TEXAS OSTEOPATHIC PHYSICIANS
JOURNAL
January 1977

THE NUMBERS GAME

HEW survey of "medically underserved" counties makes State of Texas look like a disaster area!

MEDICAID FRAUD & ABUSE

HEW to coordinate investigative efforts with Justice Department and IRS to combat violations

BULLETIN!

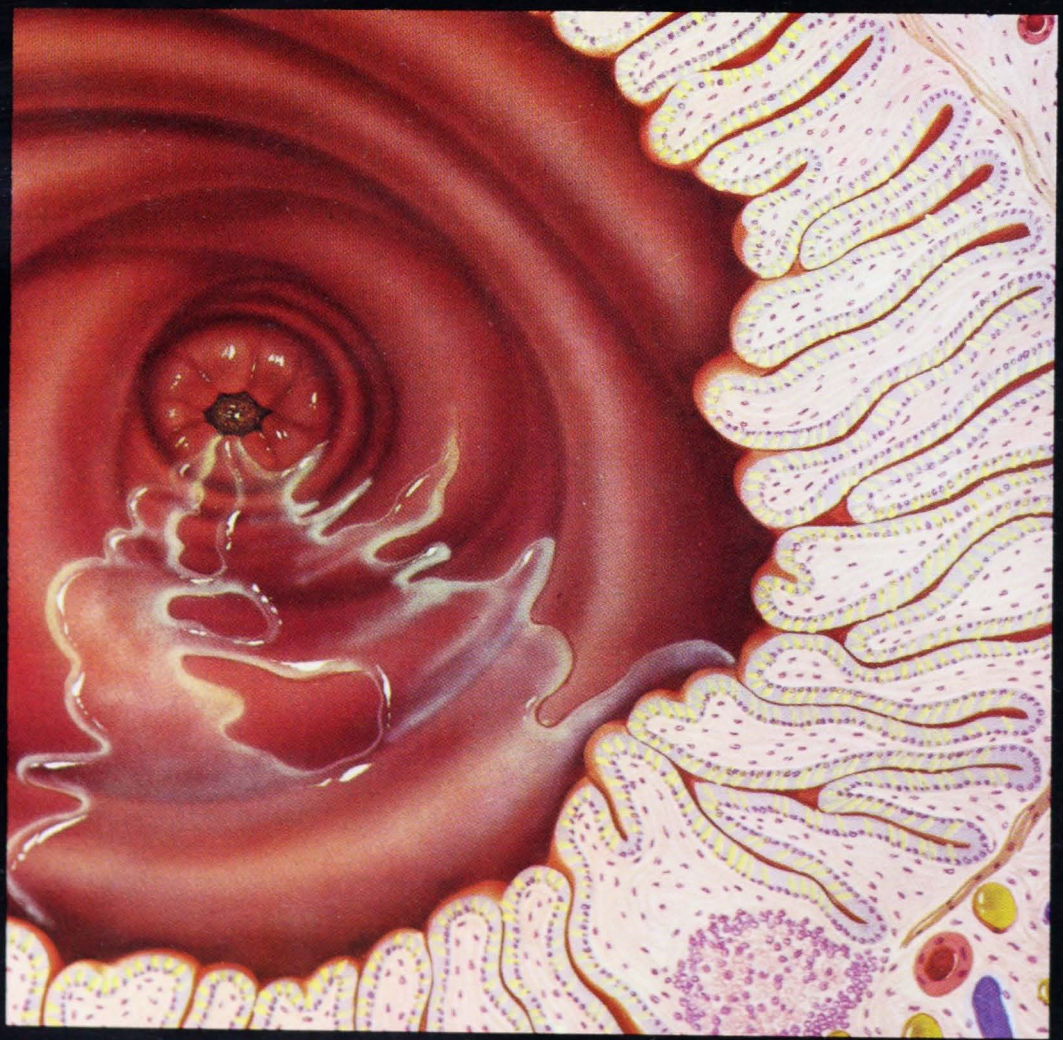
Texas gets single statewide PSRO

PUBLIC HEALTH SEMINAR

to be held in Dallas February 11–13

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.

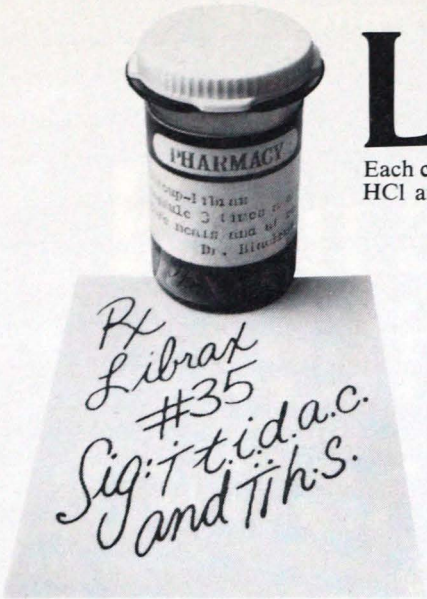
ROCHE

***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 Rx

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.

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

As with all 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 the 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 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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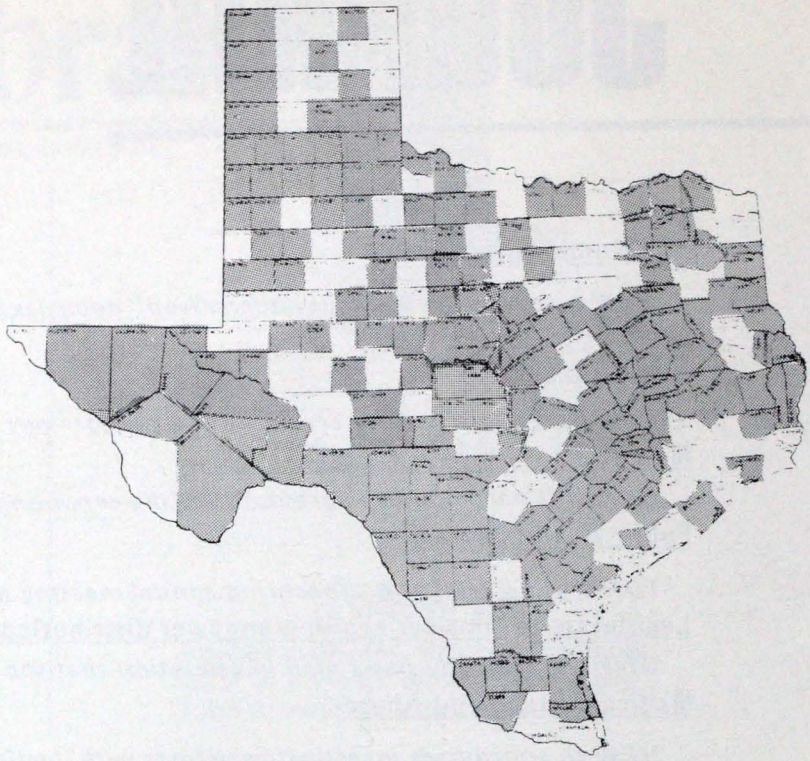
Mr. Tex Roberts, Editor

The Numbers Game



The shaded portions on the map represent medically underserved communities as designated by HEW

HEW survey of "medically underserved" counties makes the State of Texas look like a disaster area!

Have you ever heard of the "white picket fence syndrome"? Apparently it is a phrase coined by Sydney Harris and used in his column some months ago. His explanation of it is that almost anything can be proved by a set of figures—regardless of how or where the figures were obtained.

The gist of the column was that if only people who lived in houses with white picket fences were surveyed, and it was found that a certain percentage of them were afflicted with a particular disease, then it could be concluded that people who have white picket fences are more prone to be afflicted by that malady than those who had no such fences.

We must agree with his contention that too often surveys are incomplete because they were limited to certain entities or groups.

This particular column was brought to mind when Richard M. Hall, D.O., of Eden in Concho County, sent to the State Office a "List of Medically Underserved Areas" in Texas that was printed in the *Federal Register* October 15, 1976. Dr. Hall noted that Concho County was on the list and wrote, "Apparently D.O.s don't count."

Since we wondered if D.O.s *were* counted, this prompted considerable research into several surveys.

The report in the *Federal Register* comes from the Public Health Service of the Department of Health, Education and Welfare, and it explains that designation of these medically underserved areas is arrived at by a rather involved weighting system.

One part of the formula comes from the ratio of primary care physicians to the population with the explanation, "For the purpose of these computations, primary care physicians are defined to include the total number of active doctors of medicine (M.D.) and doctors of osteopathy (D.O.) who spend at least 50 per cent of their time engaged in direct patient care in the fields of family practice, internal medicine, pediatrics, or obstetrics and gynecology. The computations must include all non-Federal physicians meeting the above definition."

The report, which comes from Theodore Cooper, M.D., Assistant Secretary for Health, states that the index of medical underservice on the list is based on several sources; among them the Master File of Osteopathic Physicians, December 31, 1974, supplied by the American Osteopathic Association. So apparently in this survey, D.O.s *do* count.

Then we studied another survey, the source of which is "Distribution of Physicians in the U.S., 1973, Center for Health Services Research and Development, American Medical Association, 1974."

In this survey D.O.s *don't* count, and it is understandable that the AMA counts only the M.D.s. However, the Texas news media takes its figures from such a survey when it reports that there are 23 Texas counties without a physician, when in fact there are only 18, since five of those 23 counties are served by D.O.s.

The AMA report says that there are 12,447 M.D.s involved in patient care in Texas, but only 2,671 of these are in general practice. What it doesn't say is that about 75 per cent of some 850 osteopathic physicians in private practices are G.P.s, bringing the total number of primary care doctors in the state to about 3,300.

Since it is generally recognized that a person should see his family physician (or generalist) first, instead of diagnosing his own ills and then choosing a specialist to fit that "diagnosis," we come up with some rather wild statistics of our own that would prove most of the state of Texas to be a disaster area, medically speaking.

If each of these 3,300 G.P.s worked five days a week for 52 weeks (no vacation, but weekends off if he is lucky), each Texas resident could have a total of 34 minutes a year of his family doctor's time. (An example of the "white picket fence syndrome"?)

