Specialization, Automation, and Regulation
(1965–1990)

There are no areas in Texas, with the exception of the Big Bend country, which is farther than 100 miles from the services of the board-certified pathologist.

George W. Thoma, Jr., MD, reporting in 1965 to the Texas Society of Pathologists. 647

LABORATORY MEDICINE AND THE PRACTICE of pathology were on the verge of transformation in the mid-1960s. As critical paths of science and technology merged, however, so also did long-time political and socioeconomic trends. With science and technology on the verge of explosion, regulation of medicine was in its infancy and civil rights disturbances were at a boiling point.

In science, the sixties brought new visions of theoretical immunology and immunopathology. 648 Already, science had fostered significant advances in technology, and now automation was encouraged regardless of laboratory size. Physicians were advised that the cost of their upgraded laboratory equipment could be recovered over a period of years even when a laboratory performed only a small number of tests. 649

Norman Jacob, MD, of San Antonio, recalls his first attempt to purchase Technicon’s autoanalyzer in the late 1950s. He had attended a meeting of the American Association of Pathologists and
Bacteriologists in Houston, and had seen a demonstration of equipment that could perform two tests—urea and glucose. The cost was $5,500, but with the expenditure Dr. Jacob saw the wave of the future. Based at Santa Rosa Hospital in San Antonio, he returned to advise Sister Mary Vincent, known as a tough administrator, that it was "the way to go." Fully expecting her to balk, he was surprised when she curtly responded, "Well, get it!"

He called the company in Tarrytown, New York, and spoke with the owner's son, who promised to promptly send and set up the equipment. A few weeks later, however, the son called to say he had never received a written confirmation from the hospital, and needed that to proceed with delivery and installation.

Dr. Jacob again went to talk with Sister Mary Vincent, who quickly told him in no uncertain terms that she was good for her word, and to tell the company to send it—that he needed no written request. Dr. Jacob obliged, and so did the company. Soon, the equipment arrived, the son of the founder accompanying it. While installing it, he asked Dr. Jacob's opinion about whether other tests could be put on the instrument.

"I don't know," answered Jacob truthfully. But shortly thereafter, Technicon released a total of fifteen tests that could be run on the autoanalyzer.

"Technicon had always been a leader in tissue processing," Dr. Jacob notes, "but now it became a dominant force in automating." Later, of course, many other companies joined the trend, which would rapidly permeate the field of pathology.

Dr. George Race recalls that when he first arrived in 1959 as director of laboratories at Baylor University Medical Center in Dallas, the hospital was performing about fifteen tests, mostly by hand, and surgical pathology slides took three to five days. He quickly changed to next-day reporting, and by the 1970s, with automation, the Baylor laboratory would be performing more than two million tests per year.650

Other underlying forces also were occurring in the field of pathology, and Dr. Vernie Stembridge of Dallas alerted practitioners that the supply of pathologists was likely to diminish because only 62 percent of the country's pathology residencies were filled.

"We need 500 new physicians entering pathology residencies every year," he said, "and we must actively encourage more young physicians to enter the field."
Specialization, Automation, and Regulation 235

But perhaps the biggest worry for physicians was the uncertainty related to pending legislation in Washington—Medicare and the voluntary health insurance program under the Social Security Act. The concept of Medicare, originally proposed by President John F. Kennedy in 1960, was the provision of limited health insurance coverage to the elderly and disabled under the Social Security Act. In addition, the program was to offer an optional membership health insurance plan.651

Dr. John Childers of Dallas had attended the April meeting of the College of American Pathologists in Dallas.652

"The feeling at this meeting was strong that Medicare would pass in this session of Congress," he said, urging support for an amendment that would remove pathologists from a designation as "hospital services," a tenet currently in the bill.

Dr. Childers' prediction was right. On July 30, 1965, President Lyndon B. Johnson signed the Medicare bill into law, and it would have a profound effect on the practice of medicine for years to come.

Suddenly, everything was both more complex and more perplexing. Pathologists in private practice and in hospital laboratories faced confusing reimbursement policies, and saw their role as physicians being threatened by definition. Already, Blue Cross-Blue Shield of Texas, the Texas insurance intermediary for Medicare, had announced that different fees would be paid for tests in each institution. To combat this, Tarrant County pathologists had set a group fee scale rather than individually negotiating separate fees. Fee-setting, in itself, had the potential for creating problems with the Federal Trade Commission. Members of the Texas Society of Pathologists, however, predicted the federal government under Medicare and future medical legislation would set "some sort of relative value scale very similar to the Blue Cross-Blue Shield scale."

Practitioners also were worried about having to decrease fees for clinical laboratory procedures due to automation and the necessity of increasing tissue consultation fees because of their relatively low value compared to other laboratory procedures.

When the Social Security Administration released preliminary principles pertaining to hospital-based physicians, many physician groups stood up to oppose them. A sample working agreement between pathologists and institutions, developed by the College of American Pathologists in 1966, sought to enable all pathology fees
to be collected from the Medicare carrier under "Part B," the section under which physicians normally were reimbursed—rather than under "Part A" for hospital charges, which was proposed. Nationally, pathologists launched discussions with the Department of Health, Education, and Welfare, pointing out there was an identifiable "professional component" in each test and procedure that a pathologist performed or supervised.

"Pathology under Medicare," a program presented at the CAP meeting in April 1966 summarized "the up-to-the-minute available information on Medicare and its effect on Pathology practice." In Texas, pathologists were advised to talk with tax law firms. Anx­iety was high, and they felt new procedures instituted by Blue Cross-Blue Shield of Texas for billing and compensation for services were "rigorous." They also were troubled about denials for reimbursement based on the carrier's new seven-digit computer codes.

So began the era of "separate billing," in which pathologists associated with hospitals for the first time billed for their own services directly rather than through the hospital administrative operations. The concept of separate billing was strongly endorsed by the Texas Society of Pathologists and the Texas Medical Association. Both organizations adopted resolutions to assist hospital-based physicians in their efforts to separate professional fees from hospital charges, and declared that a physician should not engage in practices which "dispose of his professional attainments or services to any hospital, corporation, or lay body by whatever name called under conditions which permit the sale of the services of that physician by such agencies for a fee." The Texas Medical Association House of Delegates disapproved any arrangement under which a TMA member merged "his or her professional fee with the hospital cost into a single charge to the patient." 654

In 1967, Dr. John Andujar commented in the *Texas State Journal of Medicine* that the "continuing existence of the lay laboratory has received much attention from the membership of the Texas Society of Pathologists throughout the years and continues to be a distressing problem with no easy solution. The pathologist is perhaps the most vulnerable of all physicians, because of his relatively indirect relationship to the patient. The advent of Medicare has brought this into critical focus. Obviously, if an institution or government agency can employ a pathologist to diagnose the cancer of the cervix, and a radiologist to treat it, they can also employ a sur-
geon to obtain the biopsy. Problems will undoubtedly multiply with the increase of government intervention in the practice of medicine. A clear sign of the vulnerability of pathologists is the fact that a federal antitrust suit was launched against pathologists [College of American Pathologists] just as Medicare became effective in our land. The strange notion that pathology (or surgery, or medicine, or obstetrics) should be done by physicians clearly brands physicians as ‘monopolists.’” A consent decree was signed with the Justice Department in 1969 ending the suit, allowing CAP to continue setting performance standards, to inspect and accredit laboratories, and to police its own ranks.655

With developing technology pathologists could simplify and speed technical operations and reports, yet the new regulations sometimes caused administrative chaos. As reimbursement issues mounted, the term “third-party payors” became routine and negotiations with insurance carriers became commonplace.656,657

The Texas State Department of Health also had responsibilities for implementing Medicare provisions, and Dr. Stembridge, as president of the Texas Society of Pathologists, offered his organization’s help in setting up inspections of outpatient laboratories. He was advised that Dr. J. R. Rainey of Austin would become the pathology consultant to the state health department. Though the program had a new twist and involved the federal government, the exercise was reminiscent of the Society’s earlier voluntary efforts with the state to assure quality of laboratory determinations.

While Medicare seemed to be a ubiquitous problem, there were many other issues during the second half of the 1960s. For the next several years, the Texas Society of Pathologists would continue to seek passage of a statewide medical examiners bill, but gain success only in increments. Lay-owned laboratories generally would continue to worry Texas pathologists, and nationally the issue had mutated. The ASCP Board of Registry had been sued by a technologist who was refused re-registration for operating a lay laboratory. That suit was settled favorably.

In Texas, licensure attempts for laboratories and for medical technologists persisted, and already, one group, the Texas Society of Bio-Analysts, had asked the Texas Medical Association’s Council on Medical Jurisprudence for legislative support. The Council, however, had opposed the request. About this time, lay laboratories ap-
parently began concentrating their focus toward federal rather than state governments.

Meanwhile, reports indicated that the American Society of Medical Technologists, on recommendation of its Planning and Scope Committee in October 1965, desired more independence from the ASCP. Some, although reportedly not most, members of the Texas Society of Medical Technologists were supporting this trend "away from any ties to the Pathologists."

"... The Texas Society of Medical Technologists has generally enjoyed close support and cooperation of the Texas Society of Pathologists," Andujar observes, "In the educational field alone, the pathologists have pioneered in establishing schools of medical technology; the fourth school in the nation granting the master of science degree was established in Fort Worth in 1939."

In April 1966, the Texas Medical Association's legislative committee recommended that the Texas Society of Pathologists prepare a bill for licensing laboratories and laboratory directors, basing it on guidelines of a similar law passed in Illinois. Then, in late 1966, it was learned that the Department of Health, Education, and Welfare (DHEW) wanted to amend the Medicare law by adding a "Part C" that would affect pathologists and radiologists, and it announced standards for laboratories in the Federal Register. A resolution was sent to the College of American Pathologists urging that it not support the "Part C" amendment, which Texas members felt would separate pathologists from the rest of medicine.

Dr. William O. Russell of Houston became president of the American Society of Clinical Pathologists (ASCP) in 1964, the fourth pathologist with immediate Texas ties to gain national office. Also, Dr. Norman Jacob succeeded Dr. O. J. Wollenman as Texas' fourth assemblyman to the College of American Pathologists; Dr. Lloyd Hershberger became vice chairman of the ASCP Council, and Dr. Vernie Stembridge succeeded him as Texas Councilor to ASCP.

