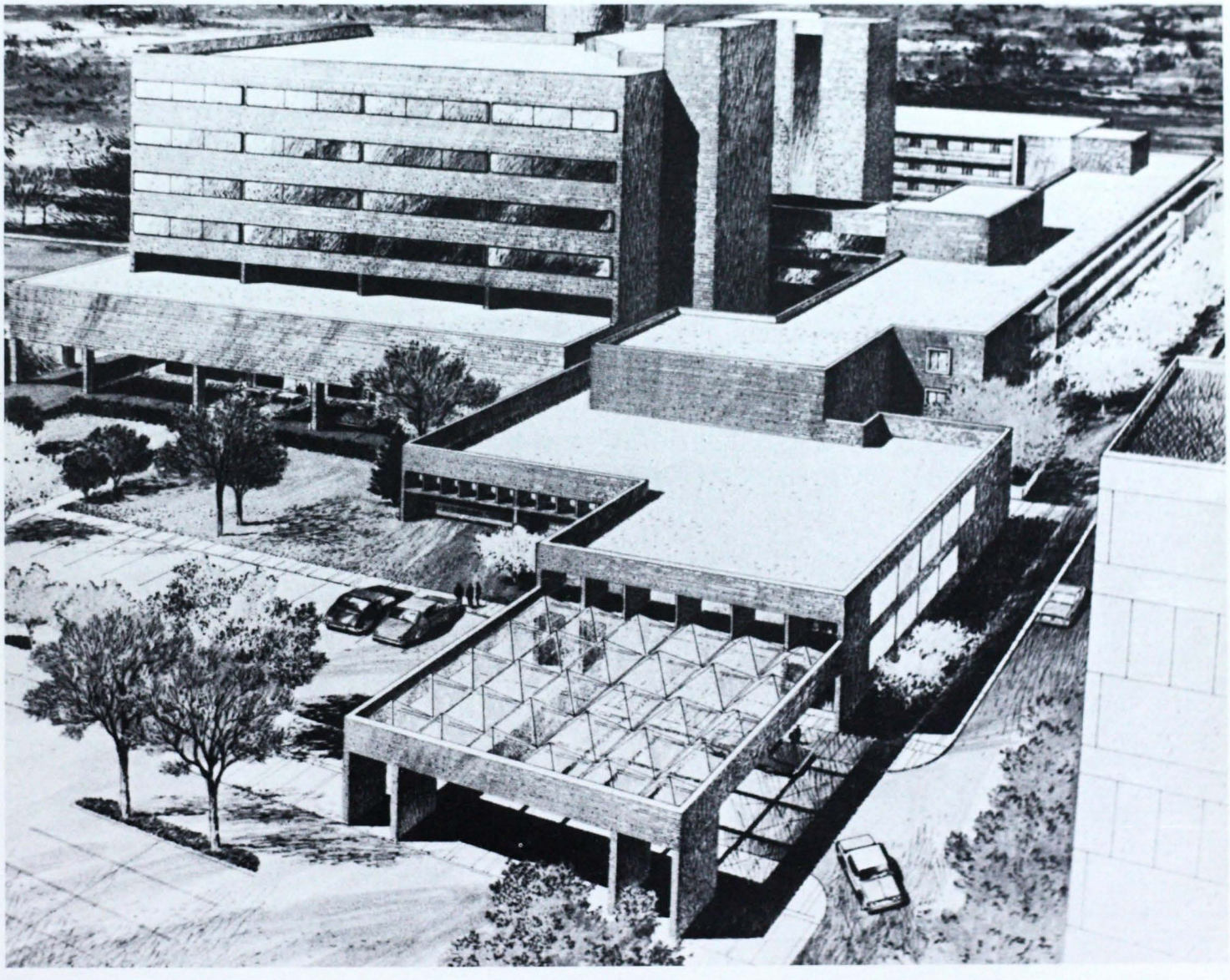
TEXAS OSTEOPATHIC PHYSICIANS

JOURNAL

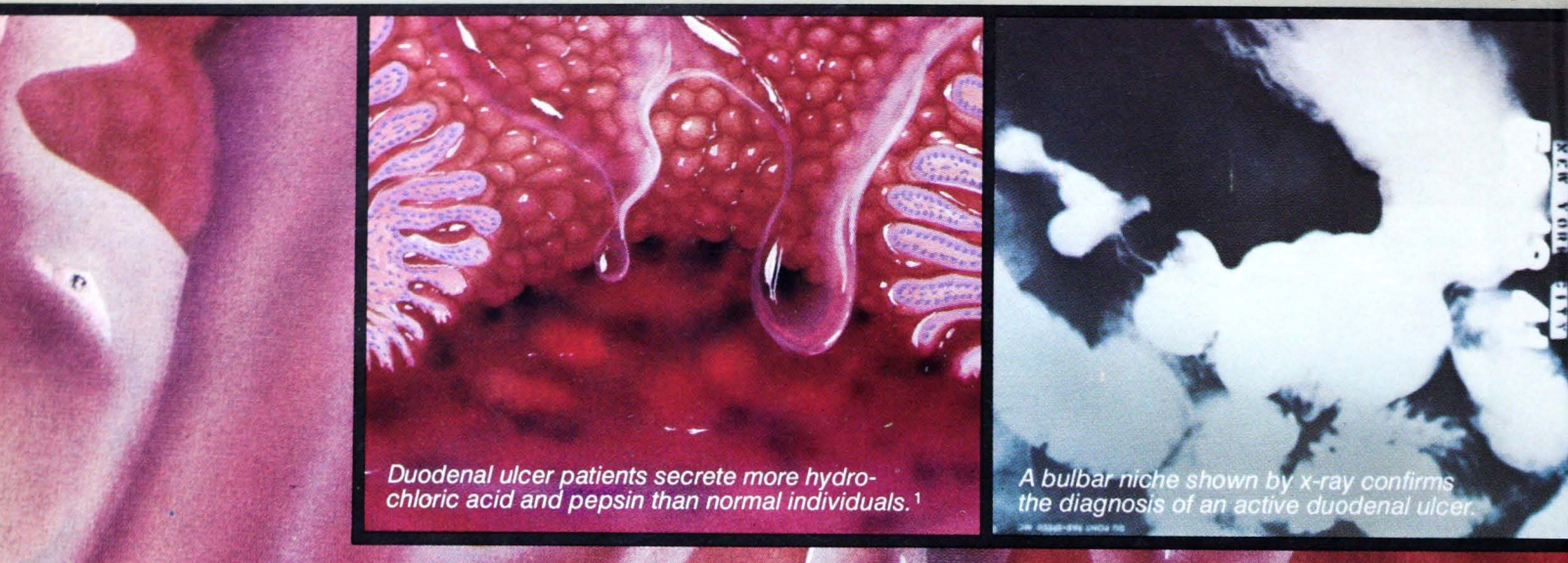
August 1977



– FWOH –

Focus on the Future

HYPERACIDITY/HYPERMOTILITY/



Duodenal ulcer patients secrete more hydrochloric acid and pepsin than normal individuals.[1]

A bulbar niche shown by x-ray confirms the diagnosis of an active duodenal ulcer.

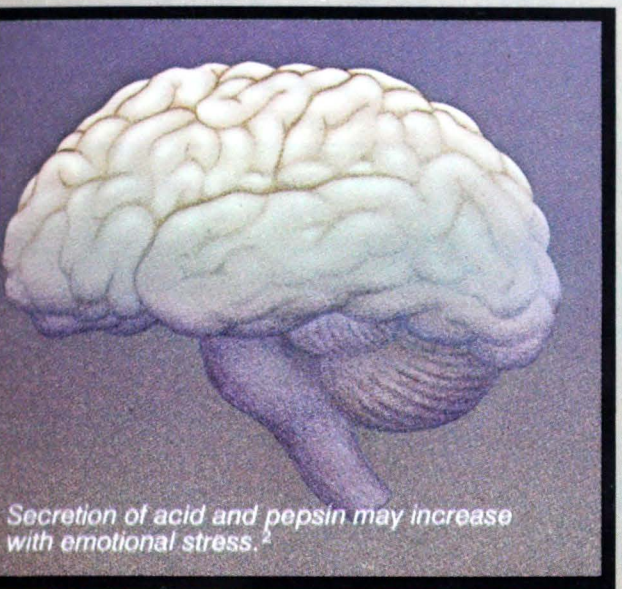
Artist's rendition of duodenal ulcer

References:

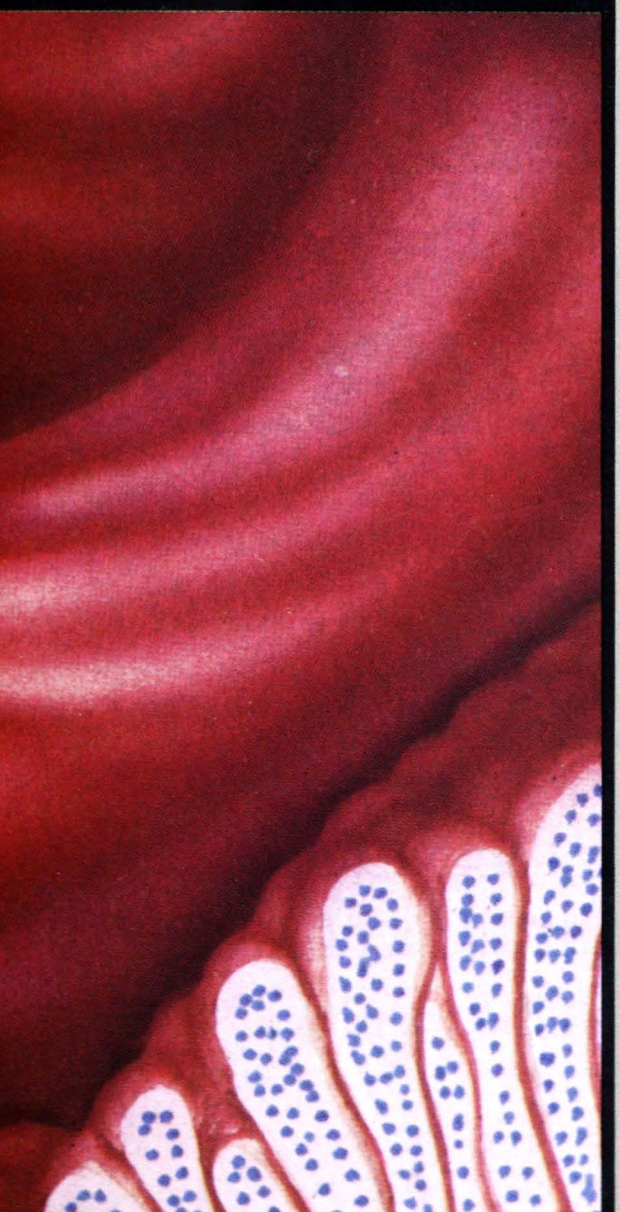
1. Isenberg JI: *Postgrad Med 57*:163-169, Jan 1975
2. Wolf S, *et al*: *Gastroenterology 69*:1161-1164, Nov 1975

ROCHE

RELATED ANXIETY...



Secretion of acid and pepsin may increase with emotional stress.[2]



ALL THREE RESPOND TO LIBRAX

The patient with duodenal ulcer may be "hyper" in more ways than one. Of course, the ulcer itself is associated with elevated acid-pepsin secretion. But frequently linked with the related pain and spasm are the subjective factors of excessive anxiety and emotional tension.

