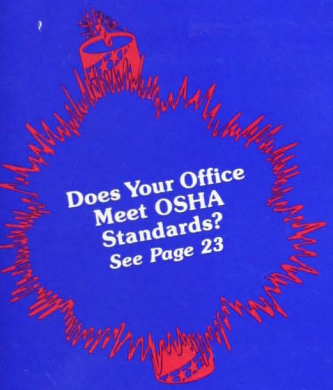
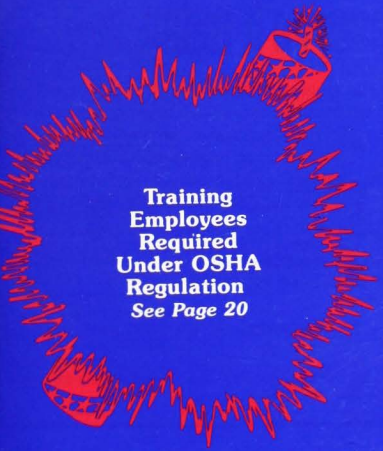
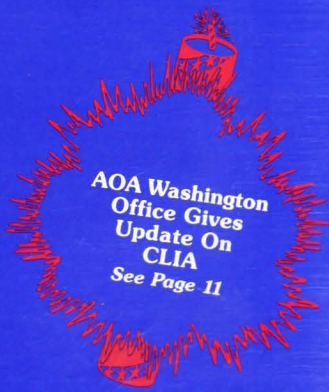
TEXAS DO

XXXIX, No. 6 TEXAS OSTEOPATHIC MEDICAL ASSOCIATION July, 1992







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For Your Information

American Osteopathic Association	312/280-5800 800/621-1773
Washington Office	202/544-5060 800/962-9008
American Osteopathic Hospital Association	703/684-7700
Professional Mutual Insurance Company	800/821-3515
Risk Retention Group	816/523-1835
TOMA Malpractice Insurance Program:	
For Premium Rates, Enrollment & Information	800/366-5706
TOMA Major Medical Insurance	1-800/321-0246
Texas College of Osteopathic Medicine	817/735-2000 Dallas Metro 429-9120
Medicare Office:	
Part A Telephone Unit	214/470-0222
Part B Telephone Unit	214/647-2282
Profile Questions	214/669-7408
Provider Numbers:	
Established new physician (solo)	214/669-6162
Established new physician (group)	214/669-6163
All changes to existing provider number records	214/669-6158
Texas Medical Foundation	512/329-6610
Medicare/CHAMPUS General Inquiry	800/725-9216
Medicare/CHAMPUS Beneficiary Inquiry	800/725-8315
Medicare Preprocedure Certification	800/725-8293
Private Review Preprocedure Certification	800/725-7388
Texas Osteopathic Medical Association	817/336-0549 in Texas 800/444-TOMA Dallas Metro 429-9755 FAX No. 817/336-8801
TOMA Med-Search	in Texas 800/444-TOMA
TEXAS STATE AGENCIES:	
Department of Human Services	512/450-3011
Department of Public Safety:	
Controlled Substances Division	512/465-2188
Triplicate Prescription Section	512/465-2189
State Board of Health	512/458-7111
State Board of Medical Examiners	512/834-7728
Texas State Board of Medical Examiners (for disciplinary actions only)	800/248-4062
State Board of Pharmacy	512/832-0661
State of Texas Poison Center for Doctors & Hospitals Only	713/765-1420 800/392-8548 Houston Metro 654-1701
Texas Workers' Compensation Commission	512/448-7900
FEDERAL AGENCIES:	
Drug Enforcement Administration:	
For state narcotics number	512/465-2000 ext 3074
For DEA number (form 224)	214/767-7250
CANCER INFORMATION:	
Cancer Information Service	713/792-3245 in Texas 800/392-2040

TEXAS DO

TEXAS OSTEOPATHIC MEDICAL ASSOCIATION

FEATURES

DEPARTMENTS

TEXAS DO
TEXAS OSTEOPATHIC MEDICAL ASSOCIATION
July, 1992

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Calendar of Events

JULY

11

Consistency in Quality Review
Texas Medical Foundation
Stouffer Austin Hotel
Austin, Texas
Call: (512) 329-6610 - Austin
1-800-725-9216 - Texas

30-AUGUST 2

"General Practice Update with Emphasis on Risk Factors"
Mid-Year Symposium of Texas Society ACGP
Doubletree Hotel at Park West
Dallas
Hours: 34
Contact: Keri Frugé
Corresponding Secretary
Texas Society of ACGP
817/870-2518

12-16

"Primary Care the Natural Way"
Arkansas Osteopathic Medical Association
7th Annual Convention
Location: Little Rock Hilton
Little Rock, Arkansas
Hours: 23
Contact: AOMA
101 Windwood Drive, Ste. 5
Beebe, AR 72012
501/882-7540

SEPTEMBER

11-13

"Midyear Meeting"
Florida Osteopathic Medical Association
Hyatt Regency Westshore
Tampa, Florida
Hours: 20 (1-A)
Contact: FOMA
904/878-7364

12

TOMA Board of Trustees Meeting
10:00 A.M.
TOMA Headquarters Building
Fort Worth, Texas
Contact: TOMA
817/336-0549

OCTOBER

24-25

Osteopathic Manipulative Medicine Seminar
University of Osteopathic Medicine and Health Sciences
Location: 3200 Grand Avenue
Des Moines, Iowa
Contact: Gena Alcorn
Continuing Education Coord.
UOMHS
3200 Grand Avenue
Des Moines, IA 50312-4198
515/271-1480

DECEMBER

12

AIDS Conference
University of Osteopathic Medicine and Health Sciences
Location: 3200 Grand Avenue
Des Moines, Iowa
Contact: Gena Alcorn
Continuing Education Coord.
UOMHS
3200 Grand AVenue
Des Moines, IA 50312-4198
515/271-1480

Biggest Test Is Yet To Come, 72 TCOM Graduates Told

"We did it!" — Members of the Class of '92 celebrate backstage at commencement.

Brig. Gen. Ronald R. Blanck, D.O. speaker for commencement of the Class of '92, is accompanied by UNT/TCOM Regent Billie Parker of Fort Worth.

The 72 graduates of the Texas College of Osteopathic Medicine Class of 1992 who received their Doctor of Osteopathy degrees at the college's 19th annual commencement on June 6 were told that graduation from medical school does not end their education; that they will remain students for the rest of their lives.

The commencement speaker, Brigadier General Ronald R. Blanck, D.O., chief of the U.S. Army Medical Corps, told the new osteopathic physicians that while the type of tests they take will change to board licensing and certification examinations, they will have to pass an even bigger test. "You are going to be tested by the ultimate instrument to see what you and who you are, and that is the patient," he advised. Blanck said that patients are the "start and finish" of medicine and cautioned the graduates that "you will be judged, you will pass or fail, on the basis of the care that you express, the compassion that you show, the listening that you offer and the pain that you share."

An estimated 1,500 family members and friends of the 57 men and 15 women graduates attended the commencement ceremony in the Tarrant County Convention Center Theatre and the President's Reception which followed at the Radisson Plaza Hotel.

TCOM President David M. Richards, D.O., urged his new colleagues to continue persevering, growing, achieving and learning. "Learn especially," he said, "the difference between success and grace." Richards noted that many people — entertainers, business executives, athletes, politicians and even many physicians are considered successful. Few, he said, achieve success and also have the sense of dignity, fitness or propriety known as grace. Richards quoted the dictionary definition of grace — "a disposition to be generous; a favor rendered by one who need not do so" — and added "I suggest to you that among those who have achieved success in their chosen field with grace are such examples as Helen Keller, Mother Teresa, Albert Schweitzer and Albert Einstein." Richards then paraphrased Einstein in telling the graduates "A successful person is one who receives a great deal from others; a person's value — some might call it grace — is measured by what one gives to others."

Blanck noted the "palpable excitement" created by the explosion of technology in medicine, but added that the U.S. is facing the greatest crisis in health care that any society has had to confront with 40 million Americans uninsured for medical care. "It seems that we're providing more and more for fewer and fewer," Blanck said. He acknowledged that doctors have been unwittingly part of the problem because "we have gotten away from what we once were." He said that he thinks Dr. Andrew Taylor Still, the founder of osteopathic medicine 100 years ago, would have the answer: "Go back to the basics; go back to where medicine, generally, and osteopathic medicine, in particular, started; go back to the patient."

Blanck encouraged the new physicians to help find solutions to the health care crisis the country is facing. "I hope that you will be a part of this (solution) because I assure you that if you are not, others less qualified and certainly less altruistically motivated will take up this challenge and will find the answers, and we won't like them," he said.

Blanck, who was awarded TCOM's highest honor, the Founder's Medal, at convocation last fall, is director of the Army Medical Corps professional services and represents all U.S. Army Physicians to the office of the Surgeon General. He was the first D.O. to achieve flag-officer status, the rank of Brigadier General, in the U.S. Army.

The 72-member Class of 1992 brings to 1,342 the number of osteopathic physicians who have graduated from TCOM. ■

Class of 1992 Recognized At TCOM's 19th Senior Awards Banquet

The achievements of Texas College of Osteopathic Medicine's Class of 1992 were recognized at the 19th Senior Awards Banquet, held June 5 at the Radisson Plaza Hotel in downtown Fort Worth. Marion-Merrell-Dow Laboratories provided financial support for the banquet.

Receiving awards and scholarships were:

- **Sigma Sigma Phi Outstanding Senior Award:** Muneer Elias Assi.
- **National Osteopathic Women Physicians Association Award:** Deanna Haller.
- **Speculum Dedication:** Joyce Fielding, financial aid
- **M.L. Coleman, J.D., D.O., Clinical Faculty Award:** Winter B. Wilson, D.O., medicine
- **M.L. Coleman, J.D., D.O. Preclinical Faculty Award:** Myron Jacobson, Ph.D., anatomy and cell biology
- **President's Scholar Awards:** Glen H.J. Stevens, Andres Gilberto Morales and Brent Lee Kutach
- **Sandoz, Inc. Award:** Brent Kutach
- **Marion Merrell Dow, Inc. Award:** Andres Morales
- **Upjohn Award:** Glen Stevens
- **Outstanding Senior Student Emergency Medicine:** Jayme Bork
- **Ross Pediatric Award:** Glen Stevens
- **Mead Johnson Pediatric Award:** Henry Landsgaard
- **Wyeth Pediatric Award:** Andres Morales
- **Allen & Hansburys Pediatric Achievement Award:** Natalie Wright
- **SmithKline Beecham Award:** Lyn Marie Berutti
- **Robert J. Nelson, D.O., Memorial Award for Clinical Excellence in Obstetrics/Gynecology:** Glen Stevens
- **Searle Award for Academic Excellence in Obstetrics/Gynecology:** Andres Morales
- **Sam Buchanan Sr. Memorial Award:** Glen Stevens
- **Dupont Pharmaceuticals Anesthesiology Award:** Brent Kutach
- **Surgery Award for Clinical Excellence:** Kevin Lynch
- **Internal Medicine Award for Academic Excellence:** Glen Stevens
- **Internal Medicine Award for Clinical Excellence:** Brent Kutach
- **SmithKline Beecham Pathology Award:** Jayme Bork
- **T. Robert Sharp Award:** Casper Webb
- **Robert G. Haman, D.O., Memorial Award:** Sheila Page
- **Michael A. Calabrese, D.O., Arrowsmith Award:** Mark Kalna
- **President's Award:** Andres Morales
- **Chancellor's Award:** Glen Stevens
- **Wayne O. Stocksteth Award:** Allison Hopper
- **L. L. Bunnell, D.O., Award:** Muneer Assi ■

TCOM Graduates Commissioned by Chief of Army Medical Corps.

Brig. Gen Ronald R. Blanck, D.O., chief of the U.S. Army Medical Corps, swore in seven members of the Class of '92 in a commissioning ceremony following Commencement.

The end of the graduate ceremony at Texas College of Osteopathic Medicine on June 6 did not end the ceremonies for eight TCOM graduates who were sworn into the U.S. Army for their postgraduate training.

Brig. Gen. Ronald L. Blanck, D.O., chief of the U.S. Army Medical Corps and commencement speaker for TCOM's 19th annual graduation, administered the oath to seven new osteopathic physicians immediately following commencement. One graduate, Beverly Land, D.O., was commissioned by her uncle, retired Brig. Gen. William Kenneth Skaer.

Those receiving commissions in the U.S. Army and their residency locations include: Michael Applewhite, D.O., Darnell Army Community Hospital, Fort Hood, Texas; Stephen Dentler, D.O., and Brent Kutach, D.O., Brooke Army Medical Center, Fort Sam Houston, Texas; James Howard, D.O., Mark Kalna, D.O., and Nathan Tillotson, D.O., William Beaumont Army Medical Center, El Paso, Texas; and Alexander Orlov, D.O., Tripler Army Medical Center, Honolulu. Land received a one-year deferment.

