# DEAN'S CORNER E-NEWSLETTER

*Texas College of Osteopathic Medicine*
*September 12, 2003*

As the summer finally begins to cool off we have had our final official welcomes of the new academic year. The annual HSC "Ranchland" welcome party was another success, with the exception of the annual horseshoe match that pits me and President Blanck against Dean Yorio and Dr. McQueen. Dr. Blanck and I succumbed to the opposition as darkness set in. In addition, TOMA held their annual welcome pool party for the first year PA and DO students at Dr. and Mrs. Mark Baker's (Chair of Radiology) home.

Another important welcome, Dr. Bruce Dubin has joined the faculty of TCOM as the new Associate Dean of Medical Education. In that role he will be responsible for the advancement of the curriculum and faculty development for the DO and PA programs. He comes to us from the Virginia Institute of Technology's new osteopathic medical school, where he was responsible for developing their curriculum and assuring their initial accreditation. He is a board certified internist, with sub-specialty training in allergy, immunology, and asthma. He is also an attorney, pilot, and flight instructor. Please help me welcome Dr. Dubin and his wife Karen to the TCOM family!

I attended a press conference Monday in Washington, DC with former Secretary of Health and Human Services Louis Sullivan, MD, former US Surgeon General David Satcher, MD, President of the AAMC Jordan Cohen, MD, President of AACOM Douglas Wood, DO, PhD, myself and other members of the Advisory Committee for Pain Education. Our committee is responsible for the oversight and development of a web-based curriculum for medical students and residents for appropriate pain care. The program was announced at this press conference, along with plans to beta-test the program at Morehouse University's school of medicine, the University of Connecticut's college of medicine, and **TCOM!**

Once again welcome to all the new members of the TCOM family.

Please supply any pertinent information to my office (deantcom@hsc.unt.edu) by the second Thursday of the month, for inclusion in this Newsletter.

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**Student Affairs:** (Dr. Thomas Moorman)
Student EAP Established

The University of North Texas Health Science Center has entered into an agreement with CorpHealth, Inc to offer counseling and wellness services to our students through the newly designed Student EAP.
The Student EAP is coordinated by the Division of Student Affairs and available to all students, student spouses, and their dependents. The program is designed to provide immediate professional assistance for personal or emotional problems. These services are provided as a student benefit, and include assistance with marital, family, work-related conflicts, financial issues, stress management, and alcohol or drug abuse.

There is no cost to students or their immediate family members to use the service. The Student EAP provides up to six (6) counseling sessions with a professional EAP specialist. Your EAP professional will help you clarify the nature of your problem or concern and determine exactly what assistance you need to get you started in the right direction. Many times individuals receive what they need during the assessment and need no outside referral.

Any and all contacts you have with the Student EAP, whether on the telephone or in person, are strictly confidential within the limits specified by law. Student names, records, and other identifying information are not shared with the UNT Health Science Center without your direct written consent. The Helpline is accessible 24 hours a day, 7 days a week.

Help is only a phone call away . . .

Student EAP:
(817) 339-8936 (Out of area, then call us collect)

Ranchland Picnic: Fun for the Whole Family

The annual Ranchland Picnic, Friday, September 5, was a wonderful success. Over 300 students, faculty, and staff took advantage of the mild September temperatures and enjoyed horse & pony rides, sand lot volleyball, bingo, a bounce house, and a delicious fajita dinner. If you missed this event, you should make plans to attend next year. You will not regret it.

**Clinical Affairs / Faculty Practice:** (Dr. Robert Adams)
*Associate Dean for Clinical Affairs/Chief Medical Officer*

As many of you heard at the recent MSRDP meeting, the clinical practice achieved one of it's primary goals for FY 03 by ending the year with a positive net revenue. This is due to the hard work of everyone in the practice and all should feel a sense of satisfaction with what was accomplished.

