
BULLETIN

Implementation Date on E&M Guidelines Delayed

The Health Care Financing Administration (HCFA) will delay the July implementation of the new Evaluation and Management (E&M) guidelines until problems can be resolved. No new date has been indicated at this time.

This announcement was made at the AMA sponsored meeting (April 27 in Chicago) attended by physicians and staff of the OSMA and several county medical societies.

HCFA also announced that physicians would not be punished for honest mistakes and that there would be no referral for sanction unless there was a pattern of knowing and willful mistakes.

The AMA has developed a proposed "New Framework" for the E&M Guidelines based on concerns expressed by Ohio physicians and others. The framework will be presented to the attendees for review and comment.

The framework includes such recommendations as:

- Simplifying history by allowing documentation of two to three history areas instead of requiring all three.

- Simplifying the examination criteria by eliminating shaded and unshaded sections, as well as distinctions between general multisystem and single-system exams.

The AMA is hoping to convince HCFA, once the guidelines are finalized, to implement them as a pilot project. Additional information on this issue will be available at a later date.

BULLETIN

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President's Page

Be Careful What You Ask For (you just may get it)

99212. NO, IT'S NOT A TV SHOW ABOUT HOLLYWOOD TEENAGERS. WE SHOULD ALL RECOGNIZE THESE NUMBERS AS CPT CODES which indicate levels of service for which physicians are reimbursed. And, unless you have been on a desert island somewhere, you are also aware of quite a controversy over physician coding.

Guidelines have been in existence since 1995 which delineate what information must be used to determine the level of coding. This came about for practical reasons, as there needed to be some mechanism of comparing what physicians (across practices) were charging their patients. For an established patient, these have typically been 99211, 99212, 99213, 99214, and 99215. Three areas must be evaluated, with their "level of service." The three areas are history, physical exam, and complexity of decision making.

No one actually enjoys this process, for it forces us to take time to document (for the inevitable audit, of course) and be consistent in our billing. It also can cause problems with patients who may have a 99213 visit one time and a 99214 visit the next time. ("Hey, Doc, how come you charged my wife more for her visit than mine? That just doesn't seem right!"). Plus, it tends to be a time-consuming matter to put what we do during an office visit down on paper in sufficient form that, in the event of an audit, we can prove that services were actually rendered.

Denise Bobovnyik, MD

I think we all agree philosophically that the level of service is an appropriate concept. I think we all feel that we do all of those things that are required at the various levels. It just becomes tedious (in terms of physician time) and expensive (in terms of staffing necessary) to actually document all of this.

Today there is an update to the E-M (evaluation and management) Guidelines. The numbers are the same for the levels of service. The three areas to be evaluated also remain the same. The difference is there are now very specific criteria which must be documented in each of the three areas to meet the various levels of service. You can no longer say, "I asked a lot of history questions and did a thorough exam, so this is a moderately complex visit and I will bill 99214."

Now you must show documentation of items such as chief complaint, history of present illness (including onset, duration, relieving measures, exacerbating measures, etc.) as well as do a "Chinese menu" documentation (one from column A, two from column B) of the physical exam. These new guidelines do two things - they give HCFA concrete items to look for during an audit, and give physicians what they have been asking for: clarification of the guidelines in order to prevent subjective interpretation of the rules.

As the saying goes, 'Be careful what you ask for...you just may get it'. Unfortunately, we got it **good**! The medical community is obviously up in arms about this, and rightly so. What most people don't realize is that these guidelines actually came from an AMA and HCFA collaboration, which came (in part) from us!

Because of the outpouring of criticism, HCFA has agreed to extend the implementation from this June until September. The AMA has also agreed to work on three areas: 1) Ensure that refinements to guidelines are comprehensive; 2) Educate physicians on the guidelines; and 3) Redo the "fraud and abuse" sections,

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From the Desk of the Editor

What Happened to the Physical Examination?

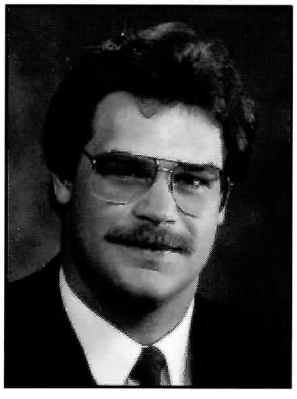
WELL, AFTER MY LAST EDITORIAL ON THE POLITICS OF MEDICINE, OR LACK THEREOF, I FELT COMPELLED TO scribble something of a more medical nature. It seems that over the years we have forgotten the importance of what used to be the mainstay of diagnosis in our country for centuries: the physical examination.