Graduate Jayme Bork, D.O., will also serve a military residency at the U.S. Navy Hospital in Pensacola, Florida.

In introducing Blanck at commencement, President David M. Richards, D.O., noted that 30 TCOM students currently receive U.S. Army Health Professions Scholarships, more than any other medical school in Texas or any other osteopathic college in the nation.

In his commencement address, Blanck said that some people might find the designation of "military medicine" to be incongruous. Blanck acknowledged that in some ways, the military and medicine are diametrically opposed, but said he also believes they are very similar. "I think, along with the ministry, that medicine and the military are the professions that most embody the societal values of selflessness and service," said Blanck. ■

Postgraduate Training Locations for TCOM Class of 1992

Akron City Hospital
525 East Market Street
P.O. Box 2090
Akron, OH 44309-2090
Dolores Annette Bailey, D.O.

Austin State Hospital
4110 Guadalupe Street
Austin, TX 78751
Alan Brent Colby, D.O.

Botsford General Hospital
28050 Grand River Avenue
Farmington Hills, MI 48336
Jack William Clark, Jr., D.O.

Brooke Army Medical Center
Department of Pediatrics
Fort Sam Houston, TX 78234-6200
Stephen Max Dentler, D.O.
Brent L Kutach, D.O.

Centurion Hospital of Carrollwood
7171 North Dale Mabry Highway
Tampa, FL 33614-2699
Edwin Alphonse Lichwa, Jr., D.O.

Chicago Osteopathic Medical Center
5200 South Ellis Avenue
Chicago, IL 60615
Anthony William Delorenzo, D.O.

Cleveland Clinic Hospital
Department of Neurology and Internal Medicine
9500 Euclid Avenue
Cleveland, OH 44195
Glen H. J. Stevens, D.O.

Cuyahoga Falls General Hospital
1900 23rd Street
Cuyahoga Falls, OH 44223
Ralph Claiborne Walsh, Jr., D.O.

Dallas/Fort Worth Medical Center
2709 Hospital Boulevard
Grand Prairie, TX 75051
Stephen Leo Hall, D.O.
Beverly C. Land, D.O.

Dallas Family Hospital
2929 South Hampton Road
Dallas, TX 75224
Steven Lane Casey, D.O.
Darren K. George, D.O.
Richard D. Raughton, D.O.

Darnall Army Community Hospital
Department of Emergency Medicine
Fort Hood, TX 76544
Michael Philip Applewhite, D.O.

Doctors Hospital, Inc.
5500 39th Street
Groves, TX 77619
Daniel Alexander Crain, D.O.

East Tennessee State University
James Quillen College of Medicine
Department of Medicine
Box 21160-A
Johnson City, TN 37614
Ronald J. C. Fejeran, D.O.
Paul Andrew Reel, D.O.
Joseph Paul Whitson, D.O.

Flint Osteopathic Hospital
3921 Beecher Road
Flint, MI 48532
Gautam Daulat, D.O.
Henry R. Landsgaard, D.O.
John E. Nile, D.O.
Casper C. Webb, III, D.O.

Highland General Hospital
1411 East 31st Street
Oakland, CA 94602
Jamshid H. Ighani, D.O.

La Grange Memorial Hospital
Family Practice Center
1323 Community Memorial Drive
La Grange, IL 60525
Joe Frank Helpenstell, D.O.

Mayo Clinic
Department of Pediatrics
200 1st Street SW
Rochester, MN 55905
Kathryn Gibson Brock, D.O.

Memorial Medical Center
Family Practice Residency Program
2606 Hospital Boulevard
Corpus, Christi, TX 78405
Claire Ritchie Zengerle, D.O.

McLennan County Family Practice
1600 Providence Drive
Waco, TX 76707
Leon Douglas Joplin, D.O.

Naval Hospital
Pensacola, FL 32512-5000
Jayme A. Bork, D.O.

Northeast Community Hospital
1301 Airport Freeway
Bedford, TX 76021-5698
Sheila Diane Page, D.O.
Bessie L. Rogers, D.O.

Osteopathic Medical Center of Texas
1000 Montgomery Street
Fort Worth, TX 76107
Douglas Anthony Albracht, D.O.
Lyn Marie Berutti, D.O.
James W. Shuffield, D.O.
Natalie B. Wright, D.O.
Jerry D. Young, D.O.

Parkland Memorial Hospital
House Staff Mail Room
5201 Harry Hines Boulevard
Dallas, TX 75235
Frank Aldo Nizzi, Jr., D.O.

Pontiac Osteopathic Hospital
50 North Perry Street
Pontiac, MI 48342
Gerald Philip Douglass, D.O.

Presbyterian/St. Luke's Hospital
601 East 19th Avenue
Denver, CO 80203
Annie Yee Johnson, D.O.
Timothy B. Judd, D.O.

Richmond Heights General Hospital
27100 Chardon Road
Richmond Heights, OH 44143
Muneer Elias Assi, D.O.
Michael G. Messner, D.O.

St. Josephs Hospital and Medical Center
350 West Thomas Road
Phoenix, AZ 85013-4496
Deanna Owen Haller, D.O.

St. Paul Medical Center
Family Practice Residency
5909 Harry Hines
Dallas, TX 75235-6285
Lance Allan Sherley, D.O.

San Jacinto Methodist Hospital
4401 Garth Road
Baytown, TX 77521
Minhhang Ba Chu, D.O.

Scott & White Memorial Hospital
2401 South 31st Street
Temple, TX 76508
John David Hinze, D.O.
Hermann Jonak, D.O.
William H. Pieratt, III, D.O.
Morey L. Price, D.O.
James C. Stinson, D.O.
Tom Tarkenton, D.O.

Sinai Hospital of Baltimore
2401 West Belvedere Avenue
Baltimore, Maryland 21215
Nabil Abdel-Malek, D.O.

Suburban General Hospital
2701 DeKalb Pike
Norristown, PA 19401
Allison Lee Hopper, D.O.

Texas Tech University at Odessa
800 West 4th Street
Odessa, TX 79763
David Byron Morehead, D.O.
Pegge D. Rasbury, D.O.

Tri-City Health Center
7525 Scyene Road
Dallas, TX 75227
Jack Edward Lamanna, D.O.

Tripler Army Medical Center
Honolulu, HI 96859-5000
Alexander Orlov, D.O.

Tulane Medical Center
1430 Tulane Avenue SL-50
New Orleans, LA 70112
Shariar Arasteh, D.O.
Jeffory W. Beaty, D.O.
Soheil Goravanchi, D.O.

Tulsa Regional Medical Center
744 West 9th
Tulsa, OK 74127
Julie Beth Greene, D.O.

University Medical Center
Texas Tech Health Science Center
5301 University Avenue
Lubbock, TX 79413
Tram Qui Thu (Gina) Nguyen, D.O.

University of Tennessee
Chattanooga Unit
921 East 3rd Street, Suite 400
Chattanooga, TN 37403
Robert Kevin Lynch, D.O.

University of Texas Health Science Center at Dallas
Department of Psychiatry
5323 Harry Hines Boulevard
Dallas, TX 75235-9000
Dhiren B. Patel, D.O.

University of Texas Medical Branch Galveston
Department of Family Practice
415 Texas Avenue
Galveston, TX 77550
Michael Joseph Lyons, D.O.
Amir H. Rassoli, D.O.
Saan S. Simon, D.O.

Virginia Commonwealth University Medical College of Virginia
MCV Station
Richmond, VA 23298-0257
Andres Gilberto Morales, D.O.

Western Reserve Care System Medical Center - Northside
Department of Anesthesiology
500 Gypsy Lane
Youngstown, OH 44504
Johnny Ray Hall, D.O.

William Beaumont Army Medical Center
El Paso, TX 79930
James Warren Howard, D.O.
Mark D. Kalna, D.O.
Nathan Tillotson, D.O.

AAO Elects President, Hires Executive Director

Judith A. O'Connell, D.O.

Stephen J. Noone, CAE

The American Academy of Osteopathy (AAO) has elected Judith A. O'Connell, D.O., as president, and hired Stephen J. Noone, CAE, as executive director of the over 3400-member organization.

Dr. O'Connell received her gavel March 26 during the AAO's Annual Convocation and awards banquet. Her new position follows a one-year term as the AAO's President-Elect, a post to which she was elected March 20, 1991, during the AAO's annual membership meeting.

Dr. O'Connell is in private practice in Dayton, Ohio, and is board certified in special proficiency in osteopathic manipulative medicine. She chairs the Evaluation of Osteopathic Principles Committee at Grandview/Southview Hospitals in Dayton and serves as the Director of the Department of Osteopathic Manipulative Medicine at Grandview. In addition, Dr. O'Connell is assistant clinical professor of osteopathic manipulative medicine at Ohio University College of Osteopathic Medicine in Athens, Ohio.

Dr. O'Connell received her undergraduate degree from the University of Dayton in 1976. Following her graduation in 1980 from the Chicago College of Osteopathic Medicine, she completed a one-year general rotating internship at Grandview Hospital and Medical Center. Subsequently, she has earned certification at the Institute for Gravitational Strain Pathology Course in the use of the Levitor (1987), and certification in Osteopathy in the Cranial Field from the Cranial Academy (1989).

Dr. O'Connell has served the Academy in numerous positions, including the Education Committee, the Hospital Assistance Committee, the Long Range Planning Committee and the Board of Governors. She also has participated in the Academy's Visiting Clinician Program and chaired the AAO program at the 1990 AOA annual convention. In addition to Dr. O'Connell's activities in the AAO, she holds memberships in the AOA, the Ohio Osteopathic Association, the American Osteopathic Academy of Sports Medicine and the Dayton District Academy of Osteopathic Medicine.

In her professional endeavors, Dr. O'Connell demonstrates commitment to the mission of the AAO, which is to teach, explore, advocate, and advance the study and application of the science and art of total health care management, emphasizing palpatory diagnosis and osteopathic manipulative treatment.

Mr. Noone was hired as AAO Executive Director effective April 1, 1992. He has served the Indiana Association of Osteopathic Physicians and Surgeons and the Indiana Academy of Osteopathy as executive director for the past seven and one-half years.

The AAO Board of Trustees explained that in the past, this position has been primarily one of administrative duties. The AAO's new focus has created a new medical paradigm which necessitates expansion into broader areas and markets, including an educational outreach. Mr. Noone believes the AAO will become a major educational force within the profession.

A certified association executive (CAE) in the American Society of Association Executives, he achieved recertification in November 1991. Prior to his tenure at the Indiana Association of Osteopathic Physicians and Surgeons, he served the schools in Indiana as high school teacher, principal and superintendent. He earned his bachelor's degree from Marian College and his master's from Butler University, and has subsequently completed extensive graduate work at Purdue University.

Mr. Noone also has participated actively in community service. He is a member of the Board of Directors at both the Westview Hospital Foundation and the Indiana Society of Association Executives. In addition, he serves on the Lay Board of Advisors for Our Lady of Grace Monastery. A past president of the Association of Osteopathic State Executive Directors (AOSED), Mr. Noone had been chairman of AOSED's membership committee. He also represented AOSED on the Steering Committee for the Centennial of the AOA. ■

TOMA HAS DISCOVERED AN IMMUNIZATION FOR THE HEALTH INSURANCE "EPIDEMIC"

The high cost, no guarantee system of health insurance coverage is a "disease" that is affecting ALL small employers. Instead of providing long-term, affordable protection from financial losses due to accidents and illness, today's health insurance industry has created tremendous short-term burdens with no certainties of continued coverage in an environment that is as volatile as ever.

A recent item from *Medical Economics* magazine (March 5, 1990) indicates further the troubles that surround small employers, and even more specifically physicians. It reads:

> "While state and federal legislators debate the merits of requiring employers to provide health-care coverage for their workers, health insurers are refusing to issue policies to more and more small businesses and professions. Some carriers are even blacklisting physicians and nurses, chiropractors, dentists, and others in the health-care field. One reason that medical workers may be excluded, carriers say, is they tend to have a high rate of utilization."

Although a total cure for these problems may still be far away, TOMA has discovered an "immunization" for its members that can help shield the frustrations that managing health insurance (or the lack of) can cause.

TOMA has appointed DEAN, JACOBSON Financial Services to handle the complexities of health insurance environment for you. They have just negotiated with CNA Insurance Company (an A+, Excellent rated company with a long, successful record in the accident and health business) to offer Major Medical coverage to TOMA members at very competitive rates. Best of all, with CNA's strength in the health insurance market and DEAN, JACOBSON's management of insurance services, TOMA will have a superior Health Insurance Program that has long been needed.

