TEXAS OSTEOPATHIC PHYSICIANS
JOURNAL
September 1976

A Texas-style reception was hosted by the delegation. Dr. and Mrs. David Armbruster and Dr. and Mrs. George Luibel greet the guests.

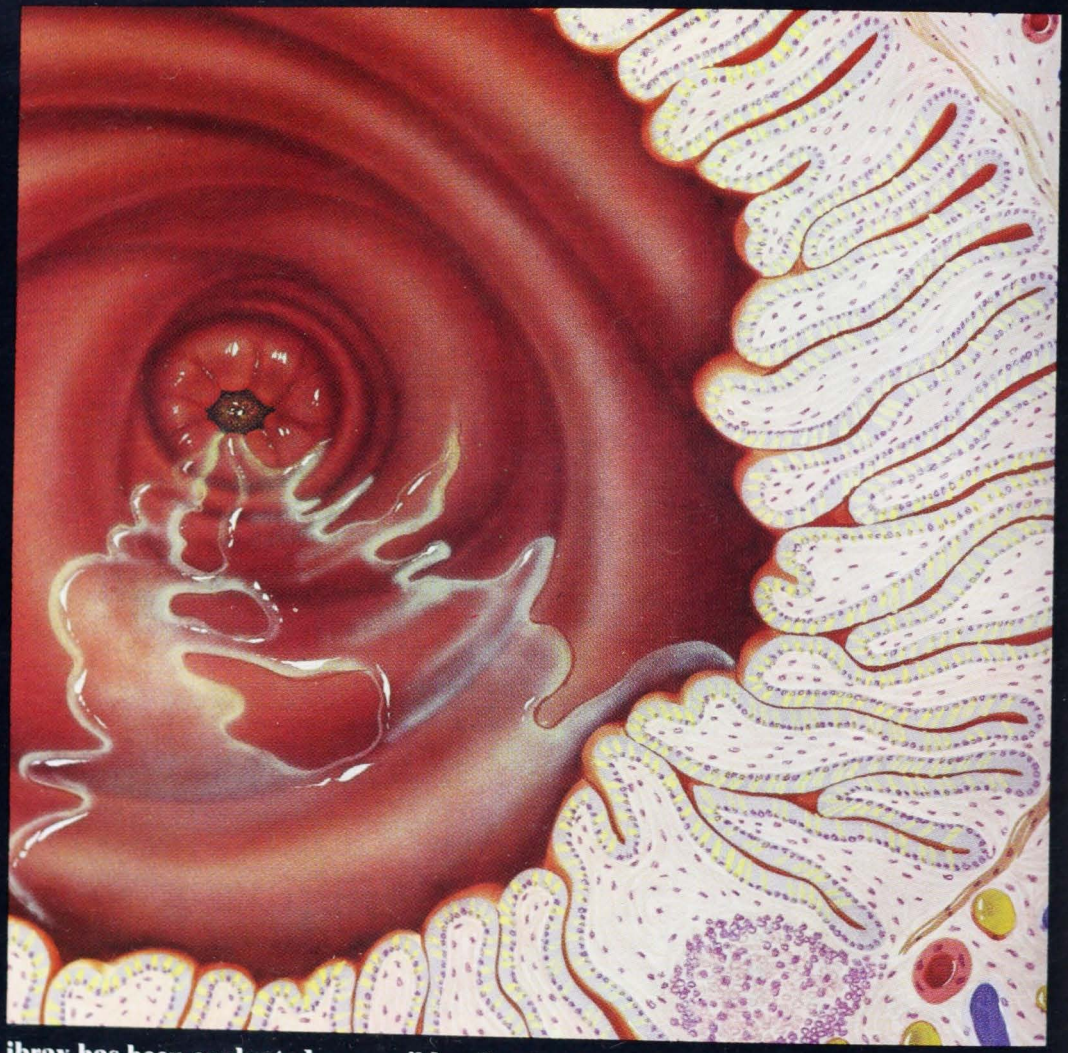
Dr. George Luibel is installed as AOA president by Dr. Earl Gabriel, outgoing president.

Texas delegates and AOA officers shown (l. to r.) are Dr. James Lively, Dr. John Cegelski, Jr., TOMA President and AOA Trustee Dr. David Armbruster, Dr. W. R. Jenkins, AOA President Luibel, Dr. Gerald Flanagan, Dr. Wiley Rountree, AOA Speaker Dr. Sam Ganz, Dr. Michael Calabrese, Dr. Robert Haman, and AOA Bureau of Insurance Chairman Dr. John Burnett.

The photographer's lens wasn't wide enough to include the entire delegation. No Texans were cropped off the picture!

Presenting Gastrointestinal Complaints

Pain and bloating with diarrhea and/or constipation may indicate irritable bowel syndrome*



*Librax has been evaluated as possibly effective for this indication. See Brief Summary.

Recurrent episodes of acute G.I. discomfort, associated with constipation, diarrhea or abdominal pain ranging from dull gnawing to sharp cramping sensations, may suggest irritable bowel syndrome and warrant further investigation. If this tentative diagnosis is confirmed, medical relief of the acute episode may be only the starting point of appropriate long-term management. Such patients often have an extended history of dietary reactions and laxative misuse with a tendency, when under severe emotional strain or fatigue, to experience a colonic "protest."

Indeed, careful questioning will usually uncover a significant relationship between periods of undue anxiety or emotional tension and the exacerbation of G.I. symptoms. This type of patient will probably need your counseling and reassurance to assist him in making beneficial modifications in his life style and attitudes.

If it's irritable bowel syndrome, consider Librax as adjunctive therapy

In most instances, the patient with irritable bowel syndrome derives maximum long-term benefits from a comprehensive medical regimen directed at both the somatic and emotional aspects of this functional disorder. The dual action of Librax has proved to be highly effective not only in relieving the distressing symptoms of irritable bowel syndrome but also in maintaining patient gains.

A distinctive antianxiety-anticholinergic agent

1 Only Librax combines the specific antianxiety action of Librium® (chlordiazepoxide HCl) with the dependable antisecretory-antispasmodic action of Quarzan® (clidinium Br)—both products of original Roche research.

2 The calming action of Librium—seldom interfering with mental acuity or performance—makes Librax a distinctive agent for the adjunctive treatment of certain gastrointestinal disorders. As with all CNS-acting drugs, patients receiving Librax should be cautioned against hazardous occupations requiring complete mental alertness.

3 Librax has a flexible dosage schedule to meet your patient's individual needs—1 or 2 capsules three or four times daily, before meals and at bedtime.

helps relieve anxiety and associated symptoms of irritable bowel syndrome*

Librax®

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

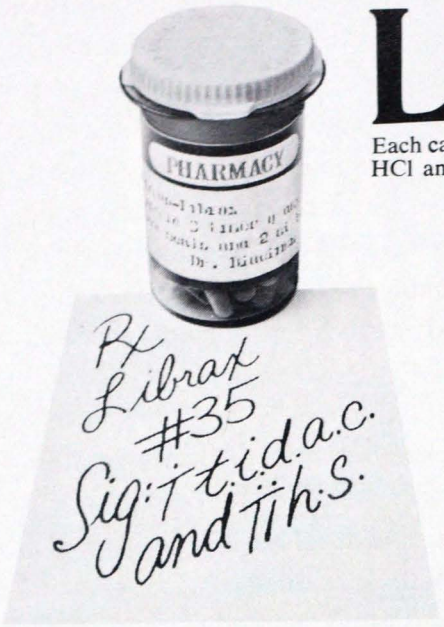
ROCHE

***This drug has been evaluated as possibly effective for this indication. Please see following page for brief summary of product information.**

Dual-action adjunctive

Librax®

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



Initial R_x

The initial prescription allows evaluation of patient response to therapy.

Follow-up

Follow-up therapy, with a prescription for 2 to 3 weeks' medication, usually helps to maintain patient gains.

helps relieve anxiety-linked symptoms of irritable bowel syndrome* and duodenal ulcer*

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

*

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).
Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacologic effects of agents, particularly potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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

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

How Supplied: Librax® Capsules, each containing 5 mg chlordiazepoxide hydrochloride (Librium®) and 2.5 mg clidinium bromide (Quarzan®)—bottles of 100 and 500; Prescription Paks of 50, available singly and in trays of 10.

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

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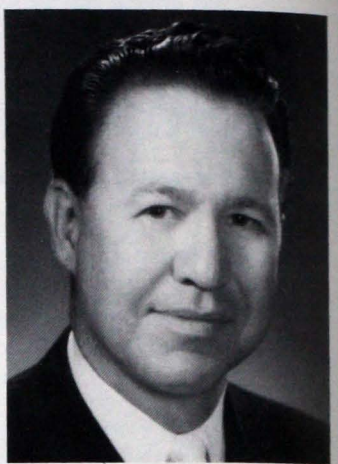
Mr. Tex Roberts, Editor

TOMA Delegates

Report on AOA House Meeting



John H. Burnett, D.O.

JOHN H. BURNETT, D.O.
Chairman of the Texas Delegation

The profession's official professional liability insurance program received a 38.8 per cent rate increase this year. A higher increase was indicated by the actuarial workup; however, the Chubb Corporation agreed to cut their cost factor from 5 per cent to 2½ per cent, and the Nettleship Company agreed to cut their production and underwriting fees from 12½ per cent to 9 per cent to accomplish the 38.8 per cent.

Eighteen months ago the malpractice crisis exploded and was officially recognized—nationwide. Malpractice claims against physicians and hospitals were increasing at an alarming rate. This was compounded by general inflation and a trend toward bigger awards to plaintiffs, making it nearly impossible to set rates with any reasonable accuracy for future claims.

Many physicians began to practice defensive medicine, at a much greater cost to patients, and a loss of medical effort and dollars in unnecessary diagnostic documentation. Legislators in almost all the 50 states began enacting laws assuring (at least for the moment) the continued availability of malpractice insurance.

Twenty-five states enacted legislation modifying aspects of the tort law as applied to medical malpractice litigation. Twenty-two states created joint underwriting or reinsurance associations to provide a vehicle to compel casualty insurers to participate in writing medical malpractice insurance.

In 15 states legislation was passed providing for binding arbitration of medical malpractice claims or the submission of claims to screening panels. These laws fall into three categories: *Binding Arbitration* in California, Michigan, Ohio and Louisiana provide for arbitration by written agreement of the parties prior to or after the treatment from which the claim arose.

Voluntary Non-Binding in Wisconsin and Arkansas and *Compulsory Non-Binding Mediation* in Illinois, Indiana, New York, Pennsylvania, Tennessee, Louisiana, Florida and Massachusetts provided that before litigation may proceed, the parties must submit the matter to a panel. Either party may proceed to trial after submitting to the panel.

Eight states enacted statutes requiring insurance companies writing medical malpractice policies to report information concerning claims to the Commissioner of Insurance.

Forty-one states created study commissions to analyze the medical malpractice situation and make recommendations for remedial legislation.

Twenty states enacted statutes granting members of peer review boards immunity from civil liability arising out of their official actions.

Nineteen states have legislated changes in statutes of limitations as related to medical malpractice.

Eight states placed limitations on contingent fees.

These legislative reforms in tort law with the exception of (1) changes in the statutes of limitation, (2) limitations on contingent fees, (3) arbitrary ceilings on recoveries and (4) admissibility of evidence of payment from collateral sources, seem likely to have a relatively minor impact.

Such reforms will not affect a horde of claims filed this year, and no one can predict for certain that changes in tort law will survive challenges in Court as to their constitutionality. Unfortunately, the massive tort law reform has not been reflected in reduced premiums.

Florida and Indiana have reported substantial rate increases in spite of new laws. Southern California physicians received a 486 per cent rate increase shortly after their comprehensive reform bill.

This year the Insurance Service Organization will propose varying rate increases in every state, with the national average increase estimated at 170%.

It is in this super complex atmosphere that thousands of articles have been addressed to the malpractice crisis, sometimes numbing the mind and obscuring the basic issues. Because the problem appeared on the medical scene so suddenly, valid statistics are in short supply and often impossible to obtain.

It has been estimated that malpractice claims ran over 40,000 in 1975 and the total amount paid in claims is approximately $1 billion annually. This represents only a small percentage of the 35 million hospital admissions and nearly 250 million outpatient visits each year.

Most negligence claims and practically all catastrophic

:ases arise within the hospital setting. As many as 10,000 persons die each year from surgical intervention (including inesthesia and postoperative complications), 30,000 die from idverse drug reactions and hospital-oriented infections strike one out of every 25 patients.

