Approved 3-14-88
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin L. Littlejohn at
Chairperson

1:30 ~~a.m.~~/p.m. on March 1, 1988 in room 423-S of the Capitol.

All members were present except:

Committee staff present:
Emalene Correll, Research
Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:
Larry McElwain, Chairman of Legislative Committee of Funeral Director's Association
Richard Parker, Health and Environment/Bureau of Epidemiology
Mack Smith, Ks. Board of Mortuary Arts
Jerry Slaughter, Kansas Medical Society
Chip Wheelen, Kansas Medical Society
Tom Bell, Kansas Hospital Society
Harold Riehm, Kansas Osteopathic Medicine Association
Richard Morrissey, Department of Health and Environment
Carl McNorton, Ks. Fire Marshal's Office

Chairman called meeting to order, noting hearings to be held on: HB 2978, 2980, HB 2977, HB 2984.

Larry McElwain, Chairman Legislative Committee of Funeral Director's Association (Attachment No. 1) noting they recommend passage of HB 2978. Passage of this bill will prevent transportation of bodies throughout the State without regard for the infectious or contagious disease that they have died from. He cited some personal business situations where the Doctor did not indicate on the death certificate AIDS was cause of death because he didn't want the newspaper to print that information. The funeral director was then not given the proper information. The issue is how this will effect the personnell in all funeral director's establishments. We intend to protect confidentiality he said, but we must be informed if a person has died with an infectious disease. He answered many questions, i.e., no, he knows of no situations where a family has been denied services for burial when a person has died of an infectious disease, (AIDS) or others; discussion on notification forms that are necessary before a body can be removed from premises; main problem they have is not with families, but with the medical community.

Mr. James Snyder, Funeral Director's Association and Mr. Mack Smith, Kansas Board of Mortuary Arts both answered questions from members.

Mr. McElwain then spoke to HB 2980:There is a need to allow funeral directors to dispose of cremated human remains if they have not been claimed within 120 days. There are some funeral homes in the state (Mr. McElwain's included), where there are some cremains dated back to 1934. There is presently no law that gives them authority to dispose of such remains. The liability responsibility is of concern and he urged for favorable consideration of HB 2980 that would answer this concern. He answered questions, i.e., this is not a National issue, this is a grass roots issue from out Association; no, he could not say why the date "prior to October 1, 1987 was used, he sees no special significance in that date.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 /a.m./p.m. on March 1, 1988

Hearings closed on HB 2980:

Hearings returned to HB 2978:--

Dr. Richard Parker, Department of Health and Welfare, (Attachment No. 2). He noted that HB 2978 duplicated provision of an existing regulation, (K.A.R. 63-3-10). He would recommend that HB 2978 is not necessary. It is their feeling that all bodies could perhaps be dealt with as though they did have a contagious disease, and this could eliminate concerns of the funeral directors and their employees. He answered questions, i.e., for every persons diagnosed today with AIDS, there may be 50 others infected with the virus. If those figures are correct, there may be 6000 persons in Kansas already infected.

It was noted by Mr. Mack Smith that current regulations will be changed as of July 1, 1988, and will delete the clause "having the doctors to report", thus the request for HB 2978. Mr. Smith also stated in reply to questions, yes we do need to strengthen Rules and Regulations with a bill such as this.

Jerry Slaughter, Kansas Medical Society stated the loophole in the bill is that there are many others infected with the AIDS virus that have not been diagnosed, so those could be missed. There are problems with notification, and their Society would be happy to discuss this concern with the Funeral Directors and work out an applicable solution. He answered questions, i.e., yes, there is concern with written notification. Mr. Furse indicated "person" is indicated because it also includes (b) (2).

At this point Mr. McElwain answered questions in regard to extra equipment and procedures followed when a body is infected with AIDS. He explained they must wear goggles, shoe covers, clothing covers, and it is difficult to maintain a dignified look when they are dressed as though they are dealing with Nuclear waste.

Hearings closed on HB 2978.

Hearings began on HB 2977:

Chip Wheelen, Kansas Medical Society, (Attachment No. 3), gave background information as to why reporting of burn cases is necessary. After the Kansas Medical Society and Kansas Hospital Society received numerous complaints from clients, they have consulted with the Attorney General's Office, and HB 2977 is the product of deliberation by physicians who have experience treating burn wounds, and recommendation from his Society for further guidance to the Fire Marshal's office. He explained the reporting form that is page two of his attachment. This reporting was initially required if arson is suspected.

Tom Bell, Kansas Hospital Association, (Attachment No. 4) stated they feel HB 2977 will provide specificity to statutes that are otherwise very general. However, he did note they feel the reporting form developed is overbroad and could perhaps be revised to concentrate on those incidents that merit investigation, and to help alleviate concerns of health care providers regarding patient confidentiality.

Carl McNorton, Kansas Fire Marshal's Office, Manager of Fire Information System, stated they are in support of the proposed changes in burn reporting regulations. They would like to see 15% of body burns indicated in the bill as they feel this would cover persons who might be involved in the setting of a fire. (Arson). Reporting gives us information on how these burns occur, and gives data about child abuse. He answered questions, i.e., 20% of body burns would be at least both arms; possibly 15% would indicate both hands, one arm. It was noted that Fire Service is required by law to report any child abuse cases.

Hearings closed on HB 2977.

Hearings began on HB 2984.

Tom Bell, Kansas Hospital Society, stated they have no problem with HB 2984, it simply codifies what is already law.

Harold Riehm, Ks. Association of Osteopathic Medicine (Attachment No. 5-A) offered background and specifics in regard to persons being denied access to Hospital Boards because of where they obtained their residency training. He noted HB 2984 addresses procedures to eliminate discrimination. To require residency training applied to all physicians licensed to practice medicine/surgery with equal recognition of their respective residency programs is one matter, but to require residency training and not recognize the formal recognition process of those in osteopathic is clearly discriminatory. We feel this is very necessary legislation. He answered questions, i.e., the Hospital he didn't name earlier was, Providence St. Margaret; we take great pride in our residency program, we now require 3 years.

Richard Morrissey, Department of Health and Environment, (Attachment No. 6). There is currently a bill in Senate, SB 701 that will adopt Drug Commission Standards such as medical staff, that would open up Hospitals to accept other licensed health care professionals. He noted this situation is not likely to get less complicated, but perhaps more complicated. Although their Department is restricted by current law K.S.A. 65-431 from promulgating regulations which would discriminate against any practitioner of the healing arts, hospitals are not prohibited from establishing their own criteria which might discriminate one branch of healing arts practitioners from the other. Their Department believes HB 2984 will have little direct impact upon its licensing responsibilities with respect to medical care facilities. He answered questions.

Hearings closed on HB 2984.

Chairman drew attention to HB 2901.

Note (Attachment No. 7) as amendment to HB 2901 offered by Rep. Gatlin and Rep. Shallenburger. Rep. Gatlin explained the amendment and proposed changes in lines 23,25,29,31. Lengthy discussion ensued, description of "licensed lodging", percentages of required alarms; costs not prohibitive; vibrating as well as flashing is necessary.

At this point Chairman requested Mr. Furse evaluate proposed amendment and put it into "Furse Form", and committee will discuss HB 2901 later.

Chair announced he has requested the following bills be protected so they can be worked on at later date. HB 3033, HB 3034, HB 3035, and HB 2842.

Meeting adjourned 3:15.

GUEST REGISTER

HOUSE

PUBLIC HEALTH AND WELFARE COMMITTEE

Date 3-1-88

NAME	ORGANIZATION	ADDRESS
Larry K. McElwain	KFDA	1603 Mass Lawrence, KS
Mack Smith	Mortuary Arts Bd.	Topeka, KS
Marilyn Bradt	KUMC	Lawrence
Jim Swyter	KFDA	Topeka, Ks.
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	"
Stacy Hoogstraten	American Cancer Society	"
Roberta B. Kunkle	American Lung Association	Topeka
RL PARKER	KDHE	Topeka
Richard Morrissey	KDHE	"
Terri Roberts	Kansas State Nurses Assoc.	Topeka
Barbara Snider	McGee & Assoc.	Topeka
Kim Baker	Ks. Cemetery Assn	Topeka
Tom Bell	KHA	Topeka
James A. Ladd	KSTTA	Wichita
Karl W. McNorton	Ks Fire Marshal Dept.	Topeka

THE KANSAS FUNERAL DIRECTORS AND EMBALMERS ASSOCIATION, INC.

EXECUTIVE OFFICE — 1200 KANSAS AVENUE, P.O. BOX 1904
TOPEKA, KANSAS 66601
PHONE 913-232-7789

AFFILIATED WITH N. F. D. A.

TESTIMONY H.B. 2980 & H.B. 2978
COMMITTEE ON PUBLIC HEALTH & WELFARE
MARCH 1, 1988

Dear Committee Members,

Thank you very much for the opportunity to appear before your committee this afternoon. My name is Larry McElwain and I am a funeral director in Lawrence and am presently the chairman of the K.F.D.A. Legislative Committee. We speak to you this afternoon in favor of the passage of both H.B. 2980 & H.B 2978.

H.B. 2980 would allow funeral directors to dispose of cremated human remains if they have not been claimed within 120 days. The law from Florida that was used as a model in writing this law specified 90 days but we felt that adding another month was very appropriate. We have surveyed a portion of our membership to see what the average number of cremains are that are being held by funeral homes unclaimed. We have found that on the average every funeral home has at least four (4) unclaimed cremains. Our mortuary in Lawrence has nineteen (19) ranging back as far as 1934. The problem here is not the storage space or inconvenience, the problem is the ongoing liability of having these in the funeral director's possession and having to produce them at some undetermined time down the road. Lawrence and other areas in Kansas have higher cremation rates

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and generally a more mobile group of people. This can cause problems in locating family members months and years following the death of the person.

We want to be reasonable in our approach to this matter and obviously, we have not been quick to act on this matter. The cremation rate is growing in the U.S. as well as Kansas so we see this as a problem that will increase with the rising rate. We as funeral directors want to give survivors time to discuss and decide on the final disposition of the ashes and 120 days seems to be an appropriate compromise since people who choose burial have to make this decision usually within two-three days. Cremation is a very final decision and we caution people to choose it after careful thought of the permanence of it. We highly recommend the passage of this bill to your committee.

2978 With respect to H.B. 2978, our association recommends the passage of this bill that would require a written notification of persons who die of a contagious or infectious disease. This notification would accompany the remains of the person who has died.

We think that this is in the best interests of hospital personnel, nursing home personnel and funeral home personnel as well as the citizens of Kansas. This will prevent the transportation of bodies throughout the State without regard for the infectious or contagious disease that they have died from.

There is a growing concern in our profession over the increased numbers of AIDS cases that we are seeing. I want to give you a personal example of why written notification is important.

In early 1986, I wrote the members of the Douglas County Medical Society and asked them to please notify our personnel when an infectious or contagious disease was diagnosed as a cause of death. On December 30, 1986, we were contacted by Lawrence Memorial Hospital concerning the death of an individual. We were not initially told that the person had AIDS but were told when we reached the hospital by the nursing staff. We took the appropriate precautions at that time. Later the doctor signed the death certificate and AIDS was not to be found on the death certificate.

I called the doctor and was informed that AIDS was indeed a contributing factor to the death but the doctor was afraid that the newspaper would print the cause of death and therefore we were not given the actual causes of death for this reason. When I questioned the doctor about the public health implications, the doctor agreed that the information could have been listed without violating the confidentiality of the patient.

I want to assure you that we intend to continue protecting this confidential information but we have an <u>equal</u> responsibility

to the public, our staff and to our own families to protect their health in dealing with infectious or contagious disease.

It has been proven that taking precaution in dealing with these types of diseases prevents the spread of the disease and actually can eliminate the bacteria and virus involved. We want to be responsible to our communities and H.B. 2978 will assist us in this as well as imposing penalties to those who disregard this important law. We have found in surveying the same funeral homes that were questioned on the number of unclaimed cremains, that the eighteen funeral homes reported twenty (20) cases of infectious or contagious diseases that were not reported upon first call from the medical personnel. I think that this clearly demonstrates a need for H.B. 2978.

Thank you for the opportunity to appear before your committee this afternoon.

Respectfully submitted,

Larry K. McElwain

Larry K. McElwain

K.F.D.A. Legislative Chairman

STATE OF KANSAS

DEPARTMENT OF HEALTH AND ENVIRONMENT
Forbes Field
Topeka, Kansas 66620-0001
Phone (913) 296-1500

Mike Hayden, *Governor*

Stanley C. Grant, Ph.D., *Secretary*
Gary K. Hulett, Ph.D., *Under Secretary*

Testimony Presented to

House Public Health and Welfare Committee

by

Kansas Department of Health and Environment

House Bill 2978

House Bill 2978 would require any physician attending a person who dies of an infectious or contagious disease or medical coroner having knowledge of the case to provide written notification describing the disease to the transporter of the body or to the embalmer or funeral director. If a person dies of an infectious or contagious disease outside of a medical facility a family member or other person making arrangements for disposition of the body must notify in writing the person transporting the body of the diagnosis. The transporter of such a body must also notify the embalmers or funeral director.

An existing regulation, K.A.R 63-3-10, requires that physicians inform and counsel those who have need to contact the body if the deceased died of a communicable disease. H.B. 2978 duplicates the provisions of this regulation, adding provisions for: 1) notification in writing, including notification by a family member when a physician is not in attendance and notification of the transporter of the body, 2) confidentiality of information, and 3) penalty for violation.

There have been 117 cases of AIDS reported through January, 1988 in the State of Kansas. It is estimated that as many as 50 persons are infected with the human immunodeficiency virus (HIV) for every case of AIDS reported, but most of these are <u>not</u> ill and therefore not known. In addition many people are infected with hepatitis B virus or other blood-borne infectious agents which may not be producing recognizable illness at a given moment. All of these, should they die of any other cause, could be of as great or even greater threat to those handling the body than a person directly dying of the disease resulting from the infection.

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Section 1(C) would require maintenance of confidentiality (which is not included in K.A.R. 63-3-10). However, it is questionable whether or not persons in contact with bodies need to know the exact cause of death since the precautions would be the same for all blood-borne diseases, all respiratory diseases, etc.

The Centers for Disease Control have recommended* that all health care workers and allied professionals deal with all patients on a "blood and body fluid precaution" basis, e.g., everyone should be regarded as a potential source of blood borne infectious agents. Morticians and others providing post mortem services for a body are included in the recommendations.

Because of existing pertinent regulations, and recommendations that universal precautions be pursued, H.B. 2978 does not appear to be necessary. It is therefore not supported.

*Recommendations for Prevention of HIV Transmission in Health-Care Settings. MMWR Supplement Vol. 36, No. 25 Aug 21, 1987.

Presented by:

Richard L. Parker, D.V.M.
Director
Bureau of Epidemiology
March 1, 1988

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue · Topeka, Kansas 66612 · (913) 235-2383

March 1, 1988

TO: House Public Health and Welfare Committee

FROM: Kansas Medical Society

SUBJECT: House Bill 2977, As Introduced

As most of you will recall, in 1985 the Legislature passed House Bill 2241 which required the State Fire Marshal to adopt rules and regulations to accommodate reporting of all second and third degree burn wounds. This was done to insure that burn cases which might warrant investigation by public safety officials would be brought to the attention of proper authorities.

Subsequent to adoption of K.A.R. 22-5-6 which became effective May 1, 1986, both the Kansas Medical Society and the Kansas Hospital Association received several complaints from members. Apparently there are many instances when ordinary accidents result in second degree burns and some instances when such accidents result in third degree burns. Furthermore, the reporting form prescribed by the Fire Marshal requires extensive information and raises questions as to whether the Legislature intended to create another exception to the confidential physician-patient relationship.

In response to these complaints we contacted Mr. Redmon, the State Fire Marshal, and requested amendment of K.A.R. 22-5-6. After consultation with a representative of the Attorney General's Office, Mr. Redmon indicated that he would prefer further guidance from the Legislature before changing the reporting requirement. House Bill 2977 is the product of deliberation by physicians who have experience treating burn wounds and is our recommendation for further guidance to the Fire Marshal.

We respectfully request that you recommend HB 2977 for passage. Thank you for your time and consideration.

CW:nb

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22-5-6. Hospitals which treat burn patients and doctors or other health care providers who treat burn patients at any location other than a hospital shall report all second- and third-degree burn wounds to the state fire marshal on forms provided by the state fire marshal. Reports must be mailed no later than the Monday following the date of the first treatment of any wound. (Authorized by and implementing L. 1985, Ch. 128, Sec. 1 (6); effective May 1, 1986.)