IN DUODENAL ULCER* ONLY LIBRAX PROVIDES:

1 The specific antianxiety action of Librium® (chlordiazepoxide HCl)

2 The potent antisecretory-antispasmodic actions of Quarzan® (clidinium Br)

Adjunctive

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Antianxiety/Antisecretory/Antispasmodic

***Librax has been evaluated as possibly effective for this indication. Please see brief summary of prescribing information on following page.**

Librax®

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

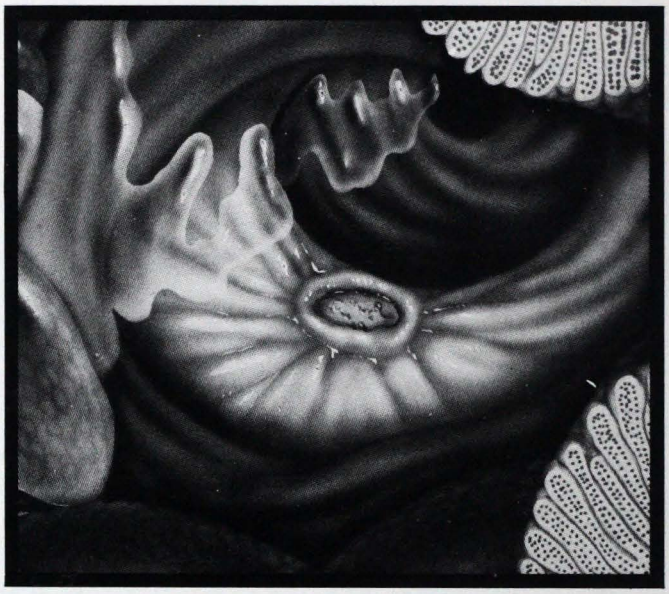
Dosage: Individualize for maximum benefit. Usual maintenance dose is 1-2 capsules, 3-4 times/day, before meals and at bedtime. Geriatric patients—see Precautions.

How Supplied: Available in green capsules, each containing 5 mg chlordiazepoxide HCl (Librium®) and 2.5 mg clidinium Br (Quarzan®)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50, singly and in trays of 10.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

To lessen hyperacidity, hypermotility and related anxiety in duodenal ulcer*



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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Because only Librax provides the specific anti-anxiety action of Librium® (chlordiazepoxide HCl) plus the potent antisecretory-antispasmodic actions of Quarzan®(clidinium Br)

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Mr. Tex Roberts, Editor

Osteopathic medical complex expands

Fort Worth Osteopathic Hospital kicks off $7.5 million project

The September 1970 issue of this *Journal* featured the Fort Worth Osteopathic Hospital and pictured that facility as it then existed on the cover.

In June of that year a new addition to the hospital had been completed, bringing its total capacity to 200 beds and 15 bassinets. Also added were an eight-bed intensive care unit and a four-bed cardiac care unit.

Coincidentally, the Texas College of Osteopathic Medicine enrolled its first class that September, and was quartered in the still to be completed fifth floor of FWOH.

Since then, the two have flourished side by side—and today both are in the midst of further expansion.

Certainly, both institutions had humble beginnings.

To fill a need

FWOH was founded in 1946 by some 20 young and eager D.O.s, spearheaded by Dr. Roy B. Fisher, who is now Chairman of its Board of Directors.

The first quarters for the new hospital consisted of an old mansion at 1401 Summit Avenue. And it was quite a step up when it moved to a new completely air conditioned building at 3807 Camp Bowie Boulevard in 1950.

FWOH — 1946

This facility included 25 beds and five bassinets and was built by contributions of the staff physicians and by a loan from the Amon G. Carter Foundation.

It was furnished by gifts from Mr. Amon G. Carter and Mr. Sid Richardson, who were long-time supporters of the osteopathic profession and patients of Dr. Phil Russell for many years.

The 1970 *Journal* reported that by 1950 the staff of the hospital had grown from 20 to 44 D.O.s, including specialists in surgery, EENT, x-ray, obstetrics and gynecology — more doctors than beds for their patients!

Third growth phase

Obviously, the ever increasing public demand for osteopathic medical facilities necessitated even larger quarters. So the third growth phase—the most ambitious to date—was begun at 1000 Montgomery.

This newest hospital, which opened in 1956, included 120 beds and 15 bassinets in a four-story modern building, and represented an outlay of $1,250,000. However, even before the new facility was built, FWOH had been accepted as qualified for intern training, and with the opening of the new hospital, a general surgical residency was begun.

FWOH — 1950

Coming up: Bigger and better osteopathic facilities

Now another expansion program is underway for Fort Worth Osteopathic—to the tune of $7.5 million.

Construction of Phase I of the expansion and renovation program is slated to begin in January, 1978 and will take approximately two years to complete. Total new construction during this period will include 60,000 gross square feet and total renovated construction will include 31,000 gross square feet.

It will begin with the building of a two-story ancillary addition to be located between the south and west wings of the existing hospital building.

Mr. Claude G. Rainey, the hospital's executive vice president, said, "We are not adding any beds. We are going to introduce outpatient surgery to our hospital setting at this time. Then we will proceed by modernizing and renovating our current facilities.

"Our expansion and modernization program has been carefully coordinated with the Texas Health Facilities Commission and a Certificate of Need has been granted to our hospital for this specific purpose," Mr. Rainey said.

Increasing demands for services dictate expansion

The new construction in Phase I will house a 24-hour Emergency Department, Surgery, Labor/Delivery, Radiology and Outpatient Services. New business offices will also be housed in this area.

The Dietary Department will be expanded and remodeled, as will the new lobby and Gift Shop, which together will create a new main entrance to the hospital.

During Phase I, all available land adjoining the hospital will be paved and landscaped for parking.

In order to improve accessibility within the hospital and to expand certain existing departments, Administration, Cardiopulmonary/Respiratory Therapy, Central Supply, the Laboratory, Medical Education, Medical Records, the Pharmacy and Purchasing will be expanded in their present locations or relocated and expanded in areas left vacant by departments transferred to the new addition.

The fifth floor of the existing hospital will be renovated and modernized to provide for the relocation of a 20-bed nursing unit.

A new central core of three elevators will be added in Phase I to service the hospital and to join the present construction with that of the second phase when it is begun.

A new central power plant will be constructed outside of the hospital and to the west to furnish power.

More growth in the offing

The master plan developed by Goleman & Rolfe, architects, provides for a second phase to include the addition of a four-story nursing tower or 160 more patient beds when such a need is indicated and subsequently approved by the Texas Health Facilities Commission.

"We carefully studied the possibility of proceeding with the additional construction at this time, but it was the Board's decision that we proceed only with plans to expand and modernize our present ancillary services," said Dr. Fisher.

"Once this demonstrated need for additional beds is apparent, we'll proceed with Phase II," he said.

FWOH — 1970

Dr. Fisher and FWOH in the future

More clinical facilities will soon be needed for TCOM

All indications are that the "demonstrated need" will surface in the not too distant future, with the Texas College of Osteopathic Medicine growing at a fast pace.

With the obvious need for more osteopathic physicians, TCOM has grown even faster than Fort Worth Osteopathic, which is its primary teaching hospital.

TCOM coming into its own

The fledgling school did not stay long in its temporary quarters at FWOH, but soon moved into a building that had once housed a bowling alley.

Born in a state of near poverty, TCOM mushroomed to where it now occupies several buildings on Camp Bowie Boulevard, and its first all new building, Med Ed I, is fast rising on a site across the street from FWOH at Camp Bowie and Montgomery.

From 20 to 500 in a decade

Starting with a class of 20, TCOM will have a student body of 273 when the 1977-78 academic year begins in September. And once these student/doctors have completed their basic science work, they will need the clinical facilities of a teaching hospital.

TCOM is already looking forward to the building of Med Ed II. Although this is still on the drawing board, when adequate facilities are ready, the student body will grow past the 500 mark.

And with TCOM's need for additional clinical facilities, Fort Worth Osteopathic Hospital will no doubt be on the grow again in the early 1980s.

HAIL TO THE CHIEFS!

Pathologist J. Thomas O'Shea, D.O., has been re-elected by the medical staff at FWOH to serve a third consecutive year as chief of staff.

Serving the 1977 term of office with the director of the hospital's clinical laboratories will be Phillip P. Saperstein, D.O., vice chief of staff, and Gary W. Earp, D.O., secretary.

Members-at-large include Bryce D. Beyer, D.O., and Stanley R. Briney, D.O.

Now certified by the American Osteopathic Board of Pathology, Dr. O'Shea joined the medical staff at FWOH in 1972, moving to Fort Worth from his home state of Michigan. Also at that time, he was named chairman and clinical professor of the Department of Pathology at TCOM.

A 1965 graduate of KCOM, Dr. O'Shea served an internship at Garden City (Michigan) Osteopathic Hospital. He also served a three-year residency in anatomical and clinical pathology at that hospital.

Dr. O'Shea presently serves on the Board of Directors of the Tarrant County Unit of the American Cancer Society, the Board of Directors of Carter Blood Center, and this past spring was elected to his second three-year term on the Board of Trustees of the Texas Osteopathic Medical Association.

He also maintains professional memberships in the American Osteopathic Association, the American Osteopathic College of Pathologists, the Tarrant County Society of Pathologists, as well as in TOMA.

Although Claude G. Rainey did not become administrator of FWOH until 1974, his experience in hospital administration started just about the time the first Fort Worth Osteopathic Hospital opened.

A native Texan, born in Enloe, he attended public schools there. He was a pre-med student at Yale University and served in the U.S. Navy Hospital Corps, Hospital Administration.

Following his honorable discharge from the Navy, he was Medical Administrative Officer, Department of Medicine and Surgery, in Veterans Administration Hospitals in Washington, D. C., Muskogee, Oklahoma, and Dallas and Temple, Texas over a ten-year period.

He served as administrator of Lakeland Medical Center in Muskogee for three years before going to work for the MKT Railroad as administrator of its prepayment health plan and administrator of the Employees Hospital Association in Denison.

In 1961 Mr. Rainey received a study grant at Columbia University's School of Public Health and Administrative Medicine. He then returned to Denison as administrator of Memorial Hospital and the Denison Hospital Authority. Prior to joining FWOH, he served eight years as administrator of Seton Hospital and Seton Medical Center in Austin.

Mr. Rainey is a Fellow in the American College of Osteopathic Hospital Administrators, as well as in the American College of Hospital Administrators.

TOMA Delegates Report

TOMA DELEGATION TO AOA HOUSE
John H. Burnett, D.O., Chairman

It has long been the goal of the American Osteopathic Association to maintain a stable and continuous national Professional Liability Insurance Program for its members, with adequate coverage, financially secure, and at a reasonable cost. Since 1934 the Association has successfully sponsored such a program. During this long period there have been numerous, the latest being Chubb/Pacific Indemnity Company whose five year commitment expired December 31, 1976.

1974 turned out to be the worst year in history for property and casualty insurance companies. Their policyholder surplus was reduced not only by heavy malpractice payouts and losses in other commercial lines, but also a staggering $6 billion drop in their investment portfolios. In medical malpractice, on a nationwide basis, it has been reported that between 1973 and 1975 claim frequency increased by 70 per cent and the amount of the various awards increased by some 20 per cent.

In some areas of the country, experience was even worse. One study revealed an 85 per cent increase in average claim settlements between 1970 and 1973, with a continuing upward trend in later years. In one state there have been 80 settlements and awards in excess of $300,000 each since 1970 and a number of settlements over $1,000,000. To add to the insurers dilemma, there have been many famous cases resulting in enormous settlements of many millions of dollars each which receive great publicity, to the detriment of the insurers.

Even in the best of recent years the medical professional liability market was relatively small — perhaps eight or nine insurance companies comprising 90 per cent of the market place. Soon this small number of insurers gave way to even a smaller group — three or five at the best.

Even those insurers who stayed in the malpractice business seriously cut back their writings, amended policy forms, hiked rates by as much as 1,000 per cent and then many times only stayed in the business due to pressure from state insurance commissioners.

The central problem became, therefore, not only the spiralling cost of malpractice cover, but the availability of a market. The net result of the ensuing turmoil was the various doctor strikes, hospitals closing who were unable to raise the premium and doctors retiring or going 'bare'.

