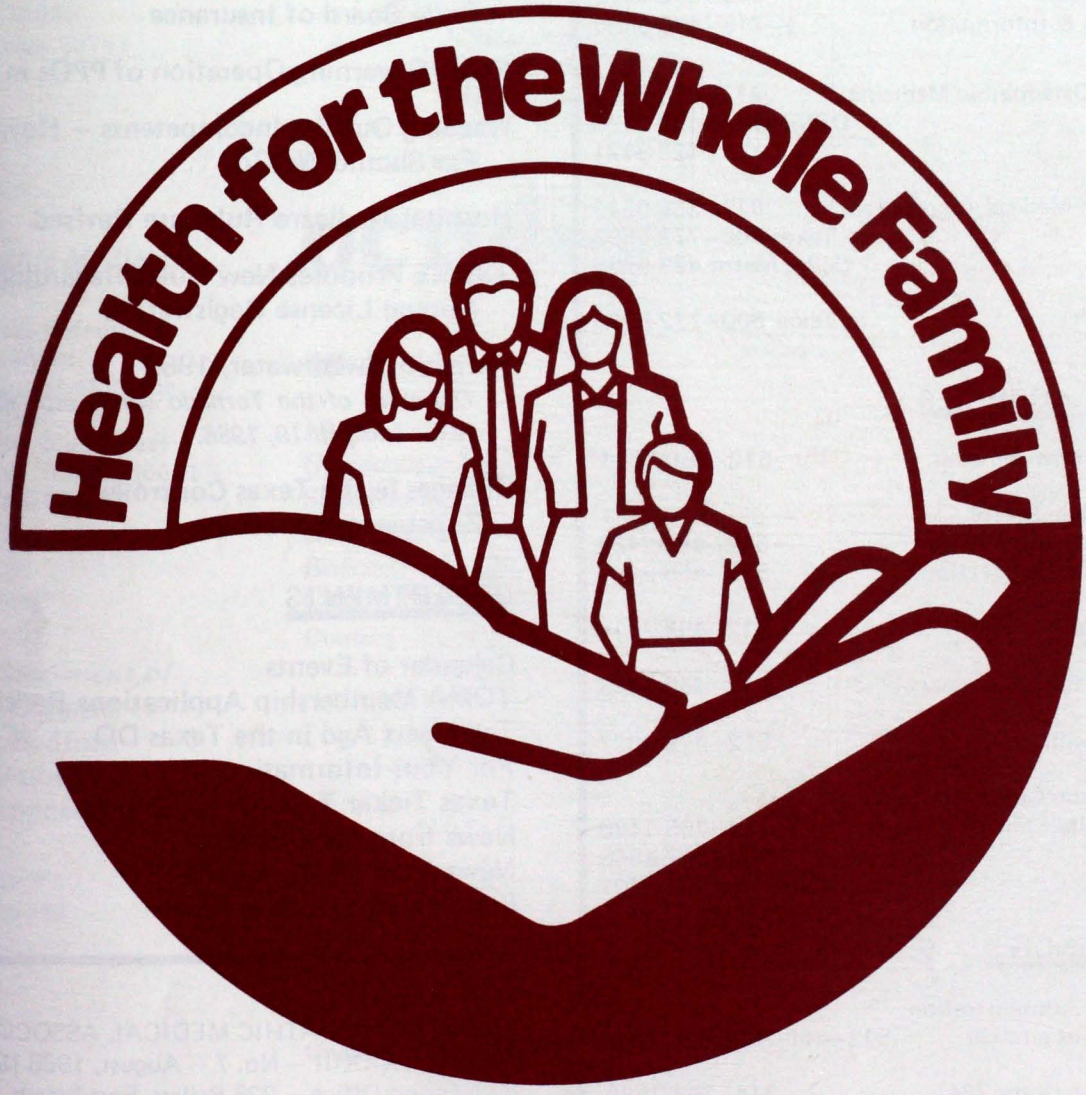
Texas DO
Texas Osteopathic Medical Association
August 1986



National Osteopathic Medicine Week
September 14-20, 1986

PHONE

For Your Information

OSTEOPATHIC AGENCIES

American Osteopathic Association	312–280-5800 800–621-1773
American Osteopathic Association Washington Office	202–783-3434
American Osteopathic Hospital Association	312–952-8900
Professional Mutual Insurance Company	800–821-3515
TOMA Malpractice Insurance Program	
For Premium Rates	1–800–392-2462
For Enrollment & Information	1–713–496-3400
Texas College of Osteopathic Medicine	817–735-2000 Dallas Metro 429-9120 429-9121
Texas Osteopathic Medical Association	817–336-0549 in Texas 800–772-5993 Dallas Metro 429-9755
TOMA Med-Search	in Texas 800–772-5993

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	512–452-1078
State Board of Pharmacy	512–478-9827
State of Texas Poison Center for Doctors & Hospitals Only	713–765-1420 800–392-8548 Houston Metro 654-1701

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

August 1986

FEATURES

DEPARTMENTS

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Tex Roberts, Editor
Diana Finley, Associate Editor
Lydia Anderson Smith, Staff Writer

Calendar of Events

September

13

Patient Education: Theory and Practice
American Diabetes Association
Marriot Hotel—D/FW Airport
8:30 a.m. - 4:45 p.m.
Fee: $25
Contact: American Diabetes Association
Texas Affiliate, Inc.
P.O. Box 14926
Austin, Texas 78761

14

14-20

National Osteopathic Medicine Week
Contact: American Osteopathic Association
Department of Public Relations
212 East Ohio Street
Chicago, Illinois 60611
312—280-5800

20

Update in the Management of Cardiovascular Disorder
Fitness Institute, Bedford
9:00 a.m. - 12:00 noon
CME: 3 Hours Applied for to the AOA
Contact: Nancy Minor
817—540-3522

26

26-28

Primary Care Update III
Texas College of Osteopathic Medicine
Departments of CME & Medicine
TCOM Campus, Fort Worth
Fee: TCOM affiliates $65
TCOM Non-affiliates $125
CME Hours: 11 Category 1-A
Contact: Cheryl Cooper
TCOM, Office of CME
Camp Bowie at Montgomery
Fort Worth, 76107
817—735-2539

October

10

10-12

Gynecology Review & Update
Stouffer's Pine Isle Resort Hotel
Lake Lanier Islands
Buford, Georgia
CME: 20.5 Applied For
Contact: Georgia Osteopathic Medical Association
1847-A Peeler Road
Atlanta, Georgia 30338
404—399-6865

11

TOMA Board of Trustees Meeting
State Headquarters
Fort Worth
Contact: Tex Roberts
TOMA Executive Director
1—800—772-5993

1

Lakeway Conference
Location to be announced
Contact: Tex Roberts
TOMA Executive Director
1—800—772-5993

November

22

2-6

AOA 91st Annual Convention and Scientific Seminar
MGM Grand Hotel
Las Vegas, Nevada
Contact: Ann M. Wittner,
Dir. of Administration
AOA
212 East Ohio St.
Chicago, Illinois 60611
1—800-621-1773 or
312—280-5814

National Osteopathic Medicine Week
September 14-20, 1986

Osteopathic Physicians Begin

Recently graduated osteopathic physicians from osteopathic colleges throughout the United States have arrived to begin their strenuous 12-month rotating internships at Texas hospitals and medical centers.

We congratulate these interns on obtaining their D.O. degrees and hope they will choose to locate their practices in Texas upon completion of their training. If TOMA can be of any assistance during the coming year or in locating a practice site when the time comes, please feel free to contact us. We are here to help.

Among the new interns training for the 1986-87 year are:

Dallas Memorial Hospital

Six new interns are already hard at work gaining valuable experience in all phases of health care at Dallas Memorial Hospital.

Joseph Benenate, D.O., is a 1986 graduate of Texas College of Osteopathic Medicine (TCOM). He received his Bachelor's degree with a double major in Psychology and English at North Texas State University in Denton.

A 1986 graduate of Kirksville College of Osteopathic Medicine (KCOM), Kirksville, Missouri, Barry Galbraith, D.O., received his Bachelor's degree in Psychology at Park College in Parkville, Missouri.

Tien Le, D.O., is another 1986 TCOM graduate. Dr. Le received his B.S. degree in Physical Sciences at the University of Auckland, New Zealand and a Master's degree in Applied Sciences at the State University of New York at Stony Brook.

Yet another 1986 TCOM graduate, Thomas Morrill, D.O., received his B.S. in pre-medicine at Davidson College in Davidson, North Carolina. He obtained his M.A. in Psychology at Chapman College in Orange, California.

A graduate of the University of Health Sciences in Kansas City, Missouri, Edward Panousieris, D.O., received his B.S. in Biology at the University of California.

Candy Ting, D.O., received her B.S. in Biomedical Chemistry at the Oral Roberts University in Tulsa, Oklahoma. Dr. Ting received her D.O. degree from the Oklahoma College of Osteopathic Medicine and Surgery.

AMERICAN MEDICINE..
a bitter-sweet pill. by **Dr. Jim Hill**

Doctors Hospital - Groves

Doctors Hospital's fourth intern class began their year of training on July 1. For the next 12 months, the four newly graduated D.O.s will be hard at work spending the majority of their time at the hospital.

John Lee, D.O., is a graduate of Brown University in Providence, Rhode Island where he obtained a degree in Human Biology. He received his D.O. degree in 1986 from TCOM. While at TCOM, he served as an active member of the American College of General Practitioners - Zeta Chapter for four years, serving as secretary-treasurer for two years and president for one year. A native of Dallas, Dr. Lee plans to enter

Internship Programs in Texas

a general and family practice upon completion of his internship.

Rebecca Lewis, D.O., a native of Tahlequah, Oklahoma, is a 1978 graduate of Bacone College, Muskogee, Oklahoma, where she obtained a degree in Nursing. In 1980 she received a Bachelor of Science degree in Biochemistry from Northeastern State University. Dr. Lewis is a graduate of Oklahoma College of Osteopathic Medicine and Surgery, Tulsa, Oklahoma and worked as an Emergency Room Registered Nurse throughout medical school. A member of the ACGP, she plans to enter a residency in Ob/Gyn following her internship.

Another 1986 TCOM graduate, Monte Clint O'Neal, D.O., obtained his B.S. degree in Biology at Lamar University in Beaumont, Texas in 1981. He is also a member of the ACGP. A native of Groves, Texas, Dr. O'Neal plans to practice in the Southeast Texas area upon completion of his internship.

A native of Denton, Herschel Voorhees, D.O., graduated from North Texas State University in 1975 with a B.S. degree in Biology. He also obtained his M.S. in Biology at NTSU. Dr. Voorhees is a 1986 TCOM graduate and was a member of Sigma Sigma Phi while at TCOM. He is married and has two children. Upon completion of his internship, Dr. Voorhees may enter into a residency program.

Brooke Army Medical Center

Richard B. Hecker, D.O., bears the distinction of being the only osteopathic physician in Brooke Army Medical Center's current intern class. Born in Chicago, Illinois, Dr. Hecker received his B.S. degree from St. Martin's College, Washington in 1981. He is a 1986 graduate of the College of Osteopathic Medicine and Surgery in Des Moines, Iowa, under the government's Health Professions Scholarship Program.

Dr. Hecker began his training at Brooke Army Medical Center on July 1 in a Transitional internship.

Fort Worth Osteopathic Medical Center

Fort Worth Osteopathic Medical Center has 19 new interns in training. All are 1986 graduates of Texas College of Osteopathic Medicine with the exception of Steven L. Gates, D.O., whom we hope will find Texas living and hospitality to his liking and decide to remain here when his training is completed.

The new interns already engaged in training are as follows:

Shahid Aziz, D.O., received a B.S. in Molecular Biology from the University of Texas at Dallas in 1979.

Charles Brady, D.O., received his B.A. degree from the University of Texas at El Paso in 1982.

