Most Physicians and Nurses Favor Mandatory AIDS Tests

Although most public health officials and health professions societies in the United States oppose mandatory testing of health care workers for the human immunodeficiency virus (HIV), 57 percent of physicians and 63 percent of nurses favor it, according to preliminary findings from a new study sponsored by the Agency for Health Care Policy and Research (AHCPR) of the Public Health Service.

The findings from the first comprehensive national survey of the knowledge, attitudes, and practices of physicians and nurses on acquired immunodeficiency syndrome (AIDS)-related issues also indicate that nearly three-quarters of the physicians and nurses favor mandatory AIDS testing of surgical patients and pregnant women.

In addition, 6 out of 10 physicians and nurses believe that physicians should be able to order the AIDS test for patients without their informed consent, and three-quarters believe that physicians should be required to report the names of HIV patients to the local health department.

Researchers at Columbia University School of Public Health led by John Colombotos, PhD, in collaboration with the University of Chicago's National Opinion Research Center, surveyed national probability samples of 958 practicing physicians in family and general practice, internal medicine, pediatrics, surgery, and obstetrics-gynecology and 1,520 registered nurses by telephone interview and mail questionnaire between July 1990 and January 1991. Physicians and nurses in New York City and San Francisco, cities with high AIDS rates, were oversampled. Overall, 80 percent of the physician sample and 73 percent of the nurse sample (weighted response rates) responded.

The study also shows that public opinion, even that of professionals working in the health field, is often influenced by lack of knowledge, mistrust, and fear. Although the majority of nurses and physicians surveyed supported mandatory testing, for patients in particular, two-thirds of the nurses and one-third of the physicians incorrectly believed that the AIDS virus and the hepatitis B virus were equally transmissible. The health care providers, particularly the nurses, also believed that official estimates of the prevalence of AIDS and HIV as well as the risk of HIV infection for health care workers were "too low" rather than "too high."

In spite of this concern, and contrary to Centers for Disease Control guidelines on universal precautions, both physicians and nurses indicated that they are much less likely to use precautions when performing venipuncture on patients of unknown HIV status than they were on patients whom they know to be HIV-positive.

While the majority of physicians and nurses acknowledge their professional and ethical obligation to provide care for HIV patients, physicians objected to the idea of being forced to do so by law. Despite both groups' sense of ethical responsibility, most indicated that they are not "completely willing" to provide care to HIV patients. Given the choice, a larger percentage of physicians and nurses would rather provide care to homosexual men than to intravenous drug users. They also reported that since the anpearance of AIDS, they had become more negative in their feelings about intravenous drug users.

Despite the commonly held belief that AIDS is discouraging young people from entering the health professions, the researchers found that few of the physicians and nurses surveyed said they were leaving patient care because of AIDS. Nurses ranked AIDS far behind job stress, salary, lack of autonomy, and lack of career mobility as a reason for leaving patient care.

The study, which was funded under grant HS06359 from AHCPR's Center for General Health Services Extramural Research, is an ongoing research project examining how health care providers' AIDS knowledge, attitudes, and practices are interrelated. The investigators are also studying how these factors vary in relation to the professional and sociodemographic characteristics of physicians and nurses and the regions, including those with high and low prevalence of AIDS, where they work.

Further information on the preliminary findings is in "Physicians, Nurses, and AIDS: Preliminary Findings from a National Study" by Dr. Colombotos, Peter Messeri, PhD, Marianne Burgunder, MN, Jack Elinson, PhD, Donald Gemson, MD, MPH, and Margaret Hynes, MPH. Single copies of the report are available from Information and Publications Division, AHCPR, 18-12 Parklawn Building, Rockville, MD 20857, tel. 301-443-4100.

NHLBI Launches Heart Attack Alert Program

The National Heart, Lung and Blood Institute (NHLBI) has begun a national educational program to reduce sudden death and disabling illness from heart attacks through faster identification and treatment of heart attack victims. NHLBI is a component of the National Institutes of Health, an agency of the Public Health Service.

Called the National Heart Attack Alert Program, the new effort seeks to decrease the time lag between the onset of symptoms and the administration of medical treatment by educating health care professionals and patients and their families to identify signs of a heart attack and take immediate action to secure medical attention.

The program is being coordinated by a committee that includes representatives of 11 Federal agencies and 24 major health organizations involved in responding to heart attacks.

