TCOM REVIEW
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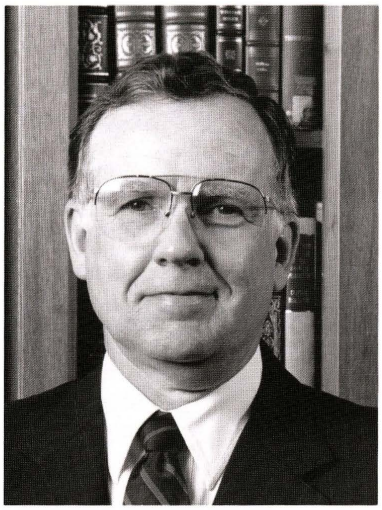
OUR AUTUMN YEARS...
A SEASON OF GOOD HEALTH?

PRESIDENT'S MESSAGE



Most people are aware that the "graying of America" is different from what we see when we look in the mirror. Our society as a whole is growing older: The Census Bureau indicates that by the year 2020 one in four Americans will be 65 or older.

The health-care needs of this segment of the population are increasingly important. As our lifespan increases, so does our vulnerability to acute and chronic illness. Although many people enjoy healthy, active lives into their 70s, 80s and even 90s, cardiovascular disease, cancer, osteoporosis and Alzheimer's disease – among others – may begin to attack.

This combination of a proliferation of health problems and expensive, high-tech medical "solutions" affirms the need for the distinctive skills and sensitivities of our communities' osteopathic physicians.

Older patients profit from every facet of the osteopathic philosophy. The importance of the musculoskeletal system in later years is evident in the frequency of bone fractures and hip problems as well as osteoporosis. The emphasis on preventive health care, too, is becoming more logical to consumers. Indeed, a holistic approach to diagnosis and treatment is more critical than ever at this stage in life, since one medical condition may provoke another, and home and social factors play a significant part in health and recuperation.

TCOM's capabilities in the art and science of geriatric medicine were greatly enhanced this summer with the addition of Texas' only board-certified and fellowship-trained osteopathic geriatrician to our faculty. We feature some of the insights of Janice Knebl, D.O., in this issue of TCOM Review. An accompanying perspective by septuagenarian faculty member Irvin M. Korr, Ph.D., reveals his "secret" to extended vitality.

As we learn more about enhancing the quality and quantity of life, those who reach maturity in the 21st century will be living testaments to the assertion made by the 19th century Scottish author George Macdonald: "Age is not all decay; it is the ripening, the swelling, of the fresh life within."

Good health to you and your family.

David M. Richards, D.O.
President

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Editor's note: At one year old, TCOM Review is still evolving. Its purpose is to give you, alumni and friends of the college, information about people and activities that you probably won't see anywhere else. Help us earn your attention by letting us know what news and views you would like to see. Write to us at the address below. Thank you.

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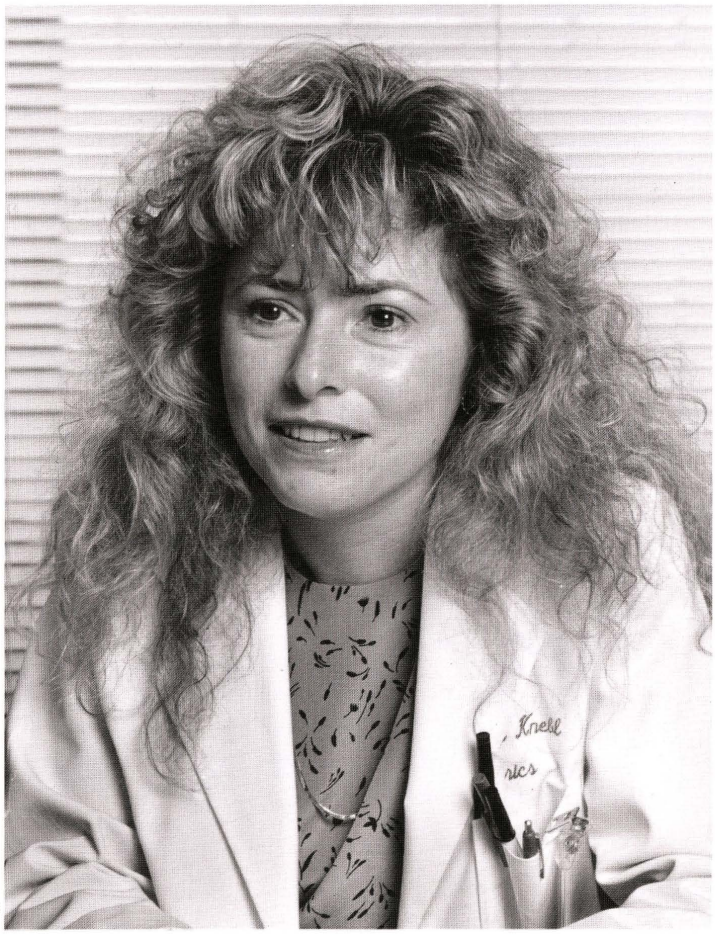
Facing page: Mrs. Opal Parchman epitomizes the ideal of aging gracefully.

Sleuth Strategist Physician Friend

An interview with Janice Knebl, D.O., about the art and science of geriatric medicine.



Geriatric medicine is in its youth. And according to TCOM's new geriatrician, Janice Knebl, D.O., it needs to grow up pretty fast in order to keep pace with a 65-and-older population that's increasing twice as fast as the rest of America's citizenry.

It's a challenge, says Knebl, because the elderly defy generalization. Some run marathons; others are confined to institutions. While scientists labor to find out why, clinicians – geriatricians – work to maintain or improve by degrees the quality of each senior's life.

The success of geriatric care, Knebl believes, lies in more innovative and multidisciplinary programs that involve a variety of professional health-care providers, researchers, educators, social workers, the government, community organizations and families. "There are so many questions that need to be answered," she says.

By coming to TCOM, Knebl hopes to help the Texas osteopathic medicine family answer a few of those questions.

But first, we wanted to ask her a few of our own.

"You develop strategies to make day-to-day life better ... to improve quality of life by degrees."

Why did you go into geriatrics?

I'm different, I think, in that I knew I wanted to go into geriatric medicine back in college. Medical school and residency were all geared toward this goal. While in college, I worked for two summers at a shore resort that catered to people over 65. I was there in a very different capacity – a waitress. Now, I grew up in an ethnic neighborhood in Pennsylvania, an extended family sort of atmosphere. My grandparents lived right across the street with my aunt and uncle. But I had never been around so many older people in my life. I just loved it. Having the opportunity to listen to them, learning their history, the history of America – so many of them could tell me that from their personal experiences – sold me on the career. I just knew that's where I wanted to be.

What distinguishes geriatric medicine?

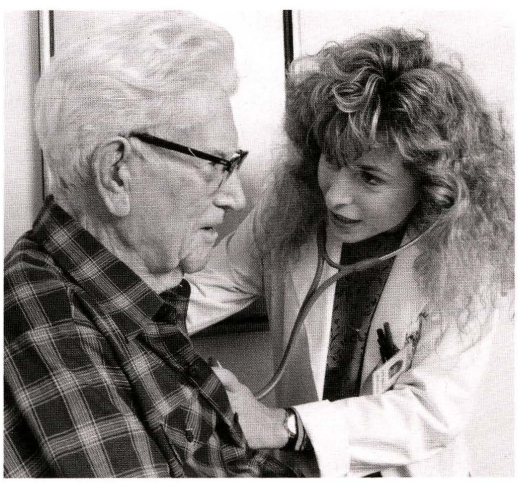
So often, as with those who are infirm and in the hospital, you have to be a detective in order to help the geriatric patient. You have to search out what's going on in their bodies and minds because they can't – or won't – tell you. You have to be a sleuth. They're not going to walk in like a 30-year-old and say, "My back hurts," and so you check out their back. They're going to come in confused or with incontinence or with a loss of balance or loss of bowel control. They don't know what's wrong. So you hunt for the causes. For me, that's the challenge and the appeal, and I enjoy it. But it's not for everybody.

Define the difference between a geriatrician and a gerontologist.

Gerontology is the study of the science of aging. Gerontology degrees are obtained by following social work tracks, psychology tracks or basic science tracks toward a Ph.D.

My route was a medical route. A geriatrician is a clinician who specializes in care of the elderly.

I'm thinking now about getting a Ph.D. in gerontology. Why? It's important today to do good research in aging. There's so much we don't know. And if you want to become a good clinical investigator, you need to develop more of those research skills, which as a clinician you don't get in your medical school training. By getting my Ph.D., I'll learn more about research methodology and statistical methods, so I can not only be a physician for the elderly population but also utilize the population to do aging studies. There are just too many questions that we need answered. Some people go for a master's degree in public health instead of a Ph.D., but I lean toward the Ph.D. because I want to focus more on all the aging issues and not just a public health overview.



