The annual "Texas Swing," the major spring recruiting event for Texas universities, took place February 18-22, 2008. TCOM Admissions counselors visited the University of Houston, Texas A&M University, the University of Texas at Austin, and the University of Texas at San Antonio, where they met with students interested in health professions careers. There are 14 additional campus recruiting visits scheduled throughout the spring. TCOM Admissions hosted a campus tour for the TCU chapter of the national premedical honor society, Alpha Epsilon Delta, in February, and for the UNT AED chapter in March.

Participation in National Meetings: Mike Kennedy, Joel Daboub, and Dr. Russell Gamber participated in the Alpha Epsilon Delta national meeting held at the Grapevine Hilton March 6-7, 2008. Messrs. Kennedy and Daboub held an interactive workshop with AED members to highlight how admissions offices screen applications for medical school. Dr. Gamber and four freshman TCOM students, Steven Ratcliff, Amanda Moody, Candice Nolan, and Noah Stratton, gave a demonstration of osteopathic manipulative techniques. TCOM Admissions staff members also represented the medical school at the Student National Medical Association annual conference in New York March 22-23, 2008, and at the American Medical Student Association national meeting held in Houston March 12-16, 2008.

Middle School Campus Tours: Kellee Randle and April Enard, both second year TCOM medical students and officers in the TCOM chapter of the Student National Medical Association, hosted campus tours for a group of 102 eighth grade students from Dunbar Middle School in Fort Worth on February 14, 2008. While on campus they visited the simulation laboratory, the anatomy laboratory, the PTRs, and they had lunch in Luibel Hall. April and Kellee previously sponsored a group of 60 sixth grade students, also from Dunbar Middle School, on November 2, 2007.

High School Campus Tours: TCOM Admissions continues to sponsor TCOM campus tours for area high school pre-health professions groups. On March 14th we hosted students from the Advanced Placement Biology class from Cooper High School in Abilene, Texas, and on March 19th we welcomed a group of area high school students who participate in the United Community Centers' after-school enrichment program in Fort Worth. The highlight of these visits was the tour of the gross anatomy laboratory, during which Dr. Harold Sheedlo introduced the students to the computer-assisted gross anatomy course, and the simulation lab where Dr. Jerry Friedman demonstrated the use of the simulation mannequins as an adjunct in teaching key medical skills.

Other News

Science and Health News

Washington Times Opinion Piece Examines Five Health Care 'Myths'

March 21, 2008

Some popular talking points politicians discuss in the health care debate "pass as the gospel truth" because "they're popular -- not because they're true," Sally Pipes, president and CEO of Pacific Research Institute and author of "Miracle Cure: How to Solve America's Health-Care Crisis and Why Canada Isn't the Answer," writes in a Washington Times opinion piece. The "five most prominent health care myths" according to Pipes are:

* "Forty-seven million Americans do not have health insurance": Although the U.S. Census Bureau indicates that 47 million U.S. residents do not have health insurance, that figure "counts anyone who went without health insurance during any part of the previous year as 'uninsured,'" meaning that "if you weren't covered for just one day in 2007, you're one of the 47 million," Pipes writes. According to Pipes, the figure also includes "10.2 million illegal immigrants and about 14 million people who are eligible for public health care programs like Medicaid or [SCHIP] but have yet to enroll," as well as about 10 million in households with incomes of more than $75,000 who "could probably afford to buy health insurance."

* "Universal health care coverage can be achieved via 'individual mandate'": According to Pipes, nearly two-thirds of uninsured people are ages 18 to 34, which "makes sense" because "healthy people aren't going to pay for expensive insurance they'll never use." Pipes adds that a mandate system would not work because many states require insurers to charge everyone the same rate. As a result, healthier individuals would pay "far more in premiums than they should -- or could -- pay," Pipes writes, adding that it is "patently unfair to force people to purchase insurance they can't afford."

* "Expensive prescription drugs are a big reason health care costs increase": Pipes writes that the "real price of prescription drugs is actually decreasing," as drug prices are increasing at a rate slower than inflation. She adds that "drug spending is but a small slice of total health care spending -- less than 11 cents out of every health care dollar goes to prescription meds." In addition, Pipes writes that "drugs actually reduce health care costs in the long term," noting that Medicare saves $2.06 for each dollar spent on prescription drugs and that prescription drugs "often obviate the need for expensive surgeries and hospital stays."

* "Drug importation will save patients a fortune": Pipes notes that foreign drug reimportation "at most" would save U.S. residents 1% over the next 10 years, according to the Congressional Budget Office.

* "The state-run health care systems in Canada and Europe are better and cheaper than America's": Pipes cites a 2007 study in the British medical journal the Lancet that found people in the U.S. have better survival rates in 13 of the 16 "most prominent" cancers and that American males with cancer have nearly a 20% better chance of surviving five years after being diagnosed with the disease than European males (Pipes, Washington Times, 3/21).

Associated Press / London
WHO Says Drug-Resistant TB Spreads Fast
By Maria Cheng
February 26, 2008

Drug-resistant tuberculosis is spreading even faster than medical experts had feared, the World Health Organization warned in report issued Tuesday.

The rate of TB patients infected with the drug-resistant strain topped 20 percent in some countries, the highest ever recorded, the U.N. agency said.

"Ten years ago, it would have been unthinkable to see rates like this," said Dr. Mario Raviglione, director of WHO's "Stop TB" department. "This demonstrates what happens when you keep making mistakes in TB treatment."

Though the report is the largest survey of drug-resistant TB, based on information collected between 2002 and 2006, there are still major gaps: Data were only available from about half of the world's countries.

In Africa, where experts are particularly worried about a lethal collision between TB and AIDS, only six countries provided information.

"We really don't know what the situation is in Africa," Raviglione said. "If multi-drug resistant TB has penetrated Africa and coincides with AIDS, there's bound to be a disaster."