Carol Browne, D.O., holds a B.S. in Biology received in 1980 from Southwestern University.

Dr. Aziz

Dr. Browne

Dr. Calderon

Dr. Dennis

Dr. Driskell

→

Jose Calderon, D.O., earned a B.S. in Medical Technology in 1978 from the University of Texas at El Paso.

Sharon Dennis, D.O. received an A.A. degree in 1976 from Brevard Community College in Florida.

Pamela Driskell, D.O., earned a Ph.D. in Psychology from East Texas State University in 1980.

Dr. Fehl

Dr. Gates

Dr. Hanby

Louis Mark Fehl, D.O., received a B.S. in Biology in 1980 from Sam Houston State University.

Steven L. Gates, D.O., as stated already is the only intern from a osteopathic college other than TCOM. Dr. Gates received his D.O. degree in 1986 from Oklahoma College of Osteopathic Medicine and Surgery. He earned a B.S. in Pharmacy from Southwestern Oklahoma State University in 1976.

Tamara K. Hanby, D.O., possesses a B.S. in Biology from Abilene Christian University in 1982.

Dr. Kaplan

Dr. Lewis

Dr. Mann

Henry B. Kaplan, D.O., earned a M.S. degree in Chemistry in 1978 from Texas Tech University in Lubbock.

A. Ray Lewis, D.O., holds a M.S. degree in Molecular Biology obtained from Prairie View University, Texas, in 1982.

Christopher R. Mann, D.O., holds a B.S. degree in Chemistry received in 1982 from Texas Tech University.

Hubert Dean Mast, D.O., earned a M.S. in Art from East Texas State University in 1973.

Frederick C. McDonough, D.O., earned his B.S. degree in 1977 at Sam Houston State University.

E. Randolph Osborn, D.O., holds a B.S. in Zoology obtained from Amarillo College in 1977.

Dr. Mast

Dr. McDonough

Dr. Osborn

Mary Parish, D.O., attended the University of Houston where she received a B.A. degree in Psychology in 1974.

Carolyn Wilson Quist, D.O., received a B.S. degree in Biology in 1982 from the University of Texas at Arlington.

Douglas Vick, D.O., holds a B.S. degree in Chemistry earned in 1982 at Northeast Missouri State.

Judith K. Werner, D.O., attended Louisiana State University where she earned her B.A. in English in 1970.

Dr. Parish

Dr. Vick

Dr. Werner

We congratulate all the new D.O.s and extend an invitation to drop by the TOMA State Headquarters for a visit and a tour.

All new interns not featured in this issue will be in the September issue of the *Texas DO*.

National Osteopathic Medicine Week
September 14-20, 1986

September 14-20, 1986

National Osteopathic Week

More than 24,000 osteopathic physicians, 220 osteopathic hospitals and 15 osteopathic medical colleges will once again observe and celebrate "Health for the Whole Family" during National Osteopathic Medicine Week, slated for September 14-20.

Sponsored by the American Osteopathic Association, the American Osteopathic Hospital Association and the Auxiliary to the American Osteopathic Association, this week of special observance will pay tribute to the osteopathic profession. Activities such as open houses, health fairs, health education courses, immunization, health "hot-lines" and a myriad of other activities will bring the osteopathic message and philosophy to the public - that of the whole-person concept in medical care.

To assist you in your NOM Week activity planning, a list of ideas are compiled below. You might wish to adapt these for your local use or use them as a stimulus for your own project ideas.

Media Publicity

Your local media are the best channels for communicating the news about osteopathic medicine. Try to take advantage of this important resource during NOM Week.

1. Send a standard NOM Week release to local newspapers.
2. Write a letter to the editor of a local paper explaining NOM Week, outlining the history of osteopathic medicine and specifying the benefits your community has enjoyed by having resident D.O.s.
3. Give an OMT demonstration to a reporter.
4. Write a guest column for your local paper to appear during NOM Week.
5. Suggest a feature story to a reporter. Some ideas to be utilized are:
   a. interview a long-time resident D.O. who recalls changes in the community over the years.
   b. interview a new D.O. in town focusing on why he or she chose your particular community and what it is like to begin a new practice.
   c. interview special D.O. teams such as husband/wife, or a father/son team.
   d. interview a D.O. who has a very interesting personal life, such as a D.O. who is also a musician or an artist.
6. Anniversaries are good occasions for publicity. If you have been practicing in one place for a number of years or are delivering your 1,000th baby during NOM Week, this sort of item would make a wonderful story.

Community Projects

Some ideas to let your community know it's NOM Week are listed. Some of these ideas might be implemented in cooperation with health organizations, community groups or local Scout troops.

1. Offer to participate in Career Day at a local high school or college.
2. Donate books and brochures about osteopathic medicine to local libraries.
3. Sponsor a "Run for Health", making sure that local media is provided with the details in order to cover the event.
4. Ask local fast food restaurants to use special tray liners announcing NOM Week and place messages on electronic displays at banks, malls and businesses.
5. Sponsor a health education course or a series of courses covering such possible topics as prenatal care, health for senior citizens, CPR instruction, first aid, weight control, nutrition and so on.
6. Deliver the osteopathic message through billboards, bus cards, bench signs and store window displays.
7. Develop hand-out instructions for simple exercises and distribute them at grocery stores and malls.
8. Plan a direct mail program to your neighborhood.
9. Man a first aid station at a local rock concert, rodeo, race track, antique show or any other such event.

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Hospital Participation

NOM Week is an excellent time for hospitals to educate the public and reward employees through special projects and activities.

1. Hold an open house or a tour of your hospital and arrange for OMT and high tech equipment demonstrations.
2. Give every new mother a NOM Week baby bib or t-shirt.
3. Stage a mock surgery for the public.
4. Utilize posters, tray liners, newsletters and NOM Week enclosures with paychecks to generate employee awareness.
5. Use NOM Week stuffers for outgoing mail.
6. Seek interviews or visits from former patients who are athletes or celebrities.
7. Offer screenings by clinical departments.
8. Ask local businesses to donate small items such as baby soap, diapers and other sample sizes of baby products and organize a community baby shower, providing tips for new mothers.

Promotional Ideas

Promos are invaluable in reminding patients, the media, community members and others that osteopathic medicine provides "Health for the Whole Family."

Some suggested promos are bumper stickers, litter bags, tray liners for hospitals and restaurants, and envelope stuffers to be used by D.O. offices and clinics, hospitals, banks, pharmacies and phone and utility companies.

Public Appearances

Many community groups invite guest speakers to their meetings and would be more than pleased to have an osteopathic physician address a specific area of health care. Some tips to remember are to address specific talks to specific audiences. For instance, the Chamber of Commerce would more than likely be interested in health problems affecting the entire community while the PTA will be more concerned about topics centering around children. As summer approaches, prepare talks on sunburn, food poisoning and the like and if OMT is not understood in your community, take this opportunity to demonstrate and explain it.

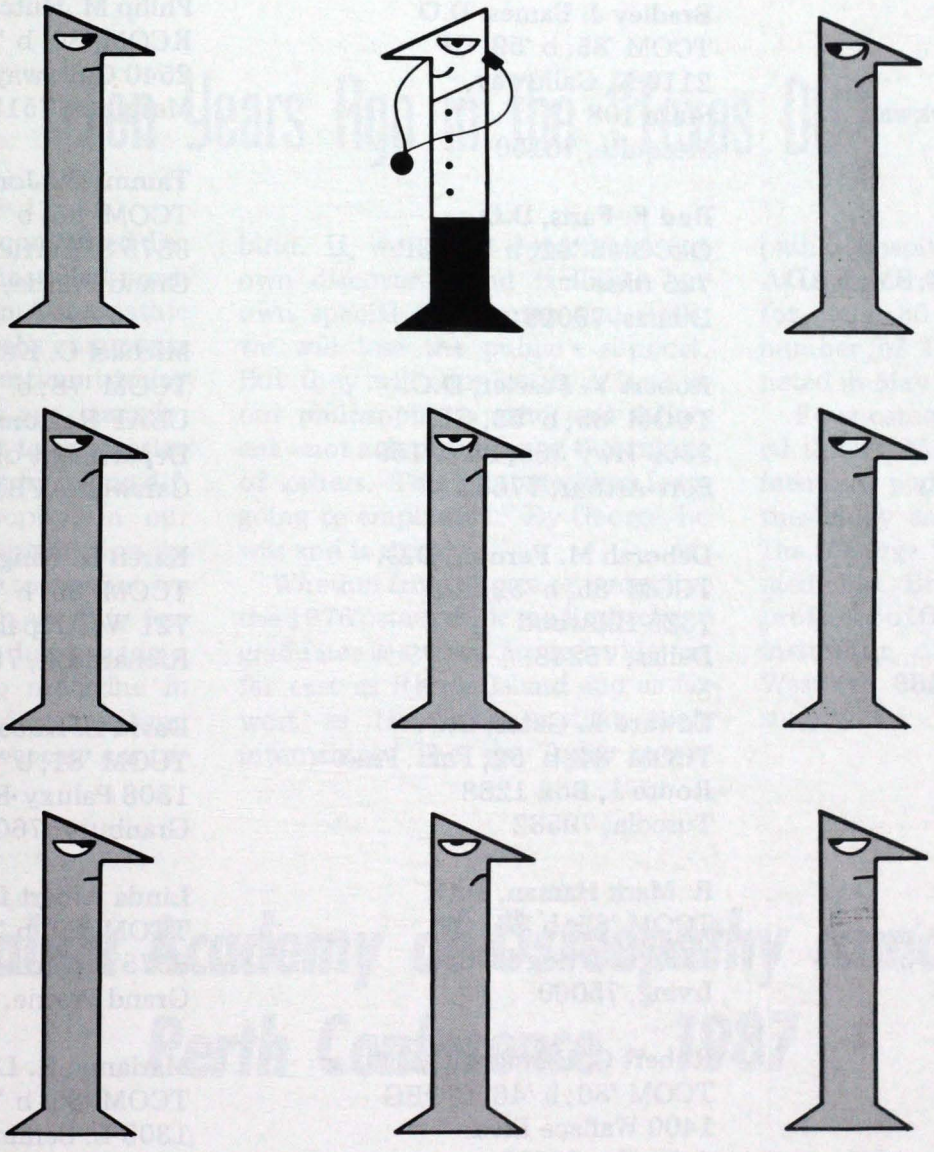
Some possible groups to address are youth clubs; senior citizen groups and nursing home residents; school-related groups; support groups such as for single parents; the local Chamber of Commerce and merchant's group; and the American Legion, VFW and their auxiliaries.

Some important tips for speakers to keep in mind are to make sure you are introduced as an osteopathic physician; seek questions and answers to follow your talk; have printed material on hand for those who request it; use correct figures when referring to the number of D.O.s, osteopathic colleges, etc. which can be found in the statistical tables section of the AOA directory. Contact the AOA for materials such as *What is a DO? What is an MD?*; the *Osteopathic Medicine* leaflet; the *What Everyone Should Know about Osteopathic Physicians* booklet; the AOA Fact Sheet and the *Personally Speaking About Osteopathic Medicine* sound slide series. In addition, the *Talk Show Tips for Osteopathic Physicians* videotape can be a great help in preparing your talk.

There are many, many ways in which you can spread the D.O. message. Some of the suggested ideas are simple and others may take a bit of planning, but anything you do will help and now is the time to make your plans. We need to educate the public on the unique aspects and philosophy of osteopathic medicine and spread the word that we offer something more, not something else.

TOMA will be sending out a statewide press release immediately before NOM Week. Your local paper should have some information on D.O.s in Texas by the beginning of September, at the latest.

