Texas Society of Psychiatric Physicians
NEWSLETTER
AUGUST/SEPTEMBER 2004

Suicide Prevention in Texas – Hope for the Future

By Merily H. Keller, Co-Chair, Texas Suicide Prevention Community Network and board member, Mental Health Association in Texas.

"In 1999, *The Surgeon General s Call To Action To Prevent Suicide* identified suicide as a serious public health problem in the United States. In that year in Texas, suicide claimed the lives of 2,002 people. In 2002, the most recent year for which statistics are available, 2,304 Texans died as a result of suicide — more than a ten percent increase over the number reported just three years earlier. 2,304 deaths by suicide: That's more than the 1,412 homicides that occurred in Texas in 2002 and significantly more than the 1,071 Texans who died from HIV that year. Suicide in Texas is a serious public health concern—and one that might be addressed successfully through a coordinated and comprehensive approach aimed at prevention." http://www.mhatexas.org/

from Texas Suicide Prevention Toolkit for Communities which will be available on CD from TSPP and available on the Mental Health Association in Texas web site after August 30, 2004.

My personal journey as a survivor of suicide has closely followed the journey of grassroots groups coming together to care about suicide in Texas. In November of 2000, my husband and I joined the more than 2,000 Texas families who lose a loved one to suicide each year. Our 18-year-old son, Chase Walter Keller, died in Austin as number five in a suicide contagion that involved boys in his private school and a nearby public school. We used our son's college fund to hire a national suicidologist to come to Austin to address the mental health community as well as parents and faculty at the school regarding best practices for "postvention" and steps which should be taken in the school and in the community to address suicide. I then went to the Texas Department of Health and said, "I'm a free MPH graduate student, use me" and was connected to a grassroots group working on suicide prevention in Texas. Throughout this process, we received the encouragement of our son's psychiatrist, Dr. Bernard (Tey) Aoueille,III who is also a "suicide survivor" since our son was the first young person he had lost to a death by suicide.

The Texas State Plan for Suicide Prevention

In 2001, this multidisciplinary coalition developed a statewide suicide prevention plan for Texas based on the national strategy for suicide prevention that was initiated by the US Surgeon General in 1999. The Texas Suicide Prevention Plan stresses a multi-disciplinary public health approach to suicide prevention and focuses on three primary areas identified by the Surgeon General's Call To Action:

- Awareness - broadening the public's awareness of suicide and its risk factors;
- Intervention – enhancing services and programs; and
- Methodology – advancing the science of suicide prevention.

The type of well-coordinated, comprehensive, multi-disciplinary response to suicide stressed in the plan has been absent in Texas. The Texas State Plan for Suicide Prevention endeavored to bring this larger perspective to the issue.

The specific goals of the plan are to:

1. Promote awareness that suicide is a public health problem and that it is preventable.
2. Develop broad-based support for suicide prevention
3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.
4. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.
5. Develop and implement community-based suicide prevention programs.
6. Promote efforts to enhance safety measures for those at risk of suicide.
7. Implement training for recognition of at-risk behavior and delivery of effective treatment.
8. Develop and promote effective clinical and professional practices.
9. Increase access to and community linkages with mental health and substance abuse services.
10. Promote and support research on suicide and suicide prevention.
11. Improve and expand surveillance systems.

Following the development of the Texas State Plan for Suicide Prevention, the grassroots group, which developed the state plan, dissolved since it had accomplished its mission. Many members of this group as well as new stakeholders in suicide prevention joined together to address suicide by forming local coalitions across Texas. Ten initial coalitions were developed following community listening sessions and became the Texas Suicide Prevention Community Network. Other members of the grassroots group decided to address suicide as a public/private partnership under the statewide Texas Suicide Prevention Partnership, which is a part of the Mental Health Work Group of the Texas Strategic Health Partnership.

These two organizations helped staff a volunteer work group organized by The Mental Health Association in Texas to develop a suicide prevention toolkit for Texas community stakeholders in suicide prevention. Dr. John Burruss, (see sidebar), helped organize the local coalition in Harris County and contributed to the Texas toolkit. I hope that other family doctors, psychiatrists, and mental health professionals will follow his lead to help lower the suicide rates in Texas on a community-by-community, county by county basis. Below are excerpts from "A Suicide Prevention Toolkit for Texas Communities: Coming Together To Care."

The Cost of Suicide for Texas

Suicide is a leading cause of death that carries a huge social cost, yet because of complex issues such as the stigma associated with mental illness and the lack of adequate research and surveillance dedicated to suicide, it is seldom recognized as a significant public health problem. But consider the toll it is taking on our state:

- Suicide is the ninth leading cause of death for Texans and the third leading cause of death among youth ages fifteen to twenty-four.
- In 2002, on average, slightly more than six Texans died from suicide each day.
- Regardless of age, males were more likely to die because of suicide than females. In fact, in 2002, 1,798 males and 502 females died of suicide in Texas.
- Suicide rates are highest among Texans seventy years and older. The highest reported suicide rate was among the eighty- to eighty-four-year age cohort, which reported a rate of 19.03 per 100,000.
- Among women, the highest suicide rate occurred among those who were between the ages of forty and forty-four. The suicide rate for this group was 9.27 per 100,000 women.
- Adolescents are a particularly vulnerable

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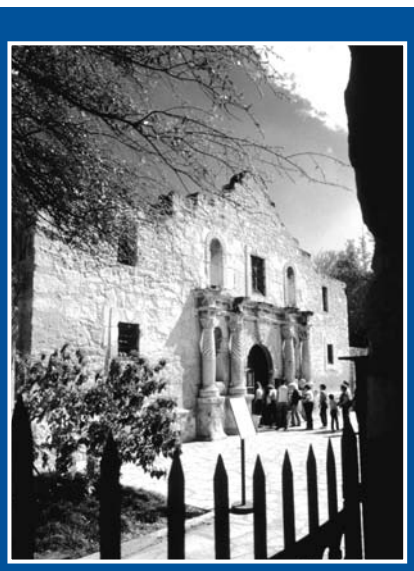

TSPP Annual Scientific Program

"Beyond Essentials: Excellence in Texas Psychiatry"

Schedule and Registration Form
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J. CLAY SAWYER, MD
President

It Takes a Physician...