State legislatures began producing numerous statutory changes in an effort to stem the tide. Some of the legislation has already been declared unconstitutional and other changes will have little effect on the problem. A number of hospital associations and physician-owned companies have been incorporated in California, New York, Missouri, Oklahoma, Texas, Wisconsin, Tennessee and other states, and offshore in Bermuda.

Chubb indicated in September, 1976 that they wished to discontinue the AOA program on December 31, 1976. Because of the late notice, they agreed to renew policies through May 31, 1977 that expired after December 31, except in Florida and Michigan. Extensive efforts were made by the Nettleship Company to find a substantial carrier to underwrite the AOA program. So many negative answers were received that we began to doubt that a willing underwriter existed.

The national insurance brokerage firm of Corroon and Black of Illinois, acting as consultants for the AOA, came to the AOA with a proposal to be underwritten by Bercanus Insurance Company, Ltd. This company commenced its underwriting activity in June, 1976 and now has a net worth of 2.4 million dollars. This is a Bermuda chartered company and is licensed as an Excess and Surplus Underwriter in the states of New York, Nebraska, Delaware and the District of Columbia. It is the intent of Bercanus to become eventually licensed as a primary insurance company in the United States.

The most positive aspect of Bercanus is the security of its treaty reinsurance program. The first $100,000 is retained by Bercanus, the next $400,000 will be reinsured by North Star Reinsurance Corporation and the next $500,000 above that will be reinsured by a group of companies; 50 per cent of which will be taken by Union Insurance Company of Lincoln, Nebraska.

These reinsurers are recognized as reputable insurance companies. The principal reinsurer, North Star, is a subsidiary of General Reinsurance Company, the premier reinsurance company in the United States. Bercanus has also established a trust fund in the amount of $500,000 with the Bankers Trust Company of New York, for the purpose of satisfying financial obligations to claimants in the case of Bercanus' failure to do so.

The Bercanus policy is written on a "claims made" basis, rather than the "occurrence" form previously offered through the Nettleship Program. This is a radical change in concept in the malpractice field and has been widely criticized, particularly by professionals considering retirement. The difference is that under an "occurrence" form, incidents occurring during the policy period are covered whenever the claim is presented, whereas under "claims made" only claims presented *during the policy period* are covered. The "claims made" is written initially with a "retroactive" date and excludes coverage for claims or occurrence prior to that date. Upon renewal, the policy coverage extends back to the original retroactive date, providing continuous coverage as long as the policy is renewed.

If the insured D.O. wishes to terminate his practice, he may buy a 60-month extension of coverage beyond the expiration of his "claims made" policy at a cost of two times the annual premium then being charged by Bercanus. This extension or discovery period provides coverage for malpractice committed, or alleged to have been committed, between the original (retroactive) policy date and the last expiration date of coverage.

A mailing of material announcing the new program was made to 8,200 members of the AOA during the last ten days of June. For various reasons, the mailing did not include D.O.'s living in the states of California, Florida, Michigan and Texas. Results from the mailing are inconclusive at this time, and it is too early to tell how widely accepted it will be by our membership.

TOMA Delegates Report

John H. Burnett, D.O.

James W. Lively, D.O.

COMMITTEE ON CONSTITUTION AND BYLAWS
James W. Lively, D.O., Chairman

The scope of this delegate's report will be confined to the activity of the Committee on Constitution and Bylaws of which I was privileged to serve as chairman.

In the area of amendments to the Constitution and Bylaws of the AOA the following actions were taken. Article III of the constitution was amended to permit the organization of a divisional society within the Uniformed Services of the United States. Article III now reads in part as follows: "This association shall be a federation of divisional societies within state or foreign country boundaries or within the Uniformed Services of the United States, which may be chartered by this association as provided by the bylaws, etc." Editorial changes were then effected throughout the bylaws to bring the bylaws into compliance with the amendment of the constitution allowing the formation of the divisional society within the Uniformed Services. This action included deletion of Article III, Section 2, Paragraph f., which waived dues payment for members on active duty in Uniformed Services. From this time on all military personnel will be required to pay the regular AOA dues.

Article III, Section 2, Paragraphs c. and d. were amended with the addition of a new paragraph e. to conform with current terminology concerning internship, residency, and preceptorship rate of dues. There was no change in the dues amount. This simply clarified the amount of dues for each classification.

Article III, Section 4 of the bylaws, concerned with refunding dues, was deleted. It was felt that individual cases requesting refund of dues may be considered by the board on individual merit. The revised constitution and bylaws will be published in toto in the forthcoming publications of the American Osteopathic Association.

Several resolutions were assigned to the committee and action taken as follows:

Resolution No. 106, Subject: Association of Military Osteopathic Physicians and Surgeons was adopted as follows:

Resolved that the Association of Military Osteopathic Physicians and Surgeons may use the central office of the AOA for it's address for legal and correspondence purposes, and be it further

Resolved that the AOA provide administrative guidance and clerical assistance in order to assure good communications among the D.O.s in the Uniformed Services and the AOA, and be it further

Resolved that the cost of such services shall be reimbursable to the AOA by the Association of Military Osteopathic Physicians and Surgeons.

Resolution No. 125, Subject: The Association of Military Osteopathic Physicians and Surgeons was adopted and reads as follows:

Resolved that the Board of Trustees recommend to the House of Delegates that a Charter as the Divisional Society of the AOA be granted to the Association of Military Osteopathic Physicians and Surgeons.

Resolution No. 124, Subject: The Committee on Ethics opinion on directories. Following is the adopted opinion:

Advice has been requested by the Bureau of Public Education on Health from the AOA Committee on Ethics with respect to ethical considerations in the content of "directories of information" concerning physicians and their services. It is recognized that numerous consumer and public interest groups have published or plan to publish local directories which contain information regarding the background, training, hours, specialities, fees and similar information covering individual physicians. However, such information generally reflects the physician's response to interviews or questionnaires and, therefore, individual physicians and state and local osteopathic associations need guidelines with respect to such responses.

Section Eight of the AOA Code of Ethics states in part ". . . A physician shall not solicit patients, commercialize or advertise his services. . ." It is the opinion of the Committee on Ethics that reasonably full information contained in directories does not constitute advertising per se. Section Eight is designed to discourage practices which would lead to false, misleading or deceptive information from being promulgated. Such practices have the effect of exploiting patients and the public and work against an informed choice of physicians and competition among physicians. Such practices would include the attempt to obtain patients by persuasion or influence, employing statements that are self-laudatory and deceptive, likely to lead a patient to a misinformed choice and unjustified expectations. Consequently, a physician may give relevant biographical information for use in such directories. Relevant information in this regard should consist chiefly of information concerning the physician's education and training. The physician also may give relevant information concerning his practice. This information would include such matters as specialty practice, hours and, if the phsyician so chooses, fee information.

It shall not be considered unethical for a physician to include his charge for a standard office visit or his fee or range of fees for particular types of services. It should be noted that in order to give the most accurate information concerning fees, there should be included any information as to variable factors in the determination of fees. With respect to all such information, the general rule should be that the information be primarily factual. Adjectival or descriptive information should be avoided. Physicians should be aware of the problems involved in allowing the form of a questionnaire or interview to dictate a response which would not adhere to these general guidelines. Generally, it is felt that responses should be kept brief.

In addition to the attention addressed to the information provided regarding his own entry in the directory, each physician should examine the directory itself. A physician should only provide information for listing in a local reputable directory. The directory must not contain false, misleading or deceptive matter.

It should also be noted that there are legal restrictions on advertising and solicitation of patients in the licensure acts of numerous states. A physician should attempt to obtain an opinion as to the effect of local law on such directories or other means of advertising.

This concluded the work of the Committee on Constitution and Bylaws. Overall this was the smoothest meeting of the AOA in my term as a delegate. Much of the credit goes to Dr. Sam Ganz for his efficient management of the House's business. Thank you for the opportunity of service.

COMMITTEE TO STUDY
HOSPITAL ACCREDITATION PROCEDURES
Gerald P. Flanagan, D.O.

The Committee met Sunday morning, July 17, with all members being present, as well as the Executive Director of the American Osteopathic Hospital Association.

The chairman had a compilation of the comments of the administrators in their post-inspection survey. The comments that dealt with the Inspection (Blue Book) Manual were forwarded to the Committee on Hospital Accreditation for evaluation and change as needed (this was not in the purview of the Committee).

The Executive Director of AOHA stated that his Association was impressed with the change in the inspection process. The Committee was appointed for another one year.

The following recommendations were made and accepted by the House:

1. Decided to send a second copy of the accreditation monitor to the medical director or the president of the medical staff for completion and return to the Chairman of the Committee.

2. Recommend to COHA that in the future only physicians (D.O.s and M.D.s) may be members of the active medical staff. Dentists presently on the active staff may be grandfathered.

3. Recognition and commendation to AOHA for its positive contributions in the development of educational programs in the area of accreditation for hospitals and inspectors.

4. Recommend that COHA consider the practicality of having the accreditation inspector's workbook xeroxed and left with the hospital at the end of the post-inspection conference.

5. Recommend that COHA and COPT appoint a joint subcommittee (with in-put from AOHA) to consider combining accreditation and intern training inspections in appropriate situations.

   Explanatory Note: This could save AOA and the Hospital money, could eliminate one inspection in the hospital, could increase productivity of a limited inspector resource by eliminating duplicative functions.

6. The Committee concurred with the recommendation to increase the accreditation fee from $800 to $1,000 annually and to review and discuss the reasons for this action with AOHA.

Gerald P. Flanagan, D.O.

William R. Jenkins, D.O.

AD HOC REFERENCE COMMITTEE
G. P. Flanagan, D.O., and W. R. Jenkins, D.O.

This Committee met and reviewed testimony and comments on the Resolutions below, with notations as to whether or not they were approved.

(Because of the length of some of these, they have been condensed for purposes of this report; however, complete copies of each are available from the State Office.)

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Resolution No. 100 – AOA Board of Trustees
Medical Liability – Proposed Policy Statement

The policy contained in this resolution was approved by the Board of Trustees in November 1976 and concerns development of a new method of malpractice claims determination. It states that "many awards, under the present system, contain rewards for medical injury in addition to compensation for it"; that the best approach would be that a "true compensation system" be devised which limits injury awards to compensation for actual measurable losses; that the adversary tort proceeding is *not* a feasible mechanism to accomplish compensation; that the present system is unpredictable because it has been warped by judges and juries who have responded "compassionately to a grievously, though not always negligently, injured litigant" . . . .

"It is the view of the AOA that medical injury compensation should proceed, without litigatiion, and with an eye to reparation and not reward. Accordingly, we have adopted the position that *each state* should enact a compensation approach to medical injury claims determination . . . . "

The resolution contains a model medical injury compensation law, drafted by the AOA for one state association. The resolution further states that such model legislation would provide for more certain relief for medical accidents resulting from negligence, would reduce the cost of the process of medical claim determination by streamlining claims procedures, reduce the cost of medical claims insurance, and create a viable long-term private insurance market.

The policy statement was approved by the House, with only one minor amendment in wording.

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TOMA Delegates Report

Resolution No. 110 – Missouri
DOPAC (Doctors of Osteopathy Political Action Committee)

This resolution urged that the AOA "use its auspices to assist in developing an independent organization . . . . such organization to be incorporated as DOPAC and to operate as a political action committee expressing the opinions and decisions of the governing body of DOPAC, and not the AOA, to be supported voluntarily by members and friends of the osteopathic profession."

Although everyone was in sympathy with this resolution, it did not pass.

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Resolution No. 113 – New Jersey
Tabulate Statistics Showing Relationship Between Musculoskeletal Deviation and Normal Disease Processes

The Committee recommended a substitute resolution for the one proposed by the New Jersey Association.

As passed by the House, it resolves that "osteopathic hospitals accredited by the AOA develop a uniform method of structural examination and appropriate therapy . . . . . that the AOA accumulate and tabulate statistics to define relationships between musculoskeletal abnormalities and disease . . . . . and that this resolution be referred to the Committee on Hospital Accreditation and report to the 1978 meeting of the House of Delegates."