WE'RE THE ONE



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Dallas, TX 75243
1-214-699-9494

TOMA Membership Applications Received

Ava C. Alter, D.O.
TCOM '83; b '51; PD
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Suite 304
N. Richland Hills, 76118

John H. Ansohn, D.O.
TCOM '85; b '49; GP
3101 E. Northwest Parkway
Suite B
Southlake, 76092

Mark A. Baker, D.O.
TCOM '76; b '51; DNB; SM; RAD
1000 Montgomery
Fort Worth, 76107

Marianne Beard, D.O.
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Robert L. Bowling, D.O.
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Fort Worth, 76107

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Dallas, 75235

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TCOM '83; b '54; Fam. Prac.
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Fort Worth, 76107

Ten Years Ago in the "Texas DO"

The feature story concerned Dr. George Luibel, newly installed president of the American Osteopathic Association. Dr. Luibel's comments in the article are as pertinent today as they were 10 years ago, namely, "The one thing I want to emphasize is that we got this far by being different in our philosophy, in our outlook, and in the contribution we made, and if we cease to do that we are not going to keep up this forward movement. We have made a great contribution to medicine in spite of our minority position. There is still much we can contribute. If we don't contribute our own discoveries and facilitate our own special philosophy and skills, we will lose the public's support. But they will support us as long as our philosophy is valid and different - not a duplication of the efforts of others. This is something I am going to emphasize." By George, he was and is right!

Whether from choice or necessity, the 1976 osteopathic medical school graduates scattered far and wide - as far east as Rhode Island and as far west as Honolulu to take their internships. The six Texas osteopathic hospitals accredited by the AOA for intern training had slots for only 30 D.O.s, just half the number of Texas D.O.s who graduated in May.

Four osteopathic physicians joined the TCOM faculty in the departments of pediatrics, medicine, anesthesiology and surgery. They were Drs. George Esselman, professor of medicine; Bruce Gilfillan, assistant professor of pediatrics; Gary Neisler, instructor of anesthesiology and Westley Raborn, instructor of surgery.

Australian Academy of Osteopathy Announces Perth Conference - 1987

If you plan to have a great 1987 then start it with this fabulous experience.

The 2nd International Congress of Osteopathic Medicine will be held "down under" in Australia and will include the elimination trials for the America's Cup in Perth, Western Australia.

However, to start the ball rolling, delegates will celebrate the new year, cruising on Sydney Harbour, with the magnificent Opera House as a back drop.

The formal meetings will include top speakers from around the world, all specialists in their field and highly respected in our industry. They include Irvin M. Korr, Ph.D., from TCOM; Harold Schwartz, D.O., F.A.A.O., from Columbus; Thomas Drummer, D.O., MRO from the European School of Osteopathy; Leon Chaitow, N.D., D.O., MBNOA, from Corfu, Greece; Colin Dove, D.O., MRO from the United Kingdom; Morton J. Morris, D.O., J.D., from Florida and the host, Alan Griffiths, D.O., Director, Australian Academy of Osteopathy in Sydney.

If you would like more details regarding this "rarer than Halley's comet" convention, contact: The Secretariat, 2nd International Congress of Osteopathic Medicine, Kuoni Conventions, 39 York Street, Sydney, 2000, Australia.

Primary Care Update III

FRIDAY, SATURDAY, SUNDAY
September 26, 27, 28, 1986

Location

Texas College of Osteopathic Medicine
Camp Bowie at Montgomery
Fort Worth, Texas

KEYNOTE SPEAKERS

David M. Richards, D.O., President
Texas College of Osteopathic Medicine
Fort Worth, Texas
"The Future of Osteopathic Medicine in Texas"

Hunter Handsfield, M.D.
Associate Professor of Medicine
University of Washington
Director-STD Control Program
Seattle-King County Department of Public Health
Seattle, Washington
"Update in Sexually Transmitted Diseases"

Topics

INFECTIOUS DISEASE
Update on AIDS; Sexually Transmitted Disease in Asymptomatic Males; Approach to the Infected Patient

NEPHROLOGY
Outpatient Evaluation of Kidney Stones; Step Care or Not? Hypertension 1986; The Kidney in Pregnancy.

CARDIOLOGY
Diagnosis and Therapy of Mitral Valve Prolapse; Cardiac Syncope; Recent Advances in the Diagnosis and Treatment of Coronary Heart Disease

NEUROLOGY
What to do with Double Vision; Sleep Disorders; Management of Diabetic Peripheral Neuropathy

GASTROENTEROLOGY
Use of Flexible Proctosignmoidoscope in Office Practice; Therapy Through the Scope

GERIATRICS
Physiology of Aging; Drug Therapy in the Elderly; Psychiatric Problems of the Aged

11 Hours CME—Category 1-A (AOA)

CONTACT:
Cheryl Cooper
Continuing Medical Education
Texas College of Osteopathic Medicine
817/735-2539

In Memoriam

Emmett E. Dunlap, D.O.

Emmett E. Dunlap, D.O., of San Diego, Texas, passed away July 6 in a San Antonio hospital. He was 72 years of age.

Funeral services were held July 9 with burial at Roselawn Cemetery in Alice.

Dr. Dunlap graduated from the Kirksville College of Osteopathic Medicine in 1938 and served the San Diego community since that time, a total of 48 years.

A TOMA member since the early 1940's, he was awarded life membership in 1985 and in 1984 was made a life member of the American Osteopathic Association. Additional memberships included TOMA District VIII and the American College of General Practitioners in Osteopathic Medicine and Surgery (ACGP). In 1959, he was selected as the "General Practitioner of the Year" by the ACGP and was at that time the youngest D.O. ever to have been selected for the prestigious award. In addition, Dr. Dunlap was a 32nd Degree Mason. Mason.

During the course of his practice, he delivered over 6,000 babies in homes, ranches, or whever the need existed and had no discrimination as to the ability of a patient to pay for his services. Dr. Dunlap was a very highly respected man in the community.

Naomi, his office manager for 20 years, said that although he was a Methodist, he contributed to the Catholic Church every month since he had been in practice. She added, "He was not only our boss, he was our friend, our counselor, you name it, he was it. He was a very greatly loved man and I don't think there will ever be another man like him."

Survivors include his wife, Mary; one son, Philip G. Dunlap, D.O., who will be taking over the practice including the nursing home which currently has about 80 patients; one daughter, Vicky Crain; a brother, Pryce Dunlap of Ohio; two grandchildren, Kim and Jason and two great-grandchildren.

In lieu of usual remembrances, the family requests that donations be made to the American Cancer Society.▲

An End to Fee Discrimination is a Possibility

The United State Supreme Court has ruled that Part B Medicare payments should be set only by the particular procedure which was performed, regardless of whether a specialist or a general/family practitioner performed the procedure in question.

The decision stems from a 10-year case brought by family physicians in Michigan, who like the majority of general/family practitioners, receive less money than specialists for the same procedures. An attorney for the American Academy of Family Physicians feels the decision will affect physicians nationwide. A spokesman for the Health Care Financing Administration (HCFA) has voiced his agreement and says that the HCFA is currently studying this issue.

Perhaps the eradication of fee discrimination by specialty is forthcoming.▲

News from the July AOA House Meeting

The AOA House of Delegates met in Dallas July 13-14 and some of the highlights of the meeting follow. Detailed reports from the delegates will appear in the September issue of the *Texas DO*.

Eugene L. Sikorski, D.O., a certified general practitioner from Pontiac, Michigan, is the new AOA president. He succeeds our own John H. Burnett, D.O., of Dallas.

Pennsylvania's claim to fame is Joseph W. Stella, D.O., the new AOA president-elect. A certified general practitioner, Dr. Stella hails from Allentown, Pennsylvania.

Elected as AOA 1st vice president was Laurence E. Bouchard, D.O., a general practitioner from Narragansett, Rhode Island.

Our own T. Eugene Zachary, D.O., was re-elected as speaker of the AOA House of Delegates and elected as vice speaker was Robert D. McCullough, II, D.O., from Tulsa, Oklahoma. Dr. McCullough is certified in both oncology and internal medicine.

The House turned down a proposal for the AOA to go into the professional liability insurance business, which would have required an initial investment of $1 million. The House also voted to leave the AOA national headquarters in Chicago. The AOA had been surveying the Dallas/Fort Worth area as well as Washington, D.C. and felt it feasible to remain in Greater Chicago.^

AMA Votes to Provide Assistance in Forced Medicare Assignment

Physicians attending the annual meeting of the American Medical Association (AMA) in Chicago voted to provide AMA expertise to states that are proposing to link Medicare participation as a condition of licensure.

The law was recently declared valid by a federal court judge in Boston in the Massachusetts case where an appeal is pending. This has set off concern and an alarming fact is that four other states are currently considering enacting similar laws, namely California, New Jersey, Rhode Island and Washington.

The adopted resolution calls for the AMA "to develop a mechanism to provide AMA expertise to states where mandatory assignment initiatives or attempted legislative actions are underway in order to help preserve Medicare's current provisions that allow physicians and patients to determine individually the need for, and appropriateness of, accepting assignment for services provided."

Due to the record federal deficit and the fear that additional cuts in physician fees might be passed on to patients, some Congressmen are toying with the idea that all physicians should be required to accept assignment on all Medicare claims. Lawmakers favoring extending the law to encompass all states are using Massachusetts as a model, reasoning that although most physicians oppose the law, most have no choice but to comply with it.

As predicted, this situation is spreading rapidly and opposition to this inane law should be voiced loudly and clearly, in unison. The harsh reality to be faced is that Texas could be next.^

Medicare Claims Processing to be Speeded Up

The American Osteopathic Association reports that the Health Care Financing Administration (HCFA) has established and funded a new policy for processing Medicare claims in a timely manner. Under Congressional and public pressure, HCFA admitted that the current performance level was unacceptable and the level of service to beneficiaries and providers was unreasonable. Therefore, effective immediately, the new policy establishes a processing and payment cycle of 27 calendar days. Twenty seven days is not the average, but the goal. Also, approximately 30 percent of the claims would take longer than 27 days due to a need for more information.

In time this will be a performance standard carriers must meet to have their contracts renewed. Carriers who currently process claims under 27 days may have funds pulled to give to those carriers taking over 27 days to even out the payment cycles.

Legislation has recently been introduced by Senator Dave Durenberger and Representatives Bill Gradison and Pete Stark to process claims within 22 days. HCFA officials stated this could only be accomplished if sufficient funds are provided.

Finally, HCFA stated it wants to clarify forms, provide better instructions, offer more "consumer" services to beneficiaries and providers, use fewer sites and a standard computer system. Not only would these steps save money, but they would also expedite the claim processing and payment cycle. HCFA feels it is slowly moving in this direction.^

PPO Regulations are Approved by the State Board of Insurance

Minimum standards for insured preferred provider plans have finally been set by the Texas State Board of Insurance. Adopted on June 4, significant features of the regulations include advisory panels of no fewer than three physicians. The panels will be selected by the insurer from lists of physicians provided by the contracting doctors. By this same selection process, the insurer must choose a physician or group of physicians to perform utilization review. The panels will provide complaint resolutions and quality assessment and will serve in an advisory role in providing due process "credentialing" of physicians who want to contract with a PPO.

Other important features of the rules include that the basic level of coverage, excluding a reasonable difference in deductibles, may not be more than 30 percent less than the higher level of coverage. Also, no "hold-harmless" clauses are allowed in favor of the insurer, which means an insurer cannot ask a contracting physician to sign a form obligating the physician to hold the insurer harmless in the event of a liability claim. Additionally, the regulations contain a provision whereby emergency services from non-preferred providers must be reimbursed at the preferred provider rate.

Rules Governing Operation of PPOs in Texas

This is not an inclusive list of rules, but rather represents the rules most significant for physicians.