About 1,250,000 Americans are stricken with heart attacks every year, 40 percent of them fatal. In 1988 the cost to the nation from coronary heart disease was an estimated $53 billion—$21 billion for direct medical care and another $32 billion in lost work days and lost future earnings.

Recent advances in techniques for treating heart attacks include several different thrombolytic drugs that break up attack-causing blood clots and automatic defibrillators that are used to shock the heart back into normal rhythm after an attack.

Currently available data suggest, however, that only a small percentage of heart attack patients who could benefit from the new therapies are receiv-

ing such treatment. There is evidence that several critical factors—such as personal inhibitions, emergency system overload, and hospital inefficiencies—delay patients from reaching immediate and effective therapy.

As in NHLBI's other national education programs, a combination of communication approaches will be used that may include educational materials, conferences, and mailings to health care professionals.

More information on the National Heart Attack Alert Program may be obtained from the National Heart, Lung, and Blood Institute, Room 4A21, Bldg. 31, 9000 Rockville Pike, Bethesda, MD 20892.

Rehabilitation Research Center Created by HHS

The Department of Health and Human Services (HHS) has established a new research center to improve the quality of life and increase the independence of the 35 million Americans with disabilities.

One of the priorities of the National Center for Medical Rehabilitation will be to support the search for better technologies and techniques to reactivate muscles, nerves, and bodily functions impaired by injury, disease, disorder, or birth defects. The Center will also fund studies on improved prosthetic devices.

The Center has responsibility as well for supporting research training programs and for disseminating health information. Eventually, it will include an intramural component that will conduct both basic sciences research and clinical studies.

The research was mandated by Public Law 101-613, enacted by the Congress and signed by President Bush in November 1990. The new Center will operate within the National Institute of Child Health and Human Development (NICHD), one of the National Institutes of Health of the Public Health Service.

NICHD Director Duane Alexander, MD, who is the acting director of the center, said of its potential, "Rehabilitation medicine and associated therapies may soon be able to use findings from basic research to improve or replace the loss of central nervous system function, and impairments resulting from arthritis, cardiovascular disorders and other functional limitations."

"In the future," he continued, "we look forward to applying the advances in microcomputer hardware and software to control externally the implanted devices that regulate a variety of body functions, such as opening and shutting anal and urinary sphincters, releasing drugs and hormones, and sequencing or modulating neural impulses to muscle groups."

IOM Committee Links Vaccines with Adverse Health Consequences

An Institute of Medicine (IOM) committee has found evidence of a causal relation between the diphtheria-pertussis-tetanus (DPT) and rubella vaccines and certain health problems.

During a 20-month review of information from epidemiologic, clinical, laboratory, and case studies, the committee examined 20 adverse health problems and the relation of each to the DPT vaccine and the currently used rubella vaccine, known as RA 27/3.

The committee said that of the 17 health problems it reviewed in regard to the DPT vaccine, it found that "the evidence indicates a causal relation" between the vaccine and anaphylaxis, a sudden, rare, and potentially life-threatening allergic reaction.

In addition, the committee said the evidence "indicates a causal relation" between the pertussis component of the DPT vaccine and extended periods of inconsolable crying or screaming, sometimes lasting 24 hours or more after the immunization.

The committee added that anaphylaxis does not appear to be a problem associated exclusively with the pertussis component of the vaccine, which is most often cited as a possible health risk. Such a reaction may be caused by the diphtheria or tetanus components as well.

In its review of the rubella vaccine and three types of health problems, the committee determined that "evidence indicates a causal relation" between the RA 27/3 vaccine and acute arthritis in women.

The committee found the available evidence weaker but still consistent with a causal relation between the DPT vaccine and acute encephalopathy and shock.

The committee found that the evidence does not indicate a causal relation between the DPT vaccine and infantile spasms, hypsarrythmia (an EEG pattern that is frequently associated with infantile spasms), Reye syndrome (an acute, often fatal childhood syndrome marked by rapid brain swelling), and sudden infant death syndrome.

For the remaining 12 health problems it reviewed, the committee said that there was no available evidence or that the evidence was insufficient to make a causal determination.

The committee recommended that research on the whole subject be intensified because of insufficient information in the medical literature.