By the time anyone reads this column, the annual summer TSPP Leadership Conference will have taken place. It is my hope that the conference will have been well attended, and that participants will have learned much from Joel Roberts not only regarding effective communication techniques with legislators/press/others, but also regarding . . . ourselves. Medical school and residency training challenged all of us in different ways and expanded the horizons of us all in ways that we could never have anticipated in college and in graduate school. It is my hope that all of us who attended the conference will have expanded even further our own communication skills through this expert guidance and instruction. I found this program helpful and effective in the past when I was taking my first steps at dealing with legislators on a personal basis. I learned that this task is not "rocket science," or even "neurosurgical science" (see previous column!), and that even I could do it! Many of our colleagues learned to use these techniques effectively, as well. As a result, we were able to better contribute to TSPP's effort in the last regular legislative session (Spring 2003) to convince legislators of just how important and how serious were our concerns about the dangers of non-medically trained people (among them psychologists) gaining prescribing privileges. We were successful.

Unfortunately, we can neither rest on, nor rely on, past successes. This threat to patient safety will, in all likelihood, be introduced yet again in the next legislative session this spring. Just as TSPP was successful at preventing psychologists from gaining hospital admitting privileges in the '80s, so we must remain successful now at preventing those who have no extensive and proper medical training from gaining medical practice privileges. We are all familiar, of course, with our usual adversaries regarding scope-of-practice issues (psychologists and other non-medical specialists and practitioners), as well as those would constrict and even end our own practice responsibilities (scientologists and others). However, we may not be nearly as familiar with the obstacles we face from an often unexpected source: complacency from within. It is all too easy to expect that "there will always be someone there to take care of this," to say that "my help and my opinion aren't all that important," and to believe that "things aren't really that serious."

We have a societal responsibility both to train other professionals to properly practice medicine and to ensure that non-medical professionals do not practice medicine.

My friends, nothing could be further from the truth. All of us in TSPP are the "someone there," the "help" and the "opinion." And, things <u>are</u> that "serious." All of us who practice psychiatry, whether in Texas or elsewhere, face the same obstacles, the same challenges, the same problems. And these obstacles, challenges, and problems are the same whether we practice in the public sector, the private sector, or the academic sector. Medicine in general is reaching a most important crossroads. As physicians, we are part of that movement and that trend. What we are now approaching is the culmination of a most significant challenge to the very core of what it means to be a physician: our professionalism.

Our professionalism is what makes us physicians, and what sets us far apart from those who would call themselves "medical professionals" without professional medical training, seeking to do so for their own ends and not for any presumed "good" for patients. As medical professionals, we know the challenges and the rigors of the training (both past and ongoing) we all endure — and master. As medical professionals, we know why that training is so necessary for patient care and safety. As medical professionals, we accept the premise that we must continue to educate ourselves (whether required by statute or not) so as to be able to enhance the quality of the care we offer to our patients. And, as medical professionals, we know that we have a duty to patients in general, and to society as a whole, to ensure the best possible quality of care by ensuring that only those who are properly and rigorously trained to do so may engage in the delivery of that care. That duty is our responsibility. No one can advocate for quality medical care for our patients more effectively than physicians.

Attacks on our professionalism are nothing new. Non-medical practitioners, scientologists, managed care, and other entities have attacked our professionalism many times over many years. Even the managed care problem is nothing new—it is common knowledge that England in the nineteenth century depended upon networks of entrepreneurs for the availability and the delivery of medical care. These entrepreneurs determined who could call themselves physicians, where a physician could practice, what a physician could be paid, the kind of care to be rendered, and who among British subjects would be worthy of receiving medical care. Any parallels to the present notwithstanding, physicians were essentially paid tradesmen who worked at the pleasure (and whim) of an entrepreneur, tradesmen who may well have felt that they had no choice but to accept their lot in life . . . until one physician stood up and reminded all of his colleagues that they were professionals, and that only they could reclaim their professionalism.

The lessons of history are clear and unequivocal. We are professionals. We have a societal responsibility both to train other professionals to properly practice medicine and to ensure that non-medical professionals do not practice medicine. And, just as only we professionals can reclaim any erosion of our professionalism which may occasionally occur, only we can allow our professionalism to be taken from us. Whether through complacency, through inaction, through inappropriately delegating professional responsiblities, through rationalization, through denial, or through sheer inattention to urgent situations as they arise, any loss of professionalism is, and will be, our own fault. The blame for any such loss will have to be placed at our own feet, not at those of anyone else or of any other group. The late and lamented Pogo stated this concept quite clearly in that last comic strip, "I have seen the enemy, and he is us."

We must not allow ourselves to be our own worst enemies, to do nothing in response to attacks on our professionalism, to assume that plenty of other physicians will be there to fight our battles for us. TSPP has been highly successful in meeting these challenges and fighting these battles. But . . . .

Who is TSPP?

TSPP is <u>us</u> — all of us who are physicians and who belong to TSPP.

All of us must take an active role in helping to fight these battles, to meet these challenges. We can continue to be successful, if we try. Using the techniques learned at the Leadership Conference will prove to be of immense help, but the desire to meet our responsibilities and to perform our duties can only come from within. We must always be true to the professionalism within which makes us physicians.

MEMBERSHIP CHANGES

NEW MEMBERS

The following membership applications have been approved by the Executive Committee and have been transmitted to the APA.

MEMBER IN TRAINING

Cather, J. Christian, MD

GENERAL MEMBER

Hopper, Ken C., MD
Leyva, Jose, MD

MIT ADVANCEMENT TO GENERAL MEMBER

Harris, Toi B., MD (Reinstatement)
Lotan, Sandra, MD
Preda, Adrian, MD

TRANSFERS FROM OTHER DISTRICT BRANCHES

Hurd, Cheryl L., MD
Timmons, Teresa, MD

Federation of Texas Psychiatry

A United Voice for Texas Psychiatry

On August 8, the TSPP Executive Council unanimously voted to apply for membership in a new organization formed to unite the various psychiatric organizations in Texas, the Federation of Texas Psychiatry.

The Federation of Texas Psychiatry, incorporated as a non-profit organization in Texas on July 1, will offer organizational memberships to state professional psychiatric societies (ie TSPP) and to state professional psychiatric subspecialty organizations. These organizations will be voting members of the Federation and will send representatives to serve on the Federation's governing body, the Delegate Assembly. The Delegate Assembly will appoint various committees and councils to facilitate cooperation and unity between its member organizations on a variety of important issues. Two such councils will be the Council on Public Policy to coordinate positions and advocacy efforts on legislative and regulatory matters and a Council on Continuing Medical Education to develop continuing medical education programs for psychiatrists and other physicians.

Associate memberships, a non-voting category, will be offered to firms, institutions and corporations that provide services, goods or assistance to help support psychiatric educational or membership activities.