1. Terms and conditions of contract must be reasonable--participation cannot be unreasonably withheld.
2. Due process for physicians who want to contract with an insurer's preferred provider plan is mandated. The review mechanism must involve an advisory role by a physician panel of not fewer than three physicians. This panel must be selected by the insurer from a list of those physicians contracting with the insurer. This list is to be provided by physicians contracting with the insurer in the applicable service area.
3. Complaint resolution shall provide for reasonable due process with an advisory role by a physician panel (selected per no. 2).
4. Quality assessment must be performed by a physician panel (selected per no. 2).
5. Utilization review must be confirmed by a physician or physicians selected by the insurer from a list of physicians contracting with the insurer (selected per no. 2).
6. Terms and conditions of a contract based on quality must be consistent with established standards of care.
7. Insureds have the right to treatment and diagnostic techniques as prescribed by their physician.
8. No "hold-harmless" clauses are allowed in favor of the insurer.
9. Services received under emergency conditions or services received from non-preferred providers must be reimbursed at the preferred provider rate where such services are not reasonably available to the insured.
10. The basic level of coverage, excluding a reasonable difference in deductibles may not be more than 30 percent less than the higher level of coverage.
11. Exclusive preferred provider contracts are prohibited.
12. Insurer may not require physicians to pay for hospital, laboratory, x-ray or other like charges which are determined by the insurer to be "unnecessary."
13. Insurers may not require the practitioner to bear the expenses of referral to specialty care in or out of the preferred provider panel.
14. Insurers may not contract with hospitals that condition staff membership or privileges on the practitioners preferred provider status.
15. Notice to all practitioners in the geographic area of the practitioner's opportunity to participate must be made in writing or by publication.
16. No payment may be made to reward practi-

tioners for not referring a patient to a specialist or for not treating a particular condition.

17. Payment for services to preferred and non-preferred providers must be prompt and efficient.
18. There can be no insurer requirement that the insured patient be referred by a practitioner in another class or by a subspecialty within the same class.
19. The insurer must make an effort to have a mix of institutional providers which includes profit, non-profit and tax-supported institutional providers.
20. Physicians may complain to the State Board of Insurance against insurers for practices not meeting regulatory requirements (unfair claims practices). ^

Dr. Ackerman Receives Certification

Bruce L. Ackerman, D.O., of Garland has been certified in the specialty of internal medicine by the Board of Certification in Internal Medicine of the American Academy of Osteopathic Internists, an affiliate of the American Association of Osteopathic Specialists, during its annual meeting held in Anaheim California.

A TOMA member since 1981, Dr. Ackerman is a 1973 graduate of the College of Osteopathic Medicine and Surgery, Des Moines, Iowa. He interned at the U.S. Public Health Hospital in New York and completed an internal medicine residency there also.

Dr. Ackerman has been a member of the American Academy of Osteopathic Specialists since 1985 and his certification is the result of the submission of logs and case reports, and the passage of both a written and oral examination. The granting of a certificate of certification is the Board's recognition of his high level of professional excellence. ^

Oklahoma Graduates 89 New D.O.s

The Tenth Annual Commencement Ceremony of the Oklahoma College of Osteopathic Medicine and Surgery was held in the Mabee Center of Oral Roberts University, Tulsa, Oklahoma.

The majority of the new graduates will practice family medicine following a minimum one year internship and many of the 62 men and 27 women will practice in rural Oklahoma, meeting the need for general practitioners.

The Oklahoma College of Osteopathic Medicine and Surgery, founded in 1972, is the state's only osteopathic college. The 1986 year marks 14 years of service to Oklahoma and a proud record of excellence in preparing osteopathic physicians.

We offer our congratulations to the new graduates. ^

Dr. Fuller is Elected President-Elect

George A. Fuller, III, D.O., of Pittsburg, has been elected president-elect of the Board of Governors of the American Association of Osteopathic Specialists during its annual meeting in Anaheim, California.

A TOMA member since 1968, Dr. Fuller is a 1959 graduate of Kansas City College of Osteopathic Medicine. He interned at Oklahoma Osteopathic Hospital and served his surgery residency at Rocky Mountain Osteopathic Hospital in Colorado.

Dr. Fuller has been a member of the American Association of Osteopathic Specialists since 1970. He was certified in surgery in 1974 and awarded the honorary degree of Fellow in 1985. He currently serves as chairman of the organization's Discipline Committee. His current election is in recognition of his outstanding contributions to osteopathic medicine specifically and the healing arts generally. ^

Weeding Out the Incompetents

We must all agree that medicine has come a long way in this century whereby individuals are living longer, more productive lives. We have seen artificial and animal heart transplants, the birth of magnetic resonance imaging, the eradication of some diseases which were death warrants in the last century, tremendous progress in cancer research and therapy and so on.

Of course, we have also seen the birth of AIDS and the agonizing decision-making ruckus of whether it is morally and ethically right to stand by and allow hopeless and terminal patients to starve themselves or detach life-sustaining equipment at either the patient's or the family's insistence.

However, in light of the tremendous progress medicine has made, the liability crisis has served to turn all of this into an ironic joke. Insurance companies are being blamed, attorneys are being blamed and physicians are being blamed. Everyone is suing everyone. Physicians delivering babies not quite up to par are being sued by parents who expect physicians to literally perform miracles, that is, to produce a perfect specimen each and every time they perform a delivery. Thus, liability premiums are so high for the specialists that many are dropping out. To rephrase an old quote, "What if a woman had a baby and no physician came?" We are coming to this type of situation and the truly sad fact is that the majority of these physicians are not incompetent; they are just expected to be workers of miracles.

Unfortunately, we must face the fact that there are physicians who, for some reason or another, are truly not fit to practice medicine and it is imperative that these individuals be weeded out and rehabilitated, if at all possible, not only to protect the public but to protect the reputation of competent physicians. Identifying the incompetents can help affect the liability crisis positively to some degree, not to say that physicians are the major cause of it, however.

The most common requirements for medical licensure, as you probably already know, are an approved medical education, acceptable personal qualifications, at least one year of approved postgraduate training and the successful passage of a licensing exam. However, you may not know that when applying for licensure by reciprocity/endorsement, a physicians' disciplinary background is checked out by the Federation's Physician Disciplinary Data Bank maintained by the Federation of State Medical Boards of the United States, Inc., representing 64 state and territorial medical licensing and disciplinary boards. The Data Bank contains information as to disciplinary actions resulting from formal charges. The information comes from reports by licensing jurisdictions, the Department of Health and Human Services, the armed services and the Canadian licensing authorities. Boards can determine through this data whether a prospective licensee has been disciplined or has surrendered licensure in another state, thereby attempting to stop incompetent physicians from state-skipping.

Unfortunately, this system, as does most others, does have its pitfalls. The major one is the ability of various boards to identify incompetent physicians, which is not an easy task if cooperation is not given by other physicians and the organizations to which they may belong. Identifying an unfit physician in a medical board room is certainly preferable than being identified in a court of law. A difficult aspect is that so many individuals tend to forget that physicians are actually human beings, also, and therefore subject to error at times, unfortunate as it may be.

In the Federation's most recent annual survey, 24 boards indicated they required some form of reporting by licensees; 37 indicated such a requirement for hospitals; 26 indicated a requirement for liability insurers or state insurance officials; 23 had such a requirement for medical societies and 14 had such a requirement for courts and/or law enforcement agencies.

Another pitfall to be faced is complaints received by the boards from the public, which while some are very meaningful, others oftentimes have nothing to do with the competence of a physician. The Federation is in the process of preparing *A Model for the Preparation of a Guidebook on Medical Discipline* for boards to utilize in helping the public to understand the scope and disciplinary function of their medical boards, thereby increasing the quality of reports from the public and reducing complaints of a frivolous nature.

Many boards are adopting more effective license reregistration rules which require applicants to report any sanctions taken against them during the reregistration time, usually of one or two years duration. The Federation is urging that medical boards employ the use of written exams to physicians seeking licensure by endorsement and who are eight to 10 years away from any other board approved testing experience. This requirement is enforced in eight states now and others are considering it.

ow Far Should We Go?

The Federation's Physician Disciplinary Data Bank and compulsory reporting, more stringent re-registration rules and written exams for endorsement are by no means an answer to solve the identification of incompetent physicians and an answer to the malpractice and liability problem, however, since there is a link between malpractice claims and incompetent physicians, it may help somewhat.

There are already too many "Big Brothers" watching each and every move a physician makes, which in effect, may make competent physicians so defensive in their practices that they may appear incompetent, which can pose a grave danger to the entire medical profession.

Cooperation between the medical boards, state and national organizations and societies and physicians themselves is probably the most effective means by which to spark any change in the climate we are facing today.

You Know You're in a Small Town When. . .

*You don't use your turn signal because everyone knows where you're going.
*You dial a wrong number and talk for 15 minutes anyway.
*You call every dog on the street by name and he wags his tail at you.
*You get married and the local newspaper devotes a quarter-page to the story.
*You write a check on the wrong bank and they cover for you.
*You miss a Sunday at church and get six get-well cards.
*The day of your father's funeral the neighbors bring in enough food to feed an army.
*You hear about your daughter-in-law's pregnancy before she does.
*The day your kitchen caught on fire you received 22 invitations to supper.
*You drive into a ditch five miles out in the country, and word gets back to your family before you do.

Court Upholds Massachusetts Law Tying Medicare Assignment to Licensure

The first round regarding the law passed by the Massachusetts state legislature late last year requiring Medicare assignment as a condition of licensure has resulted in a devastating blow. A Boston federal court judge has refused to stop implementation of the law, rejecting the major arguments of the Massachusetts Medical Society and the American Medical Association (AMA) which were: 1) Congress intended Medicare to be a federal program; 2) the state is violating physicians' due process rights by making licensure dependent on Medicare assignment, regardless of their fitness or capacity to practice and 3) the state, in linking a physician's decision to accept assignment with his right to practice, is in conflict with the intent of Congress, which was to allow physicians an option to accept or not.

The ruling will be appealed by the AMA and the Massachusetts Medical Society.

In his ruling, U.S. District Court Judge Robert Keeton stated that Congress had never specifically said it wanted to prohibit states from making their own rules in regards to physicians and Medicare participation and although he agreed that license revocations should evolve out of determination of failure of a physician's fitness and capacity to practice, he further ruled that the state had "broad powers" when it actually came down to defining "fitness and capacity".

An attorney for the AMA believes that Congress deliberately refused to accept mandatory assignment, fearing that if a physician was forced to accept assignment, he would drop out of the program. However, the federal appeals court in Boston will hear the appeal this fall to determine whether Congress' intention was to have Medicare remain a federal program, not to be toyed with by the states.

This case should prove to be a historic battle as it will determine ways and means by which states may become involved in the administration of Medicare.

Psychiatrists are Facing a Real "Catch-22"

The Supreme Court has ruled, in a 5-4 decision, that a condemned prisoner labeled as insane cannot be executed. The reasoning is that to kill an individual who is unaware of what is happening is deemed as "cruel and unusual punishment" and therefore violates the Eighth Amendment.

The "Catch-22" situation lies in the fact that an individual can be killed if he regains his sanity at a later date, as the ruling left open this possibility. Psychiatrists who deal with prisoners will have a hard road to follow.

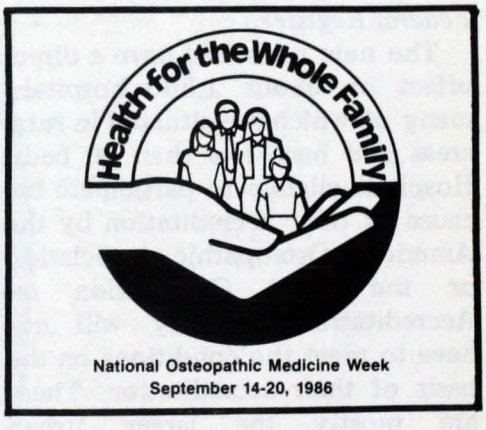
Obviously, there is much controversy surrounding this ruling. Some are questioning the morality of helping a sentenced prisoner recover his mental abilities in order to ready him for execution since this seems to be against the whole concept of what the medical profession believes in and stands for.

