DEPARTMENT OF TRANSPORTATION

Coast Guard

[CGD 84-006

Great Lakes Registered Pilotage; Meeting

AGENCY: Coast Guard, DOT.

ACTION: Notice of meeting.

SUMMARY: This notice sets forth the date and proposed agenda of a meeting regarding Great Lakes Registered Pilotage.

DATE: February 15, 1984.

ADDRESS: Federal Building, Conference Room, 31st Floor, 1240 East Ninth Street, Cleveland, Ohio 44199.

FOR FURTHER INFORMATION CONTACT: Captain George R. Skuggen, Director, Great Lakes Pilotage Staff, U.S. Coast Guard, 1240 East Ninth Street, Cleveland, Ohio 44199. Telephone: (216) 522-3930.

SUPPLEMENTARY INFORMATION: The Coast Guard is having an open meeting for all interested parties regarding Great Lakes Registered Pilotage. The meeting will be held on February 15, 1984, commencing at 10 a.m. The subject of the meeting will be limited to pilotage required by the Great Lakes Pilotage Act of 1960, that is, pilotage involving foreign vessels and U.S. registered vessels. This meeting is intended to be a frank and open discussion of issues. The following is a proposed agenda, however, interested persons are encouraged to submit (to Captain Skuggen by February 8) any additional items they wish to have added to the agenda:

- Traffic projections for future years
- Pilotage rates
- Pilot workload
- Pilot compensation
- "B" Certificates
- Canadian Saltie/Lakers
- Port rates
- Safety

Dated: January 6, 1984.

Clyde T. Lusk, Jr.,

Rear Admiral, U.S. Coast Guard, Chief, Office of Merchant Marine Safety.

[FR Doc. 84-834 Filed 1-11-84; 8:45 am]

BILLING CODE 4910-14-M

Federal Highway Administration

Environmental Impact Statement, Spokane, Spokane County, Washington

AGENCY: Federal Highway Administration (FHWA), DOT.

ACTION: Notice of intent.

SUMMARY: The FHWA is issuing this notice to advise the public that an environmental impact statement will be prepared for the proposed Ray Street Extention project in the City of Spokane, Spokane County, Washington.

FOR FURTHER INFORMATION CONTACT:

Mr. P. C. Gregson, Division Administrator, Federal Highway Administration, Suite 501, Evergreen Plaza, 711 South Capitol Way, Olympia, Washington 98501, Telephone (206) 753-2120.

Mr. Clyde L. Slemmer, P.E., Project Development Engineer, Washington State Department of Transportation, Highway Administration Building, Olympia, Washington 98504, Telephone (206) 753-6101.

Mr. Irving B. Reed, Public Works Director, Skywalk Level, City Hall, Spokane, Washington 99201, Telephone (509) 456-4300.

SUPPLEMENTARY INFORMATION: The FHWA, in cooperation with the Washington State Department of Transportation and the City of Spokane, will prepare an environmental impact statement (EIS) on a proposal that would provide an extension of Ray Street (a principal arterial) from 34th Avenue south to the Palouse Highway.

Alternatives under consideration include (1) taking no action; (2) constructing the new section of road straight south to the Palouse Highway; (3) constructing a crossover southeast to Freya Street and then south to the Palouse Highway; and (4) constructing a crossover southeast to Thor Street and then south to the Palouse Highway.

Letters describing the proposed action and soliciting comments will be sent to appropriate Federal, State and local agencies, and to private organizations and citizens who have previously expressed interest in this proposal. A series of public meetings will be held in Spokane in the early part of 1984.

In addition, upon completion of the draft EIS, a public hearing will be held. Public notice will be given of the time and place of the meetings and hearing. The draft EIS will be available for public and agency review and comment. To ensure that the full range of issues related to this proposed action are addressed and all significant issues identified, comments and suggestions are invited from all interested parties. Comments or questions concerning this proposed action and the EIS should be directed to the FHWA at the addresses previously provided.