KANSAS BURN INJURY REPORTING SYSTEM

(This form must be completed for all 2nd & 3rd degree burn victims.)

Victim's Name and Address _____

_____

Age of Victim: _____ Date of Injury: _____ Degree of Burn: _____

Area(s) Burned: _____

Local Fire/Police Chief Notified? Yes No (Please Circle)

Cause of Burn: _____

Address Where Burn Occurred: _____

Street & Number City/Town Zip Code

Name & Address of Hospital Where Treated: (if applicable) _____

_____

Name & Address of Attending Physician: _____

_____ Please mail this card no later than the Monday following the date of the first treatment to: State Fire Marshal, (before Feb., 1987) 503 Kansas Ave., Suite 303, Topeka, Kansas 66603—(after Feb., 1987) 9th & Jackson, Topeka, Kansas 66612. For further information, call: (913) 296-3401.

(Note: K.A.R. 22-5-6 on reverse side)

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

March 1, 1988

TO: House Public Health and Welfare Committee

FROM: Thomas L. Bell, Vice President

SUBJECT: HOUSE BILL 2977

The Kansas Hospital Association appreciates the opportunity to comment on H.B. 2977, regarding procedures for health care provider reporting of certain burn wounds. We support this bill and feel it provides some specificity to a statute that is otherwise very general.

Legislation requiring reporting of second- and third-degree burn wounds was originally adopted in 1985. We generally supported this legislation because we felt it could help in investigation of arson and other types of criminal cases. In our opinion, however, the form developed for these reports is overbroad.

Often health care providers treat second- and third-degree burn victims whose injuries are not in any way attributable to fire, explosion or public safety concerns. We feel the statutes should be amended to provide for reporting of those burn wounds resulting from an incident that merits an appropriate investigation. Such an amendment would accomplish two things. First, it would reduce the amount of paperwork required by the State Fire Marshal and allow that office to concentrate on those incidents that merit investigation. Second, it would help alleviate concerns of health care providers regarding patient confidentiality.

House Bill 2977 is a reasonable attempt to deal with these problems, while maintaining public safety concerns. We urge the Committee to recommend its passage.

TLB:mkc

Attm #4
3-1-88
PH&W

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436

EXHIBIT 1 SOURCE: Yearbook and Directory of the American Osteopathic Association-1987-88.

Residency training requirements of the American Osteopathic Association

July 1987

The primary purpose of this document is to assist directors of medical education, program directors, and other persons concerned with osteopathic postdoctoral training in providing the highest possible quality of graduate education for residents in osteopathic hospitals.

PROGRAM APPROVAL OF THE AMERICAN OSTEOPATHIC ASSOCIATION

A. Hospital Eligibility

An osteopathic hospital desiring approval for residency training shall comply with the following requirements before its application will be considered by the Committee on Postdoctoral Training (COPT) of the American Osteopathic Association (AOA).

1. The hospital shall be accredited by the AOA. Loss of accreditation by a hospital automatically means loss of approval for residency training. For full information about AOA accreditation requirements, the reader is referred to the current edition of *Accreditation Requirements of the American Osteopathic Association*. If not available in the hospital administrator's office or the hospital library, copies are available from the AOA, 142 E Ontario St, Chicago, IL 60611.

2. The hospital may be the sole training institution meeting requirements for training or may meet the requirements as defined in this document.

3. The hospital shall have been in operation not less than 12 months immediately preceding the date of application for approval of residency training.

4. Hospitals approved by the AOA to teach interns are eligible to apply to teach residents.

5. Hospitals may apply for a residency program if they are treating patients in a recognized specialty area.

6. The hospital shall have a director of medical education either full-time or part-time who is a DO with AOA-approved postgraduate training.

7. The chairman of the specialty department shall be a qualified or certified osteopathic specialist.

8. The program director shall ensure that osteopathic principles and practice and their application to the specialty are emphasized.

B. Hospital Applications

1. An osteopathic hospital that complies with the above requirements will be provided with a postdoctoral training questionnaire. All communications shall be directed to the Committee on Postdoctoral Training, American Osteopathic Association, 142 E Ontario St, Chicago, IL 60611.

2. Applications for new residency programs, increases in residency positions in approved programs, and reinstatement of programs shall be submitted to the AOA Department of Education. Such applications shall be made on the appropriate application forms supplied by the AOA. A copy of the application and evaluation report shall be sent to the appropriate specialty affiliate for recommendation to the COPT and final action by the Board of Trustees of the AOA.

3. A residency program may have an overlap of no more than 90 days in the number of approved residents. All other instances must have prior approval of the Committee on Postdoctoral Training.

4. Hospitals approved for a residency program may not conduct a preceptor program in the same specialty.

C. Approval/Inspection Program

1. The Committee on Postdoctoral Training has been delegated the authority by the Board of Trustees of the AOA to conduct on-site inspections of residency programs, to evaluate the inspection findings, and to recommend whether these programs should be granted or denied approval to the Board of Trustees. The Board of Trustees is the only body empowered to grant or deny approval.

The administrator, the director of medical education, and the chairman of the department and/or program director will be advised of the date of the inspection. Residency inspections are conducted throughout the calendar year by osteopathic physicians.

2. Inspectors shall submit written reports to the COPT on all residency programs inspected. These reports shall contain the findings on the quality of professional practice, educational programs, and patient care in the hospital, and other information required by the COPT. Residency program inspection reports are evaluated by the COPT's Subcommittee on Residency/Osteopathic, Residency/Non-Osteopathic, and Preceptorship Training and voted on by the full body. Recommendations of the COPT shall be based on the findings of on-site inspections and the recommendations of the specialty affiliate's evaluating committee.

3. The Committee on Postdoctoral Training must notify an institution as soon as possible after official action has been taken by the Board of Trustees of the American Osteopathic Association. An institution granted approval for residency training is provided with a Certificate of Approval and included in the *Registry of Osteopathic Postdoctoral Training Programs*, published annually by the AOA, which also lists approved intern programs.

4. The Committee on Postdoctoral Training recommends approval of osteopathic residencies that comply with the postdoctoral training requirements of the AOA specified in this document.

a) When the COPT recommends such approval, the committee shall specify whether the residency program requires an inspection again in one, two, or three years.

b) A residency program may be required to undergo a reinspection within one year if both the program director and a majority of department members change.

c) Inactive programs without a resident in training for three (3) consecutive years shall lapse. To again train residents, the institution must reapply as a new program.

d) Any active residency program which receives a recommendation of denial from the COPT shall not be permitted to contract with a new resident until the COPT's recommendation has been resolved by action of the Board of Trustees. Any active residency program which has received AOA approval of one year for deficiencies will not be permitted to contract with a new resident until such time as the program receives AOA approval for two or more years.

5. The COPT may recommend denial of approval to programs not complying with the requirements of the AOA. Institutions not recommended for training approval shall be notified immediately following the COPT meeting. These institutions may request an appeal before the Bureau of Professional Education (see Section D, Hospital Recourse).

6. Approval may be withdrawn from an institution when there is due cause. A notice of impending denial of approval is sent to the insititution addressed to the administrator, chief of staff, director of medical education, and president of the board of the hospital. Denial of approval shall be effective the date action is taken by the AOA Board of Trustees.

D. Hospital Recourse

An institution recommended for denial of approval of residency training may request an appeal before the Bureau of Professional Education within thirty days of the date of receipt of notification of the committee's recommendation. The only acceptable grounds for an appeal are errors of fact in the inspection report. The request for appeal shall be in writing and shall state the facts upon which a request for an appeal is based. If an appeal is granted, the Bureau shall schedule a hearing at its next meeting. Only two representatives of the hospital may attend the hearing to present their appeal.

HOSPITAL REQUIREMENTS

A. Introduction

This section furnishes basic guidelines for hospitals wishing to establish approved residency programs in osteopathic specialties. Basic training requirements for each osteopathic specialty are available from the Department of Education of the American Osteopathic Association. These documents are listed in the Appendix. This section addresses such elements of postdoctoral training as hospital organization and responsibilities, components of the training program, qualifications of supervisors of training, makeup of specialty

departments and services, and other related topics. Minor variations may exist among training or teaching hospitals, but the following basic elements are minimal and essential. To provide a high-quality educational experience, every training hospital should strive to exceed these requirements.

B. Definition of Residency

A residency is defined as a formal, full-time training period in a designated specialty of not less than one year in an osteopathic hospital approved to conduct such a program. This program shall be planned and conducted for the purpose of providing advanced and concentrated training in a designated specialty.

C. Concept of Residency Training

1. Postdoctoral training, leading to possible certification in an osteopathic specialty differs qualitatively from osteopathic undergraduate and intern medical education.

a) The latter are intended to produce competent general practitioners of osteopathic medicine, whereas specialty training is intended to produce competence in a limited field of practice.

b) An exception is the general practice residency program which increases the physician's competence in several areas of practice.

2. The nature of specialty practice assumes that the resident has successfully completed a broad-based undergraduate program and an AOA-approved internship. With this foundation, the resident may pursue specialty training for the acquisition of knowledge and skills requisite to certification and specialty practice.

3. Residency training in an osteopathic specialty must include:

a) Advanced training in appropriate basic sciences.

b) Clinical application of basic science knowledge.

c) The inculcation of a philosophy of specialty practice directed toward rendering the best possible patient care.

d) Growing competence on the part of the resident in the clinical techniques of the specialty.

e) Utilization of osteopathic principles and practice relating to the specialty.

4. Advanced education in the basic sciences appropriate to specialty training must not be merely a refresher course in undergraduate basic sciences.

a) The resident's need for basic science knowledge differs in kind from the need of the osteopathic medical student.

b) At the postdoctoral level, the teaching of appropriate basic sciences should acquaint the resident with the scope, content, and direction of research in the pertinent fields of the appropriate basic sciences.

c) The resident should be given thorough instruction in the basic science skills and techniques employed in the clinical practice of the specialty.

d) The resident should be well versed in acceptable clinical applications of basic science knowledge and techniques in the field of specialization.

5. The clinical application of such knowledge must involve the clinical setting with the resident both observing and actively participating, under supervision, according to his/her skill and competence. These are not acquired didactically, but through active participation in clinical diagnosis and treatment.

6. An essential part of the resident's training is the inculcation of proper attitudes towards patients, the professional staff, and the hospital administration.

a) The teaching staff should emphasize that the profession and the hospital exist for the patient.

b) It must also be emphasized that the hospital is not merely the physician's workshop.

c) Today's hospital is a facility provided by the community for the welfare of its citizens.

7. The resident should be assisted in formulating a sound philosophy of specialty training to support future specialty practice. Physicians supervising and participating in specialty training should remember that a resident is likely to formulate a particular philosophy on the basis of informal contacts and observation of the habits of the attending staff rather than during any formal presentation.

8. The resident should be instructed in the necessity for clinical review of the work of the professional staff; this is the foundation of osteopathic medicine.

a) Although the governing board has the ultimate responsibility for the quality of care in the hospital, the self-governing staff controls the quality of care rendered in the hospital.

b) The staff must be prepared to evaluate its work and to discipline itself in order to provide the best possible patient care.

c) The resident should be introduced to the importance of staff participation in review functions through compulsory attendance at staff meetings, clinicopathologic conferences, autopsies, and other educational methodologies.

9. An effective residency program will give a resident increasing competence in specialty procedures and techniques and in the use of its diagnostic and therapeutic modalities.

a) The resident should be given the opportunity to progress through observation, assistance, and supervised participation leading towards greater responsibility for diagnosis, care, and treatment of patients.

b) The resident's professional growth should include an opportunity to attend or participate in teaching and training outside the parent hospital.

c) Such opportunities are available through seminars, divisional society meetings, workshops in other hospitals, programs provided by universities, and clinical activities in affiliated outpatient clinics or specialty institutions.

d) These opportunities should be properly controlled, and each should contribute to the resident's training in the base hospital.

D. Hospital Training Requirements

1. A hospital wishing to establish a residency program shall meet the requirements as set forth under Hospital Eligibility (Section A,1).

a) Previously approved programs in smaller hospitals shall be granted continuing approval as long as each program continues to meet the requirements for approval of residency training of the American Osteopathic Association.

b) Such hospitals may not establish new residency programs unless current criteria are met.

2. A training hospital shall have a required minimum of four organized departments or committees: general practice, internal medicine, obstetrics-gynecology, and surgery.

3. A training hospital must also have adequate organized pathologic and radiologic services.

a) The pathology service must operate on a full-time basis, supervised by a full-time qualified pathologist.

b) The radiologist shall be certified or board-eligible, and shall meet the attendance requirements for staff membership and the teaching requirements for a department chairman.

4. A training hospital may have more than the four required departments or committees, especially larger hospitals and those affiliated with colleges of osteopathic medicine. The major requirement to be met is that, with the exception of the pathologic and radiologic services, residencies shall only be conducted in organized departments or committees of the hospital.

5. The suitability of the hospital's facilities and equipment for postdoctoral training shall be determined by an on-site inspection conducted by the Committee on Postdoctoral Training (COPT) of the AOA.

a) The administration and professional staff of the training institution should understand that a recommendation by the COPT shall be based upon evaluation of the inspection findings.

b) A sample inspection report should be carefully studied to gain an understanding of requirements for a specialty program.

c) Sample reports for all osteopathic specialties are available upon request from the AOA Department of Education.

d) It is recommended that the hospital perform a self-evaluation of the residency program in advance of an on-site inspection.

6. The approval policies and procedures of the AOA make it mandatory that a hospital wishing to establish a postdoctoral training program must submit the proposed program format to the COPT for approval before training commences.

a) Retroactive approval for training programs is not allowed.

b) The training institution is responsible for establishing a mechanism to control the outside professional activities of the resident.

c) All activities in a training program shall be subordinated to the program's objectives.

d) The hospital is responsible for ensuring that the resident is provided with a high quality educational experience.

e) Education, not service, is the purpose of a residency program.

7. The patient load must be sufficient to properly train a *minimum* of two residents. Interaction between the two residents, the department, the certified program director, and an adequate number of other qualified specialists will ensure a challenging, stimulating, and successful residency.

8. It is the hospital's responsibility, exercised through the director of medical education, to see that the resident has all the training proposed in the program description. The hospital should develop supervisory mechanisms to ensure that the elements of the program description are translated into an educational experience for the resident.

9. There must be in-hospital evaluation of the residency program to determine whether it is meeting its stated goals.

a) Physician supervision or participation in the training of residents is necessary to establish feasible goals.

b) Program evaluation should determine the competency level.

10. The hospital shall evaluate the program director and the residents.

a) Postdoctoral training is an important function of the hospital and should be given primary consideration.

b) The program director should be an effective teacher.

11. The hospital may discontinue the training of a resident if the resident is considered to be intellectually, educationally, temperamentally, morally, or otherwise unsuited to participate or continue in the program.

12. Effective teaching is also the responsibility of the specialty department or service, and professional staff.

a) A hospital undertaking postdoctoral training should base its educational program on the efforts and skills of the entire staff and on the willingness of all departments and services to participate in the program.

b) Hospitals not meeting these high standards are not ready to initiate postdoctoral level programs.

E. Qualifications of Program Director

1. The program director shall be certified by the AOA in the appropriate specialty.

a) Although certification is not synonymous with medical expertise, it assumes that the physician is qualified to practice a given specialty.

b) It also assumes that the program director has mastered a given body of basic science and clinical knowledge and that he/she can expertly employ the modalities of the specialty in diagnosis and treatment of patients.

c) A residency program will not be considered by the Committee on Postdoctoral Training beyond the certification status of the program director. A change of program director will necessitate a re-evaluation of the program, but not necessarily a reinspection. Any residency program that changes both the program director and the majority of departmental members will be required to have a reinspection within the period of one year.

d) A program director of an osteopathic subspecialty training program, where osteopathic certification is not available, must be certified in the basic specialty and have the necessary subspecialty training. In addition, the program director must be recognized by his/her peers as a specialist in the appropriate subspecialty.

2. A physician involved in postdoctoral training, as a supervisor or a participant, should also be able to demonstrate a breadth of clinical experience that will bring the resident more than a textbook presentation of the subject matter.

a) The program director should be aware of developments in the specialty field through continuing postgraduate education.

b) Formulation of minimum requirements for specialty postgraduate education by the specialty affiliates would be highly desirable.

c) In their absence, the physician involved in postdoctoral training must use the best possible judgment about the amount of postgraduate training that should be taken annually.

d) A physician who has not taken a substantial amount of postgraduate education in the specialty during the last five years should not be approved as a program director.

e) No program director shall simultaneously conduct more than one residency program.