The Federation will also offer management services to member organizations to conserve their financial resources and to permit them to keep their membership dues at the lowest possible rates. In addition, the Federation will provide to members of affiliated organizations information regarding options for malpractice insurance, risk management, financial planning, and office billing and management systems. The Federation will facilitate communications among Texas psychiatrists who are members of affiliated organizations through the publication of a newsletter and a website.

The formation of the Federation at this time was largely driven by the many challenges facing psychiatrists and their patients in the Texas Legislature and state regulatory agencies. In January, psychologists will be attempting for the third time to gain prescribing privileges through the Texas Legislature. Medical and psychiatric care in particular for children in foster care is being scrutinized and legislative and regulatory attempts will be made to restrict access to needed psychiatric care for children. Significant changes are underway in the delivery of public mental health services amounting to healthcare rationing, impacting access to care and the quality of care. The State's statutes regarding the insanity defense will likely be changed in the next Legislative Session. Because of these and numerous other challenges and opportunities, it is vital for Psychiatry to be engaged and to deliver a strong and united message. The Federation will provide the means for organized psychiatry to have a strong and united presence in the public policy setting.

The stated purposes of the Federation include:

A. to promote the common professional interests of psychiatrists by encouraging their participation as members of state professional psychiatric associations, including the Texas Society of Psychiatric Physicians and the Texas Academy of Psychiatry and state professional subspecialty psychiatric associations including organizations for Child and Adolescent Psychiatry, Addiction Psychiatry, Geriatric Psychiatry and Forensic Psychiatry;
B. to facilitate the coordination of and work in concert with state professional psychiatric associations and state professional subspecialty psychiatric associations, to unify programs that advance public and professional education and advocacy for psychiatry and persons with psychiatric illnesses;
C. to provide centralized services to state professional psychiatric associations and state professional subspecialty psychiatric associations;
D. to make psychiatric knowledge available to other practitioners of medicine, to scientists, and to the public; and,
E. to promote the best interests of patients and those actually or potentially making use of mental health services.

As a result of the action taken by the TSPP Executive Council, TSPP will be the first organization admitted into membership of the Federation.

Executive Council Actions...

On August 8, the TSPP Executive Council met in San Antonio during TSPPs Leadership Conference and unanimously approved the following:

- ★ The Executive Council authorized the employment of its staff by the Federation of Texas Psychiatry and terms and conditions for employment contained in an Employee Handbook.
- ★ The Executive Council approved a management agreement with the Federation of Texas Psychiatry for association management services.
- ★ The Executive Council authorized the submission of an application for membership in the Federation of Texas Psychiatry.

Suicide Prevention in Texas – Hope for the Future

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group. In 2002, 345 adolescents ages ten to twenty-four died as a result of suicide. Of these, 288 were boys and fifty-seven were girls.

Hope for Prevention

"The Centers for Disease Control (CDC) recently reported a twenty-five percent drop in the suicide rate among American children and teens between 1992 and 2001. While the CDC did not report a reason for these changes, it may be instructive to note that the drop reflected a dramatic decrease in the rate of gun suicides, perhaps indicating that education about the need to restrict children's access to firearms might be helping to prevent some suicides in this group. And while the overall suicide rate dropped among children and teens, it must also be pointed out the number of suicides by hanging or other forms of suffocation actually rose among young people in that decade. So while the report indicates that suicide is preventable, it also points to the complexity of the problem.

There is much to be learned about suicide prevention. Suicide has many different causes that involve biological, psychological, social, and environmental factors. Because suicide is complex, there is a need to address it utilizing a multidisciplinary approach that draws on expertise in not only public health, but also mental health, substance abuse, aging, and many other areas."

The appendices of the Suicide Prevention Toolkit have an extensive list of web sites, resources, books and statewide and national contacts for mental health professionals and suicide prevention advocates. This includes a list of all survivors of suicide support groups in the state and a listing of statewide hotlines and crisis centers. The 1-800- SUICIDE national hotline is always available to connect individuals to the nearest local crisis center.

How to Get Involved As A Member of TSPP

As a suicide survivor, I cannot bring back our son. But I can urge you, as leaders in mental health, to address suicide as a public health problem that is preventable if communities come together to care and invest resources, education, and funds in suicide prevention. Please let TSPP or the Texas Suicide Prevention Community Network know if you would be willing to help in your area. We need you to help stop the six deaths by suicide per day we have in Texas.

The Texas Suicide Prevention Community Network Co-chairs are:

Merily H. Keller (MPH graduate student) mhkeller@onr.com, Co-Chair, Texas Suicide Prevention Community Network (Austin # 512-327-8689)

Charles Vorkoper, LCSW, LPC, LMST, Vorkoper@msn.com Co-Chair, Texas Suicide Prevention Community Network (Dallas # 972-490-1007)

S O U R C E S

"CDC Reports Latest Data on Suicide Behaviors, Risk Factors, and Prevention," CDC, June 10, 2004. http://www.cdc.gov/od/oc/media/pressrel/r040610.htm

National Strategy for Suicide Prevention: Goals and Objectives for Action. http://www.mentalhealth.samhsa.gov/suicideprevention/strategy.asp

"Public Health Approach to Suicide Prevention," Suicide Prevention Resource Center. http://ww.sprc.org

The Surgeon General's Call To Action To Prevent Suicide, 1999. http://www.surgeongeneral.gov/library/calltoaction/default.htm

The Texas Department of Health, Bureau of Vital Statistics, 2002. *Death Tables* [Data file]. http://www.tdh.state.tx.us/chs/vstat/latest/t18.htm

Texas Youth Risk Behavior Surveillance System (YRBSS), 2003.

US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, WISQARS, 2001. http://www.cdc.gov/ncipc/wisqars

Suicide Risk and Assessment

John W. Burruss, MD

Every mental health training program includes some information about suicide risk and assessment, but few provide the kind of detailed, specific information necessary to help individuals and communities prevent and respond to this kind of loss. Part of organizing the community in suicide prevention efforts involves taking active steps to ensure that mental health professionals who are involved in community efforts have the additional education they need to be effective. Supplemental education should address awareness of:

- The relationship between suicide and mental illness
- The need for mental health screening as a tool in suicide prevention efforts
- Existing treatment guidelines that will determine best practices, such as those of:
  - American Psychiatric Association, http://www.psych.org/
  - The American Foundation for Suicide Prevention, http://www.afsp.org/professional
  - American Psychological Association, http://www.apa.org
- The limited effectiveness of "suicide contracts"
- The role of the mental health professional in helping to stop the spread of suicidal behavior in school and other group settings
- The need to work with the media to avoid glamorization of suicide, in order to limit any possible contagion effect
- The demographics of high-risk groups (as well as the limitations of demographic factors as predictors of behavior)
- Protective factors and the ability to maximize their influence within individuals and the community
- Alcohol and drug use as precipitants for suicide
- The need for professionals to take an active stance about removing highly lethal agents from the home, especially firearms
- The under-appreciated risk of suicide amongst the elderly
- The need for age-appropriate intervention among children and adolescents, including professional guidance and availability to schools, in the aftermath of a suicide

A local psychiatrist or other mental health provider should be recruited to serve as, or to work with, the community's media spokesperson in the event of a suicide. He or she will need to understand the effect of media portrayal of the suicide on the survivors and develop the skills to craft media accounts to avoid untoward outcomes such as suicide contagion. This practitioner should work closely with print, radio, and television outlets on an ongoing basis to help convey the potential risks of poorly handled public service announcements and event coverage.