If I do decide to get my Ph.D., I can do it here because of our affiliation with the University of North Texas in Denton. That was a plus in coming here from Pennsylvania. UNT has the oldest gerontology program in the country. The opportunities are

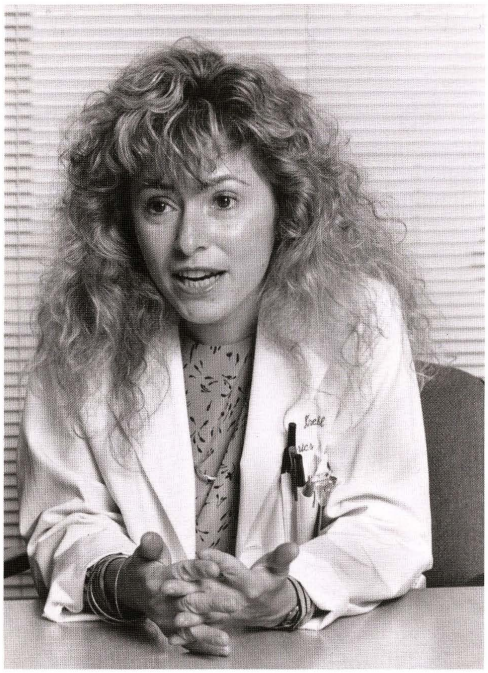
excellent, particularly because of the Gerontologic Assessment and Planning program that TCOM and UNT are collaborating on. Created in UNT's Center for Studies in Aging, it will consist of a multidisciplinary team – a geriatrician, a social worker and a gerontologic nurse practitioner. Once we get that core team concept going in outpatient care, we can expand to long-term care in hospitals. We hope to begin in early 1989.

What is the scope of a geriatrician's practice?

Basically, I'm a general practitioner who sees only older people. And I tend to like the oldest of the old. In my fellowship, the average age of my patients was 86. I've seen many who were 100. I think the 65 to 75 group are the youngsters.

The typical physician who has trained in internal medicine and hasn't worked a lot with older people may get frustrated. Many feel they can't offer enough to older patients. They want to provide an answer, a cure. Well, there are few, if any, cures in geriatrics. You develop strategies to make day-to-day life better, to make the quality of life better. All of my patients know they're going to die and they don't want me to prolong their life. What they want is to not become functionally dependent. That is their No. 1 request to me.

This changes the way you look at patients. You're not looking at them on a "cure" basis; you're looking at them with ideas in mind to improve quality of life by degrees. For example, if I can get Mrs. Smith to walk with a walker instead of be bound to a wheel chair, I'm ecstatic. She doesn't have to be running on her own to have had a success. It's easy to lose that perspective during



"When You're 65 I want you to look forward to being 85."

training because you're working in a hospital all the time, dealing with acute conditions. Older people just don't fit into a mold.

What are your medical roots?

After med school (Pennsylvania College of Osteopathic Medicine, '82), I really wanted to do the one-year rotating internship. I think that going straight into a residency and focusing so very early in your career is sort of limiting yourself. I never like to back myself into a corner; I like to have lots of options.

So I did the rotation, through surgery, medicine, obstetrics, pediatrics. I had planned that if, at the end of the year, I still wanted to go into internal medicine/geriatrics, fine, it certainly wouldn't be a wasted year. I went on to do my three-year internal medicine/geriatrics residency at Geisinger Medical Center in Danville (Pa.), then a two-year geriatric fellowship at Philadelphia Geriatric Center.

Now, I'm the only osteopathic geriatrician in Tarrant County. There aren't many geriatricians in North Texas, period. There's only a handful of D.O.s in the country who have completed their geriatric training and are out practicing. You see, the geriatrician fellowship program is only about 6 to 8 years old. And because the field is so new and people have taken different routes through their specialty training, I'm probably the only osteopathic geriatrician in the country who is both fellowship-trained and board-certified at this time.

Tell us something about your patients.

I picked up the elderly practice of another osteopathic physician when I came to Fort Worth. It's a diverse group.

For example, I saw three 90-year-olds just this week. One is totally independent, entirely mentally intact, really a joy to see. She just wants to stay healthy. Another lives with his wife, who is his primary caregiver. He has many, many medical problems – cardiovascular,

memory. The third was a man who is severely hearing-impaired, with little hope of improvement. It's his only problem, but it keeps him from enjoying an otherwise healthy life. He cannot receive information. He cannot give information. It's like he's withdrawn into a shell. It's easy for people to get the impression he's demented. He hasn't developed lip-reading capabilities, either, which many elderly people do. We want to keep his mind stimulated, so we're working with his wife on different strategies, like writing to him. Now, compare him with my other two 90-year-olds and you see three entirely different sets of concerns.

So, you can't look at someone's chronological age and pigeonhole them. I could show you 10 90-year-olds and each one would be different. It's called the heterogeneity of the elderly population. That's what makes it hard to do research, too – you can't generalize. There's a wide gamut between dependency and independency in geriatrics.

What are the major problems faced in geriatric medicine?

They're the three primary reasons older people are institutionalized:

First, the mobility and functional problems, the "getting around."

Second, the dementing illnesses. The statistics are showing that about 20 percent of those over 85 have some dementia. This may be the worst, because if you can't remember where your house is or what your phone number is, you can't live alone any more. You've lost your independence. Early dementia is hard to pick up, too. Even family members miss it because the person maintains social appropriateness for a long time and covers up the initial mild memory impairment. By the time a physician sees it, it's usually pretty advanced.

Third, incontinence. It's so unfortunate, because this is not a disease; it's a symptom of something that can be treated successfully for the most part. It will take someone who is socially active and make them homebound. But people won't tell you about it. And when they do, the physician isn't as attuned to it because it's not a regular part of the training program. Unless the physician goes to the geriatric conferences and finds out the newest strategies for dealing with this problem, the physician may not know what to do.

It's interesting that our biggest problem in geriatrics is not one particular disease. It doesn't matter what disease leads you to one of these stages, it's one of these debilitating problems that will necessitate institutionalization of the patient.

What happens when the Baby Boomers get old?

The "golden boomers" will be a significant part of the population. We've always required more from society: more education, more reforms, more jobs. As we age, we'll require more knowledge and medical systems to keep us healthy. The increase in our average education and health awareness levels will help. Today's young physicians and researchers are the Boomers, you know, and they're looking ahead and trying to make some changes. The National Institute of Aging is also putting lots of research dollars into the area of geriatrics. And the American Association of Retired Persons has built a strong lobby in Congress and can perhaps initiate better funding for medical care for the elderly. We need to start the changes now.

One thing all of us should do is to take active participation in our own health care, to make the wisest decisions nutritionally, environmentally and socially. You can tell preventive medicine pays off by looking at today's active seniors. They never had fitness centers and aerobics classes, but they're adapting. They're realizing that at 65 you don't have to look forward to fixing up chronic problems, you can look forward to being 85. I know I will!

"You can't look at someone's chronological age and pigeon-hole them. Older people just don't fit into a mold."

A way of LIFE, A way of AGING

Irvin M. Korr, Ph.D.

Osteopathic physicians have a unique opportunity, available to no other profession, not only to reduce the immense burden of ill health among the nation's elderly, but also to help make old age a time of high-level wellness. Osteopathic physicians are prepared for this opportunity by their philosophy, their methods and their profession's history.

We must expose the myths fostered by conventional thinking. The first step is to confront the stereotype of the elderly that is so much a part of American culture. We grow up with a socially ingrained image of the way an old person is supposed to look and behave – frail, bent, sedentary, dependent, involuted. The noncompliant exception to this rule – the youthful active senior – is viewed as the lucky exception. Were it not so tragic, it would be ironically amusing that what is overlooked in this attitude is that it is the exception that is the natural phenomenon, the stereotype being the artifact.

As one of the fortunate exceptions to the unspoken rule, I have become quite familiar with this social phenomenon. During the past two decades I have been asked countless times and in various versions, "What is your secret?" The question has become especially frequent and insistent since I passed into the second half of my 70s, still healthy, vigorous, professionally and athletically active, still finding life as exciting and rewarding as in any previous period.

Not Sick, But Not Quite Well

What is the so-called secret? It is definitely not in my family history, which is marred on both maternal and paternal sides by serious illness and early death: coronary artery disease with fatal infarction in middle age, peripheral vascular disease, hypertension, congestive heart failure, tuberculosis, hyperthyroidism, allergies, recurrent infections and even a lethal brain tumor. Given that history, I had resigned myself to early death, probably by heart attack or stroke, and prepared for it in every possible way. Having never been inclined toward athletics, I lived cautiously and conservatively, saving my energies for my work and hoping to stretch out my time. At age 35, I already viewed myself as middle-aged, over the hill, and headed for physical decline and death.