3. The program director should have a sincere and demonstrated interest in medical education.

a) This requires a sound philosophy of medical education and a willingness to devote time towards improving the quality of postdoctoral education in the hospital.

b) The program director should cooperate with the professional staff, residents, interns, and the paramedical disciplines in the hospital.

c) The program director must assist in developing the organization and content of the teaching program.

4. The program director shall be required to submit quarterly progress reports on each resident to the hospital administrator. Annual reports shall be submitted to the appropriate specialty affiliate. These reports shall evaluate the acceptability of the resident as a prospective specialist and other factors pertinent to continuance in training.

5. The program director should develop a community outlook and be concerned with broad social issues and policies.

a) Failure to effectively relate the teaching and practice to community needs and social ideals will reduce the effectiveness of the program.

b) The teaching physician must keep in contact with the community to be aware of social and cultural developments and the medical needs of the community.

6. The program director and/or the training institution must document the transfer and/or any change in level or status of the resident to the AOA. Credit for residency training will only be granted for time units of 12 months.

F. Requirements for Residents

1. Applicants for residency training shall be graduates of AOA-accredited colleges of osteopathic medicine and shall have completed an AOA-approved internship.

2. Osteopathic physicians applying for residency training who graduated in or prior to 1946 shall document training equivalent to an approved internship.

3. Applicants for residency training shall be members of the AOA and shall maintain membership during their specialty training.

4. The resident must complete the required minimum number of years in an osteopathic program as stipulated in the basic standards of the respective specialty affiliate before qualifying to take subspecialty training in either an osteopathic or non-osteopathic training program.

5. A physician entering a postdoctoral training program, such as a residency in one of the osteopathic specialties, accepts new duties and responsibilities.

a) As a licensed physician, the resident is already responsible to the public and governmental agencies.

b) As a resident, the physician becomes responsible to the hospital for executing certain duties and functions, such as rendering patients the best possible care.

c) The resident is responsible to the program director to pursue the training program as outlined.

d) The resident must recognize that the professional staff has a collective responsibility to participate in the training of interns, nurses, and other paramedical personnel.

e) The resident has a responsibility to help educate patients in understanding their illnesses, grasping the reasons for procedures performed, and comprehending the prescribed medical programs to be followed upon discharge.

6. The resident is legally, morally, and ethically responsible to pursue exclusively the agreed upon program of training.

a) It is the resident's responsibility not to assume outside activities of a professional or a nonprofessional nature that interfere with the program.

b) The resident is obligated to abide by the laws, rules, and regulations of the professional staff, the terms of the hospital contract, and other guidelines established by the hospital.

c) The resident is responsible for participation in all professional staff activities involving evaluation of patient care.

d) The resident shall attend specified staff meetings and maintain a satisfactory record of work performed.

e) Reports shall be submitted monthly to the program director and the chairman of the department for their review and verification. Copies of these records shall be filed with the hospital administration and shall be available at the time of inspection.

f) Residents shall not be permitted to act as consultants, but may render services to bona fide hospital clinics.

G. Teaching Case Load

1. The teaching case load for a residency program shall provide an adequate volume of patients with a sufficient scope and variety to introduce the resident to the full dimensions of the specialty and to give training in all clinical aspects of the field. Volume is not the only determinant of an adequate clinical case load.

2. Teaching case load requirements vary according to specialty. The reader seeking specific information is referred to the basic training requirements of the pertinent specialty.

3. Many judgmental factors enter into evaluating a residency. Guidelines provided in the basic training requirements enable a hospital and its clinical departments to estimate whether the teaching case load meets these requirements.

OUTSIDE ROTATIONS

A. Outside rotations are permissible when included in the basic residency program as approved by the Committee on Postdoctoral Training. The purpose of such rotations is for the enhancement of the basic program. The parent institution or organization is responsible for the outside rotations.

B. Regulations Regarding Outside Rotations

1. The resident shall remain under contract or agreement to the parent institution or organization throughout the outside rotation.

2. The resident's training log at the training site shall be included in his/her log at the parent institution or organization.

3. Written evaluation of the resident's performance must be submitted by the on-site program director to the parent institution or organization.

4. The parent institution or organization may arrange for up to a total of six consecutive months of training as an outside rotation to supplement the residency program. Such training must meet the approved requirements for that specialty. Outside rotations in excess of six consecutive months must receive prior approval by the Committee on Postdoctoral Training.

5. The total amount of outside rotations in a residency program shall be determined by the specialty affiliate and be a part of its basic requirements as approved by the AOA. In no case shall that maximum aggregate time in outside rotations be more than one half the time of the program.

HOSPITAL-RESIDENT CONTRACTS

A. General

1. Hospital-resident contracts provided by the American Osteopathic Association shall be used in executive contracts between residents and osteopathic hospitals approved for residency training.

2. All hospital-resident contracts shall be executed and submitted to the Committee on Postdoctoral Training at the earliest possible date and no later than 30 days after the residency commences.

B. Hospital Responsibilities

1. Hospitals approved for residency training shall report immediately to the COPT any change in the resident staff personnel that may occur during the year.

2. Hospitals shall designate sick leave, maternity leave, vacation, and military leave as provided under the terms of the AOA hospital-resident contract.

3. Contract violations by residents shall be reported to the COPT immediately following the incident.

4. Hospitals approved for residency training shall provide residents with certificates upon completion of training attesting that they have satisfactorily fulfilled the period of training. These certificates shall be signed by the president and secretary of the governing body or by such other hospital authorities as may be designated.

5. Hospitals that violate their contracts with residents may lose AOA approval of their training programs.

6. The AOA hospital-resident contract stipulates that in the event the program director cannot provide adequate supervision, for whatever reason, the program no longer meets the basic standards for AOA approval. The AOA Department of Education shall immediately expedite changes to ensure the continued quality of the residency training, and these changes must meet the basic requirements for AOA approval of residency training. In the event that the program is not approvable, an effort shall be made to place the resident or residents in other established AOA-approved programs. Acceptance of a resident into a residency program does not guarantee that the program will continue in an uninterrupted manner, in the event that loss of a functioning program director should occur or if the program should lose its AOA approval for other reasons.

C. Resident Responsibilities

1. The hospital-resident contract directed to the resident's attention shall be completed at the earliest date and returned to the parent hospital.

2. Any contract violation by a hospital shall be reported immediately to the Committee on Postdoctoral Training.

3. Violation of contract by a resident may result in the loss of credit for time served in the hospital.

4. A resident who breaches the hospital-resident contract may not serve an AOA-approved residency for a period of 12 months following the date of the breach.

APPENDIX

1. Aerospace Medicine — Basic Standard for Residency Training in Preventive and Aerospace Medicine

2. Allergy and Immunology—Program in Clinical Immunology and Allergy

3. Anesthesiology—Standards for Residency Training Programs in Anesthesiology

4. Angiography and Interventional Radiology—Basic Standards for Subspecialty Training in General Angiography and Interventional Radiology

5. Cardiology—Program in Cardiovascular Diseases

6. Child Neurology—Basic Standards for Residency Training in Child Neurology

7. Child Psychiatry—Basic Standards for Residency Training in Child Psychiatry

8. Dermatology—Basic Requirements for Residency Training in Dermatology

9. Diagnostic Radiology—Basic Standards for Residency Training in Diagnostic Radiology

10. Diagnostic Ultrasound—Basic Standards for Subspecialty Training in Diagnostic Ultrasound in Radiology

11. Emergency Medicine—Standards for Residency Training in Osteopathic Emergency Medicine

12. Endocrinology—Program in Endocrinology

13. Gastroenterology—Program in Gastroenterology

14. General Practice—Basic Standards for Residency Training in General Practice

15. General Surgery—Basic Requirements for Residency Approval in Surgery

16. General Vascular Surgery—Basic Requirements for Residency Training Programs in General Vascular Surgery

17. Hematology—Program in Hematology

18. Infectious Diseases—Basic Standards for Residency Training in Infectious Diseases

19. Internal Medicine—Standards for Residency Training in Osteopathic Internal Medicine

20. Medical Diseases of the Chest—Basic Standards for Residency Training in Medical Diseases of the Chest

21. Neonatal Medicine—Requirements for Approval of Subspecialty Training in Neonatal Medicine

22. Nephrology—Basic Standards for Residency Training in Nephrology

23. Neurological Surgery—Basic Requirements for Residency Approval in Neurological Surgery

24. Neurology—Basic Requirements of an Approved Residency in Neurology

25. Neuroradiology—Basic Standards for Subspecialty Training in Neuroradiology

26. Nuclear Medicine—Basic Standards for Residency Training in Nuclear Medicine

27. Nuclear Radiology—Basic Standards for Subspecialty Training in Nuclear Radiology

28. Obstetrics/Gynecology—Basic Requirements for Residency Training in Obstetrics and Gynecological Surgery

29. Occupational Medicine — Basic Standards for Residency Training in Occupational/Environmental Medicine

30. Oncology—Program in Oncology

31. Ophthalmology—Basic Requirements for Residency Training in Ophthalmology

32. Orthopedic Surgery—Basic Requirements for Residency Training in Orthopedic Surgery

33. Osteopathy—Minimum Standards and Requirements for Residency Training in Osteopathic Principles and Practice
34. Otorhinolaryngology—Basic Requirements for Residency Training in Otorhinolaryngology
35. Otorhinolaryngology and Oro-facial Plastic Surgery—Basic Requirements for Residency Training in Otorhinolaryngology and Oro-facial Plastic Surgery
36. Pathology—Basic Requirements for Training in Pathology and Laboratory Medicine
37. Pediatric Hematology/Oncology—Basic Standards for Residency Training in Pediatric Hematology/Oncology
38. Pediatrics—Basic Requirements for Residency Training in Pediatrics
39. Plastic and Reconstructive Surgery—Basic Requirements for Residency Training Programs in Plastic and Reconstructive Surgery
40. Proctology—Basic Standards for Residency Training for Proctologic Surgery
41. Psychiatry—Basic Standards for Residency Training in General Psychiatry
42. Public Health and Preventive Medicine—Basic Standards for Residency Training in Public Health and Preventive Medicine
43. Radiation Oncology—Basic Requirements and Minimum Standards for Residency Training in Radiation Oncology
44. Radiological Imaging — Basic Standards for Subspecialty Training in Radiological Imaging
45. Radiology—Basic Standards for Residency Training in Radiology
46. Rehabilitation Medicine—Basic Standards for Residency Training in Rehabilitation Medicine
47. Reproductive Endocrinology—Basic Standards for Residency Training in Reproductive Endocrinology
48. Rheumatology—Program in Rheumatology
49. Thoracic Surgery—Basic Requirements for Approval of Residency Training in Thoracic/Cardiovascular Surgery
50. Urological Surgery—Basic Requirements for Residency Approval in Urological Surgery

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For further information on this material, contact the Postdoctoral Division, Department of Education, American Osteopathic Association, 142 E Ontario St, Chicago, IL 60611

Osteopathic postdoctoral training programs

July 1987

The Committee on Postdoctoral Training of the AOA evaluates and recommends for approval all osteopathic internship and residency programs. Final approval comes from the AOA Board of Trustees. Those listed below were approved as of July 1987.

Information in this section was obtained through a questionnaire sent to each hospital approved for postdoctoral training.

Word abbreviations used below:
Adm = Admissions
Admin = Administrator
Assoc = Associate
Asst = Assistant
Avg = Average
Bass = Bassinets
Bd = Board
C=Continuing
CEO = Chief Executive Officer
Coll = College
Comm = Community
Corp = Corporation
Ctr = Center
Dir = Director(s)
Div = Division
DME = Director of Medical Education
ER = Emergency room
Exec = Executive
Exec Dir = Executive Director
Exec VP = Executive Vice-President
Genl = General
H = Hospital
M = Medical
M Dir = Medical Director
Med = Medicine
Mem = Memorial
OP = Outpatient
Ost = Osteopathic
Pres = President
Prog Chair = Program Chairman
Prog Dir = Program Director
Univ = University
VP = Vice-President
Also, standard two-letter state abbreviations are used.

INDEX TO INTERNSHIPS

See hospital listings below. Numbers following each hospital name are the numbers of approved internship positions in that institution.

AOA-approved internships:
AZ, Mesa: Mesa Genl H M Ctr, 6
AZ, Phoenix: Phoenix Genl H, 24
AZ, Tucson: Tucson Genl H, 10
CA, Downey: Rio Hondo Mem H, 10
CA, Long Beach: Pacific H of Long Beach, 25
CA, Pomona: Coll of Ost Med of the Pacific, 12
CA, San Diego: Hillside H, 5
CO, Colorado Springs: Eisenhower M Ctr, 10
CO, Denver: Rocky Mountain H, 9
DE, Wilmington: Riverside H, 6
FL, Hollywood: Humana H—South Broward, 10
FL, Largo: Sun Coast H, Inc, 14
FL, Miami: Westchester Genl H, 5
FL, North Miami Beach: Southeastern Coll of Ost Med, 10
FL, North Miami Beach: Southeastern M Ctr, 16
FL, Orlando: Orlando Genl H, 12
FL, Ormond: Peninsula M Ctr, 4
FL, Pinellas Park: Metropolitan Genl H, Inc, 10
FL, Plantation: Doctors Genl H, 9
FL, St Petersburg: Harborside H, 4
FL, Seminole: Univ Genl H of Seminole, 9
FL, West Palm Beach: Humana H—Palm Beaches, 12
GA, Tucker: HCA Doctors H, 10
IL, Chicago: Chicago Coll Ost Med, 86
IN, Indianapolis: Westview H, 9
IN, South Bend: Michiana Comm H, 8
IA, Davenport: Davenport M Ctr, 6
IA, Des Moines: Des Moines Genl H, 22
KS, Wichita: Riverside H, 12
ME, Portland: Ost H Maine, 13
ME, Waterville: Waterville Ost H, 6
MA, Boston: Massachusetts Ost H and M Ctr, 4
MI, Bay City: Bay Ost H, 6
MI, Carson City: Carson City H, Ost, 6
MI, Detroit: Detroit Ost H/Bi-County Comm H, 36
MI, Detroit: Michigan Ost M Ctr, 24
MI, East Lansing: Michigan State Univ-Coll of Ost Med, 12
MI, Farmington Hills: Botsford Genl H, Ost, 38
MI, Flint: Flint Ost H, 31
MI, Garden City: Garden City H, Ost, 22
MI, Grand Rapids: Metropolitan H, 18
MI, Lansing: Lansing Genl H, Ost, 16
MI, Madison Heights: Oakland Genl H, Ost, 22
MI, Mount Clemens: Mount Clemens Genl H, 19
MI, Muskegon: Muskegon Genl H, 6
MI, Pontiac: Pontiac Ost H, 20
MI, Traverse City: Traverse City Ost H, 6
MI, Trenton: Riverside Ost H, 15
MO, Farmington: Mineral Area Ost H, 5
MO, Jefferson City: Charles E. Still Ost H, 12
MO, Joplin: Oak Hill H (Ost), 6
MO, Kansas City: Lakeside Ost H, 8
MO, Kansas City: Univ Health Sciences, Univ H, 14
MO, Kirksville: Kirksville Ost M Ctr, 21
MO, Rolla: Phelps County Regional M Ctr, 6
MO, St Louis: Normandy Ost H, 24
NJ, Livingston: West Essex Genl H, 5
NJ, Saddle Brook: Kennedy Mem H at Saddle Brook, 15
NJ, Stratford: Kennedy Mem H-Univ M Ctr-Stratford Div, 60
NJ, Union: Union H, 18
NM, Albuquerque: Heights Genl H, 6
NY, Brooklyn: Baptist M Ctr New York, 20
NY, Old Westbury: New York Coll of Ost Med, 93
NY, Seaford, LI: Massapequa Genl H, 11
OH, Athens: Ohio Univ—Coll of Ost Med, 5
OH, Columbus: Doctors H, 40
OH, Cuyahoga Falls: Cuyahoga Falls Genl H, 17
OH, Dayton: Grandview H and M Ctr, 27
OH, Marietta: Selby Genl H, 3
OH, Massillon: Doctors H Stark County, 14
OH, Richmond Heights: Richmond Heights Genl H, 16
OH, Sandusky: Firelands Comm H, 8
OH, Toledo: Parkview H, 10
OH, Warren: Warren Genl H, 16
OH, Warrensville Heights: Brentwood H, 18
OH, Youngstown: Youngstown Ost H, 14
OK, Enid: Enid Mem H, 12
OK, Oklahoma City: Hillcrest Health Ctr, 16
OK, Tulsa: Oklahoma Ost H, 48
OR, Portland: Eastmoreland H (Ost), 7
PA, Allentown: Allentown Ost M Ctr, 13
PA, Clarion: Clarion Ost Comm H, 4
PA, Erie: Metro Health Ctr, 9
PA, Erie: Millcreek Comm H, 9
PA, Farrell: Shenango Valley Ost H, 7
PA, Harrisburg: Comm Genl Ost H, 12
PA, Lancaster: Comm H of Lancaster, 10
PA, Langhorne: Delaware Valley M Ctr, 18
PA, Norristown: Suburban Genl H, 14
PA, Philadelphia: H Philadelphia Coll Ost Med, 30
PA, Philadelphia: Metropolitan H-Central Div, 23
PA, Philadelphia: Metropolitan H-Parkview Div, 20
PA, Philadelphia: Philadelphia Coll of Ost Med, 24
PA, Springfield: Metropolitan H-Springfield Div, 16
PA, York: Mem H, 13
RI, Cranston: Cranston Genl H, 7
TX, Bedford: Northeast Comm H, 12
TX, Corpus Christi: Corpus Christi Ost H, 7
TX, Dallas: Dallas Family H, 8
TX, Dallas: Dallas Mem H, 8
TX, Fort Worth: Fort Worth Ost M Ctr, 20
TX, Grand Prairie: Dallas/Fort Worth M Ctr-Grand Prairie, 20
TX, Groves: Doctors H Nu-Med M Inc, 4
WA, Seattle: Fifth Ave M Ctr, 4
WV, Lewisburg: West Virginia School of Ost Med, 23
WI, Milwaukee: Lakeview H, 5
WI, Milwaukee: Northwest Genl H, 10
WI, New Berlin: New Berlin Mem H, 4

INDEX TO RESIDENCIES

See hospital listings below. Numbers following each hospital name are the numbers of approved residencies in each practice area.