In my private practice, I see patients with a variety of complaints on a daily basis. Roughly 80% of the time, the chief complaint is back pain! Back pain is the most common ailment known to man, with a lifetime prevalence of 60-90% and an annual incidence of 5-10%. (Fortunately, 85-90% of back pain is resolved within the first 6-12 weeks.)

When patients come to my office, I begin my diagnostic work with the traditional history and physical exam. Inevitably, not even three minutes into the process, the dreaded "Aunt Millie syndrome" rears its ugly head. We have all heard it - "My Aunt Millie had back pain 10 years ago. She had an MRI and surgery that same day."

I try to explain that we need to take an accurate history and perform the appropriate physical examination before we can go on with any other testing. Another few minutes pass and the patient, who is becoming apprehensive about the situation, says, "Can't you just fix this thing. It's only back pain. It isn't like you're operating on my heart or something."

Ronald M. Yarab, Jr., MD



Ronald M. Yarab Jr. M.D.

I do my best to explain that less than 1% of back pain patients require surgery, and almost all will respond to conservative care. By this point, however, it is apparent that I am fighting a losing battle. Nevertheless, I begin my physical examination. "Ow," says the patient, "Why are you poking me with that pin and beating me with a hammer? It's my back that hurts, not my legs! Just get me an MRI and surgery and I'll be fine."

Unfortunately, in this golden age of medicine that we live in, our patients have come to expect passive forms of treatment and diagnostics. They wan MRIs for passive diagnosis; a pill or surgery for passive treatment; and then ultrasound or massage for passive rehabilitation. With the spread of information and technology, our patients are well-educated on the diagnostics and treatments, but not on their indications for use or limitations.

We all encounter situations like this on a daily basis. And some physicians are inclined to give in to their patients' requests and order unnecessary lab work and diagnostic tests. I try to stress to my patients that the cornerstone of medicine is the history and physical examination. Our patients need to be active participants in their own care.

Sir William Osler said, "learn to see, learn to hear, learn to feel, learn to smell and know that by practice alone you can become an expert." The ability to perform an accurate examination separates the physician from the other members of the health care community. Based solely on the history and physical, we can formulate a definitive treatment plan for our patients. No other health professionals have this knowledge or training.

In this era of cost-cutting and managed care, we need to focus more attention on training our physicians-to-be in the art of the history and physical examination. This will definitely increase their net worth in the future and secure the position of physicians as leaders of the health care industry.

Another "Oslerism" that seems to fit this situation is, "Never put anything between the

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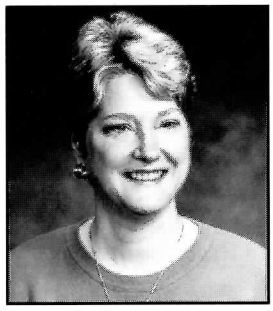
Dolly Handel receives "Gem of the Year" honors



Dolly Handel

The MCMS Alliance was pleased to present its "Gem of the Year" Award to Kathleen "Dolly" Handel at the annual combined dinner meeting of the Society and Alliance. The event, which also commemorated National Doctors' Day, was held at the Moonraker Restaurant in Boardman.

Dolly was born and raised in Cleveland, Ohio. She attended Cleveland State University, and received her bachelor's degree in elementary education. She moved to the Mahoning Valley in 1975.

She has been an Alliance member for many years, serving on numerous committees. She is a past president of both the MCMS Alliance and the OSMA Alliance, and has served on the membership committee of the AMA Alliance.

Dolly is a graduate of both the Leadership Youngstown and Leadership St. Elizabeth's programs. Active in community activities, she is a past president of the St. Elizabeth Hospital Junior Guild, and has served as an instructor for the American Cancer Society Tobacco Education program. She has also been a school volunteer.

She resides in Boardman with her husband, Dr. Daniel W. Handel. They have three adult sons: Daniel, Brendan, and Neville.

Medical Residents Report Mistreatment During Internship

ACCORDING TO A RECENT ARTICLE IN THE APRIL 15 ISSUE OF *THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION (JAMA)*, medical residents in Chicago say they experienced perceived mistreatment, discrimination, sexual harassment, and other problems during their internship.