The study, sponsored by the National Institute of Allergy and Infectious Diseases, was requested by the Congress in the 1986 National Childhood Vaccine Injury Act, which established a Federal compensation program for persons potentially injured by vaccines. Section 312 of the law called for the Institute of Medicine to review scientific and other information on specific adverse consequences of pertussis and rubella vaccines.

The 11-member committee was composed of members with expertise in infectious diseases, pediatrics, internal medicine, neurology, epidemiology, biostatistics, decision analysis, biological mechanisms of vaccines, immunology, and public health.

The committee's report is available for $39.95 (prepaid) plus $3 shipping from the National Academy Press, 2101 Constitution Ave., NW, Washington, DC 20418; tel. 202-334-2138 or 1-800-624-6242.

"Best Friends" Program Helps Adolescent Girls Avoid Pregnancy

A school-based program for adolescent girls at risk of early sexual activity and pregnancy will be started at four schools in the country through a 2-year $90,226 grant from the Robert Wood Johnson Foundation. Known as the Best Friends Program, it encourages girls to support each other in the decision not to have sex during early adolescence.

The counseling and mentoring program offers guidance and support to girls between the ages of 11 and 18. It

is based on the idea that friends can help each other to make crucial decisions in life that promote self-confidence and a positive self-image.

Established by the Georgetown University Child Development Center in Washington, DC, the program is currently operating in two schools in Washington and will be expanded with the Johnson grant to schools in Denver, Los Angeles, Dade and Lee Counties, FL, and at an additional school in Washington, DC. The grant also will fund a national conference to promote the project to other schools across the country.

Girls who choose to participate in the program become part of a strong network of friends who meet once a week in a 1 1/2- hour group counseling session headed by a trained staff member. Discussions are centered around four topics—friendship, love and dating, responsible decision-making, and self-respect. In addition to deferring sexual intimacy, other values emphasized include the importance of friendship and "saying no" to illegal drugs and alcohol.

"We stress that the teenage years should be a happy and positive time, free of anxiety and fear that sexual encounters inevitably create," said Elayne G. Bennett, Best Friends program director, who, together with Phyllis Magrab, MD, the center's director, designed the program.

The mentoring component of the Best Friends Program requires that each girl sign a contract with a female teacher of her choice whom she admires and respects. Their agreement provides that they meet for at least 45 minutes per week to talk about whatever is of importance in the student's life at that time, which may include school work, home life, and relationships. This one-on-one contact helps to reinforce the messages conveyed by the group sessions and is comforting to the girls, especially when they have problems requiring special attention, according to the program directors.

The guest speaker-role model component of the program exposes the girls to successful women beyond the realm of the classroom. Women from the community are invited into the group counseling sessions to talk about the path they took that led to their success and about the decisions they made along the way.

"Some of the most influential speakers are the ones who did not come from circumstances that would ensure success in life. They had to overcome some obstacles," said Bennett. "When these women talk about the many important decisions they have made in life, they are providing the girls with a guide, a blueprint for making thoughtful and responsible decisions about their futures.

"Best Friends is the beginning of a sound program addressing the problem of teen pregnancy," continued Bennett. "Solving this problem will take time—it is not going to happen overnight, but if we can replicate it successfully in more schools, we can begin to make progress on one of the most serious problems adolescents face today," she said.

Paid Advertising a Powerful Tool for State Health Agencies

California, Michigan, and Minnesota are the first State health agencies to use paid advertising to present health messages to the public, according to the Public Health Foundation of the Association of State and Territorial Health Officials (ASTHO). While buying advertising time can be expensive, the foundation says, it enables the agencies to place ads where and when target groups are watching and listening.

The foundation's bi-monthly "Public Health Macroview" gave this account of the new trend:

Traditionally, State health agencies have relied on no-cost public service announcements (PSAs) to reach the public. The increase in competition for free air time, however, has resulted in agencies being able to place fewer PSAs. "Mass Media and Health: Opportunities for Improving the Nation's Health," a recent publication from the Public Health Service, recommends that health departments investigate the use of paid advertising for health issues.

The California, Michigan, and Minnesota health agencies each are conducting anti-smoking ad campaigns, and the Michigan Department of Public Health is also conducting an AIDS prevention ad campaign. The California and Minnesota campaigns are financed by an excise tax on cigarettes and the Michigan campaigns by a computer software tax.

The State agencies have learned first-hand that paid advertising is expensive. The Minnesota Department of Health spent $1.7 million over 2 years to produce and place the anti-smoking ads. Minnesota negotiated one free spot for each spot purchased, however, increasing the return on its advertising dollars by getting additional free ads which are shown during equally advantageous time slots.