Anesthesiology
FL, Largo: Sun Coast H, Inc, 2
IL, Chicago: Chicago Coll Ost Med, 9
ME, Portland: Ost H Maine, 2
MI, Detroit: Detroit Ost H/Bi-County Comm H, 4

MI, Detroit: Michigan Health Care Corp, 4
MI, Farmington Hills: Botsford Genl H (Ost), 7
MI, Flint: Flint Ost H, 5
MI, Garden City: Garden City H, Ost, 3
MI, Grand Rapids: Metropolitan H, 3
MI, Madison Heights: Oakland Genl H, Ost, 2
MI, Mount Clemens: Mount Clemens Genl H, 4
MI, Pontiac: Pontiac Ost H, 4
MI, Trenton: Riverside Ost H, 3
MO, Kansas City: Univ H, Univ Health Sciences, 4
MO, Kirksville: Kirksville Ost M Ctr, 2
MO, St Louis: Normandy Ost H, 3
NJ, Stratford: Kennedy Mem H-Univ M Ctr-Stratford Div, 9
NM, Albuquerque: Heights Genl H, 1
OH, Columbus: Doctors H, 6
OH, Cuyahoga Falls: Cuyahoga Falls Genl H, 2
OH, Dayton: Grandview H and M Ctr, 3
OH, Toledo: Parkview H, 2
OH, Warren: Warren Genl H, 2
OH, Warrensville Heights: Brentwood H, 3
OH, Youngstown: Youngstown Ost H Assn, Inc, 2
OK, Tulsa: Oklahoma Ost H, 6
PA, Norristown: Suburban Genl H, 3
PA, Philadelphia: H Philadelphia Coll Ost Med, 4
PA, Philadelphia: Metropolitan H-Central Div, 3
PA, Philadelphia: Metropolitan H-Parkview Div, 2
PA, Springfield: Metropolitan H-Springfield Div, 2
TX, Dallas: Dallas Family H, 2
TX, Fort Worth: Fort Worth Ost M Ctr, 3
TX, Fort Worth: Texas Coll Ost Med, 10
TX, Grand Prairie: Dallas/Fort Worth M Ctr-Grand Prairie, 3

Angiography
OH, Columbus: Doctors H, 2

Cardiology
IL, Chicago: Chicago Coll of Ost Med, 8
MI, Detroit: Detroit Ost H/Bi-County Comm H, 2
MI, East Lansing: Michigan State Univ-Coll of Ost Med, 2
MI, Farmington Hills: Botsford Genl H (Ost), 1
MI, Madison Heights: Oakland Genl H, Ost, 2
MI, Mount Clemens: Mount Clemens Genl H, 1
MI, Pontiac: Pontiac Ost H, 1
MI, Trenton: Riverside Ost H, 2
NJ, Stratford: Kennedy Mem H-Univ M Ctr-Stratford Div, 3
PA, Philadelphia: H Philadelphia Coll Ost Med, 3

Cardiovascular Diseases
PA, Philadelphia: Metropolitan H-Central Div, 2

Dermatology
MI, Pontiac: Pontiac Ost H, 2
OH, Dayton: Grandview H and Med Ctr, 2

Diagnostic Ultrasound
OH, Columbus: Doctors H, 1

Emergency Medicine
IL, Chicago: Chicago Coll Ost Med, 14
MI, Detroit: Detroit Ost H/Bi-County Comm H, 4
MI, East Lansing: Michigan State Univ-Coll of Ost Med, 4
MI, Farmington Hills: Botsford Genl H (Ost), 4
MI, Garden City: Garden City H, Ost, 4
MI, Grand Rapids: Metropolitan H, 4
MI, Mount Clemens: Mount Clemens Gen H, 4
MI, Pontiac: Pontiac Ost H, 6
MO, St Louis: Normandy Ost H, 2
NJ, Union: Union H, 4
NY, Brooklyn: Baptist M Ctr New York, 2
OH, Dayton: Grandview H and M Ctr, 4
OH, Warrensville Heights: Brentwood H, 4
OK, Tulsa: Oklahoma Ost H, 3
PA, Langhorne: Delaware Valley M Ctr, 4
PA, Philadelphia: H Philadelphia Coll Ost Med, 14
PA, York: Mem H, 6

Endocrinology
MI, Detroit: Detroit Ost H/Bi-County Comm H, 1

Gastroenterology
IL, Chicago: Chicago Coll Ost Med, 3
MI, Farmington Hills: Botsford Genl H (Ost), 3
MI, Flint: Flint Ost H, 2
MI, Madison Heights: Oakland Genl H, Ost, 2
NJ, Stratford: Kennedy Mem H-Univ M Ctr-Stratford Div, 4
PA, Philadelphia: H Philadelphia Coll Ost Med, 2

General Practice
AZ, Phoenix: Phoenix Genl H, 6
AZ, Tucson: Tucson Genl H, 2
CA, Long Beach: Pacific H of Long Beach, 5
CA, Pomona: Coll of Ost Med of the Pacific, 2
CO, Colorado Springs: Eisenhower M Ctr, 2
CO, Denver: Rocky Mountain H, 10
DE, Wilmington: Riverside H, 2
FL, Largo: Sun Coast H, Inc, 2
FL, Miami: Westchester Genl H, 2
FL, North Miami Beach: Southeastern Coll of Ost Med, 10
FL, North Miami Beach: Southeastern M Ctr, 6
FL, Orlando: Orlando Gen H, 3
FL, Pinellas Park: Metropolitan Genl H, Inc, 2
FL, Plantation: Doctors Genl H, 2
GA, Tucker: HCA Doctors H, 5
IL, Chicago: Chicago Coll Ost Med, 20
IA, Davenport: Davenport M Ctr, 3
IA, Des Moines: Des Moines Genl H, 10
IN, South Bend: Michiana Comm H-An Ost Institution, 2
MA, Boston: Massachusetts Ost H and M Ctr, 2
ME, Portland: Ost H Maine, 6
ME, Waterville: Waterville Ost H, 6
MI, Detroit: Detroit Ost H/Bi-County Comm H, 8
MI, Detroit: Michigan Health Care Corp, 3
MI, East Lansing: Michigan State Univ-Coll of Ost Med, 8
MI, Farmington Hills: Botsford Genl H (Ost), 8
MI, Flint: Flint Ost H, 6
MI, Garden City: Garden City H, Ost, 6
MI, Grand Rapids: Metropolitan H, 2
MI, Madison Heights: Oakland Genl H, Ost, 3
MI, Mount Clemens: Mount Clemens Genl H, 2
MI, Pontiac: Pontiac Ost H, 2
MI, Trenton: Riverside Ost H, 5
MO, Kirksville: Kirksville Ost M Ctr, 3
MO, St Louis: Normandy Ost H, 4
NJ, Saddle Brook: Kennedy Mem H at Saddle Brook, 8
NJ, Stratford: Kennedy Mem H-Univ M Ctr-Stratford Div, 24
NJ, Union: Union H, 9
NY, Brooklyn: Baptist M Ctr New York, 8
NY, Old Westbury, Long Island: New York Coll of Ost M of New York Institute of Technology, 20
OH, Athens: Ohio Univ Coll of Ost Med, 3
OH, Columbus: Doctors H, 16
OH, Cuyahoga Falls: Cuyahoga Falls Genl H, 6
OH, Dayton: Grandview H and M Ctr, 10
OH, Massillon: Doctors H Stark County, 4
OH, Richmond Heights: Richmond Heights Genl H, 6
OH, Sandusky: Firelands Comm H, 2
OH, Toledo: Parkview H, 2
OH, Warren: Warren Genl H, 2
OH, Warrensville Heights: Brentwood H, 8
OH, Youngstown: Youngstown Ost H Assn, Inc, 2
OK, Tulsa: Oklahoma Ost H, 6 (pending)
OR, Portland, Eastmoreland H (Ost), 3
PA, Allentown: Allentown Ost M Ctr, 6
PA, Erie: Metro Health Ctr, 2
PA, Erie: Millcreek Comm H, 2
PA, Harrisburg: Comm Genl Ost H, 4
PA, Lancaster: Comm H Lancaster, 4
PA, Langhorne: Delaware Valley M Ctr, 8
PA, Norristown: Suburban Genl H, 8
PA, Philadelphia: H Philadelphia Coll Ost Med, 15
PA, Philadelphia: Metropolitan H-Central Div, 5
PA, Philadelphia: Metropolitan H-Parkview Div, 5
PA, Springfield: Metropolitan H-Springfield Div, 5
PA, York: Mem H, 4
RI, Cranston: Cranston Genl H, Ost, 2
TX, Bedford: Northeast Comm H, 2
TX, Dallas: Dallas Mem H, 2
TX, Fort Worth: Fort Worth Ost M Ctr, 2
TX, Fort Worth: Texas Coll of Ost Med, 11
WA, Seattle: Fifth Avenue M Ctr, 2
WI, Milwaukee: Lakeview H, 1
WI, Milwaukee: Northwest Genl H, 4

Hematology
MI, Madison Heights: Oakland Genl H, Ost, 2

EXHIBIT 3 SOURCE: Yearbook and Directory of the American Osteopathic Association - 1987-88.

Requirements for certification: Advisory Board for Osteopathic Specialists and Boards of Certification

July 1987

ADVISORY BOARD FOR OSTEOPATHIC SPECIALISTS

Chairman: Harry B. Elmets, DO
Vice-Chairman: Dorothy E. Carnegie, DO
Bureau of Professional Education: Alvin D. Dubin, DO; Howard Collier, LLD
American Osteopathic Board on Fellowship of the American Academy of Osteopathy: David A. Patriquin, DO; *Alternate:* Viola M. Frymann, DO
American Osteopathic Board of Anesthesiology: William C. Wagner, DO; *Alternate:* J.L. Margreiter, DO
American Osteopathic Board of Dermatology: David Brooks Walker, DO; *Alternate:* Charles Hughes, DO
American Osteopathic Board of Emergency Medicine: John W. Becher, Jr, DO; *Alternate:* Robert L. Hambrick, DO
American Osteopathic Board of General Practice: Frank Bonifacio, DO; *Alternate:* Samson A. Inwald, DO
American Osteopathic Board of Internal Medicine: Gary L. Slick, DO; *Alternate:* Edmund T. Carroll, DO
American Osteopathic Board of Neurology and Psychiatry: Fred Marshall, DO; *Alternate:* William F. Ranieri, DO
American Osteopathic Board of Nuclear Medicine: George T. Caleel, DO; *Alternate:* Louis W. Gierke, DO
American Osteopathic Board of Obstetrics and Gynecology: Harvey C. Orth, Jr, DO; *Alternate:* Joseph P. Bonanno, DO
American Osteopathic Board of Ophthalmology and Otorhinolaryngology: Donald M. Dushay, DO; *Alternate:* Gerald H. Kursar, DO
American Osteopathic Board of Orthopedic Surgery: William L. Smith, DO; *Alternate:* Gordon L. Thorn, DO
American Osteopathic Board of Pathology: Jeffrey D. Morasco, DO; *Alternate:* Donald Hendrickson, DO
American Osteopathic Board of Pediatrics: Michael E. Ryan, DO; *Alternate:* Philip V. Marinelli, DO
American Osteopathic Board of Preventive Medicine: Loren Hatch, DO; *Alternate:* John Mills, DO
American Osteopathic Board of Proctology: Rudi O. Wadle, DO; *Alternate:* Coburn C. Bland, DO
American Osteopathic Board of Radiology: Michael K. Willman, DO *Alternate:* Martin S. Landis, DO
American Osteopathic Board of Rehabilitation Medicine: David Rosenthal, DO; *Alternate:* Gershon R. Weiner, DO
American Osteopathic Board of Surgery: John W. Phardel, DO; *Alternate:* John R. Socey, DO.

The Advisory Board for Osteopathic Specialists (hereinafter also referred to as the Advisory Board) was organized in 1939 to meet the needs resulting from the growth of specialization in the osteopathic profession. It was thought at that time that there should be standardization of postdoctoral education and regulations for certification in the various specialties or fields of practice. Therefore, the Board of Trustees of the American Osteopathic Association, through its agency, the Advisory Board for Osteopathic Specialists, became the certifying body.

The advisory board is not only the authoritative body that establishes and maintains standards of specialization and the pattern of training for the various specialties and fields of practice, but it is also a meeting place for the exchange of experiences, for the mellowing of judgments, and for the cooperative efforts of the various certifying boards. Time has matured the workings of the certification program within the profession and has given the advisory board a respected role in its supervisory functions. The place of the advisory board in the general educational structure of the profession has become increasingly significant.

The advisory board is composed of a chairman, a vice-chairman, a secretary, one representative from each approved certifying board, and two representatives from the Bureau of Professional Education. The advisory board is a component of the Bureau of Professional Education, and its chairman is a member of the bureau.

The chairman, vice-chairman, and two members representing the Bureau of Professional Education are appointed by the president of the American Osteopathic Association; the secretary is provided by the central office. All officers, with the exception of the secretary, serve two-year terms.

Board eligibility status

Board eligibility is defined as that status granted candidates who:

a. Have documented the satisfactory completion of an AOA-approved residency or preceptorship.

b. Have met all the requirements as established by the appropriate certifying board.

c. Have applied to and have been accepted as a registrant by the appropriate certifying board.

d. Are and remain members in good standing of the American Osteopathic Association or the Canadian Osteopathic Association.

Upon satisfactory completion of the training program (or practice requirements, if applicable), the certifying board will establish the date of registration of board eligibility status for the candidate as the date of completion of the training program (or practice requirement).

Board eligibility shall terminate six consecutive years from the date board eligibility was established.

Candidates who wish to apply for board eligibility status must contact the secretary of the appropriate certifying board.

Maintaining certification

In order to maintain his/her certificate, a diplomate must:

a. Be a member of the American Osteopathic Association or the Canadian Osteopathic Association.

b. Pay the annual certification registration fee, unless classified as inactive.

c. Maintain a minimum of 150 hours of approved and documented AOA Continuing Medical Education credits within a three-year period, at least one-third of which shall be in their primary specialty (Category I or II). (This requirement will be implemented by the 1989-91 CME cycle).

In the event that a diplomate does not meet any of the above requirements, his/her certificate shall be automatically revoked.

Jurisdiction

Each certifying board has jurisdiction over particular specialties and/or subspecialties; they are listed below.