There are 254 counties in Texas and the *Federal Register* notes that 164 of them are underserved medically. We do not have the facilities or complete information to check out the "weighting" formulas used to arrive at this figure, but from statistics readily available to us, we question some of the conclusions reached by HEW.

For instance, Archer county with a population of about 6,000, including only one doctor, is not listed as underserved. On the other hand, Concho County, with about 3,000 population and two doctors is listed in bad shape. (According to the AMA report, there are *no* doctors in Concho County.)

In combining the two surveys, we find the best served county is Galveston, with one doctor for every 405 persons. HEW considers this adequate, but Kerr County, with one physician for every 538 persons, is listed as medically underserved.

In checking the distribution of doctors (according to the AMA survey) in Galveston County, however, we find that out of a total of 469 involved in patient care, only 43 (including two D.O.s) are in general practice and 253 have hospital based practices. The remainder are specialists. In other words, less than one in ten could be considered a family doctor.

Of the 39 physicians in Kerr County, 13 are G.P.s—33 per cent. Nine are hospital based and the others specialize.

We note that Jefferson County, with 282 physicians, has 92 surgeons to 77 generalists. Dallas County has about twice as many surgeons as G.P.s, and the same ratio applies in Harris County. However, Tarrant County is a little more medically balanced with the numbers of surgeons and G.P.s being about equal.

The gray areas on the accompanying map are those designated by HEW as medically underserved. Although the map's size makes it practically impossible to read county names, it does point out that a G.P. can choose almost any geographical area, climate, terrain, or you name it. There is a place to his liking in Texas where he is needed.

More detailed information is available in your State Office. Call or write if we can help on locations and statistics. ^

D.O.s Do Count

The December 1976 issue of *Texas Parade* carries a lead story by Peter Brewton, "In Search of a Country Doctor." The author has gleaned many of his "facts" from the TMA and repeats its contention that there are 23 Texas counties without a doctor.

Since Brewton is a San Angelo resident, it might be suggested that he visit Wiley B. Rountree, D.O., or Jack Wilhelm, D.O., both of that city—and both licensed to practice medicine in Texas by the State Board of Medical Examiners.

Brewton's main point is the shortage of doctors in rural and smaller communities, and there is no disputing the fact that this shortage is very real. However, he should know that a large number of D.O.s *are* serving the health care needs in these areas.

Another writer, Kay Powers of the *Austin American-Statesman,* also takes TMA's figures as to the number of counties in Texas without a doctor, according to a byline story appearing in that paper's September 29 issue.

She does, however, recognize the osteopathic profession, and took the time to interview several D.O.s for her story, which was headlined. "Doctor distribution unequal," with a subhead, "Osteopaths fill gap."

Apparently from talking to Dale Brandt, D.O., of Mason, she learned, ". . . .the level of medical education for M.D.s and D.O.s is very similar, an identical licensing examination is given both types of practitioners in Texas . . . ."

She also interviewed Dareld Morris, D.O., who is chief of staff of the Smithville hospital and who has practiced in that community since 1974. The staff includes both D.O.s and M.D.s, and she quotes Dr. Morris as saying there is excellent rapport between the hospital's doctors.

Ms. Powers reports at length on her interview with Rann Clark, D.O. of Buda, and quotes him as saying, "Many physicians are leery of going into a rural general practice where they will not have a lot of other physicians to help make decisions . . . . It's quite challenging, just as it's challenging to be a general practitioner who must treat every kind of case that walks into the office.

"But it is really rewarding because of the variety and the challenge and the close patient rapport which is possible in such a practice."

She also draws on an article from last May's issue of this *Journal* which quoted Richard M. Hall, D.O. It was a report on the lecture he gave at the 1976 TOMA convention where he said, "I think we as family physicians probably have more direct effect on the lives of these people because we work with them in emergencies—physically, mentally, emotionally, spiritually and financially.

"All of these things have something to do with your health and any of them can precipitate an emergency situation."

One important fact of which both of the above writers seem to be unaware is that there exists a Texas College of Osteopathic Medicine. Since information concerning it has been rather widely reported for some seven years, it is rather surprising that their research didn't uncover this fact.

In fact, even before the founding of this school, the Texas legislature was interested enough in the education of osteopathic physicians to provide scholarships for a number of Texans who had to receive their osteopathic medical training out of state, since there were no facilities in Texas for such training.

Dr. Clark is one who received such a scholarship, and Texas is now reaping the benefits of those relatively few dollars it spent on his training.

Since about 75 per cent of D.O.s are family doctors, and perhaps half of those practice in rural or small communities, their existence should certainly be taken into consideration by any writer on the subject of the shortage of physicians in such areas.

As reported in the July 1976 issue of this *Journal,* of the 18 members of TCOM's first graduating class (1974), 12 are now practicing family (or general) medicine in Texas and only one has set up a private practice in another state. Four of these graduates are in military service and one is an internal medicine resident at Dallas Osteopathic Hospital.

Of the 12 in private practice in Texas, only one could be considered as practicing in a large metropolitan area.

Fortunately the Texas legislature is well aware of the contribution D.O.s are making to the health care needs in the state. In 1975 legislation was passed making TCOM a state supported school under the governance of North Texas State University.

In November Governor Briscoe was the honored guest at groundbreaking ceremonies for TCOM's first brand new building—Medical Education Building I, located at Montgomery and Camp Bowie in Fort Worth.

More such facilities are on the drawing board, and it is expected that in a few short years TCOM will be graduating more than 100 doctors of osteopathy each year, many of whom will establish practices in family medicine in medically underserved areas in Texas.

Med Ed I: Harbinger of more to come

Official ceremonies marked a Texas College of Osteopathic Medicine milestone when the ground was broken for TCOM's first major construction, the $12.4 million, eight-story, 230,000-square-foot Medical Education Building I November 15 in Fort Worth.

Representing the state, the city, the college, the university and the people of Texas were Governor Dolph Briscoe, Fort Worth Mayor Cliff Overcash, TCOM Dean Ralph Willard, D.O., North Texas State University Board of Regents and President C. C. Nolen, and the Reverend and Mrs. Rae Thompson of Justin with son Tyler, representing Texans who will benefit from the health care to be provided by TCOM graduates.

"This is a great day for Fort Worth, a great day for Texas and a great day for North Texas State University," Governor Briscoe told a crowd of some 250 people, including TCOM students and their families, and several state legislators who came with obvious enthusiasm despite bitter cold weather.

"Because of institutions like TCOM, people in Texas in the years ahead will have better health care in the metropolitan areas and in the rural areas of this state."

Dr. Willard, thanking the state legislature and the U.S. Department of Health, Education and Welfare (HEW), for their help in funding the construction, called their assistance "a tangible acknowledgement of our needs . . . and we accept the challenge to produce primary care physicians."

He said the promise of the new education facility has attracted many highly qualified individuals to the faculty of TCOM, and added, "Now we will have the physical plant to match the faculty that is already being developed."

TCOM Student Council President Ron Jackson, speaking on behalf of TCOM students, said, "Medical Education Building I is only the beginning of what we think will be the best school of osteopathic medicine in the country."

Construction projected to be completed July 1979, is being funded by a $4.8 million HEW grant and by state legislative appropriations.

The building will be the first major construction since TCOM was made a state institution by an act of the legislature in 1975. At that time the NTSU Board of Regents was made the governing board of TCOM.

The school has been operating out of refurbished buildings since it first began classes in 1970.

Medical Education Building I, offering auditorium, student center, administrative offices, outpatient clinic, library, media center and four classrooms, will provide modern facilities for the clinical science program.

Governor Briscoe, with his wife Janey by his side, broke the ground with a specially designated shovel which is being preserved for future TCOM groundbreakings. Assisting the governor in the groundbreaking were six-year-old Tyler and his parents. The family, as members of the community of Justin which will benefit from the Justin Clinic which TCOM opened October 1, represented families throughout the United States whose primary health care is provided by osteopathic physicians.

Mayor Overcash lent TCOM the city's support when he told the crowd, "There is no question that TCOM will be a great asset and benefit to the City of Fort Worth. Before this is over, the City of Fort Worth will have a great investment in this institution as well (as federal and state supporters)."

As Texas Governor Dolph Briscoe turned the first shovel of dirt and began construction on TCOM's Med Ed Building I, he was joined by the Rev. and Mrs. Rae Thompson and Tyler, and A. M. Willis, Jr., chairman of the NTSU Board of Regents (r.). At the Governor's side during the official ceremony was his wife Janey. Watching from the speaker's platform are (l.) C. C. Nolen, president of NTSU and TCOM, and (r.) Dr. Ralph L. Willard, dean of TCOM.

PUBLIC HEALTH SEMINAR

sponsored by

Texas Department of Health Resources and Texas Osteopathic Medical Association

February 11–13, 1977
Conquistadore III Room
Dallas Marriot Motor Hotel
2101 Stemmons Freeway, Dallas

[15 CME CREDIT HOURS APPLIED FOR]

Speakers

Richard T. Caleel, D.O.
Chicago
Senior Consulting Surgeon
Chicago Osteopathic Hospital
Associate Professor of Surgery, CCOM

Neil A. Pruzzo, D.O.
Richardson
Rehabilitation Medicine

Ivan J. Barber, Jr., M.D.
Lubbock
Anesthesiologist
Pulmonary Patho Physiologist
Highland Hospital

Jerome Greenburg, M.D.
Austin
Deputy Director, Preventable Diseases
Texas Department of Health Resources

Charles Sweet, M.D.
Austin
Director, Laboratory
Texas Department of Health Resources

Richard B. Baldwin, D.O.
Fort Worth
Associate Professor
Department of General and Family Practice
TCOM

L. Linton Budd, D.O.
Fort Worth
Professor and Vice Chairman
Department of Obstetrics and Gynecology
TCOM

Program

FRIDAY, FEBRUARY 11

6:00– 8:00 p.m. — *Osteopathic Video Tape Medical Lectures*
Courtesy, TCOM

SATURDAY, FEBRUARY 12

8:30– 8:55 a.m. — Registration

8:55– 9:00 a.m. — Address of Welcome
David R. Armbruster, D.O.
President, TOMA

9:00–10:00 a.m. — *Utilization of State Lab Facilities in Your Practice*
Charles Sweet, M.D.