The State agency tobacco use ad campaigns focus on prevention and cessation. Radio and TV spots emphasize the social and personal consequences of starting to smoke. In evaluating the success of the media campaigns, the agencies are looking for information-seeking behavior, changes in knowledge and beliefs about tobacco-related issues, and how well target group members recall specific radio and TV ads.

The State agencies report that the media campaigns have been effective in reaching target groups. For example, in Minnesota, 55 percent of all target group members recalled at least one billboard, 70 percent recalled at least one radio ad, and more than 95 percent recalled at least one TV ad. In California, the recall rate was approximately 70 to 75 percent.

The Michigan Department of Public Health recently published the results of an outside evaluation of its 1989 smoking prevention media campaign. The findings show that, for the Michigan ads, the levels of viewer awareness are 2 to 5 times higher than those typically achieved by national advertising on network television. The evaluation also shows a strong and direct relationship between the media campaign and use of the Michigan Smoking Hotline.

More information about the ad campaigns can be obtained from Jan Ruff, Michigan, tel. (517) 335-8366, Kathy Harty, Minnesota, tel. (612) 623-5500, or Norman Hartman, California, tel. (916) 445-1967.

Neighborhood Women Serve as Maternal-Child Health Advocates in Chicago

Nine trained community residents, also referred to as maternal and child health advocates, provide individualized, intensive, and culturally sensitive

health care services to near west side Chicago residents.

The purpose of the program, called Resources, Education and Care in the Home (REACH)-Futures, is to reduce infant mortality and morbidity by promoting primary health care of mothers and infants, parenting skills, and knowledgeable use of resources.

REACH-Futures is unique because it uses as advocates community residents who grew up in the targeted inner-city neighborhoods, "know the turf," can relate well to the young mothers, and are interested in maternal and child health, project director Cynthia Barnes-Boyd said.

"The goal of this program is to empower women to do these things on their own eventually and to have the advocates provide support only," she added.

The program is coordinated by the University of Illinois Hospital and Clinics in collaboration with the Chicago Department of Health and West Side Future, a State-funded community-based organization. It is 1 of 20 programs funded as a collaborative effort between the American Academy of Pediatrics (AAP) and the Maternal and Child Health Bureau of the Public Health Service.

The advocates visit pregnant women initially to teach them postpartum care. A week after the women give birth, advocates call on them to make sure they are giving their infants the care that they were previously taught.

Advocates visit the new mothers once a week for about half an hour during the first month, then once a month for up to 18 months. A professional nurse accompanies the advocate for the second visit, at six months, and again at 12 months.

The advocates also know which community resources and services are available and pass this information on to the women. They check up on the women's clinic visits and sometimes babysit for a woman's other children when she makes a clinic visit.

The advocates follow teen mothers particularly closely to make sure their infants receive appropriate nutrition and often accompany them to clinics.

A 6-month training course is required before the advocates begin making any visits. Recently, they also received training and information on breast-feeding and child abuse and neglect, and now they are involved in a 15-week program on effective African American parenting.

The program has been so successful that the Chicago Mayor's Office of Employment and Training has contracted with the University of Illinois to train maternal and child health advocates for the city's department of health. This project, a collaborative effort inolving the College of Nursing at the University of Illinois at Chicago, and REACH-Futures, exposes a new group of women from Chicago's disadvantaged communities to the advocacy training curriculum. The current REACH-Futures advocates will be involved in the training program and, in essence, will become mentors to this new programs' trainees, Barnes-Boyd said.

"Our purpose is to demonstrate the value of the health advocate role. The model we are promoting places the advocate in a key position as facilitator, advisor, and educator. The advocate can help coordinate services for nurses, physicians, and social workers. Often they educate the health professional as well," Barnes-Boyd said.

Specific Strategies Needed to Implement Dietary Guidelines: IOM

Dietary guidelines alone will not improve America's eating habits. What's sorely needed are more comprehensive and coordinated actions for implementing those guidelines, a committee of the Institute of Medicine (IOM) has concluded.

Current implementation efforts, "although commendable, have been fragmented, not necessarily consistent, and thus far insufficient to promote large-scale dietary modification," said the 20-member report committee of the IOM's Food and Nutrition Board.