Steven R. Daugherty, Ph.D., of the Rush Primary Care Institute and Rush Medical College, in Chicago, IL, and colleagues surveyed 1,277 second-year residents listed in the AMA's medical research and information database. Residents were asked about their first year of residency, with questions focusing on general satisfaction, on-call and sleep schedules, incidents of perceived mistreatment or abuse, observations of unethical behavior by others, and experiences with harassment or discrimination.

Of 1,185 residents responding, 93% reported experiencing at least one incident of perceived mistreatment. The highest percentage was recorded for public humiliation or belittlement, with attending faculty and residents at a higher level being mentioned most often as the source of the mistreatment.

When asked about perceived mistreatment that occurred on three or more occasions, 53% of residents reported that they were belittled or humiliated by senior residents, while 21% reported someone else taking credit for their work. More than 10% of the residents reported being given "tasks for punishment," "being slapped, pushed, kicked or hit," and having someone "threatening your reputation or career" as occurring on three or more occasions.

At least one episode of what they considered discrimination or sexual harassment was reported by 30% of the residents, while 63% of the female residents reported such incidents. For women, such harassment or discrimination was most commonly reported as sexual slurs or comments (35.8%), followed by favoritism (23.7%), sexual advances (16.4%), denied opportunities (15.9%) and poor evaluations (13.1%).

Among other findings of the survey:

- 45% of residents reported observing someone falsifying medical records.
- About 70% reported observing what they considered to be mistreatment of patients by other residents.
- 70% reported observing a colleague working in an impaired condition, with lack of sleep (56.9%) as the leading cause.
- Residents reported that they spent an average of 56.9 hours a week on call at the hospital, with 25% of residents reporting that they were on call more than 80 hours per week.
- 10% indicated that sleep deprivation was an almost daily occurrence.
- Overall, residents reported a moderate level of satisfaction with their internship, with an average rating of 4.56 (good) on a scale of one (poor) to seven (excellent).
- Residents reported the highest contribution to their learning came from other residents, with special patients ranked second.

The researchers suggest that satisfaction with residency is the result of the relationship between positive learning and negative work experience. "If residents feel mistreated during their contact with their superiors, but feel that they learn from this contact, they may well discount the short-term negatives of the experience and focus on the long-term benefits of the education they receive".

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AMA Response

According to Randolph D. Smoak, Jr., MD, vice chair of the AMA Board of Trustees, the AMA is troubled by the findings of the study. "Any incident of mistreatment of patients or residents is intolerable," he said. "As professionals, we have an ethical obligation to condemn and address these wrongs. As a leader in setting standards for professional conduct and medical education for over 150 years, the AMA accepts its obligation to act, and calls upon all other responsible parties to do the same."

Dr. Smoak called specifically upon physicians to "recommit themselves to the highest level of advocacy and personal conduct in their role as champion of the rights and well-being of patients and residents in training."

NEOUCOM researcher presented with award in Germany

HANS THEWISSEN, PH.D., ASSISTANT PROFESSOR OF ANATOMY AT THE NORTHEASTERN OHIO UNIVERSITIES COLlege of Medicine (NEOUCOM), recently visited Frankfurt, Germany, to receive the prestigious Alexander von Humboldt Prize in natural science. Thewissen and his two co-authors were the first American residents honored with this award.

The Alexander von Humboldt award is given annually for the best publication in a journal of the Natural History Society of the Senckenberg Museum in Frankfurt, Germany.

Hans Thewissen, Ph.D., assistant professor of anatomy at the Northeastern Ohio Universities College of Medicine (NEOUCOM), stands in front of the skeleton of a killer whale at the Senckenberg Museum in Frankfurt, Germany.

The Humboldt prize has been awarded in the past to scientists studying in almost all disciplines of the natural sciences, such as zoology, botany, paleontology, paleobotany and marine geology.

The award is named for the famous German natural history researcher Baron von Humboldt (1769-1859), who, in spite of ongoing wars in Europe, traveled widely in the different European colonies in South America. As a researcher, Humboldt gave many promising students financial assistance and a start in the scientific community to forward their careers.

Thewissen received the award as senior author for his monographic publication entitled *"Ambulocetus natans, an Eocene cetacean from Pakistan,"* which describes findings of an ancestor of modern whales that moved both on land and in water, whose Latin name means "the walking and swimming whale." This discovery provided a "missing link" between four-footed land animals and whales.

Thewissen, the project leader, and fellow researchers discovered the 50-million-year-old fossil in Pakistan in 1992.