DEAN, JACOBSON Financial Services is recognized statewide for their expertise in insurance and related areas. So regardless of your current situation with health coverage, call DEAN, JACOBSON Financial Services to help you immunize against the health insurance "epidemic."

For information on coverages, costs, and enrollment forms contact:

DEAN, JACOBSON FINANCIAL SERVICES

(*Formerly William H. Dean & Associates*)

(817) 335-3214
P.O. Box 470185
Fort Worth, TX 76147

(800) 321-0246
(817) 429-0460
Dallas/Fort Worth Metro

AOA Washington Update

The Americans With Disabilities Act

The landmark Americans with Disabilities Act (ADA), Public Law 101-336, enacted on July 26, 1990, provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications.

Title III of the ADA, "Nondiscrimination On The Basis of Disability by Public Accommodations and in Commercial Facilities," pertains to, amongst other entities, professional offices of health care providers and hospitals. The final rule which implements title III of the ADA became effective January 26, 1992.

Title III prohibits discrimination on the basis of disability by private entities in places of public accommodation and requires that all new places of public accommodation and commercial facilities be designed and constructed so as to be readily accessible to and usable by persons with disabilities. In addition, it requires that examinations or courses related to licensing or certification for professional and trade purposes be accessible to persons with disabilities.

Due to the vague wording in title III, much confusion has arisen concerning the services that must be provided by offices of health care providers and hospitals as such entities are termed "service establishments" among the likes of barber shops, travel services, and gas stations.

For example, one recurring scenario is a deaf patient who is accompanied by an interpreter for a routine office visit. Does the ADA provide for the reimbursement of the interpreter by the physician? This question, like many others, is not definitely answered within the loosely defined rules of the ADA.

Regulation 36.303 of title III of the ADA states that "A public accommodation shall take those steps that may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the public accommodations can demonstrate that taking those steps would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations being offered or would result in an undue burden, i.e., significant difficulty or expense." (All professional offices of health care providers and hospitals are considered *public accommodations.)*

The auxiliary aid requirement is a flexible one. The ADA allows for the public accommodation "to choose among various alternatives as long as the result is effective communication." In the analysis of 36.303 in the proposed rule, the Department of Justice (DOJ), which is charged with overseeing the implementation of title III, gave as an example the situation where a note pad and written materials were insufficient to permit effective communication in a doctor's office when the matter to be decided was whether major surgery was necessary. Many commenters objected to this statement, asserting that it gave the impression that only decisions about major surgery would merit the provision of a sign language interpreter. The statement would, as the commenters also claimed, convey the impression to other public accommodations that written communication would meet the regulatory requirements in all but the most extreme situations. Does this mean that sign language interpreters have the legal right to collect fees from a physician while accompanying the physician's deaf patient? The rules do not provide a clear answer.

Based upon a careful review of the ADA legislative history, DOJ believes that Congress did not intend under title III to impose upon a public accommodation the requirement that it give primary consideration to the request of the individual with a disability. To the contrary, the legislative history demonstrates congressional intent to strongly encourage consulting with persons with disabilities. In its analysis of the ADA's auxiliary aids requirement for public accommodations, the House Education and Labor Committee stated that it "expects" that "public accommodation(s) will consult with the individual with a disability before providing a particular auxiliary aid or service." Thus, DOJ found that strongly encouraging consultation with persons with disabilities, in lieu of mandating primary consideration of their expressed choice, is consistent with congressional intent.

In response to the loosely defined rule and the difficult problems which result from it, the American Medical Association (AMA) has assembled a task force which plans to target the sections of the ADA which pertain to health care providers with the intent of soundly defining the services to be furnished to those with disabilities. The task force, in which the American Osteopathic Association expects to participate, plans to convene a meeting with DOJ and numerous consumer advocacy groups in the coming month in order to pinpoint the services to be provided by physicians. Most likely, a federal legislative mandate will be needed to better define the ADA. ▶

TITLE III HIGHLIGHTS

General Overview of Requirements

Public accommodations, which in the context of the ADA all offices of health care providers and hospitals are classified as, must:

- Make reasonable modifications in policies, practices, and procedures that deny equal access to individuals with disabilities, unless a fundamental alteration would result in the nature of the goods and services provided;
- Furnish auxiliary aids when necessary to ensure effective communication, unless an undue burden or fundamental alteration would result;
- Remove architectural and structural communication barriers in existing facilities where readily achievable;
- Provide readily achievable alternative measures when removal of barriers is not readily achievable; and,
- Design and construct new facilities and, when undertaking alterations, alter existing facilities in accordance with the Americans with Disabilities Act Accessibility Guidelines issued by the Architectural and Transportation Barriers Compliance Board and incorporated in the final DOJ title III regulation.

A public accommodation is not required to provide personal devices such as wheelchairs; individually prescribed devices (e.g., prescription eyeglasses or hearing aids); or services of a personal nature including assistance in eating, toileting, or dressing. In addition, private entities offering certain examinations or courses (i.e., those related to applications, licensing, certification, or credentialing for secondary or postsecondary education, professional, or trade purposes) must offer them in an accessible place and manner or offer alternative accessible arrangements.

Further, specialists are not required to provide services outside of their legitimate areas of specialization. For example, a doctor who specializes exclusively in burn treatment may refer an individual with a disability, who is not seeking burn treatment, to another provider. A burn specialist, however, could not refuse to provide burn treatment to, for example, an individual with HIV disease.

The ADA is a lengthy rule and many of the regulations pertaining to health care providers are unclear at this time. For specific questions or additional information, please contact the AOA Washington Office at (800) 962-9008 or contact:

Office on the Americans with Disabilities Act
Civil Rights Division
U.S. Department of Justice
P.O. Box 66118
Washington, D.C. 20035-6118
(202) 514-0301 (Voice)
(202) 514-0383 (TDD)
(202) 514-6193 (Electronic Bulletin Board)

CLIA UPDATE

Implementation of the Clinical Laboratory Improvement Amendments of 1988 is moving along quite smoothly, according to Wayne Smith of HCFA's Office of Survey and Certification. Smith reported recently that the inspection process is currently under development and should be available for comment in the coming month. He added that the interpretive guidelines for the regulation issued February 28, 1992 should also be available for review and comment by mid-June.

Smith also noted that the final regulation for organizations seeking "deemed status" to accredit laboratories is expected to be issued by the end of May. The timing of this regulation may cause a dilemma for certain laboratories, especially large hospital labs. Because HCFA intends to move ahead with the billing and registration process to ensure that all labs process a CLIA certificate by September 1, 1992 as required by the regulation, these labs may be caught on the deadline waiting for their current accreditor to receive "deemed status" under CLIA. While the Agency is well aware of this problem and reports that it is moving as quickly as possible in the hope of helping labs avoid this dilemma, HCFA plans to continue the billing and registration schedule.

Finally, Smith noted that waived labs should be conscious of the quality control and assurance measures of the regulation because these labs are not "off the hook" in terms of oversight of these measures. Statements made during the comment period implied that all the regulations were waived for labs doing only simple tests but this is not the case. The personnel and proficiency testing measures are the *only* requirements waived for these labs.

Carlyn Collins of the Centers for Disease Control reported that the CLIA advisory committee will be named by the end of June and is expected to meet some time in August. The Committee will provide input on the CLIA implementation process and make recommendations on changes in the placement of tests in the categorization scheme. As reported previously, the AOA has nominated a D.O. to this advisory panel. ▶

HCFA PLANS CRACK DOWN ON BALANCE BILLING ERRORS

HCFA announced recently that the Agency will be much more diligent about educating physicians and carriers on errors of balance billing. In response to pressure from Capitol Hill and a lawsuit filed by patient advocates, the Agency will seek to improve its monitoring system on limiting charges. Currently, there is much disagreement however about the enforcement procedures for balance billing requirements establihed under the Medicare Fee Schedule. While HCFA recommends that patients contact their carrier if a balance billing problem develops, the carriers suggest that patients call the doctors directly. Apparently the ambiguity is a result of vague enforcement language in the MFS statute.

D.O.s TO PARTICIPATE IN HHS PANELS TO REVIEW RVUS

The Health Care Financing Administration (HCFA) recently named four D.O.s to several multispecialty panels which are charged with evaluating the physician work values established for the Medicare Fee Schedule in the final rule published on November 25, 1991. The panels also will review the comments received by concerned organizations on the relative value units (RVUs).

The following osteopathic physicians nominated by the AOA met during the week of May 18 through 22 in Baltimore: Steve Weisberger of Jonesport, Maine was named to the non-invasive cardiology panel and the panel on psychiatry; Michael Trahos of Alexandria, Virginia was named to the invasive cardiology and the panel on orthopedics; and, Wayne English of Burleson, Texas and Judith Ann O'Connell of Dayton, Ohio were named to the panel on osteopathic services.

HCFA REVISES DEFINITION OF "NEW PATIENT" FOR GROUP PRACTICE REFERRALS

The Office of Payment Policy of the Health Care Financing Administration (HCFA) recently announced a revised definition of "new patient" for physicians who refer a patient for the first time to a fellow group practice member of a different specialty. The Agency reported that in such instances, the physician will be allowed to bill the new patient code for the office visit.

The Medicare Fee Schedule originally said that in these circumstances the referred patient would be considered established for the group practice as a whole even though the patient would be new to the specialist. Physicians argued with HCFA to change the policy noting that under such circumstances the specialist physician would spend the amount of time required for a new patient but would be reimbursed for only part of that time. The change in policy was made after a HCFA meeting with the Carrier Medical Directors. ■

Osteopathy In The Cranial Field

Tamarin Ring, D.O., and Douglas Vick, D.O., explore the practical application of osteopathy in the cranial field with "patient" Mary Ann Block, D.O., all participants in the CME led by the Sutherland Cranial Teaching Foundation.

Osteopathy in the Cranial Field, an approved course for 40 hours of 1-A credit, was given by the Sutherland Cranial Teaching Foundation and co-sponsored by Osteopathic Medical Center of Texas and Texas Osteopathic Medical Association May 16-20. The Radisson Plaza of Fort Worth functioned as an osteopathic education center as 48 participants expanded their understanding of cranial manipulation through lectures, discussions and applications of treatment modalities.

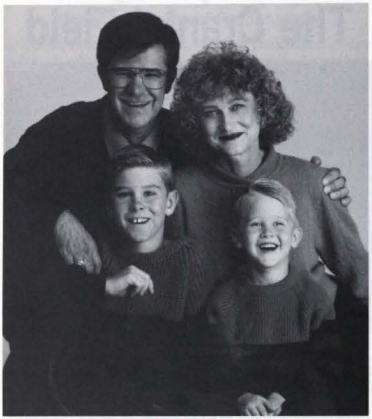
"The graduates of this course left with an improved knowledge of the anatomy, physiology and function of the body," said Douglas Vick, D.O., one of the 15 faculty members. Attending the continuing medical education were osteopathic physicians, students, interns, residents, M.D.s and dentists.

John H. Harakal, D.O., FAAO, president of the Sutherland Cranial Teaching Foundation and professor at Texas College of Osteopathic Medicine, said the study of osteopathy in the cranial field is significant because it "affords the next expansion of the osteopathic concept beyond the traditional."

According to Dr. Harakal, osteopathy in the cranial field can treat a wide variety of pathological conditions, including closed head injury, unresolved trauma, post surgical complication, headache and earache.

"It enhances the body's ability to heal using its inherent mechanisms," said Dr. Harakal. ■

TCOM Couple Enter Fellowships



Drs. Pat and Peggy Stenger and Family

Drs. Pat and Peggy Stenger are scheduled to begin three year fellowships at the University of Cincinnati starting September 1, 1992. Both physicians are TCOM graduates, and Alumni Association and TOMA members.

Patrick (TCOM '77) interned at Zeiger-Botsford Osteopathic Hospital, Inc., in Farmington Hills, Michigan after which he joined the Indian Health Service, serving at Gallup Indian Medical Center for six years, and the Albuquerque Indian Hospital for the past eight years. He is board certified by the American Osteopathic Board of General Practice. Dr. Pat's fellowship will be in Geriatric Medicine.

Peggy (TCOM '75) interned at Grand Prairie Community Hospital in Grand Prairie, Texas and then served a year on the faculty of TCOM as clinic physician at the Rosedale Clinic. She then joined the Indian Health Service working at the Gallup Indian Medical Center for seven years. Dr. Peggy completed a Pediatric residency and chief resident year at the University of New Mexico and has worked in the Pediatric Clinic of the Children's Hospital of New Mexico for the past four years. Her fellowship at the University of Cincinnati will be in Pediatric Endocrinology.

Drs. Stenger have two sons, Ryan (11) and Aaron (6).