The budget for the clinical practice has been completed for FY 04. The process this year was much more detailed and oriented toward expenses. Meetings with each of the departments will occur within the next month to discuss the budget process and how it relates to each of the providers. We have a established an excellent starting point to monitor expenses and better understand the financial needs of our practice. FY 04 will have it's own unique challenges, but with what we've learned during the past year, we should be ready.

Many of the faculty have asked about the changes to the charge master. Changes were made to coincide with the start of FY 04. The charge master should be reviewed and updated on a yearly basis. It's very important to review our payments against charges yearly if we are to receive maximum allowable reimbursement. If you have questions or have difficulty understanding why some of the changes occurred, please contact Randall Jones to discuss. The methodology used to determine the new charge master was sound, but it doesn't mean there aren't corrections that need to occur.

Thanks again for all of your efforts. We intend to move forward with our goal of providing you more information on a regular basis so that you have a better understanding of how your clinical practice is operating.

**Academic Affairs/Graduate Medical Education:** (Dr. Don Peska)
*Associate Dean for Academic Affairs*

**Competency……assessing the institution**. I attended the fourteenth annual congress on Osteopathic Medical Education sponsored by the American Osteopathic Association and the American Association of Colleges of Osteopathic Medicine. A novel perspective in competency training and assessment quietly emerged. Our students and residents pass quickly through our institutions. They take with them only a small amount of what we can offer. At best they learn how to learn and continue to educate themselves long after they're gone. What good do they get from our assessment of their competence after they graduate? Perhaps it provides them with some focus as to their strengths and weaknesses. Perhaps they will take the opportunity at some time to cultivate the former and remediate the latter. But our schools and hospitals gain the most. We learn from those that judge our "product" our strengths and weaknesses as educators, preceptors and mentors. We learn about our own competence to impart competence to others. Graduate medical education as a discipline has labored intently to incorporate competency training in the day-to day resident curriculum. Undergraduate programs seek to give their students a head start in this new culture. As accrediting bodies pour over our credentials in the future they will take note of the successes of our graduates. More so, however, they will ask important questions of our institutions: What are you doing to improve the quality of the experience in your facility? What measures do you have to be certain that you are competent to foster competence in others?.....Are we prepared to answer these questions?

**Medical Education:** (Dr. Bruce Dubin)
*Associate Dean for Medical Education*

The Changing Face of Medical Education

The Texas College of Osteopathic Medicine was well represented at a recent meeting of osteopathic medical educators in Chicago. This 14th meeting on osteopathic medical education was attended by John Bowling, DO., Don Peska, DO., Steve Buchanan, DO., and Bruce Dubin, DO - the new Associate Dean for Medical Education at the College. The incorporation of "core competencies" into pre and post doctoral curriculum was the theme of the meeting.

A curriculum is a dynamic and changing tool used in the education of physicians. Both the AOA and the American College of Graduate Medical Education have adopted the concept of tying core competencies to medical education in medical school and during residency training. As the

TCOM curriculum evolves, faculty and other members of the TCOM family have begun the process of defining and implementing core competencies of "excellence" into TCOM curricular design, teaching and assessment methods. This will be a lively process involving many aspects of the UNTHCS community and beyond. We will keep everyone abreast of this process as it develops.

**Clinical Research:** (Dr. Michael Clearfield)
*Associate Dean for Clinical Research*

The first meeting ot the newly formed Clinical and Scientific Research Club for the students of UNTHSC met on 9/10. There was good attendance with 32 students signing up for the club. I may be contacting some of you to assist as mentors for these students initial introduction into research. The final results for last fiscal year are being tallied but the clinical trials numbers are in and the clinical departments totalled $785,487. I want to congratulate all those who participated in this effort. We are on pace to meet our goals of $1 million in clinical trials for next year and $1.2 million the following year. I will hopefully have all the research data to present by the next report. Again, thank you all for a very productive year in research.

**PA Studies:** (PA Hank Lemke)

**October 6th is National PA Day**
Physician Assistants and PA students throughout the US and UNTHSC will celebrate National PA Day on Friday, October 6. The UNTHSC PA Student Association is planning many special activities which we hope you will support and attend.