10:00–11:00 a.m. — *Philosophy and Assistance of TDHR in Preventable Diseases*
Jerome Greenburg, M.D.

11:00–12:00 noon — *Treatment of Chronic Pancreatitis by Surgery*
Richard T. Caleel, D.O.

1:00– 2:00 p.m. — *General Practice Approach to Hypertension*
Richard B. Baldwin, D.O.

2:00– 3:00 p.m. — *OMT for Hypertension and Associated Problems*
Neil A. Pruzzo, D.O.

3:00– 4:00 p.m. — *Pulmonary Function Testing of Presurgical Patients*
Ivan J. Barber, Jr., M.D.

4:00– 5:00 p.m. — *Office Gynecology*
L. Linton Budd, D.O.

6:00– 8:00 p.m. — *Osteopathic Video Tape Medical Lectures*
Courtesy, TCOM

SUNDAY, FEBRUARY 13

9:00–10:00 a.m. — *General Practice Approach to Diabetes*
Richard B. Baldwin, D.O.

10:00–11:00 a.m. — *Gonorrhea Diagnostic Assistance*
Charles Sweet, M.D.
Prevention and Treatment of Gonorrhea
Jerome Greenburg, M.D.

11:00–12:00 noon — *Techniques of Office Surgery*
Richard T. Caleel, D.O.

12:00– 1:00 p.m. — *OMT for Pulmonary Diseases and Associated Problems*
Neil A. Pruzzo, D.O.

1:00– 2:00 p.m. — *Treatment of the Problem Pulmonary Patient*
Ivan J. Barber, Jr., M.D.

The Wisdom of Big Brother

by Richard L. Lesher, President
Chamber of Commerce of the United States

It now costs about $489,000 a year to keep a congressman in Washington, not counting mistakes. And some of their mistakes are lulus.

Last year, Congress inadvertently repealed the federal corporate income tax. Amended the wrong section of the Internal Revenue Code. Nothing to get excited about. The little boo-boo was quickly corrected. Besides, it was only $40 billion.

Ever generous with other people's money, the Hill people are a little tight-fisted, it seems, when it comes to spending their own: Out of 140 federal employee groups taking part in a 1975 united charity drive, the House (members and employees) managed to ante up only 1.5% of its goal, and the Senate 1%, ranking them, respectively, 139 and 140.

Business people have been having fits trying to comply with the Byzantine requirements of the Occupational Safety and Health Act of 1970. Little things like the fine that was levied against Pratt & Whitney for keeping the doors locked on a rocket engine plant doing super-secret work for the Defense Department (fire hazard, you know).

Well, misery loves company. It seems the feds aren't doing so well themselves. Earlier this year, a House Government Operations subcommittee disclosed that the majority of U. S. agencies are failing to comply with the Act.

To be fair to the Occupational Safety and Health Administration, it does have its problems. Like the time it ordered vehicles at construction sites to use back-up warning beepers, and was told by the Environmental Protection Agency that the beepers exceeded EPA's noise standards.

EPA is very sensitive about noises that could wake the dead, as the State of Indiana learned when a proposed highway overpass was vetoed by the agency because the State failed to conduct a noise abatement study for a cemetery a quarter of a mile away.

But, EPA, too, has its problems. According to the General Accounting Office, one of these problems is that health standards in EPA laboratories violate the law.

Isn't it nice to know what you're getting for your tax money? ^

Payments to be limited under MAC Drug program

Steps are being taken to lower the $3 billion annual expenditure for drugs in HEW-funded health care programs, principally Medicaid.

Known as MAC, for Maximum Allowable Cost for Drugs, the program will limit payment for certain multiple-source drugs to the lowest cost at which a drug is widely and consistently available to providers. Before a MAC limit is set on any drug, FDA will review available scientific and regulatory data to assure that there are no unresolved problems involving quality or bioequivalence that would warrant delay in setting a payment limit. The proposed MAC limits will be reviewed by an advisory committee of pharmacists, physicians, and cost reimbursement experts before formal publication for comment. Importantly, if a prescriber indicates in writing that a brand of drug priced above a MAC is needed for a specific patient, then as far as HEW is concerned, that MAC limit may be waived by the reimbursing program and reimbursement made for the higher priced brand.

The first products being considered for MAC limits are 250 mg and 500 mg ampicillin trihydrate capsules. Current surveys indicate that the 250 mg strength in bottles of 100 is priced between $6.00 and $18.74 by well known national suppliers, and that 500 mg capsules are available in bottles of 100 at prices between $9.99 and $36.20. FDA has reported no significant quality or bioequivalence problems among available brands of these ampicillin capsules.

Specification of this drug by its generic name can yield substantial savings to publicly financed health care programs without compromising the quality of care. The setting of MAC limits on ampicillin capsules in the Medicaid program alone can reduce the estimated $2.2 million dollar expenditure for these products by about $700,000.

[Reprinted from FDA Drug Bulletin] ^

Legislature to consider health manpower distribution

Oklahoma already has a plan

Texas and many other states are struggling with the problem of health manpower distribution. The Texas Legislature now in session will consider several legislative remedies and herewith is presented a plan that is in operation in Oklahoma that provides state aid but enlists participation, commitment and funding by communities, hospitals, student doctors and the medical schools.

The Oklahoma legislation ties the total picture together from the student recruitment phase through medical school education and training, and finally internship and residency in Oklahoma hospitals and clinical settings.

Administration and coordination of the entire multi-pronged program is assigned to the Physician Manpower Training Commission, which includes two lay citizens from the health care field, two D.O.s and three M.D.s. The Commission's primary charge is to increase the number of practicing physicians in underserved and rural areas.

The Oklahoma Senate Bill No. 534, signed in 1976, makes available forgiveness financial loans to student doctors, financial aid to rural communities in securing physician services, and funding with state dollars general practice internships and primary care residencies.

According to Bob E. Jones, Executive Director of the Oklahoma Osteopathic Association, osteopathic internship training in Oklahoma is expected to be funded to the level of $2 million. In addition, student doctors at the Oklahoma College of Osteopathic Medicine and Surgery in Tulsa are receiving substantial rural medical scholarship forgiveness loans that are matched by rural communities up to $5,000 for the community, and an additional $5,000 to the Commission.

The medical student must agree to practice in the community with which he contracts for a period of one year for every $5,000 loaned, with a minimum obligation of two years service required before any loan forgiveness is allowed.

The student doctor must be a bona fide resident of Oklahoma. He enters into a contract with the community and a contract with the state. The community contracts with a specific student doctor and then the two jointly contract with the Commission. In addition, the community must demonstrate the ability to support a practicing physician, be able to adequately and timely fund the community portion of the scholarship, and show a need for additional physician manpower.

If the student doctor chooses to repay the loans, it would be in cash with interest accruing at ten per cent per annum—accruing from the date each loan was made during his education and training.

In the event that a community participating in the matching fund program should fail to provide continuing support for the entire duration of the student's training, it will be unable to receive any form of repayment from the contracted student. The Commission, in this event, shall attempt to match the student with another community for the duration of academic training.

In addition, the Commission must establish and administer a cost sharing program for primary care and family practice internships and residency training programs. The Commission provides a portion ($6,000 to $8,000) of an intern or resident salary to help relieve the financial burden of the training facility.

The Commission also is assisting in the development of satellite training clinics located in communities outside the major urban medical centers in order to introduce physicians to the types of practice encountered in the non-urban areas and become acquainted with the opportunities in less populated, rural Oklahoma. The Commission also has contracted with the Oklahoma Council for Health Careers and Manpower, Inc. for physician placement services.

One section of the Oklahoma bill provides for community preceptor physician training and work experience scholarship funding for the purpose of providing state matching funds assistance and encouraging the development of a program whereby communities, hospitals and clinical training situations will receive funding for the stipends and living expenses of medical students who agree to work in these communities during vacation times while enrolled at the University of Oklahoma College of Medicine or the Oklahoma College of Osteopathic Medicine and Surgery.

The Commission contracts with individual hospitals and clinical programs for the reimbursement of intern or resident salary costs following graduation of the contracted student doctor.

At least half of the Commission's funds for training

of primary health care and family practice physicians must be for rural and medically underserved areas.

The Commission will develop the criteria and procedure by which state matching funds will be awarded to hospitals and accredited clinical situations in cooperation with the two medical schools which shall administer the programs in the hospitals and clinics. Funds will be provided to cover nonreimbursable or additional costs incurred in hospitals for training activities.

Accredited hospitals and clinical situations participating must have affiliation agreements with one or the other of the Oklahoma medical schools and submit their applications for funds to the Commission.

The Commission has the responsibility to insure that hospitals or clinical situations in all sections of Oklahoma can qualify and be utilized to take all steps necessary to assist such hospitals or clinics in obtaining necessary recognition or status, or in meeting standards for accreditation or affiliation so that they may participate in these physician training programs.

Texas is considering, in prefiled bills, funding for internship and residency programs in primary teaching hospitals which would exclude a broad-based program similar to that in operation in Oklahoma. The student doctor loan and grant program in Texas is administered by a separate Rural Medical Education Board.

Write or call TOMA in Fort Worth for a copy of the Oklahoma bill. ^

More than a Certificate of Need

by George W. Northup, D.O.

The osteopathic profession has been rightfully interested in the "certificate of need" type of legislation. In determining the need for hospital beds in the expansion of existing hospitals and in the development of new ones, the osteopathic profession cannot and should not be lumped into one homogeneous grouping of *all* hospitals. The hospital needs of osteopathic physicians (both general practitioners and specialists) and the needs of their patients are not completely met in allopathic institutions.

It is established, both traditionally and legislatively, that the osteopathic profession is a separate and distinct entity among the healing arts professions. In every respect therefore, it should be treated as such.

A further problem arises from the fact that graduates of osteopathic colleges gravitate to those states and areas where there are osteopathic hospital facilities. There are several states where the census of practicing osteopathic physicians is already very low or getting lower. All of these states have laws favorable to the practice of osteopathic physicians; the problem is that there is a lack of osteopathic hospitals.