Society, which once limited awards to patients who could prove negligence, now is inclined to reimburse every patient for any adverse result of unavoidable accident that occurs in the course of treatment. What hope does this new social philosophy hold for the future?

This year, the Council on Federal Health Programs recommended to the Board of Trustees that a position be adopted favoring Congressional enactment of a law mandating each state to enact a state compensating system for medical liability claims. This medical injury compensation approach is a plan which can provide prompt and equitable compensation to those sustaining medical injury and can be operated at a reasonable cost.

Compensation would be limited to actual damages incurred, or likely to be incurred. This would include treatment costs, loss of income, compensation for disabilities resulting from injury and rehabilitation. Collateral sources of income—private health and disability insurance, pension funds, Medicare and Medicaid—would be taken into account for determining the amount of the award. The cost would be further spread by a single admission charge to all hospital patients, with the patient purchasing catastrophic or excess coverage at the time he is admitted to the hospital.

There are tremendous problems with the present costly, erratic and time-consuming tort litigation system of handling medical malpractice claims. The cost of malpractice insurance and the fear of lawsuits threaten to cripple our health care system. It is essential that we reform the way medical injury cases are resolved and the way injured patients are compensated. The task will not be easy or quickly accomplished, but we must begin now.

The implementation—by states—of this practical proposal would be a great stride in alleviating this critical social problem before the cost of health care becomes too great for the public to bear.

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AMES W. LIVELY, D.O.
ommittee on Constitution and Bylaws

It was my privilege to serve the House of Delegates of the OA for 1976 on the Committee on Constitution and Bylaws. Several important resolutions were considered and action ken by the committee and the House as indicated in the llowing resume.

The Ethics Committee of the AOA referred a resolution ncerning advertising by HMOs to the House for study. The ain concern of the physicians presenting the resolution was eir inability to advertise as individuals, placing themselves a disadvantage in competition with HMOs. The Ethics mmittee considered the problems and offered a resolution at complied with the federal statutes and offered a measure relief from advertising of individual physicians involved in MOs as indicated in the following summary of the resolution.

It is the interpretation of the AOA that consistent with Section VIII of the Code of Ethics, and because the AOA's basic position is that the underlying purposes and goals of the legislation creating federally supported HMOs through advertising does not constitute a violation of the prohibition of advertising. This does not authorize any advertising which identifies, refers to, or makes any qualitative judgment concerning any health professional who provides services for an HMO.

The above interpretation is a summary of the complete resolution. This was recommended to the House and passed unanimously.

Resolutions 111 and 123 from Missouri and Wisconsin were concerned with default in payment or filing of bankruptcy to avoid repayment of student loans. It was the concern of the states submitting the resolution that the rate of default on student loans might increase and cause a withdrawal of lenders from the student loan market. The remedy sought was a resolution declaring default without cause, or involving bankruptcy to avoid repayment of debts, unethical and unprofessional conduct.

In the discussion of the problem it was learned that only a fraction of one per cent of students in Osteopathic schools were involved. It was also pointed out that bankruptcy required adjudication and was a decision of the court rather than an individual choice. In individual default without cause there is legal recourse for collection. The committee felt that the AOA should not involve itself in a posture which might place it in opposition to the court and expose the association to the possibility of litigation. As the problem is minimal and remedies are prescribed by law, the committee recommended disapproval of the resolutions. Both resolutions failed in the House.

Resolution 129. By action of the House in July 1975 a study was ordered concerning the establishment of an Armed Forces Component Society. Currently, by AOA statistics, there are 340 D.O.s in the uniformed armed services. Of this number there are few who actively participate or feel a part of their respective divisional societies. For this reason, a resolution from Hawaii to designate the uniformed armed forces as a separate divisional society with voice and vote in the House of the AOA was forwarded to the Constitution and Bylaws Committee. After much discussion, and with the assistance of legal counsel, the method to establish the society was outlines. A substitute resolution was sent from the committee to the House with a recommendation for approval. This passed the House unanimously and is as follows:

Resolved that a Uniformed Services Organization may apply for a charter as a divisional society pursuant to the bylaws for possible recommendation for the issuance of a charter at the next annual meeting of the House of Delegates and that the AOA provide all assistance in the formation of this society and that the executive director be instructed to arrange a meeting for the members of the Uniformed Services Organization at the next AOA convention in San Francisco, California; and be it further

Resolved, that amendments of the constitution and bylaws be submitted to the House of Delegates to provide for the inclusion and the definition of a divisional society of a Uniformed Services Society and to delete from the bylaws the waiver of dues for regular members

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who are on active duty in the Uniformed Services of the Federal Government.

The remainder of the resolution was concerned with the necessary changes in the constitution and bylaws to establish the divisional society and to change the dues-paying status of the members in the armed forces. The committee and the House felt that if this new divisional society was allowed voice and vote in the House then it would be necessary to support financially the AOA through dues in the same fashion as other voting members of the AOA.

Constitution: Changes to the constitution of the AOA which have been published in the AOA journals for the designated period of time and approved and passed by the House in this session included a change in Article VII, Officers, Section 2, which deleted the titles Treasurer and Business Manager from the Administrative Officers and added the Office of Controller.

The second change was concerned with Article VIII, Board of Trustees and Executive Committee, Section 2. This change added the Chairman of the Department of Educational Affairs, the Chairman of the Department of Business Affairs and the Chairman of the Department of Federal Affairs to the Executive Committee. These were relatively newly created departments which the Committee on Constitution and Bylaws felt should be equally represented on the Executive Committee.

Bylaws: Bylaws submitted to the Committee on Constitution and Bylaws by the House of Delegates of the AOA in 1975 are as follows:

Article III, Section 2

(a) The annual dues of regular members of the association shall be $175.00. (As you recall this was passed by the House in 1975.)

(b) There were changes in the dues paying structure with the new schedule of dues as follows: First year members, one-half of the full dues rate with the reduction in the second and third year dues being deleted. This requires all AOA members to pay full dues rate after the first year.

(f) A reduction in dues for full-time faculty members was completely deleted.

Article V, Section 2, and Article VI, Section 3, concerned with voting and method of election bylaws changes were withdrawn by the submitting parties without action.

Article III, Section 3, Assessments: This bylaw was amended to read as follows: To meet emergencies the Board of Trustees may levy such assessments as may be necessary, provided that the total of such assessments in any one year shall not exceed the amount of the annual dues. Failure to pay such assessments shall incur the same penalty as failure to pay dues. *Those dropped from membership for non-payment of dues during the fiscal year in which an assessment prior to reapplying for membership.* (The change in the bylaws is noted in italics.) All of the constitutional and bylaws changes, other than for the withdrawn Article V, Section 2, and Article VI, Section 3, were passed by the house.

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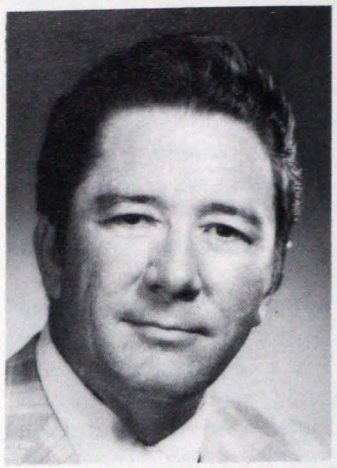
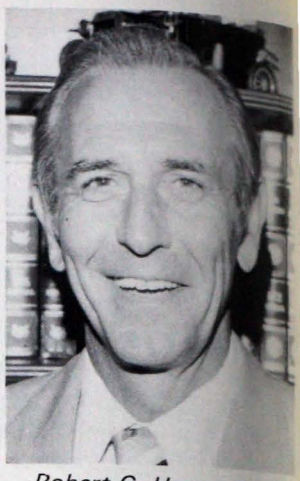


James W. Lively, D.O.



Robert G. Haman, D.O.

ROBERT G. HAMAN, D.O.
Professional Affairs Reference Committee

Chairman John Burnett, D.O., assigned me the last portion of the Professional Affairs Committee report.

This Committee worked hard on many delicate subjects and they were handled thoroughly and completely by Kirk H. Herrick, D.O., chairman of the Professional Affairs Committee.

Resolution 126 (Oregon)

Subject: Conflict of Interest
Reference Committee: Recommends be approved
House of Delegates: Passed

Whereas, the AOA administrative officers, elected officers, members of the Board of Trustees, appointed committee chairmen and committee members are ultimately responsible to the membership-at-large for their actions; and

Whereas, the actions taken by these elected and appointed individuals who serve on various levels of responsibility should always be above reproach; and

Whereas, such elected and appointed individuals should not use their respective positions with the AOA to derive direct or indirect personal profits from or with regard to the AOA to the detriment of the AOA; and

Whereas, in order to maintain their actions as being responsible to the membership-at-large and above reproach, all potential conflicts of interest arising from situations whereby such elected and appointed individuals directly or indirectly make personal profits from the AOA, or by virtue of such individuals respective positions within the AOA, should be fully disclosed; therefore, be it

Resolved, that all elected officers immediately following their election *and annually thereafter as long as they may serve* should submit conflict of interest statements to the Board of Trustees and all elected, administrative and appointed officers and officials shall likewise submit a conflict of interest statement whenever a state of facts arises or exists whereby an individual officer or official will or may directly or indirectly derive personal profit from the AOA or by virtue of such individual's position within the AOA; and be it further

Resolved, that the Board of Trustees, through the Executive

Committee, shall review all such statements *annually* and shall determine in each case whether conflicts of interest to the detriment of the AOA exist, or may exist, and shall take whatever action is deemed appropriate and necessary pursuant to the Bylaws.

esolution 130 (Board of Trustees)

Subject: Request for Charter—American Osteopathic College of Allergy and Immunology
Reference Committee: Recommends be approved
House of Delegates: Passed

esolved, that the Board of Trustees recommends to the House of Delegates that a charter of affiliation be granted to the American Osteopathic College of Allergy and Immunology.

esolution 131 (Board of Trustees)

Subject: Request for Charter—American Osteopathic Academy of Sports Medicine
Reference Committee: Recommends be approved
House of Delegates: Passed

esolved, that the Board of Trustees recommends to the House of Delegates that a charter of affiliation be granted to the American Osteopathic Academy of Sports Medicine upon insertion of the following amendments to their basic documents:

1. Insert the word "discipline" wherever the word "specialty" appears in the basic documents; and
2. Insert the following new Section 3:

(D) Any member against whom action has been taken with respect to an alleged breach of the of ethics, shall have the right to appeal for a review of the record of such action by the Board of Trustees of the American Osteopathic Association.

esolution 132 (Board of Trustees)

Subject: Request for Charter—American Osteopathic Academy of Acupuncture, Inc.
Reference Committee: Recommends be disapproved
House of Delegates: Passed on Reference Committee's recommendation of disapproval

esolved, that the Board of Trustees recommends to the House of Delegates that a charter of affiliation be granted to the American Osteopathic Academy of Acupuncture, Inc.

solution 133 (Pennsylvania)

Subject: Advance Information for House of Delegates
Reference Committee: Recommends adoptions as amended
House of Delegates: Passed as amended

ereas, the House of Delegates of the AOA is confronted each year at the annual meeting with the responsibility of approving a proposed budget and financial statement without adequate opportunity to review these documents before the meeting; and

Whereas, the House of Delegates cannot properly perform its fiscal responsibilities without this information; and

Whereas, the administrative office of the AOA has been unable to provide such information in a timely fashion; therefore be it

Resolved, that the necessary accounting changes be accomplished to facilitate such compliance.

Again it has been a pleasure to work with this group of delegates and to represent Texas at the national meeting.

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WILLIAM R. JENKINS, D.O.
Professional Affairs Reference Committee

This report involves a portion of the activities of the Professional Affairs Committee in the House of Delegates of the American Osteopathic Association at its recent meeting.

In the overall deliberations of the House of Delegates this year there was a feeling that the entire House and it's delegates wished to cooperate thoroughly in furthering the affairs of the Association. Deliberations of the entire House through this committee covered many areas. There were, of course, problems facing the Association and its members and there were differences of opinion. In the final estimate it is my opinion that the delegates parted unanimous in their decisions and with an underlying sense of unity.

Portions of the Professional Affairs which were acted on by committee and the House of Delegates on which I am to report deal with resolutions 104, 118, 121, and 125.