°°°°°°

Resolution No. 116 – Texas
Continuing Medical Education Credit Hours

This resolution, which was passed by the TOMA House last May, was denied, although Dr. Jenkins "gave eloquent support for a 180-day time (instead of 90 days), but to no avail."

An AOA Board of Trustees resolution was substituted and passed by the House as follows:

"Resolved, that at the end of a three-year CME period, an individual member may request that the last three months of the previous third year's CME credits be permitted to be counted into the following period's requirement, provided that the previous period's requirement has been satisfied, and that the individual is deficient in credits for the current period."

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Resolution No. 119 – Committee on Health Related Policies
Paramedical Health Professionals (Physician Assistants) – Proposed Policy Statement

In essence, this resolution states that the AOA supports the position that care rendered by a physician assistant should be given only under the immediate supervision of a licensed physician, and that under no circumstances should the physician assistant be called upon to make medical judgments.

It also spelled out certain requirements that should be continued as the present Medicare reimbursement policy for services rendered by a physician assistant.

The resolution was approved by the House with minor amendments, which are included in the above.

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Resolution No. 122 – Missouri
Increase of Funding for National AOA Public Education

After certain amendments were made, the House approved this resolution which, in brief, resolves that public education as conducted by the Public Relations Department of the AOA be given a higher priority by the Association and allocated operating funds commensurate with such priority; that a national public education effort be designed and initiated by the AOA in coordination with all affiliated organizations and institutions, and this resolution be referred to the Committee on Long-Range Planning and the Bureau of Finance and a report to the 1978 House of Delegates meeting.

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Resolution No. 126 – Michigan
Change in Nomenclature

The House disapproved this resolution which resolved that the term "chairperson(s)" be substituted for "chairman(men)" in all AOA and divisional society nomenclature.

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PROFESSIONAL AFFAIRS REFERENCE COMMITTEE
Robert G. Haman, D.O.

As a member of the Texas Delegation to the AOA House of Delegates which met in Chicago July 17-19, I will summarize the following resolutions from the Department of Professional Affairs, chaired by Joseph W. Stella, D.O., which were acted upon.

Resolution No. 103 – Chairman, Bureau of Conventions
Group travel and assignment of hotel room for the 83rd Annual Convention & Scientific Seminar – Hawaii, 1978

Disapproved

This resolution would have superseded only for a one-year period, the July, 1974 resolution which was adopted by the House of Delegates. Resolution No. 115 (Memo H-July/74-101). . . whereby the AOA would continue blocking advance space but upon request of any affiliated organization, such space desired by affiliate be released to the affiliate for use on group travel arrangements made by such affiliate locally.

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Resolution No. 112 – Missouri
Selection of candidates and emphasis on training in osteopathic colleges

Disapproved

This resolution resolved that colleges of osteopathic medicine be urged to adopt positions favoring the selection of candidates whose primary interests were in teaching, research, and health administration for some of the available openings in each entering class.

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Resolution No. 114 – Pennsylvania
Admission under only one physician's care

Disapproved

This resolution was in regard to the American Osteopathic Association to rescind the present regulation whereby hospitalized patients are to be admitted under only one physician's care, and may not be admitted under partnerships or physician groups. They felt this regulation interfered with continuous availablity of care, expedient completion of charts, and a practical on-call schedule.

This resolution was defeated because it was felt the present guidelines were adequate which are published under *requirements and interpretative guide for accredited hospitals* of the American Osteopathic Association–11th Edition, February, 1976. Whereby on page 37 – Section 6 it states the admitting physician shall be responsible for the patient until the patient is transferred or discharged. Under this Management and/or Consultation both the admitting physician and named consultant physician are allowed to write orders. (In this instance, the admitting physician still has overall chart responsibility.)

If an order is written for "Dr. – for management," the admitting physician may no longer write orders. If an order is written, "Dr. – for management of a specific entity or procedure the responsibility for other management remains with the admitting physician.

If an order is written, "Dr. – for consultation," the consultant may not write orders on the chart; or if an order is written "Dr. – for consultation and management," the admitting physician may no longer write orders.

The Committee recommended that the House of Delegates direct the Committee on Hospital Accreditation to obtain written clarification from the U. S. Department of Health, Education and Welfare of the exact intent of the statement, "Patients are admitted to the hospital only on recommendation of a physician," as stated in the *conditions of participation-hospitals,* Federal Health Insurance for the Aged, HIR-10 (6/67) and report back to the House of Delegates at its July 1978 meeting.

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Resolution No. 117 – Texas
Hospital Accreditation Program

Disapproved

This was a resolution that the American Osteopathic Association's Committee on Hospital Accreditation reevaluate its hospital inspection system so that there will be a cessation of the loss of AOA accredited hospitals and a greater availability of AOA-approved, accredited hospitals for postdoctoral training, thereby being a favorable position to retain Texas educated osteopathic physicians in the State of Texas and have additional osteopathic facilities for these physicians to seek their postdoctoral training. The Reference Committee recommended disapproval as it felt the intent of this resolution is being satisfied by existing AOA committees.

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Resolution No. 118 – New Jersey
Internship training

Approved Resolution–Amended by Substitution

The resolution that affiliation for the training of interns be allowed with allopathic hospitals, provided the trainer be an osteopathic physician. This was amended by substitution as follows:

Resolved, that the format (Exhibit A) to deal with institutions requesting rotation of interns on an elective basis through hospitals not accredited by the AOA be approved as amended.

EXHIBIT A

Format for rotation of interns on an elective basis through hospitals not accredited by the American Osteopathic Association

The following documentation must be submitted to the AOA Committee on Postdoctoral Training concerning the AOA-approved hospital:

1. Formal request to rotate interns through a hospital not accredited by the American Osteopathic Association. This request should include the name of the hospital, its vicinity in relation to the osteopathic hospital, and the specific circumstances supporting the request.

2. The osteopathic physician responsible for supervising this elective period and his designation within the AOA-approved hospital.

The following documentation must be submitted to the AOA Committee on Postdoctoral Training the hospital not accredited by the American Osteopathic Association:

1. Program including specific duties of interns during the elective rotation.

2. Letter of agreement to accept the interns and rotation.

3. Curriculum Vitae of the department head.

After the documentation is received in the AOA office of Osteopathic Education, an on-site evaluation of the hospital not accredited by the AOA shall be conducted by an osteopathic physician qualified in the specific discipline of the elective rotation *or the chairman of the approved department or director of medical education in the osteopathic training hospital.*

The request, plus the on-site evaluation report, will be placed on the next scheduled meeting of the Committee on Postdoctoral Training for recommendation to the Bureau of Professional Education.

If the Bureau of Professional Education approves the request, the D.O. responsible for supervising shall collect documentation from the interns (logs or charts) to substantiate the elective rotation. These logs or charts will be retained by the hospital and be made available to the AOA evaluation team during a regularly scheduled visit.

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Resolution No. 120 – Ohio
AOA Residency Approved Program

Disapproved

This was a resolution that stated that at least one year of any residency program be served in an osteopathic hospital approved by the AOA residency training program in that specific specialty be the requirement and that all future, present and past residents be given this consideration to keep the osteopathic physician specialist within our profession. This resolution was disapproved as this has already been established.

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Resolution No. 123 – Illinois
Membership in Allopathic Medical Societies for participation in malpractice insurance program

Disapproved

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Resolution No. 127 – Georgia
Podiatry in AOA Hospitals

Disapproved

This resolution was that podiatrists be provided primary admitting privileges, then have a staff physician (holder of an unlimited license) do history and physical before performance of surgery by the podiatrist.

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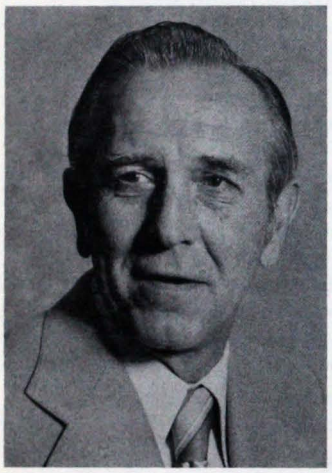
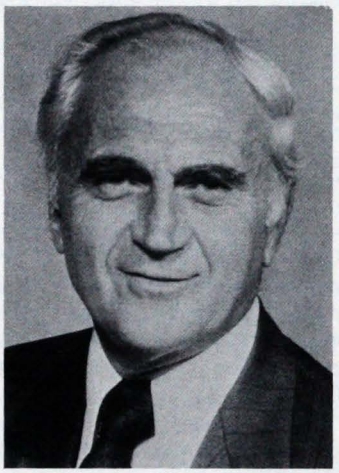
Resolution No. 128 – New Mexico
Specialists

Disapproved

This resolution was in regard to physicians who had completed allopathic residency training and were wishing to obtain osteopathic specialty certification; that they practice in osteopathic hospitals for a minimum of four years following completion of their residency training.



Robert G. Haman, D.O.



Michael A. Calabrese, D.O.

PUBLIC AFFAIRS REFERENCE COMMITTEE
Michael A. Calabrese, D.O.

Again this year I had the good fortune to sit on the public affairs reference committee chaired by Samuel Howell, D.O. of Marietta, Ohio who, as always, performed efficiently, encouraging everyone to participate in the discussions of the proposed resolutions.

Each year when I attend these meetings I am more and more impressed with the seemingly democratic camaraderie with which these convocations are held. Those of you who sometimes feel that your national organization is some big, mysterious, cold structure to which you pay dues for seemingly nothing in return ought to make a special trip to attend one of these AOA House of Delegates meetings. You would learn what a vital, active human force this organization is, working for your welfare and forever advocating the osteopathic philosophy.

As a reminder to most of you who are familiar with the workings of the House and as a matter of information to those of you who are reading this for the first time, proposed resolutions are designated to appropriate reference committees, as there are many and the House is too large to discuss them on the floor.

The resolutions are assigned to the respective reference committee members and interested personnel are urged and invited to attend these meetings in which the chairman encourages open discussion on each resolution and invites recommendations and suggestions from all in attendance. After all resolutions have been discussed in the open meeting the committee goes into executive session and each resolution is gone over again considering the added recommendations contributed by those in the open meeting.

Resolutions Numbers 101, 102, 105, 108, 109, 111, 121, and 129, were referred to the Public Affairs Reference Committee.

Resolution number 101, submitted by the Board of Trustees, pertained to Medicare and Medicaid Abuse and Fraud. The Board wanted to go on record as being aware of the fraud that exists in the programs on the part of "some providers as well as recipients" and resolved "that the AOA pledges its full cooperation and support of all reasonable and appropriate efforts by the federal government and this state to stop all fraud and the abuse of Medicare and Medicaid".

Resolution number 102, also submitted by the Board of Trustees, pertained to policy statement of immunizations. In this resolution the AOA resolved that in any future mass immunizations the federal government use "the private sector in providing immunizations to the general public".

Resolution number 105, submitted by the Florida Osteopathic Medical Association, pertained to violence on national television and wanted "the AOA to go on record as opposing the concept of excessive violence on television".

Resolution number 108, submitted by the Missouri Association of Osteopathic Physicians and Surgeons, recommended cooperation between the AOA and the AMA in the joint effort to oppose adoption of national socialized health coverage. However, there was a proviso in this resolution which asked the AMA to "retract previous positions threatening continuance of the osteopathic profession. . ." the reference committee recommended that this resolution be disapproved by the House.

Resolution number 109, also submitted by Missouri, pertained to the FDA taking barbiturates off the market. It was recommended that the AOA go on record "as opposing any change in the FDA regulation regarding medical use of barbiturates".

Resolution number 111, also submitted by Missouri, pertained to the FDA's prohibition of sales of saccharin. It cautioned the FDA to use reasonable judgment in its deliberation on the use and/or sale of saccharin.