(Catalog of Federal Domestic Assistance Program Number 20.205, Highway Research, Planning and Construction. The provisions of OMB Circular No. A-95 regarding state and local clearinghouse review of Federal and federally assisted programs and projects apply to this program)

Issued on: January 3, 1984.

Richard Schimelfenyg,

Area Engineer, Olympia, Washington.

[FR Doc. 84-792 Filed 1-11-84; 8:45 am]

BILLING CODE 4910-22-M

Sunshine Act Meetings

Federal Register
Vol. 49, No. 8
Thursday, January 12, 1984

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

CONTENTS

1

FEDERAL DEPOSIT INSURANCE CORPORATION

Agency Meeting.

Pursuant to the provisions of the "Government in the Sunshine Act" (5 U.S.C. 552b), notice is hereby given that at 5:00 p.m. on Friday, January 6, 1984, the Board of Directors of the Federal Deposit Insurance Corporation met in closed session, by telephone conference call, to (1) receive bids for the purchase of certain assets of and the assumption of the liability to pay deposits made in Farmers Bank and Trust, Winchester, Tennessee, which was closed by the Commissioner of Financial Institutions for the State of Tennessee on Friday, January 6, 1984; (2) accept the bid for the transaction submitted by Mid-South Bank & Trust Company, Murfreesboro, Tennessee, and insured State nonmember bank; (3) approve the application of Mid-South Bank & Trust Company, Murfreesboro, Tennessee, for consent to purchase certain assets of and to assume the liability to pay deposits made in Farmers Bank and Trust, Winchester, Tennessee, and for consent to establish the four offices of Farmers Bank and Trust as branches of Mid-South Bank & Trust Company; and (4) provide such financial assistance, pursuant to section 13(c)(2) of the Federal Deposit Insurance Act (12 U.S.C. 1823(c)(2)), as was necessary to facilitate the purchase and assumption transaction.

In calling the meeting, the Board determined, on motion of Chairman William M. Isaac, seconded by Director Irvine H. Sprague (Appointive), concurred in by Mr. Doyle L. Arnold, acting in the place and stead of Director C. T. Conover (Comptroller of the Currency), that Corporation business required its consideration of the matters on less than seven days' notice to the public; that no earlier notice of the meeting was practicable; that the public interest did not require consideration of the matters in a meeting open to public observation; and that the matters could be considered in a closed meeting pursuant to subsections (c)(8), (c)(9)(A)(ii), and (c)(9)(B) of the "Government in the Sunshine Act" (5 U.S.C. 552b(c)(8), (c)(9)(A)(ii), and (c)(9)(B)).

Dated: January 9, 1984.

Federal Deposit Insurance Corporation.

Hoyle L. Robinson,

Executive Secretary.

[S-84-884 Filed 1-10-84; 8:45 am]

BILLING CODE 6714-01-M

2

FEDERAL DEPOSIT INSURANCE CORPORATION

Agency Meeting.

Pursuant to the provisions of the "Government in the Sunshine Act" (5 U.S.C. 552b), notice is hereby given that at 2:30 p.m. on Monday, January 16, 1984, the Federal Deposit Insurance Corporation's Board of Directors will meet in closed session, by vote of the Board of Directors, pursuant to sections 552b (c)(2), (c)(6), (c)(8), and (c)(9)(A)(ii) of Title 5, United States Code, to consider the following matters:

Summary Agenda: No substantive discussion of the following items is anticipated. These matters will be resolved with a single vote unless a member of the Board of Directors requests that an item be moved to the discussion agenda.

Recommendations with respect to the initiation, termination, or conduct of administrative enforcement proceedings (cease-and-desist proceedings, termination-of-insurance proceedings, suspension or removal proceedings, or assessment of civil money penalties) against certain insured banks or officers, directors, employees, agents or other persons participating in the conduct of the affairs thereof:

Names of persons and names and locations of banks authorized to be exempt from disclosure pursuant to the provisions of subsections (c)(6), (c)(8), and (c)(9)(A)(ii) of the "Government in the Sunshine Act" (5 U.S.C. 552b (c)(6), (c)(8), and (c)(9)(A)(ii)).