On October 6th the first three graduate PAs in the country received their PA diploma (actually certificate) from Duke University. UNTHSC graduated its first PA class in 1999 and its first group of MPAS students in 2003. Today we have 56 alumni and over 80 enrolled PA students.

**NOVEMBER 15th is the Deadline for PA Program Application**
The PA program is already receiving applications for the PA Class of 2007 through the on-line application service. Applicants must complete the on-line application at www.caspaonline.org and a supplemental application at https://www.hsc.unt.edu/paapplication. Interviews are already scheduled to begin so applicants who complete their materials early have a better opportunity to receive an invitation. The last of three "Open House" application information sessions is scheduled for Saturday September 27th from 9:00 am to 12:00 noon in Room 506 on campus. Please contact the Admissions Office if you or someone you know would like to attend.

**PA Jobs**
Recently, the American Academy of Physician Assistants (AAPA) published information that highlights the importance of networking and marketing skills for our graduates. The AAPA reports that, "PA jobs continue to be almost evenly divided between new positions and those in which a PA is replacing another PA." Forty percent of respondents surveyed in 2002 reported they were the first to hold their current job. Half of the respondents were the first to hold their current job in solo-physician practices and 46% were the first to hold their current job in group practices. Throughout the curriculum, UNTHSC PA students receive education and information on contracting for a position as well as the importance of networking and finding the right

practice opportunity. The PA program is in the third of a 3- year grant from **HRSA** which helps support these activities

## Science and Health News:

### In Texas - Tempers flare at rally as groups clash over move to limit damages

FORT WORTH - Medical students in white coats had a tense confrontation with union leaders carrying picket signs during a campaign rally for the passage of a state constitutional amendment limiting medical malpractice awards. More than 100 interns, residents and doctors rallied at Como Elementary School, an early voting site on the city's southwest side, to speak out for Proposition 12, one of 22 constitutional amendments on the Sept. 13 ballot. Physicians, nurses, and hospital and nursing home executives say the amendment -- which would limit noneconomic damages for such things as pain and suffering -- is necessary to make health care more affordable and accessible in Texas. "We will not be silenced," Dr. John Durand shouted from a tiny stage to the medical students, who were surrounded by yelling union members who oppose the amendment. Durand is chairman of the Tarrant County Medical Society's Liability Reform Committee. Tempers flared between the two groups, but no violence was reported. Grade-school children being dismissed from school were led around the loud gaggle. Glena Davis, a first-year student at the University of North Texas Health Science Center, said that when she finishes studying obstetrics and gynecology, she'll have to pay $700,000 in insurance if the rate increases don't stop. "I'm concerned that my insurance costs will keep going up 100 percent to 300 percent a year," she said. Lawyers, union leaders, consumer and senior citizens groups, and others argue that Proposition 12 does not promise a drop in insurance rates but would rob Texans of a fundamental right to a trial by judge or jury. Tim Raiter, a union liaison with Doctors Council of Texas, said there are no guarantees that the insurance carriers will lower premiums if Proposition 12 is passed. He said he doesn't trust politicians to regulate the industry. Union leaders are also concerned because the amendment would give lawmakers authority to set similar limits in other types of lawsuits. Awards for actual damages, such as medical bills and lost wages, would not be limited."We don't want to see awards regulated by the state," Raiter said. "It should be the decision of a judge and jury." But Dr. Steve Brotherton, an orthopedic surgeon, said something must be done. He recently scaled his practice back -- he no longer conducts spinal surgeries -- because his premiums jumped from $40,000 a year to $90,000. "The opposition says they believe in tort reform, they believe in doctors, but they don't have another answer," Brotherton said. Proposition 12 is a companion to a law that took effect Monday. The new law caps noneconomic damages at $250,000 for doctors, hospitals and other institutions. It also sets a $750,000 total. The dispute over the amendment has spilled over onto radio and television, with both sides airing attack ads. Proposition 12 supporters attack personal injury trial lawyers. The amendment's foes blame the insurance companies. Save Texas Courts, the leading group opposing the amendment, began broadcasting on how an influential Houston legislator was able to collect on a questionable insurance claim. State Rep. Joe Nixon, author of the bill that includes the lawsuit limits, received $300,000 from Farmers Insurance on a mold claim. A Farmer's employee complained that the claim wasn't covered but was paid nonetheless. Nixon and Farmers executives have said the claims were legitimate. But a Travis County grand jury is investigating. "It shows how desperate the personal injury trial lawyers and their allies are and shows that they are losing the Proposition 12 debate," said Ray Sullivan, a spokesman for Yes on 12.