American Osteopathic Board on Fellowship of the American Academy of Osteopathy
- Fellow of the American Academy of Osteopathy

American Osteopathic Board of Anesthesiology
- Anesthesiology

American Osteopathic Board of Dermatology
- Dermatology

American Osteopathic Board of Emergency Medicine
- Emergency medicine

American Osteopathic Board of General Practice
- General practice

American Osteopathic Board of Internal Medicine
- Internal medicine
- Allergy/immunology
- Cardiology
- Endocrinology
- Gastroenterology
- Hematology
- Hematology/oncology
- Infectious diseases
- Medical diseases of the chest
- Nephrology
- Oncology
- Rheumatology

American Osteopathic Board of Neurology and Psychiatry
- Neurology
- Psychiatry
- Neurology and psychiatry
- Child psychiatry
- Child neurology

American Osteopathic Board of Nuclear Medicine
- Nuclear medicine

American Osteopathic Board of Obstetrics and Gynecology
- Obstetrics and gynecology

Gynecologic oncology
Maternal and fetal medicine
Reproductive endocrinology

American Osteopathic Board of Ophthalmology and Otorhinolaryngology
Ophthalmology
Otorhinolaryngology
Oro-facial plastic surgery
Otorhinolaryngology and oro-facial plastic surgery

American Osteopathic Board of Orthopedic Surgery
Orthopedic surgery
Hand surgery

American Osteopathic Board of Pathology
Laboratory medicine
Anatomic pathology
Anatomic pathology and laboratory medicine
Forensic pathology

American Osteopathic Board of Pediatrics
Pediatrics
Neonatology
Pediatric allergy/immunology
Pediatric cardiology
Pediatric hematology/oncology
Pediatric infectious diseases
Pediatric intensive care
Pediatric nephrology

American Osteopathic Board of Preventive Medicine
Preventive medicine/aerospace medicine
Preventive medicine/occupational-environmental medicine
Preventive medicine/public health

American Osteopathic Board of Proctology
Proctology

American Osteopathic Board of Radiology
Radiology
Diagnostic radiology
Radiation oncology

American Osteopathic Board of Rehabilitation Medicine
Rehabilitation medicine

American Osteopathic Board of Surgery
Surgery (general)
Neurological surgery
Plastic and reconstructive surgery
Thoracic cardiovascular surgery
Urological surgery
General vascular surgery

Examination dates

Additional information about certifying examinations, including application deadlines, can be obtained from the various certifying boards.

American Osteopathic Board on Fellowship of the American Academy of Osteopathy
21-23 Mar 1988, The Broadmoor, Colorado Springs, CO.

American Osteopathic Board of Anesthesiology
Written: 16 Oct 1987, Sheraton Tucson El Conquistador Resort Hotel, Tucson, AZ.
Oral: 17 Oct 1987, Sheraton Tucson El Conquistador Resort Hotel, Tucson, AZ.

American Osteopathic Board of Dermatology
4 Oct 1987, Orlando, FL.

American Osteopathic Board of Emergency Medicine
Oral: Oct 1987, Orlando, FL.
Written: Feb 1988, Chicago, IL.

American Osteopathic Board of General Practice
5-6 Oct 1987, Orlando, FL; Mar 1988, Jamaica (tentative).

American Osteopathic Board of Internal Medicine
Written, clinical, and oral: 15-16 Sept 1987, Palmer House Hotel, Chicago, IL; 15-16 Sept 1988, Palmer House Hotel, Chicago, IL.
Subspecialty: 13 Apr 1988, Palmer House Hotel, Chicago, IL.

American Osteopathic Board of Neurology and Psychiatry
5 Oct 1987, Orlando, FL; Spring 1988, Fort Worth, TX (tentative).

American Osteopathic Board of Nuclear Medicine
26 Mar 1988, Chicago, IL.

American Osteopathic Board of Ophthalmology and Otorhinolaryngology
15-17 Apr 1988, Hilton Head, SC.

American Osteopathic Board of Orthopedic Surgery
Written: 11 Mar 1988, Chicago, IL.
Clinical: June-August 1988.
Oral: 17 Oct 1987, Waikiki, HI.

American Osteopathic Board of Pathology
8-10 Apr 1988, Holiday Inn, City Centre, Chicago, IL.

American Osteopathic Board of Pediatrics
21-23 Oct 1987, Embassy Suites, Chicago, IL.

American Osteopathic Board of Preventive Medicine
Mar 1988, Mesa, AZ.

American Osteopathic Board of Proctology
26 Apr 1987, Tulsa, OK; Oct 1987, Hawaii.

American Osteopathic Board of Radiology
12-17 Mar 1988, Chicago, IL (tentative)

American Osteopathic Board of Rehabilitation Medicine
4-8 Oct 1987, Orlando, FL.

American Osteopathic Board of Surgery
16-17 Oct 1987, Sheraton Waikiki, Honolulu, HI.

FELLOW OF THE AAO

American Osteopathic Board on Fellowship of the American Academy of Osteopathy

Chairman: David A. Patriquin, DO
Vice-Chairman: Harold I. Magoun, Jr, DO
Secretary-Treasurer: Viola M. Frymann, DO
Executive Director: Mrs Vicki Dyson, 12 W Locust, PO Box 750, Newark, OH 43055 (614) 349-8701.
Members: Edna M. Lay, DO; James R. Stookey, DO

Requirements for certification

Section 1. To be eligible to receive certification from the American Osteopathic Board on Fellowship of the American Academy of Osteopathy, the applicant must meet the following minimum requirements:

a. The applicant must be a graduate of an osteopathic college approved by the American Osteopathic Association.

b. The applicant must be licensed to practice in a state, territory, province, or country.

c. The applicant must be able to show evidence of conformity to the standards set in the Code of Ethics of the American Osteopathic Association.

d. The applicant must have been a member in good standing of the American Osteopathic Association or the Canadian Osteopathic Association for a continous period of at least two years prior to the date of certification.

e. The applicant must have completed satisfactorily an internship of at least one year in a hospital approved for intern training by the American Osteopathic Association. The American Osteopathic Board on Fellowship of the American Academy of Osteopathy may accept a minimum of five years in general or specialty practice in lieu of one year of internship for those graduated in 1946 and prior thereto.

f. The applicant must have completed at least one year of an AOA-approved residency after the required one year of internship. The American Osteopathic Board on Fellowship of the American Academy of Osteopathy may modify this requirement by allowing credit for:

(i) An AOA-approved preceptor program of three years of no less than 2,700 hours; or

(ii) Five years of practice with documented credit of continuing medical education of 50 hours per year, 250 hours total, including at least 150 hours of programs sponsored by the American Academy of Osteopathy or approved by the certifying board. This training shall include active experience in the use of structural diagnosis and manipulative management in osteopathic medicine; and

(iii) Other equivalents may be established by the American Osteopathic Board on Fellowship of the American Academy of Osteopathy if approved by the Advisory Board and the Board of Trustees of the American Osteopathic Association.

g. The residency program shall be supplemented with four years of experience (clinical, teaching, research) before final certification can occur. In lieu of the above:

(i) A two-year residency program shall be supplemented with two years' experience.

(ii) A three-year preceptorship shall be supplemented with three years' experience.

(iii) A five-year practice fulfillment shall be supplemented with two years' experience.

h. The applicant must document his or her qualifications in the formal application. If the formal training practice requirements are in order, these will be so indicated on a formal application supplied to the applicant.

This will include documentation of training and evidence of contribution to the profession and to the development and use of the distinctive phases of osteopathic medicine.

i. The applicant must prepare and submit a scientific paper acceptable to the

American Osteopathic Board on Fellowship of the American Academy of Osteopathy and suitable for publication, as follows:

(i) Each applicant will be required to prepare a thesis outline, the subject and material of which must be approved by the American Osteopathic Board on Fellowship of the American Academy of Osteopathy prior to submission of the thesis; and

(ii) The thesis shall be on material resulting from original investigation, or on new and original application of knowledge derived from the author's practice and/or training program. The thesis should be considered suitable for professional publication; and

(iii) Sufficient copies shall be submitted to the secretary of the American Osteopathic Board on Fellowship of the American Academy of Osteopathy to permit distribution of the thesis to the members of the thesis and examination committees.

j. The applicant must prepare and submit a minimum of 15 case histories that document understanding of the neuromusculoskeletal system in health and disease.

k. The board shall establish individual eligibility of the candidates for examination.

l. A written examination and an oral-practical examination will be required of each applicant.

ANESTHESIOLOGY

American Osteopathic Board of Anesthesiology

Chairman: S. Stevon Kebabjian, DO
Vice-Chairman: Robert G. Bowman, DO
Secretary-Treasurer: Hyman Kahn, DO
Corresponding Secretary: Mrs Dolores Mannarelli, 3511 Bluejacket Dr, Lee's Summit, MO 64063 (816) 373-4700.
Members: Mary Lou Butterworth, DO; Irwin C. Gorenstein, DO; J.L. Margreiter, DO; William C. Wagner, DO.
Consultants: K. George Tomajan, DO; John E.P. Burns, DO.

Definition of specialty practice

For the purpose of the operation of the American Osteopathic Board of Anesthesiology, the following division of practice is defined.

Anesthesiology is the branch of medical science, art and practice concerned with the:

1. Use of pharmacologic agents and other methods for rendering the patient insensible to the pain and emotional stress of surgical and obstetric operations, and diagnostic and therapeutic procedures.

2. Medical evaluation and preparation of the patient prior to the administration of anesthetic agents.

3. Recognition, evaluation, and treatment of the physiologic responses coincident to the administration of anesthetic agents.

4. Care and management of intercurrent disease, before, during, and after the administration of anesthetic agents.

5. Recognition, evaluation, and treatment of complications related to the use of anesthetic agents.

6. Control of pain in patients with acute and chronic illnesses.

7. Care and management of patients unconscious from any cause.

8. Application of the principles and practice of anesthesiology to the care of the chronic and critically ill patient.

Requirements for certification

Section 1. The minimum requirements to be eligible to receive certification from the AOA through the American Osteopathic Board of Anesthesiology are as follows:

a. The applicant must be a graduate of an AOA-accredited college of osteopathic medicine.

b. The applicant must be licensed to practice in the state or territory where his practice is conducted.

c. The applicant must be able to show evidence of conformity to the standards set forth in the code of ethics of the American Osteopathic Association.

d. The applicant must have been a member in good standing of the American Osteopathic Association or the Canadian Osteopathic Association for the two years immediately prior to the date of certification.

e. The applicant must have satisfactorily completed an internship of at least one year in a hospital approved for intern training by the American Osteopathic Association.

f. The applicant must have satisfactorily completed a minimum of three years of AOA-approved formal training in anesthesiology after the required one year of AOA-approved internship.

g. It shall be the policy of the board to accept subspecialty training in anesthesiology taken in hospitals or institutions other than those approved for such training by the American Osteopathic Association as meeting the requirements of formal training subsequent to internship, providing at least two years of formal training in anesthesiology has been taken in a hospital approved by the American Osteopathic Association, and the balance of the training program has had prior approval by the Committee on Residency Training of the American Osteopathic College of Anesthesiologists, the Committee on Postdoctoral Training of the American Osteopathic Association, and the AOA Board of Trustees.

h. The applicant for the clinical examination shall have practiced as a specialist in anesthesiology for a period of at least one year subsequent to the completion of the required minimum of three years of formal training prior to 1 April of the year in which his application is submitted.

i. Following satisfactory compliance with the prescribed requirements for examination, the applicant is required to pass appropriate examinations planned to evaluate an understanding of the scientific bases of the problems involved in anesthesiology, familiarity with the current advances in anesthesiology, possession of sound judgment, and a high degree of skill in the diagnostic and therapeutic procedures involved in the practice of anesthesiology.

(i) Written, oral, and clinical examinations are conducted and required in the case of each applicant. The practical or clinical examinations are conducted only after the required year of practice has been completed.

(ii) The members of this board shall review, if not perform, the grading of each written and oral examination. The conduct of the clinical examination may be delegated to a committee of not fewer than two osteopathic physicians certified in anesthesiology by the American Osteopathic Association.

(iii) A full description of the method of conducting the examination is formulated in this board's regulations and requirements, and provision for re-examination is made.

(iv) Applicants desiring examination for certification are required to file an application which shall set forth the applicant's qualifications for examination as stated in paragraphs a. through g. in section 1 of this article. The procedure for filing applications is set forth in the regulations and requirements.

Section 2. Subject to the recommendation of the advisory board and to the approval of the AOA Board of Trustees, the board may require such further training in each of the fields coming under its jurisdiction as, in its judgment, such field may require, provided that the additional requirement for each field is clearly set forth in the regulations and requirements of this board. Additions to requirements shall go into effect one year subsequent to the announcement of such change.

Requirements for examination

Section 1. Each applicant for the *written* examination for certification in anesthesiology shall:

a. Make written request for the oral examination and pay an application fee determined by the Board.

b. Be available for a personal interview upon receiving notice from the corresponding secretary that such an interview is required.

c. Demonstrate eligibility for examination in any other manner required by the board.

d. Submit an application, required documentary evidence, and application fee to the corresponding secretary prior to *1 April* of the year in which the application is submitted. The signed application and all evidence submitted by an applicant shall remain the property of the board even though the application may be withdrawn. No part of the application fee may be returned.

e. If accepted for the written examination, the application fee determined by the board shall be the fee for the written examination.

Section 2. Each applicant for the *oral* examination for certification in anesthesiology shall:

a. Make written request for the oral examination and pay an application fee determined by the board.

b. Be available for a personal interview upon receiving notice from the corresponding secretary that such an interview is required.

c. Demonstrate that eligibility for examination has been or shall be achieved on or before *31 August*, and in any other manner required by the board.

d. Submit the request and application fee to the corresponding secretary on or before the date specified by the board prior to *1 April* of the year in which application is submitted.

e. If accepted for the oral examination, the application fee determined by the board shall be the fee for the oral examination.

Section 3. Each applicant for the *clinical* examination for certification in anesthesiology shall:

a. Make application on a form provided by the board. The applicant shall have the application endorsed by two diplomates of the board who are personally acquainted with the applicant and who can vouch for his anesthetic training, anesthetic experience, and personal character. The sponsors shall send their letters of recommendation directly to the corresponding secretary of the board.

b. Provide evidence to verify the AOA approval of the applicant's residency (program and each year of training). Verification must include:

(i)Osteopathic residents: A copy of the hospital resident certificate and a statement from the evaluating committee of the appropriate specialty college that the program has been approved as being *complete*.

(ii)Non-osteopathic residents: A copy of the AOA Board of Trustees letter granting approval of the program as being *complete* . (B-4/85)

c. Provide evidence that he has personally administered a minimum of 250 anesthetics of a diversified nature each year subsequent to completion of the required approved formal training. The determination of diversification of cases performed will be at the discretion of the board.

d. Submit a list of anesthetic procedures for the 12-month period specified by the board, giving the date, name of the hospital and case number, patient's initials, physical status, operative procedure, and anesthetics administered. This list shall be certified by the administrator or medical director of the hospital in which the anesthetics were administered.

The list shall be accompanied by a supplementary list in which the anesthetic procedures for the year are broken down into segregated totals indicating the number of each type of anesthetic administered by the applicant during the 12-month period. The totals of both lists must agree.

e. Submit a list and a report of pertinent factors where mortalities resulted in patients anesthetized by the applicant during the two year period specified by the board.

f. Present detailed case reports, acceptable to the board, of 25 anesthetics administered for major surgery, of a diversified nature, administered by the applicant within the past year. These reports shall include the preanesthetic evaluation of the patient, preoperative preparation, anesthetic agents administered, anesthetic record, recovery room record, postoperative follow-up, and final disposition of the case.

g. Be available for a personal interview upon receiving notice from the corresponding secretary that such an interview is required.

h. Demonstrate eligibility for examination in any other manner required by the board.

i. Submit the application, required documentary evidence, application fee plus deposit, lists of anesthetic procedures, lists of mortalities, case records, and letters of recommendation to the corresponding secretary prior to 1 April of the year in which his application is submitted.

j. The signed application and all evidence submitted by an applicant shall remain the property of the board even though the application may be withdrawn.

k. If accepted for the clinical examination, the expenses incurred by the clinical examiners in the conduct of the clinical examination shall be the fee for the clinical examination. No clinical examination shall be considered complete until the expenses of the clinical examiners have been paid.

Rules for the conduct of examination

All applicants shall be required to pass appropriate examinations planned to evaluate their understanding of the scientific basis of the problems involved, familiarity with current advances, possession of sound judgment and a high degree of skill in the diagnostic and administrative procedures involved in the practice of anesthesiology. The examinations shall be designed, constructed and conducted in such a manner as to evaluate the applicant's knowledge of the basic sciences, anesthetic principles and the osteopathic philosophy as it applies to the care and management of the anesthetized patient, and to determine the applicant's ability within a clinical setting.

Section 1. Written examination

The written examination may be taken on completion of the second year of the required three year formal training program and on compliance with the requirements for examination. Questions shall be of the multiple choice, completion, or short answer type based on factual information relating to the science of anesthetic practice, including the application of the basic sciences to anesthesiology. The written examination shall be designed to evaluate academic knowledge.

Section 2. Oral examination

The oral examination may be taken on completion of the required third year of formal training following successful completion of the written examination, and on compliance with the requirements for examination. Questions on practical, clinical problems shall be introduced by the examiners who may interject further questions at any time. The oral examination shall be designed to evaluate thought processes and ability to solve problems.