Raviglione said it was likely that patients - and even entire outbreaks of drug-resistant TB - were being missed.

Experts also worry about the spread of XDR-TB, or extensively drug-resistant TB, a strain virtually untreatable in poor countries. When an XDR-TB outbreak was identified in AIDS patients in South Africa in 2006, it killed nearly every patient within weeks. WHO's report said XDR-TB has now been found in 45 countries.

Globally, there are about 500,000 new cases of drug-resistant TB every year, about 5 percent of the 9 million new TB cases. In the United States, 1.2 percent of TB cases were multi-drug resistant. Of those, 1.9 percent were extensively drug-resistant.

The highest rates of drug-resistant TB were in eastern Europe. Nearly a quarter of all TB cases in Baku, Azerbaijan, were drug-resistant, followed by about 20 percent in Moldova and 16 percent in Donetsk, Ukraine, WHO said.

High rates of drug-resistant TB were also found in China and India, the world's two most populous nations that together are home to half the world's cases.

Drug-resistant TB arises when primary TB treatment is poor. Countries with strong treatment programs, like the U.S. and other Western nations, should theoretically have very little drug-resistant TB.

That is not the case in China, however, where the government says 94 percent of TB patients complete their first TB treatment.

"There's a huge, gross discrepancy there if they are then reporting 25 percent of the world's multi-drug resistant TB cases," said Mark Harrington, executive director of Treatment Action Group, a public health think tank. "They are clearly nurturing a multi-drug resistant TB epidemic and failing to report XDR-TB at all."

With growing numbers of drug-resistant TB patients, there is concern some national health systems will soon be overwhelmed.

"We are totally off track right now," said Dr. Tido von Schoen-Angerer, executive director of Medecins Sans Frontiere's Campaign for Access to Essential Medicines. He said only 30,000 multi-drug TB resistant patients were treated last year.

Experts said new drugs are needed if the outbreak is to be curbed, along with new diagnostic tests to identify drug-resistant TB strains faster - current tests take about a month for results.

WHO said a new diagnostic test able to provide results within a day is being tried in South Africa and Lesotho. If successful, the test could be introduced across Africa in a few months, though new labs would be needed to run the tests.

"Multi-drug resistant TB is a threat to every person on the planet," Harrington said. "It's not like HIV, where you are only infected through specific actions. TB is a threat to every person who takes a train or a plane."

New York Times
February 21, 2008
Justices Shield Medical Devices From Lawsuits
By Linda Greenhouse

WASHINGTON - Makers of medical devices like implantable defibrillators or breast implants are immune from liability for personal injuries as long as the Food

and Drug Administration approved the device before it was marketed and it meets the agency's specifications, the Supreme Court ruled on Wednesday.

The 8-to-1 decision was a victory for the Bush administration, which for years has sought broad authority to pre-empt tougher state regulation.

In 2004, the administration reversed longstanding federal policy and began arguing that "premarket approval" of a new medical device by the F.D.A. overrides most claims for damages under state law. Because federal law makes no provision for damage suits against device makers, injured patients have turned to state law and have won substantial awards.

The Bush administration will continue its push for pre-emption in another F.D.A. case that the court has accepted for its next term, on whether the agency's approval of a drug, as opposed to a device, pre-empts personal injury suits. Drugs and medical devices are regulated under separate laws.

The case before the court concerned only medical devices that had gone through the premarket approval process specified by the Medical Device Amendments of 1976. Most devices now available reached the market through a different process, under which the F.D.A. found them to be "substantially equivalent" to those marketed before the 1976 law took effect.

The Supreme Court ruled in 1996 that this less rigorous approval process does not pre-empt state damage suits against the manufacturers of "grandfathered" devices.

Devices subject to the premarket approval process, and thus affected by the court's opinion, tend to be more technologically advanced, expensive and, in some instances, risky.

Examples of devices that have been the subjects of recent lawsuits include an implantable defibrillator, a heart pump, a spinal cord stimulator, a drug-coated stent, an artificial heart valve, and prosthetic hips and knees.

It was not immediately clear how many of the thousands of lawsuits against medical device manufacturers would be affected, though some pending cases will almost certainly be nullified.

The decision, for example, does not foreclose lawsuits claiming that a device was made improperly, in violation of F.D.A. specifications. Cases may also be brought under state laws that mirror federal rules, as opposed to supplementing them.

Next Monday, the court will hear another F.D.A. pre-emption case, on whether a state case can be based on the claim that a drug maker committed fraud by misrepresenting or withholding information from the agency during the approval process. The administration is supporting the manufacturer in that case, Warner-Lambert Co. v. Kent, No. 06-1498, which concerns the diabetes drug Rezulin.

Writing for the majority in Wednesday's case, Riegel v. Medtronic Inc., No. 06-179, Justice Antonin Scalia said that permitting state juries to impose liability on the maker of an approved device "disrupts the federal scheme," under which the F.D.A. has the responsibility for evaluating the risks and benefits of a new device and assuring that it is safe and effective for its intended use.

A jury, looking only at the injured plaintiff, will tend to weigh only the dangers of a device and "is not concerned with its benefits," Justice Scalia said, adding, "the patients who reaped those benefits are not represented in court."

The decision affirmed the dismissal of a lawsuit by a patient who was injured during an angioplasty when a balloon catheter burst while being inserted to dilate a coronary artery. The device won F.D.A. premarket approval in 1994, two years before the incident. The patient, Charles R. Riegel, died after the lawsuit was filed, and the case was carried on by his widow, Donna.

The medical device statute contains a pre-emption clause that bars states from imposing "any requirement" related to a medical device that is "different from, or in addition to" a federal requirement. The question of statutory interpretation at the heart of the case turned on what Congress meant by "any requirement."

Justice Scalia said that state tort law, by imposing duties of care on product makers, amounted to such an additional requirement. He said the 1976 law "speaks clearly to the point at issue," regardless of the federal government's previous or current positions.