### Health Care Marketplace | Health Insurance Premiums Rose 13.9% in 2003, Marking Third Straight Year of Double-Digit Increases, Survey Says

[Sep 10, 2003]

Private health insurance premiums rose 13.9% between the spring of 2002 and the spring of 2003, the third consecutive year of double-digit premium increases and the largest such increase since 1990, according to a survey by the Kaiser Family Foundation and the Health Research and Educational Trust, *USA Today* reports (Appleby, *USA Today*, 9/10). The 2003 Annual Employer Health Benefits Survey, which was conducted between January 2003 and May 2003, includes responses from 2,808 public and private firms, ranging in size from three to more than 300,000 employees (KFF release, 9/9). Factors behind the increase include higher prices for hospital care, prescription drugs and other services; higher use of medical care; and patients' preference for less-

restrictive managed care plans, *USA Today* reports (*USA Today*, 9/10). Health care costs increased six times as fast as the estimated inflation rate for the rest of the economy, the *Philadelphia Inquirer* reports (Pugh, *Philadelphia Inquirer*, 9/10). Despite the rise in health insurance costs, 66% of companies provided health benefits in 2003, about the same as did in 2002, the survey says (Fuhrmans, *Wall Street Journal*, 9/10). The survey finds that average private health plan premiums rose to $3,383 for individual coverage, with employers paying 84% of the cost on average. Average premiums for family coverage rose to $9,068, with employers paying 73% of that cost on average (Vrana, *Los Angeles Times*, 9/10).

**Worker Payments on the Rise**

According to the survey, employees' portion of premium costs continued to grow in 2003; employees with individual coverage paid an average of $508 per year in premiums, up 52% from $334 in 2000 (KFF release, 9/9). Employees with family coverage paid an average of $2,412 this year, up 49% from $1,619 in 2000 (Brubaker, *Washington Post*, 9/10). The survey also says that 65% of companies increased employees' share of health costs in 2003. In addition, 79% of large firms said that they will increase workers' share of health costs in 2004, the *New York Times* reports (Freudenheim, *New York Times*, 9/10). In the future, 10% of firms said they would reduce eligibility and 16% said they would drop coverage entirely (KFF release, 9/9).

**More Findings**

Other findings from the survey include:

- About 62% of employers looked for different health plan arrangements in 2003, and 33% of those employers subsequently changed insurance carriers or plan types (*Los Angeles Times*, 9/10).
- Employees faced higher deductibles for out-of-network services in preferred provider plans, higher copayments for office visits in HMOs and higher copayments for prescription drugs in all plan types.
- About 38% of firms with 200 or more employees offered retired employees health insurance, a percentage unchanged from 2002 but down from 66% of all such firms in 1988 (*Washington Post*, 9/10).
- About 17% of firms with more than 5,000 employees offer a high-deductible plan -- a plan with a deductible of at least $1,000 for individual coverage -- and another 16% of such firms say the will add a high-deductible plan in 2004 (KFF release, 9/9).