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Osteopathic Medical Center of Texas

1000 Montgomery • Fort Worth, Texas 76107

A MESSAGE FROM THE TEXAS ACGP PRESIDENT

Dear Friends:

I hope you are all enjoying the summer weather and you will take some time to be with us on Thursday, July 30, 1992 at the Doubletree Hotel in Las Colinas for the Texas ACGP Mid-year Clinical Seminar and Symposium. We are planning to have an excellent program as promised to me by Dr. Benjamin Young. The program will start on Thursday afternoon, July 30 and last through Sunday, August 2. We plan to have a variety of topics as well as nighttime activities. Friday night is Hospital Appreciation Night; watch your mail for more details. Please look at the brochure when you receive it in the mail. On Saturday night, Texas ACGP will be starting a presidential installation and awards dinner. We hope that you will be there. The hotel this year is farther from the attractions but we will be providing bus service to Six Flags and Wet-N-Wild. For the spouses, the hotel will be providing a shuttle service to the Galeria. We hope that this will entertain the families so that as many as possible will be coming to the lectures. We will be having daily sign in as has been in past history. I wish to thank you all, who have come in the past for helping make this conference one of the most successful among the ACGP State Conferences. It is known that without you, the Texas ACGP would not be able to sponsor these conferences. The drug companies do afford us the opportunity to provide you with some of the country's leading speakers as well as some of the fringe benefits that have been known to accompany our seminars. Please take the time to thank these sponsors.

Again, I would like to take this time to invite any of you, who are interested in serving on different committees or running for office, to consider the same and be present at our annual membership meeting, on Saturday, August 1.

Each year, your organization tries harder to out perform the previous year. The past board and conference chairmen have done an outstanding job in making the next year's programs easier to coordinate. I thank them for their experience and guidance they have provided me.

If for no other reason, everyone should be here to thank T. R. Sharp, D.O. for his many years of service to the Texas ACGP as well as National ACGP.

Sincerely,

Howard H. Galarneau, Jr., D.O.
President, Texas Society of ACGP

Thirty-Fifth Annual Convention and 19th Mid-year Clinical Seminar

Presented by

Texas State Society of the American College of General Practitioners in Osteopathic Medicine and Surgery
in cooperation with the Texas College of Osteopathic Medicine
34 CME Hours AOA — Category 1-A

Banjamin C. Young, D.O.
Program Chairman

Program

July 30 - August 2, 1992
Doubletree Hotel at Park West

Thursday, July 30, 1992

4:00 p.m. Registration

5:00 p.m. Buffet Dinner

5:45 p.m. Welcome: *Howard Galarneau, D.O.*
President, Texas Society ACGP

6:00 p.m. "Otitis Media, Revisited"
Sandor Feldman, M.D.

6:45 p.m. "Breakthrough Hypertension"
Albert A. Carr, M.D.

7:30 p.m. "Alternatives in Peptic Ulcer Disease"
Jay Beckwith, D.O.

8:15 p.m. "Pain and Symptom Management"
C. Statton Hill, M.D.

Friday, July 31, 1992

7:00 a.m. Registration, Breakfast Buffet & Lecture
"Clinical Decision Making in Hormone Replacement"
Carol Browne, D.O.

7:30 a.m. "To Smoke Or Not To Smoke — Is It Easier Now?"
John Licciardone, D.O.

8:15 a.m. "HIV, Still Controversial?"
Hunter Hamel, M.D.

9:00 a.m. "Depression, Is It Anything to Worry About?"
Howard Masco, M.D.

9:45 a.m. Break with Exhibitors

10:15 a.m. "Psychiatric Drug Uses"
Fred Petty, M.D.

11:00 a.m. "Those Pesky Allergies"
Bruce Martin, D.O.

11:45 a.m. Lunch with the Exhibitors

1:00 p.m. "Substance Abuse and Risk Factors"
Joel Spike, D.O.

1:45 p.m. "Diagnosis and Treatment of Post MI Complications"
Dale Bratzler, D.O.

2:30 p.m. Break with Exhibitors

Optional Breakout Workshops
"Flexible Sigmoidoscopy"
Monte Troutman, D.O.
"Radio Surgery"
Don DeWitt, M.D.

2:45 p.m. "Helping Your Patients With Obstructive Airway Disease"
Robert E. Mancini, D.O., Ph.D.

3:30 p.m. "Useful Osteopathic Techniques"
Mary Ann Block, D.O.

4:15 p.m. Break with the Exhibitors

4:30 p.m. "Acute MI Risk Management"
James M. Atkins, M.D.

5:15 p.m. "Risk Factors of Artificial Implants — Controversies in Breast Implantation"
William J. Rea, M.D.
"Techniques"
Mary Ann Block, D.O.

7:30 p.m. Hospital Appreciation Night

Saturday, August 1, 1992

7:00 a.m. Registration, Breakfast Buffet & Lecture
"Immunizations, Latest Rules and Schedules"
Susan Dusek, D.O.

7:30 a.m. "Newer Concepts in Osteoarthritis"
Bernard Rubin, D.O.

8:15 a.m. Benign Prostatic Hypertrophy, What Can Be Done"
Aaron Kirkemo, M.D.

9:00 a.m. "Management of Human Papilloma Virus Infection"
Dudley Goetz, D.O.

9:45 a.m. Break with Exhibitors

10:15 a.m. "Considerations in Using NSAID's in the Elderly"
Mitchell Forman, D.O.

11:00 a.m. "Malpractice Risks with Hospitalized Patients"
Rosemary Gafner, Ed.D & Chris Launey, MBA

12:30 p.m. Luncheon and Annual Texas ACGP Membership Meeting

1:30 p.m. "Osteoporosis, A Delicate Matter"
Sydney Bonnick, M.D.

2:15 p.m. "Renal Failure, Not a Zebra"
Jack O. Gratch, D.O.

2:30 p.m.

Optional Braeakout Workshops
"EKG Interpretation"
Len Scarpinato, D.O.
"Medicare Update"
Don Self

3:00 p.m. "Parkinson's Disease"
William McIntosh, D.O.

4:00 p.m. "Rheumatoid Arthritis, Options to Consider"
Jeffrey Carter, D.O.

4:45 p.m. "The Diabetic Foot"
E. Farley Verner, M.D.

5:30 p.m. "Infections Encountered in the Elderly"
David V. Espino, M.D.

7:00 p.m. Presidential Installation and Awards Dinner

Sunday, August 2, 1992

7:00 a.m. Registration, Breakfast Buffet & Lecture
"Charting Techniques"
Linda Holland, CFNP

7:30 a.m. "The News in Coronary Artery Disease"
Russell Fisher, D.O.

8:15 a.m. "Differential Diagnosis in Chronic Arthritidies"
William O'Brien, M.D.

9:00 a.m. "What's New in Asthma"
Terry Miller, D.O.

9:45 a.m. Break with the Exhibitors

10:00 a.m. "P.I.D. and Chlamydia"
David Hemsell, M.D.

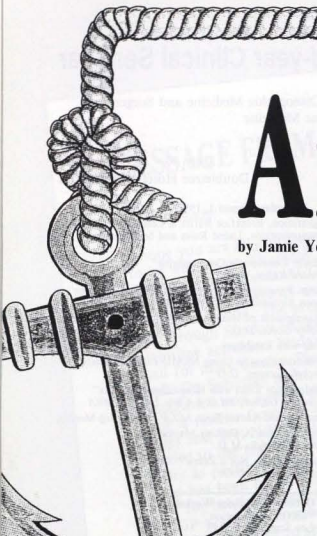
10:45 a.m. "Angina, Dx and Tx"
Len Scarpinato, D.O.

11:30 a.m. "Sexuality in Menopause and Beyond"
Jane Chiñal, M.D.

12:15 p.m. Luncheon Buffet & Lecture
"Medical Practice in Today's Legal Climate"
Martin I. Kalish, M.D., L.D., J.D.

1:00 p.m. "Consider the Sexual Needs of Your Elderly Patients"
William Shapiro, M.D.

1:45 p.m. "Nitrates as MI Preventioin"
Lloyd Brooks, D.O.



Anchored h

by Jamie Yeatts, Lubbock Avalanche-Journal

Navy Pals Maintain 46-Year R

Dr. Robert Maul and his military buddy Ralph Mountz remember the comradery that they felt while serving together during World War II. The common bond that brought the two men together has allowed them to remain friends for 46 years.

The long friendship began in Newport, R.I., where both men were sent to form a ship's company following their enlistment in the United States Navy.

Maul, an osteopathic physician in Lubbock, and Mountz, a steelworker retiree from Robesonia, Pa., were reunited in April when Mountz and his wife, Jean, came to Lubbock for a visit.

Although the families had corresponded through the years by letters, Christmas cards and an occasional phone call, the recent meeting was only the men's second in 46 years. Their first post-war get-together was in June 1991 when Maul and his wife, whose name also is Jeanne, made a one-day jaunt to Pennsylvania during a trip to visit Maul's sister in Baltimore.

"We just kept saying 'one of these days we're going to get together,'" Maul said. "We always had good intentions."

For the reunion in June, the couples had planned to meet at the Amish information center in Lancaster, Pa., Mountz said, because it was a more convenient location.

"We saw a lot of cars when we pulled into the center," Maul said. "But then I saw one car parked in a shady spot and somehow I knew it was Ralph."

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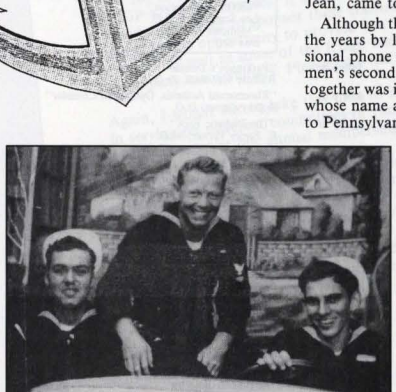

NAVY DAYS — Ralph "Moose" Mountz of Pennsylvania, left, Dr. Siegel of Massachusetts, are shown here as they take a break from Mountz, who have remained friends since their days as naval com entertainment highlights during World War II.

Friendship

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FRIENDS FOREVER — Dr. Robert Maul, left, a Lubbock osteopathic physician and certified general practitioner, and his longtime friend and Navy pal Ralph Mountz, a retired steelworker from Robesonia, Pa., reminisce about their wartime experiences as they look through photos from the past. The men recently were reunited for the second time in their 46-year friendship.

of Lubbock, center, and James
ing a liberty outing. Maul and
, bands and buddy clubs were

Training Employees Required Under OSHA Regulations

The second part of Texas Medicine's *series on the new OSHA bloodborne pathogens standard focuses on training and recordkeeping requirements that go into effect June 4, 1992.* Texas Medicine *contacted Jane Matheson, JD, a partner with the law firm of Hughes & Luce in Austin and a former deputy assistant secretary of labor for OSHA, to obtain further information about the nature of the training and recordkeeping requirements and the manner in which these requirements should be implemented. Kathryn A. Christmann, JD, also with Hughes & Luce, provided research for this article.*

THE OSHA BLOODBORNE pathogens standard requires an employer to train all employees with occupational exposure to bloodborne pathogens about the hazards associated with blood and other potentially infectious materials and the protective measures to minimize the risk of occupational exposure. An employer is also required to maintain records related to bloodborne pathogens, including exposure incidents, postexposure follow-up, hepatitis B vaccination status, and training for all employees with occupational exposure.

Physician/employers inadvertently may be vulnerable to citations for recordkeeping violations, says Jane Matheson, JD.

"Some physician/employers are already subject to certain OSHA recordkeeping regulations," she says. "Specifically, any physician/employer with 11 or more employees is required to maintain a log and summary of all recordable occupational injuries and illnesses for his or her place of business. This summary is commonly referred to as an OSHA 200 log.

"During the past several years, OSHA has focused greater enforcement efforts on obtaining compliance with recordkeeping obligations and has issued some very significant proposed penalties for recordkeeping violations. While monitoring recordkeeping compliance in the health services field was not common in the past, with the promulgation of the final standard on bloodborne pathogens, all required recordkeeping obligations will most likely become the target of greater scrutiny. In the event of an OSHA inspection, physician/employers should be prepared to provide the required OSHA 200 logs as well as records relating to bloodborne pathogens," says Ms Matheson.

Effective training is critical

Effective training is a critical element of an employer's exposure control plan. Proper training will help reduce the risk of occupational exposure, thereby reducing exposure-related infection, illness, and death.