What changed all that? In December 1945, at the age of 36, I accepted a position as professor of physiology at the Kirksville College of Osteopathic Medicine. My interest in and comprehension of osteopathic principles was purely at the intellectual and scientific level.

In the early 1950s a young osteopathic physician left private practice to join the faculty at KCOM. In his first year he volunteered to treat me manipulatively because it was his perception that, while I was not (yet) sick with a nameable disease, I was not very well either. The implied grading of wellness in itself was, for me, quite a startling departure from the conventional thought that there are only two states: sick or well, only the sick being eligible for medical care.

As diplomatically as he could, he let me know on examining me that for one in his early 40s I was as rigid of body as of temperament. In the course of the treatments, designed gradually to restore mobility, he also taught me the principles of osteopathic medicine in a deeply personal manner. With this stimulus, I began independent and deeper study of the philosophy, principles and practice, seeking their historical roots, their basis in physiology, and their relevance to my own health and that of my family.

The Metamorphosis To Good Health

Clearly, life is motion; in order for there to be motion, there must be freedom of motion. This is an abridged interpretation of osteopathic principles. Having found them biologically sound and increasingly supported by research, they began, in my early 40s, to guide my life as I took more responsibility for my health. As a result, I experienced the beginning of a physical and psychological metamorphosis. With the restoration of mobility came unfamiliar joy of movement and freedom from aches and pains. I found myself choosing to walk to and from work instead of driving and breaking into a run on my evening walks. With the limbering of the rib cage came a previously unexperienced ease of respiration and the physical and emotional impact of my very first full breath. I happily gave up tobacco and adopted a much more healthful diet.

Being in charge of my health inspired a new self-confidence and improved self-image. My work became a source of gratification rather than a compulsion. My interests broadened as I found the energy for new and challenging activities. At the age of 48 I earned my private pilot's license; at the age of 50 I took up tennis and, much later, running and serious swimming, which continue to this day. I am certainly a much better athlete now than I was in my youth. And the transformation continues. In short, I am thoroughly enjoying my old age.

No less important is the manipulative care given me through the years by skilled osteopathic physicians who understand its value to be beyond fixing lesions, and more in fine-tuning the body and mind and releasing human potential.

What Is My Secret?

It is this: I discovered that the osteopathic philosophy is not only a guide to clinical practice but a way of life, and I chose to live that way. It has required commitment to my own health, responsibility for my well-being and, paradoxically, a rigorous but liberating self-discipline.

In the past few years I have been able to confirm that these principles work equally well for others who make the commitment, even in their 60s, 70s and beyond. My colleagues and I have found that the "key" is the restoration of mobility. Ease of motion then invites, quite spontaneously, resumption of physical activity, renewed independence, self-confidence and a sense of achievement. Enhanced flexibility of the body somehow initiates a limbering of the mind and a receptivity to new interests and new ideas. It is our goal to guide as many older adults to these rejuvenating and vitalizing self-discoveries as we can.

No profession is as well prepared as the osteopathic profession to teach these principles, which encompass the art and science of healthy living. To live by these principles is to enhance the quality of life, without decrement in later years. There can be no greater service by physicians to mankind and to our nation.

Irvin M. Korr, Ph.D., 79, is professor of medical education and manipulative medicine at TCOM, and is one of the college's most popular public speakers. He has been at TCOM since 1978 and was chairman of TCOM's Task Force on Educational Goals, which prepared the precedent-setting "Design of the Medical Curriculum in Relation to the Health Needs of the Nation," adopted by TCOM and its Board of Regents as official policy in 1980.

IN *Practice*

Meeting the Special Needs of Older Patients

TCOM's geriatrician, Janice Knebl, D.O., offers these tips to physicians who want to expand their practice and better serve the needs of our growing over-65 population.

Convenience and Comfort

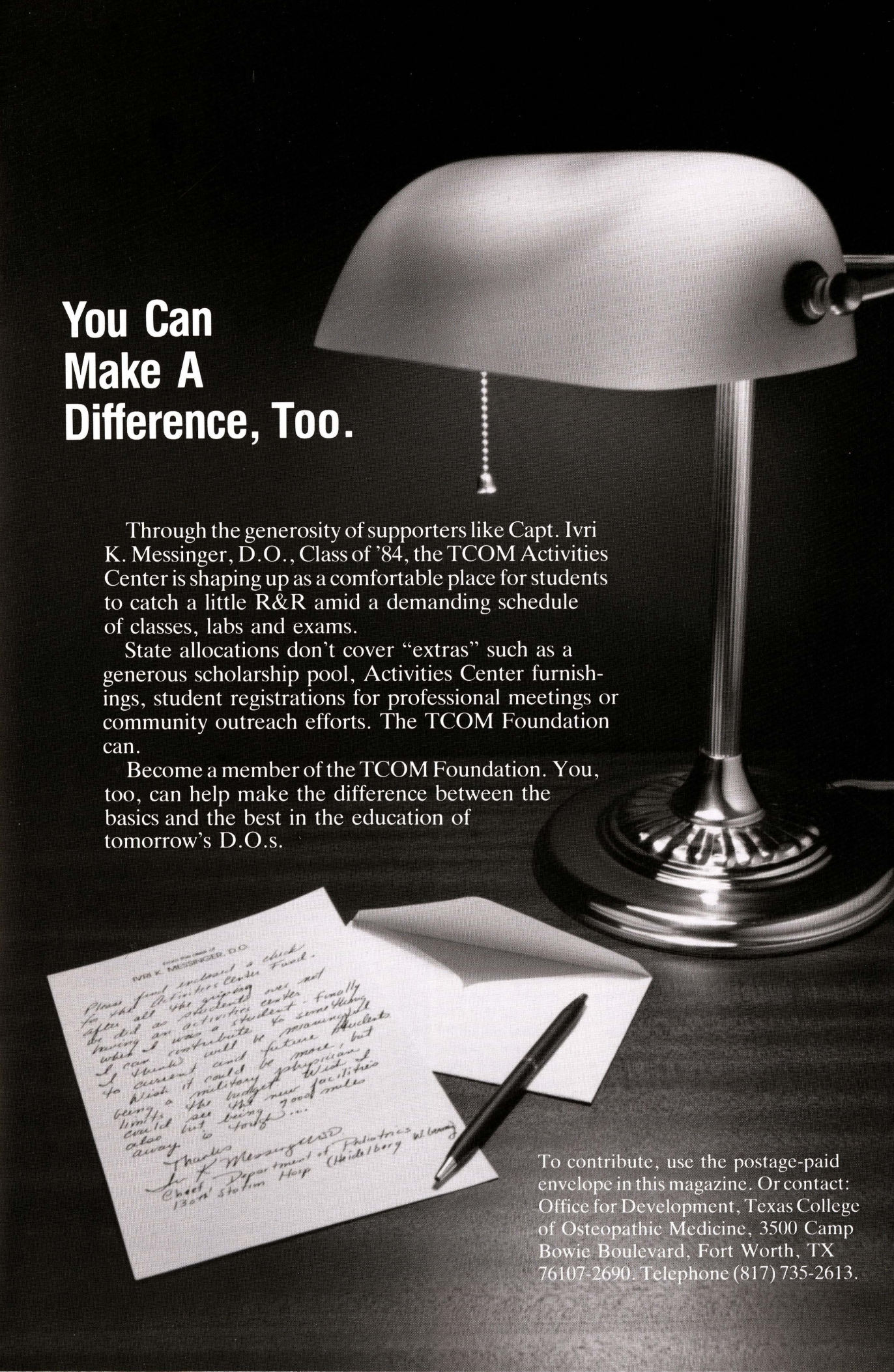
- If possible, locate your office in a neighborhood populated by older adults. Consider a location close to a pharmacy, senior center or diagnostic centers. Accessibility by walking, public transportation or short-distance driving is a definite plus. Be easy to find. This includes having a large, easy-to-read office sign.
- Have adequate parking nearby, and a street-level entrance to your office that is handicap-accessible.
- Allow enough space in your office to accommodate not just your patients but also their ambulatory aids and the family members who often accompany older patients to medical appointments.
- In your reception area, avoid low or overstuffed chairs, highly waxed floors and loose rugs. Provide good lighting and interesting reading material in large-print editions.
- Keep your examination rooms bright, cheery and warm (older patients are less cold-tolerant). Use examining tables that lower to about 25 inches or that have easy access.