The committee recommended that public- and private-sector policy makers, supermarket managers, restaurant managers, food writers, school administrators, and others become more active in encouraging and enabling people to eat better.

In its report, the committee laid out strategies to

- encourage local, State, and Federal Governments, and health care professionals to implement dietary recommendations through their actions as policy makers, role models, and agenda setters,
- enhance the public's understanding of good nutrition by providing better information about foods on labels, at points of purchase, at schools and worksites, and through organized media campaigns that are coordinated with community-based health promotion efforts, and
- increase the availability of health-promoting foods, particularly in settings where people are unable or unwilling to prepare it.

The committee addressed most of its recommendations to governments at all levels, to the private sector—particularly the food industry, to health care professionals and their associations, and to educators, ranging from schoolteachers to advertisers.

Government

The committee recommended that the Federal Government establish a coordinating body to help implement dietary recommendations in the public sector by altering Federal food assistance and subsidy programs to ensure that the nation's school children, elderly, minorities, and the poor have access to foods that enable them to follow dietary guidelines, by updating regulations to incorporate dietary principles in the labeling, grading, and promotion of foods, and by monitoring the nutritional status of the population. State and Federal legislative bodies also need to play active roles in implementing dietary recommendations, the committee said.

Private Sector

The private sector, in turn, should continue to use its considerable resources to promote dietary recommendations and encourage people to follow them as well as to increase the availability of health-promoting, appealing foods, the committee said.

Health Care Sector

For health care professionals, the committee recommended that schools establish programs to develop a research and education agenda in nutrition. It also called on nutritionists, physicians, and others to become more active as promoters of good nutrition in their communities as well as in their clinical and private practices. Health care professionals need more re-

sources to intensify research on the relationships between diet and health and how to use this knowledge to improve the food habits of the population, the committee said.

Education

Education of the public takes place in diverse settings from schools to the almost infinite variety of experiences that include watching a food advertisement on television to preparing dinner. The committee recommended that a comprehensive curriculum be developed for teaching nutrition, health, and skills in selecting and preparing foods to children from kindergarten through grade 12 and that institutions of higher learning offer a nutrition course for interested students. It urged the development of more community-based nutrition education projects that involve local leaders. In addition, the committee called on the news media to do more to decrease consumer confusion and increase nutrition knowledge. Entertainment programs, for example, could promote healthy eating through the dietary behaviors of their characters and through story plots that implicitly support good nutrition.

The committee's study was sponsored by the Henry J. Kaiser Family Foundation, Menlo Park, CA, and the National Cancer Institute of the Public Health Service. Chairman of the committee was Edward N. Brandt Jr., MD, of the University of Oklahoma, formerly head of the Public Health Service as Assistant Secretary for Health in the Department of Health and Human Services.

"Improving America's Diet and Health" is available for $29.95 (prepaid) plus $3 shipping from the National Academy Press at the National Academy of Sciences, 2101 Constitution Ave., NW, Washington, DC 20418, tel. (202) 334-3313 or 1-800-624-6242.

NIAAA Profiles Alcohol Problems of Women

Of the 15 million people in the United States who abuse alcohol or are dependent on it, about one-third, nearly 4.6 million, are women.

Based on studies in the general population by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) of the Public Health Service, while fewer women than men drink, among the heaviest drinkers, women equal or surpass men in the number of problems that result from their drinking.

Although younger women have more drinking-related problems, dependence on alcohol is greater among women between the ages of 35 and 49.

Contrary to popular opinion, women who have many roles seem to have lower rates of alcohol problems than those who do not. In fact, the researchers note, loss of a role or being deprived of one (as mother, wife, or worker), may increase the risk of a woman developing a drinking problem. Women who have never married, or who are separated or divorced are more likely to drink heavily and to have problems related to their drinking.

Studies show that black women do not drink more than white women. Although it is commonly assumed that more black women drink heavily, it has been proved that heavy drinking occurs in equal proportions among black and white women. Further, black women are more likely to abstain totally from drinking than white women.

Women have significantly higher death rates from alcoholism than men. In fact, the death rate among alcoholic women is 50 to 100 percent higher than among men. And a greater percent of female alcoholics die from suicides, drinking-related accidents, and cirrhosis of the liver. In general, chronic alcohol abuse exacts a greater toll on women than on men.