Still others feel it is a rational solution to help a condemned person acquire his sanity in order to deal with the situation and make final plans and preparations.

In a recent issue of *American Medical News*, Paul S. Appelbaum, M.D., chairman of the American Psychiatric Association's Committee on Judicial Action, was quoted as saying, "One of the physician's roles is to reduce morbidity and to prolong life. In this instance, a physician does neither."

He added, "If you want to get a real cultural perspective about the issue, reach back more than 2,000 years to the Talmud. In Jewish law, you couldn't execute a prisoner - sane or insane - without giving him intoxicating liquors to drink beforehand, until he lost contact with what was going on.

It was thought to be more humane that way," he concluded.



Hospital Medicare Rules are Revised

For the first time in 20 years, revisions have been made by the Health Care Financing Administration (HCFA) in the Medicare Hospital Conditions of Participation, which are the conditions hospitals must meet in order to participate in the Medicare program. The final rules were published in the June 17 *Federal Register*.

The new rules will have a direct effect on about 1,500 hospitals, many of which are situated in rural areas and have less than 50 beds. Hospitals eligible to participate because of their accreditation by the American Osteopathic Association or the Joint Commission on Accreditation generally will not have to meet the conditions on the basis of their accreditation. These are mostly the larger, urban hospitals.

The regulations add three new conditions requiring hospitals to put respiratory care services under the direction of a D.O. or M.D.; maintain a quality assurance program with discharge planning; and hospitals with nuclear medicine departments must be headed by a physician "qualified in nuclear medicine."

Language spelling out specific functions which can be provided by health care professionals are stated, such as only a D.O., M.D. or licensed practitioner under state law may admit patients for hospitalization.

Changes have also been made in the elimination of current credential requirements for most hospital staff, except for D.O.s and M.D.s, in that requirements will instead be based on educational experience and training.

Also eliminated are the requirements that hospitals maintain social services departments and medical libraries; standards for bylaws, meetings, committees and liaison have been eliminated as well as the education and experience requirements for a hospital CEO.

Additionally, given separate conditions of participation are four hospital services, namely, infection control, surgery, rehabilitation and anesthesiology.

The new regulations will give hospitals more flexibility in deciding the types of practitioners to be on their medical staffs with granted privileges.

HCFA says the new conditions will "eliminate unnecessary provisions, delete overly prescriptive requirements and revise requirements to reflect changes in the state of the art."

DPT Vaccine Price to be Tripled

The *Chicago Tribune* reports that due to loss of product liability insurance, Lederle Laboratories, the only supplier of diphtheria, tetanus and pertussis (DPT) vaccine, will continue to offer the vaccine, however, at a price increase of nearly three times the original cost.

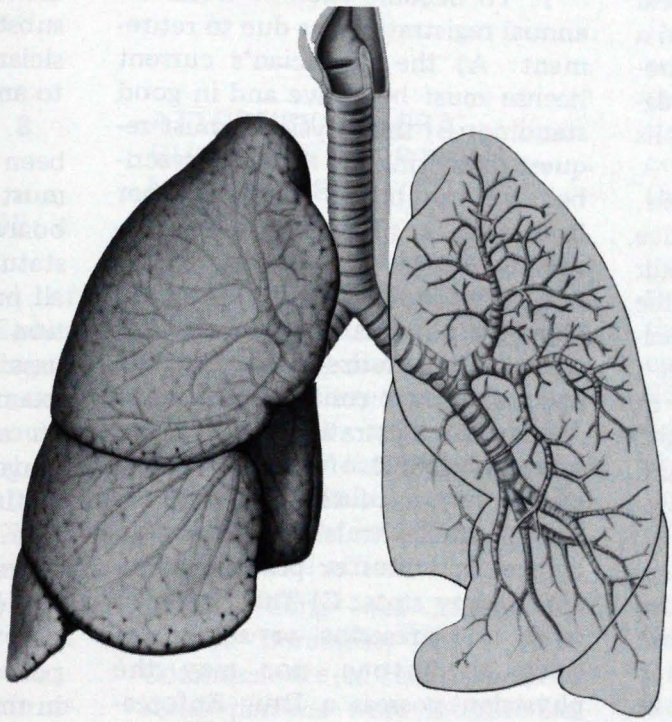
The president of Lederle, Robert B. Johnson, said that in 1985, approximately 100 lawsuits were filed against the company, claiming damages for DPT vaccine-associated injuries. This number of lawsuits is higher than the total number filed in the three previous years.

The price increase is naturally credited to the liability exposure the company must now face, thus a product liability reserve is being formed. Originally costing $4.29 per dose, the new increase will bring the cost up to $11.40, with $8 going into the liability reserve.

Mr. Johnson commented, "Because of our long-standing commitment to vaccines, we will make every effort to assure the nation's children are not deprived of this important protection."

These are shameful times indeed when we must all pay dearly for the price of protection.

Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d. offers effectiveness against the major causes of bacterial bronchitis

Haemophilus influenzae, H influenzae, Streptococcus pneumoniae, Streptococcus pyogenes
(ampicillin-susceptible) (ampicillin-resistant)

Note: Ceclor® is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Contraindications: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly)

Lilly

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

600332

TSBME Proposes New Rules Regarding Annual License Registration

The Texas State Board of Medical Examiners (TSBME) has proposed a new chapter setting out the requirements for annual registration, staggered registration and exemptions for retired physicians.

s166.1. *Physician Registration.* Each person licensed to practice medicine in Texas shall register annually and pay a fee. The fee shall accompany a written application which sets forth the licensee's name, mailing address, the place or places where the licensee is engaged in the practice of medicine, and other necessary information prescribed by the board.

s166.2. *Retired Physician Exception.* The annual registration fee shall apply to all persons licensed by the board, whether or not they are practicing within the borders of this state, except retired physicians.

1. To become exempt from the annual registration fee due to retirement: A) the physician's current license must be active and in good standing; B) the physician must request in writing on a form prescribed by the board for his or her license to be placed on official retired status.

2. The following restrictions shall apply to physicians whose licenses are on official retired status. A) The physician must continue to submit an annual registration form as required in s166.1 of this title (relating to *Physician Registration*); B) The physician must not engage in clinical activities or practice medicine in any state; C) The physician must not prescribe or administer drugs to anyone, nor may the physician possess a Drug Enforcement Agency or Texas controlled substances registration; D) The physician's license may not be endorsed to any other state.

3. A physician whose license has been placed on official retired status must obtain the approval of the board before returning to active status. The physician shall then pay all previous exempt annual registration fees. Also, the physician must pass Component II of the FLEX examination if he or she has been on a retired status five years or longer.

s166.3. *Staggered Registration.* The Board shall stagger annual registration of physicians proportionally on a periodic basis.

A public hearing on these proposed sections is expected sometime in the latter part of August. ^

News from the TMF

At its June meeting, the Texas Medical Foundation (TMF) received a current status report on the projected Medicaid (Title XIX) Prospective Payment System (PPS).

The TMF has been notified by the Texas Department of Human Services (TDHS) that PPS implementation will be delayed from July 1 to September 1, 1986 (60 days). This action will allow hospitals time to assess the adequacy of the proposed payments and provide accurate assessment to TDHS regarding the impact of the proposed PPS on both providers and recipients.

Also discussed at the meeting were plans to work in conjunction with the American Association of Retired Persons (AARP) to design, prepare, train presentors and secure public service radio and television time in an effort to communicate with Medicaid and Medicare health care recipients.

Regarding review activity, during the month of May, 20,852 Medicare medical records were reviewed. Of the total number reviewed, 95.81 percent of the admissions were approved as medically necessary. ^

FYI

FEE INCREASES PROPOSED BY THE TSBME

The Texas State Board of Medical Examiners (TSBME) has proposed amendments relating to the fees for licensure by examination, licensure by reciprocity and examination fees for both FLEX Components 1 and 2. According to the July 7 *Texas Register*, recent increases in the amount the TSBME must pay for the examination prompt this increase.

The proposed changes are as follows: *licensure by examination (includes one FLEX and jurisprudence examination fee) - to increase from the present $450 to $500; *licensure by reciprocity (includes one jurisprudence examination fee) - increase from $450 to $500; *examination fees (required and payable each time applicant is scheduled for examination): FLEX Component 1 - increase from $225 to $250 and FLEX Component 2 - increase from $225 to $250.

The amendment is proposed under Texas Civil Statutes, Article 4495b, which provide the State Board of Medical Examiners with the authority to make rules, regulations and bylaws not inconsistent with this Act as may be necessary for the governing of its own proceedings, the performance of its duties, the regulation of the practice of medicine in this state and the enforcement of this Act.

A public hearing is expected sometime during the latter part of August on the proposed amendment and the earliest possible date of adoption is August 4, 1986.

ATTORNEY GENERAL RULES ALL ABORTIONS MUST BE REPORTED

A new ruling recently issued by Texas Attorney General Jim Mattox states that the 1985 law regulating abortion licensing is to be interpreted whereby all abortions must be filed annually with the Texas Department of Health, even those abortions performed in physicians' private offices.

The ruling was sought by Robert Bernstein, M.D., State Commissioner of Health because some persons were interpreting the law in a manner inconsistent with the Department of Health. The law required that institutions covered by the Texas Hospital Licensing Law and physicians' offices licensed under the Medical Practice Act were exempt from filing the annual reports so many physicians had questioned whether the filing requirements applied to abortions performed in private offices. Thus, Dr. Bernstein requested the ruling.

Attorney General Mattox ruled that the reporting requirements extends to hospitals and physicians' offices, as well as facilities licensed under the 1985 Texas Abortion Facility Reporting and Licensing Act. He further stated that reporting requirements applied to "any place where abortions are performed, regardless of whether the place is exempt from the licensing requirements" of the law. This opinion carries the force of law unless overturned in court.

Data to be submitted to the state includes the patient's year of birth, race, marital status and state or county of residence, however, the patient's name is not to be included. In addition, a physician must record the type of abortion, the number of previous abortions, the date and the physical condition of the patient after the abortion.

Reports on all abortions during 1986 are to be filed with the Health Department in January 1987. Failure to do so could result in fines of up to $500 per day. These statistics will be a major issue regarding abortion legislation which will be filed during the 1987 session of the Texas Legislature.

MEDICARE DISCHARGE LETTER IS NOW AVAILABLE IN SPANISH

The letter that offers an explanation to Medicare patients of their right to appeal written hospital discharge notices is now available in Spanish, as well as English. It is a requirement that all hospitals accepting Medicare patients give a copy of the letter to Medicare patients upon admittance.

Patients who feel they are being discharged too early can appeal to the Peer Review Organization (PRO) for a review of the hospital's decision and the PRO must respond within three working days. However, because the hospital discharge notice must be given only 48 hours before discharge, patients who lose the appeal may wind up paying for one or more days of hospital care.

Hospitals wishing to obtain a copy of the letter in Spanish should write to Phil Dunne at the Texas Medical Foundation, 7800 Shoal Creek, Suite 150E, Austin, Texas 78757.

Texas Ticker Tape

NURSES ARE SEEKING WIDER PRACTICE AUTHORITY

In an effort to receive more practice authority, Ohio nurses have a bill in the legislature which would give them the right to diagnose and prescribe. In addition, the legislation allows "advanced practitioners of nursing" the right to independent practices which would result in direct competition with physicians. This bill would also eliminate the supervisory power of physicians over hospital nurses.

UNDERGRADUATE AMERICAN ACADEMY OF OSTEOPATHY TO PRESENT COURSE AT TCOM

The Undergraduate American Academy of Osteopathy at Texas College of Osteopathic Medicine (TCOM) will present a three-day introductory course on sacral and fasical release techniques on Labor Day weekend.

The course will be held at TCOM August 29, from 7-10 p.m.; and August 30 and 31, from 8 a.m.-5 p.m. Course leader will be Viola M. Frymann, D.O., craniosacral physician from La Jolla, California, who works extensively with children.