Recommendations for the Texas State Board of Medical Examiners

The Texas Legislature in 2005 will consider the re-enactment of the Medical Practice Act including the operations and functions of the Texas State Board of Medical Examiners. This is a function of the sunset review process which subjects every agency to an extensive review every twelve years.

The Texas Society of Psychiatric Physicians has gathered information from its members about the functions and activities of the Texas State Board of Medical Examiners (TSBME), especially as they affect psychiatry. This information, together with personal accounts of our members' dealings with the board, have been extensively reviewed by several standing TSPP committees, by the TSPP Committee on Sunset Review of the TSBME and by TSPP leadership.

TSPPs review has identified three major issues: Lack of due process; discrimination against psychiatrists, and discrimination against physicians with a history of psychiatric illness.

LACK OF DUE PROCESS

Several accounts of the manner in which the TSBME has processed complaints against member psychiatrists have been reported to TSPP and, almost without exception, they reveal a disregard for the rights of the accused physician. These are horror stories in which psychiatrists attending "informal proceedings" are dealt with in a heavy-handed and degrading manner by board members and staff, and denied even the most rudimentary due process rights.

Our members report that they are assumed by the board to be guilty of whatever is alleged in a complaint and that accused physicians must prove their innocence before board members who act not as neutral finders of fact but as prosecutors with judicial and sentencing powers. Accused physicians are denied such basic due process rights as the presumption of innocence, the right of access to details of the complaint against them, the right of discovery, the right to present evidence and witnesses in their defense, the right to cross-examine opposing witnesses and the right of appeal.

Because a physician's reputation and career are directly affected by the manner in which the board processes complaints, it is essential that there be statutory protections of the rights of physicians against whom complaints are filed.

DISCRIMINATION AGAINST PSYCHIATRISTS

A TSBME board member has stated that psychiatrists should be permitted to prescribe only psychotropic medications. Many people are misinformed about the fact that psychiatrists are fully qualified physicians. However, when a TSBME board member with essentially unchecked powers over the reputation and career of physicians espouses the view that psychiatrists are in effect second-class doctors, it sends a chilling message to our membership and possibly to other medical specialties who may be future targets.

TSPP is concerned about disciplinary actions of the board that appear to reflect its anti-psychiatry bias. We have received reports from our members that TSBME determinations of "nontherapeutic prescribing," especially of narcotic analgesics, are based less on clinical issues of appropriate pain management than on the fact that the prescriber is a psychiatrist.

Many psychiatrists, through basic and continuing medical education and through clinical experience, are capable of competently managing non-psychiatric illnesses and, in fact, often serve as primary care physicians for their patients. It is improper for the TSBME to discriminate against a group of physicians based solely on the fact that they have completed a psychiatric residency.

DISCRIMINATION AGAINST PHYSICIANS WITH A HISTORY OF PSYCHIATRIC ILLNESS

TSBME has concluded that applicants for licensure with a history of depression or other psychiatric illnesses are, by virtue of having received such diagnoses, at risk of harming their patients. As a consequence, applicants who have been diagnosed or treated for a psychiatric disorder, despite extensive documentation of their competence and excellence as physicians, are forced to travel to a distant city and obtain an evaluation by a forensic psychiatrist at their own expense.

The board's claim that physicians with a history of depression are potentially dangerous to their patients is discriminatory and lacks scientific validity. Referral of these physicians to a forensic psychiatrist for evaluation is punitive, stigmatizing and irrational. Forensic psychiatry is a legitimate psychiatric subspeciality but its practitioners do not have special expertise in assessing the ability of a physician to competently practice medicine.

A TSBME board member has stated that a physician applicant's competence to practice medicine safely could be divined by knowledge of which psychiatric medications the physician has taken — a claim which TSPP maintains is also irrational and without scientific validity.

Applicants with a history of psychiatric illness are no more likely than others with a history of seizures, stroke, head injury, coronary artery disease, hypertension or diabetes to practice medicine incompetently. TSPP maintains that physicians should be judged as acceptable applicants for licensure on the basis of their knowledge, skills and performance, rather than any diagnoses or treatment they may have received.

The TSBME board member alleged that a potential conflict of interest justified requiring that psychiatrist applicants for licensure with a history of depression travel to another city to be evaluated by a forensic psychiatrist. The board member claimed that laudatory assessments of psychiatrists' performance could not be objective because the psychiatrists may have been treated by their residency training directors during their residency.

In response to this allegation, TSPP surveyed general psychiatry and child and adolescent psychiatry training directors at every Texas medical school. Without exception, the residency training directors denied treating residents in their programs and many of them added that this practice is not only inadvisable but also unethical.

TSPP's concerns about discrimination against physicians with a history of psychiatric illness are shared by the medical community at large. A consensus statement by fifteen experts titled "Confronting Depression and Suicide in Physicians" published in the June 18, 2003 issue of The Journal of the American Medical Association finds that, "practicing physicians with psychiatric disorders often encounter overt or covert discrimination in medical licensing, hospital privileges, health insurance, and/or malpractice insurance." The article notes that, "most, but not all, state licensing boards have moved from questions about diagnosis or treatment toward questions about impaired professional performance at initial licensure and renewals, according to surveys conducted in 1993 and 1996." The concluding "recommendations for institutional change" include a recommendation that "state licensing boards ensure that licensure regulations, policies and practices are nondiscriminatory and require disclosure of misconduct, malpractice, or impaired professional abilities rather than diagnosis (mental or physical)."