Special Attention

- Allow extra time in scheduling appointments. In my initial evaluations, I allow a minimum of one hour, one and one-half hours for someone with social or functional difficulties. I allow a minimum of 30 minutes for follow-ups. Interview your patient both separately and with family members. Treat everyone with respect and dignity.
- Give one-to-one attention during your examinations and consultations and, above all, don't rush. Allow time for questions and answers. Keep your examining areas quiet. Speak in a slow, low-pitched tone for best comprehension.
- Remembering to send birthday cards is a nice "extra." Also, send thank-you letters to patients who refer others to your practice.
- Write down instructions for care at home or for taking medications; print in large, block letters. Offering to fill out insurance forms is a welcome service and guarantees that you will be compensated on a timely basis.
- Consider the older person's finances when setting fees and prescribing medications. Give out samples if available. Explore which pharmacies offer senior discounts, and get information about the American Association of Retired Persons Prescription Plan.
- Participate in the Medicare Program. You'll be listed in their directory (name, address, specialty), which is distributed free to citizen organizations and individual Medicare beneficiaries.

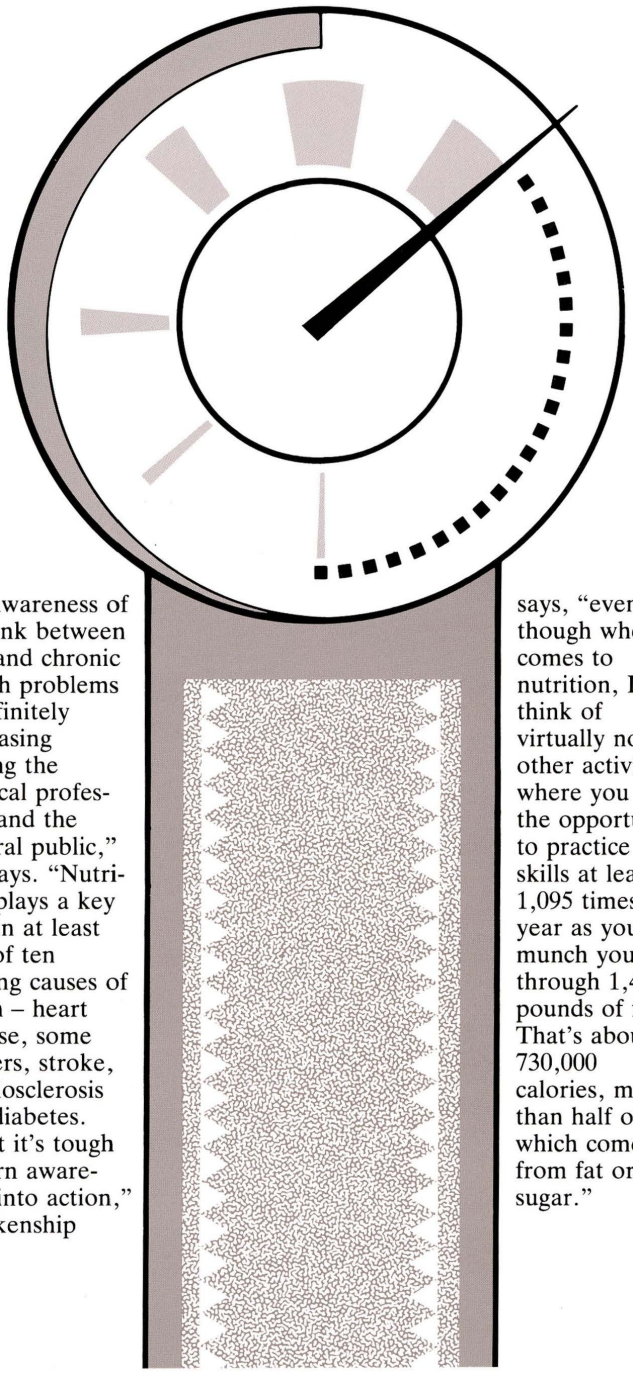
Promoting Yourself

- Publish a well-designed, easy-to-read brochure that explains your concern for the needs of the geriatric population, a map and good directions to your office, and your special services such as home-health agency referrals, home visits and Medicare participation. Include information about what your patients should expect when they see you for their initial evaluation and what they should bring (medications, prosthetics, etc.). Your local "quick" printer can help you produce an effective, economical piece.
- Take the time to talk at retirement communities, special-interest group meetings (such as Alzheimer's, arthritis, cancer support groups) and senior citizen centers. Present a short, relevant topic augmented with visual aids and handouts (such as your practice brochure), and then stay afterwards and answer questions.
- Offer to write for newsletters or other publications published by or for elderly populations.
- Put together educational brochures about special treatments or services that explain the ways in which modern medicine may improve the quality of seniors' lives. Include your practice information, and circulate throughout your community and in senior centers. Display these and other publications targeted to senior citizens prominently in your reception area.


You Can
Make A
Difference, Too.
Through the generosity of supporters like Capt. Ivri K. Messinger, D.O., Class of '84, the TCOM Activities Center is shaping up as a comfortable place for students to catch a little R&R amid a demanding schedule of classes, labs and exams.
State allocations don't cover "extras" such as a generous scholarship pool, Activities Center furnishings, student registrations for professional meetings or community outreach efforts. The TCOM Foundation can.
Become a member of the TCOM Foundation. You, too, can help make the difference between the basics and the best in the education of tomorrow's D.O.s.
To contribute, use the postage-paid envelope in this magazine. Or contact: Office for Development, Texas College of Osteopathic Medicine, 3500 Camp Bowie Boulevard, Fort Worth, TX 76107-2690. Telephone (817) 735-2613.

Diseases associated with diet account for more than two-thirds of the deaths in America each year. Government officials have set nutrition goals and are monitoring our progress. The caretakers who hope to wean us from our fat, salt and easy chairs say they've seen improvements, but it's still

EASIER SAID THAN DONE



"Substantial progress" has been made toward achieving the federal government's 1990 nutrition goals, though several targets – such as a slimmer American physique – likely will not be met, the U.S. Centers for Disease Control reported this summer.

"Awareness of the link between diet and chronic health problems is definitely increasing among the medical profession and the general public."

In 1980, federal health officials set 15 top goals for American nutrition in 1990, including such things as increasing public knowledge of the effects of salt and lowering average blood cholesterol levels. Researchers are now predicting that three of the goals will be met and that there has been progress in several other areas, according to the U.S. Office of Disease Prevention and Health Promotion in Washington, D.C., which helped the CDC prepare its report.

TCOM nutritionist Ann Blankenship, Ph.D., notes that the baseline data needed to precisely measure national progress toward the goals is skimpy, but that statistics shouldn't stand in the way of promoting good nutrition.

"Awareness of the link between diet and chronic health problems is definitely increasing among the medical profession and the general public," she says. "Nutrition plays a key role in at least five of ten leading causes of death – heart disease, some cancers, stroke, arteriosclerosis and diabetes.

But it's tough to turn awareness into action," Blankenship says, "even though when it comes to nutrition, I can think of virtually no other activity where you have the opportunity to practice your skills at least 1,095 times per year as you munch your way through 1,432 pounds of food. That's about 730,000 calories, more than half of which come from fat or sugar."

THE CHALLENGES OF REFORM

Richard Baldwin, D.O., acting chairman of general and family practice, credits the media and how they've promoted health and fitness concerns with much of the increase in awareness. "We're a better educated, information-driven society now," he says, "and health news is abundant. Americans take nutritional supplements and buy diet books at unprecedented rates. They want information on the role of diet in disease prevention, pregnancy, infancy and aging. They expect their doctors to be as knowledgeable in nutrition as they are in everything else."

"As osteopathic physicians," Baldwin says, "we should be particularly well-prepared to address preventive medicine topics. I've definitely seen improvements in patient education, but we need to develop our skills in nutritional counseling and behavior modification. We must keep up with the latest findings, goals and intervention strategies. We can be more effective nutrition educators by knowing the referral mechanisms and by working as part of a team with other allied health professionals such as dietitians and nurses."

Blankenship says that addressing nutrition education on the academic level is the first step. "TCOM was a pioneer in teaching students the practical applications of health promotion in our Developing Dimensions in Health Care workshops," she notes. "But nutrition education is not a subject covered by the licensing exam, so, unfortunately, it's not included on many medical school curricula."

Blankenship believes that the promotion of healthy nutrition patterns must come from a variety of public sectors, not just the medical community. "Business and industry must realize that employee wellness programs can save them a lot on insurance premiums and lost work days," she says. "Schools, food manufacturers, restaurants, grocery stores and community agencies must all get involved. They should seek the advice of public health officials, nutritionists, dietitians and physicians on how to help people make informed, health-enhancing food choices and how, when the choices are limited, to do the best they can. It's good business to provide what the educated consumer wants."

"We also need federal initiative to financially enable disadvantaged and elderly people to purchase the right kinds of foods and have access to the proper food sources," Blankenship says. "Good nutrition is preventive medicine and Medicaid doesn't cover preventive medicine."