Justice Ruth Bader Ginsburg, the solitary dissenter, said the court had misconstrued Congress's intent in adding the pre-emption clause to the 1976 law. The purpose, she said, was to prevent individual states from imposing their own premarket approval process on new medical devices. Devices were not regulated under federal law at the time, and California and other states had stepped in to fill the vacuum by setting up their own regulatory systems.

That was all that Congress had in mind, Justice Ginsburg said, not "a radical curtailment of state common-law suits seeking compensation for injuries caused by defectively designed or labeled medical devices." She said that Congress had passed the 1976 law "to protect consumer safety," not to oust the states from "a domain historically occupied by state law." The decision was at odds with the "central purpose" of the 1976 law, Justice Ginsburg added.

Crucial Democratic lawmakers appear to agree with Justice Ginsburg, including Senator Edward M. Kennedy, Democrat of Massachusetts, who heads the Health, Education, Labor and Pensions Committee and was the sole Senate sponsor of the 1976 legislation in question.

"In enacting legislation on medical devices, Congress never intended that F.D.A. approval would give blanket immunity to manufacturers from liability for injuries caused by faulty devices," Mr. Kennedy said in a statement. He added: "Congress obviously needs to correct the court's decision."

Representative Henry Waxman, the California Democrat who is chairman of the House Committee on Oversight and Government Reform and was on the House panel that approved the 1976 bill, expressed a similar view.

“The Supreme Court’s decision strips consumers of the rights they’ve had for decades,” Mr. Waxman said. “This isn’t what Congress intended, and we’ll pass legislation as quickly as possible to fix this nonsensical situation.”

The Food, Drug and Cosmetic Act of 1938, under which the F.D.A. regulates pharmaceuticals, does not contain a pre-emption clause. Nonetheless, the administration is arguing in the case the court has accepted for its next term, Wyeth v. Levine, No. 06-1249, that pre-emption is implicit in the structure of the statute.

The Supreme Court’s interest in pre-emption is not limited to the medical arena. In a similar case decided on Wednesday, this one unanimously, the court ruled that the federal law that deregulated the trucking industry in 1980 pre-empted two recent laws adopted by the State of Maine to regulate the shipment of tobacco products into the state.

The state laws were intended to prevent children who were not of legal age to buy cigarettes from ordering them over the Internet. The laws placed responsibility on shippers and delivery companies to verify the recipient’s identity and age.

Justice Stephen G. Breyer, writing for the court in this case, Rowe v. New Hampshire Motor Transport Association, No. 06-457, said the state law “produces the very effect that the federal law sought to avoid, namely, a state’s direct substitution of its own governmental commands for competitive market forces” in a deregulated environment.

Barnaby Feder contributed reporting from New York and Gardiner Harris from Washington.

New York Times
February 19, 2008
Gentlemen, 5 Easy Steps to Living Long and Well
By Nicholas Bakalar

Living past 90, and living well, may be more than a matter of good genes and good luck. Five behaviors in elderly men are associated not only with living into extreme old age, a new study has found, but also with good health and independent functioning.

The behaviors are abstaining from smoking, weight management, blood pressure control, regular exercise and avoiding diabetes. The study reports that all are significantly correlated with healthy survival after 90.

While it is hardly astonishing that choices like not smoking are associated with longer life, it is significant that these behaviors in the early elderly years - all of them modifiable - so strongly predict survival into extreme old age.

“The take-home message,” said Dr. Laurel B. Yates, a geriatric specialist at Brigham and Women’s Hospital in Boston who was the lead author of the study, “is that an individual does have some control over his destiny in terms of what he can do to improve the probability that not only might he live a long time, but also have good health and good function in those older years.”

The study followed more than 2,300 healthy men for as long as a quarter-century. When it began, in 1981, the subjects’ average age was 72. The men responded to yearly questionnaires about changes in health and lifestyle, and researchers tested their mental and physical functioning. At the end of the study, which was published Feb. 11 in The Archives of Internal Medicine, 970 men had survived into their 90s.

There was no less chronic illness among survivors than among those who died before 90. But after controlling for other variables, smokers had double the risk of death before 90 compared with nonsmokers, those with diabetes increased their risk of death by 86 percent, obese men by 44 percent, and those with high blood pressure by 28 percent. Compared with men who never exercised, those who did reduced their risk of death by 20 percent to 30 percent, depending on how often and how vigorously they worked out.

Even though each of these five behaviors was independently significant after controlling for age and other variables, studies have shown that many other factors may affect longevity, including level of education and degree of social isolation. They were not measured in this study.

Although some previous studies have found that high cholesterol is associated with earlier death, and moderate alcohol consumption with longer survival, this study confirmed neither of those findings.

A second study in the same issue of the journal suggests that some of the oldest of the old survive not because they avoid illness, but because they live well despite disease.

The study of 523 women and 216 men ranging in age from 97 to 119 showed that a large proportion of people who lived that long and lived with minimal or no assistance did so despite long-term chronic illness. In other words, instead of delaying disease, they delay disability.

Dr. Dellara F. Terry, the lead author and an assistant professor of medicine at Boston University, said the study showed that old age and chronic illness were no reason to stop providing thorough treatment. “We should look at the individual in making treatment decisions,” Dr. Terry said, “and not base our decisions solely on chronological age.”

Number of US Primary Care Doctors Down
February 12, 2006

Fewer American doctors are focusing on primary care, but the decline is being covered by physicians from other countries. The General Accountability Office said Tuesday that as of 2006 there were 22,146 American doctors in residency programs in the United States specializing in primary care.

That was down from 23,801 in 1995, the research arm of Congress told the Senate Health, Education, Labor and Pensions Committee.

"It is troubling to me that the number of Americans pursuing a career in primary care has declined," said Sen. Bernie Sanders, I-Vt.