**Reaction**

Drew Altman, president and CEO of the Kaiser Family Foundation, said, "Employers are between a rock and hard place. They're trying to hang on to insurance as best they can and they're eating some of those costs, but they're also passing on more and more costs to their employees" (Colliver, *San Francisco Chronicle*, 9/10). Jon Gabel, vice president for Health Systems Studies at Health Research and Educational Trust, said, "Given the state of the economy and the rapid rate of inflation, I don't think we have seen the worst of increased cost sharing with employees" (*New York Times*, 9/10). Mary Pittman, Health Research and Educational Trust president, said the aging baby boomer generation has contributed to increasing health costs, as baby boomers are receiving more health services now than ever before. She added, "We will continue to see that drive cost and utilization" (Dorschner, *Miami Herald*, 9/10).

**Future Costs, Response**

Paul Ginsburg, president of the Center for Studying Health System Change, said that the reason so few companies ended employee health benefits in 2003 is because they were able to pass some of the costs on to workers (*USA Today*, 9/10). However, Diane Swonk, chief economist at Bank One, said that companies are "only able to ladle a portion" of increasing health insurance costs to workers and

that many companies have found it difficult "to keep up with the sheer magnitude of the increases" in health insurance costs over the last several years. "I think this is one of the key reasons why businesses are not hiring, despite the improvements in demand and production," Mark Zandi, chief economist at Economy.com, said, adding, "It's not just the recent health care premium increases. ... It's the prospect that those premiums will be rising as quickly long into the future" (Marshall, Long Island *Newsday*, 9/10). "People have become used to the idea that health care costs continue to go up very rapidly, faster than their wages and faster than inflation," Gary Claxton, a Kaiser Family Foundation vice president and director of its Healthcare Marketplace Project, said, adding, "All we can say is that they are going to keep going up, period" (*Los Angeles Times*, 9/10). "There's a lot of uncertainty about what to do" about the increasing costs, Claxton added (Rovner, *CongressDaily*, 9/9). Altman said, "We're still a long way from a new big answer or a solution to this problem" (*USA Today*, 9/10).

**Resources**

The survey and other materials are available online. The survey also appears in the September/October 2003 issue of *Health Affairs*. A webcast of a briefing to release the survey also is available online. Claxton is scheduled to discuss the study Sept. 10 in an online chat on washingtonpost.com at 2 p.m. Questions and comments may be submitted prior to the beginning of the chat.

## Health Policy News:

### CMS to publish final EMTALA rule

The Centers for Medicare and Medicaid Services (CMS) plans to publish the final rule on the Emergency Medical Treatment and Labor Act (EMTALA) in the Sept. 9 Federal Register. EMTALA requires a hospital to provide an appropriate medical screening examination to anyone who comes to an emergency department and requests treatment or an examination for a medical condition. If the person has an emergency medical condition, the hospital must either provide necessary stabilizing treatment or an appropriate transfer to another facility. The new rule defines an "emergency department" to mean any hospital or facility of the hospital, whether situated on or off the main hospital campus, that is licensed by the state as an emergency room or emergency department; is held out to the public as providing care for emergency medical conditions without requiring an appointment; and has provided at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis during its previous calendar year. The rule clarifies that EMTALA does not apply to individuals who come to off-campus outpatient clinics that do not routinely provide emergency services or to those who have begun to receive scheduled, non-emergency outpatient services at the main campus. The rule also does not apply after a patient has been seen, screened, and admitted for inpatient hospital services, unless the admission is made in bad faith to avoid the EMTALA requirements.The rule also permits hospital departments that are off-campus to provide the most effective way of caring for emergency patients - without requiring that the patient be moved to the main campus - when this would be best for the patient.

### HHS makes additional state bioterrorism funds available

The Department of Health and Human Services announced that an additional $1.4 billion has been made available to states, territories, and three metropolitan areas to help strengthen their capacity to respond to terrorism and other public health emergencies. The money will allow states to continue to upgrade and improve their hospitals and public health systems. The funding is awarded through two separate but interrelated cooperative agreements - $870 million from the Centers for Disease Control and Prevention to strengthen public health preparedness and $498 million from the Health Resources and Services Administration to address surge capacity at hospitals and other healthcare facilities. This funding follows the initial investment of $1.1 billion awarded to states for bioterrorism preparedness in FY 2003. Of this amount, states have spent about $563 million.