Every employee should leave a training session with a basic understanding of the following items:

1. the hazards associated with bloodborne pathogens, particularly human immunodeficiency virus (HIV) and hepatitis B virus (HBV);
2. the modes of transmission and the symptoms of HIV and HBV;
3. the employer's exposure control plan;
4. the use of engineering controls, such as self-sheathing needles;
5. the use of work controls, such as the proper disposal of contaminated needles and other sharps;
6. the proper use of personal protective clothing, such as gloves and face shields;
7. the appropriate actions to be taken in the event of an emergency involving exposure to blood and other potentially infectious material; and
8. the reasons to participate in the hepatitis B vaccination program and in postexposure evaluation and follow-up.

The purpose behind these requirements is to ensure that employees are aware of the dangers associated with bloodborne diseases and the need to observe precautions. Employees must also be able to recognize symptoms so that they will be able to seek medical treatment in the event such treatment becomes necessary.

Training for all employees

A covered physician/employer must provide training to all employees with occupational exposure to bloodborne pathogens regardless of their professional education or other credentials. Therefore, nurses and physicians are required to participate in the training program to the same extent as housekeeping personnel with occupational exposure. The standard, however, does allow the employer some flexibility in tailoring the program to the employee's background and responsibilities.

June 4 deadline for training

A physician/employer must provide free training by June 4, 1992, to all current employees with occupational exposure.

Training also must be provided at

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

the time of initial employment for employees with occupational exposure and when there is a change in an employee's responsibilities, procedures, or work situation that would affect such employee's occupational exposure. The standard does contain a limited exception for employees who have received training on bloodborne pathogens in the year preceding the effective date of the standard. These employees, however, will still need to receive training with respect to those provisions of the standard that were not included in their original training.

Finally, the standard requires a physician/employer to provide additional training annually in order to reinforce the initial training and to provide an opportunity for the employer to present new information that was not available at the employee's initial training.

All training must be conducted during working hours at no cost to employees and at a reasonable location. It is customary for the US Department of Labor to take the position that an employer must pay employees for time spent in training.

Meeting the standard training requirements

In its explanation of the training provisions, OSHA has stated that the "training information presented must be understood by the employee; otherwise the training will not be effective" (56 Fed Reg 64166 [Dec 6, 1991]). Consequently, the standard reflects OSHA's emphasis on comprehension by requiring all training information to be provided in a manner appropriate in content and vocabulary to the educational, literacy, and language background of the employees in the training session. While OSHA has not expressly mandated that employers be able to document employee comprehension of training, the OSHA compliance directive instructs compliance officers to interview employees to determine that the training was appropriate.

To demonstrate good faith compliance efforts, physician/employers may want to document that question and answer opportunities occurred. Physician/employers may also want to consider holding multiple training sessions, depending upon the cultural and educational diversity of their employees. However, if any physician/employer elects to supplement the required training through the use of written examinations, care should be taken to avoid testing devices that inadvertently result in an adverse impact on members of a class protected by virtue of race, sex, and national origin.

All training must be conducted during working hours at no cost to employees and at a reasonable location.

The training program must address the needs of the particular employees being trained, including focusing on the specific responsibilities of each employee in the training program and how he or she may be occupationally exposed to bloodborne pathogens. Employees must also be able to recognize when they are at risk of exposure to blood and other infectious materials. Additionally, the person conducting the training must be knowledgeable about the subject matter of the training program as it relates to the employee's workplace.

Employees must also be given the opportunity to clarify any concerns regarding occupational exposure. The standard thus requires the training session to provide employees with the opportunity for interactive questions and answers with the person conducting the training session. Both the standard's preamble and OSHA's compliance directive caution that audiovisual presentations and commercial workbooks may not be substituted for the presence of a qualified trainer, although they may be used to supplement the presentation. Likewise, informal discussions are insufficient to satisfy the training requirements of the standard; a more formal program is required.

Obligations involving record-keeping

In addition to standards such as the one requiring the OSHA 200 log, the bloodborne pathogens standard requires a physician/employer to maintain medical and training records for each employee with occupational exposure. OSHA says these records are necessary to assure that employees receive appropriate information on hazards and effective prevention and treatment measures as well as to aid in developing data on the causes of occupational illnesses and injuries involving bloodborne pathogens.

An employee's medical records will include the employee's name and social security number, a copy of the employee's hepatitis B vaccination status, a copy of all results of examinations, medical testing, and follow-up procedures related to postexposure evaluation, the employer's copy of the health-care professional's written opinion, and a copy of all information required to be provided to the health-care professional treating the employee. Although it is the

physician/employer's duty to create and maintain an employee's medical records, the actual records may be kept in the office of a physician (other than the physician/employer) or other health-care professional who is responsible for treating the employees. Moreover, an employee's medical records do not need to be stored in a separate file as long as the existing file is kept confidential.

Once an obligation arises to create and maintain medical records, a physician/employer should also be aware of obligations under the access to medical records standards 1910.20 of Title 29 of the Code of Federal Regulations. This standard requires an employer to provide periodic notices to employees, advising them of the existence of covered records and the means and methods of securing access to such records.

A physician/employer is also required to maintain training records that show the dates of training sessions, the contents or summary of the sessions, the names and qualifications of the persons conducting the sessions, and the names and job titles of all persons attending the sessions. These requirements are meant to assist the employer and OSHA in determining whether the training program adequately addresses the risks involved in each job and whether each employee with occupational exposure has received the proper level of training.

Access to medical and training records

A physician/employer is responsible for ensuring that an employee's medical records are kept confidential and that they are not disclosed or reported to any person without the employee's express written consent, except as required by the standard or by applicable law. In this regard, the standard provides that an employee's medical records shall be made available to the subject employee, anyone having written consent of the subject employee, and the director of the National Institute for Occupational Safety and Health (or designated representative). In addition, an employer must remove any personal identifiers from information relating to bloodborne pathogens contained in an OSHA 200 log before granting access to such log. Although not mandated by the standard, the creation of a plan to ensure the confidentiality of employee medical records is strongly encouraged.

Unlike employee medical records, employee training records are not required to be kept confidential. Upon request, training records are to be provided to employees, employee representatives, the director of the National Institute for Occupational Safety and Health (or designated representative), and the assistant secretary of labor for Occupational Safety and Health (or a designated representative).

Employment duration plus 30 years

A physician/employer must keep an employee's medical records for the duration of employment plus 30 years. For purposes of this requirement, the standard makes no distinction among temporary, permanent, full-time, and part-time employees. Training records, on the other hand, must only be kept for 3 years from the date on which the training occurred. If a physician/employer ceases to do business and there is no successor employer to retain the medical and training records in accordance with the standard, the employer must transmit all of the covered medical and training records to the director of the National Institute for Occupational Safety and Health (or a designated representative).

Does Your Office Meet OSHA Standards?

Hugh M. Barton, JD
TMA Assistant General Counsel

On March 6, 1992, the Occupational Safety and Health Administration released information about its enforcement procedures for the bloodborne pathogens standard. These consist of instructions designed to establish policies and provide clarifications to ensure uniform inspection procedures. This article addresses only OSHA inspections for the bloodborne pathogens standard.

Q: What things will an OSHA inspector want to see in my office?

A: The OSHA inspector will want to review your office's exposure control plan and interview your employees to determine the degree of compliance with the bloodborne pathogens standard. If your office has a file of "incident reports" or a first aid log of injuries, the inspector will want to see this, too.

Q: What will the OSHA inspector look for in my exposure control plan?

A: The exposure control plan will be reviewed for several elements:

- Those job classifications in which all employees have occupational exposure.
- Those job classifications in which some employees have occupational exposure. For these employees, the specific tasks that have occupational exposure must be delineated.
- Exposure determinations must be made *without* taking into consideration the use of personal protective clothing or equipment.
- The schedule and method of implementation of the compliance, hepatitis B vaccination, hazard communication to employees, and recordkeeping requirements must be included in the exposure control plan. It may be adequate for small offices to have a copy of the final federal rules with dates of compliance written on it.
- The exposure control plan must detail procedures for evaluating exposure incidents.
- The exposure control plan must be available to employees within 15 days upon the employee's request.

Q: What records will I have to keep to satisfy the OSHA bloodborne pathogens standard?

A: OSHA is particularly interested in records of "occupational bloodborne pathogens exposure incidents." These include all needle sticks, lacerations, or splashes of blood or other body fluids and are considered to be injuries. These are to be recorded if any one of the following occurs: it is work-related; the incident results in a recommendation for medical treatment beyond first aid, regardless of dosage; and a diagnosis of seroconversion occurs.

Q: How is a worker's serostatus to be recorded in OSHA records?

A: The serological status of an employee is not to be recorded in the record. It should be recorded only as an injury (eg, "needle stick") with the date it occurred.

Q: How do I know which employees are covered by the bloodborne pathogens standard?

A: Your employees are covered if, as a result of job duties, they have "reasonably anticipated" skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials. The term "reasonably anticipated" includes the *potential* for exposure as well as *actual* exposure. Thus, the lack of history of blood exposures for first aid personnel does not preclude coverage, since there is always a potential.

Q: What practices are acceptable for compliance with the universal precautions requirement?

A: While "universal precautions" — the concept of bloodborne disease control that requires all human blood and other materials to be treated as if known to be infectious for HIV or HBV regardless of the perceived low risk of the patient — is OSHA's accepted method of control; an acceptable alternative is "Body Substance Isolation" (BSI). BSI defines all body fluids and substances as infectious and is broader than the bloodborne pathogens standard. What is *not* acceptable to OSHA is the policy of treating the blood or other materials of some patients as potentially infectious and the blood or other materials of other patients (such as children or the elderly) as not infectious.

Q: What else will the OSHA inspector look for?

A: Through interviews and observation, the inspector will determine whether proper engineering and work practice controls are being followed, such as the immediate disposal of used needles into a sharps container. A citation may be issued when there is a failure to use proper work practice controls, with an additional citation if the inspector decides that inadequate training caused the failure. Further, a citation may be made if there is no system for the regular checking of the work practice controls.

Q: How does a surgeon perform procedures that minimize splashing, spraying, spattering, and generation of blood droplets in accordance with OSHA guidelines?

A: Although surgical power tools, lasers, and electrocautery devices may generate aerosols, OSHA does not believe that current data support the mandatory use of respiratory protection for aerosol exposure, nor does OSHA believe that there is an effective engineering control to address aerosol exposure. However, OSHA does support the use of eye protection and a mask or a face shield.

Q: I know that I am responsible for providing my employees with "personal protective equipment" such as laboratory coats, gloves, scrubs, and the like. Can the employee take these items home for cleaning?

A: No. Home laundering is not permitted by OSHA because an employer cannot guarantee that proper handling or laundering procedures will be followed. OSHA will find a violation if the employer does not clean these garments or cleans them but charges the employee for the cleaning. OSHA will also find a violation if the employer charges an employee for repairs or replacement of the garment or other protective device.

Q: Exactly what things are considered to be "regulated waste" that require special care in disposal?

A: Although OSHA has not determined the degree of infectivity of certain medical wastes, the following categories, at a minimum, require special handling:

- liquid or semiliquid blood;
- items contaminated with blood or other potentially infectious materials that would release these substances in a liquid or semiliquid state if compressed;
- items caked with blood or other potentially infectious materials that are capable of being released during handling;
- contaminated sharps; and
- pathological or microbiological wastes containing blood or other potentially infectious materials.

OSHA inspectors are instructed never to squeeze or shake a bag of waste to determine the potential for release of blood or other potentially infectious materials during an inspection. While OSHA specifies certain features of regulated waste disposal, the ultimate disposal method is the responsibility of the Environmental Protection Agency and state regulations.

Q: My medical office is small. How do I comply with the regulated waste disposal rules?

A: If only a small volume of regulated waste is generated, that waste may be placed in a large holding container until the container is filled. The container must be designed to retain the waste over an extended time between pick-ups by a specialized waste service. The OSHA inspector will check for visual signs of leakage during handling, storage, or transport.

Q: I have a professional association. How will the enforcement procedures affect me personally?

A: OSHA considers physicians who are members of professional associations to be employees of the corporate entity. Thus, the professional association may be cited for violations affecting employed physicians, such as failure to provide the hepatitis B vaccine to themselves. On the other hand, physicians in solo practice are not "employees" under the Occupational Safety and Health Act; thus, a physician will not be cited if he or she is the only person who has an occupational exposure. Nor will a physician be cited if he or she is a partner in a medical partnership. Note, however, that this applies only to the activities of the physicians themselves. To the extent that the physicians employ other persons they will be responsible for compliance with OSHA requirements relative to those employees.

Q: I know I have to provide the hepatitis B vaccination to my employees beginning July 6, 1992. What are the rules for this?

A: OSHA requires that the vaccine, or more precisely, the series of vaccinations be provided at no cost to the employee. This means no "out of pocket" cost to the employee. An employer may not require the employee to use his or her health insurance to pay for the vaccination series unless the employer bears the cost and there is no deductible or copayment to the employee for the series. The employer may not have a policy of requiring the employee to pay for the series and be reimbursed by the employer if the employee is employed for a specified period of time. Finally, a contract under which the employees reimburse the employer for the cost of vaccination if they leave employment prior to a specified time is prohibited.