Copies of the NIAAA Alcohol Alert "Alcohol and Women" may be obtained from the National Clearinghouse on Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852, tel. 800-729-6686.

NIMH Funds New Centers for Minority Mental Health Research

The Harbor-University of California at Los Angeles (UCLA) Medical Center in Torrance, CA, and the University of Michigan in Ann Arbor, MI, were recently designated minority mental health research centers by the National Institute of Mental Health (NIMH).

An estimated $2.1 million in total costs was awarded over 3 years to the Harbor-UCLA Medical Center to support research on how psychobiological variations in minority populations affect responses to drug treatments for mental disorders. The Institute of Social Research of the University of Michigan, which received a 3-year grant with projected total costs of $910,000, will conduct research on the mental health of African Americans.

"At the Harbor-UCLA Medical Center, we will be studying and seeking explanations for the very strong evidence that race and ethnicity play significant roles in the differing responses to treatments of serious mental illnesses," said Keh-Ming Lin, MD, director of the new center.

The center also will investigate the cultural factors influencing the evaluation and care of patients, and their willingness to obtain treatment and use support programs.

James S. Jackson, PhD, who directs the minority center at the University of Michigan, said, "We are exploring cultural and ethnic variations in mental disorders, and studying the effectiveness of current assessment methods for Americans of African descent."

The first NIMH-funded minority mental health research centers were established in 1973. They have supported multidisciplinary research on the mental disorders of Native Americans, Asian Americans, African Americans, and Hispanic Americans. Their purpose is to provide productive environments for mental health clinicians and researchers to conduct studies on mental health services and on the epidemiology, diagnosis, and prevention of mental disorders.

NIMH currently funds four other minority mental health research centers at the University of Colorado Health Sciences Center in Denver, the University of California at Los Angeles, Fordham University in New York City, and the University of Texas Medical Branch in Galveston, TX.

Jack D. Burke, Jr., MD, MPH, Director of NIMH's Division of Applied and Services Research that supports the minority research centers said, "These centers have identified pressing questions of public health importance. Their work provides a necessary empirical knowledge base about the most appropriate and effective methods of conducting epidemiologic studies, making clinical diagnoses, and providing culturally appropriate treatment and rehabilitation for minorities."

HHS Funds Eight Regional Medical Libraries

Health and Human Services Secretary Louis W. Sullivan, MD, has announced the award of eight contracts to institutions to serve as regional medical libraries within the United States. The contracts will total some $33 million over a 5-year period.

"Our national network of medical libraries has proven its worth over the past quarter century," Sullivan said. "American health professionals can rapidly and efficiently access health information services, whether they practice in a remote, rural area or in a major medical center."

The national network consists of eight regional medical libraries, 136 "resource" libraries (primarily at medical schools), and some 3,300 local health science libraries (primarily at hospitals).

The National Library of Medicine of the National Institutes of Health, the world's largest library of the health sciences, supports the network through contracts with the regional medical libraries.

Assistant Secretary for Health James O. Mason, MD, chief of the Public Health Service, said the new contracts emphasize outreach to all health professionals—in practice, research, and education.

"Today's information systems," he declared, "allow health professionals to search the medical literature online and to obtain copies of the articles and books they require from network libraries."

Donald A.B. Lindberg, MD, Director of the National Library of Medicine, emphasized that the new contracts call for targeted programs to reach health professionals in rural and inner city areas. The goal is to make them aware of the services that network libraries can provide and to give them personally the tools to access the network.

Other network programs include the interlibrary lending of more than 2 million journal articles, books, and other published materials each year, reference services, training and consultation, and online access to MEDLINE and other databases made available by the National Library of Medicine.

The development of the national network of libraries of medicine was authorized by the Medical Library Assistance Act of 1965. The Congress has supported the concept by periodically renewing the legislative authorization and by appropriating funds for implementing the network.

A list of the regional medical libraries, and the States covered by each, follows.