**British Doctors See Chaos as EU Cuts Working Hours**

LONDON (Reuters Health) - British hospitals face chaos when European legislation reduces junior doctors' hours from a maximum of 72 to 58 per week from August, according to a survey of doctors. BMA News, the membership magazine of the British Medical Association, said 69 percent of its 100-strong doctors' panel believed hospitals would be unable to cope as a result of the European Working Time Directive. "In extreme cases some patients may die," Kent hospital doctor Barnaby Rookwood told the magazine. Like many other countries, Britain is already short of doctors and nurses, making it even more difficult to cut the working week. The Department of Health is running pilot projects in different parts of England to find new ways of organising work schedules, but the poll findings suggest doctors are not convinced this will succeed. "We just need more doctors," said Cleveland consultant physician and nephrologist Rodney Cove-Smith. "In complex tertiary centers such as the one I work in, there is a need to have specialist and relatively experienced doctors available 24 hours a day. Even increased numbers (of junior doctors) would not solve the problem." Nottinghamshire consultant thoracic surgeon David Beggs said: "Our hospital is pioneering 58 hours -- but it is proving difficult, resulting in hostility and strain." Sheffield consultant anaesthetist Ian Barker said his hospital would cope at night but only at the expense of routine surgery during the day. Ewen Sim, joint deputy chairman of the BMA junior doctors committee, criticized government agencies' failure to regulate the number of patients or caseload intensity that is placed on hospital doctors. "We would like to work collaboratively with an agency in working out something to guide trusts to a safe deployment of doctors. We do not want to wait until there is a disaster," he said.

**U.S. May Stop Reimbursing Tenet Hospital**

The government has notified Tenet Healthcare that it will hold proceedings to bar what had once been one of its most profitable hospitals from federal health care programs, the company announced yesterday. The move comes after accusations that potentially hundreds of patients had unnecessary heart tests and surgery at the hospital, the Redding Medical Center in Redding, Calif. Tenet was notified late Wednesday by the office of the inspector general with the Department of Health and Human Services of plans to begin proceedings. Tenet has 35 days to submit documents and other evidence to prove that the bar is unnecessary, and it said in a statement yesterday that it would do so. In the notice, Tenet said in a statement, the inspector general's office said it made its decision after determining that Redding Medical Center had "furnished cardiology and cardiac services (including several cardiac catheterizations and coronary artery bypass grafts) that were medically unnecessary and failed to meet professionally recognized standards of health care." The government determined that the improper treatments and procedures were provided at least from 1999 through 2002. The investigation of Redding was disclosed last October, when agents with the F.B.I. raided the hospital and the offices of Dr. Chae Hyun Moon and Dr. Fidel Realyvasquez. Dr. Moon was chief of Redding's cardiology department; Dr. Realyvasquez was its top cardiac surgeon. Since then, the Redding cardiology program was effectively - albeit temporarily - shut down. Recently, Dr. Moon agreed to urrender his medical license pending resolution of the investigation. In August, Tenet agreed to a deal with the Justice Department and other federal agencies, under which it agreed to pay $54 million to settle accusations that it engaged in what is known as medical necessity fraud - billing health care programs for treatments or diagnostic tests that were unnecessary. Under the settlement's terms, however, the Department of Health and Human Services was allowed to continue its inquiry into whether the hospital should be barred from receiving reimbursement from Medicare and other federal health programs. Such a move could be financially devastating; American hospitals often depend on such payments for half of their revenue or more.
In its statement, Tenet said it would work with the government to ensure that the services provided by the hospital, a 269-bed facility that serves nine rural communities, would continue without interruption.