Note.— Some matters falling within this category may be placed on the discussion agenda without further public notice if it becomes likely that substantive discussion of those matters will occur at the meeting.

Discussion Agenda:

Personnel actions regarding appointments, promotions, administrative pay increases, reassignments, retirements, separations, removals, etc.:

Names of employees authorized to be exempt from disclosure pursuant to the provisions of subsections (c)(2) and (c)(6) of the "Government in the Sunshine Act" (5 U.S.C. 552b (c)(2) and (c)(6)).

The meeting will be held in the Board Room on the sixth floor of the FDIC Building located at 550 17th Street, NW., Washington, D.C.

Requests for further information concerning the meeting may be directed to Mr. Hoyle L. Robinson, Executive Secretary of the Corporation, at (202) 389-4425.

Dated: January 9, 1984.

Federal Deposit Insurance Corporation.

Hoyle L. Robinson,

Executive Secretary.

[S-84-878 Filed 1-9-84; 8:45 am]

BILLING CODE 6714-01-M

3

FEDERAL DEPOSIT INSURANCE CORPORATION

Notice of Agency Meeting.

Pursuant to the provisions of the "Government in the Sunshine Act" (5 U.S.C. 552b), notice is hereby given that the Federal Deposit Insurance Corporation's Board of Directors will meet in open session at 2:00 p.m. on Monday, January 16, 1984, to consider the following matters:

Summary Agenda: No subsantive discussion of the following items is anticipated. These matters will be resolved with a single vote unless a member of the Board of Directors requests that an item be moved to the discussion agenda.

Disposition of minutes of previous meetings.

Application for consent to merge:

First National Bank of the Valley, Luray, Virginia, for consent to merge, under its charter and with the title "Jefferson National Bank," with Old Dominion Savings Bank, Winchester, Virginia, a non-FDIC insured institution.

Application for consent to establish a remote a service facility:

Barnett Bank of Palm Beach County, Rivera Beach, Florida, for consent to establish a

remote service facility at Palm Beach Mall, 1801 Palm Beach Lakes Boulevard, West Palm Beach, Florida.

Recommendation regarding the liquidation of a bank's assets acquired by the Corporation in its capacity as receiver, liquidator, or liquidating agent of those assets:

Case No. 45,889–L, The First National of Midland, Midland, Texas.

Memorandum re: Nationwide Servicer for Mortgage Loans.

Reports of committees and officers:

Minutes of actions approved by the standing committees of the Corporation pursuant to authority delegated by the Board of Directors.

Reports of the Division of Bank Supervision with respect to applications, requests, or actions involving administrative enforcement proceedings approved by the Director of an Associate Director of the Division of Bank Supervision and the various Regional Directors pursuant to authority delegated by the Board of Directors.

Report of the Director, Division of Liquidation:

Memorandum re: Sale of Property Consolidated Costa Mesa, California Liquidation Office (Case No. 45,897)

Discussion Agenda:

Memorandum and resolution re: Proposed amendments to Part 330 of the Corporation's rules and regulations, entitled "Clarification of Definition of Deposit Insurance Coverage" which concern insurance coverage of brokered deposits.

The meeting will be held in the Board on the sixth floor of the FDIC Building located at 550—17th Street, NW., Washington, D.C.

Requests for further information concerning the meeting may be directed to Mr. Hoyle L. Robinson, Executive Secretary of the Corporation, at (202) 389–4425.

Dated: January 9, 1984.

Federal Deposit Insurance Corporation.

Hoyle L. Robinson,

Executive Secretary.

[S–84–879 Filed 1–9–84 8:45 am]

BILLING CODE 6714–01–M

4

FEDERAL ELECTION COMMISSION

DATE AND TIME: Tuesday, January 17, 1984, 10:00 a.m.

PLACE: 1325 K Street, N.W., Washington, D.C.

STATUS: This meeting will be closed to the public.

ITEMS TO BE DISCUSSED: Compliance. Litigation. Audits. Personnel.