1. Middle Atlantic Regional Medical Library Program, The New York Academy of Medicine, 2 East 103rd St., New York, NY 10029, tel.: 212-876-8763. Serves: Delaware, New Jersey, New York, Pennsylvania. Online Center for Regions 1, 2, and 8.
2. Southeastern Atlantic Regional Medical Library Service, University of Maryland Health Sciences Library, 111 South Greene St., Baltimore, MD 21201, tel.: 301-328-2855. Serves: Alabama, Florida, Georgia, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, West Virginia, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.
3. Greater Midwest Regional Medical Library Network, University of Illinois at Chicago Library of the Health Sciences, P.O. Box 7509, Chicago, IL 60680, tel.: 312-996-2464. Serves: Iowa, Illinois, Indiana, Kentucky, Michigan, Minnesota, North Dakota, Ohio, South Dakota, and Wisconsin.
4. Midcontinental Regional Medical Library Program, University of Nebraska Medical Center, McGoogan Library of Medicine, 600 South 42nd St., Omaha, NE 68198-6706, tel.: 402-559-4326. Serves: Colorado, Kansas, Missouri, Nebraska, Utah, and Wyoming. Online Center for Regions 3, 4, and 5.
5. South Central Network of Libraries of Medicine, Houston Academy of Medicine, Texas Medical Center Library, 1133 M.D. Anderson Blvd., Houston, TX 77030, tel.: 713-797-1230. ext. 277. Serves: Arkansas, Louisiana, New Mexico, Oklahoma, and Texas.
6. Pacific Northwest Regional Health Science Library Service, University of Washington, SB-55, Seattle, WA 98195, tel.: 206-543-8262. Serves: Alaska, Idaho, Montana, Oregon, and Washington.
7. Pacific Southwest Regional Medical Library Service, Louise Darling Biomedical Library, University of California, 10833 Le Conte Ave., Los Angeles, CA 90024-1798, tele.: 213-825-1200. Serves: Arizona, California, Hawaii, Nevada, and U.S. Territories in the Pacific Basin. Online Center for Regions 6 and 7.
8. Regional Medical Library in New England, Lyman Maynard Stowe Library, University of Connecticut Health Center, 263 Farmington Ave., Farmington, CT 06034-4003, tel.: 203-679-4500. Serves: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

Toll-free telephone number for all Regional Medical Libraries : 1-800-338-RMLS.

IOM Subcommittee Suggests Remedies for Shortage of Occupational, Environmental Physicians

An Institute of Medicine (IOM) subcommittee has made six recommendations on how the Federal and State Governments, medical schools, and medical societies can counteract the national shortage of 3,100 to 5,500 physicians with special competence in occupational and environmental medicine.

In 1989 IOM declared that the U.S. health care system is inadequately prepared to cope with the burden of occupational and environmental illness.

The six recommendations are

- Integrate occupational and environmental medicine into medical school curriculums to increase students' interest in these fields.
- Establish 10 to 15 centers to train future teachers and researchers in occupational and environmental medicine.
- Expand occupational medicine to include the fledgling field of environmental medicine, thereby increasing the number of physicians competent to practice in either area.
- Increase funding to support medical school faculty members committed to teaching and research in occupational and environmental medicine.
- Increase support for residency and fellowship training.
- Adopt new routes to certification and accreditation in occupational and environmental medicine.

The new subcommittee report notes that environmental and occupational diseases cover a broad range of illnesses, including lung cancer from asbestos and radon exposure, bladder cancer in dye workers, leukemia from benzene exposure, asthma and chronic bronchitis from organic dust exposure, and heart disease from car-

bon disulfide exposure. The annual cost in the United States from such diseases is an estimated $6 billion, with workers' compensation contributing less than 10 percent and tort suit awards less than 5 percent of the total cost.

The study was sponsored by the Public Health Service's Centers for Disease Control, Agency for Toxic Substances and Disease Registry, and National Institute of Environmental Health Sciences, and the U. S. Environmental Protection Agency. Linda Rosenstock, director of occupational medicine, University of Washington, Seattle, chaired the subcommittee.

"Addressing the Physician Shortage in Occupational and Environmental Medicine" is available from the IOM Committee on Enhancing the Practice of Occupational and Environmental Medicine at the National Academy of Sciences, 2101 Constitution Ave., NW, Washington, DC 20418; tel. (202) 334-1715.

54 Volumes of State Reports on Physicians Available from Congress

The Bureau of Health Professions' (BHPr) Office of Data Analysis and Management recently received under contract from the American Medical Association a 54-volume series of State reports entitled, "Characteristics of Physicians: (by State), January 1, 1989." The Bureau is part of the Public Health Service's Health Resources and Services Administration.