Section 3. Clinical examination

The clinical examination may be taken on completion of the required one year of specialty practice, following successful completion of the written and oral examinations, and on compliance with the requirements for examination. Failure to take the clinical examination within three years of passing the oral examination shall inactivate the applicant's file, and the certification process shall be terminated at the discretion of the board.

The clinical examination shall consist of not less than two appropriate anesthetic procedures of a diversified character. In addition, the clinical examiners shall request hospital charts selected from the list of anesthetic cases submitted by the applicant. These charts shall be reviewed with respect to consultation, preanesthetic evaluation and preparation, anesthesia record, postanesthetic management, recovery room record, and case termination.

The clinical examination shall be an evaluation of actual performance to determine the level of anesthetic specialty practice in relation to the standards expected of a diplomate of the board.

The clinical examination shall be conducted by at least two osteopathic physicians certified in anesthesiology by the American Osteopathic Association, and the following regulations shall be observed:

a. The corresponding secretary shall notify each applicant of the appointment of his clinical examiners. The clinical examination schedule shall be arranged between the clinical examiners. The captain of the examining team shall notify each applicant of the date on which the clinical examination is to be conducted.

b. Prior to the performance of the anesthetic procedures, the applicant shall provide each clinical examiner with:

(i) A list of all anesthetic procedures for the six-month period immediately preceding the clinical examination. This list shall include the date, name of the hospital and case number, patient's initials, physical status, operative procedure, and anesthetics administered.

(ii) A list and a report of pertinent factors where mortalities resulted in patients anesthetized by the applicant during the two-year period immediately preceding the clinical examination.

(iii) Copies of the preanesthetic preparation, laboratory tests, and evaluation of the choice of anesthetic agents and techniques made for each patient to be anesthetized in the clinical examination.

c. For the clinical examination, the applicant shall administer two anesthetic procedures of a diversified character. The clinical examiners shall observe these procedures and review the applicant's hospital records.

d. Within two weeks from the date of the clinical examination, the applicant shall provide each clinical examiner with a copy of the case record for each procedure performed, including the preanesthetic evaluation and preparation of the patient, anesthetic agents administered, anesthetic record, preoperative, intraoperative, and postoperative complications and management, postanesthesia recovery record, and postanesthesia follow-up to date of the patient's discharge from the hospital.

e. Each clinical examiner shall review the patient's records and prepare a detailed summary and evaluation of the clinical examination on report forms provided by the board, recording a grade of satisfactory or unsatisfactory. If unsatisfactory, a written explanation is required as part of the report.

f. The expenses incurred by the clinical examiners shall be borne by the applicant. The clinical examiners must submit their expense accounts to the corresponding secretary of the board for approval and payment. After these expense accounts have been approved, the accounts shall be paid from the funds of the board.

g. The total expenses for all clinical examinations for the year shall be divided equally among the applicants examined and each applicant shall be billed and remit to the corresponding secretary of the board. No clinical examination shall be considered complete until the expenses of the clinical examiners have been paid.

DERMATOLOGY

American Osteopathic Board of Dermatology

Chairman: Harry B. Elmets, DO
Vice-Chairman: David Brooks Walker, DO
Secretary-Treasurer: Thomas H. Bonino, DO, 25510 Plymouth Rd, Detroit, MI 48239 (313) 937-1200.
Members: Dudley W. Goetz, DO; David C. Horowitz, DO; Daniel Koprince, DO; Charles Hughes, DO.

Definition of specialty practice

For the purpose of the operation of this board the following division of practice is defined: The practice of dermatology consists of the diagnosis and treatment of diseases peculiar to the integument and its appendages in all its phases.

Requirements for certification

Section 1. To be eligible to receive certification through the board, the applicant must meet the following minimum requirements:

a. The applicant must be a graduate of an AOA-accredited college of osteopathic medicine.

b. The applicant must be licensed to practice in the state or territory where his/her practice is conducted.

c. The applicant must be able to show evidence of conformity to the standards set in the Code of Ethics of the American Osteopathic Association.

d. The applicant must have been a member in good standing of the American Osteopathic Association or the Canadian Osteopathic Association for a continuous period of at least two years immediately prior to the date of certification.

e. The applicant must have satisfactorily completed an internship of at least one year in a hospital approved for intern training by the American Osteopathic Association. Certifying boards may accept a minimum of five years in general practice in lieu of one year of internship for those who graduated in 1946 and prior thereto.

f. A period of three years of AOA-approved training related to the specialty of dermatology is required, after the required one year of internship, or its equivalent. This board may modify the requirement by allowing a credit of one year of training toward certification for each five years of practice in the same field for physicians who graduated prior to 1946, but in no case may such applicant be accepted for examination without at least one year of approved training. This training shall include: active experience in diagnosis and treatment in such amount and diversity that it will assure adequate training in the specialty of dermatology.

g. The applicant may be allowed to take the examination at the first annual meeting following the completion of the required three years of approved training providing the documentation is in order and completed by April of that year.

h. Following satisfactory compliance with the prescribed requirements for examination, the applicant is required to pass appropriate examinations planned to evaluate an understanding of the scientific bases of the problems involved in the specialty, familiarity with the current advances in the specialty of dermatology, and the possession of sound judgment and a high degree of skill in the diagnostic and therapeutic procedures involved in the practice of the specialty.

(i) Oral, written, and clinical examinations are conducted and required in the case of each applicant.

(ii) The members of this board shall personally review, if not perform, the grading of each written examination. The conduct of the clinical examination may be delegated to committees of not fewer than two individuals maturely qualified in the specialty.

(iii) A full description of the method of conducting the examination is formulated in this board's regulations and requirements, and provision for reexamination is made.

(iv) Applicants desiring examination for certification are required to file an application which shall set forth the applicant's qualifications for examination as stated in paragraphs a. through g. in section 1. The procedure for filing applications is set forth in the regulations and requirements.

Section 2. Subject to the recommendations of the advisory board and to the approval of the Board of Trustees of the American Osteopathic Association, the board of dermatology may require such further training in each of the specialty fields coming under its jurisdiction as in its judgment such field may require, provided that the additional requirements for each field are clearly set forth in the regulations and requirements of this board. Additions to requirements shall go into effect one year subsequent to the announcement of such change.

EMERGENCY MEDICINE

American Osteopathic Board of Emergency Medicine

Chairman: Robert Aranosian, DO
Vice-Chairman: Edward J. Sarama, DO
Secretary: John W. Becher, Jr, DO, 4150 City Ave, Philadelphia, PA 19131 (215) 581-6055.
Treasurer: Robert L. Hambrick, DO
Members: James A. Budzak, DO; Donald D. Cucchi, DO; Bruce D. Horton, DO; James F. Grate, DO.

Definition of specialty practice

For the purpose of the operation of the American Osteopathic Board of Emergency Medicine, the following division of practice is defined:

The practice of emergency medicine shall consist of and include the emergency medical care of patients including evaluation and correlation of neuromusculoskeletal dysfunction as they apply to the diagnosis and therapeutics of systematic disease and its application to the osteopathic concepts within this specialty.

Requirements for certification

Section 1. To be eligible to receive certification from the AOA through the American Osteopathic Board of Emergency Medicine, the applicant must meet the following minimum requirements:

a. The applicant must be a graduate of an AOA-accredited college of osteopathic medicine.

b. The applicant must be licensed to practice in the state or territory where his/her practice is conducted.

c. The applicant must be able to show evidence of conformity to the standards set in the Code of Ethics of the American Osteopathic Association.

d. The applicant must have been a member in good standing of the American Osteopathic Association or the Canadian Osteopathic Association for a continuous period of at least two years immediately prior to the date of certification.

e. The applicant must have satisfactorily completed an internship of at least one year in a hospital approved for intern training by the American Osteopathic Association. The board may accept a minimum of five years in general practice in lieu of one year of internship for those who graduated in 1946 and prior thereto.

f. A period of two years of approved training in emergency medicine after the required one year of internship or its equivalent. In lieu of this requirement this board makes modification as follows:

(i) An individual must have practiced in an emergency medicine service approved by the Evaluation Committee of the American College of Osteopathic Emergency Physicians on a full-time basis for five consecutive years, which must be initiated prior to 1 January 1981, and concluded immediately prior to making application for the certifying examination. This provision will terminate in 1986.

(ii) An individual must have practiced in an emergency medicine service approved by the Evaluation Committee of the American College of Osteopathic Emergency Physicians on a full-time basis* for seven consecutive years, which must be initiated prior to 1 January 1986, and concluded immediately prior to making application for the certifying examination. This provision will terminate in 1993.

**Full-time is a minimum of 36 hours per week in the practice of emergency medicine.*

Osteopathic hospitals

July 1987

THE HOSPITAL ACCREDITATION PROGRAM OF THE AMERICAN OSTEOPATHIC ASSOCIATION

The American Osteopathic Association (AOA), through its Committee on Hospital Accreditation (COHA), accredits acute care hospitals, alcohol treatment centers, ambulatory surgical care facilities, freestanding psychiatric facilities, and freestanding rehabilitation centers. Each of the above are accredited separately, based on standards approved by the AOA. Copies of these standards can be purchased by writing to the Order Department at the AOA or by calling (312) 280-5826. Prices range between $5-$15 for an accreditation standard manual, depending upon the specific manual requested.

Applications for AOA accreditation can be obtained by writing to the Division of Hospital Accreditation at the AOA or by calling (312) 280-5849. The procedural steps followed in applying for AOA accreditation are the same for all facilities. Once a completed application is received by the Division of Hospital Accreditation, a list of consultants is sent to the facility. The facility is required to select and contact an AOA-approved consultant to arrange an on-site visit for the purpose of evaluating its preparedness for AOA accreditation. The consultant's report gives information to the facility on what changes are necessary to comply with AOA requirements prior to the visit by the survey team. After the facility responds to the concerns mentioned in the consultant's report, the Division of Hospital Accreditation arranges for an on-site survey by a DO team captain and an administrator-surveyor, including a review of the pathology laboratory by a pathologist, when appropriate.

The on-site survey normally lasts two days and a report is generated and reviewed by the survey team with the facility's administration and staff. Facilities are required to submit a report to the Division of Hospital Accreditation of corrective action taken on all noted laboratory deficiencies within thirty (30) days, and a progress report demonstrating corrective measures to comply with AOA accreditation requirements in all other areas within sixty (60) days.

The COHA usually meets in March and October of each year to review survey reports. Facilities are notified directly after the meeting of the recommendation sent to the AOA Board of Trustees for final action. In the event the facility does not agree with a recommendation, it has the right of address to the Appeal Committee of the Committee on Hospital Accreditation. The time required to complete all steps for AOA accreditation varies, but the average length of time is approximately five to six months.

Hospitals are encouraged to apply for AOA accreditation. The federal Health Care Financing Administration recognizes AOA's hospital accreditation for participation in Medicaid and Medicare programs. Institutions interested in AOA-approved postdoctoral programs are required to have AOA hospital accreditation as a prerequisite. AOA hospital accreditation indicates that the hospital is accepted as an osteopathic institution.

WORD ABBREVIATIONS USED BELOW:

Admin = Administrator
Assoc = Associate
Assn = Association
Asst = Assistant
Bass = Bassinets
Bd = Board
CEO = Chief Executive Officer
Chair = Chairman
Coll = College
Comm = Community
Corp = Corporation
Ctr = Center
Dir = Director
DCME = Director of Continuing Medical Education
DME = Director of Medical Education
Educ = Education
Exec = Executive
Genl = General
H = Hospital(s)
Inc = Incorporated
M = Medical
Med = Medicine
Mem = Memorial
Ost = Osteopathic
Pres = President
Serv = Service
Sr = Senior
Univ = University
VP = Vice-President

INDEX TO HOSPITALS

This section lists hospitals two ways. The first is a quick reference index to institutions arranged alphabetically by name, accompanied by city and state.

The second list is organized alphabetically by state and city with more comprehensive information provided about the hospitals, their accreditation status, and their involvement in the postdoctoral training programs.

Afton Mem H: Afton, OK
Allentown Ost M Ctr: Allentown, PA
AMI/Southeastern M Ctr: North Miami Beach, FL
Aurora H Ost: Detroit, MI
Baptist M Ctr-Scottsdale: Scottsdale, AZ
Baptist M Ctr of New York: Brooklyn, NY
Bay Ost H: Bay City, MI
Bi-County Comm H (Ost), See Horizon Health Systems-Detroit Ost H Corp-Bi-County Comm H (Ost): Warren, MI
Botsford Genl H (Ost): Farmington Hills, MI
Brentwood H: Warrensville Heights, OH
Burbank Comm H: Burbank, CA
Cameron Comm H: Cameron, MO
Carrollwood Comm H: Tampa, FL
Carson City H (Ost): Carson City, MI
Chaffee Genl H: Chaffee, MO
Charles E. Still Ost H: Jefferson City, MO
Chicago Ost M Ctr: Chicago, IL
Citizens H of Commerce: Commerce, TX
Clare Comm H: Clare, MI
Clarion Ost Comm H: Clarion, PA
Comanche Comm H: Comanche, TX
Comm Genl Ost H: Harrisburg, PA
Comm H: Grand Junction, CO
Comm H M Ctr: Phoenix, AZ
Comm H of Lancaster: Lancaster, PA
Comm Mem H: Sturgis, ND
Concho County H: Eden, TX
Coney Island H: Brooklyn, NY
Continental H Suburban: Fort Worth, TX
Corpus Christi Ost H, Inc: Corpus Christi, TX
Corpus Christi Ost H Adolescent and Adult Care Units: Corpus Christi, TX
Cranston Genl H, Ost: Cranston, RI
Cuyahoga Falls Genl H: Cuyahoga Falls, OH
Dallas Fam H: Dallas, TX
Dallas/Fort Worth M Ctr-Grand Prairie: Grand Prairie, TX
Dallas Mem H: Dallas, TX
Davenport M Ctr: Davenport, IA
Delaware Valley M Ctr: Langhorne, PA
Des Moines Genl H: Des Moines, IA
Detroit Ost H, See Detroit Ost H Corp Detroit Ost H: Highland Park, MI
Detroit Ost H Corp-Detroit Ost H: Highland Park, MI
Detroit Ost H Corp-Riverside Ost H: Trenton, MI
Doctors Genl H: Plantation, FL
Doctors H: Houston, TX
Doctors H, Inc: Groves, TX
Doctors H, Inc of Stark County: Massillon, OH
Doctors H, North: Columbus, OH
Doctors H of Montclair: Montclair, CA
Doctors H of Nelsonville: Nelsonville, OH
Doctors H, West: Columbus, OH
Doctors Mem H: Tyler, TX
Eastmoreland H (Ost): Portland, OR
Eastway H: Houston, TX
Eisenhower M Ctr: Colorado Springs, CO
Enid Mem H: Enid, OK
Family H Ctr: Amarillo, TX
Fannin County H: Bonham, TX
Fifth Avenue M Ctr: Seattle, WA
Firelands Comm H/Decatur St Facility, Inc: Sandusky, OH
Firelands Comm H/Hayes Ave. Facility, Inc: Sandusky, OH
Flint Ost H: Flint, MI
Fisher-Titus M Ctr: Norwalk, OH
Fort Worth Ost M Ctr: Fort Worth, TX
Forum H & Convalescent Ctr Trenton: Trenton, TN
Garden City Ost H: Garden City, MI
Garden City Ost H-Brookfield Clinics, Inc: Garden City, MI
Golden Valley Mem H: Clinton, MO
Grandview H and M Ctr: Dayton, OH
Grim-Smith H & Clinic: Kirksville, MO
Harborside H, Inc: St Petersburg, FL