With the rapid growth of our profession and its educational system we must place a major emphasis on the development of osteopathic hospitals in those states where only a few osteopathic physicians now practice. Such development is worthy of every effort by divisional societies and by the AOA itself. ^

WE ARE NOT ALONE!

The American Society of Association Executives (ASAE) to which your Executive Director belongs, is a voluntary membership society for more than 7,000 executives who manage leading business, professional, educational, technical and industrial associations.

This membership, in turn, represents an underlying constituency estimated at more than 22 million persons and firms belonging to national, regional, state and local associations.

In a December 15 letter to each individual member, the deliberations of a recent ASAE Board of Directors meeting were reported, and the main point brought out was, "First, as is apparent to all of us, Government Relations must receive a very top priority in ASAE . . . .

"The Board reached the decision to work on only those issues which affect the entire association community—issues such as the so-called unrelated income tax (trade show, advertising, insurance, etc.); the regulation of lobbying; association political action committees, foreign conventions; postal regulations and rates, etc.

"In addition, we need to work with agencies of the government such as the FTC, FDA, Justice Department, IRS and others on issues of common interest to all associations . . . ."

The above is just to point out that we are not alone! Although we in Texas are constantly working toward solutions to problems that arise in our profession's relations with the state and federal governments, it's good to know that the combined knowledge and experience—and clout—of more than 22 million association members throughout the country is available to us. ^

Medicaid Fraud and Abuse

Elsie M. Tytla, M.D., Medical Advisor to the HEW Medical Services Administration in Washington, delivered the following address at a meeting of the Ohio Osteopathic Association. She gave essentially the same talk in Texas in November, and has also presented it in a number of the larger states.

Doctors are the favorite whipping boys these days and are being held responsible for everything wrong with the health care system. Certainly we are being blamed for the high cost of medical care, particularly in Medicare and Medicaid. Almost every day we see headlines about some health services provider ripping off the system. Whether it actually is or is not true, in Washington it is perceived that there is great fraud and abuse in Medicaid.

I asked for this opportunity to talk to you because we want you to have the facts, to understand the problems and why and what HEW and the MSA will be doing in Ohio in the coming months. We did not want Ohio physicians to learn about our Federal activities solely through TV and newspaper stories.

Medicaid has become a very costly program. It is partially Federally financed but State administered; different in each of 53 States and territories. State funds are appropriated, thus limited, but Federal funds are open-ended. Five years ago $5 billion were spent on Medicaid. This year, the figure tripled to almost $15 billion and it is growing at approximately $2 billion additionally each year. Two thirds of the money is spent in the ten largest States—Ohio, one of them.

Seventy per cent of the dollars is spent on hospitals and nursing homes, ten per cent goes to physician services, seven per cent on drugs, three per cent on dental services, seven per cent outpatient, four per cent other.

As you can see, one of the major problems confronting Medicaid is the spiraling costs. Payment to physicians may account for only ten per cent of the expenditures but as you well know *physicians trigger the utilization of all the other health services.* But we are not just concerned with physicians but also with pharmacists and hospital administrators and operators of nursing homes and laboratories.

Because the Medicaid program is being defrauded and abused by some providers:

Patient care is jeopardized

The medical profession is mistrusted and maligned

Government administrators are considered incompetent

Tax funds are drained

Everyone gets cheated

For this reason, it is very important that physicians work with us; first to clear their own ranks and secondly to help us stop fraud and abuse by other providers of services. Our goal is to develop methodology which will easily identify the provider who clearly is the deviant and manipulating the system, but will not harass the majority of honest hard working providers.

Let me state our basic assumptions:

We believe the great majority of professional providers are honest and doing an excellent job, but they are being tainted because the small minority engaging in fraudulent or abusive practices does damage to the good names of all health professionals.

Most so-called "high-volume providers" work long hours to bring medical care to large numbers of disadvantaged often under difficult conditions.

Fraud and abuse in Medicaid divert State program dollars from the provision of health care to the poor and cause cutbacks in reimbursement levels to providers.

If fraud and abuse is stopped, more dollars will be available for legitimate health care needs of the nation's poor.

We know that poor program management is an important cause for allowing abusive practices to proliferate.

I grant you that confusing regulations, complicated paper work, inadequate or unequitable reimbursement rates, and slow payment make it difficult for honest providers to stay in the program.

Reimbursement rates probably are the key to the problem. Unfairly low reimbursement may cause some providers to stop caring for Medicaid recipients altogether, providers may resort to lower quality of care (as is practiced in so-called "Medicaid Mills")

or fraudulently bill the program resulting in greater cost.

The spillover effect of bad publicity may ultimately damage the relationship of physicians with private patients and perhaps even impact on the malpractice issue.

All health professionals suffer collective dishonor caused by the few.

What are fraud and abuse?

Fraud is the filing of false statements or claims with the *intent* of obtaining undeserved gain.

Abuse covers a broad spectrum. In general it is receiving payment for overcharges, or for overuse, or distortion of, or improper use of recognized services,

Some examples are:

Billing for services not rendered
Overstating costs
Billing for services more expensive than those rendered
Double billing
Shortchanging patients on the quantity of a prescribed drug while billing for the total amount
Splitting prescriptions
Billing for more expensive drugs than those dispensed
Charging in excess of one's "usual and customary" rate
Participating in kickbacks and rebate systems
Prescribing excessive and unneeded laboratory or x-ray services
"Ping-ponging" or gross overutilization of services (particularly consultation when not needed)
Encouraging patients to overutilize services
Gang visits to nursing homes
Billing for services that are not authorized by Medicaid, etc.

Clearly these issues go beyond questions of quality of medical care.

The Magnitude of the Problem is really unknown.

A very small number of individual providers are guilty but account for a very large number of misused dollars.

Reports and observations lead us to believe that a national rate of 8-15 per cent of both fraud and abuse is probable.

This translates into $1.2 to 2.2 billion a year of fraudulent and abusive activities.

The Department of HEW is launching a five-part program to control Medicaid fraud and abuse.

1. Management initiatives are directed at tightening "front-end" management controls, improving detection procedures and reviewing unusual provider practices. HEW has developed the Medicaid Management Information System (MMIS) and has given States financial and technical assistance to install it.
   In spite of the stormy early period in Ohio MMIS now has simplified claims payment processing and it does provide patient and provider profiles. This computer system enables truly aberrant providers to be identified more easily without undue harassment of the honest provider.
   Recommendations on improved management practices by the Medical Agency will be followed up for action.
   Better Medicaid management will enable more professionals to work with the program in providing care to the needy.

2. Deterrence of fraud will be heightened by the expansion of the HEW Office of Investigations, the establishment of the MSA Fraud and Abuse Unit and the State Investigative units.

3. A Joint Federal-State review effort has begun, starting in large-expenditure State programs. Massachusetts is the pilot where the methodology is being worked out and will be followed by Ohio later this fall. An 18-member review team will go into the State Medicaid Agency offices first and will identify the kinds of management practices and causes of fraud and abuse.
   A sample of claim forms will be chosen for verification of services delivered by reviewing the records in providers offices. Approximately 50 records from each of 25 physicians, 25 pharmacists, 25 clinical labs, and 25 nursing homes will be examined.
   Suspected offenders will then be subjected to further investigation and prosecution. Findings will be kept confidential until formal legal charges are made. Every effort will be made to prevent unfair and unnecessary publicity.

A more active Provider and Consumer involvement:

We are asking National and State professional provider organizations to take steps at self-policing. County and State Medical societies should publicize these activities and make known that offenders will not be tolerated within the profession. Both the AMA

and the AOA have already indicated their full support of the initiative. The Medical Society in Massachusetts, the first review state, is already working actively with the Medicaid Agency and the review team, to expedite the audits.

The AMA has asked that full legal action be taken against all providers found guilty of fraud.

The AMA is developing model legislation which will provide State licensure authorities the means to move against errant physicians on basis of fraudulent, abusive, or unethical behavior, as well as malpractice issues.

Medicaid agencies are being asked to provide state medical societies the names of abusers as they are identified so that some appropriate action can be taken.

A central "clearinghouse" should be established in order to identify quickly those physicians who move from one area to another after being found guilty.

The Secretary of HEW is also asking national consumer groups to develop interest in reporting alleged fraud to professional societies as well as Medicaid agencies.

Federal Agency Coordination will be expedited between HEW, Department of Justice, and Internal Revenue Service on follow-up of suspected cases.

Medical Professional Provider Involvement is needed

It is in the best interest of providers in general to identify and police unethical peers.

The medical profession does have a responsibility to protect the public from unethical practices and to apply sanctions when necessary.

We feel professionals should police members of their own group because only they have the professional expertise necessary to monitor such practices.

The more effective the professional monitoring is, the less active the role the State or Federal government is required to take in trying to control fraud and abuse.

Is the profession willing to take on the challenge? Or would it prefer Government imposing still more controls? ^

Special claim submission procedures outlined as new Medicaid contractor takes over

MEDICAID NEWSLETTER from Blue Cross-Blue Shield

Our contract with the State Department of Public Welfare as the Health Insuring Agent for the Medicaid Program expires December 31, 1976. Effective January 1, 1977, the new contractor is National Health Insurance Company, 7800 Shoal Creek Boulevard, Austin, Texas 78771. This change requires special claim filing procedures to split 1976 and 1977 charges for patients with Medicaid coverage only. The following will apply on claims which overlap the 1976-1977 periods.

1. All claims for Medicaid recipients who do not also have Medicare coverage must be split by year of service. Claims for all 1976 services (services provided on or before December 31, 1976) must be submitted to Blue Cross-Blue Shield of Texas on the "Request for Payment" billing form presently in use (Form 3506). Claims for 1977 services (services provided on or after January 1, 1977) must be submitted to National Health Insurance Company on their "Request for Payment" form T 19-005 (for all professional services other than eyeglasses) or form T 19-007 (eyeglasses). Claims involving "global fees," such as obstetrical and surgical procedures, should be billed based on the date of the surgical procedure, or the delivery date in obstetrical cases
2. Claims for Medicaid recipients who also have Medicare (those filed on the Medicare 1490 claim form) will continue to be submitted to Medicare regardless of the date of service. After processing by Medicare, information will be transferred to the contractor responsible so the appropriate Medicaid payment can be made.