Overall growth in the number of primary-care physicians "has been totally due to the number of international medical students training in America," Sanders said. "We are increasingly dependent on international medical school graduates to meet our needs. Currently, one in four new physicians in the U.S. is an international medical graduate."

In its report on primary-care providers, GAO said the number of international medical graduates training in primary care had grown from 13,025 in 1995 to 15,565 in 2006.

For specialists, the number of Americans in training went from 45,300 in 1995 to 47,575 in 2006 and over the same period international specialists grew from 11,957 to 12,611, GAO said.

"There are simply not enough primary-care providers now and the situation will become far worse in the future unless we do something," Sanders said. He urged doubling funds for the National Health Service Corps to $250 million next year.

The service corps offers scholarships to students dedicated to practicing primary care in communities of greatest need. In return for scholarship support, they must agree to practice in communities where need is the greatest.

"Part of the solution lies in making medical, dental and nursing education affordable for all Americans," Sanders said.

'Aspirin resistance' linked to increased cardiovascular events and death
January 22, 2008

ST LOUIS (MD Consult) - Patients who are "aspirin-resistant" are at increased long-term risk of cardiovascular morbidity and mortality, compared to "aspirin-sensitive" patients, according to a report published online by the British Medical Journal.

Led by Dr George Krasopoulos of Toronto General Hospital, the researchers performed a systematic review to identify studies providing data on aspirin resistance and clinical outcomes in patients with cardiovascular disease. The studies used various platelet function assays to assess aspirin resistance.

The analysis included data from 20 studies on 2,390 patients receiving aspirin as antithrombotic therapy. Most studies used an aspirin dose between 75 and 325 mg/d; six studies included adjunct antiplatelet therapy. All but three studies provided adequate data to assess compliance.

The overall rate of aspirin resistance, defined as absence of the expected inhibition of agonist-induced platelet response by aspirin, was 28%. Aspirin resistance was more common in women and in patients with previous renal impairment.

Aspirin resistance was associated with increased rates of adverse cardiovascular outcomes. The odds ratio (OR) for new cardiovascular events was 3.85, compared to aspirin-sensitive patients. Other increased risks included acute coronary syndrome, OR 4.06; graft failure, OR 4.35; and new cerebrovascular events, OR 3.78. Aspirin-resistant patients were also at increased risk of death, OR 5.99. There was no evidence that other antiplatelet therapies had benefits for patients with aspirin resistance.

It is well documented that long-term aspirin use reduces the risk of cardiovascular events, but questions remain as to why some patients do not benefit from preventive aspirin therapy. Several studies have reported on the phenomenon of aspirin resistance. However, it remains unclear how such patients should be identified and whether aspirin resistance affects major clinical outcomes.

The new review and meta-analysis suggests a 28% rate of aspirin resistance among patients with cardiovascular disease receiving aspirin as antithrombotic therapy. Patients with aspirin resistance appear to have increased rates of cardiovascular and cerebrovascular events, and to be at increased risk of death. More research is needed to identify the best test for aspirin resistance and to assess alternative therapies for aspirin-resistant patients.

Saline nasal wash relieves rhinologic symptoms, prevents infection recurrence
January 23, 2008
By Mary Ann Moon

Saline nasal wash significantly improved symptoms in children with acute common colds or respiratory flu, and also reduced recurrences, researchers reported in the January issue of the Archives of Otolaryngology and Head and Neck Surgery.

An isotonic saline nasal wash made from processed seawater thinned and reduced nasal secretions as well as relieved nasal obstruction and sore throat in a study of 401 patients aged 6-10 years. Treated children showed significantly less

use of cold medications than did controls, had fewer school absences, and had fewer complications such as otitis media and sinusitis.

The treated children also showed greater improvement in overall health status and fewer recurrences of upper respiratory tract infection when they continued using the nasal spray as a preventive after the acute illness had resolved, according to Dr. Ivo Slapak of Teaching Hospital Brno (Czech Republic).

The study was funded by Laboratoires Goemar, Saint-Malo (France), which supplied the nasal wash. The manufacturing process of this commercially available product “preserves the concentrations of ions and trace elements to levels comparable with those of seawater,” Dr. Slapak and his associates said.

Saline has anti-inflammatory activity, but the product’s mechanism of action is not known. “It is not clear whether the effect is predominantly mechanical, based on clearing mucus, or whether salts and trace elements in seawater solutions play a significant role,” they added.

Several guidelines mention the potential benefit of saline nasal wash in treating colds and flu, although “evidence of its efficacy is rather poor,” the investigators noted. A large study in adults showed that the treatment had no effect.

In what they described as the first prospective study to assess the adjunctive treatment in children, Dr. Slapak and his associates at eight pediatric outpatient clinics randomly assigned patients to receive standard treatment either alone (101 subjects) or with open-label adjunctive nasal wash at one of three strengths: medium jet flow (100 subjects), fine spray (100 patients), or a dual eye-and-nose formula with a fine spray (100 subjects).

The saline wash was administered six times per day during the acute illness and three times per day during the prevention phase of the study. Standard treatment included antipyretics, decongestants, mucolytics, and systemic antibiotics, all given at the treating physician’s discretion.

All the patients were followed for 12 weeks during cold season, from the onset of their acute illness until spring.

Acute nasal symptoms cleared more quickly in the children who received the nasal wash at any strength, and those subjects also used significantly fewer medications both acutely and during follow-up. Unblinded physicians and parents both rated the children’s health status as significantly better in the treatment groups than in the control group.

Medication use and illness prevention at preventive phase

“Results were robust, consistent, and statistically significant, in contrast to the few published articles that do not clearly show the benefits of nasal wash to treat the common cold,” the investigators said (Arch. Otolaryngol. Head Neck Surg. 2008;134:67-74).

Significantly fewer subjects who used long-term nasal wash reported days of illness, absences from school, or complications.

The saline wash was well tolerated, with children having fewer complaints about the fine nasal sprays than about the stronger flow formulation. All three strengths were equally effective. “In this age group, we did not find results supporting the hypothesis that stronger flow would be more effective than a fine spray,” they noted.

