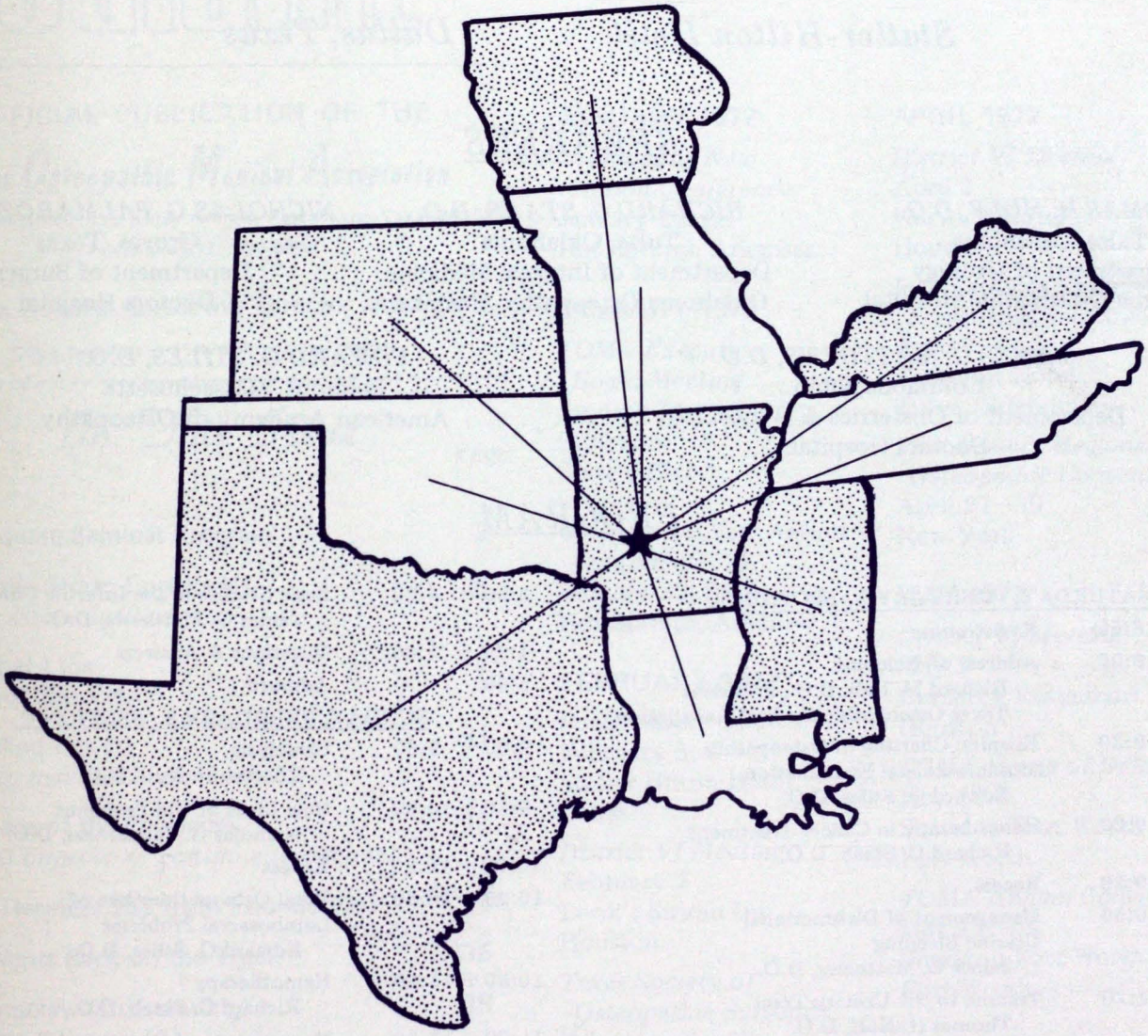
TEXAS OSTEOPATHIC PHYSICIANS

JOURNAL



Let's all go to Hot Springs!

JANUARY 22-23

SEE PAGE 4 FOR DETAILS

JANUARY, 1972

Postgraduate Seminar

under the auspices of

The TEXAS STATE DEPARTMENT OF PUBLIC HEALTH

&

The TEXAS OSTEOPATHIC MEDICAL ASSOCIATION

February 5 & 6, 1972

Statler-Hilton Hotel *Dallas, Texas*

SPEAKERS

THOMAS H. NULF, D.O.
Tulsa, Oklahoma
Department of Urology
Oklahoma Osteopathic Hospital

RICHARD C. STAAB, D.O.
Tulsa, Oklahoma
Department of Internal Medicine
Oklahoma Osteopathic Hospital

NICHOLAS G. PALMAROZZI, D.O
Groves, Texas
Department of Surgery
Doctors Hospital

JAMES G. MATTHEWS, D.O.
Columbus, Ohio
Department of Obstetrics & Gynecology
Doctors Hospital

EDWARD G. STILES, D.O.
Belmont, Massachusetts
American Academy of Osteopathy

PROGRAM

SATURDAY, FEBRUARY 5 - SECTION A

8:30 — 8:55	Registration
8:55 — 9:00	Address of Welcome Richard M. Hall, D.O., President Texas Osteopathic Medical Association
9:00 — 9:30	Hospital Charting of Osteopathic Musculoskeletal Examination Edward G. Stiles, D.O.
9:30 — 10:00	Hemotherapy in Cancer Treatment Richard C. Staab, D.O.
10:00 — 10:20	Recess
10:20 — 10:50	Management of Disfunctional Uterine Bleeding James G. Matthews, D.O.
10:50 — 11:20	Trauma to the Urinary Tract Thomas H. Nulf, D.O.
11:20 — 12:00	Questions & Answers
12:00	Lunch

SECTION B

2:00 — 2:30	Early Diagnosis of the Acute Abdomen Nicholas G. Palmarozzi, D.O.
2:30 — 3:00	Total Osteopathic Care of Chest Problems Edward G. Stiles, D.O.
3:00 — 3:20	Recess
3:20 — 3:50	Hemotherapy Richard C. Staab, D.O.
3:50 — 4:20	Basic Studies in the Infertile Couple James G. Matthews, D.O.
4:20 — 5:00	Questions & Answers
5:00	Adjourn

SUNDAY, FEBRUARY 6 - SECTION C

9:00 — 9:30	Urinalysis Thomas H. Nulf, D.O.
9:30 — 10:00	New Ideas of Old Problems Nicholas G. Palmarozzi, D.O.
10:00 — 10:20	Recess
10:20 — 10:50	Total Osteopathic Care of Lumbosacral Problems Edward G. Stiles, D.O.
10:50 — 11:20	Hemotherapy Richard C. Staab, D.O.
11:20 — 11:50	Management of Obstetrical Emergency James G. Matthews, D.O.
11:50 — 12:20	Questions & Answers
12:20	Lunch
2:00 — 2:30	Calculus of the Disease of the Urinary Thomas H. Nulf, D.O.
2:30 — 3:00	Pre- and Postoperative Care of the Severely Ill Patient Nicholas G. Palmarozzi, D.O.
3:00 — 3:30	Questions & Answers
3:30	Adjourn

Volume XXVIII — No. 9
Fort Worth, Texas—January 1972

TEXAS OSTEOPATHIC PHYSICIANS JOURNAL

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Mr. Tex Roberts, Executive Director and Editor

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In This Issue

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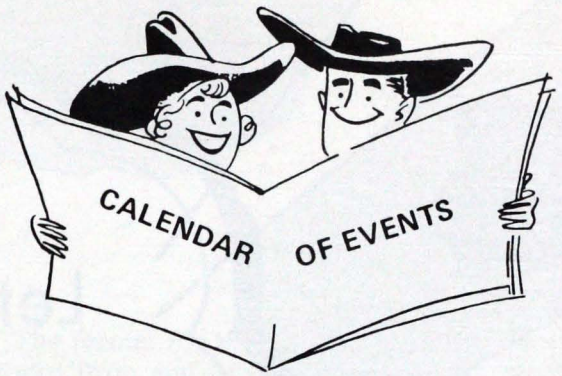