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SmithKline Beecham Awards Over $120,000 to Osteopathic Medical Colleges

Five colleges of osteopathic medicine have won grants totalling more than $120,000 for innovative projects to enhance medical education. The grants have been provided by the SmithKline Beecham Foundation through its FOCUS Program — Funds for Osteopathic Colleges in the United States. Administered annually by the American Association of Colleges of Osteopathic Medicine (AACOM), the FOCUS program enables osteopathic medical schools to experiment with new educational approaches and carry out other academic projects, such as development of new resources to aid student learning and new initiatives aimed at faculty development.

Under the competitive program, SmithKline Beecham has underwritten grants of nearly $870,000 since 1985. Winning proposals were selected in May by a Peer Review Panel comprised of four representatives from the osteopathic medical colleges, plus an independent, higher-education consultant.

"FOCUS is an exceedingly competitive and popular grant program," said Philip Pumerantz, Ph.D., AACOM Board Chairman and President of the College of Osteopathic Medicine of the Pacific in Pomona, California. "This is evident," he said, "from the fact that 13 of our 15 colleges submitted proposals for some highly innovative program."

The schools that won 1992 FOCUS Awards are as follows:

Chicago College of Osteopathic Medicine — will establish a course to help prepare medical students to handle physician-patient interaction with confidence and skill in a variety of cultural settings. $23,878.

College of Osteopathic Medicine of the Pacific — will conduct a series of activities to enhance the understanding and awareness of osteopathic medicine as a potential career path for underrepresented minority students. $24,286.

New York College of Osteopathic Medicine of New York Institute of Technology — will study whether Osteopathic Manipulative Therapy, in conjunction with standard drug therapy, is effective in alleviating gait associated effects due to torticolis. $24,286.

Ohio University College of Osteopathic Medicine — will conduct a program to help faculty members develop the skills needed to plan, implement, and evaluate changes in the curriculum. $24,265.

Philadelphia College of Osteopathic Medicine — will develop a teaching center for anatomy students, which will employ a new plastination technique for producing dry, durable whole specimens that students can easily handle and use at all levels of training and practice. $24,285.

The AACOM is the national organization for the 15 colleges of osteopathic medicine in the United States. AACOM is dedicated to the advancement and enrichment of osteopathic medical education. ■

OU-COM Dean to Return to Teaching, Medical Practice Next Year

Frank W. Myers, D.O., dean of the Ohio University College of Osteopathic Medicine (OU-COM), has announced his plans to step down as dean in June 1993 and return to a "very fondly remembered life as an osteopathic family physician and teacher."

Myers' intentions were conveyed to OU-COM faculty members by OU President Charles J. Ping at a general meeting. Ping noted that Dr. Myers, who became dean in 1977, has held that post longer than any other medical school dean in the state. He lauded Dr. Myers for decisions that were "consistently for the benefit of the college and the University."

"All of us are grateful for the extraordinary leadership you provided during the critical period of the founding of the college and the establishment of direction in its life," Ping said.

Dr. Myers said that he was proud of the many accomplishments of his tenure as dean but that there was much left to be done. He said that he looks forward to resuming his duties as a professor of family medicine and to seeing patients at the OU Osteopathic Medical Center. "Throughout the turbulent years of the founding of the college, we were able to maintain our focus on our mission to train D.O.s for underserved areas of Ohio," Dr. Myers said. "We developed an innovative educational model which has done an outstanding job of preparing well-rounded osteopathic physicians." ■

Dr. George Grainger Announces Retirement

H. George Grainger, D.O., FAAO, of Tyler, has announced his retirement from the practice of osteopathic medicine as of June 1, 1992. He has practiced for 63 years, with 56 of them in Tyler, and his list of personal and professional accomplishments is outstanding.

A 1929 graduate of Kirksville College of Osteopathic Medicine, Dr. Grainger has been a member of TOMA since the 1930s. He is a life member of both TOMA and the AOA, and served as TOMA president from 1948-49. He was the founding president of TOMA District III, serving as its president in 1971, and as secretary for numerous years.

Dr. Grainger was a member of the founding board of directors of Texas College of Osteopathic Medicine in the years before it became state supported in 1975. In 1986, TCOM awarded him a Founder's Medal, the highest award the college gives for contributions to medical education.

In 1986, he was awarded a 50th anniversary medallion by his alma mater, KCOM. These impressive gold medallions are presented to each alumnus who has celebrated 50 years and more as an osteopathic physician in recognition and appreciation for dedicated service to the osteopathic profession.

Dr. Grainger was chosen as the "General Practitioner of the Year" in 1967 by the Texas Society of ACGP due to exemplary service to the profession.

He was founding president of the Texas Academy of Applied Osteopathy. In 1963, fellowship in the American Academy of Osteopathy (AAO) was conferred, only the second year the earned fellowship program was in operation. He has been a member of the AAO since 1949, and their 1973 Academy Year Book was dedicated to Dr. Grainger.

Throughout the years, Dr. Grainger has been active in public health and civic affairs as well as serving as lecturer at state and national conventions. His loyalty and dedication to the profession is an inspiration to others.

On behalf of the Texas Osteopathic Medical Association, we offer our congratulations and best wishes to Dr. Grainger on the occasion of his retirement. ■

Campus Talk

TCOM Student Honored For Record-Setting Volunteer Service

Greg Willis, a second-year student at Texas College of Osteopathic Medicine, recently received an award for donating more time to community service during a school year than any other TCOM student in the last five years.

Willis, a Fort Worth native, volunteered 150 hours during the 1991-92 school year, far exceeding the four hours that all second-year students are required to complete. His activities included teaching first aid to Boy Scouts, anatomy to elementary school students and medical microbiology to family practice residents at John Peter Smith Hospital; and providing physicals for Boy Scouts and Texas Special Olympians.

The contributions and academic achievements of Willis and dozens of other TCOM students were honored at TCOM's 1992 Honors Day ceremony, held May 21 in the college's auditorium. As the 1992 Ciba-Geigy Community Service Award winner, Willis received a 12-volume set of medical instructional materials in recognition of his volunteer activities.

Willis is a 1982 graduate of Arlington Heights High School in Fort Worth. He received his B.S. degree in microbiology from the University of Texas at Arlington in 1989.

TCOM is a four-year, state supported medical school under the direction of the University of North Texas Board of Regents. ■

TCOM Class of 1996 Filled

On May 4, the 100th accepted applicant paid a $100 deposit to hold his place in the TCOM Class of 1996, officially filling the incoming class.

This year's incoming class was filled more than two months earlier than last year's class, said T. John Leppi, Ph.D., associate dean for admissions. "Last year we filled the class on July 11," he said. "We had a lot of great, unqualified support from faculty, alumni, staff and administration this year that made this possible. We hope to fill the class even earlier next year."

Ninety Texans and 10 non-residents comprise the class. Texas applicants increased 30 percent over last year. Some 465 Texas residents applied for admission to TCOM this year, the largest recorded number of Texans to apply to the college. ■

ATOMA NEWS

By B. J. Czewski, ATOMA Funds Chairman

ATOMA feels very proud of their fund-raising efforts this year. Any special event takes hard work, attention to details and lots of planning, but the satisfaction of raising funds makes it all worthwhile. With lots of help from our friends at the TOMA office (Diana, Dana, Nancy and Keri), and many special ATOMA members, we achieved our greatest expectations. Our total amount raised after expenses was $21,315.

We thank everyone who helped at our membership table, selling raffle tickets, golf shirts and hats. A very special "thank you" goes to everyone who donated gifts for door prizes. It really made our President's Night exciting for everyone, especially the winners of our Caribbean Cruise: Dr. Sam and Elie Nixon of Houston. P.S. Dr. Nixon is president of the Texas Medical Association. Congratulations!

From ATOMA to Rita Baker and her family, upon the loss of her father, Tommy Galbrath: In your sorrow may you be comforted by the love of friends, strengthened by your faith in life and sustained by the neverending love of God.

Congratulations to our newest ATOMA member, Diana Finley. Welcome! We are really glad to have you as a part of our association. ■

Workers' Compensation Commission to Assess Penalties

All employers who have chosen not to obtain workers' compensation insurance should have filed notice of no coverage with the Texas Workers' Compensation Commission by May 15. Beginning in July, the Commission will assess a penalty of $500 per day for each delinquent employer the Commission has to "find." All employers should have received proper forms. Mail notices of no coverage to Texas Department of Insurance, Subscriber Notice-MC2021A, P.O. Box 149106, Austin, Texas 78714. For information or to obtain a notice, call (512) 448-7900.

(TexasBusiness Today, June 1992)

Missionary Trip is Rewarding Experience

Some Christmas presents are soon put away and forgotten, but one special Christmas gift has kept on giving. Last December, four dedicated volunteers set out for Mexico to bring the gift of sight to 130 villagers. Now these once visually impaired people are enjoying the beautiful sights of spring, some for the first time in years.

William Ranelle, D.O., staff physician at Osteopathic Medical Center of Texas and clinical/adjunct professor at Texas College of Osteopathic Medicine, learned of the lack of vision care in Mexico through a Baptist missionary. To meet the tremendous need for eye care, Dr. Ranelle and his wife, Linda; Phoebe Reaves, C.O.A.; and Jo Ann Wester, C.O.A.; organized a three-day missionary trip to Durango, Mexico. Their grueling schedule included treating or performing cataract surgery on 130 patients.

"It was the experience of a lifetime," exclaimed Jo Ann. "I'd go again in a minute."

"The exciting part for us was to see the great need that existed down there, and know that we could help," said Dr. Ranelle. "They had people of all ages with cataracts, even children."

In fact, that rate of cataracts in Mexican people over the age 35 is 70 percent, according to statistics cited by the social service agency which provided assistance to Ranelle's crew. This agency screened potential patients by taking those who could not see at all.

Dr. Ranelle said the extremely high rate of cataracts could probably be contributed to poor nutrition. Chemical plants in the vicinity are also a possible factor.

These patients were from mountain villages outside of Durango, and they traveled on foot to the clinic. Ranelle's group was detained nine hours at the airport by fog, and these villagers slept in the fields, even though it snowed that night, determined to wait for the doctor.

The volunteers were overwhelmed when they finally reached Durango and saw all the villagers waiting expectantly. "It was very moving just to see the expression of hope on their faces," said Linda.

Months before the trip they collected donations and supplies from organizations, including One Day Surgery Center. ODSC also worked with Jo Ann and Phoebe to help them prepare for assisting the cataract procedures. Alcon donated a vital piece of equipment — a phaco emulsifier, which performs the most modern small-incision cataract surgery.

According to Linda, one of the hardest parts of the trip was setting up the two operating rooms at the clinic in Durango. More than 30 boxes were shipped to Mexico and within four hours they were all unpacked, and Dr. Ranelle was ready to see patients.

"The clinic was circa 1955 by our standards," said Linda. "But it was more sterile than we had anticipated, and we were fortunate to have the facility."

During the cataract surgeries, the staff did not administer IVs or put the patients to sleep as they do here. Although Phoebe said you could never do that here in the United States, the Mexican patients were very stoic and not a bit afraid of the procedure. "They were so eager, they didn't even flinch," said Phoebe.

Dr. Ranelle and his staff communicated with the Mexican patients through interpreters, but they all picked up some Spanish to get through the exams. And the Mexican nurses learned a few English words as well.

The surgeries were successful, and they had no complications. Dr. Ranelle said most patients showed remarkable improvement the day after surgery. When the patients came back for post-operative instructions, they were incredibly grateful.

"They showered us with food," said Jo Ann. The villagers brought cheese, avocados, rice, tortillas and other Mexican specialties.

Dr. Ranelle, Linda, Jo Ann and Phoebe had such a positive experience on their first missionary trip, they are making plans to go again.

Phoebe is getting ready to take a Spanish class because she says she would like to be able to communicate with the patients herself on her next missionary trip.

"Although we have a system now that we want to continue, the expense is considerable to transport the equipment and supplies," said Dr. Ranelle. "That, unfortunately, is a limiting factor."

But the gift of sight cannot be measured in dollars. "You're helping those people's lives," Dr. Ranelle said. "There's no doubt about it." ■

New Phone Numbers At CPSC

Phone numbers for the United States Consumer Product Safety Commission have been changed. The new numbers for selected offices are as follows:

Office of Information and Public Affairs .....(301) 504-0580

National Injury Information Clearinghouse....(301) 504-0424

Office of the Secretary .....(301) 504-0800

Freedom of Information .....(301) 504-0785

TCOM Officials Help Break Ground for Stop Six Clinic

Groundbreaking held for Stop Six Clinic — Participating in the April 24 groundbreaking for the Stop Six Community Health Center were *(L-R)*: A. Ray Lewis, D.O. TCOM Class of '86; TCOM President David M. Richards, D.O.; community leader Mrs. Walter Barbour; Andy Rivera of UNT, executive assistant to Chancellor Al Hurley; and Benjamin L. Cohen, D.O., TCOM executive vice president for academic affairs and dean.