* * * * *

DATE AND TIME: Thursday, January 19, 1984, 10:00 a.m.

PLACE: 1325 K Street, N.W., Washington, D.C. (Fifth Floor).

STATUS: This meeting will be open to the public.

MATTERS TO BE CONSIDERED:

Setting of Dates of Future Meetings
Correction and Approval of Minutes
Eligibility Report for Candidates to Receive Presidential Primary Matching Funds
Presidential Matching Funds for Candidates who owe Repayments of Civil Penalties—Larouche Eligibility Report
Draft Advisory Opinion #1983–43, Frank M. Northam on behalf of U.S. Defense Committee and Patrick Reilly
Request for Reagan for President Committee for stay of Commission's Final Repayment Determination Pending Appeal—(Continued from January 5, 1984)
Briefing on Government Space Program by Mr. William B. Jenkins, Director of GSA Real Estate Division
Routine Administrative Matters

PERSON TO CONTACT FOR INFORMATION: Mr. Fred Eiland, Information Officer, Telephone 202–523–4065.

Marjorie W. Emmons,

Secretary of the Commission.

[S–84–960 Filed 1–10–84; 2:39 pm]

BILLING CODE 6715–01–M

5

FEDERAL HOME LOAN BANK BOARD

TIME AND DATE: 2:00 P.M., January 16, 1984.

PLACE: 1700 G Street, N.W., 6th Floor, Washington, D.C.

STATUS: Open Meeting.

CONTACT PERSON FOR MORE INFORMATION: Ms. Gravlee (202–377–6970).

MATTERS TO BE CONSIDERED: Brokered Deposits.

J. J. Finn,

Secretary.

[No. 66, January 10, 1984]

[S–985 Filed 1–10–84; 3:51 pm]

BILLING CODE 6720–01–M

6

FEDERAL MARITIME COMMISSION

TIME AND DATE: 9:00 A.M.—January 18, 1984.

PLACE: Hearing Room One—1100 L. Street, N.W., Washington, D.C. 20573.

STATUS: Open.

MATTER TO BE CONSIDERED: 1. Agreement No. 10318–1: Extension of the United States-European Trade Carriers Cooperative Study Arrangement.

CONTACT PERSON FOR MORE INFORMATION: Bruce A. Dombrowski, Assistant Secretary, (202) 523–5725.

[S–84–993 Filed 1–10–84; 3:58 pm]

BILLING CODE 6730–01–M

7

NUCLEAR REGULATORY COMMISSION

DATE: Week of January 16, 1984.

PLACE: Commissioners' Conference Room, 1717 H Street, NW., Washington, D.C.

STATUS: Open and Closed.

MATTERS TO BE DISCUSSED

Monday, January 16

10:00 a.m.
Discussion of Corrosion in PORV's at TMI–1 (Public Meeting).

2:00 p.m.
Discussion of Future Steps in TMI–1 Restart (Closed—Ex. 5 & 10).

Tuesday, January 17

9:00 a.m.
Comments by Parties on Diablo Canyon Criticality and Low Power Operation (Public Meeting).

11:30 a.m.
Discussion of Pending Investigation (Closed—Ex. 5 & 7).

ADDITIONAL INFORMATION: Briefing on BWR Pipe Crack Issues (Public Meeting) scheduled for Thursday, January 12, *time change* from 10:00 a.m. to 2:00 p.m.

TO VERIFY THE STATUS OF MEETINGS CALL: (Recording)—(202) 634–1498.

CONTACT PERSON FOR MORE INFORMATION: Walter Magee (202) 634–1410.

Walter Magee,

Office of the Secretary.

[S–84–883 Filed 1–10–84; 8:45 am]

BILLING CODE 7590–01–M

8

PAROLE COMMISSION

Public Announcement; Pursuant To The Government In The Sunshine Act Pub. L. 94–409 (5 U.S.C. Section 552b).

AGENCY HOLDING MEETING: U.S. Parole Commission, National Commissioners (the Commissioners presently maintaining offices at Chevy Chase, Maryland Headquarters).