JANUARY 1972

Osteopathic New Action Conference
January 22, 23
Hot Springs, Arkansas

JANUARY 1972

TOMA Executive Board Meeting
January 11
9:00 a.m.
State Office

Osteopathic New Action Conference
January 22, 23
Hot Springs, Arkansas

FEBRUARY 1972

Postgraduate Seminar
February 5, 6
Statler Hilton Hotel
Dallas

District VI Meeting
February 7
Look's Sirloin Inn
Houston

Texas Society of Osteopathic Surgeons
February 25—27
Sheraton Marina Inn
Corpus Christi

MARCH 1972

Texas State Teachers Association Convention
March 16—18
San Antonio

APRIL 1972

District VI Meeting
April 3
Warwick Hotel
Houston

International Academy of Preventive Medicine Seminar
April 7—9
Fairmont Hotel
Tulsa, Oklahoma

First Eastern Regional Osteopathic Convention
April 27—30
New York

MAY 1972

District VI Meeting
May 1
Bismarck Restaurant
Houston

TOMA House of Delegates
May 10
Sheraton-Fort Worth
Fort Worth

TOMA Annual Convention
May 11—13
Sheraton-Fort Worth
Fort Worth

JUNE 1972

TAOMA Convention
June 9—11
Corpus Christi

State Board of Medical Examiners
June 12—14
Sheraton Crest
Austin

Let's seek solutions *before the storm engulfs us*

Why pull tomorrow's clouds over today's sunshine?

That sounds good in one way. We know that most of the things we worry about never happen.

On the other hand, from experience we have learned that when a small cloud appears on the horizon, we may be in for a storm and we take precautions.

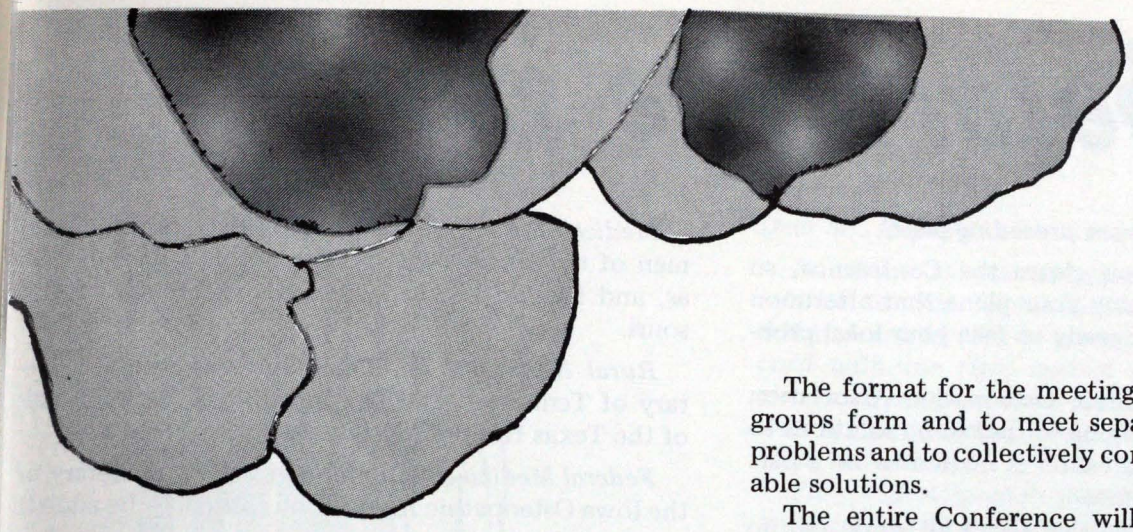
A number of clouds are looming on the horizon of this profession and some of them are not little fluffy ones that will soon waft away if we forget about them.

Although there may be those who would prefer to maintain the status quo, it simply cannot be done. Nothing is static and if we don't progress, we regress.

Because we recognize that storm clouds are gathering and that some of them have already attained near-hurricane strength, we are forced to seek higher ground—but *not* retreat into a storm cellar, hoping we will remain untouched and uninjured, and that the storm will pass leaving little damage.

As is often the case, clouds start out as separate entities and, alone, they don't do too much damage. It is when they join forces that they can wreak havoc.

On the other side of the coin, to combat these gathering storms,



members of the osteopathic profession must also join forces and throw up bulwarks that will turn these tides back upon themselves.

Which leads to the *why* of having a South Central Osteopathic New Action Conference this month.

The original idea was the brainchild of one man—as are most good ideas—and as most good ideas do—this one attracted a number of key men in a number of states—leaders who recognize the strong forces opposing this profession and who believe that a working conference can be the nucleus for solving some of the problems facing them.

Six topics have been chosen to explore by six different panels. However, the six are so interrelated that some of the groups are bound to cover some of the same ground.

This conference differs from conventions and seminars in that the doctors themselves are going to talk *with* each other—brainstorm and brain-pick and try to come up with some answers to some very difficult questions.

Dr. George B. Bean, President of the Arkansas Osteopathic Association, has invited all interested D.O.s in ten states to come to Hot Springs, Arkansas January 22 and 23 to *participate* in this meeting.

The seed was planted last July, lay almost dormant for a period, and then began to take form in the late Fall.

Dr. Bean asked the other State Presidents and state executive directors and secretaries for their cooperation and help in making this Conference a success. So since the AOA convention, a group of these has been hard at work and the topics chosen.

Included are Rural Medicine, Medical Jurisprudence (legislation), Osteopathic Education, Osteopathic Public Relations, Federal Medicine and the Fight Against Amalgamation.

The format for the meeting is to have six different groups form and to meet separately to discuss these problems and to collectively come up with some workable solutions.

The entire Conference will then go into general session, where it will hear the conclusions of these panels, and where questions may be posed that will require further study.

Following cocktails and dinner on Saturday night, the six study centers will remain open with panel coordinators in charge, so that members who have been involved with other panels during the afternoon, but are interested in a problem assigned to a separate panel, may gather in these meeting rooms for a second session on that particular topic.

The Conference officially opens at 11:00 a.m. Saturday, January 22, at which time the registrants may choose the panel on which they wish to sit and the groups will be formed.

The opening luncheon will be at noon, after which the panels will go to their meeting rooms until 4:00 p.m. at which time they will then return to the general conference for debriefing.

The after dinner informal sessions will bring up further questions and answers that will be discussed Sunday morning after the 9:30 Hunt Breakfast.

One of the highlights of the Conference comes at 11:00 Sunday morning when the Honorable Omar Burleson, U. S. Representative from Texas, will speak to the participants.

Officially, Mr. Burleson represents West Texas in the U. S. House (and has since 1947), but most physicians are familiar with his work in the health care system affecting the entire nation. He has introduced legislation that has been particularly favorable to the small hospitals and rural communities, and now has a bill before the House on national health insurance. He is one of the most knowledgeable men in Washington on the health care needs of the country and this Conference is indeed fortunate to have him bring his ideas and expertise to the participants. And he will answer questions following his address, which will be bound to give the registrants a better understanding of what Washington is doing and, also, to show Mr. Burleson what this profession is attempting to do for itself.

[please see next page]

before the storm

[continued from preceding page]

The Sunday luncheon closes the Conference, so you can plan on catching your plane that afternoon and be home that night, ready to face your local problems Monday morning.

Each member of a State Osteopathic Association who is interested in helping to find some solutions to problems facing his profession is invited to be a part of this working Conference.

We might add the old saw about all work and no play—so we'll tell you that in addition to the enjoyable fellowship we always encounter at these gatherings, Hot Springs has recreational facilities you'll want to take advantage of.

The thermal baths, of course, are what have made Hot Springs the famous national resort it is, but you'll want to come in early to take advantage of these because the Arlington bath house is only open from 7:00 to 11:45 on Saturday, but they are also open weekday afternoons until 4:00 if you can get away and be there on Friday, the 21st.

Also, guests at the Arlington have club privileges at the Hot Springs Country Club where there are two 18—hole golf courses and one nine-hole course.

Because each participating state has been busy with its own programs and the AOA convention took many key men from the Mainland for a couple of weeks, plans were a little late in taking a definite form. However, they are shaping up very well and plans are almost complete at the time we go to press with this JOURNAL.

Dr. Bean, through the other state presidents, has asked the executive directors and secretaries to be program chairmen for this Conference and they have all pitched in enthusiastically.