Tuition for the course will be $10. For more information, contact Judy Staser in TCOM's manipulative medicine department at 817—735-2461.

THIS IS NO LAUGHING MATTER

An organization known as Citizens for Liability Reform has recently been formed by a group of Maryland physicians' wives. One of the ladies brought up the proposal of a new bumper sticker which would read: "Support your lawyer. Send your child to medical school."

AOA MEMBERSHIP CARDS ON THE WAY

The American Osteopathic Association (AOA) reports membership cards are on the way to all D.O.s who paid 1986-87 dues promptly.

In addition, all 1989 graduates will receive their student membership cards at the same time.

THIS BEEPER CAN GET YOU OFF THE HOOK

Just when you think you've heard of everything, along comes a new beeper called the Ultimate Out, modestly priced at approximately $30. Appropriately named, this beeper can be activated by the physician to provide a false alarm, thereby giving the opportunity for polite "outs" at dwindling parties, eternally long committee meetings and the like. To set it off when a gracious "goodbye" seems in order, a switch is flipped and within 20 seconds, a red light begins flashing.

What a way to make a "necessary" exit!

HUMANA CAPTURES CHAMPUS CONTRACT

An agreement has been reached between the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and Humana, Inc., whereby military dependents and retirees may now receive medical care through Humana Inc.'s nationwide MEDFIRST offices. Assignment of CHAMPUS' over 6.2 million beneficiaries will be accepted, under the contract, by Humana's network of primary care physician offices.

Humana, Inc., is the Louisville, Kentucky-based hospital chain who originally revolutionized the concept that health care could be marketed, managed and distributed nationally, just as any other product. In addition, Humana was the first hospital chain to advertise its name and logo on its hospitals and walk-in care centers on a national basis. Last year, Humana showed a $216 million net income on revenues of $2.8 billion.

THIS IS A "FIRST" WHICH MAY CAUSE PROBLEMS

According to Joseph Califano, Jr., former secretary of Health, Education and Welfare, rapidly approaching is the first four-generation society in man's history. "In the first half of the next century, it will be common for two generations of the same family to be on Medicare, on Social Security, in retirement and in hospitals; we have to get ready for that," said Mr. Califano.

The wonders of modern medicine march on.

Texas Ticker Tape

CLASS D PHARMACIES

In a request for an Attorney General's Opinion concerning the proper location of Class D pharmacies, the summary of the opinion is as follows:

"A Class D pharmacy is one with a formulary that is limited to serving the purposes of a clinic that provides limited medical services. The Board of Pharmacy has discretion to determine which pharmacies can be licensed as Class D pharmacies."

THE RED CROSS WANTS YOUR BONES

Twenty-one cities are currently participating in a six-month program exploring the feasibility of tissue banks to be set up by the Red Cross.

Patients undergoing hip and knee replacement surgery are being asked to contribute their surgically removed bones for the pilot tissue banks. The program would save bones through freezing or freeze-drying, rather than discarding them after surgery.

DEATH RATE IS CUT BY COMBINATION OF HEART DRUGS

At a recent meeting of the American College of Cardiology, a landmark study was presented whereby researchers proved, for the first time, that drug therapy can prolong the lives of men with congestive heart failure.

The study used drugs known as vasodilators, which relax the muscles in blood vessels, thereby opening them up so blood flows more freely through the arteries. During the research, physicians compared dummy placebos against different vasodilator regimens and found that a combination of hydralazine and isosorbide dinitrate prolonged life. The study revealed that the death rate among those receiving the two-drug combination was 38 percent lower than the placebo groups after one year; 25 percent lower after two years and 23 percent after three years.

PEACETIME DRAFT PROPOSAL TO BE PUSHED

The bill introduced by Representative G.V. "Sonny" Montgomery requiring health care professionals to register for a peacetime draft was defeated in the House Armed Services Committee the latter part of June.

However, Representative Montgomery intends to continue to push the proposal, citing the shortage of medical care to the armed services which would result if a combat situation were to be faced.

ANOTHER MESS IN MASSACHUSETTS

Maternity patients must now be provided with obstetrical data from Massachussetts' hospitals, such as the number of caesareans performed on an annual basis. Concern on the part of the state hospital association stems from the fact that the statistics given to prospective patients does not show the parallel between the number of ceasareans and the number of patients considered high risk cases. Therefore, patients may misread the provided information with the outcome being concerned patients switching to other hospitals, which might lead to their changing doctors, also.

District News

By Bobby Joe Kennedy, D.O.
President, TOMA District VII

As you know, TOMA recently passed a resolution which created a new district with Austin as the center. The old, larger district usually met in San Antonio which was too distant for many members. Members of the new district met in Austin on June 26 and elected the following officers:

Bobby Joe Kennedy, D.O., President; Larry Lewellyn, D.O., Vice-President; and Peggy Russell, D.O., Secretary-Treasurer.

The new District VII includes Coryell, Lampasas, Bell, Burnet, Milam, Williamson, Mason, Llano, Travis, Bastrop, Caldwell, Hays, Blanco and Gillespie counties.^

ATOMA News

By Peggy Rodgers
Auxiliary News Chairman

To all District Presidents: Please let me know of any news from your district for inclusion in the *Texas DO*. We are all interested in what's going on in your area with respect to awards, activities, fund raisers, parties, and so on. We all would love to hear from each district each month.

So, Presidents, please send me any news for all of us to enjoy.

Thanks.

* * * * *

The new ATOMA officers for District XV are Peggy Rodgers, president; Roma Liverman, vice-president; and Karen Anson is the secretary/treasurer.

Our June meeting was very enjoyable and was held at the American Airlines Building. We began planning for the fall and are looking forward to next year.

We hope to reach out to more of the interns in our district and increase our membership and I hope each district will do the same. Each of us are invisible at this time but plan on reappearing in September, raring to go.

Enjoy your summer!^

Resource Update

Your Skin Self-Exam, available from the American Cancer Society, is a brochure demonstrating the four-part process of monthly skin self-exam. It is illustrated with drawings. To order: American Cancer Society, Texas Division, Inc., P.O. Box 9863, Austin, Texas 78766 or phone 1—800-252-9174. Specify number 333.01 when ordering.

Pep Up Your Life, A Fitness Book for Seniors is available from the American Association of Retired Persons (AARP). This 36-page booklet details three levels of exercises for strength, flexibility and endurance for senior citizens. To order: AARP, 1909 K Street, N.W., Washington, D.C. 20049.

How to Quit, available from the American Heart Association (AHA), is an easy to understand booklet providing a variety of tips and hints on breaking the cigarette habit. To order: Local AHA or American Heart Association, Texas Affiliate, Inc., P.O. Box 15186, Austin, Texas 78761.

The Good Life is a companion piece to *How to Quit* and reinforces non-smoking behavior and suggests ways to cope with everyday urges to smoke. Order at the address listed above.^

Houston to be Site of Nation's First Aids Hospital

Citizens General Hospital, located at 7404 North Freeway in Houston, is undergoing major overhaul after an affiliation agreement was reached between the University of Texas System and American Medical International (AMI), a for-profit hospital corporation, whereby the hospital will become the nation's first AIDS hospital.

To be known as the Institute for Immunological Disorders, conversion of Citizens General into a research institute for the study of diseases of the immune system is expected to be completed and ready to open its doors later this year. AMI will donate annual installments of $250,000 for four years to the Foundation for Immunological Disorders as seed money for research by UT faculty. Part of the agreement calls for all members of the medical and research staff to be on the faculty of UT Health Science Center or UT Cancer Center.

Patients are expected to be referred to the institute by physicians who diagnose the disease but do not have either the expertise or facilities to treat it. It is hoped that patients will refer themselves for treatment as the institute's reputation grows with time.^

Mike Ferguson Joins TCOM

Mike Ferguson, Jr., who has been with the state auditor's office in Austin for over 24 years, has been named vice president for fiscal and administrative affairs at TCOM. The appointment was approved June 27

by the NTSU Board of Regents.

His duties will be that of overseeing accounting, budget, payroll, physical plant, personnel, purchasing, news and information and campus police.

Mr. Ferguson earned his B.B.A. degree in accounting and economics at Sam Houston State University in 1962 and became a certified public accountant in 1971. He worked in the state auditor's office for two years after college, then moved to the San Jacinto River Authority for two years, returning to the state auditor's office in 1966 where he remained.

"I am looking forward to being associated with an institution that has a future as bright as TCOM," he said. "The school is building in many new directions and my wife and I are excited to be a part of it and the Fort Worth community. The possibilities for the college are unlimited."^

Fellowship Publication Award Program is Announced

The American Osteopathic College of Rheumatology, in cooperation with Riker Laboratories, Inc., has announced the formation of the first annual Osteopathic Fellow Rheumatology Publication Award. The program has been established to support creative scientific and clinical publications by Osteopathic Fellows in the fields of Rheumatology, Family Practice, Allergy and Immunology and Internal Medicine, as well as to accentuate the importance of the osteopathic profession in Rheumatology.

The Uses of NSAID's is the topic for the first original paper and judging will be done by members of the American Osteopathic College of Rheumatology. The winner will have his/her article published in an osteopathic journal and an invitation will be extended to present the paper to the American Osteopathic College of Rheumatology at the next annual convention of the American Osteopathic Association. Riker Laboratories, Inc. will pay for the trip as well as provide an honorarium.

Deadline for submission of the paper is October 1, 1986 and any received after this date will be submitted for next years' program.

Any questions concerning the program or those wishing to submit papers should contact Gerald Teplit, D.O., F.A.O.C.Rh., Chairman, Educational Council, American Osteopathic College of Rheumatology, 5402 Flatlands Avenue, Brooklyn, New York 11234.^

Political Talk

For those considering entering politics, the below should be an important consideration in determining which direction to contribute one's abilities:

How To Speak Liberalese

"Have you ever felt ill-at-ease among liberals because you didn't know what to say? With the help of the three columns below, you can soon learn to speak Liberalese with the best of them. Select any word from Column A, and combine it with any combination from Columns B and C:

negative	environmental	paranoia
simplistic	sexist/racist	manifesto
underfunded	legalistic	ramification
unfair	socioeconomic	travesty
counterproductive	social	impact
unattainable	sociodevelopmental	sexism
mismanaged	socioenvironmental	racism
undesirable	socioeducational	fascism
unjust	educational	counterdevelopment
unmerited	chauvinistic	anticonsumerism
bigoted	socioecological	extremism
misguided	ecological	mindset
inhumane	jingoistic	neglect
repressive	pseudohumanistic	funding

Thus you can win the respect and admiration of your liberal friends, beginning with such phrases as "simplistic educational funding" and working your way up to "counterproductive pseudohumanistic anticonsumerism." Don't be afraid to make phrases that are meaningless, but care must be taken so as not to create a phrase that is redundant or self-canceling."

Should you agree with me you might find it easier to fire the liberal than to learn their language.

Reprinted from Capital Consultants.^

Tornado, Sweetwater, 1986

By Jerry E. Smola, D.O.

THE TORNADO

On April 19, 1986, the National Weather Service issued a warning at approximately 7:15 a.m. that a tornado had been spotted in the Big Country area near Sweetwater, Texas. Five minues later, a police officer spotted twin funnels which merged and touched down near the southwestern edge of town. He radioed police headquarters. But, before any further warning could be given, the tornado skipped through the southern part of the city. It left a path of destruction up to 1200 feet wide for approximately two and one half minutes before it retreated into the clouds. Property damage was estimated to be in excess of $20,000,000. Over 600 residences were either destroyed or heavily damaged. Only a few businesses were in the tornado's path, a factor which held down the dollar damage considerably. The economic loss resulted in Sweetwater being declared a disaster area, eligible for full federal and state disaster aid.