A similar position is taken by the American Psychiatric Association in its Guidelines Concerning Disclosure and Confidentiality. The APA recommends three guidelines "for licensing boards, other regulatory agencies, and for training programs" and provides an example of the way a question might properly be posed in a licensure application. The guidelines and example are quoted below:

1. Prior psychiatric treatment is, per se, not relevant to the question of current impairment. It is not appropriate or informative to ask about past psychiatric treatment except in the context of understanding current functioning. A past history of work impairment, but not simply of past treatment or leaves of absence may be gathered.
2. The salient concern is always the individual's current capacity to function and/or current functional impairment. Only information about disorders that currently impair the capacity to function as a physician, and which are relevant to present practice, should be disclosed on applications forms. Impairment may be a clue to general medical conditions or mental disorders, including substance use disorders.
3. Applicants must be informed of the potential for public disclosure of any information they provide on applications.

As an example of a question that might be asked, the following is suggested:

In the last two years have you had any medical condition, mental disorder, or use of alcohol or drugs which has impaired your ability to practice medicine or to function as a student of medicine?

Much is at stake for physicians applying for licensure – their professional reputation and their livelihood. It is essential therefore that their applications be processed in a thorough but fair manner and that applicants' capacity to safely practice medicine be based on objective criteria and opinions of reputable physicians who have supervised them during their training and observed their performance as clinicians. This determination should not be based on the biases or whims of individual board members.

As a result of TSPPs review of agency practices, TSPP has formulated the following recommendations for reforming the TSBME.

RECOMMENDATION 1: DIVISION OF FUNCTIONS

Although TSPP acknowledges that major restructuring of TSBME may not be politically or economically feasible at this time, we offer this recommendation to divide the functions of the TSBME, based on the experience of other states and in an effort to promote fairness and objectivity in decisions that affect the lives and careers of physicians.

The duties and functions of the current TSBME fall into two distinct categories: the first, review of applications for medical licensure and relicensure, conducting and scoring of examinations, and granting and renewal of licenses; the second, receiving and processing complaints against physicians, conducting of investigations, disciplinary procedures and imposition of sanctions. Although the two functional areas intersect at points, e.g., when a disciplinary action includes suspension of physician's license, TSPP believes that for clarity of purpose and avoidance of conflict, the two functional areas should be separated.

The separation could be accomplished by establishing two distinct authorities within the agency — two executive directors and/or medical directors reporting to separate standing committees of the board. Alternatively, the current TSBME could be abolished and succeeded by two separate agencies - the Texas Board of Medical Examinations and Licensure

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and the Texas Board of Medical Investigations and Sanctions. Although the last proposal would entail some additional staff positions, the total membership of the two newly created boards should not vary significantly from that of the current board, most administrative and support services would be shared by the two agencies and additional costs would be minimal.

Statutory functions of the medical examinations and licensure functional area (or board) would consist of reviewing applications, conducting and scoring examinations, issuing licenses, collecting fees and, as a result of disciplinary actions imposed by the medical investigations and sanctions functional area (or board), suspending, revoking or restoring medical licenses. The medical investigations and sanctions functional area (or board) would investigate all complaints; conduct due process hearings and settlement conferences; determine sanctions against offending physicians; direct the medical examinations and licensure functional area (or board) to limit, suspend or revoke licenses; and review denials of medical licensure by the medical examinations and licensure function (or board), providing physicians so denied with a due process appeal.

RECOMMENDATION 2: STATEMENT OF LEGISLATIVE INTENT

TSPP believes that, in recreating the TSBME or successor agencies, the Texas legislature should declare its support for fairness and objectivity in the processing of applications for medical licensure, and protection of the due process rights of physicians against whom complaints are lodged, including protection against discrimination based on medical specialty, locale of a physician's training, and a physician's history of psychiatric or other medical illnesses. Accordingly, TSPP recommends that Section 151.003 of the current Medical Practice Act be expanded by inclusion of two new subsections (3) and (4) as set forth below:

(3) A physician against whom a complaint is filed shall be afforded by the board a full panoply of substantive and procedural due process rights including the presumption of innocence pending a final determination by the board or an administrative law judge, the right of notice, the right to counsel, an opportunity to review the complaint and related information in detail, the right to be judged by reasonable and objective standards of what constitutes the proper practice of medicine, the right to present evidence and call factual or expert witnesses in the physician's defense, the right of discovery, the right to cross-examine opposing witnesses, the right to be sanctioned by the board only after a finding by a predominance of the evidence that the physician failed to practice medicine in a professionally acceptable manner, and the right of appeal.

(4) The board shall not discriminate against any physician with respect to granting of licensure or processing of complaints, or hold any physician to a higher standard than other physicians by virtue of the physician's age, race, ethnicity or religion; the locale, state, country or institution in which the physician received medical, undergraduate or postgraduate education; the medical specialty of the physician; or any history of psychiatric or other medical illnesses or treatment received by the physician for such illnesses unless the board has determined that, as a result of such psychiatric or other medical illnesses, the physician fails to practice medicine in a professionally acceptable manner.

RECOMMENDATION 3: DUE PROCESS

TSPP recommends that the legislature incorporate into statutory reenactment of the Medical Practice Act a range of due process protections for physicians against whom complaints are filed. The complaint process is essential for identifying and sanctioning physicians who violate the trust of their patients and practice medicine in an unprofessional or incompetent manner. But some complaints are factually erroneous or, for other reasons, without merit. They may be filed by a person who is misinformed, misinterprets the actions of a physician, or whose knowledge of alleged misconduct of a physician is based on rumor or hearsay. On occasion, complaints are filed maliciously by persons over a perceived slight by the physician. Because a physician's professional integrity and career are placed in jeopardy by any complaint filed by any person, whether the complaint is valid or invalid, fairness dictates that the physician be afforded the basic due process protections outlined below.

RECOMMENDATION 3.1: PRESUMPTION OF INNOCENCE, BURDEN OF PROOF AND STANDARD OF PROOF.

The current system is unfair to a physician against whom a complaint is filed. The physician is assumed to be guilty of whatever is alleged and must face the formidable TSBME bureaucracy, all components of which function in a prosecutorial mode. The physician has no assurance that those investigating the complaint will seek exculpatory evidence, e.g., medical records from other physicians, statements from the patient, family members or from the physician's professional colleagues. Informal settlement conferences are uniformly one-sided with the physician on the defensive, defending against allegations, the details of which the physician may never learn. The dark cloud of guilt and ignominy hovers over even the most professionally competent and ethical physician for the many months it takes the TSBME to investigate and resolve the complaint.

TSPP recommends that the Medical Practice Act incorporate the presumption of innocence as a right of physicians against whom complaints are filed. Accordingly, the burden of proof should be placed on the agency attempting to establish that a physician has practiced medicine in a dishonorable, unprofessional or incompetent manner. TSPP recommends that the standard of proof for such a determination be that of a preponderance of the evidence.