TIME AND DATE: Thursday, January 12, 1984—2:00 p.m.

PLACE: Room 420–F, One North Park Building, 5550 Friendship Boulevard, Chevy Chase, Maryland 20815.

STATUS: Closed pursuant to a vote to be taken at the beginning of the meeting.

MATTER TO BE CONSIDERED: Referrals from Regional Commissioners of approximately 5 cases in which inmates of Federal prisons have applied for parole or are contesting revocation of parole or mandatory release.

CONTACT PERSON FOR MORE INFORMATION: Linda Wines Marble, Chief Case Analyst, National Appeals

Board, United States Parole Commission, (301) 492–5987.

Date: January 9, 1984.

Joseph A. Barry,

General Counsel United States Parole Commission.

[S–84–951 Filed 1–10–84; 8:45 am]

BILLING CODE 4410–01–M

9

SECURITIES AND EXCHANGE COMMISSION

Notice is hereby given, pursuant to the provisions of the Government in the Sunshine Act, Pub. L. 94–409, that the Securities and Exchange Commission will hold the following meetings during the week of January 16, 1984, at 450 Fifth Street, NW., Washington, D.C.

Open meetings will be held on Tuesday, January 17, 1984, at 9:30 a.m. and on Wednesday, January 18, 1984, at 3:00 p.m.

A closed meeting will be held on Tuesday, January 17, 1984, following the 9:30 a.m. open meeting.

The Commissioners, Counsel to the Commissioners, the Secretary of the Commission, and recording secretaries will attend the closed meeting. Certain staff members who are responsible for the calendared matters may be present.

The General Counsel of the Commission, or his designee, has certified that, in his opinion, the items to be considered at the closed meeting may be considered pursuant to one or more of the exemptions set forth in 5 U.S.C. 552b(c)(4), (8), (9)(A) and (10) and 17 CFR 200.402(a)(4), (8), (9)(i) and (10).

Chairman Shad and Commissioners Treadway and Cox voted to consider the items listed for the closed meeting in closed session.

The subject matter of the open meeting scheduled for Tuesday, January 17, 1984, 9:30 a.m., will be:

1. Consideration of whether to adopt Rule 17Ad–14 under Section 17A(d)(1) of the Securities Exchange Act of 1934. That rule would require registered transfer agents acting for bidders as "tender agents"—i.e., as "depositaires" during tender offers or as "exchange agents" during exchange offers—to establish special accounts with certain securities depositories. These accounts would permit depository participants (e.g., broker-dealers and banks) to deliver tendered securities to, or receive withdrawn securities from, the tender agent by book-entry. Tender agents would have to establish these accounts with all registered securities depositories that have Commission-approved automated tender offer procedures, within two business days after the tender or exchange offer begins. For further information, please contact Thomas V. Sjoblom at (202) 272–7379.

2. Consideration of whether to propose for public comment amendments to rule 12d–1 and rescission of rule 2a–3 under the Investment Company Act of 1940 and related disclosure requirements. The proposed amendments to rule 12d–1 would permit investment companies to invest in securities issued by persons engaged in securities activities, directly or indirectly, as a broker, dealer, underwriter, or investment adviser. For further information, please contact Elizabeth K. Norsworthy at (202) 272–2048.

The subject matter of the closed meeting scheduled for Tuesday, January 17, 1984, following the 9:30 a.m. open meeting, will be:

Formal orders of investigation.
Dissolution of injunctive action.

The subject matter of the open meeting scheduled for Wednesday, January 18, 1984, at 3:00 p.m., will be: The Commission will meet with representatives from the American Society of Corporate Secretaries to discuss matters of mutual interest. For further information, please contact Steven L. Molinari at (202) 272–2589.

AT TIMES CHANGES IN COMMISSION PRIORITIES REQUIRE ALTERATIONS IN THE SCHEDULING OF MEETING ITEMS. FOR FURTHER INFORMATION AND TO ASCERTAIN WHAT, IF ANY, MATTERS HAVE BEEN ADDED, DELETED OR POSTPONED, PLEASE CONTACT: JoAnn Zuercher at (202) 272–2014.