The destruction in many areas was near total. The two hardest hit areas were a federal housing project for the elderly and a trailer park. The federal housing project was a group of one-story brick veneer apartments. Many were completely demolished while others were spared. Many mobile homes were heavily damaged. Nine were totally destroyed. Their steel frames were found up to 100 yards from the original sites, devoid of the siding which had originally covered them. In addition, their interiors were gone. The most severe injuries occurred in these areas.

Tornado intensity is rated on the Fugita scale from a low of F0 to a high of F5. This tornado was classified F3, above average in intensity of damage. In comparison, the tornado which struck Wichita Falls in 1979 was classified F4.

THE HOSPITAL

Rolling Plains Memorial Hospital is a mixed-staff community hospital serving Sweetwater and Nolan County, Texas. The active medical staff is made up of six family and general practitioners, a general surgeon, an obstetrician/gynecologist and a radiologist. The hospital has a five bed Intensive Care Unit, two surgical suites and an eight bed Obstetrical Unit in addition to 72 medical/surgical beds.

THE INITIAL DISASTER PHASE

The hospital was first warned of the tornado by an off-duty nurse who heard the police report on a scanner. She called the ER immediately. There were 40 inpatients present that morning who were promptly moved to interior hallways and other reinforced areas of the hospital. Due to severe weather conditions, most of the 11 p.m. to 7 a.m. nursing staff was present in the hospital to assist the day shift.

The tornado had swept through the city approximately one-fourth mile north of the hospital. It's passage disrupted all electrical service to the area and left the hospital almost without telephone service. One outside telephone line was usable at intervals which functioned long enough to call the medical staff to the hospital. The internal phone system was also disabled. All messages from one part of the hospital to another were carried by a runner. Emergency generators activated to supply electrical power to critical hospital areas.

Rolling Plains Memorial Hospital had its disaster plan modified after several critiques of previous disaster drills. These drills had been held within the previous two years in conjunction with area disaster, law enforcement, fire and ambulance services. The hospital was about to see the results of the disaster planning.

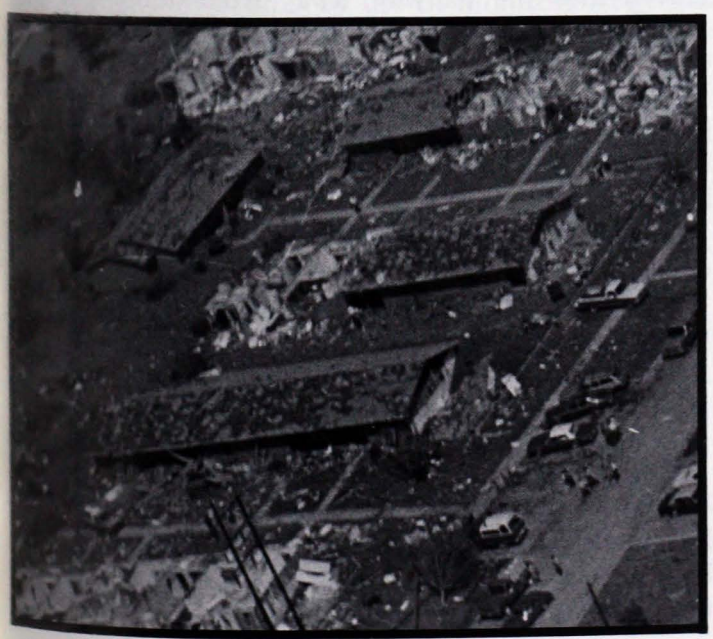
Emergency department personnel used the two-way radio to notify the Sweetwater Fire Department and Ambulance Service of the disaster. Surrounding area hospitals heard the notification and radioed back. They indicated a willingness to receive tornado victims and send any help requested. Such help arrived rapidly and consisted of ambulance services with EMTs and paramedics, nurses, physicians and supplies.

The first victims arrived by pick-up truck at approximately 7:35 a.m.

When the tornado struck, two physicians were in the hospital. A contract physician was covering the Emergency Room for the weekend and one of the general practitioners was about to deliver a baby.

Within five minues, casualties were arriving in a steady stream. Within 20 minutes, three more general practitioners, the surgeon and the radiologist had arrived.

Photos courtesy of Sweetwater Reporter



TRIAGE

The first active staff member to arrive from outside the hospital was a general practitioner with an interest in disaster medicine. He began triage.

Triage was set up under the large overhand outside the Emergency Department entrance. The triage officer routed minor problems to the First Aid area. Critical-appearing patients were sent to the Emergency Room for resuscitation and management. Patients with known severe, but stable injuries were sent to the medical/surgical floor. Patients who appeared stable, but would require close observation, transfer or frequent reassessment were sent to the Holding Area.

Triage generally went smoothly. However, in this situation, triage was made more difficult by the noise of the emergency generators which made physical examination and history taking very difficult. This generator noise was also a significant factor in the Emergency Room which served as the critical care staging area. All patients were appropriately tagged and sent to the proper areas.

In the initial phase of the disaster, it was difficult to ascertain how to best employ available resources. It was initially not clear if we had received the first of many critically injured patients or had already cared for most of them. This was a problem in the critical care, triage and surgical areas, also. Triage decisions are affected by a knowledge of, or anticipation of the extent of the casualties as well as their arrival rate.

In the critique following the disaster, it was noted that had the disaster occurred at night, the triage area would have had no light, as this area was not covered by the emergency powered generator system.

CROWD CONTROL

Very effective crowd control allowed all medical personnel to work without interruption. This crowd control was maintained by hospital personnel and local law enforcement personnel. Previous disaster simulations had included "hysterical" families, "pushy" press and other disturbances. Local law enforcement agencies had made it a priority to protect the hospital. Two persons failed to observe police warnings in the hospital and were promptly arrested. The press received periodic updates, but were not granted interviews until all patients were treated.

In this disaster, crowd control may have been much more difficult had the hospital not been physically separated from the rest of the town by the disaster area which was rapidly cordoned off by the police.

EMERGENCY MEDICAL DECISIONS

The hospital disaster plan was well enough known by members of the medical staff and hospital em-

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ployees that little deviation from the formal plan was made. However, early in the sequence of events, three medical decisions were made by the members of the medical staff: 1) A decision was made not to suture any lacerations unless absolutely essential to hemostasis. A high incidence of wound infection had been noted in primarily sutured wounds after the Wichita Falls tornado of 1979. This point had been stressed by Dr. Ted Alexander, Jr., of Wichita Falls, several years ago. We understood that similar infections were common in primarily sutured lacerations after the 1970 Lubbock, Texas tornado; 2) Relying on the above experience, it was emphasized that patients with lacerations were not to leave until appropriate Tetanus prophylaxis with Tetanus Immune Globulin and/or Tetanus Toxoid had been administered; and 3) Small fractures needing more than simple casting and all neurologic problems would be transferred as soon as they were stable for transfer.

The staff felt that by eliminating suturing and other than immediately necessary orthopedic care, efforts could be better concentrated on proper observation and diagnosis of the remaining patients.

Since only one patient was taken to surgery here, we were spared having to make any decisions about how many surgical patients we were able to handle. Had there been several patients requiring emergency surgery, decisions would have been required regarding not only priority for surgery, but also whether to call other surgeons to Sweetwater, to transfer patients to other hospitals, or both.

CRITICAL CARE

All cases appearing critical were routed to the Emergency Room for stabilization and initial diagnosis. This area was staffed by the contract Emergency Room physician (who had never been at our hospital before), a general practitioner from our active staff and the surgeon.

The only fatality which resulted from the tornado was brought in early by a pick-up truck in full cardiorespiratory arrest. He had multiple traumatic injuries including crush injury of the chest. He was entubated, resuscitated and sent to the Intensive Care Unit for diagnosis and surgical work-up. He experienced another cardiac arrest refractory to resuscitative efforts. He was pronounced dead shortly after arrival in the Intensive Care Unit.

A critically injured young woman was found to be in shock upon arrival. She had an open mid femur fracture, intra-abdominal hemorrhage diagnosed by a peritoneal lavage and had sustained an upper thoracic cord transection. She was stabilized with intravenous fluids and transfusion in the Emergency Room and sent promptly to the Operating Room. She remained on the spine board while hepatic fractures were repaired and the femoral fracture was debrided and stabilized. She was subsequently transferred to Abilene for neurosurgical care.

In the early stages of the disaster, two patients were sent to the medical/surgical floor after IVs were started in the ER. In retrospect, these patients might better have been sent to the Holding Area. One patient was suspected of having a cervical spine injury and did indeed have cervical cord function interrupted. He remained on a spine board and was transferred for neurosurgical care in Abilene in one of the first ambulances available. The other was a young woman admitted with a provisional diagnosis of concussion, contusions, superficial lacerations and abrasions. Approximately two hours after admission, she became very confused and disoriented. She was transferred back to the critical care area where an extensive work-up showed no evidence of hypovolemia, dehydration, internal or neurological injury other than the closed-head injury. She was transferred, also, to Abilene for neurosurgical care. In neither case was proper treatment, diagnosis or transfer delayed.

Several persons with chest pain were assessed in the critical care area. One was admitted with suspected coronary insufficiency and another patient was admitted after sustaining a myocardial contusion when his apartment wall collapsed upon him, trapping him in the debris.

Patients with multiple fractures were stabilized for transfer. Many patients were evaluated for internal or neurologic injury and were found to have only superficial injuries.

A glenohumeral dislocation was reduced and a patient having spinal compression fractures was evaluated, stabilized and admitted. Simple removal of foreign bodies was accomplished, simple fractures were cast, splinted or otherwise stabilized after proper disposition was made of all other problems.

MEDICAL/SURGICAL FLOOR

When the initial warning came, all patients were moved into the hallway, away from doors and windows, and patients who were stable were marked for discharge.

Arrangements were made to provide for frequent monitoring of all newly admitted patients by the nursing staff and reassessment by physicians at regular intervals.

A system of runners to carry messages to and from other areas of the hospital was established.

Full electrical and telephone services were restored to this area late in the afternoon.

SURGERY

One patient was taken to surgery. No problems were encountered. However, it was later noted that no power had been available in the sterile supply area. This would have been a problem had multiple surgeries been required.

FIRST AID

The designated first aid area was the Physical Therapy department. This is a large room without windows which was not on the emergency generator system. Nevertheless, this was utilized for first aid using flashlights, and later extension cords to carry lights into the area. It could have easily been moved to an adjacent area which had light available through windows.

HOLDING AREA

This area was a large hallway adjacent to surgery, x-ray and the emergency room. It functioned well. There was, however, a traffic problem, but the constant flow of nurses, physicians and technologists through this area resulted in all patients being observed frequently.

When the disaster was over, we were rather shocked to discover that no one had been put in charge of this area. No problem developed because whenever a patient seemed unstable, someone promptly contacted a physician who saw that the problem was properly resolved. However, this area should have had a director to coordinate activities.

Consideration is now being given to moving the area to another location because of the traffic problem. There is, however, much to say for the present area in view of its proximity to diagnostic and critical care areas.

INTENSIVE CARE UNIT

All ICU patients were moved into the adjacent Recovery Room on receipt of the tornado warning. Stable patients were later transferred to the medical/surgical floor, to make room for casualties. While this area is on the emergency generator system, the central monitor console and bedside units had sporadic breakdowns caused by power surges resulting from the electrical storm which preceded the tornado. These failures were partially overcome by use of monitors from the Recovery Room. Large portions of the monitoring equipment in the ICU continued to have problems which required repair later in the week. This situation has now been rectified by installation of adequate surge protection equipment.

X-RAY

This area functioned exceptionally well during the disaster. However, of the three x-ray rooms present, only one functioned on the emergency power system. This, along with the portable x-ray unit, was utilized for all the x-ray studies during the disaster.

A system is being developed to allow all x-ray rooms to be used under emergency power conditions. If necessary, relays will be placed to allow sequential use of the units.

Consideration is also being given to altering the disaster plan to provide for keeping each disaster patients' x-rays physically with the patient until the emergency phase has passed.