The researchers disclosed that they had received speakers’ honoraria from various pharmaceutical firms, and some have worked or will work on projects for commercial drug laboratories.

New York Times
February 5, 2008

A Medical Mystery Unfolds in Minnesota

By Denise Grady

AUSTIN, Minn. — If you have to come down with a strange disease, this town of 23,000 on the wide-open prairie in southeastern Minnesota is a pretty good place to be. The Mayo Clinic, famous for diagnosing exotic ailments, owns the local medical center and shares some staff with it. Mayo itself is just 40 miles east in Rochester. And when it comes to investigating mysterious outbreaks, Minnesota has one of the strongest health departments and best-equipped laboratories in the country.

And the disease that confronted doctors at the Austin Medical Center here last fall was strange indeed. Three patients had the same highly unusual set of symptoms: fatigue, pain, weakness, numbness and tingling in the legs and feet.
The patients had something else in common, too: all worked at Quality Pork Processors, a local meatpacking plant.

The disorder seemed to involve nerve damage, but doctors had no idea what was causing it.

At the plant, nurses in the medical department had also begun to notice the same ominous pattern. The three workers had complained to them of “heavy legs,” and the nurses had urged them to see doctors. The nurses knew of a fourth case, too, and they feared that more workers would get sick, that a serious disease might be spreading through the plant.

“We put our heads together and said, ‘Something is out of sorts,’ ” said Carole Bower, the department head.

Austin’s biggest employer is Hormel Foods, maker of Spam, bacon and other processed meats (Austin even has a Spam museum). Quality Pork Processors, which backs onto the Hormel property, kills and butchers 19,000 hogs a day and

sends most of them to Hormel. The complex, emitting clouds of steam and a distinctive scent, is easy to find from just about anywhere in town.

Quality Pork is the second biggest employer, with 1,300 employees. Most work eight-hour shifts along a conveyor belt — a disassembly line, basically — carving up a specific part of each carcass. Pay for these line jobs starts at about $11 to $12 an hour. The work is grueling, but the plant is exceptionally clean and the benefits are good, said Richard Morgan, president of the union local. Many of the workers are Hispanic immigrants. Quality Pork's owner does not allow reporters to enter the plant.

A man whom doctors call the "index case" — the first patient they knew about — got sick in December 2006 and was hospitalized at the Mayo Clinic for about two weeks. His job at Quality Pork was to extract the brains from swine heads. "He was quite ill and severely affected neurologically, with significant weakness in his legs and loss of function in the lower part of his body," said Dr. Daniel H. Lachance, a neurologist at Mayo.

Tests showed that the man's spinal cord was markedly inflamed. The cause seemed to be an autoimmune reaction: his immune system was mistakenly attacking his own nerves as if they were a foreign body or a germ. Doctors could not figure out why it had happened, but the standard treatment for inflammation — a steroid drug — seemed to help. (The patient was not available for interviews.) Neurological illnesses sometimes defy understanding, Dr. Lachance said, and this seemed to be one of them. At the time, it did not occur to anyone that the problem might be related to the patient's occupation.

By spring, he went back to his job. But within weeks, he became ill again. Once more, he recovered after a few months and returned to work — only to get sick all over again.

By then, November 2007, other cases had begun to turn up. Ultimately, there were 12 — 6 men and 6 women, ranging in age from 21 to 51. Doctors and the plant owner, realizing they had an outbreak on their hands, had already called in the Minnesota Department of Health, which, in turn, sought help from the federal Centers for Disease Control and Prevention.

Though the outbreak seemed small, the investigation took on urgency because the disease was serious, and health officials worried that it might indicate a new risk to other workers in meatpacking.

"It is important to characterize this because it appears to be a new syndrome, and we don't truly know how many people may be affected throughout the U.S. or even the world," said Dr. Jennifer McQuiston, a veterinarian from the disease centers. In early November, Dr. Aaron DeVries, a health department epidemiologist, visited the plant and combed through medical records. The disease bore no resemblance to mad cow disease or to trichinosis, the notorious parasite infection that comes from eating raw or undercooked pork. Nor did it spread person to person — the workers' relatives were unaffected — or pose any threat to people who ate pork.

A survey of the workers confirmed what the plant's nurses had suspected: those who got sick were employed at or near the "head table," where workers cut the meat off severed hog heads.

On Nov. 28, Dr. DeVries's boss, Dr. Ruth Lynfield, the state epidemiologist, toured the plant. She and the owner, Kelly Wadding, paid special attention to the head table. Dr. Lynfield became transfixed by one procedure in particular, called "blowing brains."

As each head reached the end of the table, a worker would insert a metal hose into the foramen magnum, the opening that the spinal cord passes through. High-pressure blasts of compressed air then turned the brain into a slurry that squirted out through the same hole in the skull, often spraying brain tissue around and splattering the hose operator in the process.

The brains were pooled, poured into 10-pound containers and shipped to be sold as food — mostly in China and Korea, where cooks stir-fry them, but also in some parts of the American South, where people like them scrambled up with eggs. The person blowing brains was separated from the other workers by a plexiglass shield that had enough space under it to allow the heads to ride through on a conveyor belt. There was also enough space for brain tissue to splatter nearby employees.

"You could see aerosolization of brain tissue," Dr. Lynfield said.
The workers wore hard hats, gloves, lab coats and safety glasses, but many had bare arms, and none had masks or face shields to prevent swallowing or inhaling the mist of brain tissue.

Dr. Lynfield asked Mr. Wadding, "Kelly, what do you think is going on?"
The plant owner watched for a while and said, "Let's stop harvesting brains."
Quality Pork halted the procedure that day and ordered face shields for workers at the head table.