Specialization and education

IN THE MIDST of changing socioeconomic conditions, Texas pathologists also continued to adhere to their basic love—science. After all, the role of the pathologist was to provide the bridge between pure science and clinical medicine. One such example was evident
when the Texas Society of Pathologists decided against co-sponsoring only a hospitality function and instead supported the scientific program of the American Society of Clinical Pathologists, prepared by Dr. C. T. Ashworth for the ASCP upcoming meeting in Dallas. Commending Dr. Ashworth for the program, Dr. Russell emphasized its importance “in view of the concern by some of the members of ASCP about the possibility of discontinuing scientific papers at the meetings.” Within a few years the American Medical Association would actually drop its scientific meetings, ascribing the reasons to growing specialization. Continuing education was becoming an increasingly more visible issue in medicine, and the ASCP in 1965 announced a new effort in this regard—a one million dollar educational laboratory to be built for members in Chicago, and to be used primarily for workshops.

Another implication for the future

AFTER SEVERAL organizations in 1966 began blanketing Texas with “do-it-yourself-cytology kits,” the Texas Medical Association Committee on Cancer passed a resolution “against the advisability of this program.” Even as pathologists sought to become better qualified in the field through American Cancer Society guidelines and a subspecialty certification, such kits also would grow in popularity.

Medical examiners’ systems; a tragedy occurs

ON ANOTHER TIME-HONORED subject—medical examiners’ systems in the state—there was some optimism. Travis County was considering the establishment of a system, “occasioned by a Grand Jury recommendation to the Commissioners Court.” Texas pathologists supported the effort in Travis County, and offered their help in setting up a system.

Tragedy, however, struck again before anything could be implemented. On August 1, 1966, a young man in Austin, Charles J. Whitman, after killing his wife and his mother, climbed the famed tower of The University of Texas and began shooting wildly across the campus. By the time he was subdued with a gunshot wound to the head, he had killed sixteen and wounded thirty-one people. Following the catastrophe, Texas Governor John B. Connally, who had himself suffered severe gunshot wounds in a public attack in Dallas
only three years earlier, appointed a special “Blue Ribbon” commit­
tee to study the incident. Among the committee of thirty-two were
pathologists Kenneth M. Earle, MD, then chief of the Neuropa­
thology Branch of the Armed Forces Institute of Pathology, a
Texan and former dean of The University of Texas Medical Branch
at Galveston; Joseph A. Jachimczyk, MD, senior consultant in fo­
rensic pathology, Houston; Tate M. Minkler, MD, assistant pa­
thologist and medical systems analyst and William O. Russell,
MD, head of the Department of Pathology and chief of the Section
of Anatomical Pathology, both of The University of Texas M.D.
Anderson Hospital and Tumor Institute, Houston; Coloman de
Chenar, MD, of Austin.

R. Lee Clark, MD, director, and Robert D. Moreton, MD, as­
sistant to the director and professor of radiology, of The University
of Texas M.D. Anderson Hospital and Tumor Institute, were
among other members of the committee. In addition to a number of
recommendations pertaining to mental health, counseling, violence,
and campus safety, the committee echoed a position promoted for a
number of years by the Texas Society of Pathologists—that a state­
wide medical examiners’ office should be developed.

Selected autopsy materials on Whitman were provided the
committee, but its study was limited because the autopsy was not
performed until approximately twenty-four hours after death; the
body had received arterial and trocar embalming before the initial
examination; many parts of the brain were damaged by the penetra­
ing fragments of bone created by the gunshot wounds; all pieces of
the brain were not recovered, and the brain had been sectioned at the
time of the autopsy. The committee presented its findings in the
auditorium of the Texas Medical Association in Austin, and offered
its final pathologic diagnosis on Whitman. These included the find­
ings resulting from the multiple gunshot wounds to the head and
face—contusions and lacerations of the brain, subarachnoid hemor­
rhage and cerebral edema. Two pieces of tumor reportedly removed
from the right temporo-occipital white matter by Dr. Coloman de
Chenar on August 2, 1966, demonstrated glioblastoma multiforme.

The committee’s report stated that the tumor removed by Dr.
de Chenar of Austin, who provided autopsy services under the Trav­
is County coroner’s system, microscopically exhibited the features
of “a glioblastoma multiforme with a remarkable vascular compo-
nent of the nature of a small congenital vascular malformation, and contained widespread areas of necrosis with palisading of cells characteristic of the tumor."

The task force concluded that "the relationship between the brain tumor and Charles J. Whitman's actions on the last day of his life cannot be established with clarity. However, the highly malignant brain tumor conceivably could have contributed to his inability to control his emotions and actions. Without a recent psychiatric evaluation of Charles J. Whitman, the task force finds it impossible to make a formal psychiatric diagnosis."668

Later, some members of the task force indicated certain doubts that the tumor, if it existed, was the cause of the violent outburst, and have leaned toward a psychiatric diagnosis.

Just as the assassination of President Kennedy ultimately led to development of a medical examiner system in Dallas County, so did the Whitman massacre at The University of Texas at Austin spur into action the development of the system in Travis County. Nevertheless, the development of the system was not immediate, and there would be many delays.669

An escalation of war

WHILE CHARLES WHITMAN'S private war took place on The University of Texas campus, the crisis in Vietnam was growing more desperate, and physicians were being drawn into the escalating conflict. Texas physicians there in 1966 on a voluntary basis discovered filth and poverty breeding disease.670

There were many things about this war that were different from earlier wars, but Major General Spurgeon Neel of the U.S. Army writes that despite the complexity of the medical challenges in the hot, humid environment, all blood in Vietnam came from military donors—and did not disrupt the civilian supply. There were no contracts with the American Red Cross nor the American Association of Blood Banks.671

Laboratory quality was a challenge in Vietnam. Laboratory service, Neel reports, finally reached a high level of quality in 1970 as "a result of co-ordination between the medical laboratory system and preventive medicine"—bringing it to the level of effectiveness comparable to that in World War II. Neel points out that in World War II, both activities were an integral part of the laboratory system.672
Neel also reports that the wounded soldier in Vietnam “re­ceived better care more quickly than in any previous conflict.”673 The experiences in Vietnam thus would translate to civilian life in the management of trauma, emergency response systems, increased use of ancillary personnel and the team concept in medical care. There also would be benefits from research on the pathophysiology of stress and the study of disabling cutaneous diseases.674

Kenneth R. Dirks, MD, professor emeritus of the department of pathology and laboratory medicine, Texas A&M University College of Medicine in College Station, attests to the review of the Vietnam experience cited by Major General Neel. He had served in the United States Army in three wars—World War II, Korea, and Vietnam. In Vietnam, between 1967 and 1968, he was commanding officer of the 406th Mobile Medical Laboratory, and later moved to the third field hospital, the “Walter Reed of Saigon,” as commanding officer.

With severely wounded patients, it was not unusual to give more than 100 units of blood. Brought to the laboratory by helicopter, patients often had wounds of a severity not seen in previous wars. The survival rate was remarkable, Dr. Dirks said, and, as a result of the way blood was screened, there was little concern regarding hepatitis. It was very unusual to see a post-transfusion case.

He saw firsthand the development of knowledge that would later be translated to civilian services: the tremendous work of the hemodialysis unit in acute renal failure; dramatic improvement in vascular surgery, and progress in knowledge of transplants when livers were destroyed by high velocity missiles and had to be replaced. Further, a great deal of work was done during the Vietnam war to enhance the antimalarial armamentarium.

Dr. Dirks had been laboratory chief at a number of Army installations in the United States and in Germany, would serve as director of research at the U.S. Army Medical Research and Development Command, Washington, DC, and become superintendent of the Academy of Health Sciences, Fort Sam Houston, Texas, the center for education and training programs of medical enlisted personnel and officers.

Dr. Dirks retired with the permanent rank of Major General (Medical Corps).675

In 1980, after retirement from the military, he would join the faculty of Texas A&M University College of Medicine.
Although the Vietnam war continued, in late 1966 President Johnson had announced the end of US bombing in North Vietnam in an attempt to break the stalemate in the peace talks. The following year President Nixon began withdrawal of American troops from the area.

Medical education and manpower

By 1967, as medical manpower shortages grew, shortages in the laboratory became particularly acute. There was continuing concern that many approved residencies in pathology were not being filled throughout the country, and that one-third of the pathology residents were graduates of foreign medical schools. Recommendations were made to enhance the training opportunities for various supporting laboratory personnel, including greater use of junior colleges.

Texas began focusing on adding new medical schools to assure an adequate supply of physicians for the state. Funding had been provided for The University of Texas Health Science Center at San Antonio in 1959, but various delays kept the school from opening until 1966, when the first class of students entered. When it opened, it had a tremendous positive impact on the medical community in San Antonio, recall Drs. Delmer, Jacob, Townsend, and others.

Texas would continue the efforts during the 1970s to expand the number of educational facilities for physicians, and in 1971, The University of Texas Health Science Center at Houston would be established. One component, the UT Medical School at Houston, would become the second medical school in the city.

Leadership and more change

Evidence of changing attitudes regarding the field of osteopathy was evident in 1967 when the Texas Medical Association adopted the simple position that "Doctors of Osteopathy who practice scientific medicine on an ethical basis are not cultists." James D. Murphy, MD, president of the association, announced that the resolution "allowed the Osteopathic physician to utilize the consultation and educational facilities available to other physicians in Texas. This monition did not make them MDs nor open to them membership in county medical societies or on hospital staffs."
Pathologists remained eager for camaraderie and for intellectual stimulation in the 1960s. Such was the case when a group of physicians formed the Dallas Academy of Pathology on March 7, 1967, to stimulate and improve the science of pathology and to create mutual understanding among the professional practicing pathologists. It was open to doctors of medicine who limited their practice to pathology, and included physicians practicing in Dallas County, nonresidents and honorary members. Only Dallas County members could vote or hold office, but otherwise there was no distinction made on responsibilities or privileges. A candidate for membership could not qualify until four years after internship and had to be recognized as a qualified specialist in pathology, certified by the American Board of Pathology and acceptable to the membership committee. An annual assessment of $25 was charged.

Members signing as charter members were George J. Race, MD; R. R. Rember, MD; Gerard Noteboom, MD; Marc Garza, MD; J. H. Childers, MD; E. H. Valentine, MD; Norman G. P. Helgeson, MD; William Crofford, MD; Gwendolyn Crass, MD; Wm. Hickey, MD; M. Weatherby, MD; Donald D. Van Fossan, MD; D. S. Johnson, MD; and John L. Goforth, MD.