DISASTER CONTROL CENTER

The hospital disaster control center was established in the lobby area. Most volunteers arrived here and were assigned duties from this area. Other than the in-hospital communication problem, this area functioned well.

GENERAL COMMENTS

During the morning and early afternoon of the tornado, 93 casualties were received and treated at Rolling Plains Memorial Hospital. Of these, one died, 11 were transferred for specialty care and nine were admitted to Rolling Plains Memorial Hospital.

Patients transferred included: one with concussion; two with spinal cord injuries; one with a fracture dislocation (after reduction of the dislocation); one with severe facial lacerations; one with facial nerve laceration and four with multiple fractures. Diagnoses of patients admitted to Rolling Plains Memorial Hospital were: myocardial contusion; angina pectoris; spinal compression fractures; premature labor; renal contusions; concussion; lumbar strain and multiple contusions; possible internal injuries; tendon laceration and forearm fractures plus deep laceration and puncture wound of the lumbar area.

Several other problems arose which were noted and are now in the process of being corrected. Some examples are: the blood gas analyzer was not on the emergency generator system; the disaster tags were not large enough to record what had happened to the patient in the hospital nor were they sturdy enough; identification tags indentifying workers as doctors, nurses, etc. would have been extremely helpful; Holding areas were needed for patients who had been dismissed, but had no transportation or place to go; walkie talkies or other inhouse back-up communication was needed; a scanner for emergency service radio frequencies would be helpful to alert the hospital to developing emergency situations and provisions need to be made to control patient information given to the press and others in the days immediately following the disaster.

On a more positive note, other observations need to be made.

All employees began work at their designated areas with only minimal direction. They promptly and appropriately performed any tasks assigned with little guidance being needed.

The patients and their families expressed almost no complaints of pain, anxiety or impatience. All seemed to realize they would be properly cared for as soon as possible.

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Physicians, nurses, paramedics, EMTs, medical technicians, veterinarians, law enforcement personnel and other volunteers, including many from surrounding communities, arrived promptly and offered invaluable help. Area hospitals offered any needed supplies and readily accepted all patients we wished to transfer.

The dietary department and local merchants made sure that everyone was fed during the time of the disaster.

The morbidity and mortality rates were extremely low considering the tremendous property damage. It may be theorized that this relatively low casualty rate might have been related to two factors which kept people in their homes. One was the unusual early Saturday morning timing. Most tornados occur during late afternoon or evening hours. The other factor, ironically, might have been the lack of warning. Studies performed following the tornado in Wichita Falls indicated that a high percentage of the deaths and serious injuries incurred there involved persons who had left a subsequently undamaged indoor area. In that tornado, only five of the 47 total traumatic deaths occurred in persons who had remained indoors.

No hospital or physician charge was made for any of the emergency treatment rendered tornado victims on that day.

Even with all the problems cited, the hospital disaster plan worked well. The previous disaster simulation drills had provided effective training to insure that all knew their roles and performed the tasks expected of them.

In closing, I would like to give credit to the members of the medical and nursing staff at Rolling Plains Memorial Hospital who helped in the preparation of this article.

Changes in the Texas Controlled Substances Schedules

The Federal Comprehensive Crime Control Act of 1984 included the Diversion Control Amendments. These Amendments permit the Drug Enforcement Administration (DEA) to schedule substances temporarily in Schedule I of the Federal Controlled Substances Act if such action is necessary to avoid an imminent hazard to the public safety. Scheduling under these provisions is effective for one year from the date on which the final rule is published in the *Federal Register*.

Pursuant to this authority, the DEA has scheduled each substance listed in this change order for control in Schedule I of the Federal Controlled Substances Act. Each listed substance has been produced in clandestine laboratories and each is known as a "designer drug" encountered in the illicit drug traffic.

On August 6, 1985, the Commissioner of Health placed 3, 4-methylene-dioxy methamphetamine (MDMA, MDM) in Schedule I of the Texas Controlled Substances Act (Section 2.03., Article 4476-15, Vernon's Texas Civil Statutes) under paragraph (f) as a temporary listing. However, after this action by the Commissioner, on September 1, 1985, Section 2, Chapter 227, Acts of the 69th Legislature, Regular Session, 1985 (S.B. 639), became effective. In this section, the 69th Legislature added the substance permanently to paragraph (d) of Section 2.03., Texas Controlled Substances Act.

In my capacity as Commissioner of Health, and pursuant to the authority granted to me in Section 2.09. (e) of the Texas Controlled Substances Act, I do hereby order that Subsection 2.03. (f) of the Texas Controlled Substances Act be amended to remove 3, 4-methylene-dioxy methamphetamine (MDMA), its optical, positional and geometric isomers, salts and salts of isomers, to add ten substances and to read as follows:

Sec. 2.03.

(a) * * *
(b) * * *
(c) * * *
(d) * * *
(e) * * *

(f) Temporary listing of substances subject to emergency scheduling by the Federal Drug Enforcement Administration. Any materials, compound, mixture or preparation which contains any quantity of the following substances:

* * *

1-(2-phenylethyl)-4-phenyl-4-acetyloxypiperidine (PEPAP), its optical isomers, salts and salts of isomers;

N-[1-(1-methyl-2-phenyl) ethyl-4-piperidyl]-N-phenylacetamide (acetyl-alpha-methylfentanyl), its optical isomers, salts and salts of isomers;

N-[-1-(1-methyl-2-(2-thienyl) ethyl-4-piperidyl]-N-phenylpropanamide (alpha-methylthiofentanyl), its optical isomers, salts and salts of isomers;

N-[1-benzyl-4-piperidyl]-N-phenylpropanamide (benzylfentanyl), its optical isomers, salts and salts of isomers;

N-[1-(2-hydroxy-2-phenyl) ethyl-4-piperidyl]-N-phenylpropanamide (beta-hydroxyfentanyl), its optical isomers, salts and salts of isomers;

N-[3-methyl-1-(2-hydroxy-2-phenyl) ethyl-4-piperidyl]-N-phenylpropanamide (beta-hydroxy-3-methylfentanyl), its optical and geometric isomers, salts and salts of isomers;

N-[3-methyl-1-(2-(2-thienyl) ethyl-4-piperidyl]-N-phenylpropanamide (3-methylthiofentanyl], its optical and geometric isomers, salts and salts of isomers;

N-[1-(2-thienyl) methyl-4-piperidyl]-N-phenypropanamide (thenylfentanyl), its optical isomers, salts and salts of isomers;

N-[1-(2-(2-thienyl) ethyl-4-piperidyl]-N-phenylpropanamide (thiofentany), its optical isomers, salts and salts of isomers;

N-[1-(2-phenylethyl)-4-piperidyl]-N-(4-fluorophenyl)-propanamide (para-fluorofentanyl), its optical isomers, salts and salts of isomers.

Done in Austin, Texas on this 12th day of June 1986, in witness whereof I have hereunto set my hand and seal of office.

Robert Bernstein, M.D., F.A.C.P.
Commissioner of Health

Opportunities Unlimited

PHYSICIANS WANTED

FAMILY PRACTICE, GARLAND AREA — Growing practice in growing area. Great location/exposure. 2800 sq ft., lab x-ray, hospital assistance, much more. Reply to F.P., 4706 Duck Creek, Garland, 75043.

POSITION OPEN for assistant in practice either as salary or as percentage of practice. Phone 512—452-7641 or write Joseph L. Love, D.O., 4400 Red River St., Austin, 78751.

WANTED — Family Practice doctors to supervise four TCOM sophomore medical students and work at the Virginia Ellis Clinic on Wednesdays from 5-8 p.m. This is a free screening clinic in the Bethlehem Community Center located at 970 E. Humbolt, Fort Worth, 76104, and serves low income families. Must have own malpractice insurance. Not necessary to work every Wednesday. Pays $25/hour. Call Community Services, 817—735-2450, if interested.

ONCOLOGIST/INTERNISTS — Available in July 1987. M.D. Anderson trained AOA approved. Will consider all offers. Please contact: Rich McKinney, D.O., 713—667-9272.

ANESTHESIOLOGY RESIDENCIES Texas College of Osteopathic Medicine accepting applications for residency in anesthesiology for January and August 1987. Contact:

Paul A. Stern, D.O.
Professor & Chairman
Dept. of Anesthesiology
Camp Bowie at Montgomery
Fort Worth, TX 76107
Equal Opportunity Employer

FAMILY OR GENERAL PRACTICE PHYSICIAN — Needed to join a very busy West Texas Family Practice Medical Center. Modern, well equipped clinic. Excellent opportunity for person willing to work hard. Contact L.R. Moses, D.O., 1300 Hailey, Sweetwater, Texas, 79556 or telephone 915—235-1717.

OCCUPATIONAL MEDICINE PHYSICIAN — A position is available for an Occupational or Industrial Medicine Physician (M.D./D.O.) in a large well-established multi-disciplinary spine rehabilitation center. Applicants should be experienced in employment physicals, executive physicals, workmen's compensation evaluations, on-site industrial visits and be prepared to see walk-in industrial injuries and diseases. Applicants should also be familiar with risk management concepts and health care cost containment. Applicant may be an M.D. or D.O. with preferable internal medicine or family practice residency and be board certified or eligible. The physician would also have opportunity for a limited family practice. Additional responsibilities for the applicant will include the management of the multi-disciplinary team (P.T., O.T., Psychology) and the supervision of associated additional physician staff as growth predicts these additions. Interested applicants should submit a letter of inquiry, curriculum vitae, a bibliography, the names of three references and a statement of salary expectations. The material should be mailed to Richard Guyer, M.D., 3801 W. 15th Street, Suite 300, Plano, Texas 75075.

RURAL GENERAL PRACTICE FOR SALE — Three year old satellite clinic ideal for physician who wants low stress or semi-retired hours. Will hospitalize for you if desired. Coverage available. Minutes from great fishing and boating in beautiful East Texas yet one hour from Houston. Owner will lease building for $300.00 per month. Fully equipped and furnished. Present doctor expanding primary practice but willing to help new physician settle in. 409—829-4749 (office), 409—634-6223 (home).

FULL-TIME PHYSICIAN POSITION — for general practice/internal medicine clinic. Partnership available in one year. Excellent opportunity. Write or call S.J. Kechejian, M.D., 609 S. Main Street, Duncanville, 75116, 214—780-0093.

POSITIONS DESIRED

URGENT — Mature student with family, TCOM class of '88, needs immediate and/or long term financial assistance. Any repayment option considered. Contact: TOMA, Box "401", 226 Bailey Avenue, Fort Worth, 76107.

GASTROENTEROLOGIST — 36, available about January, 1987, trained in all endoscopic procedures, desires group or associate practice. Please contact TOMA, Box "402", 226 Bailey Avenue, Fort Worth, 76107.

PHYSICIAN AVAILABLE — for locum tenens in the Dallas/Fort Worth area. Please contact Barbara E. Gallagher, D.O., 817—485-6296.

OFFICE SPACE AVAILABLE

WELL ESTABLISHED SOUTHWEST DALLAS COUNTY — physician wishes to sell completely equipped clinic facility as practice package or building only. For details and terms contact Nancy Findley, American Professional Realty, Inc., at 214—291-2536, 214—780-0653 or 214-291-4484.

SIX MONTHS FREE RENT ON MEDICAL OFFICE SUITE — 1500 sq. ft., ideal for one or two physicians. Residential area in the center of Grand Prairie, close to Dallas/Fort Worth Medical Center. Call 214—262-7866.

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For more information about ATOMA, please contact: Chris Godell, ATOMA President, 2103 Wilson Drive, Arlington, Texas 76011, 817—469-7648 or 817—275-3535; Sue Urban, ATOMA Treasurer, 7813 Fairwood Ct., Fort Worth, Texas, 76179; or TOMA State Headquarters, 1—800—772-5993.

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