Although the list of panel coordinators is not quite complete, those who have agreed to serve in this capacity include:

Medical Jurisprudence: Dr. Bobby G. Smith, Chairman of the Medical Jurisprudence Committee of Texas, and Mr. Ed Borman, Executive Secretary of Missouri.

Rural Medicine: Dr. Paul Grayson Smith, Secretary of Tennessee, and Dr. John Boyd, Vice Speaker of the Texas House of Delegates.

Federal Medicine: Mr. Herman Walter, Secretary of the Iowa Osteopathic Association (others to be added).

Osteopathic Professional Public Relations: Dr. James F. Routsong, President of Oklahoma, and Mr. Tex Roberts, Executive Director of Texas.

Osteopathic Education: Dr. Joel Alter, Texas College of Osteopathic Medicine Coordinator of Clinical Instruction, and Mr. Bob Jones, Executive Secretary of Oklahoma.

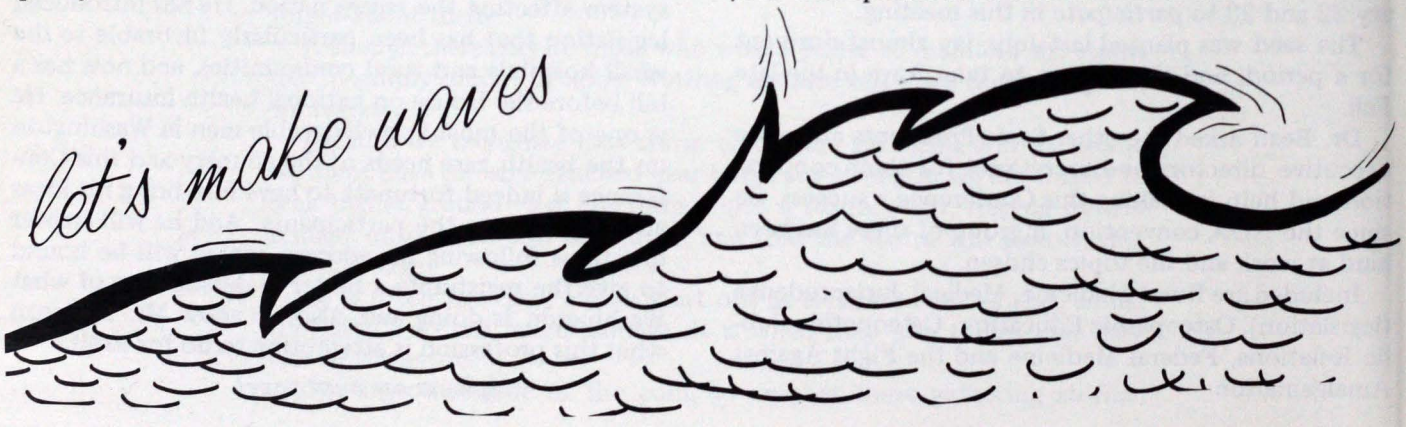
Fight Against Amalgamation: Dr. Richard M. Hall, President of Texas, and Mr. Lloyd Hall, Executive Secretary of Kansas.

There will be a registration fee of $15 per person to cover the expenses of the Conference, such as printing, postage, and speaker transportation.

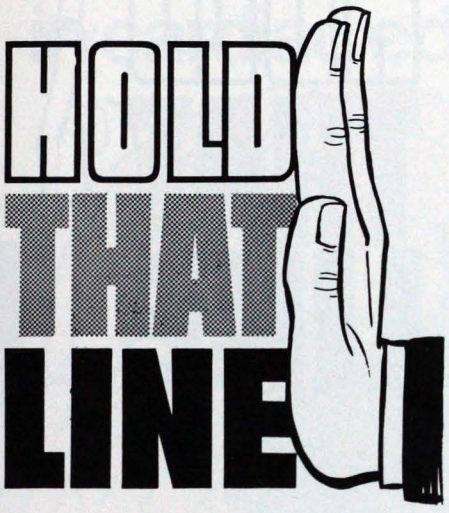
Tickets for meals will be sold at the registration desk.

Although the doctors will be hard at work a good part of the time, Mrs. Bean hopes that many wives will accompany their husbands. They may either sit in on the work sessions or just have a relaxing two days. They are bound to meet old friends there and surely will make new ones.

The Arlington Hotel has sent invitations and room reservation cards to state association members in the ten states and those cards should be returned as soon as possible so that the Conference and the Hotel may better coordinate to make this, hopefully, only the *first* Osteopathic New Action Conference. ▲



THE MEMBERS SAY



AGAINST THE TMA

On December first each member of TOMA received a letter from the State Office which was designed to better acquaint the membership with the Association's official policy toward the Texas Medical Association and the American Medical Association.

Comments were invited concerning what had been published in this Journal on the allopathic attempt to obliterate the osteopathic profession.

Although none of the respondents asked that their replies be kept confidential, we did say that opinions and not names would be reported. Therefore, the following random samples of replies to this letter are printed without signatures.

We are pleased to report that no letters were received disagreeing with the official stand of TOMA in this regard.

Dear Tex:

If we are to survive we must retain our identity. My vote is to not amalgamate.

The thing that makes a man a success in life is to have something just a little different from his competitor. If we join the TMA we shall lose that spark that makes us different.

Dear Mr. Roberts:

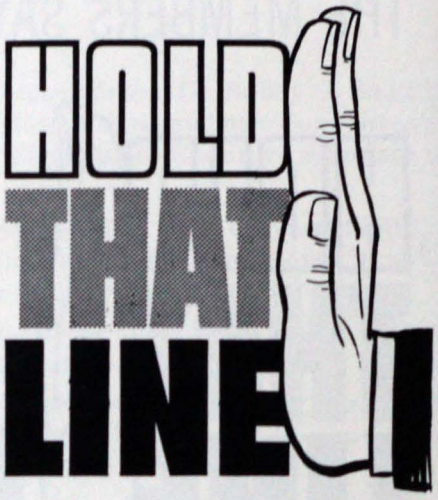
In answer to your inquiry of December 1, 1971, relative to this "squabble" with the TMA and the AMA, I would like to say that I am in complete accord with the fight against such interference. I am also in complete accord with our president, Dr. Hall, who is one of the very best presidents that our association has ever had.

The only suggestion that I can make would be to try to put on an overall program to improve the image of our professional members, and to communicate with the TMA and AMA to this degree—that it is far better to have a two party system than to have the one party system which they are trying to accumulate. A great deal could be said about this, but I believe that the majority of our members understand what I am talking about. At the same time I think what has been said has been necessary, but I believe in the future we should "cool it" so to speak, and let it be known to their leaders that if this molesting and badgering continues that some legal action will be taken against the individual offices that is responsible for such comment, and then really go to work on it and take some action against them. For example, I believe class action could be taken against their executive secretary or president for allowing this type of harassment and threats to be continuously presented.

For some time I have had a thought that is probably ridiculous, but we might in turn offer members of the TMA an opportunity to qualify to practice in our hospitals after they have taken and passed a course in manipulative therapy. You see, this might even be more newsworthy than the garbage that they are throwing out at this time. Give it some thought! Anyway, I am behind the osteopathic philosophy, you as our executive director, and Dr. Hall and his committeemen one hundred per cent.

Dear Tex:

Thanks for your recent letter relative to the Journal. I wish to thank you more, however, for the imaginative, forthright, vigorous, "pro-osteoprofessional" policy which is being consistently pursued. If there were a Pulitzer Prize for osteopathic publications (and writers) Texas Osteopathic Physicians Journal should be due to win it.



Dear Sir:

In regard to enclosed letter received Dec. 1, 1971. Regards A.M.A.'s attempt to absorb and obliterate our profession. I have personally heard the State President and I have talked with him in regards to his opinions and reports given to the district meeting recently. I am in total agreement with him and feel that I do understand the danger that faces our profession in Texas today.

Dear Tex:

It is my opinion that the question of a merger of the two professions is one that shouldn't even be discussed. I am perfectly happy being a D.O. and practicing good Osteopathic Medicine as I see fit. I don't feel being buried by the AMA is going to benefit either myself or my patients.

The bulk Medics probably aren't really that interested in the merger. I feel it is probably a few biased uninformed individuals in the top medical-political positions who are pushing this thing so hard. If these people would concentrate on good medical care for all instead of constantly stirring up trouble we would all profit. After all, most people are better off under the care of good Osteopathic Physicians anyway!