By far the most time consuming in the realm of debate, both in reference committee, open hearing, and in the House was involved with resolution 104. I believe that for information, this resolution should be printed as it was passed and it is included below:

This resolution deals with graduates of Osteopathic medical schools who have taken an internship and/or residency in non-AOA approved programs. These physicians have, either because of lack of information or in deference to rules at the time they entered the training, not complied with AOA regulations and are now requesting reinstatement into the AOA structure with approval of their training and eventual certification by the various specialty boards. The enclosed resolution was presented, as you can see, by the Board of Trustees on the recommendation of the Bureau of Education. Dr. Phillip Adler, the AOA President-Elect, was one of the men in our organization who worked most diligently on this resolution. This resolution has encompassed approximately 18 months of work by various committees to reach this stage.

It was felt by the reference committees, after an open hearing on the matter, and by the House of Delegates in session, that this instrument was sound and would give the accrediting bodies guidelines to go by. The attitude of the House seemed to be one of compassion toward these applicants, but the House seemed to feel that all accreditation and

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certification guidelines set forth previously by the American Osteopathic Association could not and should not be ignored.

The House, in passing this resolution unanimously, agreed that it did give the guidelines to the accrediting committees and bureaus and also gave the committees some leeway for individual applications.

It was the opinion of the Texas delegation that this instrument was sound and was a beginning working tool. This instrument, you must realize, is a retroactive instrument and applies only to those people who have already completed a non-AOA approved training and are now seeking AOA affiliation. Rules regarding future applicants are specifically spelled out and guidelines are available.

Resolution 118 submitted by the Ohio Osteopathic Association had to do with the American Osteopathic Association's requirement that the first year of a residency program be served in an AOA approved hospital for any given specialty. Ohio wished to substitute the words "any year" for "first year" of residency training.

Resolution 121 was submitted by the Pennsylvania Osteopathic Association and dealt with reinstatement of California osteopathic physicians. The osteopathic profession was legally reinstated in the state of California and this resolution dealt with accepting back into the California Osteopathic Association those who now possessed the little m.d. degree and who desire to return to the osteopathic profession. After committee and conference committee and hearing, it was agreed in consultation with the California delegation at the House of Delegates that the American Osteopathic Association through its committee on membership would seek a mechanism, in consultation with the osteopathic physicians and surgeons in California, to return those physicians so desirous to the osteopathic profession. There was much discussion about back dues and court proceedings to be paid by any member desirous of returning. It was thought that each member probably would have to be treated on an individual basis was the reason for the consultation with the California Osteopathic Association and the membership committee. This resolution passed, as edited by the House.

Resolution 125 had to deal with the discharge of a previously appointed conference committee which was no longer necessary. This action passed unanimously by the House.

As I previously stated, it was a pleasure to be in the House this session as there was a down to business type of attitude with serious debate and final agreement. I believe that this House and each member was seriously attempting, to the best of its ability, to perform for the benefit of it's members.

Resolution 104

Resolved, that the *"Procedure for candidates seeking AOA specialty certification who are presenting non-AOA education credentials"* be approved.

I. *Purpose*

To provide for those osteopathic physicians, who for one reason or another, have taken postdoctoral educational programs in the allopathic profession that have not been previously approved by the Committee on Postdoctoral Training, and now wish to obtain certification by the appropriate certifying board of the American Osteopathic Association.

II. *Application*

Application is made to the American Osteopathic Association Committee on Postdoctoral Training for consideration of approval of the training program.

III. *Procedure*

1. The applicant must present documentation of satisfactory completion of a first year rotational postdoctoral educational program (internship) approved by the American Osteopathic Association.
2. The applicant must present documentation of satisfactory completion of an acceptable allopathic postdoctoral program, as approved by the Liaison Committee on Graduate Medical Education. Documentation might include (but not be limited to) logs, certificates, affidavits from the trainer, retrospective inspection, etc.
3. The applicant must obtain a counselor who is certified by the American Osteopathic Association in the specialty field of the applicant and who is acceptable to the American Osteopathic Association. The counselor shall interview and advise the candidate, and monitor his/her progress in seeking certification by the American Osteopathic Association. The counselor will *not* be personally responsible nor involved in the additional postdoctoral training required of the applicant.
4. The applicant will be required to take one year of training in the AOA approved program, such as an osteopathic fellowship, preceptorship or residency in the involved specialty area. Such program will be subject to the usual rules of the Committee on Postdoctoral Training. (Note: The total amount of time in postdoctoral training in both the allopathic and osteopathic programs may exceed but in no instance be less than that required for candidates in regularly approved AOA programs.)
5. The applicant will be required to complete a program in the area of osteopathic principles and concepts: palpatory diagnosis and manipulative therapy, as it applies to the particular specialty field. The program may be one given by (a) a college of osteopathic medicine, or (b) an osteopathic specialty college, or (c) the American Academy of Osteopathy. The program may consist of a research project or teaching assignment in an osteopathic educational institution. The program must be submitted by the applicant to the Committee on Postdoctoral Training for prior approval. The objectives, program statement, evaluator, and evaluation mechanism will be required for approval.

IV. *Evaluation*

All of the foregoing requirements will be monitored and evaluated by the Committee on Postdoctoral Training. When the applicant has fulfilled all of these requirements, the Committee on Postdoctoral Training may recommend approval to the Board of Trustees and notify the specialty board, to which application is being made, of the fulfillment by the applicant of these requirements.

The residual requirements for board eligibility, including practice period requirements, will remain the same for these applicants as they are for applicants from regularly approved AOA postdoctoral training programs.

V. This special procedure shall become effective the date of action of the Board of Trustees and House of Delegates. This special procedure will not be available for graduates of colleges of osteopathic medicine who begin their postdoctoral training one year after the date of action of the Board of Trustees and House of Delegates.

I. A suitable document should be prepared and made part of the AOA intern matching manual material in order to properly inform students of the proper protocol to follow concerning postdoctoral training programs, and the proper committees and bureaus of the AOA to seek approval of programs that would be outside of AOA training institutions.

II. A Speakers Bureau will be established consisting of persons knowledgeable in the areas of AOA proper protocol concerning postdoctoral training programs. Osteopathic Colleges will be required, on an annual basis, to set up student clinical assemblies to have persons from the AOA Speakers Bureau inform the students of the proper protocol in seeking approval of postdoctoral training programs. (The Bureau of Professional Education, with the approval of the Board of Trustees shall establish the Speakers Bureau.)

II. Every AOA affiliated organization (divisional societies, specialty colleges, certifying boards, osteopathic colleges, and directors of medical education) will be required to inform trainees of the proper committees of the AOA, which are the Committee on Postdoctoral Training, Advisory Board for Osteopathic Specialists and/or the Bureau of Professional Education, as the only qualified comcittees under the AOA organizational structure to be contacted referable to information concerning the proper protocol for approval of postdoctoral training programs.

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William R. Jenkins, D.O.

John J. Cegelski, Jr., D.O.

JOHN J. CEGELSKI, JR., D.O.
Public Affairs Reference Committee

It appears that the Washington meeting of this year's House of Delegates of the AOA was a fine example of the close family relationship this profession has been showing in the past two years for working out the problems of the future for the profession. We are more than ever involved in the problems of national health care and increased government intervention.

Of considerable interest was Resolution 110 that resolved that the AOA be urged to continue its efforts for and support to activities which emphasize the delivery of health care through private and free enterprise, without increased involvement of the federal or state governments; and to support legislative activity, and those legislators, which favor limited government involvement in health care delivery.

This resolution was disapproved, after much discussion, with an explanatory statement: that after consultation with the AOA attorney, the Committee recommends no action (disapproval), although they are in sympathy with the intent of the resolution.

Many questions were asked in regard to the legal aspects of Resolution 112 which was the Establishment of Policy on Nationwide Immunization Against Influenza. It was noted that many states will offer the vaccine *when* and *if* it becomes available for mass inoculation in a different manner and plans are yet to be worked out by federal and state health agencies for this vaccine distribution.

This resolution was approved with minor changes; that the AOA House of Delegates establish the policy of complete cooperation with federal and state health agencies in this crisis; to work with those agencies in establishing plans for the mass inoculation program.

Resolution 128 was concerned with National Licensure of Health Manpower. It resolved that the AOA House of Delegates take a position opposing national standards for licensure, or the compulsion of state licensing agencies or health profes-

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TOMA Delegates Report

sionals to conform to desired federal or national standards by withholding of reimbursement for services rendered under federal health programs; and notify the appropriate federal agency as to such position; and it was further resolved that the AOA, seeking assistance of affiliated osteopathic institutions, state divisional societies, and individual members, make every effort to influence Congress to avoid passage of legislation establishing national licensure or standards therefor. This resolution was approved by the Committee.

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MICHAEL A. CALABRESE, D.O.
Public Affairs Committee

Again this year it was my privilege to have the opportunity to sit as a member of the Public Affairs Committee chaired by Samuel W. Howe, D.O. of Ohio.

There were eight resolutions referred to this committee, three of which were submitted by the Board of Trustees of the AOA, four from the State of Missouri and one from the State of Ohio.

Resolution 100 submitted by the Board of Trustees pertained to the AOA Position on Primary Health Care. It reiterated the profession's stand that 75 to 80 per cent of D.O.s are primary care physicians and that all of the osteopathic colleges are geared to the training of family physicians. With a few minor changes in the wording of some of the text of the resolution it was passed by the House of Delegates.

Resolution 101, also submitted by the Board of Trustees, was a policy statement regarding National Health. The gist of this policy was that the AOA being aware of federal health programs and at times its necessity, "strongly supports the concept of Private Enterprise in development of National Health Policy articulating such health care objectives". This was passed by the House of Delegates.

Resolution 103, also submitted by the Board of Trustees, was directed toward the U.S. Congress in supporting the concept of "closer congressional scrutiny of the administrative rulemaking process". The passage of this resolution stimulated the concept of similar resolution directed to "State Scrutiny of Administrative Rulemaking".

Resolution 110, submitted by the State of Missouri, pertained to the "increased government involvement and intervention in health care delivery". As the intent of this resolution was covered in Resolution 103 and consultation with the AOA attorney recommending its disapproval, it was disapproved by the House.

Resolution 112, submitted by Missouri, pertained to the establishment of Policy on nationwide immunization against the swine flu. The AOA went on record that it would cooperate fully with federal and state agencies in establishing plans for the mass inoculation program. This passed unanimously in the House.

Resolution 113, also submitted by Missouri, was referred to the Committee on Finance as it involved the distribution of funds. It pertained to the establishment of a consumer Health Education Committee in order to provide more information to the public on health delivery on a continuing basis in the form of developing, publishing, and distributing local directories for the public relative to professional backgrounds and services offered. This was passed.

Resolution 117, submitted by Ohio, was withdrawn and thus was not officially acted upon.

Resolution 128, submitted by Missouri, pertained to National Licensure. The resolution urged that the AOA take a position opposing national standards for licensure and urged state and divisional societies to make every effort to influence Congress to avoid or defeat passage of such legislation. This resolution was passed by the House of Delegates.

As AOA delegate, it was indeed a pleasure to serve you. This particular meeting was exceptional in that our own Dr. George Luibel assumed the gavel as president of the AOA. Also I am pleased to report that I sensed a tremendous espirit de corps which seemed to permeate throughout this convention. From the House of Delegates there seemed to emanate a confidence, a sureness and brotherhood which seemed inexplicable at the time. But now in retrospect I feel I can explain it in one word– "pride": Pride to be in and part of a noble profession, accepted at face value, giving a service to mankind.

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GERALD P. FLANAGAN, D.O.
Ad Hoc Reference Committee

Since many members of the Reference Committee spoke against the medical liability insurance statement as proposed by the Board of Trustees of the AOA (Resolution 102), the Committee recommended it be disapproved and this was done by the House of Delegates. As a substitute, Resolution 136, from Michigan, was approved by the House.

Resolved, that the AOA Board of Trustees and the House of Delegates be directed to establish an Ad Hoc Committee for the purpose of studying the feasibility and desirability of promoting the development of patient medical risk insurance and other methods of resolving this program, such as legislation, modification of the tort system or state compensation.

The Committee also heard testimony on Resolution 108, from Florida, as to the Medicare fee schedule and recommended approval by the House, which was approved. It reads:

Resolved, that the AOA initiate action through all available channels to secure future increases in Medicare fee schedule allowances to absorb the huge increase in malpractice costs of operations of office, et cetera.

Resolution 119, submitted by Oklahoma, and related to the Osteopathic Progress Fund:

Resolved, that the House of Delegates of the AOA encourage each divisional society to incorporate a dues structure to allow the Osteopathic Progress Fund to be supported through dues.

The Committee recommended approval and the House concurred.