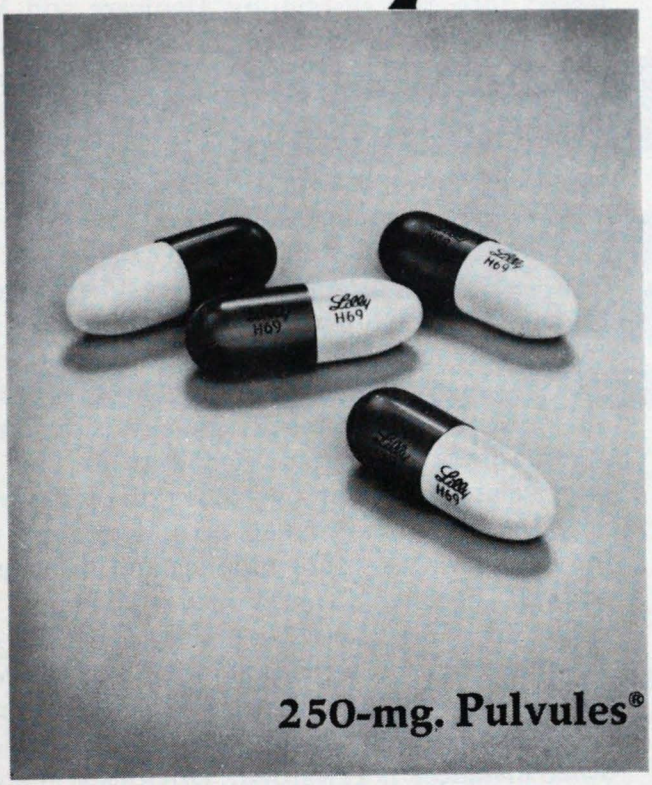
Resolution number 121 was withdrawn by the Missouri delegation only after much discussion by the reference committee. It was decided that the intent of the resolution was good (volitional disorders) but the wording was ambiguous and the Missouri delegates agreed to withdraw, rewrite and resubmit it next year.

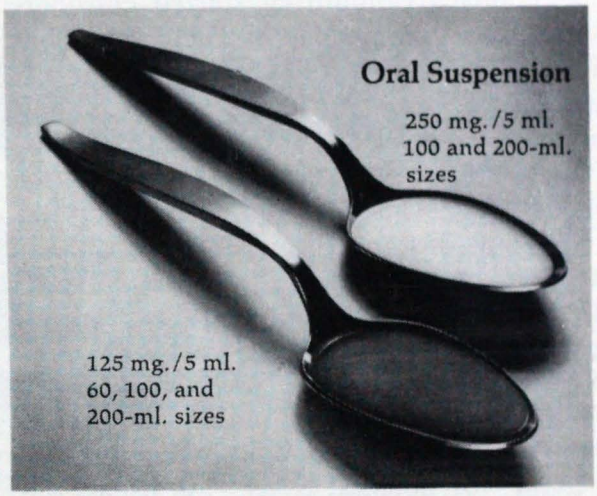
Resolution number 129 submitted by Pennsylvania, pertained to confidentiality of patient records. It resolved "that the AOA constantly endeavor to obtain legislation to protect the confidentiality of patient records".

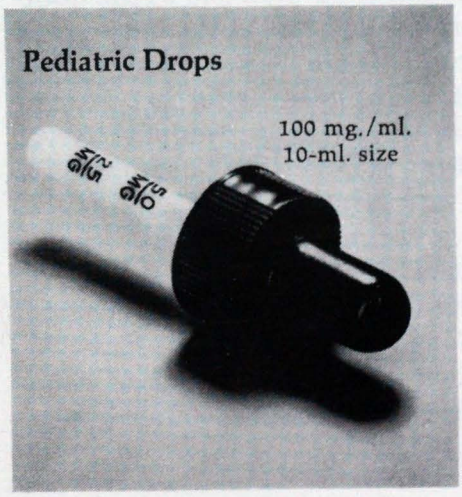
All Resolutions were approved by the House of Delegates with the exception of Resolution number 108 as mentioned above.

It has been a pleasure serving you as a delegate from Texas to the AOA, and I hope I have been able to convey to you the dedication and concern the national office has for its fellow members.

easy to take







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Government Programs Cause Health Care Inflation

by Omar Burleson, M.C.
17th District, Texas

This past week the Subcommittee on Health of the Ways and Means Committee started consideration of a measure recommended by HEW proposing to contain hospital costs.

On March 25, 1976, we wrote about soaring costs of hospital care. It is the Government's attitude that the high cost of health care is a rip-off by the doctors, hospitals and all other facets of the business. In some instances this is undeniably a factor but it has been encouraged by the Government itself. The problems in our medical pricing system have been largely created by the Government, yet, the basic truth is continually ignored.

The administration is telling us all the drastic things we need to do to curtail the "devastating inflationary trend" of hospital costs. As usual, the blame for the evil complained of is laid at the doorstep of private enterprise and not at the network of Government controls. There is no acknowledgement anywhere that the problem is further Federal meddling, added to all the previous meddling. Never is there any indication the Federal Government is largely the problem, not the solution.

Studies by both government and private institutions find that Federal involvement in the public health-care field has virtually wrecked the medical pricing system. Government programs have unleashed a surge of demands into the medical economy over the past decade, producing spiraling inflation now being experienced.

Between 1965 and 1975, taxpayer dollars released into the system by Medicare and Medicaid increased from around $7 billion to $41 billion. All that money, biding for medical resources, would have had an inflationary effect in any event but the impact was made particularly acute in the case of hospitals, through the special emphasis of Government programs on hospital care.

From the standpoint of the consumer, hospital care (and other medical services) is perceived as "free" or virtually so. Normal restraints on demand have been abolished and the pricing system is no longer able to perform its usual function of sorting out priorities. As a result, the sky is the limit. Under methods now used, hospitals are paid a daily rate, related to their own cost of operation. The hospital administrator can no longer deny requests for higher wages, more supplies and other intensive costs on the ground that money is lacking.

Put all of this together and we have the crisis of rising hospital costs complained of by HEW, representing the Administration. Efficiency of operation is, in many cases, penalized while inefficiency in other instances is rewarded. Obviously, it should be the other way around.

From start to finish, the current mess in medical pricing is the creation of the Government itself and there will be little remedy until that fact is recognized, admitted and something done about it.

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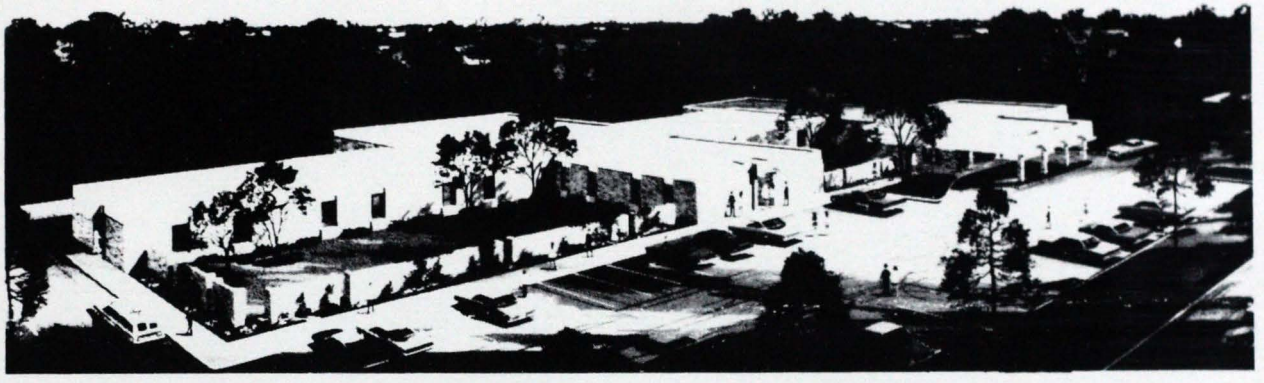

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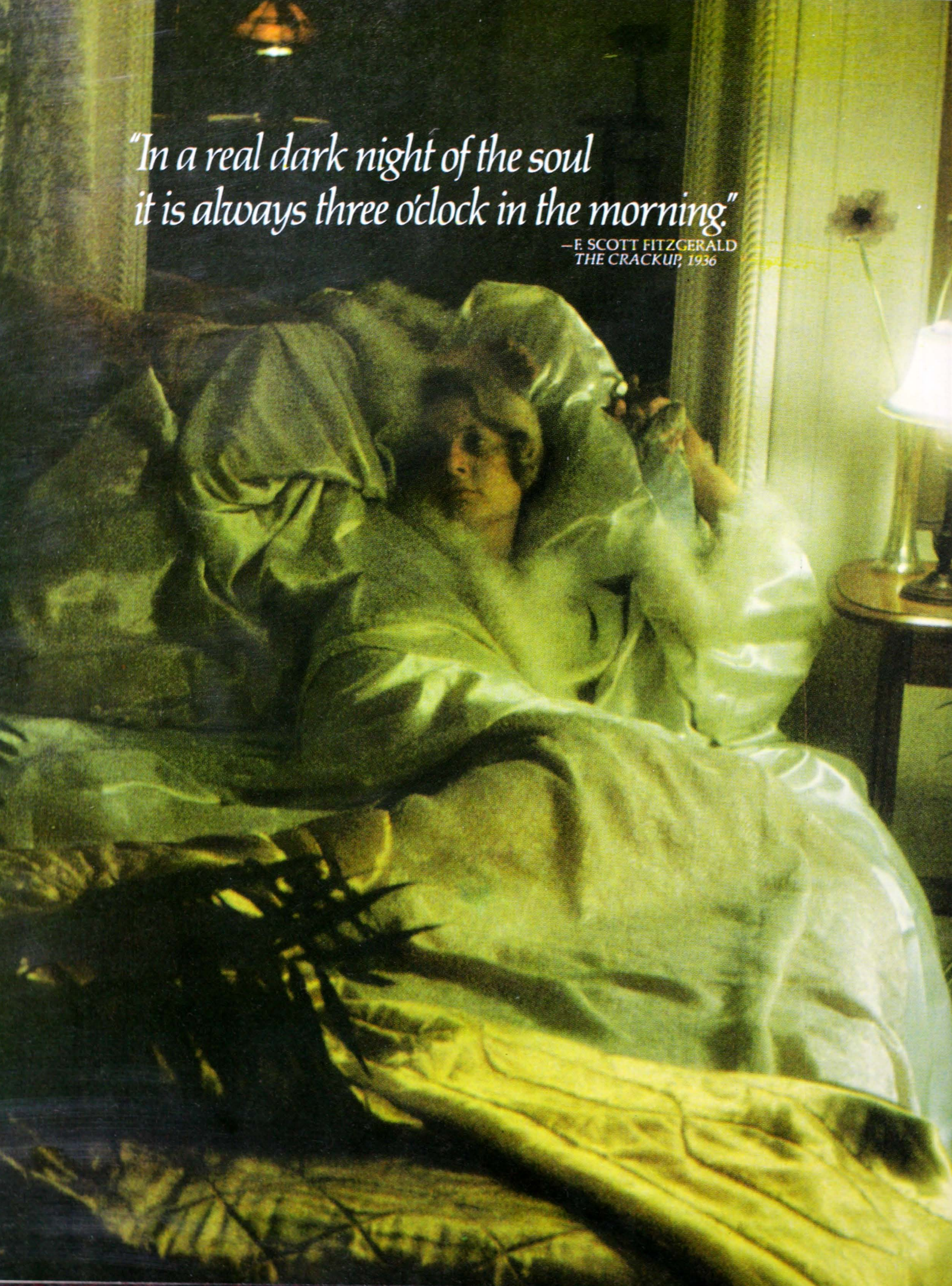
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1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

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Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

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For complete prescribing information please see package insert or PDR.