Bold face type indicates AOA accreditation

Harrison Comm H: Mount Clemens, MI
HCA Doctors H: Tucker, GA
Heights Genl H: Albuquerque, NM
Heritage H: Muskegon Heights, MI
Hermann Area District H: Hermann, MO
Hillcrest Health Ctr, Inc: Oklahoma City, OK
Hillside H: San Diego, CA
Hollywood Comm H: Hollywood, CA
Horizon Health Systems (Detroit Ost H Corp): Oak Park, MI
Horizon Health Systems-Detroit Ost H Corp-Bi-County Comm H (Ost): Warren, MI
H of the Ost M Ctr of Philadelphia: Philadelphia, PA
Humana H Palm Beaches: West Palm Beach, FL
Humana H South Broward: Hollywood, FL
Jackson Ost H: Jackson, MI
Jacksonville M Ctr: Jacksonville, FL
Kennedy M H at Saddle Brook: Saddle Brook, NJ
Kennedy Mem H-Univ M Ctr-Cherry Hill Division: Cherry Hill, NJ
Kennedy M H-Univ M Ctr-Corporate Offices: Stratford, NJ
Kennedy Mem H-Univ M Ctr-Stratford Division: Stratford, NJ
Kennedy Mem H-Univ M Ctr-Washington Township Division: Turnersville, NJ
Kirksville Ost M Ctr: Kirksville, MO
KOMC/Laughlin Pavilion: Kirksville, MO
Lakeside Comm H: Chicago, IL
Lakeside Ost H: Kansas City, MO
Lakeview H: Milwaukee, WI
Lansing Genl H, Ost: Lansing, MI
Livingston Comm H: Livingston, NJ
Manning Genl H: Manning, IA
Martin County H District: Stanton, TX
Massachusetts Ost H and M Ctr: Boston, MA
Massapequa Genl H: Seaford, Long Island, NY
M Ctr of Manchester: Manchester, TN
Mem H: York, PA
Menard H: Menard, TX
Mercy Forest Glen H: Canyonville, OR
Mesa Genl H M Ctr: Mesa, AZ
Mesquite Physicians H: Mesquite, TX
Metro Health Ctr: Erie, PA
Metropolitan Genl H, Inc: Pinellas Park, FL
Metropolitan H: Dallas, TX
Metropolitan H: Grand Rapids, MI
Metropolitan H: Philadelphia, PA
Metropolitan H-Central Division: Philadelphia, PA
Metropolitan H-Parkview Division: Philadelphia, PA
Metropolitan H-Springfield Division: Springfield, PA
Michiana Comm H, Inc: South Bend, IN
Michigan Ost M Ctr-Acute Care H: Detroit, MI
Michigan Ost M Ctr-Adult Mental Health Facility: Detroit, MI
Michigan Ost M Ctr-Corporate Offices: Detroit, MI
Michigan Ost M Ctr-Lakeshore Unit: Detroit, MI
Millcreek Comm H: Erie, PA
Mineola Genl H, Inc: Mineola, TX
Mineral Area Ost H: Farmington, MO
Moberly Regional M Ctr: Moberly, MO
Moots Ost H, Inc: Pryor, OK
Mount Clemens Genl H: Mount Clemens, MI
Muskegon Genl H: Muskegon, MI
New Berlin Mem H: New Berlin, WI
New Valley Ost H: Yakima, WA
Normandy Ost H-North: St Louis, MO
Normandy Ost H-South: St Louis, MO
Normandy Ost M Ctr of St Louis, Inc: St Louis, MO
Northeast Comm H: Bedord, TX
Northeastern Ohio Genl H: Madison, OH
Northwest Genl H: Detroit, MI
Northwest Genl H: Milwaukee, WI
Northwest M Ctr: Knoxville, TN
Oak Hill Ost H: Joplin, MO
Oakland Genl H, Ost: Madison Heights, MI
Oakwood Family H: Lubbock, TX
Oklahoma Ost H: Tulsa, OK
Olympia Fields Ost M Ctr: Olympia Fields, IL
OMNI H and M Ctr: Houston, TX
Ontario Comm H: Ontario, CA
Orchard Hills H: Belding, MI
Orlando Gen H: Orlando, FL
Ost H of Maine, Inc: Portland, ME
Otto C. Epp Mem H: Cincinnati, OH
Pacific H of Long Beach: Long Beach, CA
Park Lane M Ctr: Kansas City, MO
Parker Comm H: Parker, AZ
Parkview H: Toledo, OH
Peninsula H Ctr: Far Rockaway, NY
Peninsula M Ctr: Ormond Beach, FL
Phelps County Regional M Ctr: Rolla, MO
Phoenix Genl H: Phoenix, AZ
Pontiac Ost H: Pontiac, MI
Pulaski County Mem H: Waynesville, MO
Reynolds County Mem H: Ellington, MO
Richmond Heights Genl H: Richmond Heights, OH
Rio Hondo Mem H: Downey, CA
Riverside H: Wichita, KS
Riverside H: Wilmington, DE
Riverside Ost H, See Detroit Ost H Corp-Riverside Ost H: Trenton, MI
Rocky Mountain H: Denver, CO
St John and West Shore H: Westlake, OH
St Joseph's H-Division of the Catholic M Ctr of Brooklyn & Queens, Inc: Flushing, NY
Saint Lawrence H and Healthcare Serv: Lansing, MI
Saint Lawrence H-Dimondale Ctr: Dimondale, MI
Scotland County Mem H: Memphis, MO
Selby Genl H: Marietta, OH
Shenango Valley M Ctr: Farrell, PA
Sheridan Comm H (Ost): Sheridan, MI
Shorewood Ost H: Seattle, WA
South Barry County Mem District H: Cassville, MO
Treatment Ctr: South Charleston, WV
South Charleston Comm H, Inc: South Charleston, WV
Southfield Rehabilitation Center: Southfield, MI
Southview H and Family Health Ctr: Dayton, OH
Springfield Genl Ost H: Springfield, MO
Still (Charles E.) Ost H: See Charles E. Still Ost H: Jefferson City, MO
Suburban Genl H: Norristown, PA
Sun Coast H: Largo, FL
Sunnyside Comm H: Sunnyside, WA
Taylor H: Bangor, ME
Tigua Genl H: El Paso, TX
Traverse City Ost H: Traverse City, MI
Troy Comm H: Troy, PA
Tucson Genl H, Inc: Tucson, AZ
Union H: Union, NJ
United Comm H: Grove City, PA
Univ Genl H of Seminole: Seminole, FL
Univ H: Holly Hill, FL
Univ of Health Sciences Univ H: Kansas City, MO
Valley H: Pomona, CA
Visitors H: Buchanan, MI
Warren Genl H: Warren, OH
Waterville Ost H: Waterville, ME
Weirton Ost H, Inc: Weirton, WV
Wellington H and Clinic: Wellington, KS
Westchester Genl H: Miami, FL
Westview H: Indianapolis, IN
Wirth Ost H: Oakland City, IN
Youngstown Ost H Assn, Inc: Youngstown, OH

AOA HOSPITAL CLASSIFICATIONS

The Committee on Hospital Accreditation evaluates and recommends hospitals for *accreditation;* the Committee on Postdoctoral Training evaluates and recommends hospitals for *approval for intern and/or residency training.*

1. In the following list, the names of hospitals accredited by AOA are printed in boldfaced type.

2. Hospitals accredited and approved for intern and/or residency training have a "•" preceding their names. More information on the training programs offered by these hospitals is presented in the section, "Osteopathic postdoctoral training programs."

3. The names of other hospitals approved or licensed by controlling state agencies but not presently AOA accredited are printed in lightfaced type in the listing of Osteopathic Hospitals. *For further information on this material, contact the Division of Hospital Accreditation, American Osteopathic Association, 142 E Ontario St, Chicago, IL 60611.*

ARIZONA

MESA

• **Mesa General Hospital Medical Center** 515 N Mesa Dr 85201
Beds-145, Bass-10
Exec Dir: Mark Werber
DME: George W. Northup, DO
Dir, Serv Ost Med: George W. Northup, DO
M Dir: George W. Northup, DO
Tel (602) 969-9111

PARKER

Parker Community Hospital PO Box 1149, 85344
Beds-39, Bass-0
Admin: William G. Coe
Chief of Staff: Joseph E. Treon, DO
Tel (602) 669-9201

• Indicates AOA-approved postdoctoral training

HARRISBURG
• **Community General Osteopathic Hospital** 4300 Londonderry Rd PO Box 3000, 17105
Beds-157 (119 med/surg; 16 Gyn; 8 OB; 14 special care), Bass-17
Pres: George R. Strohl, Jr
DME: John E. Dougherty III, DO
Tel (717) 652-3000

LANCASTER
• **Community Hospital of Lancaster** PO Box 3002, 1100 East Orange St, 17604
Beds-202 (Short procedure unit-12), Bass-16
Pres: Joanne Judge Kiser, CPA, FHFMA
DME: Jeffrey N. Levine, DO
Dir, Serv Ost Med: H. Keith Weiss, DO
Pres M Staff: Jeffrey N. Levine, DO
Tel (717) 397-3711

LANGHORNE
• **Delaware Valley Medical Center** 200 Oxford Valley Rd 19047
Beds-173, Bass-0
Pres, Bd of Dir: Harry Glass, DO
Chief Operating Officer: Rocco Mastricolo
Tel (215) 750-3000

NORRISTOWN
• **Suburban General Hospital** 2701 DeKalb Pike 19401
Beds-153, Bass-12
Pres: Edward R. Solvibile, CPA
DME: Harold Schreiber, DO
M Dir: Paul C. Cipriano, DO
Tel (215) 278-2000

PHILADELPHIA
• **Hospital of the Osteopathic Medical Center of Philadelphia** 4150 City Ave 19131
Beds-200, Bass-28
Exec: Walter R. Brand
DME: Daniel L. Wisely, DO
Tel (215) 581-6262

Metropolitan Hospital
801 Arch St 19107
CEO: Stephen M. Patz
Chief M Officer: Albert Bonier, DO
Tel (215) 238-2000
(See also Metropolitan Hospital—Central Division, Philadelphia, PA; Metropolitan Hospital—Parkview Division, Philadelphia, PA; and Metropolitan Hospital—Springfield Division, Springfield, PA)

• **Metropolitan Hospital—Central Division** 201 N Eighth St 19106
Beds-215, Bass-18
Exec Dir: Michael Brossette
M Dir/DME: Stanley Schiff, DO
Chair, Ost Manipulative Med: Marvin Blumberg, DO
Tel (215) 238-2000

• **Metropolitan Hospital—Parkview Division** 1331 E Wyoming Ave 19124
Beds-231 (185 med/surg; 12 ICU-CCU; 12 maternity; 22 psychiatric), Bass-10
Exec Dir: Irvin Berland
M Dir/DME: Richard A. Anderson, DO
Tel (215) 537-7400

SPRINGFIELD
• **Metropolitan Hospital—Springfield Division** Sproul Rd & Thomson Ave 19064
Beds-122, Short Procedure Unit-8, Bass-8
CEO: Stephen Patz
Exec Dir: Gerald E. Pierson
M Dir/DME: A. Archie Feinstein, DO
Tel (215) 328-8700

TROY
Troy Community Hospital 100 John St 16947
Beds-45, Bass-0
CEO: Mark Webster
Tel (717) 297-2121

YORK
• **Memorial Hospital** PO Box M-118, 17405
325 S Belmont St 17403
Beds-162, Bass-14
Pres: Dennis P. Heinle
VP, M Affairs: Martin L. Lasky, DO
Tel (717) 843-8623

RHODE ISLAND

CRANSTON
• **Cranston General Hospital, Osteopathic** 1763 Broad St 02905
Beds-80, Bass-0
Admin: Elliot E. Benadon, FACOHA
DME: James W. Cole, DO
Tel (401) 781-9200

SOUTH DAKOTA

STURGIS
Community Memorial Hospital
2100 Davenport St 57785
Beds-37, ECF-84, Bass-9
Admin: Michael Penticoff
Tel (605) 347-2536

TENNESSEE

KNOXVILLE
Northwest Medical Center
5310 Western Ave 37921
Beds-25, Bass-0
Chief of Staff: Larry Zechman, DO
DME: John Thompson, DO
Tel (615) 584-9191

MANCHESTER
Medical Center of Manchester
Route #6, Box 6015, Interstate Dr 37355
Admin: Erby Lamons
Tel (615) 728-6354

TRENTON
Forum Hospital & Convalescent Center Trenton
2036 Hwy 45 By-Pass, PO Box 168, 38382
Beds-46 (CC beds-44), Bass-5
Admin: Ray Holmes
Tel (901) 855-4500

TEXAS

AMARILLO
Family Hospital Center 2828 SW 27th St, PO Box 7408, 79109
Beds-50, Bass-7
Exec Dir: Rodney Bailey, CPA
Dir, Serv Ost Med: Richard D. Chandler, DO
Tel (806) 358-3131

BEDFORD
• **Northeast Community Hospital** 1301 Airport Freeway 76021
Beds-200, Bass-16
Admin: Robert M. Martin
DME: Russell J. Martz, DO
Chief of Staff: Jim Linton, DO
Tel (817) 283-6700

BONHAM
Fannin County Hospital
504 Lipscomb 75418
Beds-65, Bass-6
Admin: Michael Mosely
Tel (214) 583-8585

COMANCHE
Comanche Community Hospital
211 S Austin 76442
Beds-25, Bass-5
Admin: Charley C. Latham
Tel (915) 356-2012

COMMERCE
Citizens Hospital of Commerce
2900 Sterling Hart Dr 75428
Beds-30
Admin: Mr J.F. Biggerstaff
Tel (214) 886-3161

CORPUS CHRISTI
• **Corpus Christi Osteopathic Hospital, Inc** 1502 Tarlton St 78415
Beds-140, (7 CCU/ICU), Bass-10
Admin: Robert R. Tamez
DME: Paul Wakim, DO
Tel (512) 886-2300

Corpus Christi Osteopathic Hospital Adolescent and Adult Care Units
1502 Tarlton St, PO Box 7807, 78415
Beds-46 (26 Adult, 20 Adolescent), Bass-0
Alcoholism and Drug Abuse Treatment Program Admin: Robert R. Tamez
Tel (512) 886-2300

DALLAS
Dallas Family Hospital 2929 S Hampton Rd 75224
Beds-104, Bass-0
Exec Dir: vacant
Managing Dir: Mr C.P. O'Connor
DME: Timothy Sullivan, DO
M Dir: A.R. Young, DO

• **Dallas Memorial Hospital** 5003 Ross Ave 75206
Beds-167, Bass-12
Admin: Mr J.J. FitzGerald
DME: John W. Wilson, DO
Tel (214) 824-3071

Metropolitan Hospital 7525 Scyene Rd 75227
Beds-137, Bass-10
Admin: Steven J. Peterson
DME: Peggy J. Yurkon, DO
Tel (214) 381-7171

EXHIBIT 5: OBJECTIVES AND REQUIREMENTS OF THE RESIDENCY TRAINING PROG
IN ANESTHESIOLOGY - METROPOLITAN HOSPITAL- PARKVIEW DIVIS
PHILADELPHIA, PA

METROPOLITAN HOSPITAL
Parkview Division

1331 East Wyoming Avenue
Philadelphia, Pennsylvania 19124
(215) 537-7400

RESIDENCY TRAINING PROGRAM IN ANESTHESIOLOGY

OBJECTIVES:

1.) To provide training and education in the specialty of Anesthesiology to qualified Osteopathic physicians, in preparation for the practice of Anesthesiology.

2.) To present the basic requirements toward eventual certification by the American Osteopathic Board of Anesthesiology and the American Osteopathic Association.

3.) The Chairman of the Department of Anesthesiology shall be directly responsible for the training of residents in Anesthesiology.

4.) The residency program shall be under the supervision of the Medical Education Committee.

REQUIREMENTS:

1.) The candidate must be a graduate of an approved Osteopathic College.

2.) The candidate must have satisfactorily completed a rotating internship of no less than ONE year, in a hospital approved by the Committee on Hospitals and the Board of Trustees of the American Osteopathic Association (A.O.A.), OR, in a hospital acceptable to the American Osteopathic College of Anesthesiologists (A.O.C.A.) and the American Osteopathic Board of Anesthesiology (A.O.B.A.).

3.) The candiate must be licensed to practice medicine and surgery in Pennsylvania, OR, must recieve permission from the State Board of Medical Examiners to practice in Pennsylvania while in residency training at Metropolitan Hospital - Parkview Division.

4.) The candiate must be acceptable to the Chairman of the Department of Anesthesiology, who shall so signify, in writing, to the Medical Executive Committee of the Medical Staff.

5.) Completed application must be submitted to the residency trainer for his/her review and approval. It also must be reviewed by the Medical Education Committee.

6.) Approval must be granted by the Medical Executive Committee of the Staff.

7. Notification shall be made to successful candidates, to the A.O.B.A. and to the A.O.A., in proper form and time.

PROGRAM:

This program recognizes that the resident in Anesthesiology is a physician, and every effort will be made to utilize all of his/her previous training in preparing him/her for the specialty of Anesthesiology.

DURATION of the program shall be TWO (2) years. Satisfactory completion of the FIRST YEAR shall be a requirement for the privilege of recieving an appointment for a second year; at the discretion of the Chairman of the Department.

BASIC SCIENCES: It is planned to have the resident in Anesthesiology take TWO (2) weeks in each of the years of residency in order to obtain a well-rounded exposure to the Basic Sciences. This program will provide 160 hours and includes Anatomy, Biochemistry, Physiology, Pharmacology, Pathology, Bacteriology, etc.