Please review very carefully all claims involving services which may overlap 1976-1977 for "Medicaid only" recipients, and be certain these are submitted to the proper contractor. Following these instructions closely will help both contractors process your claims promptly and accurately. ^

DOCTORS-MEMORIAL HOSPITAL

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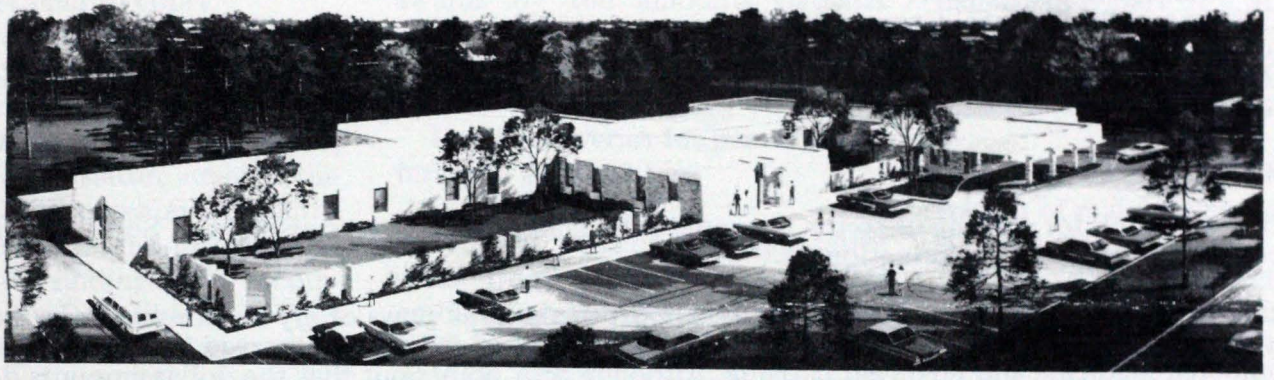

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Texas Osteopathic Medical Association

Office of the Executive Director
MR. TEX ROBERTS

December 6, 1976

Mr. Ralph Tunnell, Program Officer
District Offices and Professional Groups
Department of Health, Education and Welfare
1200 Main Tower Building
Dallas, Texas 75202

Dear Ralph:

Thank you very much for alerting us to the proposed rules and important reassessment of Social Security's policies concerning release of information.

As an officer of this Association and reflecting the almost unanimous views of my doctor members, I object strenuously to the release of information totaling up the amount of federal dollars paid to a physician for services rendered Medicare and Medicaid patients. Although SSA points out that the dollar amounts do not necessarily imply fraud or over-utilization, the fact that the totals are published on a few physicians across the country fixes itself in the public mind of some reflection of wrongdoing, when in fact fewer and fewer physicians are rendering services to old people and poor people because of this and other sometimes unnecessary and frustrating red tape.

There are better ways to deal with those physicians who abuse these programs but, more importantly, the big gap in the system results from a lack of requirements placing responsibility on these classes of patients to not over-utilize and to take care of their health. There is a vast amount of solid information available proving that the American people, regardless of whether they are old, poor or middle-class, do not accept any appreciable degree of responsiblity for their own health habits.

Patients receiving health care—paid for with federal dollars—should be required to file an annual certificate of participation and compliance. It could be a simple checkoff form, with a few spaces for recording information as to whether the recipient had received care during the preceding year, and his own certification that he was following his doctor's instructions. It would only be used in cases where utilization seemed to be higher than normal and for purposes of counseling with these people or denying or reducing their benefits.

From a personal standpoint, SSA should be prohibited from releasing my Social Security number tied to my health, my economic status, or any other information it might possess concerning me. The statistics should only be available as aggregate figures and in a manner that it cannot be tied to an individual doctor, lawyer or individual.

There should be a few places remaining where an individual can expect privacy, and these include information possessed by his physician, his lawyer, his minister and his banker.

Please permit me to point out to you and the Department that rights to privacy and confidentiality of personal and sensitive information are principles that have almost disappeared, especially in Washington. Too many ribbon clerks in and out of government are running loose exploiting private and confidential information that they have been allowed to get hold of legally or illegally.

In the beginning, we were promised that our Social Security number would not be used for identification purposes—the principal reason being that some unauthorized snooper can't push a button in a vast governmental computer network and print out our entire life's history, including warts and all.

We will appreciate your help in urging the Department to strive for balance between the sometimes conflicting public interest and the private individual's right to privacy.

Cordially,

Tex Roberts

Tex Roberts, CAE
Executive Director

Malpractice Study Commission Report Ready for Legislature

A special commission on medical malpractice insurance has approved a final report that includes mandatory screening of all claims before they can be taken to court.

While commission members are expected to file individual dissents from various parts of it, the report as a whole was approved 12-0.

The 1975 legislature created the Texas Medical Professional Liability Study Commission and instructed it to report its findings and recommendations by December 1.

The commission found that high rates and lack of coverage resulted from a combination of factors. These included the vast new array of technical and scientific developments in the health care field.

The commission majority recommended passage of a law requiring review of each malpractice claim—prior to the filing of a lawsuit—by a screening panel of five health care providers with a district judge as nonvoting presiding officer. The panel's findings would be admissible as evidence if the case went to court, and its members could be called as witnesses.

Other recommendations would, if passed by the 1977 legislature:

Reduce settlements and jury awards by the amounts patients receive from other insurance, such as hospitalization policies.

Limit recoveries for pain and suffering to $100,000.

Prohibit petitions in malpractice suits from specifying the dollar amount of damages that is sought.

The commission observed that this often is the figure that gets in the newspapers while "the fact that most claims are settled for much less than the damages alleged or that there is no liability on the part of the defendant is never publicized."

Continuation until December 31, 1979, of the Joint Underwriting Association that provides malpractice coverage to doctors and hospitals that cannot buy it on the open market.

Continue requiring the State Insurance Board's prior approval of malpractice rates before they can be placed into effect.

When compensation for "future damages" is part of a settlement or judgment, parcel out those exceeding $100,000 over a period of time instead of in a lump sum.

Allow voluntary binding arbitration of malpractice claims.

Require patients to give 60 days' written notice and to request negotiations before filing suit.

Empower the Texas Board of Medical Examiners to discipline doctors for incompetence.

Require reporting of medical malpractice claims to the board of medical examiners.

Authorize the board to limit a doctor's ability to practice in specified areas of medicine for up to five years or require a doctor to take remedial training or practice under the supervison of another doctor. *—Associated Press, Austin.*

Heart Association Seminar in Fort Worth in January

An all day Physician Seminar entitled "Recent Developments in Cardiovascular Medicine" will be held on Saturday, January 29th at the Green Oaks Inn at Fort Worth. The seminar is sponsored by the Physician Education Task Force of the American Heart Association, Tarrant County Division.

Topics to be discussed will include *New Developments in Diagnosis and Therapy of Hypertension, Complications of Acute Myocardial Infarction, Stress Testing, Sudden Death, Cardiac Surgery Update,* and *Recognition and Management of Arrhythmias.* Each topic will be presented by a separate faculty member which include local and out of the city speakers. Guest speakers will include Henry McIntosh, M.D., Immediate Past President of the American College of Cardiology who will present a special lecture on *"Sudden Death."*

Registration forms were mailed to all area physicians November 18 and additional forms are available at the American Heart Association office. The phone number is 732-1623.

New Medical College Shelved

by Mack Williams

Plans to build an $11 million Texas Woman's University Medical school on the North Side have been shelved, *The News-Tribune* learned yesterday.

Three firms that offered to donate 60 acres of land at Loop 820 and Interstate 35 in June, 1974 have been released from their pledge by the Fort Worth Medical School Steering Committee.

Loss of the land valued at $1.5 million means that Texas Woman's University will almost certainly be unable to get an authorizing bill for the medical college through the Legislature. Rep. Doyle Willis of Fort Worth has pre-filed such a bill. It also calls for the establishment of a medical college in the Rio Grande Valley.

Decision of the Fort Worth Medical School Steering Committee to release the donors from their pledge is the final blow for the TWU project, which already had drawn opposition from several sources.

Critics questioned the economics of locating a second medical college in Fort Worth. The Texas College of Osteopathic Medicine, a division of North Texas State University, has been training family physicians here for several years.

Both Texas Woman's University and North Texas State University are located in Denton.

The offer to donate 60 acres of valuable land to TWU was made by the American Manufacturing Co. of Fort Worth through John E. Lott, president; Sears, Roebuck & Co. and Ray L. Hunt, of Dallas, head of the Woodbine Development Corporation.

Buildings costing nearly $10 million were planned for the site by TWU.

Although the university admits only women, it planned to make the medical college co-ed. TWU, with about 6,700 students, has campuses in Dallas and Houston, as well as Denton, where nurses are trained. The TWU College of Nursing is the largest in the nation.

Both Governor Dolph Briscoe and the Coordinating Board of the Texas College and University System had given TWU's medical college plans a cool reception.

The Fort Worth Medical College Steering Committee, a group of civic leaders, is headed by Councilman Henry Meadows.

(Reprinted from the Fort Worth News-Tribune December 17, 1976)

Guilt by Innuendo?

HEW's release of the names of 995 physicians who earned $100,000 in 1975 Medicaid payments brought quick response from AMA Executive Vice President Dr. James H. Sammons: "This releasing of names is nothing less than an attempt at guilt by innuendo. It simply makes a tough practice tougher for the thousands of dedicated, honest ghetto physicians. If HEW wants to drive medical care out of the ghetto completely, it has certainly hit upon a highly effective method." List included 33 physicians and 29 groups from Texas. HEW statement accompanying names said, "The fact that the medical providers received the stated amount. . .should not be construed as any evidence of wrongdoing."

[Reprinted from TMA Action, November 1976]

TOMA supports full funding of existing medical schools – first

TOMA and its Fort Worth District II officially went on record in October with widely circulated resolutions opposing any new medical schools in Texas and rejecting the idea of a joint D.O.—M.D. medical school on a shared campus in Fort Worth.