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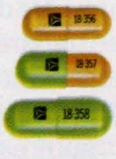

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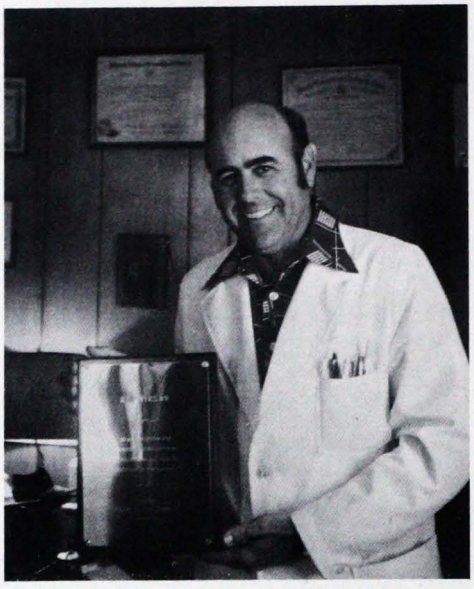
PROFILE Dr. Robert L. Peters

Sometimes our news clipping service picks up such articles as the following and forwards them to the State Office—but sometimes it doesn't.

Not only is publication of items about TOMA members good public relations in the communities in which they are printed, but also, we would like to share them with your colleagues.

This Journal *and the TOMA Public Information Committee would appreciate your clipping items concerning our members and forwarding them to this office.*

This article was published in the July 14 issue of The Round Rock Leader.*—Ed.*



Dr. Peters is the health officer for two cities, Calvert and Round Rock.

Robert Lee Peters Jr. was born in Austin. His father is also a doctor, now doing a limited practice in Austin. Dr. Peters attended schools in Midland, graduating from high school in 1951. He played the French horn in the school band. During free time from school he worked for an oil company, doing everything from office work to roughnecking on a drilling rig.

After graduating from high school he enrolled at Texas A&M in a pre-med program. He was a member of the Corps and played in the Aggie Band. After finishing the pre-med course he enrolled in the Kirksville (Mo.) College of Osteopathic Medicine, earning the degree of Doctor of Osteopathy in 1958. He interned for one year at Houston Community Hospital.

In 1959 Dr. Peters set up his practice in Pasadena and continued there for about four years. To get away from big city stresses and to live in a rural community where a closer doctor-patient relationship was possible, he established himself at Calvert, Texas, in 1963. As the only doctor in the community, he directed the Calvert Medical Clinic doing surgery and general practice. An average of 125 babies were born annually at the clinic.

Besides his medical practice Dr. Peters was involved in community affairs. He served on the city council for five years, being mayor protem for four years. In 1966 the Calvert Chamber of Commerce conferred on him the Citizen of the Year Award. Finding a good school in a small town and because of the need for a doctor here, he moved his family to Round Rock and set up practice at the Round Rock Medical Clinic in January of 1972.

Mrs. Peters, the former Ruby Pope of Jacksonville is a registered nurse and is her husband's best assistant. The Peters met while they were at the Houston Community Hospital.

Dr. Peters is a member of the American Osteopathic Association, past president District VII Texas Osteopathic Medical Association, a delegate to the Texas House of TOMA and an alternate to the House of Delegates of the AOA. He is a member of the Texas Institute for Medical Assessment, which is to be designated as the Physicians Standard Review Committee for the state of Texas.

As in Calvert, Dr. Peters is active in community affairs here. He served as a member and in 1975, as chairman of CAPCO's Health Advisory Committee. That group established health needs and wrote the health plan for the capital area. He is presently vice-president of the Round Rock Kiwanis Club and is a member of the chamber of commerce. He is a member of the Round Rock City Charter commission. The Peters are members of the Presbyterian Church.

TCOM Announces Faculty Additions

Five new faculty members and one new administrative staff member joined TCOM in July.

New faculty members are Dr. David Barker, assistant professor of physiology; Dr. Clinton Burns, instructor of osteopathic philosophy, principles and practice; Dr. William Hinsberg, associate professor of general and family practice; Dr. Irwin Schussler, associate professor of psychiatry; and Dr. Stephen Urban, assistant professor of general and family practice.

Joining the administrative staff as acting director of public information is Dr. Judy Alter.

Prior to joining TCOM, Dr. Barker was assistant professor in physiology and biophysics at the University of Illinois.

He has done postdoctoral work at the University of Wisconsin in neurophysiology and received his Ph.D. and M.A. degrees in psychology from Illinois University.

Since his graduation from TCOM in 1975, Dr. Burns has been serving a rotating internship and residency in obstetrics and gynecology with the U.S. Public Health Service in New Orleans.

A 1956 graduate of KCCOM, Dr. Hinsberg has been in private practice in family medicine in Warren, Michigan prior to joining TCOM. He received a B.S. degree in pharmacy from the Detroit College of Pharmacy in 1951.

He did his psychiatric training at Temple University, Philadelphia.

A 1968 graduate of CCOM, Dr. Schussler comes to TCOM from the University of Florida where he has been assistant professor of psychiatry and pediatrics.

He has also served as director of inpatient psychotherapy of the Adult and Adolescent Inpatient Unit at Shands Teaching Hospital in Gainesville, Florida.

Dr. Schussler served his residency and a fellowship in general psychiatry at the University of Florida College of Medicine.

A 1963 graduate of KCOM, Dr. Urban has been in private practice in Wakefield, Rhode Island since 1974. Prior to that he was on the faculty of Michigan State University College of Osteopathic Medicine.

The new acting director of public information, Dr. Alter received a Ph.D. degree in English from Texas Christian University in 1970. She received an M.A. degree in English education from Northeast Missouri State University and B.A. degree in English from the University of Chicago.

Dr. Alter co-authored the book, *The Quack Doctor*, with the late Dr. Phil R. Russell.

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Dr. Millington Chairs Administrators Board

Dr. Wilford Millington of Nixon was elected Chairman of the Texas Board of Licensure for Nursing Home Administrators on July 1.

He has served on the Board since its creation in 1969. Dr. Millington is a practicing physician and graduated from Kirksville College of Osteopathic Medicine.

He was one of the organizers of the National Association of Boards of Examiners for Nursing Home Administrators. Dr. Millington is now serving as President of that Association.

The Nursing Home Administrators' Board is a State Agency, given the authority by the Legislature to license Nursing Home Administrators throughout the State of Texas.

Reprinted from The Nixon News, *July 14, 1977.*

"The purpose of life is not to be happy – the purpose of life is to matter – to be productive, to have it make some difference that you lived at all. Happiness, in the ancient noble sense means self-fulfillment – and is given to those who use to the fullest whatever talents God bestowed upon them. Happiness lies in the stretching to the farthest boundaries of which we are capable, the resources of the mind and heart."

Leo C. Rosten
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Dr. Joe Alexander Honored by Scouts

Dr. Joe P. Alexander of Abilene was recently honored when he was selected by the National Council of Boy Scouts to receive its Silver Antelope Award.

Nominated to receive it by the South Central Regional Board of Directors, the award is made "for noteworthy service of exceptional character to boyhood by registered Scouters."

The following is quoted from the biographical sketch printed in the awards presentation booklet.

Dr. Alexander has served the Chisholm Trail Council since 1960. He has been a member and later Chairman of a Troop Committee. Since 1962 he has been Advisor of Post 288 and since 1963, a member of the Council Executive Board. As a member of the Board he has served in many capacities such as Council Vice President from 1970 to the present time.

Dr. Joe has served as Scoutmaster for two Jamborees in 1964 and 1968, as well as serving on the Medical Staff in 1973. He is holder of the Vigil Honor of the Order of the Arrow and has his Wood Badge beads. He was awarded the Silver Beaver in 1968.

As an active member of St. Paul Methodist Church in Abilene he has served on the Administrative Board for many years.

Among his many community activities are included the Lions Club, Chamber of Commerce, Elks Club, Masonic Lodge, Suez Shrine, American Osteopathic Association and Texas Association of Osteopathic Medicine of which he is currently President of District 4.

Dr. Alexander is a graduate of Baylor University and the Kirksville College of Osteopathic Medicine, Kirksville, Missouri. He and his wife, Janie, have two daughters and a son.

Notice of Examination

The next examination of the Texas State Board of Examiners in the Basic Sciences has been set for Friday and Saturday, October 14-15, in Austin.

Details as to time and place may be obtained by writing to the Executive Secretary of that Board at 319 Sam Houston State Office Building, Austin, Texas 78701.

Applications for the October examination must be complete and in that office by September 16 and all necessary information and documents required of examinees by the Board must be completed and in the applicant's file by that date.

Those interested in participating in this examination should act immediately.

Dr. Sharp Appointed to Family Practice Residency Advisory Committee

Dr. T. Robert Sharp, clinical professor of general and family practice at Texas College of Osteopathic Medicine, has been appointed to serve on the Texas Family Practice Residency Advisory Committee. Dr. Sharp is a general practitioner in Mesquite.

Provided for in House Bill 282, the committee will be responsible to the Coordinating Board, Texas College and University System for the purpose of reviewing applications for the funding of family practice residency training programs and recommending standards to be followed in the approval of such residency programs to receive state funds.

House Bill 282, passed by the 65th legislature and signed by Governor Dolph Briscoe, authorizes the Coordinating Board to contract with medical schools, licensed hospitals and non-profit corporations so that state funds can be used for the establishment and operation of family practice residency training programs.

The purpose of the residency program is to improve medical care in underserved rural and urban areas by better distribution of family physicians.

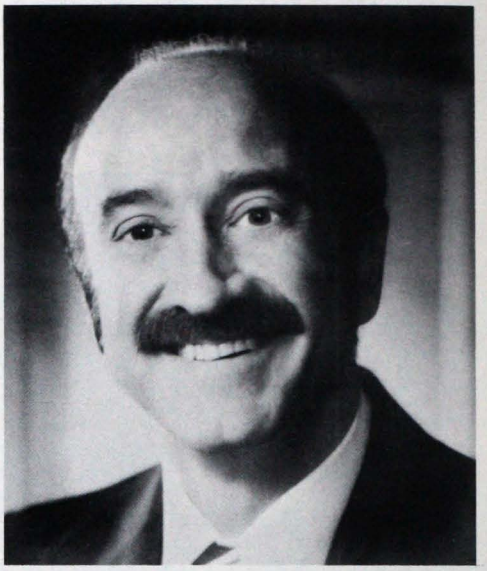
The advisory committee will be composed of six physicians, two hospital administrators, three members of the general public and the president of the Texas Academy of Family Physicians.

Of the six physicians, two will be appointed by the Association of Directors of Family Practice Training Programs; two appointed by the Texas Academy of Family Physicians; and one each from the Texas Osteopathic Medical Association and Texas Medical Association. The hospital administrators will be appointed by the Texas Hospital Association and will come from hospitals with family practice residency training programs. The three committee members representing the general public will be appointed by the governor.

Formerly chairman of the Department of General and Family Practice at TCOM, Dr. Sharp (KCOM '44) is a Fellow of the American College of General Practitioners and is a Diplomate of the American Osteopathic Board of General Practice.

Dr. Sharp is a member of the American Osteopathic Association, Texas Society of the American College of General Practitioners, American College of General Practitioners and TOMA. ^

Dr. Ganz Re-elected Speaker of AOA House



Re-elected to the office of Speaker of the AOA House of Delegates during its July meeting was Dr. Samuel B. Ganz.

At the time of his first election to that office in 1972, he was already eminently qualified, having served some dozen years as Vice Speaker or Speaker of the TOMA House.

A quick check of records indicates that only two members have served more years in the TOMA House than has Dr. Ganz—whose total is 19.

He was a delegate from Texas to the AOA House for several years before he was first elected to the position of Vice Speaker, and subsequently to that of Speaker.

He was named President-Elect of TOMA in 1976, and assumed the office of President at the annual meeting of the House of Delegates this past May. ^

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DALLAS — E. R. physician needed. Guaranteed income. Needed seven days a week from 7:00-12:00 p.m. Contact Mr. John Isbell, Administrator, Stevens Park Osteopathic Hospital, 2120 W. Colorado Blvd., Dallas, Texas 75211. Phone 214—943-4631.