Dear Tex:

A great American tradition is that competition provides better business for all parties involved. In the case of two professions in the business of caring for the health of the American public, I feel this is especially true. There is too much likelihood of a monopoly taking unfair advantage of a gullible people in this very important field. I have had many instances of this fact already in my practice.

For the good of all, osteopaths should maintain a separate identity and continue to challenge allopaths to greater endeavors not only in the care of the sick but in the development of newer methods and medicines that will keep the medical field advancing with our generation.

I definitely vote for education of the public so that they will knowledgeably cooperate with their doctors to the furtherance of good medical care. The days of a doctor being some king of a super-educated minor god are over. We should, allopaths and osteopaths, enter into a new age of communication with patients, where possible, on a basis that we are dealing with intelligent people and not with under-educated patients.

Dear Mr. Roberts:

In regard to your recent correspondence of December 1; I feel that this has been a long standing problem between the TMA and AMA/AOA. When I was in school ten years ago it was being discussed at that time, and it is my opinion that the average medical practitioner does not want association with the osteopathic physicians. I have not suffered whatsoever due to the separation and I see no advantage in my joining the Texas Medical Association, nor would I see any advantage in my acceptance of a MD license from this organization. I feel that we should leave well enough alone, continue building our hospitals and building our professions and proceeding ahead with separate degrees.

I thank you for your inquiry.

Dear Tex:

I agree completely with everything I have heard our president say or what I have read in the Journal with reference to your letter of December 1, 1971. I would like for it to go on record to this effect.

Dear President Hall:

In response to the letter from the TOMA executive director regarding the TMA, I say (as Harry Truman surely would have) give 'em hell! ▲

The most widely used diuretic in cardiac edema

This technique of unwrapping a sphere to make a flat map was invented by Johann Werner, a mathematician who lived at the time of Columbus, long before the exact shape of the New World continents was known. To achieve such an equal-area projection, he kept the central meridian a straight line and intersected it at true distances with parallel lines.

Lasix®
(furosemide) Tablets and Injection

Please see prescribing information which follows.

In a wide range of cardiac edemas— the response you want by selecting the dosage your patient needs

Lasix®

furosemide Tablets/Injection

WARNING—Lasix (furosemide) is a potent diuretic which if given in excessive amounts can lead to a profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required, and dose and dose schedule have to be adjusted to the individual patient's needs. (See under "DOSAGE AND ADMINISTRATION.")

DESCRIPTION—Lasix is a diuretic, chemically distinct from the organomercurials, thiazides and other heterocyclic compounds. It is characterized by:

- a high degree of efficacy;
- a rapid onset of action;
- a comparatively short duration of action;
- a ratio of minimum to maximum effective dose higher than 1:10;
- the fact that it acts not only at the proximal and distal tubules but also at the ascending limb of Henle's loop.

Lasix (furosemide) is an anthranilic acid derivative. Chemically, it is 4-chloro-N-furfuryl-5-sulfamoylanthranilic acid.

INDICATIONS—Lasix (furosemide) is indicated for the treatment of the edema associated with congestive heart failure, cirrhosis of the liver, and renal disease, including the nephrotic syndrome. Lasix is particularly useful when an agent with greater diuretic potential than that of those commonly employed is desired.

If the gastrointestinal absorption is impaired or oral medication is not practicable for any reason, Lasix is indicated by the intramuscular or intravenous route. The intravenous administration of Lasix is indicated when a rapid onset of the diuresis is desired, e.g., acute pulmonary edema.

Parenteral administration should be reserved for patients where oral medication of Lasix (furosemide) is not practical.

Hypertension—Lasix Tablets may be used for the treatment of hypertension alone or in combination with other antihypertensive drugs. Hypertensive patients who cannot be adequately controlled with thiazides will probably also not be adequately controllable with Lasix (furosemide) alone.

CONTRAINDICATIONS—Because animal reproductive studies have shown that Lasix (furosemide) may cause fetal abnormalities, the drug is contraindicated in women who are or may become pregnant.

Lasix is contraindicated in anuria. If increasing azotemia and oliguria occur during treatment of severe progressive renal disease, the drug should be discontinued. In hepatic coma and in states of electrolyte depletion, therapy should not be instituted until the basic condition is improved or corrected. Lasix is contraindicated in patients with a history of hypersensitivity to this compound.

Until more experience is accumulated in the pediatric use of Lasix (furosemide), children should not be treated with the drug.

WARNINGS—Excessive diuresis may result in dehydration and reduction in blood volume, with circulatory collapse and with the possibility of vascular thrombosis and embolism, particularly in elderly patients.

Excessive loss of potassium in patients receiving digitalis glycosides may precipitate digitalis toxicity. Care should also be exercised in patients receiving potassium-depleting steroids.

Frequent serum electrolyte, CO_2 and BUN determinations should be performed during the first few months of therapy and periodically thereafter, and abnormalities corrected or the drug temporarily withdrawn.

In patients with hepatic cirrhosis and ascites, initiation of therapy with Lasix (furosemide) is best carried out in the hospital. Sudden alterations of fluid and electrolyte balance in patients with cirrhosis may precipitate hepatic coma; therefore, strict observation is necessary during the period of diuresis. Supplemental potassium chloride and, if required, an aldosterone antagonist are helpful in preventing hypokalemia and metabolic alkalosis.

As with many other drugs, patients should be observed regularly for the possible occurrence of blood dyscrasias, liver damage, or other idiosyncratic reactions.

In those instances where potassium supplementation is required, coated potassium tablets should be used only when adequate dietary supplementation is not practical.

There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated thiazides with potassium salts. These lesions may occur with enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides, or certain other oral diuretics.

These small-bowel lesions have caused obstruction, hemorrhage, and perforation. Surgery was frequently required, and deaths have occurred.

Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated, and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occurs.

Patients with known sulfonamide sensitivity may show allergic reactions to Lasix (furosemide).

PRECAUTIONS—As with any potent diuretic, electrolyte depletion may occur during therapy with Lasix, especially in patients receiving higher doses and a restricted salt intake. Electrolyte depletion may manifest itself by weakness, dizziness, lethargy, leg cramps, anorexia, vomiting, and/or mental confusion. In edematous hypertensive patients being treated with antihypertensive agents, care should be taken to reduce the dose of these drugs when Lasix is administered, since Lasix potentiates the hypotensive effect of antihypertensive medications.

Asymptomatic hyperuricemia can occur and gout may rarely be precipitated. Reversible elevations of BUN may be seen. These have been observed in association with dehydration, which should be avoided, particularly in patients with renal insufficiency.

Cases of reversible deafness and tinnitus have been reported following the injection of Lasix. These adverse reactions occurred when Lasix was injected at doses exceeding several times the usual therapeutic injection dose of 1 to 2 ampules (20 to 40 mg.). Transient deafness is more likely to occur in patients with severe impairment of renal function and in patients who are also receiving drugs known to be ototoxic. Periodic checks on urine and blood glucose should be made in diabetics and even those suspected of latent diabetes when receiving Lasix. Increases in blood glucose and alterations in glucose tolerance tests with abnormalities of the fasting and two-hour postprandial sugar have been observed, and rare cases of precipitation of diabetes mellitus have been reported.

Lasix (furosemide) may lower serum calcium levels, and rare cases of tetany have been reported. Accordingly, periodic serum calcium levels should be obtained.

Patients receiving high doses of salicylates, as in rheumatic diseases, in conjunction with Lasix may experience salicylate toxicity at lower doses because of competitive renal excretory sites.

Sulfonamide diuretics have been reported to decrease arterial responsiveness to pressor amines and to enhance the effect of tubocurarine. Great caution should be exercised in administering curare or its derivatives to patients undergoing therapy with Lasix, and it is advisable to discontinue oral Lasix for one week and parenteral Lasix two days prior to any elective surgery.

ADVERSE REACTIONS—Various forms of dermatitis, including urticaria and rare cases of exfoliative dermatitis, pruritus, paresthesia, blurring of vision, postural hypotension, nausea, vomiting, or diarrhea, may occur.

Anemia, leukopenia, aplastic anemia, and thrombocytopenia (with purpura) may occur. Rare cases of agranulocytosis have occurred which responded to treatment.