RECOMMENDATION 3.2: INVESTIGATION AND DISMISSAL OF COMPLAINTS.

TSPP recommends that the Medical Practice Act require that investigations of complaints be conducted in a fair and impartial manner, that sufficient information be gathered to determine the veracity or lack thereof of complaints, and that complaints found to be frivolous, erroneous or malicious be promptly dismissed.

RECOMMENDATION 3.3: CONFIDENTIALITY OF COMPLAINTS.

The mere filing of a complaint should not result in stigmatization of a physician. TSPP recommends that the Medical Practice Act require that complaints against physicians, until finally resolved by the board or an administrative law judge, be considered confidential and not subject to disclosure. This provision precludes release of the names of physicians with pending complaints to legislative committees (Sec. 154.055), publishing the names in the Texas Medical Board Bulletin, or posting the names on the internet.

RECOMMENDATION 3.4: THE RIGHT OF A PHYSICIAN TO OBTAIN INFORMATION ABOUT WHAT IS ALLEGED.

TSPP recommends that the Medical Practice Act require that a physician against whom a complaint is filed be provided with sufficient details of the complaint to prepare an adequate defense. The physician should have the right to query the complainant or opposing fact or expert witnesses by means of interrogatories, and should have the right to request production of documents relevant to the physician's defense.

RECOMMENDATION 3.5: THE RIGHT TO PROVIDE INFORMATION TO INVESTIGATORS.

TSPP recommends that the Medical Practice Act guarantee that, at any time during the processing of a complaint, the physician against whom the complaint was filed shall have the right to provide investigators with documents or other information, orally or in writing, concerning the facts surrounding the complaint with the assurance that such documents and information will be reviewed by investigators.

RECOMMENDATION 3.6: THE RIGHT TO BE MEASURED AGAINST REASONABLE AND OBJECTIVE STANDARDS OF ACCEPTABLE MEDICAL PRACTICE.

According to several reports received by TSPP from its members, decisions about acceptable medical practice are often based on the opinions of individual board members rather than on an established standard. TSPP recommends that the Medical Practice Act require that the determination of acceptable medical practice be based on generally recognized professional standards that acknowledge the diversity of opinion that exists with respect to the diagnosis and appropriate management of many illnesses.

RECOMMENDATION 3.7: ESTABLISHMENT OF STANDARDS FOR SELECTION OF REVIEWING PHYSICIANS, NURSE INVESTIGATORS, OTHER TSBME PROFESSIONALS, AND EXPERT PANELS.

TSPP recommends that the Medical Practice Act establish standards for the professional education, continuing medical education and postgraduate certification of those who evaluate the merits of complaints against physicians. Members of expert panels should be required to possess expertise and experience in the specific areas addressed in the complaint and should be free of bias and conflicts of interest.

RECOMMENDATION 3.8: OFFICE OF PHYSICIAN ADVOCATE.

TSPP recommends that the Medical Practice Act require the establishment of an office of physician advocate within the TSBME. The office should be staffed by persons whose task it is to thoroughly review all matters pertaining to a complaint against a physician, assure that the physician is dealt with fairly during the course of the investigation, and assure that the physician's defense is adequately presented in any proceedings conducted by the board.

RECOMMENDATION 3.9: REFORM OF INFORMAL PROCEEDINGS.

Informal proceedings (Sec. 164.003 of the Medical Practice Act), as abundantly documented by TSPP members, are typically of an inquisitorial nature and bereft of even a sem-

continued on page 7

New Video About the Role of the TSBME

A new video about the Texas State Board of Medical Examiners (TSBME) gives physicians clear guidance on how to apply for a medical license, how to keep the license up to date, and what to do when a complaint is filed. The video reviews the composition, purpose and scope of the TSBME; the relationship between the TSBME and professional associations; the licensing process; the responsibilities of the licensee; common violations of the Medical Practice Act; and the investigative process of the Board. It even takes an inside look at an Informal Settlement Conference, which is the tool most often used to resolve complaints against physicians.

The video was produced and funded by the Texas Medical Foundation (TMF), the medical quality improvement organization for Texas, as a service to Texas physicians.

The video, titled "The TSBME: A Glimpse of Licensure and Discipline," is available at no charge to Texas physicians, medical organizations, medical schools and residency programs.

"The TSBME: A Glimpse of Licensure and Discipline" is available on the TMF website, www.tmf.org for online viewing. It has been designated by TMF to meet the one hour Category I continuing medical education (CME) requirements in the area of medical ethics and/or professional responsibility. A copy of the video may be obtained by calling the TMF at 800/725-9216.

TEXAS SOCIETY OF PSYCHIATRIC PHYSICIANS

2004 Annual Convention & Scientific Program:
"Beyond Essentials: Excellence in Texas Psychiatry"

Omni Hotel • San Antonio, Texas

DAILY SCHEDULE

FRIDAY, NOVEMBER 12

7:00 am - 8:00 pm	Registration/Information
8:00 am - 6:00 pm	TSPP Committee Meetings
12:00 pm - 1:15 pm	Member Luncheon
2:30 pm - 5:00 pm	Exhibits Set-Up
2:45 pm - 4:15 pm	Members in Training and Early Career Psychiatrists Program "Establishing Your Own Successful Psychiatry Practice — One Doctor's Story"
6:00 pm - 7:00 pm	Exhibits Opening/Welcome Reception
7:00 pm	TSPP Annual Awards Banquet

SATURDAY, NOVEMBER 13

7:00 am - 4:00 pm	Exhibits
7:00 am - 7:00 am	Registration/Information
7:30 am - 8:30 am	Continental Breakfast for Program Registrants with Exhibitors
8:45 am - 12:000 pm	**Scientific Program Morning Session:**

"Treating Borderline Personality Disorder in Public Services"
Presenter: Elizabeth E. Weinberg, MD
Co-Presenters: A. John Sargent, III, MD and Avrim B. Fishkind, MD

"New Patient Oriented Research Findings in Bipolar Disorders:"

Maintenance Treatment: Illness Course and Specific Drug Efficacy
Presenter: Charles L. Bowden, MD

Imaging the Hippocampus, Amygdala and Prefrontal Cortex in Bipolar Disorder in Adolescents and Adults
Co-Presenter: Jair C. Soares, MD

Mixed States in Bipolar Disorders: How to Classify and Treat
Co-Presenter: Vivek Singh, MD

12:30 pm - 2:00 pm	Annual Business Meeting Luncheon
2:00 pm - 5:30 pm	**Scientific Program Afternoon Session:**