HOUSTON — Guaranteed income plus fringe benefits for Spanish-speaking D.O. Call David J. Levy, D.O., 713—675-2777; 723 Shotwell, Houston 77020.

CISCO — Opportunity for D.O. in Cisco clinical office. Space and personnel furnished or negotiable. Two M.D.s, one D.O. currently on staff. For details call collect: Garner Altom, E. L. Graham Memorial Hospital 817—442-3951, Cisco, Texas 76437.

DALLAS — Oak Cliff Medical Center and Hospital (including 3 clinics) needs General Surgeon willing to do General Practice and 2 G.P.s; Busy E/R and Outpatient; daily referrals. Fully equipped rent free office. Write C. Richard Harrell, Administrator, South Oak Cliff Medicai Center, 728 So. Corinth, Dallas 75203 or call 214—946-4000.

D.O. ANESTHESIOLOGIST — With Texas license looking for full-time opportunity, preferably in smaller community. No. G.P. work. Write Box D. TOMA, 512 Bailey, Fort Worth 76107; or call Tex Roberts 817—336-0549.

HOUSTON — Professional Medical & Surgical Clinic Association has openings for specialists in the fields of Int. Medicine, Pediatrics, General Practitioners, General Surgery, OB-Gyn. Write Chris S. Angelo, D.O., 2902 Berry Road, Houston, Texas 77016 or call 713—695-5149 or 713—335-4881.

PEARSALL—Is booming! Population 8,000; one D.O. and one M.D. to care for all of them. Young D.O. desperately needs help. Preferably D.O. who will do surgery. Fully equipped office can be rented, or one is for sale. Open staff 20-bed hospital; 50 miles southwest of San Antonio. Graduating resident welcome. Contact Daniel L. Schmidt, D.C., 322 Berry Ranch Road, Pearsall 78061; phone 512—334-3351.

HOUSTON — Physicians interested in the Houston area (family practice or pediatrics urgently needed). Contact Ronald Calicha, Administrator, Eastway General Hospital, 9339 N. Loop E., Houston, Texas 77029:Phone 713—583-8585

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

PETERSBURG — G.P. wanted to take over well-established rural practice in D.O. community. It has been covered by D.O.s for 20 years. Rich farming community and is 30 miles from Lubbock. Contact Norman D. Truitt, D.O., Box 10, Petersburg, Texas 79250. Phone 806—667-3581 or 806—667-3376.

MABANK — Family clinic needs doctor $3,000 month guaranteed. Present doctor going into residency, grossing over $100,000 a year. Contact Robert L. Hamilton, D.O., P. O. Box 267, Mabank, Texas, 75147: Phone: 214—887-2161.

SAN ANTONIO — Office for rent, fully equipped. Contact Sara Netts, Estate of Dr. Waldemar D. Schaefer, 510 West Harding Blvd., San Antonio 78221.

G.P. wishes to join group or association of same in Texas. 7 years G.P. experience; 1 year Internal Medicine residency. Prefer to associate with no initial outlay of cash; a guarantee; fringe benefits. Please write Ronald Severtis, D.O., 3360 Cardinal Drive, Sharpsville, Pennsylvania 16150.

FORT WORTH—Office space for lease. New building. Suitable for medical or dental practice. 1500 square feet. Located at 4201 Camp Bowie Blvd. Contact David M. Beyer, D.O., 4201 Camp Bowie Blvd., Fort Worth 76107. Phone 817—731-0801.

Life or Death? The Patient's Rights

by Ray Farabee
Texas State Senator, District 30

Last February, a Tennessee court chancellor ruled that a respirator keeping a 41-year-old heart attack victim alive could be removed at the request of her family if her doctor thought there was no chance she would emerge from a three-month coma.

In March, a grief-stricken father from Wilkes-Barre, Pennsylvania, asked for an order to allow his three-year-old son, who was critically injured when hit by a car, to die before the child's body deteriorated.

The case of an 84-year-old North Miami Beach woman, a sufferer of Parkinson's disease who spent 24 hours in a hospital at a cost of $1,014 before her death, provoked a major newspaper article on the ethics of the cost of dying.

And before the Texas Legislature last spring, leukemia victim Sally Tulles pleaded with the committee handling the proposed natural death act to approve the law which would allow her to sign a directive to protect her right to refuse life-prolonging procedures.

Curiously, the one certain event of death has become a social issue.

Ever since Karen Quinlan's tragic overdose which led to her questionable existence on a respirator, the national media and the national conscience have been directed toward a new examination of the spectre of death. This orientation has resulted in a polarization of viewpoints and values, with one side casting modern medicine as a new technological desecrator of life which is more villianous than death, and the efforts of doctors as the new outlaw's handiwork. The opposing side also points an accusing finger at doctors and health care administrators as being eager plug-pullers who are but a step away from active euthanasia.

Some hospitals are beginning to structure ethics committees to try to deal with the issues raised by technology which can keep a body functioning mechanically long after any cognitive life has fled. These attempts at a solution have ranged from "classifying" patients according to allowable treatment to merely advising a physician as to whether a patient's condition is indeed terminal.

Most physicians seem to avoid taking a public stand on the issue in favor of doing the best they can according to each patient's unique circumstances. Eight states, including Texas, have passed "natural death" laws, while the Society for the Right To Die seeks to make it 50.

Certainly, legislation cannot answer these difficult issues which seem to have spun off from a basic question of the quality of death versus all possible death prevention. What the Texas Natural Death Act does attempt to do is guarantee the individual the right to retain the sense of a measure of control over the circumstances of his death, while leaving the hands of physicians free to do their work.

Most specifically, the Act does not authorize "mercy-killing." The law provides that a person may, under certain circumstances, sign a Directive to Physicians which asks that life-sustaining measures be withdrawn or withheld once it is determined by two doctors that his or her death is imminent.

The new law does not threaten hospital procedures which may allow the same withdrawal or withholding under the proper circumstances. Nor, as it specifically states, does it supersede the medical practice of allowing such decisions to be made by either a patient's physician or his family when the situation warrants.

The key limitation of the Act is that only doctors may determine whether a patient's death is imminent and irreversible, so only physicians can enforce the directive. A key protection is that should a physician rely on a patient's directive and make the decision that death is irreversible and life-support mechanisms can be withdrawn, he or she is protected from criminal or civil liability. But the provisions of the law must be followed, or a directive will be invalid.

Guidlines

1. A person must be at least 18 years old and of sound mind to sign a directive to physicians to give legal effect to his or her wishes to avoid artificial prolongation of the dying process. The directive must be signed, notarized and witnessed by two persons who are not related to the

patient by blood or marriage, are not mentioned in the declarant's will, are not potential claimants to his or her estate and are not involved in the patient's medical care. Therefore, neither the patient's physician nor his employees can serve as witnesses. Neither may a patient or employee in the health care facility in which the declarant is a patient serve as a witness.

2. The directive is only in effect for five years, after which the patient may sign a new one. It should be made part of the patient's record.

3. The directive is invalid if the patient is pregnant, and her doctor knows of the diagnosis.

4. The directive cannot be honored unless the declarant has been diagnosed and certified to be afflicted with a terminal condition by two physicians—one of whom shall be the attending physician—who have personally examined the patient.

5. The patient's doctor is not bound by the directive if the declarant signed it while in good health. However, if the patient is subsequently diagnosed as terminal, it may be carried out if, in the doctor's judgment, all of the circumstances justify doing so.

6. The directive is binding if the patient has been certified as terminal by two physicians and at least 14 days have elapsed since the patient was notified of his condition and before the directive was signed. In this case, life-support mechanisms must be withdrawn or withheld. If the physician does not wish to do so, he or she must transfer care of the patient to a doctor who will honor the directive.

7. The law does not prohibit the administration of pain-killing drugs. The Act refers to mechanical or other "artificial means" which sustain vital functions only to postpone the moment of death.

8. A patient may revoke the directive at any time by destroying it or otherwise defacing it, or by signing and dating a written revocation or by verbally revoking the directive. However, the physician must be made aware of a revocation by either the patient or by a person acting in the patient's behalf.

9. If a revocation occurs, the directive must be marked "void" on each page of the directive in the patient's medical record.

10. No one may be forced to sign a directive. A directive has no effect on a person's health or life insurance policies, nor does it limit a person's right to accept or reject health care of any kind. A person who has not signed a directive may not be denied health care, or health or life insurance.

11. A person who knowingly conceals or destroys a a valid directive is quilty of a misdemeanor. A person who forges or falsifies a directive or who withholds knowledge or a revocation may be prosecuted for unlawful homicide.

12. The directive must be identical to the following form authorized by the Texas Legislature for the law which went into effect August 29, 1977:

Directive to Physicians

"Directive made this _____ day of _____ (month, year).

"I, _____, being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

"1. If at any time I should have an incurable condition caused by injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my attending physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

"2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

→

"3. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

"4. I have been diagnosed and notified at least 14 days ago as having a terminal condition by _____, (M.D. or D.O.) whose address is _____ and whose telephone number is _____. I understand that if I have not filled in the phycian's name and address, it shall be presumed that I did not have a terminal condition when I made out this directive.

"5. This directive shall have no force or effect five years from the date filled in above.

"6. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

"7. I understand that I may revoke this directive at any time.

"Signed _____
City, County and State of Residence_____
_____

"The declarant has been personally known to me and I believe him or her to be of sound mind. I am not related to the declarant by blood or marriage, nor would I be entitled to any portion of the declarant's estate on his decease, nor am I the attending physician of declarant or an employee of the attending physician or a health facility in which declarant is a patient, or a patient in the health care facility in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his decease.

"Witness_____
"Witness_____

"STATE OF TEXAS
COUNTY OF _____

"Before me, the undersigned authority, on this day personally appeared_____, _____, and_____ _____, known to me to be the declarant and witnesses whose names are subscribed to the foregoing instrument in their respective capacities, and, all of said persons being by me duly sworn, the declarant, _____, declared to me and to the said witnesses in my presence that said instrument is his Directive to Physicians, and that he had willingly and voluntarily made and executed it as his free act and deed for the purposes therein expressed.

"Declarant_____
"Witness_____
"Witness_____

"Subscribed and acknowledged before me by the said declarant,_____, and by the said witnesses,_____, and _____ _____. on this _____ day of _____ _____, 19 ___.

_____
Notary Public in and for
_____County, Texas

~~~~~~~~~~~

When the above article was received at the State Office, it was immediately noted that in the "Directive to Physicians", No. 4. read, "I have been diagnosed and notified at least 14 days ago as having a terminal condition by _____, M.D. . . . ."

We immediately got in touch with Senator Farabee and he assured us that the intent of the Legislature was that this should include any physician duly licensed by the Texas State Board of Medical Examiners to practice medicine in Texas.

For the record, we then wrote Senator Farabee as follows:

I appreciate your call this morning regarding the form called out by the Texas Natural Death Act, and you stated that licensed physician, whether M.D. or D.O., was the legislative intent.

I would like to suggest that whatever state agency generates this form for use by the legal profession, hospitals and physicians—that they include the letters M.D. or D.O. in this particular place or substitute the words "licensed physician". Otherwise, lawyers will be generating forms that say only M.D. and cause considerable anguish for patients of osteopathic physicians.

If conditions get down to this critical point, it would be a terrible time for there to be a question as to whether or not the family physician, if a D.O., could certify and sign the directive. Don't you think so?

We would appreciate any help you can give in clarifying this as the law is implemented.
~~~~~~~~~~~

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Actions: Pyrvinium pamoate appears to exert its anthelmintic effect by preventing the parasite from using exogenous carbohydrates. The parasite's endogenous reserves are depleted, and it dies. Povan is not appreciably absorbed from the gastrointestinal tract.

Indication: Povan is indicated for the treatment of enterobiasis.

Warnings: No animal or human reproduction studies have been performed. Therefore, the use of this drug during pregnancy requires that the potential benefits be weighed against its possible hazards to the mother and fetus.