The two TOMA resolutions were hand-delivered to the Coordinating Board within hours after their passage, and they were mailed to each member of the Texas Legislature. (See pages 8 and 9, November *Journal)*

One of the resolutions supported the Coordinating Board in its stand that existing medical schools in Texas should be fully funded before establishing new ones and that state support for teaching hospitals would be more productive of physicians going into practice in Texas than a new medical school.

TOMA states that the uniqueness of the osteopathic school of medicine should not be compromised by combining with an allopathic school of medicine.

The osteopathic school of medicine (D.O.) furnished 20 per cent of the net gain in the number of physicians that entered practice in Texas in the year ending March, 1976.

greener fields?

make•your•move

OPPORTUNITIES FOR OSTEOPATHIC PHYSICIANS IN TEXAS

EYE REFRACTION — Tutorial short course training in eye refraction wanted. If available, please write to: Gerard K. Nash, D.O., P. O. Box 7482, Amarillo, Texas, 79109.

GRAND PRAIRIE—Three AOA-approved residencies are available: They are in anesthesiology, general surgery and orthopedics. Apply immediately by contacting Mr. R. D. Nielsen, Administrator, Grand Prairie Community Hospital, 2709 Hospital Blvd., Grand Prairie, 75050.

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.

PEDIATRIC RESIDENT — Will conclude residency August 1977; now looking for permanent location for pediatric practice. Contact Gerald L. Dickman, D.O., 7232 NW 11th, Oklahoma City, Oklahoma, 73217.

DALLAS—Well established, successful and financially rewarding practice. Architecturally designed building suitable for two plus general physicians or specialists available for lease or purchase. Building 20 minutes from any place in Dallas and only 5 minutes from D.O.H. Reason for leaving - full time faculty position with T.C.O.M. Contact John H. Harakal, D.O., 3516 Camp Bowie Blvd., Fort Worth, Texas 76107. 817—338-9011.

TEXAS—Certified ophthalmologist (D.O.) would like to relocate. Contact Mr. Tex Roberts, 512 Bailey Avenue, Fort Worth, Texas 76107.

FORT WORTH—Texas College of Osteopathic Medicine needs G.P.s as faculty members in Department of General and Family Practice. Expanding clinical and academic program. Request C.V. and/or contact L. L. Bunnell, D.O., Chairman, 3516 Camp Bowie Blvd., Ft. Worth, Texas 76107. 817—731-2741.

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.)

TROUP—Excellent opportunity in East Texas. Share established practice with only physician in area. Separate rent free office available. Hospital facilities nearby. Nursing home. Good location easily accessible to major cities. Contact Carl F. List, D.O., 705 West Duvall, Troup, Texas 75789. Call 214—842-3366 or 214—842-3325.

DALLAS—Positions open for several beginning G.P.s to establish local private practice and provide emergency room services for a 127-bed hospital, starting July 1, 1977. Contact R.J. Halbrook, Adm., East Town Osteopathic Hospital, 214—381-7171, Ext. 68.

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

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

Exhibit space almost sold out for '77 convention

Some of the best news your State Office has to report this month is that, although the facilities for our 1977 convention in Corpus Christi can only contain 50 exhibits, by mid-December nearly all of the exhibit spaces had been reserved.

Because the new addition to the LaQuinta Hotel —convention headquarters— is still under construction, no diagram of exhibit space was available to us until early November. So in October we wrote to our best prospects, explaining the delay in getting a prospectus to them. We gave them as much information as we had on this meeting, and enclosed a card which we asked that they return to us if they planned to participate in this convention.

A large number of these cards were returned immediately. Then in mid-November a detailed brochure was mailed out, along with a booth reservation card.

There was some apprehension about whether we would be able to sell this space, since we were late in getting the information to prospective exhibitors. But, like most things we worry about, this didn't happen.

It is with pleasure that we list below the names of firms who have reserved exhibit space to date—38 of them. Also listed are those who returned our first card, indicating they do wish to exhibit, but have not as yet reserved space.

And so far three firms have indicated they would supply a grant in lieu of exhibiting.

May we suggest you keep this list handy and extend every courtesy to those firms who are supporting your Association by helping to defray the cost of your convention?

Exhibitors

Ayerst Laboratories
Beecham-Massengill Pharm.
Boehringer Ingelheim Ltd.
Bristol Laboratories
Business Data Center
Ciba Pharmaceutical Co.
Comatic Laboratories, Inc.
Compu-Center, Inc.
Dista Products Company
Frigitronics of Connecticut, Inc.
Geigy Pharmaceuticals
International Medical Electronics
Ives Laboratories, Inc.
Kremers-Urban Co.
Landry Pharmaceuticals, Inc.
Lederle Laboratories
Marion Laboratories, Inc.
Milex Southern, Inc.
Miller Pharmacal, Inc.
Nutri-Dyn
Ortho Pharmaceutical Corp.
Pfizer Laboratories, Inc.
Phone-A-Gram Systems, Inc.
Professional Mutual Insurance Co.
Rachelle Laboratories, Inc.
Reed & Carnrick
Riker Laboratories
A. H. Robins., Inc.
Roche Laboratories
Ross Laboratories
Rucker Pharmacal
Sandoz Pharmaceuticals
W. B. Saunders Co.
Southwest & Johnson X-Ray Co.
E. R. Squibb & Sons, Inc.
Stuart Pharmaceuticals
Syntex Laboratories
Texas Vitamin Co.
Tex-E-Comp Corporation
Tutag Pharmaceuticals, Inc.
The Upjohn Company
United Medical Research, Inc.
USV Pharmaceutical Corp.
Vita-Mix Corporation
Western Research Labs
William H. Dean & Associates
Wyeth Laboratories
X-Ray Sales & Service Co.

Grantors

Eli Lilly
Mead Johnson
Parke-Davis

FOOLS

We despise fools. But all of us are at times fools, foolish, dumb and stupid, and need the human right to be less than wise and even downright ridiculous many times in our lives.

Course on Clinical Depression Features Two Television Films

A five-part medical education course on the history and diagnosis of and current concepts in clinical depression, has been developed for primary care physicians. One of the unique aspects of this course is the use of commercial television to maximize exposure and physicians participation. The total educational program, entitled "A Course on Clinical Depression," is sponsored by the Department of Psychiatry of the Univeristy of Pennsylvania under a grant from Pfizer Laboratories Division, Pfizer Inc. All necessary information and tests will be mailed directly to primary care physicians nationwide.

Two half-hour documentary television programs are planned which trace clinical depression as recognized and treated from ancient times through the most current methods of diagnosis. The television programs are expected to reach over 85% of all practicing primary care physicians. The first television program will be aired during the last two weeks of January, 1977, and the second during the first two weeks of March, 1977.

The first of the two telecasts, "Clinical Depression: Historical Perspectives," portrays depressive illness from antiquity to the early 20th century. Filmed on location to depict Ancient Greece and Rome, Medieval and Renaissance Europe, and 18th-19th century Europe and America, the scenes and narration combine to bring alive the words and experiences of physicians, philosophers and authors who played their parts in the changing attitudes toward depression.

From the narrated scenes comes a continuing contrast between "physical" and "spiritual" theories of the causes of clinical depression. For example, Hippocrates, in the dawn of scientific medicine, pioneered the view that depression originated from biological causes, and could be treated with a vegetable diet and abstinence from all excesses.

The Middle Ages, dominated by religion, treated clinical depression as an affliction of the soul. Here the television camera travels through medieval towns where banishment and burning were once prescribed to free the poor victims of clinical depression from demonic possession.

The coming of the Renaissance reversed this pattern, and once again depression (or "melancholia") was seen as a physical ailment, for which bloodletting was often the prescribed remedy. During the following centuries depression continued to be treated as a naturally caused illness, with increasing emphasis placed on human kindness and understanding to help in treatment of the disease.

In the 20th century, physicians have come to appreciate the complexity of clinical depression and with the development of psychoanalysis, electroshock therapy and the contributions of modern pharmacology, to more effectively supervise its management.

The second telecast, "Clinical Depression: Current Concepts of Diagnosis," summarizes contemporary approaches to the diagnosis of depression and looks at present research that may contribute to the development of future therapies.

The two-part television program is written, produced and directed by Philip Gittelman. Executive producer is Dick Cox of DCA Productions in New York. The films will be shown in late January and early March, 1977. Physicians will be receiving notification by mail of the time, date and channel of the films showing in their area. ^

Via WESTERN UNION

December 7, 1976

The Honorable Jim Wright
House of Representatives
Washington, D. C. 20515

The nearly 900 members of the Texas Osteopathic Medical Association would like to be counted among your many, many friends and well-wishers who are proud to have such an eminently qualified Texan ascend to the prestigious position of majority leader of the House of Representatives. We know that in the performance of the duties of this high office you will be a credit to Texas and to the nation.

David R. Armbruster, D.O.,
President, TOMA

Dean Willard acting V.P. for Medical Affairs

The appointment of three vice presidents and the realignment of some top administrative responsibilities have been announced by North Texas State University President C. C. Nolen.

As of Novenber 15, Dr. Marvin Berkeley, dean of the College of Business Administration, will become vice president for administration, ad interim; Dr. Roy K. Busby, assistant to the president and secretary to the Board of Regents, will assume responsibilities as vice president for university relations; and Dr. Ralph Willard, dean of TCOM, will have the additional title of acting vice president for medical affairs.

The appointments, which are subject to approval of the NTSU Board of Regents, were made "in an effort to improve the flow of communication, clarify areas of administrative responsibility, simplify the delegation of authority and more clearly identify administrative control," President Nolen said.

Dr. Berkeley, former director of public affairs at Texas Instruments and a past president of the Dallas School Board, has been dean of the College of Business Administration since January 1973. In his new role, he will be responsible for the Physical Plant; Police Department; and the Office of Facilities, Construction and Maintenance; University Planning and Analysis; University Legal Advisor; and Equal Opportunity.

Noting that Dr. Berkeley has agreed to serve as vice president on an ad interim basis through May 1977, President Nolen said that a continuing evaluation will be made of the organizational relationships and the various assignments in the central administration during the interim period.

Dr. Berkeley will continue as dean of the College of Business Administration, with Dr. Henry Hayes serving as administrative dean, responsible for the day-to-day activities of the college.