One encouraging sign, Blankenship notes, is that in Texas private insurance companies may reimburse, though with considerable limitations, expenses for nutrition counseling by licensed dietitians. She believes that it is just a matter of time before all states follow this example, first in licensing dietitians, then in allowing insurance companies to reimburse for nutrition education.

"The big question is," Blankenship asks, "are you going to reimburse for preventive measures or therapeutic measures? It's a question of philosophy. And, of course, the osteopathic community has been asking it for years."

America's nutrition goals for 1990: How are we doing?

- Federal officials hoped that by 1990 more than 75 percent of the population would be aware of nutritional risks for conditions such as heart disease, high blood pressure and tooth decay (with fat, salt and between-meal sweets being the public enemies). Awareness already runs as high as 90 percent in some categories, the CDC report said.
- Ninety percent of U.S. adults should be aware that to lose weight they must eat fewer calories or increase physical activity, or both. The report said the percentage was 73 in 1985 and is rising quickly.
- A comprehensive national nutrition status monitoring system should be implemented. The CDC reported that it is already in place.
- Federal health officials hoped that by 1990 fewer than 10 percent of American men and 17 percent of American women would be over the "significantly overweight" level (more than 20 percent over desired weight). It's still about one-fourth of the country, according to CDC reports.
- A goal was to have 50 percent of the overweight population on a weight-loss program combining diet and exercise. The CDC said recent surveys show that half the nation's overweight people are indeed trying to lose weight but that only half of them are using both diet and exercise.
- The average adult level of harmful serum cholesterol needs to be reduced to below the 200 mg/dl count. 1987 statistics revealed that more than half of the nation's adults had levels over 200 mg/dl. One quarter of those had levels over 240 mg/dl.
- The government hoped that at least 75 percent of all mothers would be breast-

feeding their babies at the time they leave the hospital. A 1984 survey put the figure at 61 percent. In 1978, the number was 45 percent.

- All packaged food should be labelled with "useful calorie and nutrient information." Only 55 percent of the packaged foods do so, but even so, that is up from 42 percent, the CDC reported.
- Nutrition counseling should be included in "virtually all routine health contacts with health professionals." The figure was less than 30 percent, according to a 1985 survey.
- The government wants to eliminate cases where a child's growth is retarded because of nutritional deficiencies. Data is limited to disadvantaged populations.
- Government health officials hoped that nutrition education would be included in the required school curriculum in all states by 1990. By 1985, only 12 states had such a requirement. Good news: Texas is one of them.
- The goal was to reduce sodium in processed foods by 20 percent. Good news: Between January 1981 and July 1985, 173 new lowered-sodium brands were introduced into the marketplace.
- Government health officials hoped to see adults reduce their daily sodium intake to between three and six grams (from between four and ten grams in 1979).
- By 1990, the proportion of pregnant women with iron deficiency anemia ought to be reduced to 3.5 percent (from 7.7 percent in 1978).
- Officials want more than half of employees and school cafeteria managers aware of and actively promoting federal dietary guidelines by 1990. The baseline data is unavailable for precise tracking, but reports are encouraging, according to the CDC.

IN *Practice*

Increasing Your Nutrition Knowledge

TCOM nutritionist Ann Blankenship, Ph.D., has these practice-enhancing tips for physicians:

- To find a dietitian for patient referrals, check the nutritional support services of your local hospital. Many do outpatient counseling at reasonable fees.
- Take advantage of the literature available from your regional health departments. Also, contact pharmaceutical companies, food companies and groups like the Dairy Council or the American Heart Association – many have free or low-cost literature. Display these in your office.
- Call the director of the nutrition department of a nearby college or university to talk about mutually beneficial services for you and their interns and graduate students.
- Learn about the nutritional assistance programs available in your area. You can help certify your qualified clients for assistance. Know about the child-care food programs in which licensed, stay-home day-care providers serving six or fewer children may be eligible for monetary assistance in providing nutritious meals.
- Learn about your area's senior centers and their services. They're mandated to provide nutrition education in addition to providing nutritious meals. Also, learn about other congregate feeding centers in your area.
- Know about the school lunch programs in your area. Participating schools are required to serve a meal that meets one-third of the daily recommended dietary allowance of most nutrients for the children.
- Many schools and hospitals are looking to expand their meal services. You may be able to send your senior clients to eat lunch for low cost.
- Get an introductory textbook on nutrition from a local college bookstore. You'll have a complete review of the basics.
- Get to know the people at your closest chapter of the American Dietetic Association.
- Get involved! The Texas State Health Plan (based on the federal government's plan) was compiled by regional planning commissions. Know whom to contact in your region. Write the Texas Department of Health, ask for a copy of the Texas State Health Plan. Meet with your regional contacts and tell them about the health needs you see; you can't assume planners know about the conditions you think ought to be addressed. Too many times too few people go to the meetings where goals are set.

YOU ARE WHAT YOU EAT

Warning: The U.S. surgeon general has determined that the American diet can be hazardous to your health.

He also reminds us that it doesn't have to be.

This summer C. Everett Koop released the first Surgeon General's Report on Nutrition and Health. Koop called the report, the first on diet and health by the Public Health Service, a "landmark" effort that he hoped would have the impact of a similar volume in 1964 on the relationship of cigarette smoking to health. That report led to national efforts to cut tobacco use.

The report cites dietary fat as a leading cause of disease and marks the first time the government has identified reducing fat consumption as the No. 1 dietary priority of the nation.

The 712-page report does not present new research findings, and its recommendations for dietary change, such as reducing intake of fats and sodium and avoiding obesity and heavy alcohol use, are similar to those of other government and private studies.

But federal health officials and others said the report is so comprehensive and authoritative that it should provide an important scientific underpinning for nutrition and health programs and also for legislation on food-related issues.

TCOM's nutritionist, Ann Blankenship, Ph.D., praised the report. "I predict it will have an important and long overdue impact on nutrition education, how Americans regard their diet and on products sold by the food industry," she said. "It endorses ideas that the American Heart Association has been pushing for some time."

How to get a copy: Copies of the Surgeon General's Report on Nutrition and Health can be obtained by writing to the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402-9325. An 80-page summary is $2.75; the full report is $22.

WAR ZONE MEDICINE

Memories of Pakistan from outstanding alum Marcia Pehr

"I never got trapped by a tribal war when rotating through Fort Worth Osteopathic Hospital!"

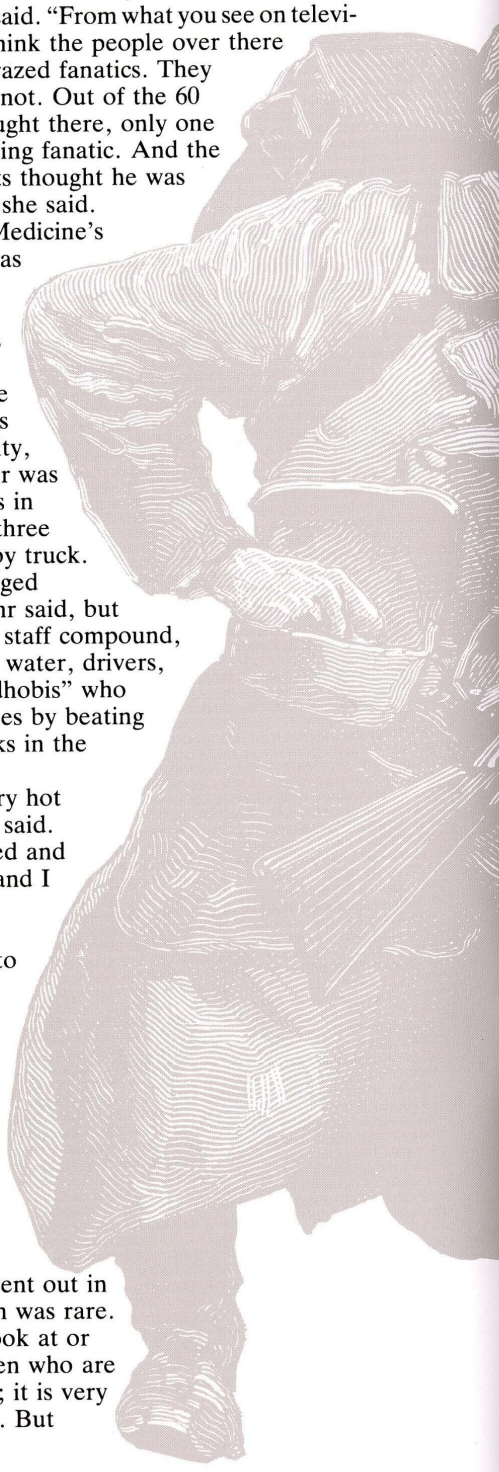
But Marcia Pehr, D.O. ('78), ran the risk of finding herself in the middle of such conflicts when she spent six months in Pakistan in 1987 training the medics of the Afghan rebels. The training program is a project of a private humanitarian organization, Freedom Medicine, and is funded through a grant from the U.S. Agency for International Development and personal contributions.