Epidemiologists contacted 25 swine slaughterhouses in the United States, and found that only two others used compressed air to extract brains. One, a plant in Nebraska owned by Hormel, has reported no cases. But the other, Indiana Packers in Delphi, Ind., has several possible cases that are being investigated. Both of the other plants, like Quality Pork, have stopped using compressed air.
But why should exposure to hog brains cause illness? And why now, when the compressed air system had been in use in Minnesota since 1998?

At first, health officials thought perhaps the pigs had some new infection that was being transmitted to people by the brain tissue. Sometimes, infections can ignite an immune response in humans that flares out of control, like the condition in the workers. But so far, scores of tests for viruses, bacteria and parasites have found no signs of infection.

As a result, Dr. Lynfield said the investigators had begun leaning toward a seemingly bizarre theory: that exposure to the hog brain itself might have touched

off an intense reaction by the immune system, something akin to a giant, out-of-control allergic reaction. Some people might be more susceptible than others, perhaps because of their genetic makeup or their past exposures to animal tissue. The aerosolized brain matter might have been inhaled or swallowed, or might have entered through the eyes, the mucous membranes of the nose or mouth, or breaks in the skin.

“It’s something no one would have anticipated or thought about,” said Dr. Michael Osterholm, an epidemiologist who is working as a consultant for Hormel and Quality Pork. Dr. Osterholm, a professor of public health at the University of Minnesota and the former state epidemiologist, said that no standard for this kind of workplace exposure had ever been set by the government.

But that would still not explain why the condition should suddenly develop now. Investigators are trying to find out whether something changed recently — the air pressure level, for instance — and also whether there actually were cases in the past that just went undetected.

“Clearly, all the answers aren’t in yet,” Dr. Osterholm said. “But it makes biologic sense that what you have here is an inhalation of brain material from these pigs that is eliciting an immunologic reaction.” What may be happening, he said, is “immune mimicry,” meaning that the immune system makes antibodies to fight a foreign substance — something in the hog brains — but the antibodies also attack the person’s nerve tissue because it is so similar to some molecule in hog brains. “That’s the beauty and the beast of the immune system,” Dr. Osterholm said. “It’s so efficient at keeping foreign objects away, but anytime there’s a close match it turns against us, too.”

Anatomically, pigs are a lot like people. But it is not clear how close a biochemical match there is between pig brain and human nerve tissue.

To find out, the Minnesota health department has asked for help from Dr. Ian Lipkin, an expert at Columbia University on the role of the immune system in neurological diseases. Dr. Lipkin has begun testing blood serum from the Minnesota patients to look for signs of an immune reaction to components of pig brain. And he expects also to study the pig gene for myelin, to see how similar it is to the human one.

“It’s an interesting problem,” Dr. Lipkin said. “I think we can solve it.”
Susan Kruse, who lives in Austin, was stunned by news reports about the outbreak in early December. Ms. Kruse, 37, worked at Quality Pork for 15 years. But for the past year, she has been too sick to work. She had no idea that anyone else from the plant was ill. Nor did she know that her illness might be related to her job.

Her most recent job was “backing heads,” scraping meat from between the vertebrae. Three people per shift did that task, and together would process 9,500 heads in eight or nine hours. Ms. Kruse (pronounced KROO-zee) stood next to the

person who used compressed air to blow out the brains. She was often splattered, especially when trainees were learning to operate the air hose.
“I always had brains on my arms,” she said.

She never had trouble with her health until November 2006, when she began having pains in her legs. By February 2007, she could not stand up long enough to do her job. She needed a walker to get around and was being treated at the Mayo Clinic.

“I had no strength to do anything I used to do,” she said. “I just felt like I was being drained out.”

Her immune system had gone haywire and attacked her nerves, primarily in two places: at the points where the nerves emerge from the spinal cord, and in the extremities. The same thing, to varying degrees, was happening to the other patients. Ms. Kruse and the index case — the man who extracted brains — probably had the most severe symptoms, Dr. Lachance said.

Steroids did nothing for Ms. Kruse, so doctors began to treat her every two weeks with IVIG, intravenous immunoglobulin, a blood product that contains antibodies. “It’s kind of like hitting the condition over the head with a sledgehammer,” Dr. Lachance said. “It overwhelms the immune system and neutralizes whatever it is that’s causing the injury.”

The treatments seem to help, Ms. Kruse said. She feels stronger after each one, but the effects wear off. Her doctors expect she will need the therapy at least until September.

Most of the other workers are recovering and some have returned to their jobs, but others, including the index case, are still unable to work. So far, there have been no new cases.

“I cannot say that anyone is completely back to normal,” Dr. Lachance said. “I expect it will take several more months to get a true sense of the course of this illness.”

Dr. Lynfield hopes to find the cause. But she said: “I don’t know that we will have the definitive answer. I suspect we will be able to rule some things out, and will have a sense of whether it seems like it may be due to an autoimmune response. I think we’ll learn a lot, but it may take us a while. It’s a great detective story.”

Health Policy News

Chairman Dingell Introduces Medicaid Moratorium Legislation

House Energy and Commerce Committee Chair John Dingell (D-Mich.) and Health Subcommittee member Tim Murphy (R-Pa.) March 13 introduced bipartisan legislation, the "Protecting the Medicaid Safety Net Act of 2008" (H.R. 5613), that would prohibit until April 2009 any CMS actions related to the

Medicaid GME proposed rule, the Medicaid Cost Limit/Unit of Government ("IGT") final rule, and five other recently issued Medicaid regulations. Reportedly, Chairman Dingell may mark up H.R. 5613 shortly after the spring recess, which ends March 28.

House Members Call for NIH Increase

A total of 179 members of the House of Representatives signed a March 19 letter to the leadership of the House Appropriations Committee requesting a 6.5 percent increase in the NIH budget for the coming fiscal year. The letter, which was sent to Reps. David Obey (D-Wis.) and Jerry Lewis (R-Calif), the chair and ranking member, respectively of the House Appropriations Committee, notes the Administration's proposal to fund NIH at the current level "is deeply troubling given the high rate of biomedical inflation.... [T]he NIH budget will need to increase by 3.5 percent simply to maintain its existing purchasing power."