Cases of reversible deafness and tinnitus have been reported. These adverse reactions occurred when Lasix Injection was given at doses exceeding several times the usual therapeutic dose of 1 to 2 ampules (20 to 40 mg.). (See "PRECAUTIONS.")

In addition, the following rare adverse reactions have been reported; however, relationship to the drug has not been established with certainty: sweet taste, oral and gastric burning, paradoxical swelling, headache, jaundice, thrombophlebitis and emboli (see "WARNINGS"), and acute pancreatitis.

Lasix induced diuresis may be accompanied by weakness, fatigue, lightheadedness or dizziness, muscle cramps, thirst, increased perspiration, urinary bladder spasm and symptoms of urinary frequency.

As far as hyperglycemia is concerned, see "PRECAUTIONS."

Transient pain after intramuscular injection has been reported at the injection site.

DOSAGE AND ADMINISTRATION

Oral Administration—The usual dose of Lasix is 1 to 2 tablets (40 to 80 mg.) given as a single dose, preferably in the morning. Ordinarily, a prompt diuresis ensues. Depending on the patient's response, a second dose can be administered 6 to 8 hours later. This dosage and dosage schedule can then be maintained or even reduced. If the diuretic response with a single dose of 1 to 2 tablets (40 to 80 mg.) is not satisfactory, e.g., in a patient with congestive heart failure refractory to maximal doses of thiazides, the following schedule should be used: Increase this dose by increments of 1 tablet (40 mg.) not sooner than 6 to 8 hours after the previous dose until the desired diuretic effect has been obtained. This individually determined single dose should then be given once or twice daily (e.g., at 8:00 a.m. and 2:00 p.m.). The dose of Lasix may be carefully titrated up to 600 mg. per day in those patients with severe clinical edematous states. Higher doses are currently under investigation.

The mobilization of edema may be most efficiently and safely accomplished by utilizing an intermittent dosage schedule in which the diuretic is given for 2 to 4 consecutive days each week. With doses exceeding 80 mg./day and given for prolonged periods, careful clinical and laboratory observations are particularly advisable.

Hypertension—The usual dose of Lasix (furosemide) is one tablet (40 mg.) twice daily both for initiation of therapy and for maintenance. Careful observations for changes in blood pressure must be made when this compound is used with other antihypertensive drugs, especially during initial therapy.

The dosage of other agents must be reduced by at least 50 per cent as soon as Lasix is added to the regimen to prevent excessive drop in blood pressure. As the blood pressure falls under the potentiating effect of Lasix, a further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary. It is further recommended, if one tablet (40 mg.) twice daily does not lead to a clinically satisfactory response, to add other hypotensive agents, e.g., reserpine, rather than to increase the dose of Lasix.

Until more experience is accumulated in the pediatric use of Lasix (furosemide), children should not be treated with the drug.

Parenteral Administration—The usual dose of Lasix is 1 to 2 ampules (20 to 40 mg.) given as a single dose, injected intramuscularly or intravenously. The intravenous injection should be given slowly (1 to 2 minutes). Ordinarily, a prompt diuresis ensues. Depending on the patient's response a second dose can be administered two hours after the first dose or later.

If the diuretic response with a single dose of 1 to 2 ampules (20 to 40 mg.) is not satisfactory, e.g., in a patient refractory to maximal doses of thiazides, the following schedule should be used under careful medical supervision: Increase this dose by increments of 1 ampule (20 mg.) not sooner than two hours after the previous dose until the desired diuretic effect has been obtained. This individually determined single dose should then be given once or twice daily. Parenteral administration should be reserved for patients where oral medication is not practical. Parenteral therapy with Lasix can be replaced by treatment with Lasix Tablets as soon as this is practical for continued mobilization of edema.

Acute Pulmonary Edema—Since the diuresis evoked by Lasix given intravenously commences within five minutes and leads to an intensive diuresis, the treatment of patients with acute pulmonary edema with Lasix (furosemide) intravenously has proven particularly valuable.

The following schedule is recommended: 2 ampules (40 mg.) of Lasix are to be slowly injected intravenously immediately. Then this dose should be followed by another 2 ampules (40 mg.) one to one and one-half hours later if that is indicated by the patient's condition.

If deemed necessary, additional therapy (e.g., digitalis, oxygen) can be administered concomitantly.

Until more experience is accumulated in the pediatric use of Lasix (furosemide), children should not be treated with the drug.

HOW SUPPLIED—Lasix Tablets are supplied in white, monogrammed, scored tablets of 40 mg. in amber bottles of 100 (FSN 6505-062-3336), 500, and Unit Dose 100's (20 strips of 5). **Lasix Injection,** brand of furosemide, is supplied as a sterile solution in 2 ml. amber ampules; boxes of 5 (FSN 6505-435-0377) and 50. Each ml. contains 10 mg. furosemide (with sodium chloride for isotonicity and sodium hydroxide to make the solution slightly alkaline).

Note: Exposure to light may cause slight discoloration which, however, does not alter potency.

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YOU ASKED FOR IT!

Group Life and Major Medical Insurance now available to D.O.s, their families and employees

In mid-December all D.O. offices in Texas received an enrollment kit for the new, officially approved TOMA group insurance plan that has been under study for two years.

A large 9 x 12 white envelope from the State Office contained a brochure on the plan, enrollment cards, trust agreement and instructions.

Carrier for the plan is the Prudential Insurance Company of America. Members of TOMA, their families are all eligible to join the plan but a minimum of 100 D.O.s is needed before Prudential will assume liability for the state-wide group.

Evidence of insurability does not have to be submitted on a doctor's employees if the doctor enrolls his group before March 31. The expenses of illness and non-job accidents, both in or out of the hospital, are paid by the plan.

About the only expenses not covered are flat feet, bad teeth, acts of war, anything not ordered by a doctor or services and supplies paid for by the government. There are no maternity benefits except in the case of complications.

Major medical expenses are subject to $100 deductible for everyone in the plan, except that the doctor has the option of a $300 deductible policy at a saving of 27 percent. After the deductible, the plan pays 80 per cent of expenses to $5,000 and 100 percent thereafter to a limit of $50,000.

Group term life insurance for the doctor is available up to a limit of $50,000 (state law for group life plans), and to his employees in the amount of $5,000 if earnings are under $7,500 a year and $10,000 if the employee earns more than $7,500 annually.

The TOMA House of Delegates two years ago, at the urging of Richard M. Hall, D.O., now TOMA President, asked the Executive Director to survey various group insurance plans and recommend a Life and Major Medical group plan. The Prudential group now offered has official TOMA approval and its establishment and success depend on an original enrollment of 100 D.O.s.

This number of participants hopefully can be reached by mid- or late January.

If you misplaced your kit or for further information contact one of the following:

Dallas Group Office
Mr. Rollin Lacy
214—742-2582

Houston Group Office
Mr. Richard Losson
713—223-1133

San Antonio Group Office
Mr. Jim Fiestner
512—224-1671

Fort Worth Prudential
Mr. Ray Fails
817—336-8121

Tex Roberts, Executive Director, TOMA
817—336-0549

the image of the physician

WILL IT IMPROVE OR CONTINUE TO DECLINE?

by Dr. T. T. McGrath

The image of the physician in this country has probably reached an all time low. There are many reasons for this trend and it is time for those in all of the healing arts to make an organized effort to put the record straight.

So what are the reasons for our now being looked upon as the bad guys in black, when we were once the heroes in white?

Some of us in the osteopathic profession feel the present dilemma is due—in part—to the rapid change from private and independent practice to present systems which have so many regulatory agencies that we can no longer be practical, nor use any initiative in treating the sick and injured. Certainly the allopathic and dental professions have similar thoughts.

The guidelines handed down by H.E.W. have complicated the practice of medicine and surgery by developing rules and regulations that are impossible to comply with. The R.N.-patient ratio hospital regulation is one example. Although complete compliance with the ruling that an R.N. must be on duty in a hospital 24 hours a day has been staved off for the present, it will be back with us in a short time. Other impossible regulations are still with us and have caused the closing of many small hospitals throughout the country.

Costs to the hospitals (and thus to the patient) in complying with various rules and regulations (not necessarily laws, but rulings made by administrators of various bureaus) have become exorbitant.