Representatives of Fort Worth, Tarrant County, the county hospital district and the community joined officials of TCOM and the University of North Texas on April 24 to break ground for a primary health clinic to serve the medically underserved residents in Fort Worth's Stop Six neighborhood. The Stop Six Community Health Center will be built at Stallcup Road and Pinson Street in Southeast Fort Worth.

The symbolic beginning of construction on the new clinic culminated efforts that began in 1989 when community leaders Marion "Jap" Jones and Mrs. Walter Barbour helped form an organization, Stop Six Community Services Inc., to obtain and manage a family health care clinic to serve residents of the neighborhood. The area has 16,000 residents, no clinic, only one private physician who will retire soon and little, if any, access to basic health care services.

Sarah Peyton, Greg McQueen, and Drs. Benjamin Cohen, Tim Coleridge, John Mills, Reni Courtney and Greg Smith from TCOM, along with Dr. Susan Eve of UNT, began working with the Tarrant County Hospital District and other institutions began working with the community group. UNT and TCOM representatives wrote a grant proposal for federal funds to build the clinic. Through Fort Worth Councilman Eugene McCray's leadership, the council approved $400,000 in federal grant funds. The hospital district has pledged $600,000 annually for the clinic's operation. TCOM will provide the services of a fulltime board-certified physician and a resident physician four half-days per week at the clinic. A grant proposal for additional funding has been submitted to the Robert Wood Johnson Foundation in Washington, D.C. The Amon Carter, Richardson and Tandy foundations of Fort Worth have pledged funds to match the grant from the Johnson Foundation.

"This clinic represents more than the building the health care it will provide," President David M. Richards, D.O., said at the groundbreaking. He described it as the very fabric of bringing together foundations, the hospital district, the community, TCOM and physicians in an unprecedented spirit of cooperation among health care institutions. "We think that as we go forward with our colleagues from the Tarrant County Hospital District that this clinic can be a model for future partnerships in providing adequate health care to those who need it most."

Tim Philpot, hospital district president and CEO, said that "the type of collaborative effort that you who live in this community have insisted on is a method that those of us in health care leadership must respect." ■

Blood Bank Briefs for Physicians

PreOperative Autologous Blood Donations by High-Risk Patients

Margie B. Peschel, M.D., Medical Director — Carter Blood Center, Fort Worth, Texas

Transfusion practices have changed dramatically in this country since the 1980's. The hematocrit level considered as the development of alternative to homologous transfusion with use of hemodilution intraoperative cell salvage and preoperative autologous blood donation.

A consequence of the increased awareness of the advantages of autologous blood transfusion has been an increased number of medically high risk patients requesting preoperative phlebotomy. Also, the number of older potential autologous donors with cardiovascular disease continues to expand in proportion to the "graying" of the general population. One practical effect of these events is a dilemma that occurs not infrequently, when the high risk candidate for autologous donation present themselves at the blood center and an on spot accept or reject decision must be made.

Patients categorized as high risk are if one or more of the following criteria are met:

A history of angina, previous myocardial infarction, cardiac arrythmias, hypertension requiring two or more medications for control, congestive heart failure, valvular heart disease, congenital heart disease, seizure disorder, previous cerebrovascular accident or demonstrated cerebral vascular insufficiency. Patients with unstable angina, aortic stenosis or a recent myocardial infarction are deferred.

In view of the risk of hemodynamic changes which occur from phlebotomy, Carter Blood Center must have a conservative approach for the evaluation of high risk candidates for preoperative autologous donation. First, the medical director makes every effort to ensure that high risk donors, especially elderly ones, undergo phlebotomy only when there is a reasonable likelihood that presurgical donations will be transfused. The medical director is available at the time of donation. Second, we encourage every effort be made to include perioperative hemodilution and/or intraoperative salvage in the management of high risk patients who may develop hemodynamic instability during a phlebotomy. Many of these patients will be undergoing cardiovascular surgery in which intraoperative salvage and hemodilution are most effective and during which they can be monitored carefully. Third, the importance of communication between the blood center and the ordering physician/surgeon cannot be overemphasized.

The medical director of the blood center ultimately must be the gatekeeper for autologous blood donation. The awareness of the hemodynamic events associated with phlebotomy in high risk donors demands every effort be made to avoid any adverse reactions. At the present time, the drawing of these patients for blood for autologous use appears to be a reasonable procedure if high risk autologoous donations are closely evaluated.

References:

Spiess BD, et al. Autologous blood donation: hemodynamics in a high-risk patient population. Transfusion 1992;32:17-22.

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Public Health Notes

Improving Access to Health Care

Nick U. Curry, M.D., M.P.H, F.A.C.P.M.

One year ago I wrote an article in these pages on this subject. I presented data which is by now very familiar to most of us: 37 million Americans without basic health insurance; 3.9 million uninsured Texans under age 65; 50 million Americans with inadequate insurance coverage; a system "that is separate, unequal, and increasingly ineffective."

During the intervening year, a great deal has been written and said about health care reform on a national scale. Plans have been presented by the AMA, President George Bush, various members of Congress, economists, public health officials, and many others. National polls have indicated that in the minds of many Americans, a solution to the "health care crisis" is second in importance only to improving the economy. Interestingly, in some instance when members of Congress have attempted to obtain input into the design for an improved health services system, constituents have been less forthcoming. Are these two findings contradictory? Probably not. They may simply mean that people have defined a problem to be solved but also recognize that the solution may not be simple.

In this article I will attempt to name some of the proposed health care plans and briefly characterize them — briefly, because tens of thousands of pages have been written about each. To fully explore the complexity and subtleties of these various proposals is beyond the range of these few pages.

- Universal Publicly Funded Insurance System (The Canadian System) — This is a publicly funded, universal health insurance system. There is one insurer, the Canadian Government, which functions through its ten provincial insurance plans. Everyone is insured via tax revenues. It is not "socialized medicine." The physicians and other providers are not employees of the government. The Canadians spend less of their gross national product on health care than do Americans and in general have better health status indicators; however, their system has less of the service-on-demand structure than is found in the United States. Cost containment and quality assurance are overseen by the provincial administrations. The conventional wisdom is that such a system is "not American" and would not work here. The General Accounting Office thinks otherwise.
- Pay or Play — These plans are employer based, that is, they depend on employer contributions. The employer would be required to pay 80 percent of the cost of insurance (traditional private insurance) for workers and dependents, or pay a flat payroll tax. The worker would pay 20 percent of the premium cost on the payroll tax plan, less any subsidy for low-income status. The federal government would pay the premium for those non-working individuals not able to pay for the premium. Such plans would provide insurance for all Americans. Given the choice, it is estimated that 35-40 percent of workers now covered by private insurance would be shifted to the payroll tax funded public plan. This is added to the currently uninsured who would be covered under the public arm of the plan. With all their options, special circumstances and subsidies, these are complex proposals. The economic impact is uncertain. There are no incentives for improved quality of service or cost containment. These proposals have support in Congress.
- Managed Competition — This proposal was originated by Alain Enthoven of Stanford University and other members of the Jackson Hole Group. In this proposal approach, individuals are assured health care services as a member of a group, work-related or other. This proposal, similar to Pay or Play, is for the most part employment based. That is, for those who are employed, the group is established relative to that employment situation. Those who are medically indigent would be placed in groups established by some unit(s) of government. Each group has a "sponsor." This individual obtains bids for service contracts from various competing insurers and/or providers. Members of the group may select from the various providers on the sponsor's list; however, employer payment for premiums/memberships would be limited to the lowest bidder for the package of services in the contract. Additional costs for more expensive providers/insurers would be borne by the individual.

  In addition, limitations would be placed on tax deductibility of employer-paid insurance/memberships to encourage the choice of low-cost managed care plans over costly fee-for-service plans. Tax deductions would also be denied to small employers who refuse to join groups. This proposal assumes that managed care is the most effective approach to standardized universal coverage and cost containment. Those who wish to spend more for fee-for-services care and can afford it can do do.

These are three approaches to improving access to health care for all Americans; there are others. These three are perhaps the most widely discussed at this point. None of them offer perfection. What is clear is that the American people are telling us it is time for action, perhaps revolutionary action. Just as they are telling the two traditional political parties "business as usual is no longer acceptable," they are telling us. To ignore that is to court considerable loss and danger. We must be actively engaged.

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Anemia, Pneumonia Threaten Older Men More Than Women At Very Advanced Ages

Men in their 80s and 90s have significantly higher rates of anemia and pneumonia than women of similar age and health status, according to recent studies supported by the National Institute on Aging. The studies also show that both men and women at very advanced ages have lowered levels of serum albumin, a blood protein with several important physiological functions. These findings represent some of the most complete information to date about the health of very old people, and they are particularly important in describing some heretofore unknown differences between very old men and women.

"The degree to which men in their 80s and 90s are affected when compared to women in a surprise," says Marcel E. Salive, M.D., an epidemiologist with the NIA's Epidemiology, Demography, and Biometry Program. "For anemia, for instance, the condition was 50 percent to 100 percent more prevalent in men than in women in the oldest age groups." According to Salive, the NIA scientist who evaluated the new data, "We have known for some time that these conditions can be more common with aging, although we didn't know the extent to which men of advanced age are affected."

Anemia is characterized by low blood levels of hemoglobin, the body's oxygen-carrying protein. Pneumonia is a serious infection of part of the lung. Results of the anemia analysis appear in the May issue of the *Journal of the American Geriatrics Society.* Salive presented the pneumonia findings at a recent meeting of the American College of Preventive Medicine. The serum albumin results are outlined in the March issue of the British *Journal of Clinical Epidemiology.*

The results are from blood tests and interviews of thousands of older people participating in one of the NIA's major epidemiological projects, the Established Populations for the Epidemiologic Studies of the Elderly, or EPESE. Investigators in three communities — East Boston, Massachusetts; New Haven, Connecticut; and Iowa and Washington counties, Iowa — have conducted annual interviews since 1981, seeking information on a variety of health and social issues associated with aging. In 1988, many participants allowed samples of their blood to be taken in an effort to obtain basic health data. Information from the EPESE and other efforts will become increasingly important as the U.S. and world populations age over the next few decades.

These latest EPESE results are detailed below:

Anemia. Blood samples were taken from 3,946 people. Overall, some 15 percent of the men and 13 percent of women aged 71 and older had anemia. Between ages 71 and 74, an equal proportion of men and women were anemic, but after that, an increase in anemia with age became more prominent among men. By age 90 and over, 41 percent of the men were anemic compared with 21 percent of women that age.

Scientists evaluated several factors relating to anemia, such as smoking, weight, cancer, history of hospitalization, and race, to attempt to explain the differences, but found no differences that would explain the higher rates of anemia in men. Salive and his fellow researchers suggest that the higher occurrence of anemia in men probably is due to a combination of biological differences and different underlying causes of anemia, which could not be accessed in the study.

Anemia can be an indication of a physical problem which requires evaluation by a physician. Other studies suggest that the most common reasons for anemia are iron deficiency and chronic diseases, while other nutritional deficiences are at fault to a lesser degree. In older people, anemia can worsen congestive heart failure and can contribute to symptoms such as fatigue, weakness, leg swelling, and shortness of breath during exercise. Most anemia is mild and without symptoms, and it can be treated with nutritional supplements, drugs, or transfusions, depending on the severity of the anemia and its cause.

Pneumonia. Looking at data from all 11,000 EPESE participants, scientists examined how physical and mental limitations might affect pneumonia deaths. Pneumonia mortality rates for men aged 65 and above were significantly higher than for women at all ages, especially over age 75. At ages 75 through 84, the mortality rate for women was 6.6 deaths per thousand person-years, while for men in that age group, the rate jumped to 18.7. At age 85 and older, the rate of pneumonia deaths among women was 17.5 per thousand person-years, but soared to 39.9 for men. When scientists looked at factors that might increase pneumonia mortality risk, they found a link with cognitive impairment and difficulties with daily activities and mobility.

The research, according to Salive, underscores the need to provide pneumoccocal and influenza vaccine to older adults, especially those with disabilities. Pneumonia is the fifth leading cause of death among older people in the U.S., and its mortality rate increased over 25 percent between 1982 and 1988.