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100 mg. phenylbutazone USP
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A fast way to put out the fires of arthritic pain.
Rheumatoid arthritis can sometimes spread like wildfire, with joint after joint going up inflamed.
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A fast way to put out the fires of arthritic pain.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existance of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.

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Resolution 122, by Texas, in relation to CME, was disproved in committee, mainly due to the cost factors omputer programming) as presented by Dr. Donald Siehl, d the resolution was also disapproved by the House.

There was much discussion on Resolution 127, from ennessee, by the small states in that they wanted 20 per cent spaces in osteopathic colleges reserved for incoming students om small states. It was:

esolved, that the House of Delegates communicate to the American Association of Colleges of Osteopathic Medicine, and to the individual colleges, that it is their strong recommendation that they encourage recruitment of qualified students from states which have small osteopathic population.

Resolution 135, submitted by the Committee, on conrns of small states, was discussed and the Committee recomended approval, which was done by the House. This resolun is submitted in total.

solution 135

Subject: Concerns of Small States
Reference Committee: Committee on Concerns of Small States
House of Delegates: Passed

ereas, the Committee on the Concerns of Small States has been appointed as a special committee by the House of Delegates, and

ereas, this committee has met, discussing the various problems and concerns of the small states, and

ereas, throughout this committee's discussions it has been felt by the committee members that no one program can provide a total solution to the many facets of the problems of the small states,

erefore, the Committee on the Concerns of Small States recommends a number of actions be taken in concert with AOA departments, bureaus and staff; these recommended actions are as follows:

olved, that the AOA Department of Public Relations work closely with the Student Osteopathic Medical Association in developing programs designed to place students in states with small D.O. physician population, and be it further

olved, that preceptorship programs be developed and promoted "matching" interested students with practicing physicians in small states, similar to the present American College of General Practitioners in Osteopathic Medicine and Surgery—Squibb Pharmaceutical Preceptorship program, and be it further

olved, that the Bureau of Public Education on Health alert small states to opportunities of educational support, such as the Minnesota plan and the Western Interstate Council on Higher Education and provide guidance and assistance to small states in pursuing legislative programs supporting osteopathic education which would ultimately return the graduating physician to a priority small state, and be it further

Resolved, that strong, viable divisional societies assist neighboring states with small D.O. populations in identifying needs and problems, and be it further

Resolved, that the AOA encourage the colleges of osteopathic medicine ro re-emphasize their admission and recruitment policies by actively seeking qualified students who are knowledgeable and strongly motivated toward osteopathic principles and goals, and be it further

Resolved, that the AOA in conjunction with the Student Osteopathic Medical Association develop and initiate guidelines for urban and rural osteopathic medical preceptorships particularly aimed to assist priority small states in recruiting osteopathic medical students and physicians to these areas, and be it further

Resolved, that the AOA, its affiliates and the Committee on Concerns of Small States be encouraged to work cooperatively with the Student Osteopathic Medical Association in publicizing and administering these programs, and be it further

Resolved, that the existence of the Committee on Concerns of Small States be continued to oversee, assist and implement the above listed resolves.

SUPPLEMENTAL REPORT
COMMITTEE TO STUDY HOSPITAL ACCREDITATION

Submitted by Dr. Flanagan, Member of the Committee

This Committee held its first meeting December 14, 1975. At that meeting a number of resolutions were passed, which were then forwarded to the AOA Board of Trustees and adopted by it at its February, 1976 meeting. These resolutions read:

Resolved, that the proposed revision of the Accreditation Requirements of the AOA shall include under Credentials Committee: 'should give particular attention to whether a physician is currently continuing his postdoctoral education as documented by the physician's AOA individual Activity Report concerning CME credit .

Resolved, that the Committee on Hospital Accreditation instruct the AOA hospital accreditation inspectors that once the basic documents of the governing body and the staff of an institution are approved, that they need not be reevaluated or reinspected each time unless there have been changes in such documents since the time of the last inspection.

Resolved, that the Committee on Hospital Accreditation instruct the AOA hospital accreditation inspectors that the attitude and philosophical approach in the conduct of inspection must be one of a positive and helpful character.

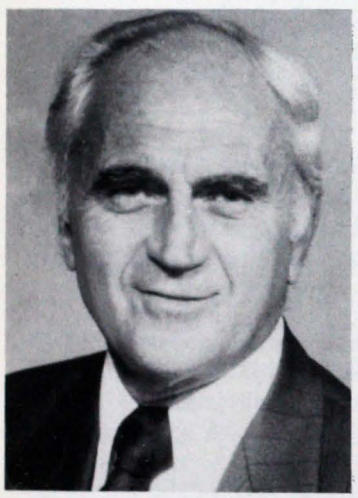
Resolved, that any person accepting a 3-year term appointment on the Committee on Hospital Accreditation who has not had previous experience will henceforth be obligated, within the first six months, to accompany the AOA accreditation team, for purposes of auditing an educational experience of a minimum of one full inspection.

TOMA Delegates Report

Resolved, that 90 days following action by the AOA Board of Trustees in adopting the proposed revised *Accreditation Requirements of the American Osteopathic Association* (11th Edition), a questionnaire will be sent to each hospital inspected between the dates of March 15, 1976 and June 15, 1976 for purposes of establishing whether or not the recommended changes in attitude and philosophy of conducting the inspection are being adhered to, and also as to whether or not communication between the proposed new Office of Hospital Accreditation and the institution are satisfactory.

This Committee met again July 18 in Washington, D.C., and made the following recommendations:

1. An attempt be made to select an administrator inspector that is geographically close to the hospital to be inspected so that expenses are reduced.
2. The questionnaire be sent through the Office of Hospital Accreditation with the inspection report carried by the inspector.
3. If a new questionnaire is formulated by the Office of Hospital Accreditation, it should take into consideration the information contained in the original questionnaire and pertinent points incorporated therein.
4. Each hospital should be given at least a 90-day notice prior to inspections.
5. The Committee to Study Hospital Accreditation Procedures should be continued with the intent of monitoring the actions of the Office of Hospital Accreditation and inspection progress. The next meeting of the Committee will be at the time of the 1977 Annual Meeting of the Board and House at no cost to the AOA.
6. This Committee, the Committee on Hospital Accreditation and the American Osteopathic Hospital Association, all support the resolution that an additional hospital inspector be employed. It is important that the backlog of hospital inspections be reduced.



Michael A. Calabrese, D.O.

Gerald P. Flanagan, D.O.

TCOM Building Expansion Under Way

Architectural plans for Texas College of Osteopathic Medicine's first major building, Medical Education Building I, were made available by the architectural firm of Fisher & Spillman of Dallas August 19 for bidding by interested construction firms, according to Donald Denney, construction manager. The contract will be awarded later in the fall.

Medical Education Building I is a $12.8 million clinical science building which was approved by the North Texas State University Board of Regents, TCOM's governing body, in August 1975. It will house a 250-seat auditorium, outpatient clinic with 30 examining rooms, library and offices for the clinical science departments and one of the basic health science departments.

The exterior of the building will be cast stone finish with bronze solar glass.

In addition to $8 million appropriated from the State of Texas for construction of Medical Education Building I, $4.8 million is being supplied by the U.S. Department of Health, Education and Welfare.

Denney said the bids will be taken on plans for a six-floor construction with alternate additives for a seventh floor, a shell of the eight floor and demolishing of several buildings west of the present Administration Building at 3516 Camp Bowie Boulevard.

It is expected that construction will take approximately 30 months.

"This is a new major step in a continuing growth of the College of Osteopathic Medicine in partnership with the Fort Worth Community. We will, as President C. C. Nolen has frequently said, 'build the finest college of osteopathic medicine in the country,' " Dr. Ralph L. Willard, dean, said.

"This building will initiate the first phase of a totally new campus for Fort Worth's only school of medicine," Denney said.

"We are starting with Medical Education Building I as the first of a proposed complex of structures that will permit all functions of the College to operate as a single continuous unit. At the present time, operations are conducted at several locations including the main campus of NTSU at Denton," he said.

Basic health science courses which are taken during the first two years are currently being taught in the NTSU Biology Building and the last two years of clinical science are being taught at the Administration Building and Administration Annex at 3120 West Seventh Street and in several hospitals and clinics in the metroplex area. ▲

A BETTER WAY

Alcohol, Physicians and Attitudes

by Neil Connelly, D.O.
and
Ralph Stolz, D.O.

Ambivalence may be the best word to describe the attitudes of physicians in regard to alcohol use, abstinence, abuse and addiction. This ambivalence is also a general culture pattern and is notably present in a number of American subcultures and ethnic groups. Physicians tend to condemn and shun the alcoholic patient but on the other hand are quite uncritical of their own drinking-related practices.

Under-estimation of consumption all too common. Consumption may be defined as involvement in volume, frequency, type and duration as well as the effects that it produces. Many who are not drinkers often pass harsh judgments on those who are. Although there has been an encouragingly aggressive increase in public and professional education exposure toward alcohol information in the past several years, there is still much to be desired.

The apparent problem areas that have been defined and are being more deeply explored are not only those of earlier identification and recognition by our community, social and private resources available to the health professionals and to public at large but, most important- the attitudes.

Prevention Multiple Faceted

Multiple approaches are necessary to enhance human well being, health and dignity in order to prevent alcoholism, especially since multiple factors seem to contribute to the problems. The sociology of medicine as it relates to alcohol-related behavior perhaps has more meaning and needs to be further discussed.

Consider the following areas: familiar learning factors, environmental circumstances, social changes, hygienic practices, improving conditions surrounding alcohol-related behavior, preventive aspects even though the etiology is not known nor agreement as to what may be considered acceptable drinking-related behavior.

Several important factors are (1) physicians' attitudes toward alcohol-related problems; (2) the actual behavior patterns that we engage in which are not always necessarily the same as our attitudes and (3) the laws and customs which contribute so much to our kaleidoscope of inconsistency in drinking-related practice. Examples would be patterns of consumption, economics, availability, monies and environment.

Recently, awareness through educational advertising and exposure surveys has shown attitudinal changes. Questions and data included (1) heavy drinking, a very serious problem in the country today; (2) alcohol is a drug; (3) there is no known cure for a hangover; (4) drunkenness is usually like an overdose of drugs; (5) a host who encourages heavy drinking among guests can be described as, a. a drug pusher, b. a bad host. Those questions may be answered yes or no and over a three-year period there has been an overall positive awareness of plus 22% which is a significant change. This type of organized campaigning is continuing and growing and hopefully will sustain the awareness of alcohol as a major social problem before the general public.

The next logical, but poor and undemocratic step might be for us as physicians to continue demanding behavioral changes in our patient groups. Psychologically, this has been shown to reverse any already initiated positive trends. An example of this may be illustrated by the prohibition era.

A more satisfactory way might be a continuously updated scientific and public information bank such as is available through the National Clearing House for Alcohol Information. This would help standardize information and identify the benefits and difficulties from the various phases of alcoholism and of alcohol use. This could also be the basis upon which to influence decided pattern changes in individuals and groups and could strongly affect our ability to drink for pleasure, or not drink, to experience the values of drinking and to minimize the problems precipitated by irresponsible drinking.

Factors Affecting Consumption

Religious, ethnic, national and social factors aid positively in changing the patterns of drinking. Several examples of this are (1) the national campaigns of France, where their high taxation decreased alcohol consumption: (2) Denmark, where distilled spirits were decreased through high taxes and beer sales increased; and (3) the USA school programs which are designed for younger age groups.

It is necessary to develop special prevention programs for special groups of people such as the young, the adolescent and the aging, as well as the American Indian population. In this program education must be clearly defined with obtainable, practical objectives; behavioral effects, attitudinal changes and information must be measurable and finally, objective evaluation is essential.

Inconsistent regulations and regulators are also contributing to the alcohol problems. The extent of this

factor has not yet been fully realized and is just now being more carefully researched and documented.

Through extensive legislation, the Alcohol Beverage Control Board possesses the power to regulate morals and ethics and to establish social policies concerning alcohol.

The ABC was created in a temperance and avoidance atmosphere and to regulate out of existence the presumed cause of alcoholism and its related problems. The prohibition experience suggests that social policies which conflict with widely accepted social practices and mores fail, impair the operation of law and justice institutions in that alcohol availability has broad public support.

There is as much variability and difference in state ABC control as there is in number of states in our country—or more! Some of these differences relate to licensed and monopoly states in licensing, state control provisions, definition of alcohol and intoxicating beverages, prices, location, hours and eligibility. ABC control further variably defines restriction as to sales to minors (18,19,20 and 21), types of alcoholic beverages each group can purchase (females can purchase at one age and males at another), the legal status of minors drinking in the presence of their parents regardless of age in one state, the illegality in another. In another state it is illegal for parents to supply and/or allow their children alcohol except for medicinal purposes. Other factors are the retail license limits and quotas.