Dr. Busby, as vice president for university relations, will be responsible for the Public Information Office, Development Office and Intercollegiate Athletics, offices which heretofore have been directly responsible to the president.

A former director of the Public Information Office, Dr. Busby has been assistant to the president since May 1973 and was elected secretary of the Board of Regents last February. He also is an assistant professor of journalism.

Dr. Willard, dean of TCOM since fall 1975, will have the additional title of acting vice president for medical affairs and will remain the chief operating officer for TCOM.

Before joining the Fort Worth medical school, Dr. Willard served as associate dean of the Michigan State University College of Osteopathic Medicine.

The three newly appointed vice presidents will join Vice President of Academic Affairs Miles Anderson, Vice President for Fiscal Affairs John Carter and Vice President for Student Affairs Jane Smith in comprising the NTSU President's Cabinet. ^

M.D. Anderson to operate Rio Grande Center

The University of Texas System Cancer Center M. D. Anderson Hospital and Tumor Institute has agreed to staff and operate the Rio Grande Radiation Treatment Center, which is owned by the nonprofit Rio Grande Radiation Treatment and Cancer Research Foundation, Inc. Dr. Robert C. Hickey, director of Anderson Hospital, says the center "keeps families from suffering disruptions to daily life caused when one member must travel long distances for periodic cancer treatment."

The new treatment center, located in McAllen, will begin accepting cancer patients from the Valley area in January 1977. About 6,000 patient visits are expected in the first year, with the number doubling within two to three years. The center is governed by a 35-member board of directors of community leaders from all major lower Rio Grande Valley towns.

In addition to patient care, the staff of the Rio Grande Radiation Treatment Center will take part in several cancer education programs for both health professionals and the public in South Texas and cooperate in research projects at Anderson Hospital in Houston. ^

Texas Ticker Tape

DR. KENNEDY ELECTED DELTA OMEGA OFFICER

Dr. Evalyn Hall Kennedy of Beeville was elected grand vice-president of Delta Omega medical sorority at the organization's annual dinner meeting in San Francisco recently.

Dr. Kennedy, who is in general practice in Beeville, is also a fellow of the American Academy of Osteopathy.

DR. WILLARD TO HEAD NEW AACOM TASK FORCE

Ralph Willard, D.O., Vice President for Health Affairs at North Texas State University and Dean of Texas College of Osteopathic Medicine, has been appointed Chairperson for the AACOM Task Force on Educational Opportunities. The Task Force will operate under direction of the Board of Governors and will be responsible for providing guidance and assistance to member institutions and the Office for Special Opportunities, and developing a comprehensive plan for the ongoing recruitment and support of minority and disadvantaged osteopathic students. Membership on the Task Force will be solicited from the osteopathic colleges and similarly affiliated organizations.

AOHA ELECTS LEE BAKER

Lee Baker, administrator of Lubbock Osteopathic Hospital, is the new chairman-elect of the American Osteopathic Hospital Association. He was elected to office when that group held its 42nd annual convention in Boston in November. In the AOHA official structure the executive director is the permanent president and the highest elective office is that of chairman of the board. Mr. Baker will serve in that capacity during the 1977-78 fiscal year.

ACOHA AWARDS FELLOWSHIPS TO TEXANS

At a recent meeting of the American College of Osteopathic Hospital Administrators, fellowships were awarded to two Texans: W. L. "Dubb" Davis, administrator of Southwest Osteopathic Hospital in Amarillo; and R. J. Halbrook, administrator of East Town Osteopathic Hospital in Dallas.

According to ACOHA; fellowship in the College is bestowed after rigid requirements of writing and experience in the hospital field have been served.

FEDERAL GOVERNMENT CONTINUES TO PAY FOR ELECTIVE ABORTIONS

Despite Congressional action to block use of Medicaid funds for elective abortions. Judge John Dooling has ruled that such a prohibition is unconstitutional and the U.S. Supreme Court has refused to block enforcement of the judge's decision pending appeal. The government reportedly is appealing the decision.

DR. TAVEL RECEIVES DISTINGUISHED SERVICE AWARD

Lester I. Tavel, D.O., a certified proctologist of Houston, received a distinguished service award from the American Osteopathic College of Proctology for 24 years service to the College. He was also reelected to a new five-year term on the Board of the College.

LEGISLATIVE REPORT - -

At press time, there were five more bills prefiled in the Texas Legislature that would be of general interest to physicians.

S.B. 60

Introduced by Senator Chet Brooks, Senator Kent Hance, et al, this bill would grant authority to the Coordinating Board to contract with teaching hospitals in Texas attached to state supported medical schools, including the Texas College of Osteopathic Medicine.

Under the bill, the Board could contract with a primary teaching hospital to provide staff, employees, buildings, facilities, equipment and materials for the education, training, development and preparation of students of the medical schools served by the teaching hospital.

The Board could compensate the hospital for its costs in providing the services, including salaries of staff and expenses for operation, administration, improvement, construction, maintenance and repair of the hospital and its buildings, facilities, equipment and materials.

H.B. 181

This bill prefiled by Rep. Anthony Hall of Harris County, would grant public hospitals the right to reimbursement from the State of Texas for the reasonable cost of medical care and treatment rendered to indigents. It would appear that this bill addresses itself to a serious problem, and it should be supported in principle.

In its present form, H.B. 181 is too restrictive in that it limits this right to public hospitals when there are numerous additional non-profit community hospitals that are burdened with indigent patient costs and should be included in the plan if they are licensed and certified for Medicare and Medicaid services.

H.B. 154

Another bill, prefiled by Rep. John Wilson of Fayette County, is known as the Texas Sunset Act and calls for periodic review and termination of state regulatory agencies and advisory committees depending upon their continued relevance.

The bill would provide for public hearings on whether a public need exists for the continuation of the agency or committee. This is one approach to the growing bureaucracy in state and federal governments.

S.J.R. 8

Of interest to hospitals as well as physicians is S.J.R. 8, prefiled by Senator Walter H. Mengden, Jr. of Travis County, which proposes an amendment to the Texas Constitution to guarantee the right of a person to work for an employer without regard to whether he is a member of or makes payments to a labor organization.

The specter of strikes in a hospital frightens many Texans. This also applies to police and fire departments and other vital governmental functions.

H.J.R. 16

Introduced by Rep. Frank Madla and Rep. Frank M. Tejeda, both of Bexar County, H.J.R. 16 would amend the Constitution to call for annual regular sessions of the legislature. The citizens of Texas have rejected this idea before, and there are a number of important considerations involved. If becoming a state representative or state senator involves almost a full-time job called for by annual sessions, then the compensation should be sharply increased in order that a broad segment of the population could afford to serve if elected.

You would have to decide whether you agree with Justice Oliver Wendell Holmes who once said the republic is in danger as long as the legislature is in session. ^

Not the Last Hurrah

by Robert D. Cousins

Memories of the patriotic displays, the pilgrimages of tourists to historic spots, the pageants in town squares, the parades down main streets, and the inspiring publicity surrounding the excitement of our bicentennial year are beginning to fade away. The celebrations of 1976 will soon be history.

This resurgence of pride and confidence in the great American democracy was needed by us all. The damaging effects of inflation, combined with high unemployment and recession, had drained the resources of our nation's people. The heartaches of a winless Asian conflict that involved so much human suffering had divided us. Loss of confidence in a president and a vice president and open displays of lack of respect for many of our traditional institutions and moral values seemed to deteriorate the strength of the country. The spirit of revival was timely, and we welcomed it from border to border, from coast to coast.

It is so easy to become preoccupied with problems that we minimize the achievements of the greatest industrial and agricultural nation in the world. Our definition of poverty is a level of income that is higher than the average income level in the world's second most powerful nation. We have the highest standard of living ever known. Our achievements in education, science, and art have been truly remarkable. Equal opportunity gives all our people the chance to cultivate their abilities and achieve their fullest potential. Many flee the political and religious supression of other countries to seek the freedom this land offers her citizens. The overall history of the United States has really been one that is highly successful, and our nation's outlook for the future is optimistic.

Now that most of the bicentennial fanfare and outward displays of joy and revelry are over, the pendulum has swung back to basics. We discern a return of our accepted foundations of the spiritual and moral values that made this country great. Let's appreciate our freedom and be excited that those of us in private enterprise can be creative in our own ways to contribute to the growth of our nation. Let's work to support sound government and the good citizenship on which our nation was founded. Let's proclaim our confidence in the American system through our actions and expressed thoughts in the 201st year of our independence.

[Reprinted from the Curtis Courier, Holidays 1976.]

Two more D.O.s join TCOM faculty

Dr. Robert R. Brown, associate professor of general and family practice, and Dr. Richard C. Wright, clinical associate professor of general and family practice, have been named to the faculty of Texas College of Osteopathic Medicine. The announcement of the new faculty members was made by Dr. Ralph L. Willard, acting vice-president for medical affairs and dean.

A native of Parkersburg, West Virginia, Dr. Brown moved to Fort Worth from Dayton, Ohio, where he was in private practice. He is a 1965 graduate of the College of Osteopathic Medicine in Des Moines, Iowa, and received a bachelor of science degree from Ohio State University in 1960. After receiving his D.O. degree, Dr. Brown served a rotating internship from 1965-66 at Grandview Hospital in Dayton. He is a member of the AOA, Ohio Osteopathic Association and Texas Osteopathic Medical Association.

A lieutenant Colonel in the U. S. Air Force, Dr. Wright is stationed at Carswell Air Force Base. Dr. Wright received his D.O. degree from Kirksville College of Osteopathic Medicine in 1954 and a bachelor of arts degree from Iowa Wesleyan College, Mt. Pleasant, Iowa. Dr. Wright served an internship at the Osteopathic Hospital of Maine in Portland.

Among the various organizations he holds membership in are Texas Osteopathic Medical Association, AOA, American College of Family Practice and U. S. Air Force Flight Surgeon Association. Dr. Wright is chairman of TOMA's Military Affairs Committee.

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Compensation approach to medical injury claims

In 1970, the AOA sponsored the First National Conference on Medical Malpractice. It was apparent then, and is dramatically evident today, that a new method of claims determination needs to be developed.