Thewissen's find was first reported in the January 14, 1994 issue of *Science* Magazine. Additional articles were published in *Nature* Magazine in 1996 and 1997, and, most recently, in *Paleobiology* (November 1997). The monograph for which the award was given is the only publication that describes all known bones of Ambulocetus and analyzes in detail the way the animal once lived.

Thewissen's co-authors were Sandra Madar, Ph.D., assistant professor of biology at Hiram College in Hiram, Ohio, who earned her doctoral degree through the combined biomedical science programs of NEOUCOM and Kent State University; and Taseer Hussain, Ph.D., professor of anatomy at Howard University College of Medicine in Washington, D.C.

Thewissen came to NEOUCOM in 1993 from Duke University where he was a research associate in the Department of Biological Anthropology and Anatomy. He received both B.S. and M.S. degrees in biology from the University of Utrecht, the Netherlands. Thewissen earned a Ph.D from the University of Michigan.

A native of the Netherlands, he has done fieldwork in Pakistan since 1985, and is in India until April 8 to find more fossil whales.

Analyze Your Practice to Succeed Under Managed Care

Here's the best way to identify your benefits and demonstrate them to plans.

Address these subjects

WITH MANAGED CARE SO PREVALENT, PRACTICES MUST INCREASINGLY SELL THEMSELVES TO THE PLANS THEY want or need to contract with. Your main challenges: *identify* how a plan will benefit by sending you its patients and *demonstrate* those benefits.

And in highlighting your features, you must provide plan officials with objective evidence of both your clinical quality and ability to save the plan money. "Saying you're good is no longer enough; you've got to show it," noted urologist Neil Baum, MD, at the Medical Group Management Association's recent Annual Meeting. Dr. Baum accomplished this in his practice by conducting an internal "practice analysis" and presenting it in writing to officials of the plans he wants to attract.

The Process

Baum broke the challenge into four parts:

- Collect information
- Compile results
- Analyze and qualify results
- Present the results in a professional and attractive manner

You can do this in-house, hire an outside consultant or combine internal and external resources. For instance, consider asking an independent medical marketing advisor to help plan the undertaking and then have your manager or administrator gather and compile the needed information. The outside expert can then draft the brochure.

As we see it, this is an important project for an effective manager/administrator to undertake with only moderate oversight by the physician or physician-leader.

The Necessary Ingredients

Dr. Baum went on to list a whole host of subjects to develop for your practice analysis:

- **Credentials.** Include physicians' CME, publications and even testimonials from patients. Provide the same information about your non-doctor staff. And you might as well state your malpractice record, since the plans will obtain it anyway.

- **Patient profile.** Collect data by age and sex ratios, along with zip codes, and include a map of your service area to demonstrate it.

- **Office description.** Your staff, office hours (show distinct advantages in your schedule), exam rooms, procedures performed and hospital affiliations.

- **Hospital factors.** Give your hospitals' payer profile, among other things, and show that they understand how to handle managed care patients.

- **Value-added services.** Stress such things as your community services, wellness and

prevention efforts, extended office hours and whatever else you can identify to show you are patient-oriented.

- **Cost-effectiveness.** List your main procedures by CPT and/or RVUs (both office and hospital) and provide your cost per procedure. Dr. Baum obtained from his hospital specific data on his costs of handling key diagnoses and procedures, compared to other unnamed doctors in his specialty. And include outcomes data, like length of stay, complications, mortality and quality of life information.

- **Patient feedback.** Conduct patient surveys and report on them, of course, but also show your return rate (to the PCP, if you are a specialist), record of complaints to the plans, and how many of the plan's patients have transferred out of your practice. Conduct and report on surveys to your physician-referrers, too. If any survey items have a low score, take action on them and then report the improvement in an analysis update.

- **Records and documentation.** Indicate how you assure that all reports are initialed; your documentation of weekend care, call-backs and phone conversations; and your use of electronic charting (which we continually urge), patient education techniques and recall systems.

- **Staff performance and quality.** Employee manuals, weekly random chart review, periodic performance reviews and weekly staff meetings can all be noted. You might even include a sample staff meeting agenda to show how it focuses on what you want to impress upon plan officials.

- **Safety and special needs.** Though mundane, list your fire safety equipment, wheelchair access, staff CPR training, equipment sterilization policy and even when and how you check the crash cart. It's the sort of information that ends up in plans' accreditation reports, among other things.