Hospital audit costs are way up because those institutions must comply with I.R.S. rulings, H.E.W. rulings or XYZ rulings (ad infinitum) that they prepare many records that must be kept and be made available to government inspectors, auditors and surveyors.

One hospital administrator says, "The many, many forms to be completed are so complex, no sane hospital administrator would attempt to understand them—much less attempt to prepare them for submission to the Fiscal Intermediary . . ."

He also says, "They keep coming (inspectors and auditors). We are compelled to provide office space, office equipment and personnel time. Daily routines are disrupted to provide these visitors with records, conferences, et cetera."

He says that red tape is everywhere. "Hospital administration continues to be more complex, with so many regulatory agencies telling us how it should be done. Every move we make we have to be sure is made in a direction to keep peace with several visiting inspectors who are sure to come. In order to keep out of trouble—and in order to get out of trouble when we get into it—we employ an attorney (the cost of which we must pass on to the hospitalized patient)."

That's just a small part of the hospital's side of the reasons for rising costs in health care. Most of this is not reported by the communications media, although many stories *are* presented by them which are avidly devoured by the public—with facts out of context.

One example we hear is of some mother and father who had to sell their home in order to provide for an operation for their little girl; thus leaving the impression that the doctor and the hospital were money-hungry monsters. The true facts, in most situations like this, are that there are charity hospitals available—to perform surgery on a charitable basis when indicated.

A few years ago there was a great hue and cry about the overworked and underpaid paramedical personnel. Too true in many cases. So their salaries were raised—their hours shortened. And it follows as the day the night, that more personnel had to be added to the staffs. Now we have more people working shorter hours at higher wages. So who absorbs the costs? Is the hospital getting rich? Is the doctor paid more than his services are worth? Of course not—on both counts.

The patient is paying the tab. He is also getting better care, whether in or out of the hospital.

Not only do the bureaucrats constantly look over the hospitals' shoulders—they have put the physician in the same precarious position. As Dr. Bobby G. Smith so aptly put it in an address to the Texas Private Hospitals and Clinics Association, "The bureaucrats are now practicing medicine." They tell us what we can do for a patient—how much we can charge him, and how often we can treat him.

The doctor must also hire more paramedical personnel at higher wages to keep his office records in such precise order that they can be inspected at any time. (And he can only hope that he has understood all the government regulations clearly enough that he has abided by them to the letter!)

There is something to be said in support of the stand Vice President Agnew has taken in regard to the communications media. News is slanted. Scare headlines sell newspapers. The tone of voice, gesture, or facial expression of a TV news commentator can change the entire meaning of what he is reporting.

How often these days do we read where a doctor has been sued for malpractice, and that the courts have awarded the plaintiff an exorbitant amount of money for the doctor's negligence, maltreatment, misdiagnosis, or what have you?

Such suits make for great press coverage: They are of "human interest". But if the physician or hospital wins the suit, how much coverage does *that* receive from the news media? Usually all the general public remembers is that Dr. John Doe was hauled into court for malpractice, and they are so sure that "where there is smoke, there is fire". They seldom see the small item, buried on page 10 of the newspaper, that the doctor has been exonerated or that the judge considered it a nuisance suit and tossed it out without even bringing it to trial.

The jurymen—brainwashed by the media—seem to have the idea that all doctors are making a fortune from their patients (and thus, from the jurymen themselves). And since the doctors have so much money, "Sock it to em!" And when those same jurymen next visit a doctor or are hospitalized, they are going to shout to high heaven about exorbitant charges, not even considering that they have helped to raise these costs by their unreal awards in malpractice cases.

So the physicians and the hospitals must carry malpractice insurance—insurance at rates that have been doubled and trebled.

Does the patient really expect that the doctors and the hospitals can absorb all these added expenses without passing some of the costs on to him?

We said that the patient is getting better care, which is true only to a degree. You can be sure he is getting *more* care—whether he needs it or not. The threat of malpractice has caused the doctors to practice defensive medicine, which means that more x-rays are taken, more medicine is used, consultations with specialists are requested, longer and more frequent hospitalization. All of these precautionary procedures are expensive.

In this article we have been concerned with the "whys" of the adverse image of the physicians and hospitals. Now we are concerned with the "hows" of improving that image—in the face of these almost overwhelming odds. Although it is almost impossible to countermand all this bad publicity we in the health care fields are receiving, the osteopathic physician—in particular—has never been one to back off from a challenge or from a job that needs doing. So let's get on with it.

The grapevine, the rumor mills and the jungle drums are almost faster than the speed of light, so let's start nourishing them with correct and complete information—and food for thought.

Where to start? First by educating our own paramedical people who have contact with the patient, who has contact with his neighbors—and the word spreads.

But too many of our own people are sadly lacking in even the basic knowledge of the principles and concepts of osteopathic medicine.

All of them need to be educated along these lines, and it is up to you to see that they are supplied with the material they need—material that has complete and accurate information. ▲

We're doing something

DISTRICT I

by Gerard K. Nash, D.O.

Dr. (Lt. Col., MC, USAR) Gerard K. Nash, Amarillo, attended the course Aerospace Pathology, November 22—24, at the Armed Forces Institute of Pathology, Washington, D.C.

* * * * *

DISTRICT III

We're (not) Doing Things

by H. George Grainger, D.O.

Other than Jane Pock, who won a ribbon at the recent Tyler Art League annual show, and The Lesters, who went to Hawaii ostensibly to attend the AOA Convention, there ain't no news.

Jane, talented spouse of Tyler's Neal Pock, is quite a terrific sculptor, though she won her ribbon on a painting.

The following appeared in the "Letters to the Editor" department of a recent issue of *Medical World News*. It was in reply to an earlier news item relative to "casualties" in New York State relative to abortion.

HOW MANY DEATHS?

SIR: Your figures on abortion in Focus on the News (MWN, Oct. 25) *don't add up, do they?*

Gordon Chase, you say, said: "The estimated 205,614 abortions. . . caused only ten deaths."

Shouldn't that have read, "only 205,624 deaths"?

H. G. Grainger, D.O.
Tyler, Texas

Tip from Benjamin Franklin: "I early found that when I worked for myself alone, myself alone worked for me. But when I worked for others also, others also worked for me."

TCOM Receives $$$ from Foundations

The Texas College of Osteopathic Medicine has been given $54,000 for special medical equipment by an Oklahoma foundation.

The grant, earmarked for capital improvement in the departments of biochemistry and physiology, was presented to development director Ray Stokes by John W. Cox, Fort Worth resident and a trustee of the J. E. and L. E. Mabee Foundation of Tulsa.

Stokes remained optimistic about the financial future of TCOM. He was encouraged with progress shown from several sources of income, including other foundations that have indicated an interest in the new school.

"We are gaining recognition in general and in particular with philanthropic persons who give liberally to the healing arts," Stokes emphasized.

He said the current budget of $528,000 should be met from a conservative estimate of $533,000 due in total revenue, grants and pledges.

"We have about $140,000 due from the Texas profession in 1971-72," Stokes added, "and we expect to get around the same amount from the State of Texas."

The development director, who recently was named acting business manager, pointed out another source of income is derived through "Memorial Contributions" made in memory of a deceased relative, associate or friend.

Stokes said all such gifts are acknowledged promptly, and the family of the person in whose memory the gift is made also is advised of the gift.

He said a final way of implementing TCOM's future can be done with a donation of valuable equipment. Stokes stated that Dean Henry B. Hardt has a list of necessary equipment that any concerned person might donate or purchase for the school.

AMA Wants Back on the Track

For the first time in 124 years the American Medical Association is "considering" overhauling that association's organizational and governing structure, according to reports coming out of a meeting of its House of Delegates in December.

The AMA president, Dr. Wesley W. Hall, first proposed that the AMA call a constitutional convention for this purpose when he took office last June. However, the Board of Trustees has opposed such action, and it was not until the last session of the House of Delegates last month that the decision was made to hold "open hearings" on whether there is a need for a major overhaul of the AMA's programs, priorities and governing structure, according to an Associated Press release, which termed this "unexpected action at least a partial victory for the AMA's president."

It was the Wisconsin delegation that declared that the AMA "cannot fly in the face of mounting criticism from individual members that the association is not as responsive as it should be to their needs and desires" in caring for patients.