For her efforts, Pehr received the TCOM Alumni Association's first outstanding alumni award, presented last spring at the Texas Osteopathic Medical Association annual convention in Galveston.

Pehr admitted she was a bit worried about going to Pakistan. "I'm female, I'm American and I'm Jewish," she said. "From what you see on television, you'd think the people over there are all just crazed fanatics. They certainly are not. Out of the 60 students I taught there, only one was a screaming fanatic. And the other students thought he was a jerk, too," she said.

Freedom Medicine's base office was located with other relief organizations in Peshawar, Pakistan. The organization's training facility, to which Pehr was assigned, was in Tahl, about three hours away by truck. Tahl was rugged territory, Pehr said, but there were a staff compound, showers, hot water, drivers, cooks and "dhobis" who washed clothes by beating them on rocks in the river.

"It was very hot there," Pehr said. "One hundred and ten degrees and I had to wear clothes that covered me to my ankles and wrists, and I had to keep my head covered. I didn't have to wear a veil, but native women did when they went out in public, which was rare. You don't look at or talk to women who are not relatives; it is very disrespectful. But



since I was a foreign woman my students considered me sort of an 'honorary man.' And since I was their teacher they also thought of me as their 'mother.' So, it was all right to look at me and talk to me."

Because she is a woman Pehr was not allowed to rotate to dangerous areas, but only to the small village of Garumcheshma, high in the mountains near the Afghan border. She was there for short periods that totalled about two months.

"Garumcheshma was my love," Pehr said. "I really felt like I was in Afghanistan, even though I was actually still in Pakistan. It was a staging area. The troops would come out of Afghanistan for 'R&R' and to resupply, and they'd go back into the mountains to fight. We were there basically to run a clinic for them, but the casualties we'd get were not too bad because those who were badly wounded just didn't make it out of the mountains. And, we weren't allowed to go into Afghanistan."

The troops slept on the ground and lived on bread and tea. The physicians, nurses and other relief workers had it a little better. "We lived in a mud hut covered by a tarpaulin, with cots and a camping stove and lantern," Pehr said. "We had running water: the river across the road!"

She said the river water was used for drinking, cooking, washing clothes, bathing, watering horses and as a garbage disposal. "Needless to say," Pehr quipped, "I lived on tea."

"And the 'ladies room' was this cornfield down the road," Pehr said. "Hey, I was born in Brooklyn. I'd never been camping. And here I am out in the middle of Pakistan surrounded by 200 fierce guerrilla fighters and these corn stalks!"

Mealtime wasn't the same as dining at a New York five-star restaurant, either. Everyone used their fingers to eat from the same bowl. "The men, who called me Dr. Sahib Marcia, were so concerned about me that they'd push part of their food to my side of the bowl," Pehr said. "Now, I've been eating hospital food for more than 20 years, so you know I'm not a gourmet. But Afghan food is reprehensible. However, I wasn't going to argue with those men. Remember, some of them probably had been killing Russians, maybe with their bare hands, for five years."

Despite the sometimes-primitive living conditions, extreme temperatures, radically different culture and less-than-elegant cuisine, Pehr said she has no regrets about going to Pakistan for six months. "I liked it," she said. "I got to practice medicine there. I don't get to do that here. I sit around and document charts and listen to all the government regulations on utilization review. Over there, all I had to do was keep the patient alive."

Her stay in Pakistan wasn't Pehr's first venture into possibly perilous areas. She was in Sri Lanka for three months in 1982 and in Guatemala for a month in 1985.

Pehr is an emergency medicine physician for a medical agency in Floral Park, N.Y. She isn't sure where her next adventure will take her.

"I think I'll make a little money for a while. That's the one problem: making a living. Some day you do have to come home," she said.

But the yearning to help others in exotic – even dangerous – locations still smolders. Asked if she would go back to Pakistan tomorrow Pehr answered quickly and emphatically, "Oh, yes. Absolutely!"

Working for those who Follow

Kim Davis, D.O. ('78), president of TCOM's Alumni Association since April, believes the association has matured sufficiently that it should expand its programs to benefit the college and its students.

The energetic mother of two is in family practice in the Fort Worth suburb of Bedford and practices emergency medicine in Dallas County.

Davis is encouraged by the increased participation of TCOM graduates in alumni activities and the life of the college. "This is not a 'good old boy' club," she said. She praised alumni Nelda Cuniff, Carla Devenport, Jim Hawa, Larry Burrows and Carlisle Holland for the time and energy they have given to alumni. "They worked hard over a long time when they really didn't have much time to give," said Davis. "With such a small group in the beginning, there wasn't much an alumni association could do. But they persisted, kept the association together, held the meetings, organized homecoming and other activities, and saw to it that everything got done."

Davis acknowledged that the Alumni Association is still a small organization with a relatively small base, since only about half of TCOM graduates are active members. "I hope to develop a wider base of graduates as dues-paying members of the association. Then we can do more than just contribute money that goes directly to scholarships, student loans and medical books," she said. "We can build an endowment fund and use the interest to help future students and the growth of the college."

Davis believes the Alumni Association's main emphasis should be to benefit current and future students. She's considering a plan patterned after the Big Brothers and Big Sisters programs.

"Using alumni and other local D.O. physicians in a mentor relationship with medical students would give the students a broader, more practical perspective of the practice of medicine. And it would involve local physicians in the life of TCOM," she said. Davis even suggested that the physician couple consider taking a student couple out to dinner occasionally. "Socializing also is part of the support mechanism for students," she said.

Another way to assist students is for alumni to encourage continued cultivation of a mutually rewarding student-faculty relationship. "After all," Davis said, "we're all going to be colleagues some day."

RESEARCHER TAKES EXPERTISE TO CHINA

Robert Gracy, Ph.D.

A government request for information about the science of aging and research funding sent Robert Gracy, Ph.D., biochemistry chairman, to China last summer. An infatuation with the culture, beauty and intellectual ambitions of the exotic Far East and its people will probably lure him back this spring.

Gracy, who has traveled the world on behalf of science, medicine and education, said the five-week excursion was "the only one of its kind." He gave 16 lectures in several cities including the capital, Beijing, in the northeast; Nanjing, in central China; Shanghai and Suzhou ("the Venice of Asia"), in the east; Hangzhou, on the East China Sea; and the British colony of Hong Kong, on the South China Sea. He spent a week in Taiwan. It was a journey by plane, train and limousine of about 17,500 total miles, about 2,600 of it on the lecture circuit. The Chinese government paid all expenses in exchange for Gracy's expertise.

"Unlike a typical tourist, I saw the Chinese culture from the inside out," he said. "I was with fellow scientists and students all the time, in medical schools, hospitals, labs and institutes. After lectures, in the evening, students would line up outside my door in the guest dormitory, eager to talk more. We would discuss everything from science and medical education to politics, art, music and geography. The pervasive sense of sincerity in wanting to catch up (after the Cultural Revolution) was overwhelming. Yes, I plan to return."

Gracy had two primary missions in China: to advise officials who are new at funding research programs and to share knowledge on the science of aging. He met with officials from the National Science Foundation of China, an equivalent of our National Institutes of Health, to discuss how to establish funding policies and reporting procedures, improve research facilities, and identify the most promising projects and students. They reviewed what strategies have and have not worked in the United States and Europe. The foundation was formed only about three years ago and is seeking advice from researchers around the world.

Gracy said China's research programs in aging are already impressive. "There's a lot more than in the United States or anywhere else I know," he said. "At every lecture site I was questioned about my work in aging. I think their intense interest is due in part to a culture that has always revered the wisdom of older people. Much of the traditional Chinese medicine, such as acupuncture and herb therapy, is aimed at chronic diseases that afflict the elderly. And much of the aging research that is done seeks to find a scientific basis for how and why these traditional remedies work."

Gracy said that TCOM is recognized as having one of a small number of successful labs studying the science of aging. His own explorations into the aging process have earned him the largest grant ever received by a TCOM faculty member. A National Institutes of Health long-term MERIT grant worth more than $3 million over the next 10 years will allow Gracy and his research team to expand their work into the areas of cellular and molecular changes in aging, wound healing and the progressive impairment of vision in the elderly.

Medicine Clinic Expands

TCOM's Internal Medicine Clinic, challenged by the logistics of how 15 physicians, 15 students/residents and 10 staff take care of 50-70 patients a day in a one-story building roughly the size of two tennis courts, is enlarging its service area by half.