- **Access to care and triage.** Show your telephone protocols, recall systems and management of no-shows. And describe fully how you define patients to be seen ASAP and how your entire triage process works. If you have a special triage nurse, say so and show his or her qualifications.

- **Medications.** How do you manage narcotics? If you dispense meds, tell how. Emphasize your policy of purging expired meds and your control over Rx pads.

So there is plenty to accumulate, develop and write up in a good practice analysis brochure. Make sure, adds Dr. Baum, to do all you can to develop and emphasize your practice profile of clinical information like utilization rate by diagnosis and cost per admission, for it will obviously be important to a plan. Where any of those factors are low, try to describe how you plan to improve them – better yet, how you are already improving them.

Finally, be sure the analysis emphasizes the unique characteristics distinguishing your practice from others in your area. Doing so helps show the advantages of contracting with you rather than a local competitor. While you may know you are the plan's best choice, following Dr. Baum's example helps make sure the key decision-makers know so, too.

Editorial Note: We acknowledge the cooperation of Leif Beck, who has granted reprint rights for topics which have appeared in his regular monthly publication, The Physician's Advisory. His organization, The Health Care Group, with offices in Plymouth Meeting, PA, is a group of leading national consultants and attorneys specializing in medical practice organization and management.

President's Page

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which are criminally punitive for simple billing errors.

Nowhere does it guarantee that any of these guidelines will be changed. However, several states (most notably California) are working especially hard on having the AMA revise the specific guidelines. I have a feeling that these guidelines are here to stay unless we take action.

As a physician in practice, you must do two things: First, look at these guidelines with an open mind. Determine how they will affect your practice and try to implement them. Only then can you do the second thing, which is to write to the AMA, HCFA, the legislature, your specialty society, and anyone you can think of, to tell them why these guidelines do (or do not) work for you in your practice. List any suggestions you have for altering these guidelines, and be specific about concerns you might have, such as time for patient care or financial costs for hiring additional personnel. Specific comments are more likely to lead to changes than general complaining.

If we do not approach this in a credible manner, I am afraid we will continue to be seen as whining adolescents who don't want to follow rules just because they are rules. And also, the next time you complain, be careful...because somebody may actually be listening.

From the Desk of the Editor

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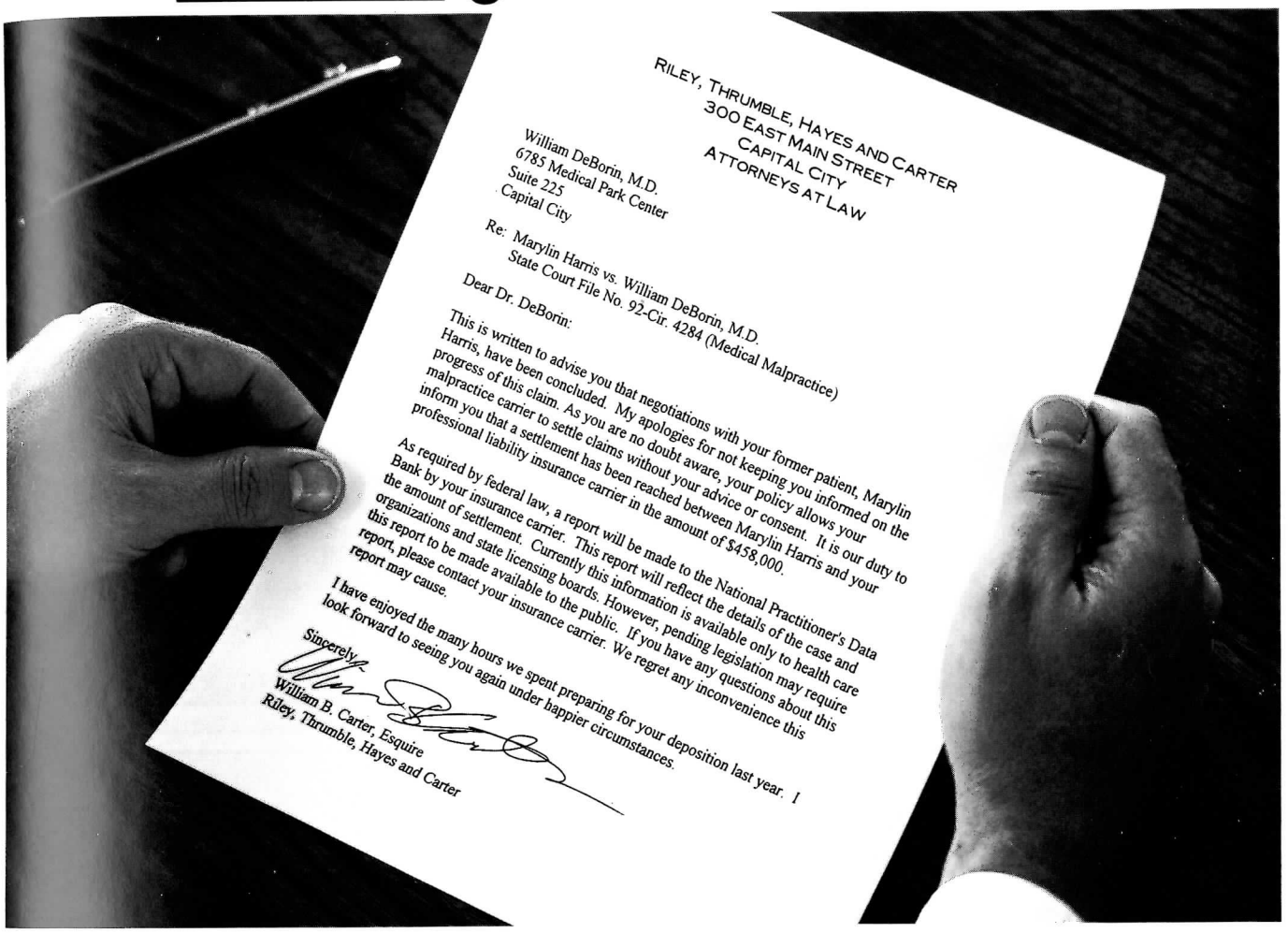
physician's hand and the patient." To me, this means that diagnoses are made by experienced, properly-trained physicians, not by submitting each patient to a battery of laboratory tests, x-ray beams and magnetic fields!