## Research and Funding Opportunities:

NIH Guide for Grants and Contracts - Week Of September 12, 2003
http://grants.nih.gov/grants/guide/2003/03.09.12/index.html

NOTICES

UPDATED AHRQ POLICY ON MINORITY SUPPLEMENTAL AWARDS TO GRANTS
(NOT-HS-04-025)
Agency for Healthcare Research and Quality
INDEX: HEALTHCARE RESEARCH, QUALITY
http://grants.nih.gov/grants/guide/notice-files/NOT-HS-04-025.html

REQUESTS FOR APPLICATIONS

PAUL B. BEESON CAREER DEVELOPMENT AWARDS IN AGING
(RFA-AG-04-004)
The John A. Hartford Foundation
The Atlantic Philanthropies
The Starr Foundation
National Institute on Aging
INDEX: JOHN A. HARTFORD FOUNDATION; ATLANTIC PHILANTHROPIES; STARR FOUNDATION;
AGING
http://grants.nih.gov/grants/guide/rfa-files/RFA-AG-04-004.html

THE ROLE OF AIR POLLUTANTS IN CARDIOVASCULAR DISEASE
(RFA-ES-03-010)
National Institute of Environmental Health Sciences
National Center for Environmental Research, Environmental Protection Agency
INDEX: ENVIRONMENTAL HEALTH SCIENCES; ENVIRONMENTAL RESEARCH, ENVIRONMENTAL PROTECTION AGENCY
http://grants.nih.gov/grants/guide/rfa-files/RFA-ES-03-010.html

DEVELOPMENT OF HIGH RESOLUTION PROBES FOR CELLULAR IMAGING
(RFA-GM-03-013)
National Institute of General Medical Sciences
National Institute of Biomedical Imaging and Bioengineering
National Human Genome Research Institute
INDEX: GENERAL MEDICAL SCIENCES; BIOMEDICAL IMAGING, BIOENGINEERING; HUMAN GENOME
http://grants.nih.gov/grants/guide/rfa-files/RFA-GM-03-013.html

MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES RESEARCH CENTERS 2004
(RFA-HD-03-027)
National Institute of Child Health and Human Development
INDEX: CHILD HEALTH, HUMAN DEVELOPMENT
http://grants.nih.gov/grants/guide/rfa-files/RFA-HD-03-027.html

NEUROLOGICAL INDICES OF LONG TERM SOLVENT EXPOSURE IN WORKERS
(RFA-OH-04-001)
National Institute for Occupational Safety and Health
Centers for Disease Control and Prevention
INDEX: OCCUPATIONAL SAFETY, HEALTH; DISEASE CONTROL, PREVENTION
http://grants.nih.gov/grants/guide/rfa-files/RFA-OH-04-001.html

PROGRAM ANNOUNCEMENTS

HEALTH PROMOTION AMONG RACIAL AND ETHNIC MINORITY MALES
(PA-03-170)
Agency for Health Research and Quality

National Institute of Nursing Research
National Institute on Aging
National Institute of Child Health and Human Development
National Institute of Diabetes and Digestive and Kidney Diseases
National Heart, Lung, and Blood Institute
Office of Behavioral and Social Sciences Research
Office of Disease Prevention
INDEX: HEALTH RESEARCH, QUALITY; NURSING; AGING; CHILD HEALTH, HUMAN DEVELOPMENT; DIABETES, DIGESTIVE, KIDNEY DISEASES; HEART, LUNG, BLOOD; BEHAVIORAL, SOCIAL SCIENCES; DISEASE PREVENTION
http://grants.nih.gov/grants/guide/pa-files/PA-03-170.html

## Quotes

The most tragic paradox of our time is to be found in the failure of nation-states to recognize the imperatives of internationalism.
Earl Warren

Each man must for himself alone decide what is right and what is wrong, which course is patriotic and which isn't. You cannot shirk this and be a man. To decide against your conviction is to be an unqualified and excusable traitor, both to yourself and to your country, let me label you as they may.
Mark Twain

It is not easy to see how the more extreme forms of nationalism can long survive when men have seen the Earth in its true perspective as a single small globe against the stars.
Arthur C. Clarke

Marc

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