OTHER POST-GRADUATE WORK:

1.) Review courses as presented by members of the staff of Parkview Division, i.e.: Fluids and Electrolyte Balance, ECG Conferences, etc.

2.) Professional staff meeting attendance is required, i.e.: Surgical Staff, Anesthesiology Staff, General Staff, Pathology Conferences, etc.

3.) Attendance at meetings of the American Osteopathic College of Anesthesiologists. The resident will be encouraged and assisted in qualifying for membership.

4.) Attendance at regional meetings of the American Society of Anesthesiologists, is encouraged.

5.) The resident will actively participate in the training of interns and of his fellow residents, i.e.: Surgical, Obstetrics, etc.

6.) Scientific Papers: The resident will be required to present at least ONE (1) paper. This paper shall be on a subject selected by the resident and the Head of the Department and/or trainer, and shall be written and preparted as for publication. If the paper is presented for publication, the head of the Department shall appear as one of the authors.

ADDENDUM:

7.) Outside rotations in Open Heart Techniques, Pediatric Anesthesia, Pulmonary Medicine will be available to the resident.

8.) Conferences at the University of Pennsylvania on a weekly basis in regards to Case Management.

9.) Attendance at an approved course in Cardiopulmonary Resuscitation.

10.) Participation in the hospital's Disaster Plan.

11.) Attendance and participation in scheduled lectures given by the Department of Anesthesia.

PRE AND POST-OPERATIVE CARE:

The resident shall be required to evaluate each patient scheduled for surgery. He/She shall participate in the pre-operative preparation of the patient jointly with the surgical resident. He/She shall make a pre-operative visit and examine each patient.

He/She shall be instructed in and participate in the explanation of the anesthesia contemplated to the patient.

He/She shall be instructed in and will participate in the pre-medication of patients.

He/She shall make post-operative visits to patients until they are free of any complications attributable to anesthesia. In post-operative complications he/she shall discuss the same with the Chief of the Department or other members of the Department and shall carry out and/or supervise the treatment.

PATHOLOGY AND LABORATORY:

The resident shall participate in the educational programs as presented by the Department of Pathology and Laboratory. He/She shall be required to attend necropsies whenever possible. Attendance at all necropsics on patients who expire within twenty-four (24) hours of surgery and anesthesia is mandatory.

He/She shall participate in the work of the Mortality Review Committee of the medical staff.

By study in the laboratories and reading, he/she shall become proficient in fluid and electrolyte problems and their management, and with the problems associated with transfusions, etc. Instruction will be given in the recognition and management of disturbed protein balance, disturbed electrolyte and fluid balance, prothrombin deficiencies, hemorrhage, shock, adrenocortical deficiency and/or exhaustion, etc.

MEDICAL SERVICE:

The resident will participate in conferences with the Department of Internal Medicine in instances of patients having medical complications for the purpose of appreciating the problems he/she will confront in the anesthetic pre and post operative management of these patients.

The Department of Internal Medicine will be expected to intruct the resident in their recommendations in regards to management of cardiacs, arrythmias, diabetics, asthmatics, etc. They will provide the resident an appreciation of ECG studies and their significance.

RADIOLOGY:

There will be coordinated efforts made to evaluate patients with the assistance of the Department of Radiology, problems of ventilation, airway distortions, etc., will be evaluated jointly. The residents will be instructed in techniques assigned to facilitate Operating Room, Radiography, i.e.: cholangiograms, hip pinnings, etc.

OSTEOPATHIC MANIPULATION THERAPY:

Instruction will be provided by the Department of Anesthesiology in the diagnosis and management of problems which are most readily managed by osteopathic manipulation pre and post-operatively. Osteopathic managment of post-operative segmental atelectasis and postspinal cephalgia will be demonstrated, etc.

READING PROGRAM:

The resident will be required to read and/or subscribe to the following journals:

A.) Anesthesia and Analgesia - Current Researches

B.) Regional Anesthesia

C.) Survey of Anesthesiology

D.) Journal of the American Osteopathic Association

E.) Yearbook of Anesthesia

In addition he/she will be required to participate in reading programs and journal club, etc., as be jointly established by the Department and/or the resident staff.

He/She shall have access to the basic textbooks as may be recommended by the Chief of the Department or trainer and shall be responsible for the material contained therein. In addition, he/she shall be responsible for such reading assignments as may be designated by the Department from time to time.

He/She shall have access to Audio Digest series of Anesthesiology tapes of the Department of Anesthesia.

RESIDENT'S LOG BOOK

The resident shall keep a continuing record during the entire period of his/her residency program which will be available both to his/her trainer and to the A.O.B.A. for verification.

This will consist, in essence, of Surgical and Anesthetic Statistics, Reading Program, conferences, lectures, etc., and number cases performed under supervision. This will be kept on a daily basis.

TRAINING PROGRAM:

FIRST YEAR: Assistantship with some work under supervision recommended is primarily spent in base institution. This will consist of basic science orientation, development of fundamental techniques and skills, and pre-and post-operative management of patients.

SECOND YEAR: Devoted primarily to work under supervision with the majority of outside rotations in selected specialty areas and assistantship in regards to any new techniques and modalities.

THIRD YEAR: (optional) Spent in the area of sub-specialization or post doctoral work.

Clinical training shall include, but not be limited to:

1.) Pre-operative medications: Chemistry, Pharmacology, indications, contra indications, dosage, etc. All drugs in this class will be reviewed.

2.) Drug interactions

3.) Fluids and Electrolytes: Chemistry, Physiology and management.

4.) Blood and Blood Component Therapy - Blood substitutes, selection, usage and management.

5.) Corticosteriods and their role in Anesthesia.

6.) Anesthetic Agents: Their chemistry, pharmacology, physiologic effects and rationale for usage.

   a.) Local anesthestic agents
   b.) Nitrous Oxide
   c.) Ethrane
   d.) Halothane
   e.) Penthrane
   f.) Forane
   g.) Narcotic techniques - Neurolept Anesthesia and Analgesia
   h.) Ketamine
   i.) Depolarizing and non-depolarizing muscle relaxants
   j.) Intravenous barbiturates
   k.) Intravenous Valium

7.) Anesthetic Techniques

   a.) Inhalation Techniques
      1.) Semiclosed and closed circle filter CO_2 absorption
      2.) Non-rebreathing techniques
      3.) Humidification

   b.) Endotracheal
      1.) Oral and nasal technique
      2.) Blind intubation
      3.) Use of Flexible Laryngoscope

   c.) Intravenous technique

   d.) Spinal Anesthesia - single dose, continuous technique, hypo and hyper-baric methods

   e.) Epidural and caudal technique both single does and continuous catheter.

   f.) Regional blocks (I.V. Regional, Axillary, Brachial Plexus blocks, Intercostal, Stellate Ganglion, etc.) diagnostic and therapeutic usage

g.) Hypotensive (controlled) Anesthesia

h.) Obstetrical Anesthesia - both Vaginal and C-Sections

i.) Techniques of Inhalation Therapy and Pulmonary Physiotherapy

j.) Vasopressor agents: Chemistry, Pharmacology and Interactions with medications

k.) Resuscitation: The role of the Anesthesiologist in Respiratory and Cardiac Arrest

l.) Medical-Legal considerations in Anesthesia

m.) Proper charting and anesthetic record keeping

n.) Proper positioning of patients

o.) Proper administration and supervision of Recovery Room area, Anesthesiology Department and Inhalation Department.

p.) Current state of the art advances in Anesthesia

This program is designed to produce a didactically and mechanically trained anesthesiology specialist capable of independent judgement and management and adaptive to the utilization of his or her skill in a cooperative effort with other specialty fields in the overall management of an individual patient.

IRVIN S. BERLAND
Administrator

RICHARD ANDERSON, D.O.
Medical Director, D.M.E.

CARL S. CROSS, D.O.
Co-Chairman, Dept. of Anesthesia

PETER F. ARINO, D.O.
Co-Chairman and Trainor,
Dept. of Anesthesia

Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

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MARCH 1, 1988
TESTIMONY ON H.B. 2984

Mr. Chairman and Members of the House Public Health Committee:

My name is Harold Riehm and I represent The Kansas Association of Osteopathic Medicine. I appear today in support of H.B. 2984. KAOM appreciates the Committee introducing this Bill at our request.

The Bill's specific aim is to require licensed Hospitals in Kansas to recognize Osteopathic residency training program and the accompanying requirements for board certification and board eligibility, as well as those that apply to the allopathic (M.D.) profession. Or, stated another way, to preclude discrimination against osteopathic residency training by specifically stating that only M.D. approved residency training will be accepted as a condition of obtaining hospital privileges.

Mr. Chairman, this can be a very complex description of conditions as they are changing today. Permit me to just list some of these developments and comment briefly on them.

(1) Residency training, once associated only with practicing in a speciality area, is now becoming a norm for practicing in the family or general practice areas also. But, in this development the D.O. profession had much farther to proceed, and the rate of change is much slower than in the M.D. profession. UNFORTUNATELY, the "penalties" for not being residency trained are becoming increasingly evident--most frequently in eligibility for malpractice insurance and in obtaining hospital practice privileges.

(2) KAOM has genuine concerns about the impact of immediate effects of requiring residency training in the general practice area, particularly when the requirement is made immediate while changes in training of general practititoners are in a state of change toward that end.

(3) H.B. 2984 does not address this general development. It does address a development potentially more detrimental to the osteopathic profession. If residency training, board certification, etc. is required for hospital privilege but only those approved by an M.D. approval body or mechanism are accepted, then D.O.s are automatically denied hospital privileges. This is what is the subject of H.B. 2984.

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3-1-8
PHHW

A SPECIFIC CASE

KAOM can not document how wide spread this problem is. We do know of two recent instances, one of which was resolved, and one which appears to be unresolvable. The latter includes these developments.

(1) A metropolitan hospital in Kansas requires residency training/board certification/ or board eligibility as a condition of obtaining hopsital privileges in its Department of Anesthesia. The rules and regulations for the Department, however, recognize only M.D. approved programs (i.e., certification by the American Board of Anesthesia, or those who qualify for examination for the American College of Anesthesiology.

(2) An osteopathic physician was approved for privileges by the Anesthesia Department but was turned down by the Hospital Executive Committee, on October 14, 1987. The reason stated was this:

> "The residency training you received, as documented in your application, does not meet the guidelines for membership in the Department of Anesthesia. These guidelines were adopted several years ago following approval by the Medical Staff Executive Committee and the Board of Directors."

(3) The osteopathic physician applying for privileges graduated from the Kansas City Osteopathic College in 1984, did a one year rotating internship at Orlando General Hospital, and a two year residency in anesthesiology at Metropolitan Hospital-Parkview Division, in Philadelphia, PA. At the time he did his residency training, the requirement was for only two years beyond the internship; that has subsequently been changed to three. This D.O. is now Board Eligible and will be certified upon taking and passing the required certification exam.

(4) The osteopathic profession has developed a broad and comprehensive approach to residency training. General requirements for all residencies must be approved by The Advisory Board for Osteopathic Specialists and Boards of Certification. Specific requirements for each of the specialty areas subject to approval by their respective Boards -- for example, in the area of anesthesiology, by The American Osteopathic Board of Anesthesiology. (This is the D.O. counterpart to the specific institution required for approval of a residency program that meet qualification for privilege in the above noted hospital.)

(5) KAOM attempted to work with the Hospital in resolving this conflict. No progress was made. Instead, it appears the hospital is proceeding to adopt new language that will preclude most all D.O.s from obtaining hospital privileges.

To require residency training applied equally to all physicians licensed to practice medicine and surgery in Kansas and with equal recognition of their respective residency programs is one matter. But to require residency training and not recognize the formal recognition process of those in osteopathic medicine, is clearly discriminatory. We welcome comparison of the respective residency training programs. Were such practices to become wide spread, including in the family or general practice areas, it could well mean a day in the not distant future when no osteopathic physician could obtain hospital privileges.

We gave considerable thought to the wording of this Bill--not wanting it to do either more or less than specifically address this problem. It perhaps could use some additional language that requires acceptance of the respective approval systems for residency approval, used both by the osteopathic and allopathic professions. We think, though, that this will address the matter. Should it pass and we later find it does not, we will again approach you for a solution. We consider this vital to the osteopathic profession in Kansas.

A separate bound handout offers deatils of Residency Training Requirements of the American Osteopathic Association; Osteopathic Postdoctoral Training Programs (list); Requirements for Certification - General and in Anesthesiology; and, Objectives and Requirements of the Residency Program in Anesthesiology of the D.O. in the example above.

STATE OF KANSAS

DEPARTMENT OF HEALTH AND ENVIRONMENT
Forbes Field
Topeka, Kansas 66620-0001
Phone (913) 296-1500

Mike Hayden, *Governor*

Stanley C. Grant, Ph.D., *Secretary*
Gary K. Hulett, Ph.D., *Under Secretary*

TESTIMONY PRESENTED TO

HOUSE JUDICIARY COMMITTEE

BY

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

House Bill 2984

Background

House Bill 2984 would amend KSA 65-431 which authorizes the Kansas Department of Health and Environment to adopt regulations pertaining to medical care facilities but restricts the promulgation of regulations "which would discriminate against any practitioner of the healing arts who is licensed to practice medicine and surgery in this state."

Although the department is restricted by current provisions of KSA 65-431 from promulgating regulations which would discriminate against any practitioner of the healing arts, hospitals are not prohibited from establishing criteria which might discriminate one branch of healing arts practitioners from the other. Therefore, House Bill 2984 would amend current law by requiring that:

> In the selection of professional staff members, no hospital licensed under KSA 65-425 et seq shall discriminate against any practitioner of the healing arts who is licensed to practice medicine and surgery in this state for reasons based solely upon the practitioner's branch of the healing arts or the school or health care facility in which the practitioner received medical schooling or postgraduate training.

Consistent with KSA 65-431, the Kansas Department of Health and Environment has not promulgated regulations which discriminate against any practitioner of the healing arts licensed to practice medicine and surgery. Kansas hospital regulations, in fact, define "physician" as: "A person holding a valid license from the Kansas State Board of Healing

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Arts to practice medicine and surgery" (KAR 28-34-1[12]). Kansas hospital regulations also define the authority and responsibility of governing bodies (KAR 28-34-5) and medical staff (KAR 28-34-6) in the selection of hospital staff. Historically, medical staffs have been composed of MDs and, to a lesser extent, DOs. However, in recent years, accrediting and regulatory agencies have expanded the definition of "medical staff" to include other practitioners. For example, the Joint Commission on the Accreditation of Health Care Organizations defines the characteristics of a medical staff to include "fully licensed physicians and may include other individuals permitted by law and by the hospital to provide patient care services independently in the hospital." Medicare certification requirements have similarly expanded the categories of practitioners who are eligible candidates for appointment to the medical staff.

As stated earlier, individual hospital boards of directors/trustees may currently adopt physician selection criteria which might tend to favor one branch of healing arts, schooling, or postgraduate training.

It should be noted that at Line 0032 on page one of the bill a reference is made to the authority of hospitals to select members of the professional staff "in accordance with law." It is assumed that this reference to "in accordance with law" does not have a specific substantive purpose but merely clarifies the fact that the governing authority of each hospital must exercise due care in the credentialing and privileging process. However, to the extent that this reference has some more specific meaning, the committee might want to explore that issue further.

Recommendations

The department believes that House Bill 2984 will have little direct impact upon its licensing responsibilities with respect to medical care facilities. It is not opposed to enactment of this legislation and it has not promulgated any regulations which discriminate among those practitioners who are licensed to practice medicine and surgery by the State Board of Healing Arts.

Presented by: Richard J. Morrissey, Director
Bureau of Adult and Child Care

March 1, 1988

Session of 1988

HOUSE BILL No. 2901

By Representative Brown

2-10

AN ACT concerning the food service and lodging act; requiring hotels to provide portable smoke detectors or rooms located in certain places in the hotel for deaf and hearing impaired guests.

Be it enacted by the Legislature of the State of Kansas:

Section 1. (a) Every licensed lodging establishment designated as a hotel shall provide to deaf and hearing impaired guests, upon request of such guests, portable smoke detectors of the type suitable for providing visual warning to such guests. ~~In lieu of providing such portable smoke detectors, the hotel shall provide deaf or hearing impaired guests with rooms on the lowest floor of such hotel on which guest rooms are located~~ and shall provide such rooms at a rate not more than the rate for rooms in other areas of the hotel which were requested by such guests.

(b) This section shall be part of and supplemental to the food service and lodging act.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

or motel

and vibrating

with devices

lodging establishments shall have available devices for 10% of their rooms provided no lodging establishment shall be required to have more than 10 or less than 2

Attm #7
3-1-8
DXHW