After all, it does not take a rocket scientist to order an MRI on a patient with back pain. It does, however, require a little more thought when you have a large right-sided herniation at L2-3 by MRI, but on physical examination the patient has decreased sensation at the left S1 dermatome, and an absent left ankle jerk. Try to explain that to Aunt Millie!

Medical Protective Policyowners *NEVER* get letters like this!



RILEY, THRUMBLE, HAYES AND CARTER
300 EAST MAIN STREET
CAPITAL CITY
ATTORNEYS AT LAW

William DeBorin, M.D.
6785 Medical Park Center
Suite 225
Capital City

Re: Marylin Harris vs. William DeBorin, M.D.
State Court File No. 92-Cir. 4284 (Medical Malpractice)

Dear Dr. DeBorin:

This is written to advise you that negotiations with your former patient, Marylin Harris, have been concluded. My apologies for not keeping you informed on the progress of this claim. As you are no doubt aware, your policy allows your malpractice carrier to settle claims without your advice or consent. It is our duty to inform you that a settlement has been reached between Marylin Harris and your professional liability insurance carrier in the amount of $458,000.

As required by federal law, a report will be made to the National Practitioner's Data Bank by your insurance carrier. This report will reflect the details of the case and the amount of settlement. Currently this information is available only to health care organizations and state licensing boards. However, pending legislation may require this report to be made available to the public. If you have any questions about this report, please contact your insurance carrier. We regret any inconvenience this report may cause.

I have enjoyed the many hours we spent preparing for your deposition last year. I look forward to seeing you again under happier circumstances.

Sincerely,

William B. Carter, Esquire
Riley, Thrumble, Hayes and Carter

Any allegation of malpractice against a doctor is serious business. If you are insured by The Medical Protective Company, be confident that in any malpractice claim you are an active partner in analyzing and preparing your case. We seek your advice and counsel in the beginning, in the middle, and at the end of your case. In fact, unless restricted by state law, every individual Medical Protective professional liability policy guarantees the doctor's right to consent to any settlement--**no strings attached!** In an era of frivolous suits, changing government attitudes about the confidentiality of the National Practitioner's Data Bank and increased scrutiny by credentialing committees, shouldn't you have The Medical Protective Company as your professional liability insurer? Call your local General Agent for more information about how you can have more control in defense of your professional reputation. Also available through select Independent Agents.