An informal group, the North Texas Society of Pathologists, had preceded the Dallas Academy of Pathology, often gathering to review slides at the Turnpike Restaurant between Dallas and Fort Worth but there had been no formal organization.

In Fort Worth, a group of osteopathic physicians formed the Texas College of Osteopathic Medicine in 1969. In future years, the spouse of a Texas pathologist, Senator Betty Andujar, Fort Worth, would be instrumental in bringing the school under the umbrella of North Texas University.

Space exploration, crises, and success

AS THE DECADE catapulted forward America in 1967 experienced the first deaths tied to its space testing program when Apollo 1 burned on the ground at Cape Kennedy, Florida. Despite the setback, the space effort remained in full swing, purposefully aiming to achieve the goal set by President John F. Kennedy that America would put a man on the moon by the end of the decade.

That technological changes, some to arise from the space pro-
gram, were affecting pathology became clearly evident in January 1968 when the Texas Society of Pathologists held a symposium on automation in the clinical laboratory, moderated by George Z. Williams, MD, director of clinical laboratories, National Institutes of Health. Speakers included Jack P. Abbott, MD, of Methodist Hospital, Houston, on private laboratory automation; B. B. Trotter, MD, of Abilene on small hospital automation, and Donald D. Van Fossan, MD, Baylor Hospital, Dallas, on hospital automation in larger hospitals. Another symposium, in the afternoon, was held on diagnosis, management and experience with pediatric tumors, moderated by H. S. Rosenberg, MD, Texas Children's Hospital, Houston.

Another horrifying incident shocked the American people on June 5, 1968. Senator Robert F. Kennedy, brother of slain President John F. Kennedy, was himself campaigning for the country's Presidency at the Ambassador Hotel in Los Angeles. Suddenly, Kennedy was struck by gunfire, and he died early the next morning, wounded fatally by a Jordanian immigrant, Sirhan Sirhan.

Kenneth M. Earle, MD, who had left the deanship at The University of Texas Medical Branch at Galveston in 1962 and was chief of the Neuropathology Branch of the Armed Forces Institute of Pathology in Washington, D.C., with two other AFIP consultants, was flown to Los Angeles. There, they assisted Thomas T. Noguchi, MD, medical examiner for Los Angeles, in performing the autopsy on Senator Kennedy. Because of the furor that had surrounded President Kennedy's death, Dr. Noguchi immediately sought the help of the AFIP. By the time Dr. Earle and his colleagues arrived five hours later, the autopsy was nearly complete, the brain removed and the skull open. Under a gag order, the team was sequestered for four days, and heard no news of outside events. During that time it conducted a meticulous autopsy, and had everything photographed in detail. To the team's surprise, Time Magazine nevertheless acquired information, describing where the bullet was located.

So confusing were the regulatory impositions and the social disturbances of the 1960s that the march of science occurred behind the scenes. But in July 1969 it came vividly to the fore as Americans once again glued themselves to their television screens and watched
Astronauts Neil Armstrong and Buzz Aldrin step onto the lunar surface from Apollo II—the first men to walk on the moon.

A medical examiner system in Dallas

DR. VERNIE STEMBRIDGE guided a cooperative effort to link a new medical examiner system in Dallas between the county commissioners, the city police department, and The University of Texas Southwestern Medical School. It was designed to assure autonomy, quality, and efficiency in the forensic process. As chairman of the school’s department of pathology, Dr. Stembridge then invited Charles S. Petty, MD, to move to Dallas from Indianapolis to head the Southwestern Institute of Forensic Services, which combined under the medical examiner’s office medicolegal autopsies, toxicology, and criminalistics. All professional appointees would be required to have a faculty appointment. The location of the unit was considered important politically as well as scientifically. As was the case in Travis County, there would not always be smooth sailing.

When Dr. Petty arrived in Dallas in June 1969, he had in hand a letter signed by the county judge stating what the county would do in the new situation. One never knew, however, he said later, where the county judge stood on any given issue, and often, the judge would caution, “we don’t want to move too fast.” Later, however, he would agree to Dr. Petty’s requests. On an interim basis for two and one-half years the medical examiner operation was housed at Parkland Memorial Hospital, but, as Dr. Petty observes, hospital pathology runs “countercurrent” to forensic pathology because the needs are different.

“A hospital must handle a large volume, and be prompt. Surgical specimens are the priority,” he said. Therefore the hospital sometimes was clogged with bodies awaiting autopsy.

Meanwhile, plans were being drawn for a separate building for the medical examiner. Even so, when he inquired about the surveyor’s plat, he was told to oversee the survey himself—which he did. In addition, the land required deeding from three different political units—The University of Texas Southwestern Medical School, the county hospital district, and Dallas County.

Controversy frequently boils around a medical examiner system, with the examiner trapped in a no-win situation. Dr. Petty recalls one difficult situation in Dallas around 1970. Newspaper ar-
articles "were terrible," he said, and he was ready to leave Dallas. But Dr. A. J. Gill, former dean of the medical school, hooking his cane over his left arm, said, "I think there's something that can be done. I'll see to it."

Dr. Gill formed a committee of three physicians, three hospital administrators, and three morticians. Though Dr. Petty recalls the meetings as difficult, the problem was worked out after several discussions.

The key to forensic pathology, Dr. Petty states, is investigation, and often, "things really aren't what they seem to be."

By team effort, he reports, a good criminal investigation system was established in Dallas, and, among other activities, the Rape Crisis Center was later added to his responsibilities. The Rape Protocol established by Dr. Petty and The University of Texas Southwestern Medical School obstetrics department would become the basis for most rape protocols in the United States.

Dr. Petty also served on the Senate Select Committee that studied the assassination of President John F. Kennedy.

Medical examiners' systems, however, evolved slowly in locations around the state. Corpus Christi pathologists in 1971 submitted to the Texas Legislature a bill amending Article 49.25 of the Code of Criminal Procedure, 1965. When enacted the bill permitted two or more counties to create a medical examiner's district and to jointly maintain a medical examiner's office. The Texas Society of Pathologists hoped the legislation would bring the state one step closer to "the desired goal" of a uniform statewide Medical Examiners' System.

Texas Society of Pathologists; a sign of growth

DR. JACK LINE SMITH of Beaumont served as the secretary-treasurer of the Texas Society of Pathologists from 1965 to 1970. The Society had grown considerably since 1921, and periodically there had been a post of "assistant secretary-treasurer," so onerous were the duties.

When the secretary-treasurer completed his or her tenure—often a job that lasted several years—loads of files and records were transferred to the successor. In February 1970, however, the Society made arrangements with the Texas Medical Association to provide
administrative services, and Iris Wenzel of Austin, a member of the TMA staff, then assumed the duties. She would maintain sole responsibility for the administrative work for many years. Later assisted by other staff, she would retain oversight of administrative services for specialty societies until her retirement on December 31, 1993.

Dr. Smith recalls happily turning over files to Mrs. Wenzel—and transferring minutes, invoices, and other materials. Perhaps he was a little envious, too, of his successor in the office—Dr. Jim Stinson of Temple—for having Mrs. Wenzel’s assistance.

**Legislative and regulatory shock in the 1970s**

TEXAS PATHOLOGISTS used numerous approaches to address legislative and regulatory matters, but a few examples follow.

At the request of the Texas Medical Association in 1970, the Texas Society of Pathologists had considered writing legislation to improve clinical laboratory services in Texas. Interestingly, however, members felt that the federal statute and regulations dealing with inspection and certification of clinical laboratories was “generally providing adequate direction,” and that a Texas bill was redundant. They, however, supported a state bill requiring disclosure to patients of actual laboratory charges for a test.\(^6\)

The Texas Medical Association’s Board of Councilors unanimously reaffirmed its position on lay-owned laboratories, stating it was unethical for a physician to utilize, enter the employ, or otherwise participate in the function of such an institution. In 1971 the Board of Councilors urged the Texas State Board of Medical Examiners to act against any physician who entered an agreement with a corporate body, noting the agreement could be in violation of the state’s Medical Practice Act.\(^7\) That same year, the Joint Commission on Accreditation of Hospitals (later the Joint Commission on Accreditation of Healthcare Organizations) published its position that a physician must supervise the clinical pathology laboratories, but that a non-MD might be acceptable as a technical director. The physician director was not required to be full time and not required to be a pathologist.\(^8\) Various suits were filed in this era against the College of American Pathologists pertaining to its position on lay-owned laboratories and on the voluntary quality control programs it conducted.

In January 1971, the real socioeconomic shocker startled many
pathologists in private practice as the Social Security Administra-
tion issued “sharp guidelines” for billing professional clinical pa-
thology services covered by Medicare. The guidelines declared that
payment of fees by hospital-based physicians for Medicare patients
should be billed as “Part A” (or hospital services) unless there was a
specific service performed by a doctor of medicine. The Texas Medi­
cal Association declared that pathologists should bill separately for
their services.688

The issues became more complex. Dr. Carl Lind of Houston in
January 1972 reported to his colleagues in the Texas Society of Pa­
thologists that the Social Security Administration had advised sev­
eral organizations to make plans for quality control and inspection
of their own laboratories, including physicians in the specialties of
internal medicine and family practice, and that their laboratories
must meet accreditation requirements. He discussed the economic
impact from the regulations, predicted a profound effect on path­
thologists and declared that the relationships of hospitals and path­
thologists would be affected.689

Meanwhile in San Antonio, Drs. A. O. Severance and Merle W.
Delmer became the first pathologists in the state to establish the
principle of separate billing, and quickly worked out an equitable
arrangement with Baptist Hospital there.

It was a different story, however, for Dr. Thomas H. McCon­
nell, III, of Dallas. He vividly recalls those days in the early 1970s,
when the new regulations sent many pathologists scrambling to
work out suitable hospital agreements.690

When he joined Dr. Charles Ashworth as a pathologist at Dal­
las Presbyterian Hospital in 1970, the two were members of a group
of pathologists paid a salary from a hospital fund.

"The fund accumulated money from billings sent in the names
of pathologists," he recalls, "but the pathologists had no control of
any kind over the fund. When Dr. Ashworth left to go into practice
at his private lab, I became chairman of the department and chal­
lenged the legality of this arrangement in 1975 after failing to get the
hospital to negotiate a change. My tactic was to send a copy of the
contract to the State Board of Medical Examiners. They in turn con­
sulted with the Attorney General’s office.”