Dr. Hall (again according to the Associated Press) says the AMA is placing too much emphasis on "politics and legislation"—at the expense of its traditional goals of promoting scientific and medical education in the interests of the nation's health. AP reports Dr. Hall as saying that there is a serious struggle for power going on among elected officers of the AMA...and that all this bodes ill for AMA's physician members and their patients unless steps are taken to correct the situation he said exists.

On December 3 Dr. Hall is quoted as saying, "We have been placing more and more emphasis on politics and legislation and relatively less and less on scientific and medical education."

In proposing the constitutional convention Dr. Hall said that extraordinary means were necessary to "get our organization back on the track and restore our profession to the highly respected status it once enjoyed."

Dr. Mary Burnett Named President Elect of ACGP

Dr. Mary M. Burnett of Dallas was named president-elect of the American College of General Practitioners in Osteopathic Medicine and Surgery at their annual Congress of Delegates' meeting in Honolulu on November 17.

Dr. Burnett, active in organizational affairs, is a past president of the Colorado Osteopathic Association, served as chief of staff of Rocky Mountain Osteopathic Hospital in Denver and is currently a member of the AOA Committee on Postdoctoral Training and AOA Liaison Committee with regional offices of HEW. Dr. Burnett is a 1949 graduate of KCCOM.

Door Closed on Future Sellout

CALIFORNIA—Again issuing licenses to D.O.s, both by examination and reciprocity, according to reports from California D.O.s (as directed by the Court.)

Some residual carping by the CMA is to be expected, but it does not appear likely to affect the return of this profession to the Golden State. . . . . .thanks to the tremendous efforts of a handful of ever faithful Osteopathic Physicians plus the great support given them in their fight by the "Citizens for Osteopathy" in California.

This court decision closes the door on any proposed future sellout of this profession by a handful of dissidents.

[from the Arizona Osteopathic Digest December issue.]

TCOM Classes Elect Officers

Freshman and Sophomore classes of TCOM have announced the results of recent class elections.

Officers of the Sophomore class are Jobey Claborn, president, Amarillo; John Williams, vice president, Arlington; and Sterling Lewis, secretary-treasurer, New Market, Maryland.

The Freshman class elected four of its student-doctors to office. They are Clinton Burns, president, Dallas; Roger Hamilton, vice president, Mabank; Peggy Hall, only woman in the class, secretary, Arlington; and Robert Wilson, treasurer, Wichita Falls.

NOTICE (Please!)

To make things easier for all of us! Please notice this important notice about notices. You may have noticed the increased amount of notices for you to notice. We notice that some of your notices have been noticed. On the other hand, some of our notices have not been noticed. This is very noticeable! It has been noticed that the responses to the notices have been noticeably unnoticeable. This notice is to remind you to notice the notices and respond to the notices because we do not want the notices to go unnoticed.

Notice Committee
for Noticing Notices

[from Wives' T-COMments dated November 23, 1971]

Go forward with your Association—or backward alone!

Dr. Nunneley "Outstanding"

Robert L. Nunneley, D.O. of De Soto, Texas was named by the Chamber of Commerce as De Soto's "Outstanding Man over 35" at its annual awards banquet on the evening of December 2, 1971.

Dr. Nunneley has been active in civic affairs in De Soto, a suburb south of Dallas, since he began family practice in 1963. He is the outgoing president of the Chamber of Commerce and has served on the Board of Directors for three years.

In 1966, he was appointed by the City Council as the first city health officer of De Soto. He held that post until April of this year when he resigned because of his election to the City Council. He is now serving a two-year term.

During Dr. Nunneley's presidency, an annual De Soto Chamber of Commerce golf tournament was established to which he contributes $100 scholarship in memory of his father to the college, medical, or dental student who shoots the lowest score.

A 1962 graduate of the Kansas City College of Osteopathy and Surgery, he interned at Oklahoma Osteopathic Hospital in Tulsa before moving to De Soto.

Bob and his wife, Harriet, have two daughters, Terri and Nancy.

Mrs. Nunneley is in obvious agreement with the Chamber's choice of Dr. Nunneley to receive the "Outstanding" award, here presented by Dave Braden.

If you'd enjoy life
And not make it a grind,
Keep your mind on your work—
Not your work on your mind.

NOF Has Helped 103 Texas D.O.s

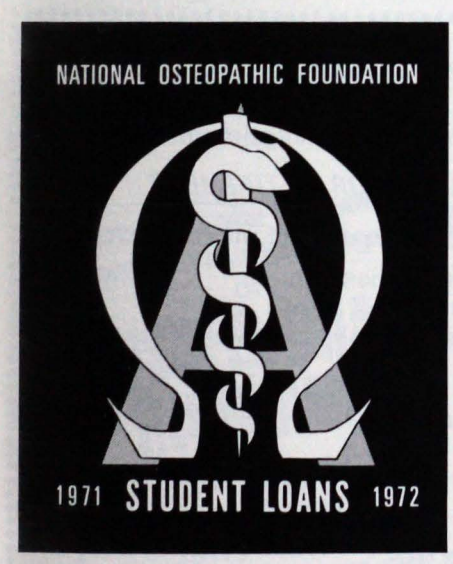
Loans from the osteopathic seal program over the years have aided 103 Texas D.O.s in getting their medical education, according to a search of the national records by Mrs. Lee Dunham, chairman, national osteopathic seal program.

The National Osteopathic Foundation (NOF) receives part of its funds from the seals sales program and from direct contributions from doctors, patients and other sources.

Of the 103 in Texas, a dozen of them are nonmembers!

It takes members to build an organization. It takes an organization to build an osteopathic educational system. But if that system produces nonmembers the results will eventually be zero!

Whatever happened to such things as gratitude and loyalty? ▲



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Terrell Supply Company
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The Upjohn Company
Western Research Laboratories
X-Ray Sales & Service Co.

Those firms who have written to decline are:

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Cutter Laboratories
Eaton Laboratories
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Parke, Davis & Company
Roche Laboratories
Ross Laboratories
Rowell Laboratories
Sandoz Pharmaceutical
Savage Laboratories
Schering Corporation
Smith Kline & French Laboratories
Southwestern Surgical Supply

[Smith Kline and French and Roche Laboratories support TOMA through advertising in the Journal.]

Medical Examiners to meet in June

The next meeting of the Texas State Board of Medical Examiners when examinations will be given and reciprocity applications will be considered is scheduled for June 12—14, 1972, in Austin, Texas. The examinations will be given at the University of Texas Student Union Building and the Board meeting will be held at the Sheraton Crest Inn.

Graduates from out of state medical schools who are applying for a license by examination must file their completed applications thirty days prior to the meeting date.

Graduates from Texas medical schools and students taking the pre-clinical examination must file their completed applications by May 1.

Foreign medical graduates who are applying for a license by examination must file their completed applications sixty days prior to the meeting date.

Applicants applying for a license by reciprocity must file their completed applications sixty days prior to the meeting date. ▲

What Texas D.O.'s need, is a Malpractice Liability Carrier that won't fade when trouble comes.

This means the up-to-date carrier. The one that's replete with innovations and new developments in this clouded, sensitive area of liability protection. And the one that doesn't talk malpractice coverage just to get a foot in the door for every other kind of insurance. We don't write other kinds of insurance.

What Texas D.O.'s need, is Casualty Indemnity Exchange, the carrier that pioneered the modern approach to malpractice coverage, and *the* carrier geared to STAY in the market.