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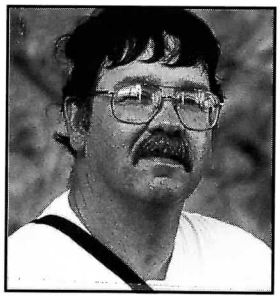

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In Memoriam

PATRICK B. CESTONE, MD

March 31, 1918
April 23, 1998

In Memoriam

JOHN J. McDONOUGH, MD

June 23, 1908
March 28, 1998

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From the Bulletin

A Look Back...

Sixty Years Ago
Spring 1938

After a long and successful career in medicine, **James Bennett** passed away. One of his sons, **Wendell Bennett**, continued the practice, while another son became Judge Eugene Bennett. **Gordon Nelson** had an article on "Acute Atypical Appendicitis", and stressed the importance of history and physical examination, rather than depending on laboratory tests. New members were **Sam Goldberg** and **Harlan McGregor.**

Fifty Years Ago
Spring 1948

M.M. Szucs addressed the combined staffs of the Salem City and Alliance Hospitals. His topic was "Therapy in Arthritis", at a time when no steroids or nonsteroidals were available. **Vernon Goodwin** and **J.B. Kupec** conducted a symposium on plastic surgery at St. Elizabeth Hospital. The Mahoning County Chapter of the Ohio Academy of General Practice was formed. The Academy's first officers included: **J. Clair Vance**, president; **Gabe DeCicco**, vice-president; and **Dave Levy**, secretary. New Society members were **Nathan Belinky, Lou Bloomberg, R.V. Clifford, Arnoldus Goudsmit, John R. LaManna, U.A. Melaragno, Bill Newcomer, James Patrick, S.G. Patton, R.J. Scheetz,** and **Oscar Turner.**

Forty Years Ago
Spring 1958

Editor **Morris Rosenblum** wrote "This is Cancer Week... and how helpless we feel in the treatment of this malady". **James Smeltzer** had another article on cancer control that was more optimistic. He emphasized early detection and urged physicians to participate in the use of the Papanicolou test, pioneered in this community by **Winifred Liu Mutochman. Wayne Hardin** had an article on "Modiastinal Disorders"; New members were **William Bunn, Jr., E.J. Gluck, John Kalfas, D.D. Krongold, A. Lutz, William H. Taake, B. Taylor, Roy Thomas** and **Isador Werbner**, as well as intern members **Jim Fulks, Bill Martin**, and **Eli Saadi.**

Thirty Years Ago
Spring 1968

Eli Saadi was elected vice-presidet of the Northeast Ohio Regional Medical Program. **Richard Murray** was treasurer of the Mahoning Valley Health Planning Association. **Ray Scheetz**, in his third year as president of St. Elizabeth's medical staff, was elected to that hospital's advisory board. **Leonard Caccamo** was elected as the Ohio delegate to the American Society of Internal Medicine. **James Fulks** lectured on "Aseptic Tracheotomy Care" at the Ohio Chapter for the American Association of Inhalation Therapists in Youngstown. **John E.L. Keyes** passed away at the age of 81. New members were **John R. Madison** and **Anthony Pannozo.**

Twenty Years Ago
Spring 1978

Editor **Dean Limbert** philosophized about the new DNA research and the possibility of cloning human beings. He also addressed the problem of the increasing cost of medical care, and indicated that increasing the number of physicians would increase the number of services and would actually add to the cost. President **George Dietz** urged all members to support the AMA, reminding us that "in unity there is strength". New members were **Charles R. Luttenton** and **Escarlito Sevilla**. A long list of local physicians were awarded faculty rank at the new Northeastern Ohio Universities College of Medicine in Rootstown, Ohio.

Ten Years Ago
Spring 1988

The Society seemed to be focusing on the business of medicine and the interference of state and federal regulations in the practice of medicine. President **Hai-Shiuh Wang** editorialized about the loss of professional autonomy. He prescribed more involvement in the decision-making process by talking to community health organizations, community leaders, and political incumbents. Editor **John LaManna, Jr.** urged physicians to follow their own advice and become physically fit themselves, while encouraging their patients to do the same. New members were: **Jane R.F. Butterworth, Mark Campano, Richard W. Lobritz, Raul Lopez, Jose Lopez-Gonzalez, Richard Michaels, Niranjan N. Patel, William Stechschulte, Eric W. Svenson, Vincent W. Vanek, Keith M. Wilson, Larry A. Woods,** and **Gary A. Young.**