The reports provide hitherto unpublished national and county data on both Federal and non-Federal physicians, disaggregated by medical specialty, major professional activity, specialty board certification, military status, sex, and age. Physician practice and location data, broken down by medical school attended, are also included. The volumes cover each of the 50 States, the District of Columbia, Puerto Rico, Pacific Islands, and Virgin Islands, and include national, State, county group, and individual county data.

Free copies of the reports are not available, but the Bureau submitted the reports to the Congressional Information Service (CIS), where they can be purchased in hardcopy and microfiche form. For cost and ordering information, contact Sharon Schmedicke, CIS, 4520 East-West Highway, Bethesda, MD 20814-3389, tel. (301) 654-1550 or 1-800-638-8380.

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A Fitness Classic

In the decade or so of the "fitness craze," one of the leading proponents of disease prevention and health promotion through fitness has been the U.S. Public Health Service (PHS).

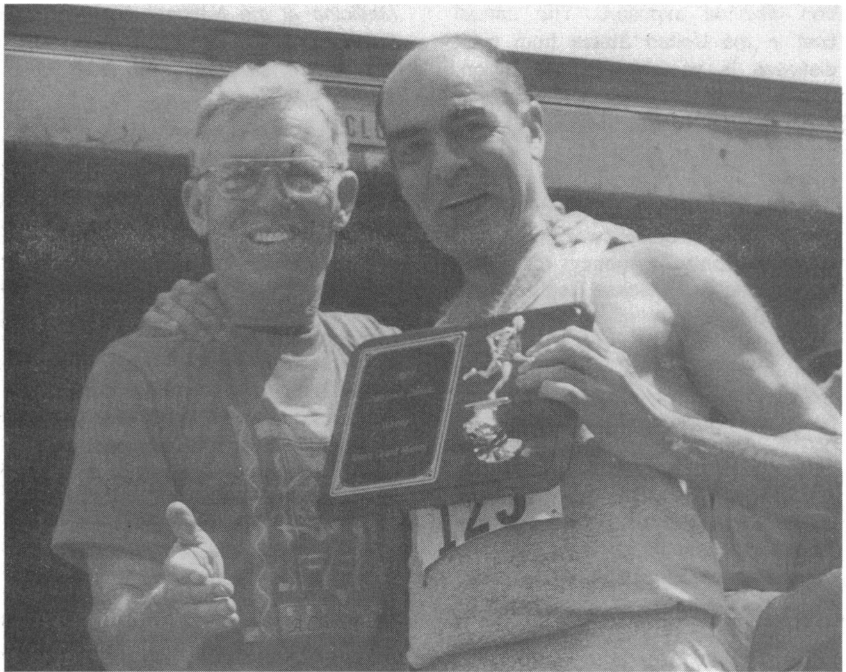
Lest the Federal agency be found guilty of not practicing what it preaches, PHS encourages healthy lifestyles for its own employees though counseling programs, weight training, aerobics classes, smoking cessation clinics, weight control sessions, and the like.

And every year since 1976, PHS has held an annual walk-run event for the employees of the parent Department of Health and Human Services (HHS) that rivals in intensity and attendant hoopla many similar private sector affairs that are better known.

Called the "Parklawn Classic" after the Parklawn Building in Rockville, MD, where some 7,500 PHS employees are stationed, the event, held the last Friday in April every year, features a 5-mile run and a 2½-mile health walk. The 1991 classic saw nearly 2,000 HHS "health bureaucrats" participate—250 in the run and 1,700 in the walk.

Trophies were awarded to the top 20 runners in three age categories, with medals for "place and show," and ribbons were given all walkers. Winner of the 16th classic was Matthew Myers, 32, of the Food and Drug Administration, with a time of 29:33 for the 5 miles.

HHS Assistant Secretary for Health James O. Mason, M.D., who is head of PHS, was a busy man that day. He set an example by firing a gun to start the race, running the 5 miles himself, and then handing out the awards when it was over.



Ernie Hurst (right) receives his winner's plaque from Dr. James O. Mason, head of the Public Health Service. Hurst, 60, who is with the Alcohol, Drug Abuse, and Mental Health Administration, won the over-55 category in the 5-mile Parklawn Classic for the third time.

Dr. James O. Mason, head of the Public Health Service (right foreground), prepares to fire the starter's gun as 250 Federal runners toe the mark in the annual Parklawn Classic.

A portion of the 1,700 Department of Health and Human Services employees near the end of the 2½-mile health walk that was part of the Parklawn Classic.

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