The consumption and lognormal curve theory proponents refer to price elasticity affecting alcohol consumption. An example would be, as the price goes up, the consumption decreases. A problem here is that some addicts, depending upon their affluence, may affect the majority of non-addicted drinkers.

Questions are also being raised in regard to what level of taxation, if any could have an effect on the growth of illicit sources of alcohol or, as far as our youth is concerned, substitution and development of different drugs, e.g. marijuana, hard drugs and poly drug abuse. The prohibition and drug questions are only part of the broader sociological, economical, psychological, anthropological and political questions. There is reliable evidence to warrant further investigation into the validity of the price-consumption-problem theory and to explore its potential as a primary preventive tool.

Broader Approach Needed

A broader, coordinated, effective social-problem-oriented, multidisciplinary approach is urgently needed to more adequately deal with the alcohol abuse problems. Objectives which must be considered are alternate activities and policies, examination of myths of alcohol and its control, increasing cooperation and communication among government, non-government, professional and voluntary and self-help groups and agencies; formulation and standardization of effective rehabilitation for direct alcohol problems, e.g. drunkenness, alcohol-related crimes, violence and drinking and driving. The basic concepts and philosophies of many of the already existing programs, agencies and groups are sound but must be re-examined further and possibly changed from the standpoint of being isolated and tradition-bound with a lack of innovativeness. Interest in planning, conferences and programs should also be multidisciplinary, reinforced and stressed.

Osteopathic physicians are an important influencing force in our communities and, as such, have a responsibility, whether desired or not, to actively participate in the formulation of issues of public policy, attitudes, education and regulation, and custom of alcohol use, abstinence, abuse and addiction.

We, too, must be innovative, not tradition-bound or isolated from the people, public and communities we serve. Let us not be over-confident, careless or ignorant of this one of many of the important areas of our responsibilities as D.O.s.

SOME SUGGESTED GUIDELINES FOR RESPONSIBLE USE OF ALCOHOL

- Make sure that the use of alcohol improves social relationships, rather than impairing or destroying them.
- Make sure the use of alcohol is an adjunct to an activity rather than being the primary focus of action.
- Make sure alcohol is used carefully in connection with other drugs.
- Make sure human dignity is served by the use of alcohol.

Encouraging Responsibility in Others

- Respect the person who chooses to take alcohol in moderation or who abstains; do not be insistent about "refreshing" or refilling, and keep down the amount of alcohol he or she drinks.

- Provide food with alcohol at all times, especially proteins such as dairy products, fish and meats.
- Provide transportation or overnight accommodations for those unable to drive safely, recognizing that the host is just as responsible for preventing drunken driving as his or her guests.

Any One or More Signs Indicating a Drinking Problem

- Gulping drinks for the effect that rapid drinking produces.
- Starting the day with a drink.
- Drinking alone, from a desire to escape reality or boredom or loneliness.
- Alcohol-taking behavior criticized by an employer, spouse or others; or absenteeism or impaired job performance because of drinking.
- Rationalizing in regard to drinking behavior, characterized by such comments as, "I just need one more to relax," or "How about one for the road?"
- Marked personality and behavioral change after taking one or more drinks.
- Frequent overdosing with alcohol or drunkenness.
- Experiencing "blackouts"—alcohol-induced amnesia.
- The psychological impact of hangovers to relieve discomfort and, thereby, perpetuate a vicious cycle: the more one drinks, the worse he or she feels and the more one drinks.
- Requiring medical or hospital attention or having frequent minor accidents or physical complaints as a result of alcohol taking. ^

Reprinted from Spring Issue of Pennsylvania Osteopathic Medical Association Journal

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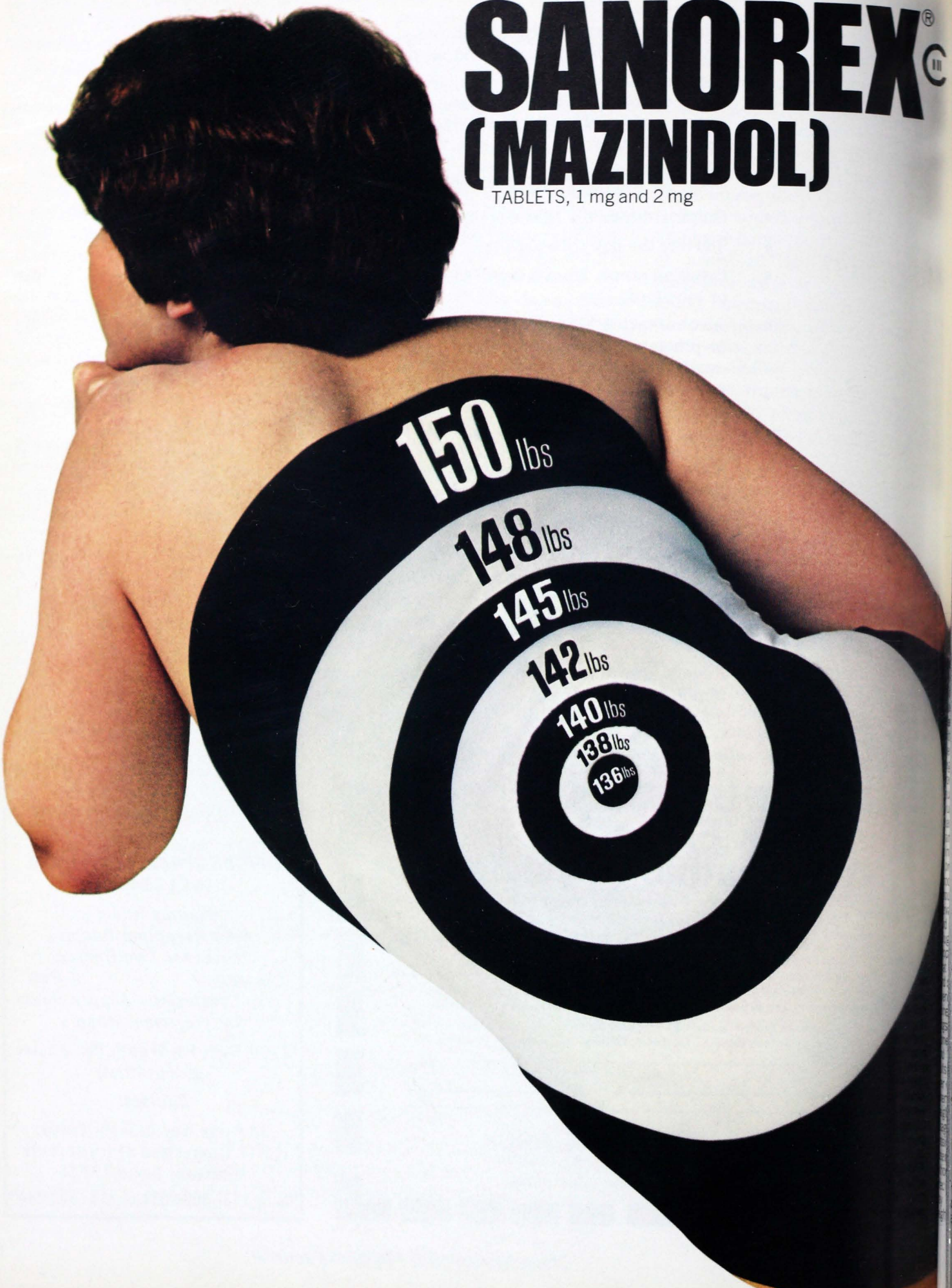

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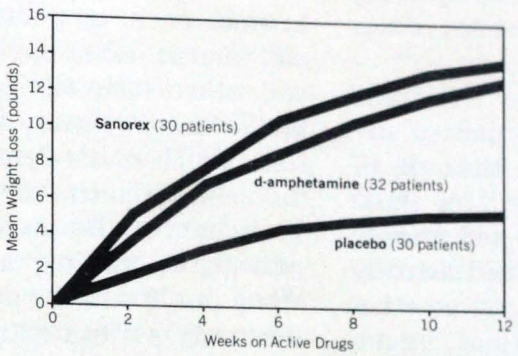
In a double-blind study,[1] body weight analyses were made for 92 obese patients; 30 patients received Sanorex (mazindol) (1 mg t.i.d.), 30 received placebo, and 32 received d-amphetamine (5 mg t.i.d.).

During the 12-week phase of active medication in conjunction with dietary restriction, patients on Sanorex lost an average of 14.06 lb, compared with 13.06 lb for d-amphetamine and 5.63 lb for placebo patients.



1. Vernace BJ: Controlled comparative investigation of mazindol, d-amphetamine, and placebo. Obesity/ Bariatric Med 3:124, 1974.

Indication: In exogenous obesity, as a short-term (a few weeks) adjunct in a weight-reduction regimen based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors.

Contraindications: Glaucoma; hypersensitivity or idiosyncrasy to the drug; agitated states; history of drug abuse; during, or within 14 days following, administration of monoamine oxidase inhibitors (hypertensive crisis may result).

Warnings: Tolerance to many anorectic drugs may develop within a few weeks; if this occurs, do not exceed recommended dose, but discontinue drug. May impair ability to engage in potentially hazardous activities, such as operating machinery or driving a motor vehicle, and patient should be cautioned accordingly.

Drug Interactions: May decrease the hypotensive effect of guanethidine; patients should be monitored accordingly. May markedly potentiate pressor effect of exogenous catecholamines; if a patient recently taking mazindol must be given a pressor amine agent (e.g., levarterenol or isoproterenol) for shock (e.g., from a myocardial infarction), extreme care should be taken in monitoring blood pressure at frequent intervals and initiating pressor therapy with a low initial dose and careful titration.

Drug Dependence: Mazindol shares important pharmacologic properties with amphetamines and related stimulant drugs that have been extensively abused and can produce tolerance and severe psychologic dependence. Manifestations of chronic overdosage or withdrawal with mazindol have not been determined in humans. Abstinence effects have been observed in dogs after abrupt cessation for prolonged periods. There was some self-administration of the drug in monkeys. EEG studies and "liking" scores in human subjects yielded equivocal results. While the abuse potential of mazindol has not been further defined, possibility of dependence should be kept in mind when evaluating the desirability of including the drug in a weight-reduction program.

Usage in Pregnancy: An increase in neonatal mortality and a possible increased incidence of rib anomalies in rats were observed at relatively high doses.

Although these studies have not indicated important adverse effects, the use of mazindol in pregnancy or in women who may become pregnant requires that potential benefit be weighed against possible hazard to mother and infant.

Usage in Children: Not recommended for use in children under 12 years of age.

Precautions: Insulin requirements in diabetes mellitus may be altered. Smallest amount of mazindol feasible should be prescribed or dispensed at one time to minimize possibility of overdosage. Use cautiously in hypertension, with monitoring of blood pressure; not recommended in severe hypertension or in symptomatic cardiovascular disease including arrhythmias.

Adverse Reactions: Most commonly, dry mouth, tachycardia, constipation, nervousness, and insomnia. *Cardiovascular:* Palpitation, tachycardia. *Central Nervous System:* Overstimulation, restlessness, dizziness, insomnia, dysphoria, tremor, headache, depression, drowsiness, weakness. *Gastrointestinal:* Dryness of mouth, unpleasant taste, diarrhea, constipation, nausea, other gastrointestinal disturbances. *Skin:* Rash, excessive sweating, clamminess. *Endocrine:* Impotence, changes in libido have rarely been observed. *Eye:* Long-term treatment with high doses in dogs resulted in some corneal opacities, reversible on cessation of medication; no such effect has been observed in humans.

Dosage and Administration: 1 mg. three times daily, one hour before meals, or 2 mg. once daily, one hour before lunch. The lowest effective dose should be used. Should GI discomfort occur, mazindol may be taken with meals.

Overdosage: There are no data as yet on acute overdosage with mazindol in humans. Manifestations of acute overdosage with amphetamines and related substances include restlessness, tremor, rapid respiration, dizziness. Fatigue and depression may follow the stimulatory phase of overdosage. Cardiovascular effects include tachycardia, hypertension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting and abdominal cramps. While similar manifestations of overdosage may be seen with mazindol, their exact nature have yet to be determined. The management of acute intoxication is largely symptomatic. Data are not available on the treatment of acute intoxication with mazindol by hemodialysis or peritoneal dialysis, but the substance is poorly soluble except at very acid pH.