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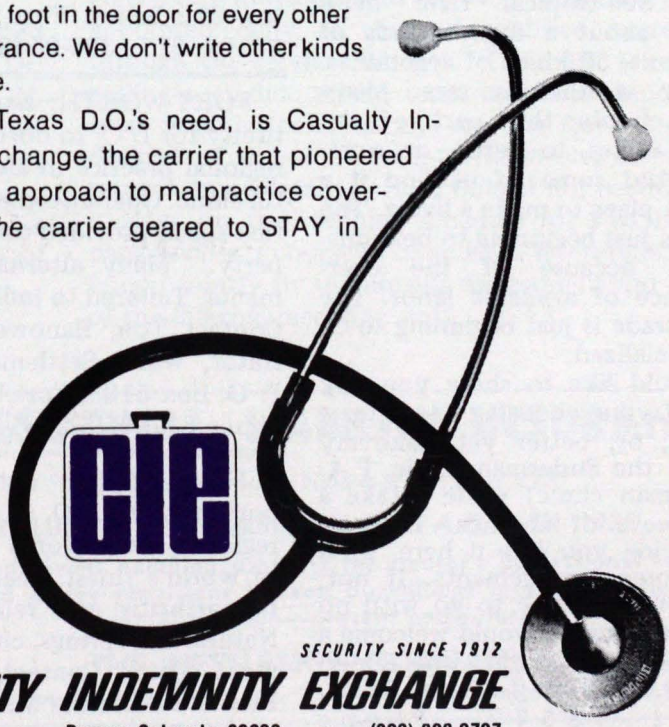
(817) 332-9269



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OPPORTUNITIES FOR OSTEOPATHIC PHYSICIANS IN TEXAS

ROUND ROCK — A growing city without a physician. Seven miles from Austin city limits. Large completely equipped clinic building available. Large trade area, beautiful area to live in. Contact N. G. Whitlow, Pres., Farmers State Bank, Round Rock 78664; or phone at 512—255-3622.

NEW CLINIC—To be completed by January 1 needs another G.P. to help two doctors with well-established practice. Guaranteed income with no overhead makes this an ideal situation for new D.O. Contact Samuel B. Ganz, D.O., 3914 Leopard, Corpus Christi 78408; Phone 512—883-3433.

RIO GRANDE VALLEY, (South Texas): Sub-tropical river delta growing about a dozen kinds of citrus fruit, 50 kinds of vegetables. Freezing weather is rare. Many people choose this part of the United States to retire or semi-retire. And some of us find it a splendid place to make a living. The Valley is just beginning to be industrialized because of the over-abundance of available labor. The tourist trade is just beginning to be commercialized.

I would like to show you any place of your choosing to set up a practice; or, better yet, take my place in the Suderman Clinic, P.A. (a two-man clinic) while I take a year's leave of absence. Then, if you decide you like it here, we'll make some arrangements. If not, you would be free to go with no strings attached. I would welcome a new graduate. Contact Joe Suderman, D.O., 710 S. Cage, Pharr, Texas 78577. Phone 512—787-4271.

LUBBOCK—Need three general practitioners for West Texas area as members of a 9 to 12 man group. Guaranteed salary. All the benefits of a corporation. Complete general practice including OB, hospital, minor surgery. Send resume to V. Wayne Ramsey, D.O., 1702 Parkway Drive, Lubbock, 79403.

ARANSAS PASS — Excellent opportunity for D.O. to operate, lease, rent or purchase large 25-year general practice location. Very nice clinic building and up to date equipment. Warm climate, good schools and hospital in thriving Gulf Coast community of approximately ten thousand. For more information contact Tex Roberts, Executive Director, TOMA Locations Committee, 512 Bailey, Fort Worth, Texas 76107, 817—336-0549.

FORT WORTH—Excellent opportunity for D.O. to develop local and regional practice in already successful clinic. Guaranteed minimum. Office space provided on hospital property. Many alternative arrangements. Tailored to individual needs. Contact Tom Banowetz, Administrator, White Settlement Hospital, P. O. Box 5128, Fort Worth 76108, phone 817—246-2491.

MARLIN—Has outstanding opportunity for D.O. to develop local, regional and national practice. One of world's finest treatment centers for arthritis and related diseases. Natural hot springs, clinic and treatment center. Contact J. M. Leath, First State Bank of Marlin, Box 720, Marlin, Texas 76661.

EDEN—40 miles from San Angelo, is in desperate need of two D.O.s. Has plenty of space and people to support their practice. 32-bed nursing home, 12-bed hospital. Contact Mrs. S. J. Wilkerson, Box 545, Eden, Texas 76837, or call 915—889-2101.

HEMPHILL—One or two D.O.s needed in high income Toledo Bend Reservoir Resort area. Office and equipment furnished. No capital needed in associateship with established young D.O. High gross income assured. Contact Y. K. Fults, Box U, Hemphill, Texas; Phone 713—787-2616.

AMARILLO — Room for two D.O.s in large, brick clinic building that has housed long-time successful practices. Lots of room for ancillary facilities, offices, treatment rooms, finished basement work areas. Buy, lease or associate. The location is minutes from the modern, expanding Southwest Osteopathic Hospital. Contact E. W. Cain, D.O., 1608 Washington Street, Amarillo, 79102, phone 806—374-5213.

DALLAS—Will build to suit tenant. Leases being accepted in new professional building in north Dallas near Richardson, across from developing $150 million Park Central Complex. Contact Ronald Regis Stegman, D.O., 214-231-6161 or 214-369-2233 or Westwood Clinic, Coit Road at Beltline, Richardson, Texas 75080.

(For information call or write Mr. Tex Roberts, Executive Director, TOMA Locations Committee, 512 Bailey, Fort Worth, Texas 76107, 817-336-0549.)

CPR Clinic at FWOH

A Cardio-Pulmonary Resuscitation Clinic was the latest in a series of educational programs for nursing personnel at Fort Worth Osteopathic Hospital. The course, aimed at providing the hospital with trained emergency teams on each shift, was planned and presented by members of the nursing staff, with selected lectures given by physicians, the hospital pharmacist and an inhalation therapist.

Recognizing that more than one isolated lecture on CPR technique was necessary to give nurses confidence in their own ability, four 2-hour sessions were planned. The classes were directed toward professional and vocational nurses, though other members of the nursing department and para-medical employees were welcome. About 50 people came to the first session, and attendance remained fairly constant throughout the clinic.

The four sessions covered "Diagnosis of Cardiac Arrest and Basic Emergency Care," "Emergency Drugs in Action," "The Concept of the Emergency Team," and "Team Mobilization." Visual teaching aids from skits to the overhead projector were used to augment lectures. When Mrs. J. Bearden, Director of Nursing Services, talked on the concept of the emergency team, her lecture was translated into action through two skits, the first showing inefficient handling of an arrest and the second demonstrating the correct response of an emergency team. Class members then performed the same techniques before the entire group. Demonstration and practice sessions were also held for manual CPR, the Cardio-2 and the drug cart.

The final session of the clinic was primarily devoted to a summarizing panel discussion moderated by Dr. Chester Godell, resident in internal medicine at FWOH. Among the topics covered were policing the area, record keeping and priorities. Mrs. Janet King, R.N., pointed out the necessity of directing traffic in an emergency and keeping work space relatively free for members of the team. For instance, she advised moving the trash basket so no one steps in it, placing the drug cart so that it is available but not obstructing traffic, getting furniture out of the patient's room.

Dr. Ray Denson, intern, discussed priorities in a cardiac arrest, emphasizing that the team must get air to the patient's lungs and blood to the brain immediately to maintain life. Nurses must anticipate the doctor's orders in handling an arrest, and Dr. Denson advised having the standard medications ready before the doctor needs them.

Stressing that a cardiac arrest can never be a learning procedure while it is happening, Dr. Lynn Powell, intern, presented a record sheet to be kept by an observer so that teams can later review their performance with an eye to improvement of the handling of emergencies.

A theme that ran throughout the clinic was that this educational experience is just a beginning for nursing personnel. Continual training is a necessity. A retraining clinic will be held in six months and the CPR Clinic will become an annual event. In addition, demonstrations of CPR technique are held four times a year at FWOH, and attendance is mandatory for nursing personnel as well as for maids and porters. Those who attended the recent clinic have been invited to call the Intensive Care Unit anytime they feel unsure about a specific technique. Special demonstrations will be scheduled for them on request, and Mrs. Bearden reports that several such lessons have already been given by ICU personnel.

Fort Worth Osteopathic Hospital now has trained emergency nursing teams on each shift. The teams are appointed daily so that all qualified nurses rotate through the service. When a "Code 99" is called, signalling a cardiac arrest, team members respond from their various locations and no one floor is suddenly drained of nurses. A back-up team also responds but returns immediately to floor duty if not needed.

Next on the teaching schedule for FWOH nursing personnel is a course in basic EKG interpretation to be taught jointly by the nursing department and members of the internal medicine staff.

TEXAS OSTEOPATHIC MEDICAL ASSOCIATION
512 Bailey Avenue
Fort Worth, Texas 76107

Address Correction Requested

BULK RATE
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