"Case Presentations: Treatment of Severe Mood Lability and Aggression in Adolescents in the Juvenile Justice System"
Presenter: Brigitte Y. Bailey, MD
Co-Presenters: Anne T. Lopez, PhD and Steven R. Pliszka, MD

"Stereotactic Functional Neurosurgery for Severely Disabling, Medically Intractable Psychiatric Disorders"
Presenter: Terrence S. Early, MD
Co-Presenter: Haring J.W. Nauta, MD, PhD

5:30 pm - 7:00 pm	TSPP Executive Council Meeting
7:00 pm	Board Buses for Riverwalk Reception

SUNDAY, NOVEMBER 14

7:30 am - 1:00 pm	Registration/Information
8:00 am - 12:30 pm	Scientific Program Session

Resident Paper Competition Winner Presentation

"Ethical Considerations in Privacy for Couples, Families and Groups: Split Alliances, Dual Duties and Trust"
J. Ray Hays, PhD, JD

"Fibromyalgia Syndrome: Diagnosis, Pathogenesis and Management"
I. Jon Russell, MD, PhD

ANNUAL CONVENTION CONTRIBUTORS

The Texas Society of Psychiatric Physicians is pleased to recognize the following confirmed contributors and educational grants to the 2004 Annual Convention and Scientific Program:

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TEXAS SOCIETY OF PSYCHIATRIC PHYSICIANS

2004 ANNUAL CONVENTION & SCIENTIFIC PROGRAM

November 12-14, 2004 • Omni Hotel, San Antonio, Texas

Please complete this form and return it with your check, money order or credit card information for your registration and event fees to the Texas Society of Psychiatric Physicians, 401 West 15th Street, Suite #675, Austin, Texas 78701 **by October 24** to receive the discounted registration fee. Registration forms and payments by credit card may be FAXED to TSPP at 512/478-5223.

NAME _____ E-MAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

NAME(S) SPOUSE/GUEST(S) ATTENDING (for name badges) _____

REGISTRATION FEES

Indicate the **NUMBER** of individuals who are registered for each event in the appropriate enrollment category listed below. Please note the enrollment fees are PER PERSON and your payment should reflect the proper fee for the number of individuals registered per event.

NUMBER ATTENDING EVENT	DISCOUNTED REGISTRATION (If postmarked before 10/24)	AFTER 10/24
WELCOME RECEPTION - Friday Evening		
#☐ NOT Registered for Scientific Program	$40	$50
#☐ Registered for Scientific Program TSPP Members/Texas Academy of Psychiatry Members/Non-Members/Spouse/Guest	No Chg	No Chg
MEMBERS IN TRAINING/EARLY CAREER PSYCHIATRISTS PROGRAM: "Establishing Your Own Successful Psychiatry Practice – One Doctor's Story" - Friday Afternoon		
#☐ Attending @ No Charge		
SCIENTIFIC PROGRAM - Saturday and Sunday		
#☐ TSPP/Texas Academy of Psychiatry Member	$190	$235
#☐ TSPP/Texas Academy of Psychiatry MIT/ Medical Student	$ 25	$ 35
#☐ Non-Member	$235	$290
#☐ Non-Member MIT/Medical Student	$35	$50
#☐ Allied Health Professional	$ 105	$130
#☐ Spouse	$ 95	$120
#☐ Advocacy Organization Leadership	$ 35	$50

NUMBER ATTENDING EVENT	DISCOUNTED REGISTRATION (If postmarked before 10/24)	AFTER 10/24
TSPP/TEXAS ACADEMY OF PSYCHIATRY MEMBER LUNCHEON		
#☐ TSPP/Texas Academy of Psychiatry Member Luncheon - Friday	$15	$20
AWARDS BANQUET – Friday Evening		
#☐ Awards Presentations/Banquet	$25	$35
ANNUAL BUSINESS MEETING LUNCHEON		
#☐ Annual Business Meeting and Luncheon – Saturday	$15	$20
RIVERWALK RECEPTION – Saturday Evening		
#☐ Riverwalk Reception	$15	$25

TOTAL REGISTRATION FEE ENCLOSED $ _____

#☐ Vegetarian Plate Requested
** No add'l charge if requested prior to 10/24*
*** After 10/24 & On-site add add'l $5.00 for each Luncheon/Banquet Fee*

If you require any special assistance to fully participate in this conference, please contact TSPP at (512) 478-0605.

METHOD OF PAYMENT - *Make checks payable to "Texas Society of Psychiatric Physicians"*

Method of Payment

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CANCELLATION POLICY: In the event of cancellation, a full refund will be made if **written notice is received in the TSPP office by October 24, 2004, less a 25% handling charge. No refunds will be given after October 24, 2004.**

Return to: TSPP • 401 West 15th Street, Suite #675 • Austin, TX 78701 • (512) 478-0605 • FAX (512) 478-5223

The Ethics Corner

Milton Altschuler, MD

Does anyone remember "THE GOLDWATER RULE?"

Psychiatrists are often called on to discuss possible explanations for activities of individuals that may be in the headline of the week. It is tempting to be quoted by the media either in writing or on television and to be recognized as an expert of aberrant behavior.

I was reminded of the seductiveness of this invitation to extemporize on someone's behavior when a forensic psychiatrist appeared on national television to state that an individual with Asperger's Syndrome could certainly experience intimacy because he had been married on two occasions. The material he reviewed for his "expert" opinion was based on reading a trial deposition and observing him in a televised courtroom appearance that was broadcast on Court TV.

Prior to the 1968 presidential elections Senator Barry Goldwater was denounced by prominent psychologists and psychiatrists as at best paranoid and at worst having paranoid schizophrenia because of his stand against the Soviet Union. Both the psychological and the psychiatric professions were embarrassed by the revelations that these "expert" psychologists and psychiatrists had based their opinions on seeing him on television and reading media reports concerning a very prominent and public senator from Arizona.

I have noticed that, particularly on talk shows, there are various psychologists and psychiatrists being asked for their opinions regarding the "criminal of the week."

Bear in mind that the Principles of Medical Ethics with Annotations especially applicable to psychiatry state that "On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention, or who has disclosed information about himself/herself through public media. It is unethical for a psychiatrist to offer a professional opinion unless he/she has conducted an examination and has been granted proper authorization for such a statement."

I believe that we, as individuals and as a profession, will gain greater respectability and credibility if we keep this ethical standard in mind when we deal with the media. If you have any comments please do not hesitate to contact me at my email address: malt1@swbell.net

Recommendations for the Texas State Board of Medical Examiners

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blance of due process.