How Supplied: Tablets, 1 mg. and 2 mg., in packages of 100.

Before prescribing or administering, see package circular for Prescribing Information. SAN 6-543

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SANDOZ

THE ATTENDING PHYSICIAN

A Role of Responsibility

by Ervin E. Baden, M.D.
Texas Department of Public Welfare

Since the mid 1940's the trend toward specialization in health care has caused more individuals to state that it is impossible to see the same physician twice. There is no doubt that there has been a move towards specialization and that in doing so the health care industry has developed new and better techniques for the care and treatment of our health needs.

While there has been this trend towards specialization, particularly in the outpatient area, the role of the attending physician, for those individuals in hospitals and nursing care facilities, has remained virtually unchanged. Regardless of whether the person is admitted to an institution for oral surgery, long term recovery care or geriatric nursing services, the attending physician remains responsible for the total care that is provided to that patient.

In order to assure that the person received adequate care and treatment while a patient is in a facility, the attending physician prepares a total plan of care for each individual. In this plan the needs of the patient are assessed and documentation made in the health records as to how these needs are to be met. Only in this manner can the attending physician be assured that each patient receives the care and treatment that is medically necessary and prescribed for that individual.

It has been noted that in some instances physicians have written in the health record that ancillary services such as podiatry, hearing aid, dental care, physical therapy and other such services could be provided as necessary by other persons. Further, the determination of the need for such services has often been left to the discretion of the patient or facility administrator. When this occurs the attending physician has in effect relinquished part of his professional judgment to other persons who do not have his training or knowledge.

The attending physician must ensure that all care and services provided in an institution such as a hospital or nursing care facility are provided only upon his direct order as documented in the health record, and that the results of all examinations, treatments or services are immediately made available for his evaluation and determination as to continued course of treatment. The facility staff should not be authorized to act as an agent for the physician in the procurement of professional services. Neither should the facility allow the wholesale testing or examination of patients for a particular service (i.e., eyeglasses, hearing aids, etc.) even when the provider offers to do the services at no initial cost to the patients. Too often what was seemingly a free service is later added on the bill for the complete treatment series or medical device.

If a patient needs specialized care or treatment they should of course have this provided to them, but only when the attending physician has determined that a need exists and has so stated in the health record. All care and services so provided must then be documented in the health record by the individual providing such service. Only through a continuing review of the health record can the attending physician ensure that he remains totally responsible for the complete range of services provided to all patients whose care he has been entrusted. ▲

ADEQUATE PREMIUMS?

by Caleb Belove, President
Professional Mutual Insurance Company

1975, for Professional Mutual Insurance Company, was a most unusual year in that we seemed at times to be the only market available for fairly priced malpractice insurance. In 1959 when we began, our largest problem was the lack of capital, which in those days firmly fenced us in.

1975 was the beginning of the end for a number of companies who had been in the malpractice business, and who apparently had found the solution to the problem of adequate premiums beyond their competence. Other insurance companies met the problem head-on, trying to recoup their losses by increasing their rates drastically, to the point of getting the attention of the press. For months, the newspapers, television, magazines (how about *Woman's Day*?) used the malpractice problem to fill space which had been occupied shortly before by Watergate.

There is a rule in the insurance business, as well as any other business, that you must have sufficient capital. It backs up the amount of premiums written, because without capital there is no protection for the insured in case the premiums turn out to be inadequate to pay all the claims. We were woefully undercapitalized in the beginning. That condition was mitigated by the investment in our company via the surplus note route, by our insureds.

In liability insurance, there is a concept which is known as the "tail". In fire insurance, you know immediately if there has been a fire. But people who have been injured are not always sure they are hurt, so bodily injury liability, including automobile, takes a little longer to finalize. In malpractice insurance, it is called a "long tail", because the time distance between a medical accident and the final adjudication seems to average between four and five years, and even in our limited experience, final settlement has taken as long as twenty-three years.

All of this would indicate how difficult is the decision with regard to the size of premium that should be charged for a policy when, as the result of an occurrence which happens today, final disposition probably will not take place for at least four or five years.

For rate-making, this creates a very difficult judgmental undertaking in these days of continuing inflation. What has taken place is that inadequate rates of long ago have forced the insurance companies now to have to charge enough to make up for past losses in the same manner as is proposed in the "claims-made" policy.

How much premium is enough? How much premium is enough for a non-profit organization like Professional Mutual, which was created to serve the doctors? Is it our obligation to furnish insurance cheap, at the risk that such a tactic may be fiscally irresponsible? Actually, I would suggest that our most pressing need is to be able to offer the full protection that the insurance is supposed to afford. Doing this demands "adequate" premiums, and again, the question becomes "What is adequate?" How do you make such a determination, considering the fact that Professional Mutual is the servant of its policyholders? It should take from them only what it needs.

Probably you are expecting me to tell you that anybody knows how to do that. If I really knew how to predict five to fifteen years into the future, it would not be necessary for me to be sitting here, struggling over the next words to way about "adequate premiums".

Regardless of what many doctors think, we have paid out more dollars in claims than we have received in premiums. We get criticism from time to time because we are constantly forced by circumstances to increase our rates. In the instance of your company's charges, you might find if you check the competition, generally speaking, we have either the lowest premium or are nearly lowest of all markets available. And, I might add, we write an "occurrence" policy—a much more favorable policy for the insured than "claims-made".

If losses continue to develop, with the average loss per policy going ever higher and higher, along with the increases in expenses, it will continue to be our unpleasant task to try to achieve that illusive goal called "adequate premiums". ▲

Texas Ticker Tape

DR. NOLEN NEW AACOM OFFICER

The Board of Governors and component councils of the American Association of Colleges of Osteopathic Medicine met July 14-16 in Alexandria, Virginia and elected new officers. Elected president was Myron S. Magen, D.O. (MCOM); vice president, Robert A. Kistner, D.O. (CCOM); secretary-treasurer, C. C. Nolen, Ph. D. (TCOM), and executive committee member-at-large, Thomas M. Rowland, Jr., B.S. (PCOM).

ACADEMY HAS NEW DIRECTOR

On July 1, Martha Drew, Ph.D., assumes the post of director of the American Academy on Osteopathy. She succeeds Louise W. Astell, D.O., who is retiring.

The Academy offices are at 2630 Airport Road, Colorado Springs, Colorado, 80910.

DR. JORDAN TAKES POSITION AT U.T. CANCER CENTER

William M. Jordan, D.O. (KCCOM '73) a student member of TOMA who has been taking a residency in internal medicine in Michigan, following his internship at FWOH, has accepted a position in the Department of Developmental Therapeutics at the University of Texas System Cancer Center. He was recommended by Dr. John H. Boyd and Dr. J. Thomas O'Shea.

LEST YOU FORGET

It was two decades ago that C. Northcote Parkinson formulated his famous law: "Work expands so as to fill the time available for its completion." Later, he added this supplementary rule: "Expenditure rises to meet income."

ANNUAL CLINICAL ASSEMBLY TO BE IN NEW ORLEANS

The Fairmont Hotel in New Orleans will be headquarters for the Forty-ninth Annual Clinical Assembly of Osteopathic Specialists October 17-21. Programs are being planned for surgeons, radiologists, pathologists, orthopedists and anesthesiologists.

DR. GEORGE SMITH APPOINTED MEDICAL DIRECTOR

West Rest Haven of West, Texas, has announced the appointment of George N. Smith, D.O., as its medical director. A 1975 graduate of KCCOM, Dr. Smith interned at Lakeside Hospital in Kansas City. He established his practice in West last year following completion of his internship.

Texas Ticker Tape

THE DEAN IS ALSO COLONEL WILLARD

TCOM Dean Ralph L. Willard D.O., was recently on reserve duty as a colonel with the U.S. Air Force in Japan. He served as Acting Chief of Surgery at the USAF Hospital at Yakota, and for another five days as Acting Director of Professional Services at the same hospital. He reports that "it was a most exciting and productive time."

TWO NEW COLLEGES APPROVED FOR PREACCREDITATION

In action confirming the recommendation of the Bureau of Professional Education and its Committee on Colleges, the AOA Board of Trustees granted preaccreditation status to the Ohio University College of Osteopathic Medicine at Athens, Ohio. The new college has an entering class of 24 students, and will begin classes in September 1976.

The board also granted preaccreditation status to the New York College of Osteopathic Medicine at the New York Institute of Technology, Old Westbury, N.Y. The school is still in the development stage, and no classes will be enrolled before September 1977.

DR. BECKER ON CRANIAL ACADEMY PROGRAM

Reporting on the Sutherland Cranial Teaching Foundation meeting conducted by the Cranial Academy of Osteopathy June 22-26 in Milwaukee, the Cranial Academy Newsletter says, "Registrations for the Introductory Course in Osteopathy in the Cranial Field, directed by Rollin E. Becker, D.O., (of Dallas).....was most startling and gratifying in that it exceeded anticipatory expectations of attendance. Three times registrations were closed and were tentatively reopened, pending availability of additional SCTF faculty, requiring finally a faculty of 12 for 42 students."

Among the registrants was another Texan, Lewis N. Pittman, D.O., of Amarillo.

FATHER AND SON TEAM UP

Dr. John S. Turner, II, has joined his father, Dr. John S. Turner, in practice at the Turner Clinic in Canton. The younger Dr. Turner is a 1975 graduate of KCOM, the school from which his father graduated in 1933. He served his internship at Oklahoma Osteopathic Hospital this past year. He is married to the former Barbara Williamson, daughter of Dr. and Mrs. James C. Williamson of Seagoville. Dr. Williamson is also a KCOM alumnus.

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OPPORTUNITIES FOR OSTEOPATHIC PHYSICIANS IN TEXAS

HOUSTON: Clinic with active practice for lease or sale. Close vicinity of excellent D.O. hospital. Gross annual income 90,000 plus. Terms negotiable. Owner can finance. Write or call: TOMA, Box T, 512 Bailey Avenue, Fort Worth, 76107, phone 817—336-0549.

AUSTIN— Assistant or partner wanted in large office practice. Salary open. Contact: Joseph L. Love, D.O., 4400 Red River Street, Austin, Texas 78751, Phone: 512-452-7541.

HOUSTON—General Practitioners and internists needed in expanding Texas Hospitals. Guaranteed income. Group and solo practices available. No fee. Excellent facilities. Send curriculum vitae to: Director, P. O. Box 2128, Houston, Texas, 77001.

KIRBYVILLE—in Deep Southeast Texas has GP practice opportunity. Potential unlimited—Salary to start negotiable—Good schools, hospital, lakes and hunting, mild weather. Contact John L. Sessions, D.O., 713-423-2166.

WANTED: Young ambitions G.P. to associate with clinic group in a growing town on lake and near metropolitan center. Good schools, churches, water sports, hunting, fishing and recreational facilities available. New modern hospital facilities. Write or call: Box B TOMA, 512 Bailey Avenue, Fort Worth, 76107; phone 817—336-0549.

KNOX CITY—This North Texas community welcomes a D.O. Staff privileges on Knox County Hospital, associateship, excellent gross existing. Contact Glen Rumley, Knox County Hospital, 817—658-3535.

BONHAM—Excellent opportunities for D.O. general practitioner in town of 8,000, and modern general hospital. Mixed staff, four D.O.s, two M.D.s. Contact Robert D. Van Schoick, D.O., Chief of Staff, or John Templain, administrator, Fannin County Hospital. Telephone 214-583-8585.

GRAHAM—Plans are underway for building a new clinic on the banks of Possum Kingdom Lake. Excellent opportunity for two General Practitioners. D.O.s welcome on the professional staff of 40-bed general hospital. Population: 9,000 in city; 12,000 plus in total area. Financial incentives available. Contact Mr. Howard Thurmond, 817—549-3500, 446 Elm Street or Mr. C.G. Young, Administrator, 817—549-3400, P.O. Box 690, Graham, Texas 76046.

WANT TO RELOCATE: Surgeon who will do general practice wants to relocate in central or south Texas. Age: 59. Write Box P, TOMA, 512 Bailey Avenue, Fort Worth, 76107.

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

LUBBOCK—Office with six fully equipped treatment rooms; first three months rent-free. Willing to work with new doctor by referring patients and utilizing present charts. Inquiries invited from graduating interns. Contact H. Eugene Brown, D.O., 3303 University, Lubbock,79410. Phone 806—792-2331 or 806—795-6466.

DALLAS—Well established and financially rewarding practice (primarily manipulative) is available for rent or sale. Office is centrally located five minutes from D.O.H. For further information contact: John H. Harakal, D.O., 3516 Camp Bowie Blvd., Fort Worth, 76107; or call 817—338-9011.