"In an incredible stroke of good luck," he says, "as it turned
out, while the TSBME and the AG were considering this topic, the
U.S. Supreme Court, in Garcia v. State of Texas, handed down its
verdict in favor of the State of Texas and its medical practice act. The key issue was the 'corporate practice of medicine.' The Garcia decision supported the right of states to have a law prohibiting the corporate practice of medicine, stating in effect that no one in the state could hire a doctor on a salary, or bill in the doctor's name, or keep physician-generated income after expenses.

Dr. McConnell adds that the hospital subsequently fired him for raising this thorny issue, and the matter became a "nasty, newsworthy dispute which made the front page of both Dallas newspapers several times." Dr. McConnell, however, later realized the distasteful situation was "the best thing that ever happened" to him because he then went into business for himself where he "succeeded beyond my wildest expectations."

Eventually the hospital and Dr. McConnell's successor, who was not found for more than a year, negotiated a separate billing contract along the lines he originally was seeking.

Richard Hausner, MD, had graduated in 1971 from the State University of New York Upstate Medical Center. A younger-than-average student needing experience, he first took a clinical internship in pediatrics at the University of Michigan, and because there still was a military draft and he had a one-year doctor's draft deferment, he entered the Navy doing considerable pediatric medicine. He then returned to the University of Florida College of Medicine for a residency in pathology, moving to Texas in 1978 to join the faculty of Baylor College of Medicine, Houston, as an assistant professor of pathology.

He recalls his academic period as a time of "excellent experience," in pathology, whether or not one pursued an academic career. Although he enjoyed his work, with family responsibilities during the era of financial hyperinflation, he decided to enter private practice in 1981. Joining a new group with J. B. Askew, Jr., MD, and Ena Mocega, MD, as equal partners, he practiced pathology at Houston Northwest Medical Center.

At the time separate billing was considered a given at the hospital, and the administration advised the group, "You do your thing; and we do ours." On the cusp of changes in Medicare, he began under the Reasonable Compensation Equivalent (RCE) form of reimbursement for government health care programs, which was replaced when diagnosis-related groups (DRGs) were instituted. The
latter required the pathology group to negotiate with the hospital for its component of the Medicare "Part A" services.

In 1983, Dr. Hausner moved to Cypress Fairbanks Medical Center but continued also to serve Houston Northwest Medical Center until 1985. Subsequently his group split, the others remaining at Houston Northwest Hospital and he at Cypress Fairbanks.

Having a slightly different view than some regarding the merits of separate billing, he observes that in Texas it was especially difficult to estimate payment for particular services. In many cases, pathologists did not have great bargaining leverage with administrations after the separate billing episode, and it became difficult under the new DRG system to obtain reimbursement for "Part A" of Medicare.

Also, by the time he had entered practice, automated technology was in full swing. Although automation facilitated delivery of results, he points out that a test itself is "not truly automated." "Without the human element," he observes, "the instrument would stop."

James M. Goforth, MD, of Amarillo, whose uncle was pioneer pathologist Dr. John L. Goforth of Dallas, decided when he was very young that he wanted to be a pathologist. Later, while he was attending The University of Texas at Austin in the 1960s, a cousin talked him into taking the Medical College Admission Test (MCAT). He did well on the test without having studied, and decided to apply to medical school. Accepted at every place he had applied, he chose to attend Washington University in St. Louis. There he studied with Drs. Paul Lacey and Lauren Ackerman. The latter discouraged him from returning to Texas for a residency, and he then decided to take his postgraduate education at Johns Hopkins in Baltimore. Caught, however, in the civil rights disturbances of the 1960s, which were particularly acute on the east coast, he decided to return to Texas, and completed his residency at The University of Texas Southwestern Medical School in Dallas, under Drs. Vernie Stembridge, Frank Vellios, Bruce Fallis, Tony D'Agostino, Ben Dowdey, and others.

While earning extra money as a *locum tenens* in Amarillo, he first became interested in the locale. Since it was near the end of the Vietnam era, he, however, had to complete deferred military service but found that his two years as a pathologist at Fort Leonard Wood, Missouri, were excellent preparation for practice, including daily decisionmaking in a variety of areas. In 1974, he and Rod M.
Nugent, Jr., MD, who had been a resident with him at Parkland Memorial Hospital and UT Southwestern in Dallas, joined forces to open a private laboratory in Amarillo.

When they arrived in the city, Drs. Ralph Zientek, Bob Brierty, and John Denko already were serving the community.

Drs. Goforth and Nugent sought a contract at St. Anthony Hospital, and succeeded in getting it. Later they also obtained a contract from Northwest Hospital.

Drs. Goforth and Nugent had been joined in 1983 by James “Hap” Hamous, MD, and in the late 1980s, by Robert Todd, MD. Their practice grew well and rapidly, and over the years, they also covered a number of small surrounding community hospitals, including Guymon Memorial in Guymon, Oklahoma; and hospitals in Dalhart, Spearman, Canadian, Hereford, and Dumas.

In 1974, it was still standard in Amarillo to have a percentage contract, but in 1976, the group turned to separate billing. Dr. Goforth recalls taking “some flack,” for his group’s approach—for they essentially reversed the normal approach to charges, assigning more weight to microscopic and tissue work than to clinical laboratory tests, reasoning that their time really was spent on those areas. Apparently, there was disgruntlement expressed at a meeting of the Texas Medical Association about their approach, and even Dr. Vernie Stembridge called with concern about statements made at the meeting.

“But,” Dr. Goforth responded, “we spent most of our day at the microscope and with tissues and we needed our income to come from what we actually did rather than from the clinical laboratory functions, such as blood glucose, and so on.”

Their efforts in separate billing did break ground for other pathologists in Amarillo.

The city had seen an expansion of clinical and anatomic pathology, but never had been successful at obtaining a medical examiners’ system with a qualified forensic pathologist, thus justices-of-the-peace continued to control the system. There had been a number of difficulties. Jose A. F. Diaz-Esquivel, MD, for awhile had provided the forensic autopsy service. Another practitioner, Ralph Erdmann, MD, who had once been in Lubbock and Amarillo, then practiced in Childress, returned to provide coroner’s services for the county. He, however, encountered personal difficulties. Reportedly performing too many autopsies in an effort to support the district
attorney and law enforcement officers, he also had to conduct them in inadequate facilities. The situation led to falsification of records. He was charged with falsifying official documents through the justice-of-the-peace system, and was imprisoned.

Dr. John Denko, a pathologist who had been in Amarillo since 1950, had retired.

The Coffey Memorial Blood Center in Amarillo provided blood services to the region, and the director of the center in 1995 would be Mary Townsend, MD.

Migration and evolution in the Permian Basin

CHRISTOPHER L. HALL, MD, of Midland, the original medical director of the Permian Basin Regional Blood Center, reports on the continuing development of pathology in other parts of West Texas.691

Midland.—Dr. Martha Madsen was joined in 1977 by Richard Schmickrath, MD, and in 1978 by David Shneidman, MD. Dr. Shneidman built a busy dermatopathology and forensic pathology practice, but would leave for Washington state in 1989. Elisa Hall, MD, specializing in neuropathology, became part of the practice from 1984 until 1991. Leena Shroff, MD, at the Big Spring Veterans Administration Medical Center (VAMC) until about 1987, also would begin working in Midland.

Big Spring.—Robert Rember, MD, spent the late 1970s until late 1980s at the Scenic Mountain Medical Center; and later would go to Big Spring VAMC.

Odessa.—Robert Bright, MD, would work at Odessa Women's and Children's Hospital from 1980 to 1989, bringing board certification in forensic pathology to the area for the first time. James Howell, MD, arrived in Snyder in 1981, and moved to Odessa Women's and Children's Hospital in 1988. In 1990, he would be joined by Stuart Myster, MD.

About 1983, Baylor University Medical Center in Dallas began providing pathologists to Medical Center Hospital by contract. Full-time pathologists since that time have included Sparks Veasey, MD, James Bagnell, MD, (deceased), Morgan Dyer, MD, and John Lewis, MD. Dr. Veasey completed additional training in forensic pathology and would return to West Texas in 1992 as Ector County Medical Examiner, later moving to Lubbock.
Also in the West Texas area in 1992, the Regional Blood Center would be formed as a joint venture between Odessa Medical Center Hospital and Midland Memorial Hospital, Dr. Hall becoming the first director.

_Pampa_—Joe Lowry, MD, of Pampa reports changes in recent decades in this area.692

Except for 1966 when a pathologist lived in Pampa briefly, Dr. John Andujar of Fort Worth provided services until 1969 at which time Victor Trammell, MD, arrived. Dr. Trammell had a good friend, L. M. Kimbell, MD, who started practice in Borger at the same time, and the two shared calls.

In 1976, Dr. Trammell left Pampa and was succeeded by James F. Tilden, MD. Dr. Tilden, originally from Michigan, had been a general practitioner for several years before taking a pathology residency at the University of Colorado. In 1979, Dr. Kimbell was killed in a car wreck, and Andrew J. Kalivoda, MD, who was trained in New Mexico, became the pathologist in Borger. Drs. Kalivoda and Tilden also shared calls. HCA had bought Highland General Hospital in 1982. A few years earlier, Worley Hospital had closed. HCA also built Coronado Community Hospital in 1983.

When Dr. Tilden retired in 1984, Dr. Lowry became the pathologist at Coronado Community Hospital. Dr. Kalivoda, who continued as pathologist in Borger, shared calls with him. The hospital in Borger, however, was closed in 1989, and Dr. Kalivoda returned to New Mexico. He died in 1992 and Dr. Tilden died in 1994.

_Lubbock._—In 1972, Texas Tech University School of Medicine opened on schedule, the Association of American Medical Colleges having reported that it had set a new national record for the establishment of a new school. The school had been authorized by the Texas Legislature in May 1969, a dean appointed in 1970, and classes had begun in the fall of 1972. The AAMC may have forgotten about the World War II instant development of Southwestern Medical College in Dallas, but nevertheless for start-up time at this period of history, the record was impressive. Sixty-one students were enrolled, and there were 120 faculty and staff members.693

“Pathology was drastically changed in 1972/73 when the School of Medicine opened in Lubbock,” comments Louis Nannini, MD, of Lubbock.694 Harry Sproat, MD, was appointed as acting chairman and became the first pathology chairman. Dr. Sproat re-
cruited Donald MacNair, MD, and Carter Alexander, MD. Dr. Sproat would resign in 1984, his position filled by Dale Rector, MD, as acting chair until 1985 when Thomas M. Sodeman, MD, would be appointed chairman. Meanwhile, several other pathologists joined the staff, among whom was Dale Dunn, MD, who would become chairman.