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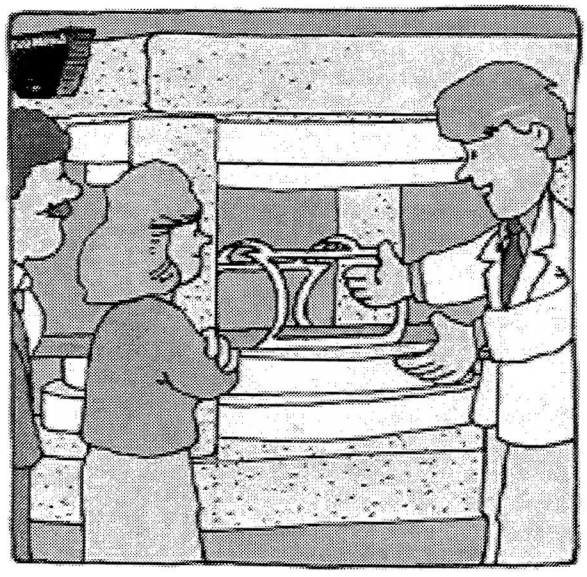

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On The Cover

"Fantin La Tour Pin Up"

Watercolor, 35" x 27"

NANCY KEARNS MORRIS WAS BORN IN ROCHESTER, NEW YORK AND RECEIVED HER BACHELOR'S DEGREE IN ART FROM Connecticut College. Her post-graduate study includes two years at the Art Students League in New York City, as well as additional art and art education courses at Youngstown State University.

Nancy Kearns Morris

Her professional experience began in the early '50s when she worked for several New York advertising agencies. She has taught art classes for both children and adults, and is a past education director at St. John's Episcopal Church.

Nancy works primarily in watercolor on a gessoed surface, but also does mixed media pieces. "My work is very personal," she said, "usually reflecting my surroundings and family." She added that she tries to "find new ways of looking at the familiar."

Over the years, she has actively participated in art-related volunteer work. She is a cofounder of the YWCA's annual regional women's art show (Women Artists: A Celebration), and continues to serve as a committee chairman and advisor. She was a member of the planning committee for the first annual Jewish Community Center juried Winter Art Show, and has co-chaired that event. A former Board member of the Youngstown Area Arts Council, she has also served as a docent for the Butler Institute.

Her current memberships include the following organizations: Butler Institute of American Art, Mahoning Valley Watercolor Association, and the Trumbull Art Guild.

Nancy's works have been featured at numerous art exhibitions and she has won awards in several local shows, including the Butler Area Artists, YWCA Women Artists, Jewish Community Center, and the Unitarian Church. She has participated in one- and two-person shows held at the Youngstown Playhouse, the Jewish Community Center, the Youngstown YWCA, and at Christ Church in Warren. Her paintings can be seen in many private collections.

Nancy, who resides in Youngstown, is the owner of Sharp Lumber Company and continues to work as a free-lance artist. She and her husband, the late John M. Morris, have four children, one of whom is deceased. They also have four grandchildren.

YWCA of Youngstown Holds 17th Annual Women's Art Exhibit

For 17 years, the YWCA of Youngstown's *Women Artists—A Celebration* has recognized and provided an opportunity for local women artists to showcase their work. The show will be held at the YWCA, 25 W. Rayen Ave., Youngstown on May 8 with a patron party at 6 p.m. It will be open to the public May 9-16.

A historical look at the world of art will reveal a great lack of recognition in the area of women's art. The YWCA is trying to correct this oversight by allowing women their own venue to encourage and support their talents and efforts as well as providing a richer future for the women artists of tomorrow.

More than $1,000 in prizes will be awarded. The show will be judged by P. Lynn Cox, Art Department Chair of Westminster College. All artistic media will be represented including painting, graphics, photography, sculpture, ceramics, fiber, metal work, computer-generated art and videos.

For more information call the YWCA at 746-6361.

Medical Residents Report Mistreatment During Internship

continued from pg. 8

The authors recommend a two-pronged approach to residency directors who wish to improve feelings of satisfaction among residents: "First, they should strive to increase the learning opportunities for residents. This can be accomplished by a combination of things: increasing the accessibility of residents to the attending faculty; facilitating contacts among residents, or providing time for independent reading. Second, residency directors must make clear the standards of conduct for all professional personnel and intervene when conduct falls short of these standards. Although the discomforts of residency cannot be eliminated, a conscious effort at reducing the intern's sense of being mistreated should enhance residents' satisfaction."

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Call the MCMS office (788-4700) for details.

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