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Adverse Reactions: Nausea, vomiting, cramping, diarrhea, and hypersensitivity reactions (photosensitization and other allergic reactions) have been reported. The gastrointestinal reactions occur more often in older children and adults who have received large doses. Emesis is more frequently seen with Povan Suspension than with Povan Filmseals.

How Supplied: Each Povan Filmseal® contains pyrvinium pamoate equivalent to 50 mg pyrvinium, supplied in bottles of 50 (NDC 0710-0747-50; NSN 6505-00-134-1966). Povan Suspension, a pleasant-tasting, strawberry-flavored preparation containing pyrvinium pamoate equivalent to 10 mg pyrvinium per milliliter, is supplied in 2-oz bottles (NDC 0071-1254-31; NSN 6505-00-890-1093).

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DR. HARAKAL SPEAKS AT CRANIAL CONFERENCE

Dr. John H. Harakal, Chairman of the Department of OPP&P at TCOM, was a featured speaker at the annual cranial conference sponsored by the Sutherland Cranial Teaching Foundation in Des Moines June 13-15. The program theme was "Fluids in Motion".

DR. WIMBISH CERTIFIED IN FORENSIC TOXICOLOGY

Dr. Gary H. Wimbish, assistant professor of pathology at TCOM, has been certified as a Diplomate of the American Board of Forensic Toxicology. Certification is based on examination, recommendations and credentials, and only about 40 toxicologists in the United States are board certified, according to Dr. Wimbish.

HOSPITAL BOARD RIGHTS AT ISSUE

According to a note in the *Arizona Osteopathic Digest*, June 1977, in that state malpractice insurance may not be demanded by hospitals from physicians seeking staff privileges. A Superior Court decision has had the effect of telling one Arizona Hospital that its board of directors *could* require a physician to have such coverage, but that decision was overturned by the Appellate Court.

The case is now before the Supreme Court of the State, which has not as yet accepted jurisdiction in the matter. The *prime issue here* is whether or not a hospital's governing board has the right to *establish criteria* for staff membership.

IMMUNIZATION ACTION MONTH

August has been designated Immunization Action Month and a major immunization promotion attack has been launched for the purpose of significantly increasing immunization levels for diphtheria, pertussis, tetanus, polio, measles, rubella and mumps.

All TOMA members received notice of the program during July, which included the information that immunization reminder cards were available through the State Office. Since the number of requests for these cards was something less than overwhelming, a good supply is still on hand and can be had without charge.

KCOM IS NOT A LOCAL RADIO STATION

"KCOM Is Not a Local Radio Station" is the message of a T-shirt worn by a registrant at the recent convention of the Indiana Association of Osteopathic Physicians and Surgeons, whose picture was printed in the June *Hoosier Bulletin*.

AAOA SCHOLARSHIPS TO TCOM STUDENTS

TCOM students have been named recipients of the National Osteopathic College Scholarships from the Auxiliary to the American Osteopathic Association.

Each receiving $300 tuition scholarships are Judy Mills of Fort Worth and Hector Lopez of El Paso. Both Mrs. Mills and Mr. Lopez will be first-year students at TCOM this fall.

What does the best health care package look like to TOMA members?

Very complete.

It is a package designed specifically for TOMA members and their employees. And these are just the highlights:

Hospital coverage for 365 days per period of confinement.

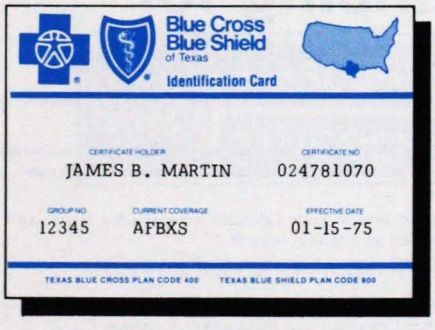
A $30.00 basic room allowance.

Most usual hospital charges covered in full.

Intensive Care and Coronary Care Units covered in full.

A Surgical Schedule for physicians' services.

In addition to the coverages above, $250,000 in Major Medical benefits with a $100 deductible and $65 room allowance. For the first $2,600 in eligible expenses under this Major Medical program, a $100 deductible is applied and the $2,500 balance is paid at 80% during any benefit period. During the remainder of the benefit period, 100% payment will be made under Major Medical for eligible Major Medical expenses exceeding $2,600.



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Mr. Tex Roberts, Executive Director
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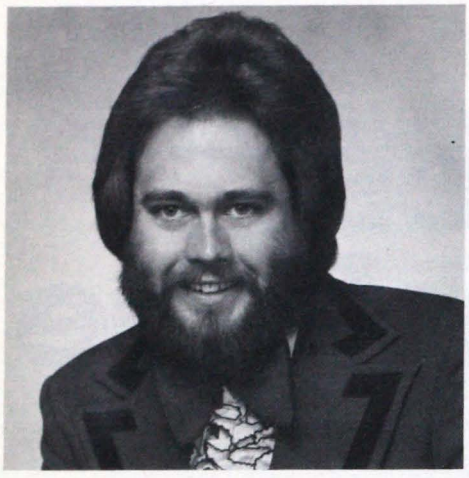

Tom N. Jones, D.O.
Dallas

Dr. Jones is one of the new D.O.s who graduated from KCCOM in May whose father is also a graduate (1950) of that school. His parents are Dr. and Mrs. Sam P. Jones of Dallas.

The new Dr. Jones received his B.A. degree from Southern Methodist University and is interning at the Center for Health Sciences in Kansas City.

While attending KCCOM he was active in Phi Sigma Gamma Fraternity.

(The above information was received too late to include it in the July issue, along with other Texas graduates.)

Clinical Specialists Meet in October

When the 50th Annual Clinical Assembly of Osteopathic Specialists is held October 2-6 in Los Angeles, several Texas D.O.s will be active participants.

On the program for neurological surgeons, Dr. Charles R. Biggs of Fort Worth is scheduled to speak twice on October 4. In a morning session his subject will be *Microneurovascular Surgery.* In the afternoon he will speak on *Cervical Disc Disease—Microscopic Anterior Diskectomy.*

Dr. David P. Sufian of Houston will be on a "Cracker Barrel Round Table" on the Thoracic-Cardiovascular Surgeons section Wednesday, October 5, as a discussant on *Peripheral Vascular Lab.*

Scheduled for Monday morning, October 3, for the American College of Osteopathic Surgeons program, is a panel discussion on *Invasive Diagnostic Techniques and Their Efficacy in the Jaundiced Patient,* with Dr. Joel Alter of Fort Worth acting as moderator.

The American Osteopathic College of Anesthesiologists will hold its opening session Sunday afternoon, October 2, with Dr. S. Stevon Kebabjian of Dallas speaking on *The Competent Anesthesiologist.*

A certified orthopedic surgeon from Tyler, Dr. Edward E. Rockwood, will moderate a panel Sunday afternoon on *Problem Clinic* during the opening session of the American Osteopathic Academy of Orthopedics program.

Two Texas D.O.s will appear on the program of the American Osteopathic College of Proctology. Dr. J. Edward Vinn of Houston speaks Monday morning on *Cryptitis and Anal Ulcer.* Dr. Louis Mancuso of Dallas will speak Tuesday morning on *Gastrointestinal Disorders and the Relation to Mineral Metabolism.*

Dr. Anthony G. Bascone of Dallas is the Texas representative on the program of the American Osteopathic College of Radiology. He will be on a panel both Sunday and Monday on *Viewpoints on a Changing Practice.* During each of these sessions he will discuss *Computer Billing Systems.* ^

Setting the Record Straight
on Physician Shortages in Texas

When Dr. James W. Linton of Hurst read Senator Lloyd Bentsen's June Report from Washington, *he was understandably disturbed that the Senator quoted some statistics stating that there were 23 Texas counties that did not have physicians.*

Dr. Linton wrote the TOMA State Office:

"Did none of these 23 Texas counties even have a physician, D.O.?

"If D.O.s were in some of these counties, then perhaps Senator Bentsen should be advised that D.O.s are physicians also."

We wrote the following letter to Senator Bentsen:

Dear Lloyd:

We realize that sometimes you have to accept information from sources that you deem reliable, but in so doing you're bound to come up with some erroneous figures or facts, so please revise the number of Texas counties without a physician. It's 18 — not 23.

What brings this on is your June Report on "Better Medical Care for the Elderly" in which you state there are 23 Texas counties without a physician. These are figures put out by the TMA or AMA and do not include osteopathic physicians who, as you know, comprise the minority medical profession, and who are licensed in Texas by the State Board of Medical Examiners, taking the same examination for licensure as given allopathic physicians (M.D.s).

So to set the record straight, of the 23 counties that the TMA says have no physician, five are fortunate enough to have D.O.s located in them, although there are no M.D.s practicing there. These include Armstrong, Carson, Concho, Roberts, and San Jacinto. Therefore, I believe that as of this year, there are only 18 counties in Texas without a qualified licensed physician.

We only wish we had more to send out to these underserved areas. The Texas College of Osteopathic Medicine in Fort Worth graduated its fourth class of 55 D.O.s this spring. Its first class had a total of only 18 graduates, and our figures tell us that 12 of those are now practicing in Texas in smaller communities where they are needed. None of them located in the large cities. Of the remaining six, only one has set up practice out of the State of Texas. The other five are either in military service or are still in residencies.

It's too early to have complete and accurate figures on the 1975 and 1976 graduates of TCOM, and of course the 1977 graduates are all taking their internships now. However, it looks as if we would retain from 75 to 80 per cent of the Texans who attend TCOM.

Although osteopathic physicians in Texas number only about one in twelve, 75 per cent of them are in general (or family) practice and they care for the health needs of 18 per cent of the people in Texas, — and doing an excellent job of it, I'm proud to say!

Keep up the good work in Washington.

Tex Roberts, CAE

Herewith is the Senator's reply:

Dear Tex:

Thank you for your recent letter and the updated information regarding the number of counties in Texas without a physician.

It is good news to know that the situation has improved, and that the Texas College of Osteopathic Medicine is adding so many physicians that are in general practice. I am hopeful that the trend toward your graduates serving in rural areas will continue.

Thanks again for the helpful information.

Lloyd Bentsen

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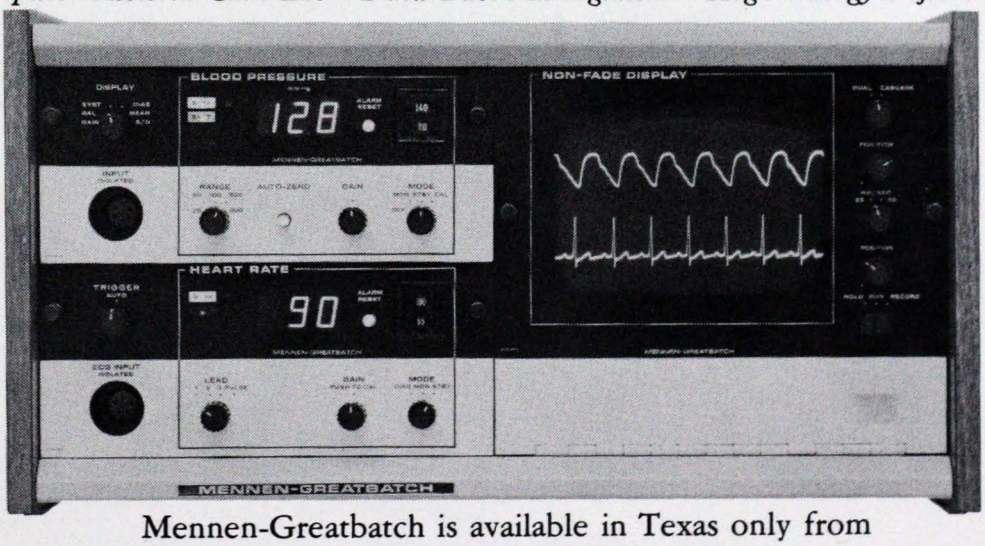

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