The issues continue

AS SPECIALIZATION of American medicine continued, there sometimes were disagreements about categories and requirements of new specialties. In 1972, the American Board of Nuclear Medicine was scheduled to conduct examinations in its field, and Texas pathologists expressed concern that the Board’s requirements would eliminate qualified pathologists from involvement in nuclear medicine.696 In 1972, the Texas Society of Pathologists, however, voiced support for limited certification by the American Boards of Pathology and Radiology in the areas of radioisotopic pathology and nuclear radiology.697

The Texas Society of Pathologists had been concerned about quality of laboratories since its inception in 1921, and had conducted its own reviews, sometimes in conjunction with the State Department of Health; however, in the 1970s, “quality control” became a highly visible topic, often related to government health care programs. The Society encouraged research and development in the
area of quality assessment, and planned to develop its own program of laboratory assessment. A special committee on quality control recommended moving forward with a chemistry quality control program—using a computer service of the College of American Pathologists.698

Perhaps it was timely that the "year of pathology" was observed by Texas pathologists in 1972—for during the previous year the Texas Society of Pathologists had celebrated its fiftieth anniversary, with Dr. Vernie Stembridge of Dallas serving as chairman of the event,699 and this year the wife of a pathologist, Betty Andujar (Mrs. John J.) of Fort Worth, became the newly elected state senator from Tarrant County.700

A stream of federal laws showered physicians over the next few years, among them Public Law 92-603, passed in 1972, which included a section establishing Professional Standards Review Organizations, providing for a review mechanism for Medicare programs. The law also contained a section pertaining to billing for laboratory services by pathologists. In 1974, there would be PL 93-641 (the National Health Planning and Resources Development Act of 1974) which terminated the Hill-Burton Act and other health planning legislation and initiated a new "comprehensive health planning" approach.701 Also being discussed was the "Forward Plan for Health" developed by the Department of Health, Education, and Welfare.

The Texas Medical Association attempted to have the state placed under one PSRO through an organization it formed with osteopathic physicians, known as the Texas Institute for Medical Assessment.702

Then, in January 1973, the Texas Medical Association House of Delegates implemented the Texas Medical Foundation, which began working with specialties to set up physician profiles related to reimbursement for Medicare patients. The challenge, though the foundation was attempting to help physicians, posed difficulties for pathologists because government profiles were set up by number of patients seen, diagnosis, and other factors not directly pertinent to pathologists. However, Dr. J. R. Rainey of Austin reported he was working with Blue Cross-Blue Shield of Texas to set up nomenclature for pathologists.703
Cost containment was to become a larger and larger issue throughout the decade and beyond.

A foreshadowing of change in the practice milieu for medicine also was evident with the development of Health Maintenance Organizations, and in 1973, there was early opposition to an HMO bill in the Texas Legislature that would authorize any corporation to deliver health care services. The bill was reported favorably out of committee, but did not gain enough support to suspend rules for a vote.704,705

Pathologists also saw incursions into realms of scientific medicine, and protested a bill before the Texas Legislature on premarital serologic testing for rubella for all women under fifty, an issue that the Texas Society of Pathologists felt lacked the clear direction of scientific knowledge. The Society declared that “the pathologists of Texas have watched with dismay the increasing legal incursions into the practice of medicine and of pathology, including such misadventures as compulsory PKU [phenylketonuria] testing and the like, without consulting with bodies best qualified to advise.” The Society vigorously opposed the “unwarranted and unfortunate legislation.”706

Computer coding systems would continue to be developed in conjunction with reimbursement for Medicare, and in the fall of 1974, Blue Shield of Texas announced that it would adopt the Current Procedural Terminology (CPT-3) system.707

In January 1975, Sidney W. Kowierschke, MD, president of the Texas Society of Pathologists, returning from a CAP-ASCP meeting, referred to high points of the “bureaucrats” messages, reporting their belief that since Hill-Burton legislation had provided the country with facilities, now the nation’s manpower must be developed. Further, he reported, they felt that health care was too costly and must be controlled by increasing productivity through using more nonphysician personnel; that health care must be made more competitive, and the number and geographic distribution of specialists should be controlled; that medical students’ education should be subsidized in exchange for postgraduate placement into needy areas and there should be use of more foreign graduates. Citing the euphemism “provider of services,” he noted the time was getting closer when the term would be implemented. A provider could be a physician or a hospital, and if a patient sought service at a
A new medical school opens

TEXAS A&M College of Medicine opened classes in September 1977 with thirty-two students. The college had been initiated in 1971, when the Texas Legislature authorized the Coordinating Board for Higher Education to apply for Veterans Administration funding to establish a new school. The VA program was directed at relieving the nation’s manpower shortage and maldistribution, mak-
ing use of VA hospitals and state institutions of higher learning. Dr. Joyce Stripling Davis, associate professor of pathology at Baylor College of Medicine, Houston, became head of the new pathology program at Texas A&M.\textsuperscript{713}

A time of ferment and opportunity

A SCIENTIFIC DEVELOPMENT in the 1970s, spurred by experience during the Vietnam war, called for new legislative approaches. Transplantation of organs was becoming a growing aspect of care in medical institutions. In Texas, in March 1977, the Legislature responded, giving authority to justices of the peace and medical examiners to permit the taking of corneal tissue for transplants, providing immunity in certain civil suits. A leader in passage of the bill, Senator Betty Andujar (Republican-Fort Worth) was commended in a resolution by the Texas Society of Pathologists for her overall service. Her colleagues in the Texas Senate unanimously had named her president pro-tem of the Senate in January 1977, and on May 7, 1977, she was inaugurated and became Governor-for-a-Day. Senator Andujar served ten years in the Texas Legislature, stopping only when faced with triple bypass heart surgery in 1985.

Regulation droned on in the 1970s. The Medicaid and Medicare fraud and abuse bills were enacted, cost containment bills were in progress, and in 1977, the Clinical Laboratory Improvement Act was passed. In Texas, as a result of long-time efforts to improve the medical liability situation, which continued to see a rise in cost and number of suits filed, the Texas Legislature passed the Texas Medical Disclosure Act.

Gradually, medical examiner systems were spreading across the state. In mid-1977, Robert Bucklin, MD, became the first medical examiner in Travis County, bringing to nine the number of counties in the state with a chief medical examiner. Roberto Bayardo, MD, succeeded him in 1978.

Dr. Bayardo had entered the field of forensic pathology "by accident." He had been in a rotating internship, had taken two years of general surgery, and then an elective in pathology. Liking it better, he applied for a pathology residency. His mentor became Berne Newton, MD, on the faculty of Baylor College of Medicine and the staff at Methodist Hospital, Houston. Soon, Dr. Bayardo also met
Dr. Joseph Jachimczyk, the forensic examiner in Harris County, who in 1976 asked him to help out on weekends and holidays.

After two years of conducting hospital autopsies, Dr. Bayardo then left Methodist Hospital and joined Dr. Jachimczyk full time. Soon, he also was helping Travis County Medical Examiner Dr. Robert Bucklin. When Dr. Bucklin left Austin, Dr. Bayardo “was in the right place at the right time,” and in 1978 he moved to Austin. The city at first did not have the proper physical facilities, but during the 1980s voters would approve an upgraded system. However, that vote would not be implemented until 1995 when new facilities would be built.

For fifteen years, working every day, Dr. Bayardo was the only medical examiner in Travis County until Suzanne E. Dana, MD, who had been in San Antonio, joined him in 1993. Dr. Bayardo initially had responsibility for twelve central Texas counties and by 1995 he would provide services to thirty-five counties.

Government intervention was causing physicians to become more and more involved in negotiation processes in the 1970s, and Texas pathologists even participated in AMA negotiations courses to help them deal with confrontations.

Voluntary continuing medical education remained a hot topic, and the Texas Society of Pathologists and the Texas Medical Association adopted positions during the 1970s and 1980s strongly favoring voluntary continuing medical education (CME). They also were opposed to government involvement, and making CME mandatory for licensure.

The joint Texas Society of Pathologists-College of American Pathologists’ geographic quality control program grew considerably during this era, with a number of laboratories participating. The program, however, would not preclude a number of government agencies from becoming involved in “quality assurance” programs.

In 1979, the Texas Society of Pathologists and seventeen other specialty societies became members of the Texas Medical Association Specialty Society Committee, and each was seated as a nonvoting member of the Texas Medical Association House of Delegates. Dr. John Webb became the representative and Dr. Rainey the alter-
nate representative. In 1989, specialty society delegates would be given voting privileges in the TMA House of Delegates.\textsuperscript{714,715}

**Goodbyes during the 1970s**

During the 1970s, Texas pathologists lost several prominent colleagues to death. A Northwest Texas pioneer in pathology, Dr. Thomas P. Churchill of Amarillo, died in 1970.\textsuperscript{716} In 1971, Dr. Truman Conner Terrell, a past president of the Texas Medical Association and five times president of the Texas Society of Pathologists, died at the age of eighty-one, having served medicine in many capacities for more than fifty years.\textsuperscript{717} Another pioneer and founder of the Texas Society of Pathologists, Dr. Marvin DeWitt Bell of Dallas, also died in 1971,\textsuperscript{718,719} as did Dr. Francis Elbert Council of Sherman.\textsuperscript{720} Dr. Herbert J. Schattenberg of San Antonio died in 1972;\textsuperscript{721} Dr. Charles Thomas Brierty of San Antonio in 1973; Dr. Maynard Sterling Hart of El Paso in 1975,\textsuperscript{722} and Dr. Ellen D. Furey of Beaumont in 1976. A long-time pathologist and a past president of the Texas Medical Association, Dr. George Turner, died in 1976. Dr. A. B. Cairns, formerly of Dallas and an early director of laboratories at Parkland Memorial Hospital and later for many years at Methodist Hospital in Dallas, died in 1979.\textsuperscript{723,724}

Dr. A. J. Gill, former dean of medicine at The University of Texas Southwestern Medical School in Dallas, also died in 1979, following a tractor accident on his farm.