SAGINAW—Office building for lease three miles north of Meacham Field. Four treatment rooms, emergency room, laboratory, X-ray, private office, business office and waiting room—total of 2600 square feet. Call or write Mrs. Arthur H. Clinch, Post Office Box 79679, Saginaw, Texas 76179; telephone 817-232-2762.

WEST—(17 miles north of Waco), D.O. needs same to join established practice in furnished clinic. Salary with partnership potential. Small town of 2500, 42-bed well equipped hospital available. Contact George N. Smith, D.O., Post Office Box 129, West, Texas 76991 or call 817—826-5372.

D.O. or M.D.?

Member suggests official forms reflect a choice

by Tex Roberts

Although the Texas Constitution clearly states, "no preference shall ever be given by law to any schools of medicine," we continue to receive reports where state agencies, commissions, et cetera, as well as other organizations that are chartered or licensed by the State, definitely give preference to the allopathic school – at least by inference.

This is done by publication and distribution of forms that require the signature of an examining physician, and many of these forms carry the line, "Signature of M.D." – or simply leave a line for the physician's signature, followed by "M.D."

As we have reported previously, whenever such an instance is called to the attention of the State Office, a letter is written to the offending organization calling this discriminatory form to its attention, which is quite often sufficient to get the form changed.

After reading some of these items in the *Journal*, one member wrote this office giving us some historical notes on some methods TOMA had used in the past to cut down on such discriminatory practices.

Although we have been suggesting to organizations that still use only "M.D." on their forms that this be changed to read "signature of physician", we like the idea of our correspondent who says, "Seems to me the best route to take would be to *leave* M.D. on the forms, but to add D.O. and leave it to the signer to circle the one that applies or scratch the one that doesn't, as was done with the 1950 change on birth certificates.

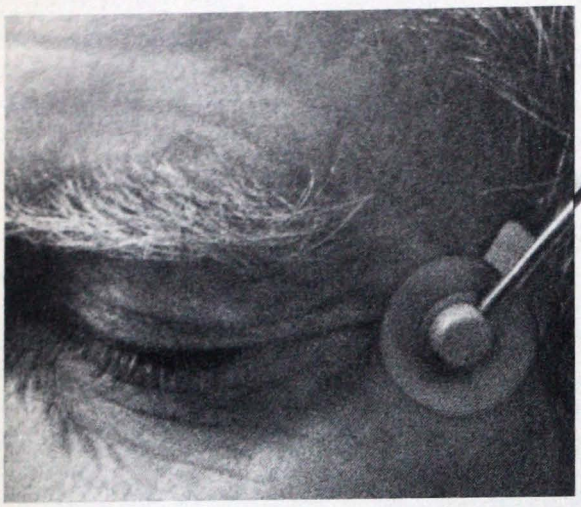
"The way we reasoned that one was that by printing the D.O., it gave us 'advertising'. It gives notice that there is such a thing as a D.O. to clerks that otherwise would not know. Insurance and government clerks seeing it on all medical forms would tend to automatically accept it rather than to automatically reject it when first confronted with a D.O. signature.

"The trouble has been mostly with people seeing D.O. for the first time. Many counties have never had one. Of course many people are still growing up without hearing of a D.O. even where they exist.

"I'd bet that not two per cent of our patients ever knew we were not M.D.s here in this clinic, in spite of name plates of three doctors with D.O. *plainly* following their names and D.O. on thousands of Rx's that have gone out of this office. They just don't pay attention. Clerks do."

The writer of the above asks to remain anonymous and we respect his wishes. Suffice to say that he is a member of long standing who has been most active in TOMA programs and has not stood idly by when there was a battle to be fought for osteopathic medicine.

We will continue to fight the battle of discrimination, and with such members on the alert for such instances as the above, we may eventually see the practitioners of osteopathic medicine receive the recognition that has been their due for lo these many years. ▲



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AOHA TESTIFIES TO HEARINGS ON HEALTH CARE COSTS

The nation's osteopathic hospitals are taking definite action to contain costs, the American Osteopathic Hospital Association said in testimony presented to the Council on Wage and Price Stability. The Council conducted two-day hearings on cost containment in the health care industry, July 20-21, as a follow-up to its broadly publicized background paper, "The Problem of Rising Health Care Costs."

The AOHA statement, submitted by Michael F. Doody, president of the association, said, "Our hospitals have taken a variety of cost-cutting steps such as mergers, shared services, the development of ambulatory care programs, cost containment reviews, and many other internal management programs.

"In addition, there are a number of governmental and voluntary controls in existence such as the accreditation procedures, reimbursement controls, certificate-of-need for facilities and services that are all directed at this same issue.

Doody pointed out that the amounts hospitals must pay to meet operating expenses have risen steadily over the past several years. The major components of the rising costs include such things as energy, food, malpractice insurance premiums, and labor costs.

"The hospital market basket is becoming increasingly more expensive, and is considerably higher priced than the Consumer Price Index," Doody said. He explained that hospitals buy an extraordinary amount of utilities and petroleum-related or petroleum-based products. At the same time, hospitals do not produce a uniform product such as the steel industry or other manufacturers produce.

"The hospital product, a patient day of quality health care, is an extremely complex item to produce, and it is a product that is constantly changing and improving," Doody said. "Government regulations, third-party payer requirements and accreditation programs all aimed at improving quality also have significant financial implications."

In its recently published paper on escalating costs in the health care field, the council indicated that the incentive structure of the health industry appears to encourage greater quantity of service rather than efficiency. The report also said that, within limits, all costs incurred by a hospital in treating a patient will be reimbursed, and that such a payment mechanism provides little incentive for the hospital to be efficient.

"We agree that the reimbursement system promotes and rewards inefficiencies, but we take exception to the statement that the system reimburses hospitals for all costs incurred in treating a pateint," the AOHA statement said. "It does not meet an institution's full financial requirements, and this Association has in fact recommended changes in the system to include the use of additional methods of payment to hospitals including those approaches containing incentive programs.

"It is vitally important that high quality and cost efficiency go hand in hand," the statement continued. "We have therefore often recommended to the Congress that incentives be provided for those institutions which maintain high quality and which prove to be efficient in the delivery of health care."

The AOHA statement showed that in 1975 osteopathic hospitals had more than $959 million total expenses while providing 6.1 million inpatient days of care and 2.8 million outpatient visits. The nation's 205 osteopathic hospitals represent 23,030 inpatient beds and employ 60,185 persons. ▲

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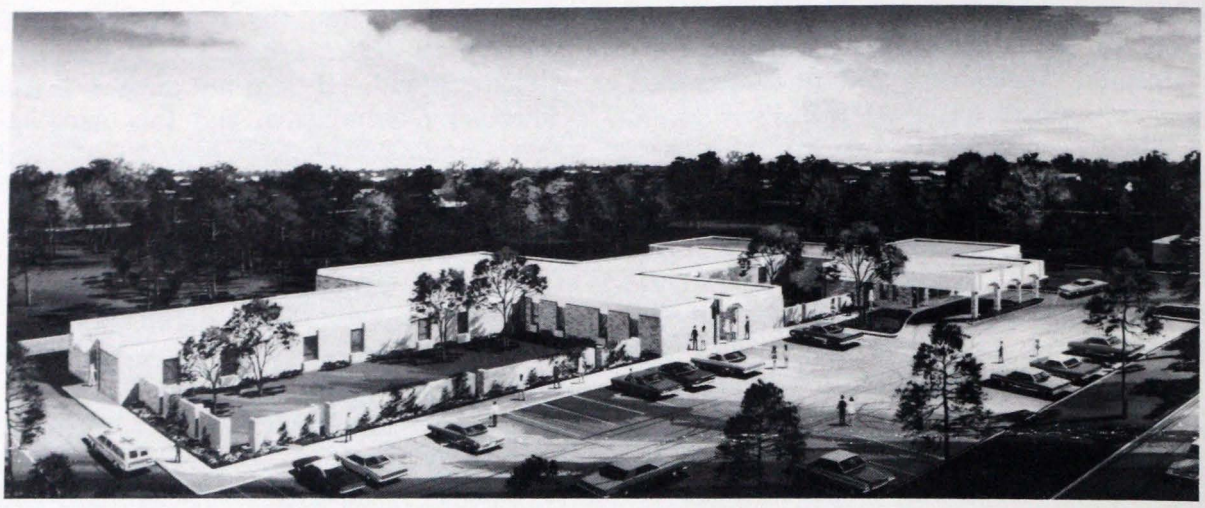

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LACK OF COMMUNICATION ???

ADMINISTRATOR REPORTS

A copy of a letter from an osteopathic hospital administrator reporting on his first time to attend a meeting of the TOMA Hospitals and Insurance and Peer Review Committee serves as a reminder that communications are really the number one problem in any association.

Robert J. Halbrook, administrator of East Town Osteopathic Hospital, was appointed recently to the TOMA H&I Committee by the new president of the Texas Osteopathic Hospital Association, Pat Borden, administrator of Doctors Community Hospital in Euless.

After attending his first meeting of H&I, Mr. Halbrook reported to his president, via the following letter, which was copied to the State Office. It was written to Mrs. Borden, president of TOHA:

"Dear Pat:

"I attended my first meeting of the TOMA Hospitals & Insurance & Peer Review Committee at 8:30 a.m., July 23, 1976 at the Airport Marina Hotel at the D/FW Airport. I think that this is a very good committee and that it would be of help to all hospital Administrators throughout the state to be more aware of the availability of the committee.

"Very briefly, the meeting is held to assist the hospitals and insurance companies with problems that have arisen either through complaints from the patient, insurance company or doctor/hospital. Some of the problems that have been brought to the committee's attention was where the insurance claim had been paid to the patient, where the carrier had requested a review of charges, a complaint regarding the services of the doctors and charges, where a carrier had denied payment of an OMT, a complaint where a patient wasn't admitted to the hospital and then the doctors refused to go see the patient when called.

"All in all there were 16 cases that were reviewed and decisions were made on a major portion of them with some being referred back for more information. I feel that this committee should be of help to the Administrators when they run out of recourse within their own hospitals. As far as I know, the procedure to get a case on the agenda would be to send all pertinent information to Mr. Tex Roberts, Executive Director, TOMA, Fort Worth, Texas.

"I would appreciate it very much if this information about the committee could be researched a little further with Mr. Tex Roberts and then the information mailed out to the Administrators, both members and non-members, in the State of Texas. I will be attending the meetings of the committee and will keep you informed as to the results.

Sincerely yours,
R. J. Halbrook, Administrator"

Osteopathic physicians and hospitals in Texas can be proud of the fact that the profession has been carrying on successful and meaningful peer review for more than 20 years—long before the PSRO ever was promulgated by Washington.

Osteopathic hospital awareness of the committee's work is welcome and encouraged. ▲

PHS Scholarship Stipends

A notice in the *Federal Register* of July 27, designates the gross stipend amount to be paid to medical (M.D. and D.O.) and dental students under the Public Health and NHSC program as $6,750 for any 12 month period of scholarship award. Applicants will be evaluated and selected by the Secretary of Health, Education and Welfare, taking into consideration:

(1) academic performance
(2) faculty recommendations
(3) work experience
(4) relative need of the PHS for particular health-related specialties.

In making these selections for 1976-77 academic year, the following are named as the most important factors:

1. *Graduation date.* Priority will be given to qualified applicants who are nearest to their dates of graduation.

2. *Specialty preference* (for M.D. and D.O. students). First priority to Family Practice and Osteopathic General Practice; second priority to General Internal Medicine, General Pediatrics, Obstetrics/Gynecology, and General Psychiatry; third priority to all other specialties.

3. *Academic performance* and *faculty recommendation.* Priority will be given to those applicants with a level of academic performance, clinical skills, and personal qualities, that would qualify them for primary care professional practice in an urban or rural health manpower shortage area under specific programs of the U.S. Public Health Service.

Additional, secondary factors which will be utilized in selecting scholarship recipients are:

Career goals: Special consideration will be given to applicants who plan to enter a primary care practice in a rural or urban health manpower shortage area, either privately or through a career in the U.S. PHS.

Work experience: Special consideration will be given to applicants with health-related work or community volunteer experience in medically underserved rural or urban areas or minority ethnic communities.

Community experience: Special consideration will be given to applicants who have resided in medically underserved areas or minority ethnic communities for a substantial period of time. Applicants may include a statement of minority status for consideration under the Federal Affirmative Action hiring policy established by Executive Order 11478 of August 8, 1969.