Slated for completion in December 1988, the 3,000-square-foot addition to the 6,000-square-foot clinic is a "significant improvement," said Michael Clearfield, D.O., medicine department chairman and clinic director. "Physicians, students and nurses were sometimes working three to a desk," he said, "and our patient backload was growing because we literally did not have room for them in the clinic."

The expansion will bring more examining rooms and a larger lobby, and will free up more room for the 10 subspecialties practiced at the clinic. "Specifically, we will expand our endoscopy, cardiovascular and pulmonary function services and we will generally be able to do more procedures for more patients," Clearfield said. "All in all, we will be a more efficient clinic in which to practice, teach and learn."

An extra benefit was evident as soon as construction began. "Just at the prospect of not running into each other all the time," Clearfield said, "morale jumped 100 percent."

Outlook 'Excellent' for Liver Transplant Patient

Sheila Denise Chambers, a 20-year-old Fort Worth native, had battled a rare liver disorder since she was 15 when Monte Troutman, D.O., a digestive disease specialist with TCOM's Internal Medicine Clinic, helped her secure "her only chance of having a normal life" – a liver transplant – last summer.

Chambers received her new liver in a 10 1/2-hour operation at Baylor University Medical Center in Dallas Sept 3. Troutman said she was released "in record time" Sept. 16. "Sheila is incredible, a real fighter," he said, "and the outlook is excellent."

Troutman first saw Chambers about four years ago, when she was referred to him by Fort Worth general and family practitioner Harold Johnson, D.O., a 1984 TCOM graduate. Chambers' mother, Judy Chambers, took an active role in her daughter's care, Troutman said, which included tracking down all the X-rays and treatment records from the numerous doctors Sheila had seen over the years. Troutman confirmed that the liver disorder was Budd-Chiari syndrome. He did a liver biopsy and began treatment for the underlying cause of the syndrome, a blood disorder known as polycythemia rubra vera, and several secondary disorders such as malnutrition, anemia and edema.

When Chambers' condition stabilized enough to go ahead with the transplant, Troutman contacted Baylor, where about 200 liver transplants have been performed over the last five years. Goran Klintmalm, M.D., a surgeon with the University of Texas Southwestern Medical School in Dallas and director of transplantation at Baylor, performed the surgery.

Troutman and Judy Chambers had negotiated with Medicaid to pay the estimated $265,000 cost of the surgery even though, Troutman said, "Medicaid is not usually receptive to transplant costs." Word came before the surgery occurred that Medicaid had agreed to cover most of the expenses and that Baylor had waived the remaining balance.

Because Chambers must still have her blood disorder treated in order to prevent Budd-Chiari syndrome from recurring, she will continue to see both Troutman and the doctors at Baylor.

Judy Chambers, Dr. Monte Troutman and Sheila Denise Chambers

Activities Center Shapes Up

The building's exterior is still that of a 1950s church, but the big screen TV, VCR, microwave oven and weight-training machines inside are dead giveaways to the thoroughly modern purpose of TCOM's newly renovated Activities Center.

"Generous gifts to the school have allowed us to make this facility something all faculty, staff and students can enjoy year-round," said Mary Schunder, Ph.D., associate dean for student affairs. "During the two years we've been renovating the building, we've used it for student parties, aerobics classes, college-wide carnivals and our most recent convocation luncheon. There's equipment for basketball, pool, ping pong and weight training, and we hope that plans for a volleyball court outside will materialize. It's truly a multipurpose facility."

The Activities Center shares the 12,000-square-foot building, purchased by the school in 1980, with the Department of Public Health and Preventive Medicine's Health and Human Fitness and Rehabilitation/Sports Medicine divisions.

Improvements to the property have included minor structural renovation, groundskeeping, painting, new mini-blinds and carpeting, modern kitchen equipment, redwood deck, and tables and chairs to accommodate 125. Texas Osteopathic Medical Association District 15 (Arlington) funded the installation of a sound system, and the Class of 1988 donated the 45-inch color TV, VCR and microwave oven. A full-time center coordinator was hired in November. Soon to come, according to Schunder, are a security system, showers and lockers rooms. Remaining on the "wish list," she said, are deck chairs, lounge furniture and a feasible fresh-food service system.

Students Excel on Exams

All 93 juniors who took Part I of the National Osteopathic Board Examination and the 1988 graduates who took the Federation Licensure Examination in June have something besides good study skills in common: a 100-percent passing rate.

"This is a first for TCOM," Eugene Zachary, D.O., vice president for academic affairs and dean, said of the National Board scores, which were released last fall. "It is indicative of the quality of our students and their hard work, and it speaks well of the excellence of our faculty." Zachary said scores of the TCOM students in six of the seven exam subjects were far above the mean scores of students taking the test at the country's 14 other osteopathic colleges.

Part I of the examination is given to all osteopathic medical students after completion of their sophomore year. Part II is administered in the second half of their senior year. TCOM students must pass both parts to graduate.

The Texas Board of Medical Examiners reported that all 47 of the 1988 graduates who took the licensing exam passed both Component I (basic science) and Component II (clinical science). The 1988 graduates and seven graduates from earlier classes who took the FLEX together achieved a 92-percent passing rate on the jurisprudence test, the third element required for licensure to practice in Texas. The scores were the culmination of a steady improvement in overall FLEX performance that began in 1984 when changes were made at TCOM in the areas of student recruitment, admissions, curriculum development and academic standards.

TCOM Founder Named AOA Educator of the Year

One of TCOM's three founders, George J. Luibel, D.O., was named The National Osteopathic Foundation's 1988 Educator of the Year and honorary program chairman of the NOF annual seals campaign. The announcement was made at the American Osteopathic Association House of Delegates meeting in July and was promoted publicly during National Osteopathic Medicine Week, Sept. 25-Oct. 1.

Luibel, who has practiced medicine in Fort Worth since 1946, was one of the three initial directors of TCOM when it was chartered by the state in 1966 and was the first chairman of its board of directors, serving from 1966 to 1974. A Fellow of the American Academy of Osteopathy, Luibel was the first Texan elected president of the AOA in 1976. He is a staff member of Fort Worth Osteopathic Medical Center and is chairman of the board of managers of the Tarrant County Hospital District, the first D.O. to hold that position.

The NOF's Osteopathic Seal Program Committee began the Decade of Educators series of osteopathic seals six years ago, and each year, in the order of their founding, one of the country's 15 osteopathic colleges selects the outstanding Educator of the Year to be represented on the official seal stamp. Proceeds from sales of the stamps and related materials go to student loans and osteopathic research funding.

ADVICE, HONORS, AWARDS HIGHLIGHT CONVOCATION '88

The 93 members of the Class of 1992 were challenged at Fall Convocation to "aim high," look to preceding students as models to be followed, learn sensitivity as well as medical expertise and commit themselves to the kind of service to others as exemplified by TCOM's three 1988 Founders' Medal recipients.

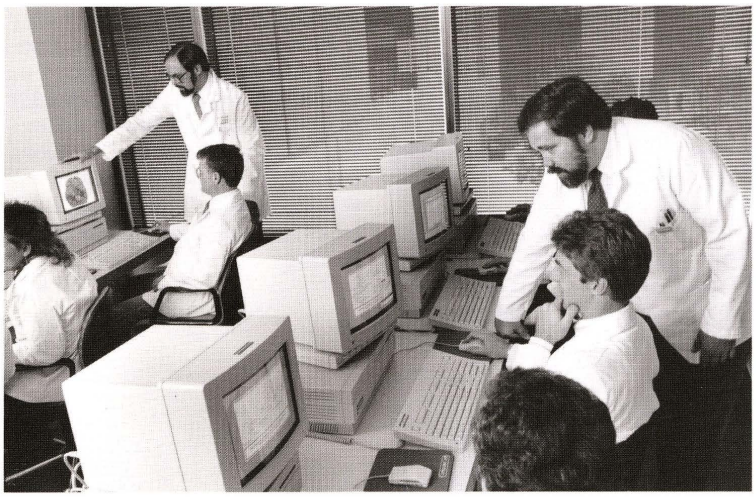
Founders' Medals were presented Sept. 23 during the 11th annual convocation to welcome the new class to TCOM. Recipients were Roy B. Fisher, D.O., founder of Fort Worth Osteopathic Medical Center; Col. Peter F. Hoffman, M.D., Ph.D., former commander of medical facilities at Carswell Air Force Base; and state Sen. Bob McFarland of Arlington.

Fisher, who founded Fort Worth Osteopathic Medical Center in 1946 on the lower floor of his home and has guided its development into a 265-bed complex, was cited for "his inspiration, determination and leadership that has helped countless patients to be healed, many young physicians to be motivated and educated, and osteopathic medicine to achieve higher commitments of excellence."