In 1979 also, at age fifty-eight Dr. Feliks Gwozdz died two weeks after returning from his native Poland, where he had been presented an award by the Nicholas Copernicus Medical Academy (at 600 years the oldest medical school in Poland). The award commended his outstanding achievements in forensic medicine. He was honored posthumously also with the Texas Society of Pathologists’ Caldwell Award and by the National Association of Medical Examiners, which presented a plaque to his family citing his zest for life emphasized “by his warm smile, friendly voice, and the way he communicated happiness—through Music.”

**Role of pathology threatened**

The need for pathology services continued to increase, but during the 1980s, some felt its importance was not reflected in the
Dr. Vernie Stembridge in 1981 considered the status of pathology in the light of Darwinian principles, and pointed out that as the basic science subjects were correlated with the clinical sciences of physical diagnosis, internal medicine, and surgery, pathology began to lose its genuine “bridging” features, and often was reduced to a recitation limited to anatomic pathology. “Consequently,” he said, “students and faculty had less appreciation for the true significance of the role of pathology.”

In addition, in some schools, the amount of time for pathology had been reduced significantly,” he said, “and many students no longer were exposed to pathology as a vital basic science. They thus often had no appreciation for the subject as a specialty branch of medicine.

He further pointed out the importance of the autopsy, and its waning emphasis.

A grim but necessary procedure, the autopsy also produced a moment of humor for Dr. Billy Bob Trotter of Abilene in the early 1980s. For lack of facilities in the hospital, he conducted odoriferous medical legal autopsies in what was called “the alligator pit” at the Abilene Zoo. For his unusual plight, Texas Monthly magazine gave him one of its annual “Bum Steer Awards.” Perhaps the magazine writers should have heard Dr. George T. Caldwell’s admonition that “you could practice in a barn if you had the brains.”

Around 1985, Dr. Trotter stopped doing medicolegal autopsies, the services thereafter provided by the Tarrant County Medical Examiners’ System.

Hassles, in effect, were becoming typical for the world of medicine and of pathology. During the 1980s, a number of organizations were involved directly or indirectly in surveying private laboratories including the Centers for Disease Control in Atlanta, the Health Care Financing Administration (HCFA), Food and Drug Administration (FDA) and other governmental units and voluntary agencies. There was considerable opposition to the multiple surveys. In addition, none of the governmental/regulatory agencies had the quality of programs in the private sector.

To compound problems, in July 1981, HCFA stipulated that hospital-based pathologists and radiologists must accept assignments for reimbursement under Medicare “Part B” on all hospital-
ized patients in order to receive 100 percent allowable reimburse-
ment.

In addition, there was a continuing shortage of qualified allied
health care personnel, including medical technologists and cyto-
technologists. To help alleviate the shortage and encourage qualified
individuals into the field of medicine, Dr. Margie Peschel of Fort
Worth, chairman of the Texas Medical Association's Committee on
Health Careers, led a comprehensive program, encouraging projects
such as science bowls in communities to raise awareness regarding
career choices in the field.

In the early 1980s Dr. George Race was appointed by Governor
William P. Clements to the Governor's Task Force on Higher Edu-
cation and Dr. Wm. Gordon McGee to the Radiation Advisory
Board. Dr. Dorothy Patras was elected to the TMA Council on Leg-
islation (formerly the Council on Medical Jurisprudence).

In May 1982, the Texas Society of Pathologists, following an
earlier recommendation, adopted the concept of a House of De-
egates policymaking structure, and would become the first state so-
ciety of pathologists to adopt such a process. With Dr. Andujar as
chairman, the other interim directors were Drs. John D. Milam of
Houston, Wm. Gordon McGee of El Paso, and Dub Crofford of
Dallas. They were to establish the delegate system and nominate the
thirty delegates and thirty alternate delegates. The system was ap-
proved by members, with a plan to review the process in three years,
and in May 1984, the new system was implemented.

Reminiscent of concerns posed by pathologists years earlier
when M.D. Anderson Hospital in Houston attempted to start a tu-
mor registry were those expressed in the early 1980s when the State
Department of Health planned expansion of its statewide tumor
registry. Furthermore, the department planned to make the pro-
gram compulsory. Although some of the anxiety related to pro-
posed punitive measures for noncompliance, as in earlier years,
there was apprehension regarding bureaucracy. In addition, there
was concern about the confidentiality of patient-physician records.

Texas celebrated its 150th year of existence in 1986, marking its
independence from Mexico and its first year as the Republic of
Texas. To observe the event, Texas pathologists coordinated a program with peers in Australia, which also was celebrating 150 years as a country.

Yet another acronym came to haunt Texas pathologists in the 1980s—TEFRA. It stood for the Tax Equity and Fiscal Responsibility Act, which brought hospital ancillary units, including laboratories, under reimbursement limits and once again changed the basis for reimbursements to pathologists, challenging the tenets of separate billing and the professional component of laboratory work. Regulations were to invoke "prospective payment," where appropriate, in the Medicaid program. Pathologists prepared to develop new contracts with hospitals as government programs under Medicare changed to diagnosis-related-groups (DRGs) and to adapt to an updated computer code for reimbursement (CPT-4). Under DRGs, there was confusion about how to determine the professional component of charges in both anatomic and clinical pathology.

"Town-Gown" issues also escalated in Galveston (UTMB) and Houston (Baylor) during the 1980s as medical schools and hospitals developed new approaches in the delivery of medical care. There was growing concern among private practitioners that certain institutions were providing professional services in nonacademic settings. Some communities, such as Dallas, experienced no friction, attributable largely to the fact that a member of the full-time faculty at Southwestern served on the Dallas County Medical Society board.

**Organ transplantation**

MUCH WORK WAS undertaken during this decade to facilitate and assure proper procedures for organ transplantation. Dr. William T. Hill of Houston, chairman of the Texas Medical Association's Council on Scientific Affairs, particularly sought help in procuring organs for transplant and establishing guidelines. He guided the four-year project between the Texas Medical Association, the Texas Osteopathic Medical Association, the Texas Hospital Association, and the Texas Nurses Association. He also asked each pathologist in Texas to organize his or her hospital with the help of anesthesiologists, emergency room physicians and others "as the basic group to handle procurement of organs." Proposed organ transplantation legislation was controversial.
One bill would amend the justice-of-the-peace or medical examiner system so that, if there was no known objection, at the request of a Texas nonprofit medical facility performing organ transplants, various organs could be removed for transplantation. That would include the taking of eyes, heart, skin, bone, liver, kidney or pancreas and other tissues as they proved clinically useable for transplants. Dr. John Andujar urged all concerned to increase the procurement of organs for transplantation and hormones, with the procedure to be without compensation, and the removal of such tissue performed without disfigurement of the body. At the same time, he urged obtaining prior consent from next of kin or a representative party in charge of the funeral before recovery of tissue. The TMA House of Delegates also adopted a position stating that the individual’s right to choose the disposition of a loved one’s body was paramount, but that, after reasonable attempts to contact next of kin had failed, the coroner had the right to authorize the removal of suitable organs for transplantation purposes.

By 1986, Dr. Hill reported that the TMA Council on Scientific Affairs had surveyed hospitals with more than 100 beds to determine which were affiliated with a transplant center, had criteria for determining brain death, and had bylaws that permitted transplant teams to enter and work in the hospital. With a 40 percent return, he noted that 55 percent were linked with an organ transplant and 45 percent had established brain death bylaws to allow organ retrieval teams to come into hospitals.

Honors

DR. JOYCE DAVIS, chairman of the department of pathology and laboratory medicine at Texas A&M College of Medicine, College Station, was named the 1984 distinguished alumnus at Baylor University, Waco. Harris County Commissioners voted to name their new medical examiner building after Dr. Joseph Jachimczyk. In 1986, Dr. May Owen of Fort Worth was inducted into the Texas Women’s Hall of Fame.

In medical education, among the endowed chairs announced during the 1980s were those by Dr. John and Senator Betty Andujar for the chairmanship in pathology, and by Patsy Goforth, the widow of Dr. John L. Goforth, for a professorship at The University of Texas Southwestern Medical School at Dallas. Dr. Frank M. Town-
send's faculty at The University of Texas Medical School at San Antonio also honored him when he stepped down as chairman of the department of pathology there with the establishment of the Dr. Frank M. Townsend Professorship. Dr. Vernie A. Stembridge, former chairman of the department of pathology at The University of Texas Southwestern Medical School in Dallas, in 1981 received the Ward Burdick Award of the American Society of Clinical Pathologists, in 1982, the Ashbel Smith Distinguished Alumnus Award from The University of Texas Medical Branch at Galveston, and in 1987, the Joint ASCP-CAP Distinguished Service Award.

Dr. John J. Andujar was honored for many contributions to pathology, and Dr. Townsend was made an honorary past president of the Texas Society of Pathologists.

Era of "medically necessary" and increasing medical liability issues

In 1986, A MEDICARE Newsletter informed all Texas physicians that pathologists were being monitored on "quantitative comparison" to other pathologists and audited for compliance to regulations. For a pathologist to bill for services, all consultation for clinical pathology had to be "medically necessary," physician-generated, and require physician judgment.

As the medical care environment moved rapidly toward managed care, and Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) developed, pathologists were encouraged to become involved.

Medical liability issues became some of the most serious concerns during the 1980s, and the Texas Society of Pathologists joined the Texas Civil Justice League with other organizations in 1986 to promote tort reforms as one solution to the problem.

There also were continuing efforts to expand the medical examiner system in Texas. Supporting data from a Texas Medical Association study showed that justices of the peace had pronounced 14,000 people dead in Texas in 1985, and requested 2,465 autopsies, and that medical examiners pronounced 13,000 deaths and requested 6,000 autopsies. It was suggested that a regional system should be developed as an alternative to the existing county-by-
county basis. Because of economic conditions, however, it was felt that a law would not be passed and funded. Since only the Lubbock area of the state was thought to be not well covered, a bill therefore focused on that area.