The insurance industry has begun to make it clear, by words and acts, that the field of medical liability is rapidly becoming uninsurable. The unfortunate consequences, to patient and physician, which will follow the ultimate evaporation of an insurance marketplace are obvious.

We believe that it is no less obvious that the principal cause of problems in the private insurance market is the present system of claims determination, which is *not* a medical injury *compensation* system. The present system no longer admits an actuarily sound insurance rating, because claims awards no longer reasonably relate to totally identifiable, quantifiable losses. Stated simply, many awards, under the present system contain rewards for a medical injury in addition to compensation for it.

The AOA perceives the best approach to medical injury claims determination to be a *true* compensation system. By "true compensation system", we mean a system which limits injury awards to compensation for actual, measurable losses.

We do not believe that the adversary tort proceeding is a feasible mechanism to accomplish compensation.

While the present system has many objectionable attributes, including the cost of claims administration and its slowness, its greatest weakness is its unpredictability (in both the finding of liability and amount of award) for both claimant and defendant.

The system is unpredictable because it has been warped. It has been warped by judges and juries who have found sufficient exceptions to general tort rules to respond compassionately to a grievously, though not always negligently, injured litigant.

We understand the human nature which wants to make a fellow creature whole. In fact, we endorse that concept. But we do not believe it should, or can any longer, be implemented through an ostensibly adversary proceeding.

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

AOA Council on Federal Health Programs ^

BULLETIN! Texas Gets Single Statewide PSRO

Four days before Christmas word was received at TOMA state offices that the official decision has been made by Secretary Mathews of HEW to designate Texas a single statewide Professional Standards Review Organization (PSRO).

This culminates four years' struggle by the Texas Osteopathic Medical Association and other health professionals to administer and coordinate federally mandated peer review at a state level, rather than through multi-area PSROs.

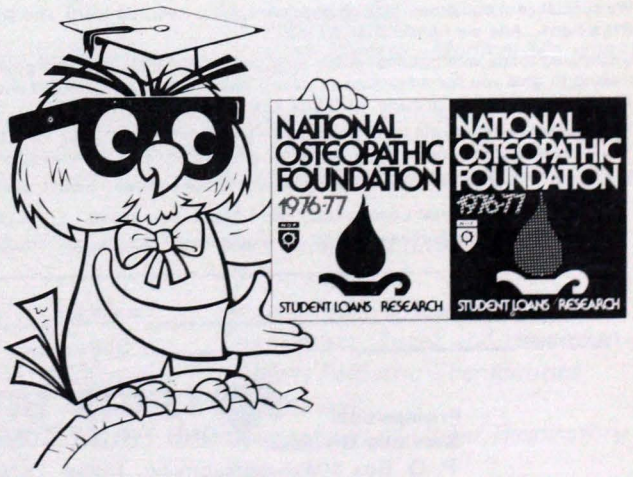
HEW held two public hearings in the late summer and fall two years ago and heard almost unanimous recommendations from Texas that the state be designated a single statewide PSRO area, but the then Secretary designated nine areas.

Texas Medical Association filed suit in Federal district court in Austin and, with vital testimony given by TOMA officials, won the case nullifying the nine-area designation.

The official decision reached in late December to redesignate Texas a single statewide PSRO area was to have been published in the Federal Register early this month, January 1977.

If that occurred it is the direct result of the unity of all the health professions in Texas including state agencies, medical schools, THA hospitals, TMA and TOMA.

All of these entities are active and organized in the Texas Institute for Medical Assessment (TIMA) which has been meeting regularly over the years and is now ready to submit its application for administering PSRO in Texas.



TOMA Membership Card No. 1 Goes to Dr. Ryan

TOMA membership card Number One for the 1977-78 fiscal year goes to Dr. John Ryan of Garland—again!

Each year there seems to be a race between Dr. Ryan, Dr. Joe Love of Austin and Dr. George Grainger of Tyler to see which one can get his dues in first and, by so doing, receive card Number One.

Except for the first five cards, ordinarily each member's card number remains the same each year. The reason for this is because those who are in the TOMA group insurance program are assigned numbers for their insurance and, for the sake of simplicity, these are also their membership card numbers.

The exceptions to this rule are numbers one through five. This necessitates a little extra work and care in the office, but since the race for these first few low numbers has become something of a tradition, a different numbering system has been devised in these cases.

Copy for the 1977-78 TOMA membership cards has gone to the printer and as soon as they are delivered, card Number One will be in the mail to Dr. Ryan. ^

Good and Bad News on Social Security

The bad news is that, beginning January 1, the taxable wage base for Social Security will increase from the present $15,300 to $16,500. Therefore, the maximum tax a wage earner will pay next year will be $965.25, an increase of $70.20 over this year.

When you add the equal employer tax it amounts to almost $2,000 for the employee earning $16,500. The maximum tax for self-employed persons will be $1,303.50.

The good news is that by the end of 1974 about 8,300 of the over 30 million persons receiving Social Security benefits were centenarians, i.e., at least 100 years of age. Of all centenarian beneficiaries 87% were white, 11.7% black, and 1.3% other races—a racial distribution almost identical to the racial distribution of the 1970 census.

The moral of this story is that you should firmly resolve to live to be a centenarian. If you make it, and we hope you do, then in the long run that heavy tax burden may earn you a lasting benefit.

(Reprinted from Washington Report, U.S. Chamber of Commerce) ^

Making medical records available to patients

When Dr. R. Glynn Raley of Goldthwaite recently announced his retirement, the Goldthwaite Eagle printed a lengthy letter from him to his many patients and friends in the community he had served since 1953.

In it he announced a plan for making medical records available to his patients.

Since the State Office has had numerous inquiries about the best way this should be handled, reprinted below is the arrangement Dr. Raley is using.

"For the next month or so my office at 1118 Fisher in Goldthwaithe is being kept open by my receptionist, Suzette Keating, for *financial* transactions only and for the purpose of receiving in *writing* over your signature, any request for summary of your medical records to be sent to the *one* doctor *only* and until January 1, 1977, will be furnished free of charge. After January 1, 1977, a charge for search, typing, etc., of around $1.50 per typed page will be charged, or if my practice might be sold or transferred, other arrangements concerning medical records may be made. Any accounts owing to me will be gladly received and any accounts I owe, please leave bill with Suzette or mail to me in Goldthwaite." ^

Big Litterbug

The Chamber of Commerce of the United States has been conducting surveys aimed at the developing $40 - billion - a - year - paperwork burden imposed on the public by the Federal government. One harassed businessman put his complaint this way: "We need relief before we 'litterally' drown in paperwork."

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Jack Blumenthal, D.O.
Houston, Texas
Ernest E. Bartimmo, M.D.
Houston, Texas
Ladd T. Tucek, D.O.
Houston, Texas

Gerald E. Hoffman, D.O.
Houston, Texas
Jarek Fisher, M.D.
Houston, Texas
Ernest P. Schwaiger, D.O.
Houston, Texas
David Hall, D.O.
Norman, Oklahoma

Mitchell Porias, D.O.
Houston, Texas
David P. Sufian, D.O.
Houston, Texas
Robert M. Komorn, M.D.
Houston, Texas
James G. Gengelbach, D.O.
Houston, Texas

Gerald M. Ketner, D.O.
Houston, Texas
James R. Marshall, D.O.
Houston, Texas
Floyd O. Hardimon, D.O.
Houston, Texas

Program

SATURDAY, FEBRUARY 26, 1977

8:00– 8:50 a.m. Registration

8:50– 9:00 a.m. Welcome—David R. Armbruster, D.O., President of the Texas Osteopathic Medical Association

9:00– 9:30 a.m. *Anesthesia for the Cardiac Patient*
Dr. Harman

9:00–10:00 a.m. *Current Aspects of Peptic Ulcers Medical or Surgical?*
Dr. Blumenthal

10:00–10:30 a.m. *Respiratory Diseases in the Adult*
Dr. Bartimmo

10:30–11:00 a.m. Round Table Discussion
Drs. Tucek, Harman and Blumenthal

11:00–11:30 a.m. *Skin is a Mirror Reflecting Internal Diseases—Part I*
Dr. Fisher

11:30–12:00 noon *Skin is a Mirror Reflecting Internal Diseases—Part II*
Dr. Fisher

12:00– 1:00 p.m. Luncheon—Memorial Lecture
Dr. Schwaiger

1:00– 1:30 p.m. *Management of Essential Hypertension*
Dr. Hall

1:30– 2:00 p.m. *Pediatric Ophthalmology—Part I*
Dr. Porias

2:00– 2:30 p.m. Round Table Discussion
Drs. Hall, Porias and Tucek

2:00– 3:00 p.m. *Pediatric Ophthalmology—Part II*
Dr. Porias

3:00– 3:30 p.m. *Evaluation Peripheral Cardiovascular System—Part I*
Dr. Sufian

3:30– 4:00 p.m. *Evaluation Peripheral Cardiovascular System—Part II*
Dr. Sufian

SUNDAY, FEBRUARY 27, 1977

9:00– 9:30 a.m. *Congestive Heart Failure—New Therapeutic Approaches*
Dr. Hall

9:30–10:00 a.m. *Differential Diagnosis Neck Masses*
Dr. Komorn

10:00–10:30 a.m. *Uterine Dysfunctional Bleeding—Part I*
Dr. Gengelbach

10:30–11:00 a.m. Round Table Discussion
Drs. Hall, Tucek and Komorn

11:00–11:30 a.m. *Uterine Dysfunctional Bleeding—Part II*
Dr. Gengelbach

11:30–12:00 noon *Thyroid Disease—Medical Management*
Dr. Hall

12:00– 1:00 p.m. Luncheon—Lecture
Dr. Tucek

1:00– 1:30 p.m. *Extremity Fractures—Part I*
Dr. Ketner

1:30– 2:00 p.m. *Extremity Fractures—Part II*
Dr. Ketner

2:00– 2:30 p.m. Round Table Discussion
Drs. Ketner, Tucek and Hardimon

2:30– 3:00 p.m. *Current Pediatric Therapeutics*
Dr. Marshall

3:00– 3:30 p.m. *Management of Upper Respiratory Diseases*
Dr. Marshall

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