House Members Urge Title VII Restoration

A total of 131 Representatives signed a March 14 letter urging appropriators to restore funding for the Title VII health professions training programs to $300 million, the FY 2005 level. Organized by Reps. Diana DeGette (D-Colo.) and Cathy McMorris Rodgers (R-Wash.), the letter warns "at a time of serious health professions shortages, reducing this resource has already had devastating effects to the country's neediest communities." Reps. DeGette and McMorris Rodgers were joined by 21 Republicans and 7 appropriators in signing the letter.

On the Hill

Rep. Tom Reynolds (R-N.Y.) announced March 20 that he will retire at the end of his term, stating it is time "to take up new challenges." Rep. Reynolds is serving his fifth term and is a member of the House Committee on Ways and Means.

House and Senate Approve Budget Resolutions

On Thursday, the House and Senate voted to approve their respective budget resolutions, nonbinding blueprints for the annual appropriations process.

The President released his proposed budget in early February, requesting $991.6 billion in discretionary funding for fiscal year (FY) 2009. The Senate budget would provide an additional $21.8 billion in discretionary funding over the President's budget request, while the House would provide $25.4 billion more.

The House budget includes reconciliation instructions to the Ways and Means Committee to find $750 million in savings over five years from mandatory programs under its jurisdiction. Any resulting reconciliation bill could be the legislative vehicle to which a Medicare physician fee patch will be attached, as

such legislation only requires a simple majority for passage. The Senate budget did not include reconciliation instructions.

The Senate overwhelmingly voted to approve an amendment offered by Senators Harkin (D-IA) and Specter (R-PA) to provide an additional $2.1 billion to the National Institutes of Health (NIH) for increased research in the life sciences.

The two budget resolutions will now be conferenced, but do not have to be signed by the President.

House Committee Approves TBI Legislation

The House Energy and Commerce Committee approved legislation this week to reauthorize the Traumatic Brian Injury (TBI) Act (PL 104-166), clearing the way for consideration by the full House.

The TBI Act was first enacted in 1996 and is intended to assist in the development of state-level infrastructure and service delivery systems for individuals with TBI and their families by providing grants to states. The programs specifically focus on TBI treatment and rehab, individual and family support, returning to work, housing or supportive living, personal assistance services, assistive devices and technologies, behavioral health services, and substance abuse services. The Act was reauthorized in 2000 and provisions on protection and advocacy services for individuals with TBI and their families were added.

Introduced by Congressmen Pascrell (D-NJ) and Platts (R-PA), the House bill would authorize a new study through the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH) to research the incidence, prevalence, and treatment of TBI. The measure also would authorize a study on improving access to care for veterans with traumatic brain injury, as TBI has become one of the signature injuries of the war in Iraq.

The Senate approved its companion TBI bill late last year.

Hospital Associations File Lawsuit to Stop Implementation Medicaid Rule

The Alameda County Medical Centers, the National Association of Public Hospitals and Health Systems, the American Hospital Association, and the Association of American Medical Colleges filed a lawsuit this week to stop implementation of a Medicaid rule that would reduce federal reimbursement for public hospitals and limit payments to public providers.

The group of hospital associations states that the Centers for Medicare and Medicaid Services (CMS) overstepped its authority in promulgating the rule and improperly issued the final rule when Congress had passed a one-year moratorium on its implementation. CMS stands by the rule and states that it will preserve the integrity of the federal-state Medicaid partnership and improve transparency.

The rule would narrow the definition of a public provider and limit Medicaid payments to public hospitals to no more than the cost of the service provided. According to CMS, the rule is expected to save approximately $4 billion for federal Medicaid over five years: however, the hospital groups state the number is closer to $5 billion. The rule is one of seven recent Medicaid rules from CMS which have been criticized for threatening the stability of state Medicaid programs and access to care for Medicaid beneficiaries.

Congressional efforts are underway to extend the current moratorium on implementation of the hospital rule, which is in place until May 25, 2008.

The Austin Chamber of Commerce has released a study it commissioned from The Perryman Group, a Waco consulting firm, that reports, "A university-backed medical school in Austin would generate $2.38 billion in yearly spending locally..." The report says the statewide economic impact of the school would be $2.9 billion, and it would create 19,307 jobs in the Austin area.
<http://www.bizjournals.com/austin/stories/2008/02/11/daily4.html>
<http://www.perrymangroup.com/>

An article in the Austin American Statesman on Tuesday discusses the extreme caution University of Texas System officials are taking in discussing deliberations about a possible new medical school in Austin. The paper reports, "The question is politically and financially charged, and officials say no decisions have been made."
<http://tinyurl.com/2cucmt>

Southwestern studies possible Austin medical school
Another article on competition between UTSW and UTMB for a branch campus in Austin.
http://www.statesman.com/news/content/news/stories/local/12/22/1222medschool.html?cxntlid=inform

Texas Tech University Health Sciences Center President John C. Baldwin, M.D., announced late Tuesday that the Paul L. Foster School of Medicine "has been approved as a four-year medical school within the Texas Tech University System" by the Liaison Committee on Medical Education (LCME). The school received initial, provisional accreditation and intends to admit its first class of 40 students in August 2009, eventually growing to accept some 80 students per year. The LCME does not publicly announce accreditation decisions.
<http://tinyurl.com/yqf8px>

Research and Funding Opportunities

NIH Funding Opportunities and Notices
Weekly NIH Funding Opportunities and Notices
NIH Guide for Grants and Contracts
February 8, 2008

Notices

Reminder: Letter Required for the Ruth L. Kirschstein NRSA for Individual Predoctoral Fellowships (F31) to Promote Diversity in Health-Related Research (NOT-OD-08-039)
National Institutes of Health
http://grants.nih.gov/grants/guide/notice-files/NOT-OD-08-039.html