The Secretary of HEW is required by the terms of the Public Health Service Act (41 U.S.C. 234, part 62) "from time to time to designate and publish in the *Federal Register* those health related specialties for which the Service has need and for which scholarship support will be available as well as the amount of the scholarship stipend." ▲

(reprinted from Update)

TCOM
fall term underway

Orientation for 73 first-year students at the Texas College of Osteopathic Medicine and registration for first-, second- and third-year students was held August 27.

The new freshman class brings the total enrollment at TCOM to 260 student doctors.

The orientation program, held in the Administration Annex, was from 9:00 a.m. to 12:00 noon, followed by a catered luncheon.

Second-year students registered at 9:00 a.m. and third-year students at 10:30 in the Student Center.

The orientation program for the seventh class to enter TCOM included a panel presentation on such subjects as administrative organization, history and future plans of the College, pre-clinical and clinical sciences. Faculty and staff members were introduced to the incoming students.

Among the administrative personnel participating in the orientation were Dr. Ralph L. Willard, dean; Dr. Charles A. Kline, associate dean for clinical affairs, and Dr. C. G. Skinner, assistant dean for basic health sciences.

Following the luncheon and preceding registration of the first-year class, four scholarships awarded by the Texas Osteopathic Medical Association were presented by Dr. Frank J. Bradley, chairman of the TOMA Membership Services and Professional Development Committee.

The $1,000 Phil R. Russell Scholarship went to S/D Charles Kenneth Gordon of Denton. Scholarship checks for $750 each were presented to S/D Melinda Ligon of Denton, S/D Thomas B. Bennett of Houston, and S/D Dennis Neill Graham of Lubbock.

The fifth TOMA scholarship awarded this year went to S/D Philip M. Hutchison of Austin, who has been accepted into the freshman class at the Kirksville College of Osteopathic Medicine. ▲

Nine Texas D.O.s on Clinical Assembly Program

When the Annual Clinical Assembly of Osteopathic Specialists is held in New Orleans October 17-21, TOMA will be well represented on the programs.

AOA President Dr. George J. Luibel is scheduled to bring greetings to four of the specialty groups at their opening morning sessions, so he is going to be rushed.

The Assembly program first lists him for the formal opening session of the American Osteopathic College of Anesthesiologists, of which another Texan, S. Stevon Kebabjian, D.O., of Dallas is president-elect.

Dr. Luibel will also be on the opening morning program of the American College of Osteopathic Surgeons. Jack P. Leach, D.O., of Houston will be the moderator for that society's afternoon session.

William R. Jenkins, D.O., of Fort Worth will address the surgeons Monday morning, October 18, on "Intestinal Obstruction". He will be followed by another Fort Worth D.O., Dr. Jay G. Beckwith whose topic will be "Endoscopists's Role in Assisting Surgeons".

At the Wednesday afternoon session of the ACOS, Victor H. Zima, D.O., of Houston will be the moderator. Dr. Leach and Dr. Zima are cochairmen for the ACOS program.

Hurrying from the surgeons' meeting Sunday, Dr. Luibel will greet members of the American Osteopathic College of Radiology. Anthony G. Bascone, D.O., of Dallas is slated to be the moderator for the Monday morning session of the AOCR.

The Neurological Surgeons Section of ACOS will meet separately from that society and Charles R. Biggs, D.O., of Fort Worth is scheduled to review Microneurosurgery during the Monday afternoon session.

For the Urological Section of ACOS the program lists as a speaker Charles A. Kline, D.O., Kirksville, Missouri; however, Dr. Kline is now with the Texas College of Osteopathic Medicine. His topic Monday morning, October 18, will be "Management of Neurogenic Bladder Dysfunction in Children with Meningeomyelocele (Artificial Sphincter)".

Dr. Luibel's next duty is to bring greetings from the AOA to the American Osteopathic Academy of Orthopedics—again during the Sunday morning opening session.

After diligent study of the program mailed by the ACAOS August 10 for this 49th Annual Assembly, we find no other TOMA members listed as participants. If our eyesight is faulty, or if there were any omissions in the program, let us hear about it! ^

LETTERS

CAN ANYONE HELP?

••••

Dear Tex:

In May or June of this year one of the many journals that crosses each doctor's desk had a two or three page article that dealt with the classifying of Geriatric patients. This article dealt with all of the physical and mental disabilities that we encounter with this group of people, and graded them on a score of 1-2-3 or 4.

I placed the journal to one side as I wanted to study the article further and possibly adopt it in my charts of my nursing home patients, but for some unknown reason the magazine has been lost or thrown out.

I do not remember the name of the journal or the title of the article, but I wonder if some of our doctors over the State saw the article and may have a copy of it. It was rather unique in its brevity and style and I am sure caught the eye of more than one doctor.

I will appreciate it if you will put this letter in the JOURNAL and hopefully I can recover a copy of the item.

Fraternally,
W. G. Millington, D.O.

•••••••

A TEXAN AT HEART

••••

Dear Mr. Roberts:

Please excuse this stationary and red ink but we have recently moved to Illinois and our stationary and pens are still in a moving van in Michigan.

Although as you have stated in your letter I am not a Texan by birth, I must inform you that I am one by heart.

I am presently starting an Internal Medicine residency at Chicago Osteopathic Hospital and plan upon completion to enter a cardiology fellowship. However, upon completion of my training I sincerely hope that TCOM will have use for a cardiologist as my main aspirations are to join the TCOM faculty.

Thus please continue my membership in TOMA and also consider me a naturalized citizen of Texas.

Thank you,
Ronald C. Sebold, D.O.

•••••••

WASHINGTON RECEPTION

••••

Dear Tex:

Thanks again for stage managing the wonderful Texas reception for us at the Mayflower. It was really a gala affair and if any of the succeeding presidents can have such a rousing send-off they are really going to have to pull all of the stops.

It was a beautiful party and we appreciate all of your efforts.

Sincerely,
George J. Luibel, D.O., F.A.A.O.

••••

Dear George:

I appreciate the kind word. Bette Vaught put in a lot of time on the party and without her help, it would have been a difficult situation.

AOSED changed its bylaws, and I am president until the San Francisco AOA convention. I would appreciate a chat with you about the possibilities of getting more production out of some of our execs on behalf of the AOA committees and programs.

Cordially,
Tex Roberts, CAE

THANKS FROM TWO WINNERS

••••

Dear Dr. Bradley:

First allow me to offer my sincerest apologies for being so dilatory in this correspondence. My wife and myself have been making final arrangements for our move to Denton and I have been working 12 hours 7 days a week due to a strike by the union employees of the company for which I work.

I would like to convey to you and to your committee through you, my heart-felt thanks for the honor and financial aid which you have bestowed upon me through the scholarship you have seen fit to grant me. I will make every effort to live up to the faith you have shown in my ability, and to the high standards of the Osteopathic professional as I have been acquainted with him. I am looking forward to a long and fruitful association with TOMA.

Sincerely yours,
Thomas B. Bennett

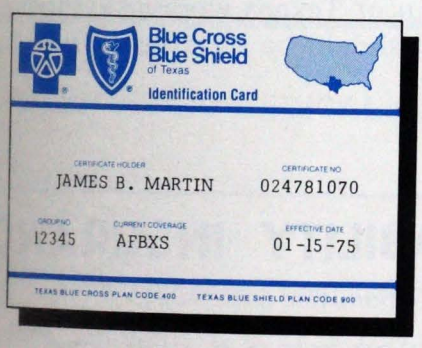
••••

Dear Sir:

I would like to thank you very much for selecting me to receive a $750 scholarship. I appreciate the trust you have put in me to live up to your academic standards. I can assure you that I will do my best while in school. This scholarship comes at a time when I need financial aid very much. Thank you for helping me.

Your friend,
Melinda Ligon

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



Very complete.

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

Hospital coverage for 365 days per period of confinement.

A $30.00 basic room allowance.

Most usual hospital charges covered in full.

Intensive Care and Coronary Care Units covered in full.

A Surgical Schedule for physicians' services.

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

For details contact:
TOMA
Mr. Tex Roberts, Executive Director
512 Bailey Avenue
Fort Worth, Texas 76107
Phone (817) 336-0549

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TOMA Members Fill Important AOA Posts

Although there has been considerable publicity concerning the election of Dr. George J. Luibel as President of the American Osteopathic Association, and Dr. Samuel B. Ganz's reelection to the office of Speaker of the House, there are some 16 other Texans who will hold important positions in the AOA structure during the coming year who have not been recognized in this *Journal* heretofore.

Dr. John H. Burnett of Dallas holds a particularly important position as chairman of the Bureau of Insurance, a field in which he has been working for a number of years. Appointed to help share the load in this department is Dr. Elmer Baum of Austin, who will also serve as vice chairman of the Council on Federal Health Programs.

Dr. Lee J. Walker of TCOM serves on the Committee on Hospital Accreditation, and Mr. John B. Isbell, administrator of Stevens Park Osteopathic Hospital in Dallas is an alternate on the Appeal Committee on Hospital Accreditation, as well as a member of the Advisory Committee on Osteopathic Education.

Two Texans who have been appointed to the Bureau of Professional Education as public representatives are Mr. Bevington Reed, chairman of the Coordinating Board of the Texas College and University System and Mr. Jay Sandelin of Fort Worth. Mr. Sandelin will also serve on the advisory committee on the Council on Osteopathic Educational Development.

Also under the Bureau of Professional Education is the Committee on Colleges and TCOM's dean, Dr. Ralph L. Willard has been appointed to serve on it.

Dr. Mary M. Burnett of Dallas and Mr. Claude Rainey, executive vice president of Fort Worth Osteopathic Hospital and a representative of the American Osteopathic Hospital Association, were appointed to the Committee on Postdoctoral Training. Both also serve on the Subcommittee on Intern Training, and Mr. Rainey is a member of the Subcommittee on Residency/Osteopathic, Residency/Non-osteopathic and Preceptorship Training.

Dr. Margaret Dennis (Willard), a respresentative of the American Association of Colleges of Osteopathic Medicine and a TCOM professor, will work with the Committee on Continuing Medical Education.

Dr. T. Robert Sharp of Mesquite will represent the GP society on the Advisory Board for Osteopathic Specialists, and Dr. Gerald P. Flanagan of Denton was reappointed to the ad hoc Committee to Study Hospital Accreditation Procedures.

Texas is represented on the Committee on Constitution and Bylaws by Dr. James W. Lively of Corpus Christi, who also serves in that capacity for TOMA.

TOMA's President, Dr. David Armbruster, is a member of the AOA Board of Trustees and, in addition, will serve this year on the AOA Committee on Membership and on a Board Reference Committee.

Dr. Catherine K. Carlton of Fort Worth was appointed to the Committee on Medical Economics, and Dr. Robert G. Haman of Irving will serve on three AOA committees, including Committee on Health Related Policies, Committee on Program and Committee on Scientific Exhibits.

In addition to their other duties, Dr. Luibel is on the Executive Committee and the Bureau of Finance, and Dr. Ganz is a member of the Committee on Long-Range Planning, as well as the Committee on Editorial Policy.

With this group of Texans working in these important positions, it should be a very good year for the AOA! ^

Paying interest on the national debt has now become the third largest item in our budget — ranking behind only national defense and social security. In fact, paying interest on the debt now costs us more than $160 a year for every man, woman and child in the country.

William E. Simon

In Memoriam

Theron D. Crews, D.O.

Dr. Theron D. Crews of Gonzales died August 20 after a lengthy illness. In spite of his ill health, he had maintained a limited practice in Gonzales for some time until his retirement in July.

A 1936 graduate of the College of Osteopathic Medicine and Surgery, Des Moines, and a native Iowan, Dr. Crews came to Texas in 1937. He opened the Crews Hospital and Clinic in Gonzales in 1944.

His brother, Dr. Willis Crews, COMS '37, joined him in practice in Gonzales in 1944 and they were associated until Dr. Willis' death in 1971.

Dr. Crews is survived by his wife, Freda, and one son, Nicholas of Houston.

Funeral services were held in Gonzales August 23. The family requests that any memorials in his name be sent to the Texas College of Osteopathic Medicine.

State Board sets Examination Date

The next examination of the Texas State Board of Examiners in the Basic Sciences has been set for Friday and Saturday, October 15-16, 1976, in Austin, Texas.

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

Applications for the October examination must be complete and in this office by September 13, 1976 and all necessary information and documents required of examinees by the Board must be completed and in the applicant's file by that date. Those interested in participating in this examination should act immediately. ^

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

Address Correction Requested

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