Hoffman was honored for his leadership and enthusiastic cooperation in enabling TCOM physicians and students to serve in TCOM's general and family practice CHAMPUS clinic at Carswell, a "first" for the Air Force and a model of civilian-military cooperation. "No one had ever successfully brought a civilian physician on base to take care of those patients that the (base) hospital simply couldn't because of its size or specialty (needed)," Hoffmann said. "They said it couldn't be done. But we're doing it."

Sen. McFarland has been a member of the Texas Legislature since 1977, first as a state representative and now serving his second term as state senator. He was honored for his work on behalf of higher education and his long-time support of TCOM.

Fourteen sophomores, a junior and two graduate students shared the convocation spotlight with the freshmen and honored dignitaries. The Preclinical Awards for Excellence in anatomy, neurobiology, pharmacology and physiology, and the Texas Osteopathic Medical Association's first Academic Achievement Award also were presented.



BECOMING COMPUTER LITERATE – Robert Bourdage, Ph.D. (left), and James Sims, Ph.D. (right), assist students in TCOM's new microcomputer lab in the Health Sciences Library, a state-of-the-art facility used for now-mandatory computer literacy courses, computer-assisted instruction and staff training.

CAMPUS NEWSMAKERS

President David M. Richards, D.O., was elected chairman of the Board of Governors of the American Association of Colleges of Osteopathic Medicine and will be installed in July 1989. He is now chairman of AACOM's Committee on Finance. Richards was also AACOM's nominee to the American Osteopathic Association's Council on Osteopathic Education and Development; he was elected council chairman for a three-year term that expires in 1991.

In American Osteopathic Association elections, **Eugene Zachary, D.O.,** vice president for academic affairs and dean, was re-elected speaker of the House of Delegates; **William R. Jenkins, D.O.,** surgery, was elected chairman of the Bureau of Insurance; and **Samuel T. Coleridge, D.O.,** emergency medicine, was elected first vice president.

Richard C. Hochberger, D.O., pediatrics, and **Robert Adams, D.O.,** obstetrics/gynecology, were appointed to the medical committee of the Fort Worth Mayor's Task Force on Infant Mortality, which is investigating the high rate of infant deaths in the city. The committee will make proposals and provide information to the task force and the mayor, as well as review the proposals of two committees looking into social and educational aspects of the problem.

Stephen Putthoff, D.O., pathology chairman, was appointed to the Pathology Test Construction Committee of the National Board of Medical Examiners for Osteopathic Physicians and Surgeons.

Robert Bourdage, Ph.D., anatomy, received a $30,060 grant from Apple Computer for the development of medical courseware. The grant provides four Macintosh II computers and collateral equipment and software for computer-based instruction development.

David Ostransky, D.O., medicine, received a $69,000 grant from Boehringer Ingelheim Pharmaceuticals Inc. for a drug study to compare treatments for patients with chronic obstructive pulmonary disease. He also was selected to serve on the Environmental Health Subcommittee of the American Lung Association of Texas and was appointed chairman of the association's Tarrant County chapter.

Johannes Steenkamp, D.O., public health and preventive medicine, was elected president of the American Osteopathic College of Preventive Medicine; he took office in December.

Peter Raven, Ph.D., physiology, was named to a two-year term as editor-in-chief of Medicine and Science in Sports and Exercise, the official journal of the American College of Sports Medicine.

Russell Gamber, D.O., assistant director of TCOM's Center for Osteopathic Research and Education, was named a Fellow of the American Osteopathic College of Preventive Medicine.

John Deagle, D.O., emergency medicine, has been elected a Fellow in the American College of Osteopathic Emergency Physicians.

Michael Clearfield, D.O., Robert Garmon, D.O., and **Howard Graitzer, D.O.,** were elected Fellows in the American College of Osteopathic Internists.

Irvin M. Korr, Ph.D., manipulative medicine, received Ohio University College of Osteopathic Medicine's Phillips Medal for his "significant contributions to the improvement of health care in the United States."

Minerva Hobart "Tiny" Batts, community services coordinator for Texas Electric Service Co.; **Erma C. Johnson,** vice chancellor of Human Resources for Tarrant County Junior College; and **Jay Sandelin,** president of Park Central Bank and a TCOM Foundation Board member, were reappointed to three-year terms on TCOM's Advisory Council; Sandelin is chairman. A new appointment was that of Corpus Christi businessman **Wayne O. Stockseth,** former chairman of the TCOM/University of North Texas Board of Regents. Continuing on the council are **Maxie Davie; M. McKim Davis, D.O.; Carl E. Everett, D.O.; Carlisle Holland, D.O.; Robert M. Lansford; Lewis T. "Pat" Patterson; Bill H. Puryear, D.O.; M. Lee Shriner, D.O.; E. Bruce Street Sr.; Carson R. Thompson; and Harry K. Werst.**

New faculty positions: **Richard Baldwin, D.O.,** TCOM general and family practice associate professor, is acting chairman of that department. **Paul Cook, Ph.D.,** TCOM biochemistry professor, is chairman of microbiology and immunology. Joining TCOM last summer were **John Bowling, D.O.,** associate professor of general and family practice, from a private practice in Lancaster, Ohio; **Linda Cunningham, M.D.,** assistant professor of pathology, from a private practice in Mesquite; **Gregory Dott, D.O.,** instructor of manipulative medicine, from directing Grapevine's Main Street Medical Clinic; **Linda Hurley, Ph.D.,** assistant professor of general and family practice, from a family practice residency in Flint, Mich.; **Mark McKinney, Ph.D.,** associate professor of medicine, from the University of Nebraska Medical Center; and **David Vick, D.O.,** assistant professor of manipulative medicine, from a private practice in Dallas. Joining TCOM this winter was **Stephen R. Grant, Ph.D.,** assistant professor of biochemistry, from the University of Texas M.D. Anderson Cancer Center.

New staff positions: Joining TCOM last summer was **Brent Jones, Ph.D.,** Fellow of the National Science Foundation at Texas Christian University, who is now TCOM's minority retention adviser. **Greg McQueen,** formerly an associate dean at Humber College of Applied Arts and Technology in Ontario, Canada, Health Sciences Division, is assistant to the vice president for academic affairs and dean. **Richard Sinclair, Ph.D.,** TCOM's director of admissions, is acting assistant dean for admissions. **Roger Swift,** formerly assistant to the vice president for academic affairs and dean, is director of graduate medical education.

In memoriam: **Linton Budd, D.O.,** chairman of TCOM's Department of Obstetrics and Gynecology from 1983 to 1987, who died Oct. 24; **Helen Farabee,** wife of state Sen. Ray Farabee, chairman of the Governor's Task Force on Indigent Health Care in Texas when she received the TCOM Founders' Medal in 1985, who died July 28; **Roger Hamilton, D.O.,** 1975 TCOM graduate and family practitioner in Granbury, who died May 3; **Henry Hardt, Ph.D.,** the "founding dean" of TCOM and 1980 recipient of the Founders' Medal, who died May 3; and **Craig Raupe,** TCOM/University of North Texas Board of Regents member since 1985, who died Oct. 14.

C A L E N D A R

JANUARY 17	Alumni Association Board of Directors Meeting	TCOM Rare Books Room
FEBRUARY 25	11th Annual Cowtown Marathon	Fort Worth Stockyards
MARCH 8-12	National Society of American College of General Practitioners in Osteopathic Medicine and Surgery Annual Convention	Marriott Rivercenter San Antonio
APRIL 1	Dallas Family Hospital and TCOM Office of CME: Spring Update for the Family Practitioner III	Dallas Family Hospital
APRIL 18	Alumni Association Board of Directors meeting	TCOM Rare Books Room
APRIL 27-29	TOMA 90th Annual Convention and Scientific Seminar, 15th Annual TCOM Alumni Association Assembly	Arlington Convention Center
MAY 20	TCOM 16th Commencement	Tarrant County Convention Center
JUNE 15-17	American Academy of Osteopathy International Symposium	Omni Netherland Plaza Cincinnati, Ohio
JUNE 23-25	TCOM Office of CME: 9th Annual General Practice Update – A Summer Symposium for the Family Practitioner	Holiday Inn Emerald Beach Corpus Christi
JULY 18	Alumni Association Board of Directors Meeting	TCOM Rare Books Room
AUGUST 4-6	Texas State Society of ACGP 16th Midyear Clinical Seminar/Symposium	Arlington Hilton

DISCOUNT NOTICE
TCOM Alumni Association active members receive a 10 percent discount on registration fees for all programs sponsored by the TCOM Office of Continuing Medical Education. For more information, or to verify that you are on the TCOM CME mailing list, contact Cheryl Cooper, CME coordinator, (817) 735-2539.

Texas College of Osteopathic Medicine's Office of Continuing Medical Education is supported by Dallas Southwest Osteopathic Physicians, Inc.

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