TSPP recommends that the Medical Practice Act delete the word "informal" in the designation of these proceedings; require that, at the discretion of the physician subject, these proceedings be made open to the public; require that the individual presiding at the proceedings be a neutral finder of fact and arbiter of law, that transcripts be provided for each proceeding, that the subject physician be permitted to present evidence as well as fact and expert witnesses in the physician's defense, and that the physician or the physician's counsel have the right to cross-examine all individuals providing evidence or testifying against the physician.

RECOMMENDATION 3.10: THE RIGHT OF APPEAL.

The administrative hearing provision in the Medical Practice Act (Sec. 164.007) purports to permit a physician to appeal a decision of the TSBME to an administrative law judge. In reality, the appeal is an artifice, since the act permits the TSBME to disregard the administrative law judge's findings and conclusions. According to our members who have pursued this "appeal," the board does not hesitate to ignore contrary rulings by an administrative law judge, making such appeals costly and usually fruitless for physicians.

TSPP recommends that the Medical Practice Act provide a true right of appeal. The language of Sec. 164.007 should be changed to read:

> A formal hearing shall be conducted by an administrative law judge employed by the State Office of Administrative Hearings. The judge's findings of fact and conclusions of law shall be final and promptly conveyed to the board which shall act in accordance with the judge's findings of fact and conclusions of law.

TSPP also recommends that the judicial review process of the Medical Practice Act (Sec. 164.009) permit a physician whose license is revoked or is subject to other disciplinary actions of the board to appeal to any Texas district court within thirty days of a final decision of the board.

RECOMMENDATION 4: PROTECTION AGAINST DISCRIMINATION

TSPP recommends that the Medical Practice Act prohibit discrimination against physicians applying for licensure or relicensure, or against physicians against whom complaints have been filed, based on age, race, gender, religion, national origin, locations of professional training or education, medical specialty, or any history of psychiatric or other medical illnesses.

TSPP Leadership Conference

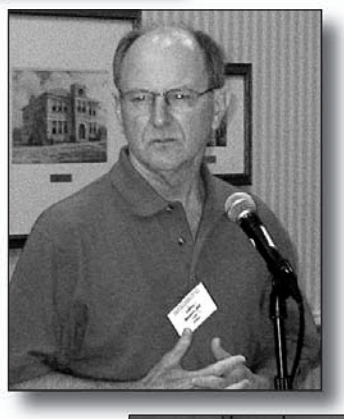
The TSPP Leadership Conference conducted in San Antonio at the Hyatt Regency Hill Country Resort on August 7-8 was a huge success. The Saturday program for the Mental Illness Awareness Coalition, attended by over 135 members of the coalition including the Mental Health Association in Texas, NAMI Texas, Texas Depression and Bipolar Support Alliance, Texas Mental Health Consumers, TMA and TSPP, featured a communications workshop conducted by Joel Roberts entitled "Communicating With Impact from CNN to Capitol Hill." The Conference luncheon speaker was Eduardo Sanchez, MD, MPH, Commissioner of the new Department of State Health Services. Following the program, the TSPP Executive Council met. On Sunday morning, TSPP members participated in a political advocacy planning meeting.

NAMI's Joe Lovelace makes a point during the Leadership Conference.

Joel Roberts briefs TSPP members on plans for a Capitol Day during the next Legislative Session.

TSPP lobbyist Steve Bresnen briefs members on the challenges of the upcoming Legislative Session.

Joel Roberts of Los Angeles received rave reviews for his communications training program.



Leslie Secrest, MD outlines plans for TSPPs Political Advocacy Task Force.

Eduardo Sanchez, MD, MPH, Commissioner of the Texas Department of State Health Services discusses plans for the new state agency.

Joel Roberts emphasizing a key point as Dana Kober, MD, Shirley Merritt, MD and Angelica Garcia listen attentively.

Sylvia Muzquiz, MD practices an interview with Joel Roberts as Jim Van Norman, MD and Martha Leatherman, MD look on.

Calendar of Meetings

November 2004

3-6 **Learning Disabilities Association Annual Conference**
"Yesterday, Today, Tomorrow"
Renaissance Austin Hotel
Austin, TX
512/458-8234

6 **Borderline Personality Disorder: Professional, Family and Consumer Perspectives**
Cullen Auditorium, 1200 Moursund St., Houston, TX
Sponsored by: The National Education Alliance for Borderline Personality Disorder, The Menninger Clinic and The Menninger Dept. of Psychiatry and Behavioral Sciences at Baylor College of Medicine, and NAMI Metropolitan Houston
Contact: Pam Gierhart, 281/398-2478

12-14 **TSPP Annual Convention and Scientific Program**
"Beyond Essentials: Excellence in Texas Psychiatry"
Omni Hotel
9821 Colonnade Blvd.
San Antonio, TX
210-691-8888

Daily Schedule

Friday, November 12

7:00 am - 8:00 pm	Registration/Information
8:00 am - 6:00 pm	Committee Meetings
12:00 pm - 1:15 pm	Member Luncheon
2:30 pm - 5:00 pm	Exhibits Set-Up
2:45 pm - 4:15 pm	Members in Training & Early Career Psychiatrists Program "Establishing Your Own Successful Psychiatry Practice – One Doctor's Story"
6:00 pm - 7:00 pm	Exhibits Opening/Welcome Reception with Contributors
7:00 pm	Annual Awards Banquet

Saturday, November 13

7:00 am - 7:00 pm	Registration/Information
7:30 am - 8:30 am	Continental Breakfast for Program Registrants w/Exhibitors
7:00 am - 4:00 pm	Exhibits
8:45 am - 5:30 pm	Scientific Program
4:00 pm	Exhibits Tear Down/Depart
10:30 am - 11:00 am	Refreshment Break
12:30 pm - 2:00 pm	Annual Business Meeting/Luncheon
5:30 pm - 7:00 pm	Executive Council Mtg
7:00 pm	Board Buses for Riverwalk Reception

Sunday, November 14

7:30 am - 1:00 pm	Registration/Information
8:00 am - 12:30 pm	Scientific Program
10:15 am - 10:30 am	Refreshment Break

TSPP Member Information Update

NAME

ADDRESS

CITY STATE ZIP

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TELEPHONE FAX E-MAIL

Send your update information to:

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401 West 15th Street, Suite 675
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512/478-5223 (fax)/TSPPofc@aol.com (E-mail)

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Display advertising is available and publication is determined on a case by case basis by the Editorial Board. The Editorial Board reserves the sole right to accept or reject any submitted advertising copy.

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