Serum Albumin. Serum albumin transports various substances, such as calcium, hormones, and drugs, through the bloodstream and serves other functions. Albumin levels among some 4,000 EPESE participants were analyzed to determine their relationship to health status and age. Scientists found that serum albumin levels for men were lower with age, from 41.6 g/l (grams per liter) at age 71 through 74 to 38.5 g/l at age 90 and older, with a similar reduction in women. ▸

Several studies in recent years have reported significantly lower serum albumin with age, but the EPESE results indicate that reduced levels may not be due to aging alone. They found that lower serum albumin may be related to a variety of factors, including anemia, heavy smoking, recently diagnosed cancer, prior hip fracture, significant physical limitations, and residence in a nursing home. Salive and other scientists are now looking at the relationship between lower albumin levels and death among older people. In addition, they recommend more research to identify interventions that might raise serum albumin and to determine if those actions could protect against any adverse effects of low albumin levels.

The NIA is one of the 13 Institutes comprising the National Institutes of Health. The NIA conducts biomedical, behavioral, and social research on various aspects of aging. The EPESE interviews and blood tests were conducted by teams from the University of Iowa, Yale University, and Harvard University.

Reprints of the journal articles on anemia and serum albumin and an abstract on pneumonia mortality rates may be obtained from the National Institute on Aging, Public Information Office, Building 31, Room 5C27, Bethesda, Maryland 20892; telephone (301) 496-1752. ■

Rural Health Factline

- Texas added 70,900 new jobs from November 1990 to November 1991, more than any other state. Of the five largest states, only Texas experienced job growth.*
- Mayors in rural Texas rank the following in order as their top concerns: job opportunities, economic diversification, local government revenue, and health services.*
- Only 13 percent of the farmers in the United States are under age 35. The number of farmers under age 35 peaked in 1910 at 1,833,000; it had reached its lowest point by 1987,with only 279,000.#
- The number of U.S. farmers under the age of 25 has dropped by more than 45 percent since 1982.#
- Farmers aged 65 or older were responsible for 21 percent of all farming in the U.S. in 1987, compared with 12 percent in 1969.#
- About 54 percent of U.S. farmers work second jobs off the farm.#

*Fiscal Notes, a publication of the Texas Comptroller of Public Accounts, February 1992

#"Austin American-Statesman," March 15, 1992

Reprinted from Rural Health Reporter, Spring 1992.

Opportunities Unlimited

PHYSICIANS WANTED

FULL AND PART-TIME PHYSICIANS WANTED — for two primary care/minor emergency clinics in the D/FW area. Flexible schedule, excellent potential for growth and financial success. Please send resume or contact: Karen Grizzle, Business Manager, Ready-Care Medical Clinic, 4101 Airport Freeway, Suite 101, Bedford, 76021; 817/540-4333. (19)

PHYSICIAN-OWNED EMERGENCY GROUP — is seeking Full or Part-time D.O. or M.D. emergency physicians who practice quality emergency medicine. BC/BE encouraged, but not required. Flexible schedules, competitive salary with malpractice provided. Send CV to Glenn Calabrese, D.O., FACEP, OPEM Associates, P.A., 100 N. University, Suite 212, Fort Worth, 76107. 817/332-2313. FAX 817/335-3837. (16)

POSITION OPEN IN HOUSTON — Established solo practitioner specializing in OMT seeks associate with like interest to join practice. Please call Reginald Platt, III, D.O., 6815 North Hampton Way, Houston, 77055. 713/682-8596. (04)

FORT WORTH — Clinic seeking energetic general practitioner to work full-time and act as medical director. Salary open. Contact: Bill Puryear, D.O. or Jim Czewski, D.O. at 817/232-9767. (27)

HOUSTON — Established practice specializing in internal medicine and cardiology seeking associate with like interest to join practice. Send c.v. to: Doctors Medical Clinic, 6031 Airline Drive, Houston, 77076. (22)

SAN ANTONIO — Seeking a BE/BC Internist to join a busy internal medicine office. Partnership available, salary negotiable, situation flexible. Please send resume to: Shane Carter, 4411 E. Southcross, San Antonio, 78222. (34)

GENERAL PRACTICE RESIDENCIES AVAILABLE, Oklahoma City — Accepting applications for 1992 residencies in general practice under the direction of Hillcrest Health Center. AOA approved, two-year program, relocation allowance available. Send inquiries to Donn Turner, D.O., Residency Program Director, Hillcrest Health Center, 2129 SW 59th Street, Oklahoma City, OK 73119 or call 405/680-2105. (30)

FAMILY PRACTICE, CRANE — Enjoy city amenities without having to live there. Crane Memorial Hospital is looking for two family practitioners. Beautiful modern 28-bed hospital and office building. Small town, medically underserved area. Healthcare professional shortage area. Only 45 minutes from international airport. Only 30 minutes from interstate highway. Excellent schools. Warm dry climate. Great recruitment package. Contact: Steve Goode, Administrator, Crane Memorial Hospital, 1310 S. Alford Street, Crane, 79731. Phone 915/558-3555. (29)

GENERAL PRACTICE RESIDENCIES AVAILABLE, Oklahoma City — Accepting applications for 1992 residencies in general practice under the direction of Hillcrest Health Center. AOA approved, two-year program, relocation allowance available. Send inquiries to Donn Turner, D.O., Residency Program Director, Hillcrest Health Center, 2129 SW 59th Street, Oklahoma City, OK 73119 or call 405/680-2105. (30)

PHYSICIAN ASSOCIATE VACANCY — Mid-Cities D/FW Location — Search underway for BE/BC family physician. Growing Mid-Cities Fort Worth family and women's health practice. Strong desire to spend time with and be available for patients required. NO ADMINISTRATIVE DUTIES — just practice "old fashioned" medicine with patients. Compensation includes salary + bonus; vesting after three years; all insurances provided. Respond in confidence to L. Hempstead, D.O.; 1816 Norwood Drive, Suite 101, Hurst, TX 76054. (37)

HOUSTON AREA — The town of Anahuac needs a family practice physician. A new office and a reasonable guarantee awaits. We are on the bay in Chambers County. Contact: John Luff, Bayside Community Hospital, Anahuac, 77514 or call 409/267-3143. (38)

ESTABLISHED PRACTICE FOR SALE — Available June 5, 1992. Good growth potential. Send inquiries to TOMA, Box 39, 226 Bailey Avenue, Fort Worth, TX, 76107. (39)

ESTABLISHING CHIROPRACTIC/D.O. — multi-disciplinary clinic near DFW. Immediate need 214/462-9161, Dr. Hale. (25)

BUSY THREE-PHYSICIAN PRACTICE IN WEST CENTRAL TEXAS — being operated by two aging osteopathic physicians, needs third to share the load. Salary commensurate with training and experience. Opportunity for partnership after one year. No obstetrics or major surgery. Twenty-bed district hospital, 80 bed nursing home, and 500-bed detention center for federal detainees. Call 915/869-6171. (40)

EXCELLENT OPPORTUNITY — to join established practitioner in full service clinic in rural south Texas. Nearby full-service hospital. Excellent hunting and fishing area. Qualifies as shortage area for government loan pay-back program. Salary and/or association negotiable. Position available immediately. Contact Jerry B. Liles, D.O., 512/394-5301. (32)

OKLAHOMA CITY, OKLAHOMA — Excellent opportunity for an osteopathic neurologist. Hospital currently has one neurologist on staff with a definite need for another to meet demands of community. A large patient base is present in South Oklahoma City, with an excellent referral base of general practitioners. The hospital offers an attractive compensation package. If you are looking for the ideal combination of quality medicine and quality living, send CV to: Hillcrest Health Center, Attn: Derek Mountford, 2129 S.W. 59th, Oklahoma City, OK 73119; 800/725-6671. (33)

PHYSICIAN WITH TEXAS LICENSE — needed to practice general medicine at Student Health Center September through May. Forty-hour week, Monday-Friday. Minimal call duty. Fringe benefits. Contact Sheila Meyer, Director, University of North Texas Health Center, P.O. Box 5158, Denton, 76203, 817/565-2786. Equal Opportunity/Affirmative Action Employer. (35)

OKLAHOMA (OKLAHOMA CITY) — Excellent opportunity for an osteopathic pediatrician. Hospital currently has two pediatricians on staff with a definite need for another to meet demands of community. A large patient base is present in South Oklahoma City, with an excellent referral base of General Practitioners. The hospital offers an attractive compensation package. If you are looking for the ideal combination of quality medicine and quality living, send CV to: Hillcrest Health Center, Attn: Derek S. Mountford, 2129 SW 59th Street, Oklahoma City, OK 73119. (43) ▸

POSITIONS DESIRED

LOCUM TENEN SERVICE — for the Dallas/Fort Worth Metroplex. Experienced physician in family practice and emergency medicine offering dependable quality care for your patients at competitive rates. Contact: Doyle F. Gallman, Jr., D.O., 817/473-3119. (24)

OFFICE SPACE AVAILABLE

FOR LEASE — Medical office; established medical-dental building on Hulen between Vickery and W. Fwy.; approx. 1,400 sq. ft. which includes 3-4 exam rooms, lab, business office, private office, and extras. Recently remodeled and ready to move in. 817/338-4444 (12)

FOR RENT — Medical Office in Arlington. Three to six months free rent with proper lease. Ideal for general practitioner. Call 817/265-1551. (15)

FOR LEASE OR PURCHASE — Medical practice, 1000 sq. ft. building, newly remodeled, fully equipped. IBM System 36/AS 400 Medical Billing System. Office located in central Richardson. Contact Judith Pruzzo, 214/231-7482 or 214/931-8760. (26)

GRANBURY — Quality office space for lease adjacent to Hood General Hospital. Call Linda Powell, 817/573-1595. (18)

FOR SALE — Profitable Osteopathic General Practice — in the Fort Worth/Watauga area. Office fully equipped including office manager and LVN. OB optional. Please call Debbie Stanley at 817/284-7380. (08)

FOR RENT OR LEASE — in Amarillo. Medical office 2,000+ sq. ft. Six exam rooms with lots of storage and a telephone system. Next to established pharmacy. Very reasonable. Contact Phil Duram or Ray Doherty at 806/383-3377. (41)

MISCELLANEOUS

RECONDITIONED EQUIPMENT FOR SALE — Examination tables, electrocardiographs, sterilizers, centrifuges, whirlpools, medical laboratory equipment, view boxes, weight scales, IV stands and much more. 40-70 percent savings. All guaranteed. Mediquip-Scientific, Dallas, 214/630-1660. (14)

FOR SALE — OB/GYN Table. Call Carolyn Delaney, 817/923-6111. (31)

EXPERIENCED CLINIC PHARMACY GROUP — interested in leasing a small area in physician's office or clinic. Heavy Medicaid and insurance okay. We need to talk. Respond to Pharmacist, P.O. Box 563, Grapevine, 76099. (17)

ASSUME PAYMENTS — Lightly used QBC 11 with Printer. Good Condition. Call Cindy Sullivan, 214/254-6129. (36)

FOR SALE: QUIDEL QUICK READ MACHINE — Runs: Total Cholesterol, HDL Cholesterol, and Triglycerides with ability to calculate LDL Cholesterol. Original price $695; asking $350; 1½ years old. Call 817/232-8055. (10) ■

TMF Holiday Schedule

CHAMPUS Review Activities Suspended On Nationally-Recognized Holidays

Texas Medical Foundation review activities will not be performed on these nationally-recognized holidays:

Independence Day Observed .....Friday, July 3, 1992
Labor Day .....Monday, September 7, 1992
Thanksgiving Day .....Thursday, November 26, 1992
Christmas Day.....Friday, December 25, 1992
New Year's Day .....Friday, January 1, 1993

Please note that on these days, preadmission/preprocedure authorization services will not be available. Physicians should obtain preadmission/preprocedure authorization prior to the observed holiday. ■

Newsbriefs

MEDIAN INCOME FOR TEXANS BELOW AVERAGE

The *Current Population Survey* reports the median United States family income is $32,800. An average Texas family, however, earns $26,300. In Texas, 63 percent of two-parent families have mothers in the work force, and 70 percent of those mothers work full time. Nationwide that number is 66 percent of two-parent families with mothers in the work force, with 64 percent working full time. Despite the high rate of parents in the work force, family income levels still remain very low. Currently, one-fifth of all Texas children live in poverty.

DR. DAVID GREENE WINS CONTROL-O-FAX SYSTEMS DRAWING

David B. Greene, D.O., of Dallas, was the lucky winner of a "Watchman TV" during TOMA's annual convention in Corpus Christi. The prize was given by Control-O-Fax Systems, Inc., who held a drawing at their booth during the convention.

Our congratulations go to Dr. Greene as the recipient, and thanks to Control-O-Fax Systems, Inc.

TEXAS OSTEOPATHIC MEDICAL ASSOCIATION
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Fort Worth, Texas 76107

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