Amendment: RFA AI-08-002 Regional Centers of Excellence for Biodefense and Emerging Infectious Diseases Research (RCE) Program
(NOT-AI-08-034)
National Institute of Allergy and Infectious Diseases
http://grants.nih.gov/grants/guide/notice-files/NOT-AI-08-034.html

Notice to Clarify that "Research Projects" are "Pilot Research Projects" and to Correct the Page Limit for these Pilot Projects for the NIDA Core "Center of Excellence" Grant Program (P30) PAR-08-073
(NOT-DA-08-009)
National Institute on Drug Abuse
http://grants.nih.gov/grants/guide/notice-files/NOT-DA-08-009.html

Notice of Change of Resubmission Receipt Dates for AIDS-Science Track Award for Research Transition (R03) PA-07-349
(NOT-DA-08-012)
National Institute on Drug Abuse
http://grants.nih.gov/grants/guide/notice-files/NOT-DA-08-012.html

Addendum to RFA-DK-07-004 George M. O'Brien Urology Research Centers (P50)
(NOT-DK-08-009)
National Institute of Diabetes and Digestive and Kidney Diseases
http://grants.nih.gov/grants/guide/notice-files/NOT-DK-08-009.html

Notice of Change in Receipt Date and NIBIB Contact Person on TPA-06-504, Enabling Technologies for Tissue Engineering and Regenerative Medicine
(NOT-EB-08-001)
National Institute of Biomedical Imaging and Engineering
http://grants.nih.gov/grants/guide/notice-files/NOT-EB-08-001.html

Amendment to NOT-NS-07-010: Policy Revision of the National Institute of Neurological Disorders and Stroke (NINDS) for Competing Program Project (P01/P50) Grant Applications
(NOT-NS-08-010)
National Institute of Neurological Disorders and Stroke
http://grants.nih.gov/grants/guide/notice-files/NOT-NS-08-010.html

Notice Regarding RFA-OH-08-002 Expansion of the National Mesothelioma Virtual Registry and Tissue Bank (U24)

(NOT-OH-08-002)
National Institute for Occupational Safety and Health
http://grants.nih.gov/grants/guide/notice-files/NOT-OH-08-002.html
Requests for Applications

Rare Diseases Clinical Research Consortia (RDCRC) for the Rare Diseases Clinical Research Network (U54)
(RFA-OD-08-001)
National Institutes of Health
National Cancer Institute
National Heart, Lung, and Blood Institute
National Institute on Aging
National Institute on Alcohol Abuse and Alcoholism
National Institute of Allergy and Infectious Diseases
National Institute of Arthritis and Musculoskeletal and Skin Diseases
National Institute of Child Health and Human Development
National Institute of Dental and Craniofacial Research
National Institute of Diabetes and Digestive and Kidney Diseases
National Institute of Neurological Disorders and Stroke
Application Receipt Date(s): August 20, 2008
http://grants.nih.gov/grants/guide/rfa-files/RFA-OD-08-001.html

Data Management and Coordinating Center (DMCC) for the Rare Diseases Clinical Research Network (U54)
(RFA-OD-08-002)
National Institutes of Health
National Institute of Neurological Disorders and Stroke
Application Receipt Date(s): April 22, 2008
http://grants.nih.gov/grants/guide/rfa-files/RFA-OD-08-002.html
Program Announcements

Health Behavior Change in People with Mental Disorders (R01)
(PA-08-089)
National Institute of Mental Health
Application Receipt/Submission Date(s): Multiple dates, see announcement.
http://grants.nih.gov/grants/guide/pa-files/PA-08-089.html

Metagenomic Analyses of the Oral Microbiome (R01)
(PA-08-090)
National Institute of Dental and Craniofacial Research
Application Receipt/Submission Date(s): Multiple dates, see announcement.
http://grants.nih.gov/grants/guide/pa-files/PA-08-090.html

Novel Approaches to Study Polymicrobial Diseases (R01)
(PA-08-091)
National Institute of Dental and Craniofacial Research
National Heart, Lung, and Blood Institute
National Institute on Deafness and Other Communication Disorders
Application Receipt/Submission Date(s): Multiple dates, see announcement.

http://grants.nih.gov/grants/guide/pa-files/PA-08-091.html

Novel Approaches To Study Polymicrobial Diseases (R21)
(PA-08-092)
National Institute of Dental and Craniofacial Research
National Heart, Lung, and Blood Institute
National Institute on Deafness and Other Communication Disorders
Application Receipt/Submission Date(s): Multiple dates, see announcement.
http://grants.nih.gov/grants/guide/pa-files/PA-08-092.html

Developing Centers for Intervention and/or Services Research (DCISR) (P20)
(PAR-08-087)
National Institute of Mental Health
Application Receipt/Submission Date(s): June 24, 2010
http://grants.nih.gov/grants/guide/pa-files/PAR-08-087.html

Advanced Centers for Intervention and/or Services Research (ACISR) (P30)
(PAR-08-088)
National Institute of Mental Health
Application Receipt/Submission Date(s): June 24, 2010
http://grants.nih.gov/grants/guide/pa-files/PAR-08-088.html

National Institute of Mental Health (NIMH) Career Opportunities in Research
(COR) Honors Undergraduate Research Training Grant (T34)
(PAR-08-093)
National Institute of Mental Health
Application Receipt/Submission Date(s): May 12, 2010
http://grants.nih.gov/grants/guide/pa-files/PAR-08-093.html

Quotes

Science is a way of thinking much more than it is a body of knowledge.
--Carl Sagan

Science is a first-rate piece of furniture for a man's upper chamber, if he has common sense on the ground floor.
--Oliver Wendell Holmes

If an elderly but distinguished scientist says that something is possible, he is almost certainly right; but if he says that it is impossible, he is very probably wrong.
--Arthur C. Clarke

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