**AIDS poses threats to blood banking**

BLOOD SAFETY became a concern in the 1980s in regard to transfusion-transmitted diseases—particularly AIDS. A "look-back" program to trace recipients of blood from donors who were HTLV-III-antibody positive was approved by the American Association of Blood Banks, the American Red Cross, and the Council on Community Blood Centers. There was concern that some individuals currently having a confirmed positive test could have been infectious in the period before testing was initiated. Likewise, the Texas Medical Association's Committee on Blood Banking and Blood Transfusion, chaired by Dr. Margie Peschel of Fort Worth, encouraged implementation of the program in Texas, urging blood banks and hospitals to participate. Legally facilitating the look-back procedure, the Texas Legislature in 1987 passed a bill allowing blood banks to share information on donors having positive blood tests for infectious disease while protecting their confidentiality. Dr. Peschel reported to the TMA House of Delegates in May 1987 that, through the cooperative efforts of hospitals, pathologists and other physicians, the look-back program had been implemented over the state.

**Science and globalization**

THE METRIC SYSTEM for laboratories was promoted by the American Medical Association in 1986, which reported that it responded to hundreds of thousands of publications to "one medical world" and that the Metric *Systeme* International Units would be beneficial, if adopted. Although there was concern with making such a change in every laboratory, the AMA promised to help educate everyone on the new system.

**Town-Gown problems erupt**

AS TOWN-GOWN problems mounted, the Texas Medical Association House of Delegates in November 1986 adopted a resolution
regarding solicitation of private patients by The University of Texas Medical Branch at Galveston, and its plans to establish satellite clinics. The TMA delegates demanded that “UTMB and all state-supported medical schools or group practices made up of their staff discontinue pursuing the policy of attempting to purchase medical practices and inducing physicians to change their referral practices based on monetary or other than purely good medical indications.” In January 1987, medical school representatives met in Austin to discuss the issue, and following the meeting, UTMB stated “it had not purchased and did not plan to purchase private practices, nor establish satellite clinics solely for economic purposes.” The school also reported that it was inviting its volunteer faculty in Galveston to participate in UT-MED [the private practice plan developed by the school].  

In Houston, there also were concerns regarding Baylor College of Medicine’s “intrusion” in the private practice of medicine, and the principal parties there reported a misunderstanding and plans to work out an arrangement that was satisfactory to both academic and private physicians.

Science and socioeconomics clash

THE PARADE OF scientific revelations grew ever more futuristic in the 1980s, which brought the first artificial intelligence program for medical diagnostic usage, MYCIN, introduced by Ted Shortliffe, and designed to assist with managing drug interactions in antibiotics; 737 various tumor markers for specific cancers; the discovery of oncogenes by R. Weinberg and M. Barbacid, and observation of the Rb gene with retinoblastoma, the first oncogene to be localized, by R. S. Sparks, et al. The Jarvik-7 artificial heart had been inserted in Barney Clark, and a natural hormone, tissue plasminogen activator (TPA), had been made available for treatment of heart disease and stroke. Also being developed were genetically-engineered drugs.

A newer body scanner, especially for soft tissues, Magnetic Resonance Imaging (MRI), became available as did Magnetic Resonance Spectroscopy (MRS) for analysis of body chemistry. Similarly, MRI cine-imaging was under development to show the motion of the heart, and at Loma Linda Medical Center in California, an “automated doctor” was being designed.
Science was moving too rapidly to be readily codified in regulations or by insurers, and occasionally that meant denial of Medicare reimbursement for procedures. Such was the case for cardiac enzymes at Baylor Medical Center in Dallas. In 1987, the Texas Society of Pathologists adopted a resolution affirming the medical necessity of physician observation and clinical evaluation of these studies, and stating that the process constituted a valid medically necessary consultation by a clinical pathologist or a physician with appropriate background and training. It further stated that cardiac enzymes were a vital and essential part of the evaluation of a patient suspected of having a myocardial infarct.\textsuperscript{738}

The Clinical Laboratory Improvement Act of 1988 (CLIA 88) had raised new concerns regarding certification and regulation of clinical laboratories. Practitioners reported Medicare inspection problems, and opposed a Health Care Financing Administration (HCFA) position that readings of microscopic slides were a laboratory test. Problems also continued with CPT coding for Medicare reimbursements, and on the horizon a new reimbursement scheme was being worked out on a national scale—the Resource Based Relative Value Scale. Developed by a Harvard professor, it assigned points to physicians' cognitive and technical services. An old idea had come full circle and then some.

A few more acronyms appeared during the 1980s, among them the MAAC (Maximum Allowable Actual Charges). Applied now to pathologists, it limited anatomic pathology charges and specified significant penalties for failure to comply.

Texas Medical Association studies in 1988 and 1989 had shown that professional liability and the cost of malpractice insurance was the number one problem facing Texas physicians. In a litigious society, "risk management" had become a familiar term, and Dr. William T. Hill of Houston, chairman of the Texas Medical Association's Council on Scientific Affairs, saw a way for pathologic analysis to help. He therefore guided studies in 1989 in the high risk area of obstetrics where lawsuits often amounted to more than a million dollars. He felt it would cost less than half that amount if placental examinations were done to help elucidate the pathologic etiology.

The Joint Commission on Accreditation of Healthcare Organizations became more stringent in requiring evidence of continuing competence for purposes of credentialling medical staff privi-
leges in hospitals, and there was increasing pressure for pathologist board recertification.

Migration and adaptation continue

As Texas grew rapidly, the movement of pathologists became more routine across the state.

Many traditionally small towns in Texas would grow relatively large. Dr. Dudley Jones observes that even a small town like Arlington has a very complex and intertwined history with regards to the practice of pathology. By the 1990s, Arlington would no longer be a small bedroom community, but would have a population of 250,000.739

In 1967, Henry Owens, MD, had joined John Liles, MD, to help in the private laboratory and with coverage for the Arlington Memorial Hospital. After Medicare, Dr. Liles, apparently made some demands at the hospital that were not agreeable to the administration, and his contract was terminated in late 1968 or early 1969. Then C. D. Fitzwilliam, MD, Fort Worth, provided temporary coverage to the hospital until George Peacock, MD, took over the practice of pathology in the summer of 1969, upon completion of his residency training at Parkland Memorial Hospital, and Southwestern Medical School at Dallas.

In 1970 William Tom Sparrow, MD, joined Dr. Peacock at the hospital, and left in 1971 to join the faculty of The University of Texas Southwestern Medical School at Dallas. He subsequently moved to Tyler.

In July 1972, Dr. Jones joined Dr. Peacock at Arlington Memorial Hospital. Although there was an initial partnership, it was formulated into a corporate structure January 1, 1973, and became the Arlington Pathology Association. This association held a contract with Arlington Memorial Hospital and also created an independent laboratory for Pap smear and tissues biopsy specimens. Sadly, in October 1974, Dr. Peacock diagnosed his own case of acute granulocytic leukemia and died in early February 1975.

In June 1975, Clifton R. Daniel, MD, joined Dr. Jones at Arlington Memorial Hospital. In 1976, Robert Karper, MD, and in 1977, Jim Helgeson, MD, joined the group at Arlington Memorial Hospital—bringing the total number of pathologists to four. Dr. Karper left in 1980 to take charge of the laboratory at HEB Method-
ist Hospital in Euless. In 1978, Joel Barton, MD, joined the Arlington group but left after two years for private practice in Gaithersburg, Maryland. In late summer 1989, J. M. Gilbert, MD, joined the group at Arlington Memorial Hospital and subsequently became partner in the Arlington Pathology Association.

In the early 1970s, Drs. Liles and Owens sold Western Clinical Laboratory to Bio-Medical Laboratories of New York, but continued to operate under the original name. Dr. Liles moved to Waco in 1973 to practice at the Veterans Administration Hospital, and Dr. Owens opened his own laboratory in Arlington, primarily for anatomic pathology since the clinical laboratory was then owned by Bio-Medical Laboratories. He operated his private laboratory and supplied some pathology services to Arlington Memorial Hospital (since there was an open staff) until his untimely death in 1987 of carcinoma of the liver.

In the initial years of Arlington Community Hospital, Ken Ford, MD, and Reggie McDaniel, MD, provided coverage for pathology. Vic Trammell, MD, contracted with Arlington Community Hospital, and was later joined by Steve Aldred, MD. They formed Trammell-Aldred Pathology Associates, but Dr. Trammell became ill and in 1990 left the group. Dr. Aldred then formed a corporate entity, Arlington-Mansfield Pathology Associates—covering also a small hospital in Mansfield. Dr. Aldred joined Barbara Shinn, MD, and John McDonald, MD.

In Wichita Falls, Donald Fletcher, MD, had retired in 1978, and Nello Brown, MD, who had joined him in 1968, retired from Wichita General Hospital in January 1988, and became the full-time medical director of the Wichita Falls Chapter of the American Red Cross. He also was made an honorary lifetime member of the board of directors for his outstanding work on behalf of the American Red Cross in the community.740

John Byron Parker, MD, had practiced occasionally, usually part-time, at Wichita General Hospital from 1972 to 1981. John Webb, MD, joined Dr. Eleanor Irvine at Bethania Hospital in 1978, and would retire from pathology in 1987.

Carlos Mattioli, MD, would practice with Dr. Irvine at Bethania from 1990 to 1992.

At times, although rarely, a pathologist leaves the practice of pathology. Such was the case of Dan Moser, MD, who had left Wadley Hospital in Texarkana in 1984 as director of the laboratory,
served as pathologist in several other locations, including Wichita Falls, and began working as a *locum tenens.* A graduate of The University of Texas Southwestern Medical School at Dallas, he later decided he wanted to undertake a family practice residency and, in 1994, would be accepted into a residency at the University of Arkansas program in Texarkana, Arkansas.

In Temple, Alan R. Jay, MD, in 1968 succeeded Dr. W. N. Powell as director of the division of clinical pathology at Scott and White. He had been director of laboratories at Swedish Hospital, Minneapolis.

Colonel Albert Leibovitz came to Scott and White in 1970, and would spend most of his time on tissue culture and cell biology. He would be the first to establish a cell line in colon cancer.

Donald A. Jutzy, MD, arrived at Scott and White in 1972 as director of the Division of Clinical Pathology. Upon retirement in 1990, the Donald A. Jutzy, MD, Laboratory Information Suite would be named for him. He later would go to China to become the country's first clinical pathologist, and would die during his sojourn there.

Robert Thompson, MD, arrived in Temple in 1972. He had done cancer research in France, spent half of his time in the department of pathology as director of the blood bank and the other half in clinical oncology. He left in 1975.

John F. Greene, Jr., MD, joined the department of pathology at Scott and White in Temple in 1973, as a surgical pathologist and administrator. After 1982 he would be director of the division of anatomic pathology. He also would become involved in research and would be instrumental in reestablishing the reference laboratory service.

Jaime A. Diaz, MD, joined Scott and White in 1978, as a surgical pathologist and teacher at the medical student, resident and staff levels. He has a subspecialty in dermatopathology.

Daniel J. Ladd, MD, joined Scott and White in 1978, and in 1982 would become director of the division of clinical pathology.

Howard W. Huntington, MD, would be the first neuropathologist at Scott and White, joining the Clinic and Hospital in 1982, from UT Medical School in San Antonio.
Edward S. Rappaport, MD, would join the pathology department in 1982 as hematopathologist and chief of the section of hematopathology in the division of clinical pathology.

Raymond A. Trompler, MD, would join the pathology staff in 1984. Sheila Dobin, MD, also would join in 1984 as the first cytogeneticist, after training in cytogenetics in the department of pathology at The University of Texas Southwestern Medical School, Dallas. Also a medical geneticist, she would have a half-time appointment in the department of pediatrics, and would be involved in many activities, including the TEX-GENE program. She would be highly respected as a cytogeneticist.

Ludvik R. Donner, MD, PhD, would join the Scott and White staff in 1986. He grew up in Czechoslovakia and attended Charles University, Prague, the oldest university in Central Europe. Before coming to the United States, he conducted genetics research, continuing it after his arrival in 1976, and became involved in immunopathology and molecular biology research at the National Cancer Institute.

Steven C. Bauserman, MD, in 1986, succeeded Dr. Huntington as neuropathologist after having served as chairman of the department of pathology at Blodgett Memorial Hospital in Grand Rapids, Michigan.

V. O. Speights, DO, began his residency at Cleveland Clinic, and finished at Scott and White before joining the staff in 1987. He would teach and conduct research, especially in urologic pathology.

Jorge E. Bilbao, MD, was a resident at Scott and White, and completed a surgical pathology and immunopathology fellowship at the Mayo Clinic. He would join the staff in 1988. He grew up in Chihuahua, Mexico. In 1990, he would join a group of pathologists in El Paso.

R. Steven Beissner, MD, PhD, completed a residency at Scott and White and would join the staff in 1988 as associate director of clinical pathology and director of the Reference Laboratory and later the division of anatomic pathology, assuming directorship of the pathology residency program and replacing Dr. Jutzy as medical director of the Laboratory Information System.
Goodbyes during the 1980s

DR. EDWARD S. REYNOLDS (1928-1983), chairman of the department of pathology at The University of Texas Medical Branch at Galveston, died unexpectedly in 1983. That same year, Dr. Charles J. Thus, Jr., of San Antonio died in a private plane crash with his son and two passengers, and Dr. Diane Kay Beach of Lubbock died at age thirty-six in an accident attributed to smoke inhalation after a fire in her home.

There were several deaths in 1985. Among them were long-time leaders of Texas pathology, Drs. Charles T. Ashworth, professor of pathology at The University of Texas Southwestern Medical School, Dallas, and Dr. John L. Goforth, a pioneer Texas pathologist. Also, Dr. Robert L. Casao, a native of Mexico and resident of El Paso; Dr. Coloman de Chenar, a native of Hungary and resident of Austin who had assisted in the investigation of deaths following the 1966 shootings on The University of Texas campus; and Dr. Sidney Wayne Kowierschke, who had practiced in Bryan, El Paso and Huntsville.

Dr. Howard W. Huntingon, who had served as chief of the Audie Murphy Veterans Administration Hospital in San Antonio and at Scott and White in Temple, died in 1986.

A pioneer San Antonio pathologist, Dr. John M. Moore, born in 1890, died in 1987 at age ninety-seven. He had had a long career in pathology at Santa Rosa Hospital in San Antonio. “The first lady of Texas pathology,” Dr. May Owen of Fort Worth, past president of the Texas Medical Association, died at age ninety-six in 1988. Dr. Stuart A. Chamblin, Jr., of San Antonio died in 1989.

Transformation, recession, and more acronyms

THE MID-1960s through the 1980s had been eras of explosive scientific growth, and had seen application of that growth to daily life. Environmental issues became paramount—antitobacco campaigns mushroomed, as did efforts to eliminate asbestos from buildings. As a result of more than 10,000 claims against their company by those attributing their medical problems to asbestos exposure, the Manville Corporation—the nation’s biggest producer of asbestos—filed for bankruptcy in August 1982.741

In 1984, the National Heart, Lung and Blood Institute an-
nounced a relationship between heart attacks and cholesterol; the first baby was born from a donated embryo and another from a frozen embryo; researchers reported identification of the viruses that caused AIDS, and the heart of a baboon was planted in baby girl; in 1985, a teacher taking fertility drugs gave birth to sextuplets.

Texas physicians at Baylor College of Medicine in Houston—DeBakey, Cooley, Milam, and others—continued their work in the realm of heart transplants and artificial hearts.

Drs. Michael Brown and Joseph Goldstein of The University of Texas Southwestern Medical School at Dallas shared the 1985 Nobel prize in medicine and physiology for their work on LDL-receptor defects in atherosclerosis. In March 1986, the New England Journal of Medicine published a sixteen-year study showing the role of exercise in longevity. As the number of deaths from AIDS continued to rise, with predictions of much higher numbers, Surgeon General Everett Koop urged Americans to educate their children more explicitly on sexual matters to slow its spread. In January 1987, the first mass market television to accept advertisements for condoms appeared. In 1988, Masters and Johnson found AIDS increasing in the heterosexual community.

Also in the 1980s, biologists claimed a woman living 200,000 years ago was the biological ancestor of every living person, and inventors patented new forms of animal life obtained from genetic engineering and gene splicing.

The Human Genome Project continued its pursuit of knowledge on the human gene pool, and in 1989 U.S. researchers first injected genetically engineered cells into human patients.

In 1989, Surgeon General Koop issued a report that cigarettes and other drugs were addictive, and that cigarettes reportedly caused nearly 400,000 deaths.

Tragedies also struck during the 1980s requiring the resources and abilities of Texas pathologists in forensic areas. A major catastrophe occurred on August 2, 1985, when a Delta Airlines aircraft crashed at Dallas-Fort Worth Airport. The Dallas County Medical Examiner's office conducted examination of the bodies, receiving many compliments for its work.

A different kind of terrorism arose around research laboratories and medical schools in the 1980s, as several groups opposed the use of animals in experiments. A laboratory at Texas Tech Univer-
The University Health Sciences Center was sabotaged in 1989 by alleged animal rights activists. The 1980s also saw a period of economic boom in Texas as people flocked to the nation’s Sun Belt, but in the aftermath of a flush real estate market and the continuing decline of the oil industry, the boom was followed by a severe recession. During the discouraging era, it was said that the vast Texas Medical Center in Houston had become that city’s sustaining industry—quite amazing since only four decades earlier, the land on which the Center stood was a thick forest.

Advertising became a greater issue in medicine. In 1965, Walter Walthall, MD, chairman of the Texas Medical Association’s Board of Councilors, had solemnly written, “A physician’s self-aggrandizement or his aggrandizement by friends, family, or associates ultimately destroys his usefulness. History has borne this out.”

In the late 1970s, however, outside forces challenged this long-held position. “Despite their financial fragility and the operational realities of their lives as businessmen, graduates of respectable medical schools did not advertise their services to the public,” writes Robert L. Martensen. “In fact, the AMA code of ethics prohibited advertising by physicians, retracting from the position in the 1970s under pressure from decisions by the U.S. Supreme Court (eg, Goldfarb v Virginia State Bar, 1975) regarding advertising and the professions in general.”

As institutions in Texas began to advertise their medical services—to put it mildly—Dr. Edward F. Cooke and the other founders of the Texas Society of Pathologists might have turned over in their graves. Long had they discoursed on the ethics of advertising during their first meetings in the 1920s!

In 1983, the last episode of MASH was shown—with the largest-ever television audience for a single show—ending after 250 episodes. By that time, the setting for the show, South Korea, was a vibrant, prospering area. In 1989, the Berlin wall came down, uniting Germany and breaking the long Cold War between East and West.

During the 1980s, the American Medical Association had reviewed the future of pathology, and observed that, “with renewed emphasis on quality of care in the health professions, the pathology specialty has the potential to make substantial contributions to the
quality and art of medical practice, and is likely to remain at the center of efforts to refine methods of quality assessment and implementation."

By the end of the 1980s, access to health care for certain groups and the cost of health insurance became more prominent issues, stirring debates on reforming the health care system. Social conflicts developed around treatment of people with AIDS, challenging the once accepted role of conquering communicable diseases through a public health approach. The "environmental" movement continued but not without conflict. "No smoking" and "smoke-free" buildings, however, were becoming the norm. Better nutrition and less fat in the diet and more exercise were identified as highly important health factors. Lifestyle and personal responsibility were defined as significant causes of poor health. Organ transplants became more common.

Terms like mammography and MRIs and lasers became part of the lexicon as advancing technology made equipment ever simpler to use. More physicians were overcoming their fears of desktop computers, only to be confronted with threats from computer "viruses" if they had online connections.

Over its two-and-one-half decades, Medicare had ushered in an era of intense regulation—along with an amazing array of acronyms, among which were PSRO (Professional Standards Review Organization), TIMA (Texas Institute for Medical Assessment), PPS (prospective payment system), RCEs (reasonable compensation equivalents), DRGs (diagnosis-related groups), TEFRA (Tax Equity and Fiscal Responsibility Act), HCFA (Health Care Financing Administration), HSAs (Health Service Agencies), PPRB (Provider Reimbursement Review Board), OIG (Office of the Inspector General), OBRA (The Omnibus Budget Reconciliation Act), PRO (Peer Review Organizations), OSHA (Occupational Health and Safety Administration), MMPPPA (Medicare and Medicaid Patient Program Protection Act), CLIA (Clinical Laboratory Improvement Act), ICD-9 (International Classification of Diseases diagnosis codes), OMB (Office of Management and Budget), and a title change from DHEW (Department of Health, Education, and Welfare) to DHHS (Department of Health and Human Services).

Not only had the world of medicine been transformed, the entire world had changed right before everyone's eyes. People began talking about the upcoming millennium.