George A. Fitzsimmons,

Secretary.

January 10, 1984.

[S–84–965 Filed 1–10–84; 8:45 am]

BILLING CODE 8010–01–M

federal register

Thursday
January 12, 1984

Part II

Department of Energy

Federal Energy Regulatory Commission

Determinations by Jurisdictional Agencies Under the Natural Gas Policy Act of 1978; Notice

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Vol. 1035]

Determinations by Jurisdictional Agencies Under the Natural Gas Policy Act of 1978

Issued: January 6, 1984.

The following notices of determination were received from the indicated jurisdictional agencies by the Federal Energy Regulatory Commission pursuant to the Natural Gas Policy Act of 1978 and 18 CFR 274.104. Negative determinations are indicated by a "D" before the section code. Estimated annual production (PROD) is in million cubic feet (MMCF).

The applications for determination are available for inspection except to the extent such material is confidential under 18 CFR 275.206, at the Commission's Division of Public Information, Room 1000, 825 North Capitol St., Washington, D.C. Persons objecting to any of these determinations may, in accordance with 18 CFR 275.203 and 275.204, file a protest with the Commission within fifteen days after publication of notice in the **Federal Register.**

Source data from the Form 121 for this and all previous notices is available on magnetic tape from the National Technical Information Service (NTIS). For information, contact Stuart Weisman (NTIS) at (703) 487–4808, 5285 Port Royal Rd, Springfield, Va 22161.

Categories within each NGPA section are indicated by the following codes:

Section 102–1: New OCS lease
102–2: New well (2.5 Mile rule)
102–3: New well (1000 Ft rule)
102–4: New onshore reservoir
102–5: New reservoir on old OCS lease
Section 107–DP: 15,000 feet or deeper
107–GB: Geopressured brine
107–CS: Coal Seams
107–DV: Devonian Shale
107–PE: Production enhancement
107–TF: New tight formation
107–RT: Recompletion tight formation
Section 108: Stripper well
108–SA: Seasonally affected
108–ER: Enhanced recovery
108–PB: Pressure buildup

Kenneth F. Plumb,

Secretary.

NOTICE OF DETERMINATIONS

ISSUED JANUARY 6, 1984

JD NO	JA DKT	API NO	D	SEC(1)	SEC(2)	WELL NAME	FIELD NAME	PROD	PURCHASER
KANSAS CORPORATION COMMISSION									
-AMERICO PETROLEUM INC				RECEIVED:	12/05/83	JA: KS			
8410434	K-83-0499	1515520555		103		ROYER #1	FRIENDSHIP EXT	47.0	PEOPLES NATURAL G
-ASSOCIATED PETROLEUM CONSULTANTS IN				RECEIVED:	12/05/83	JA: KS			
8410430	K-83-0520	1509521349		102-2		ALBERS #1 15095-21349	KOMAREK	800.0	DELHI GAS PIPELIN
8410499	K-83-0453	1509521262		102-2		HAUSER #1 15-095-21262	(WILDCAT)	500.0	DELHI GAS PIPELIN
8410473	K-83-0573	1500721629		102-4		MOTT RANCH #8 15-007-21,629	AMBERMILLS SOUTH	1.1	DELHI GAS PIPELIN
-BENJAMIN F SPRINGER				RECEIVED:	12/05/83	JA: KS			
8410443	K-83-0606	1512526002		102-2		SHOUSE #1	COFFEYVILLE - CHERRYV	21.6	NORTHWEST CENTERA
8410445	K-83-0608	1512526001		102-2		SHOUSE #2	COFFEYVILLE - CHERRYV	27.0	NORTHWEST CENTRAL
8410444	K-83-0607	1512526152		102-2		SHOUSE #3	COFFEYVILLE - CHERRYV	27.0	NORTHWEST CENTRAL
-BENSON MINERAL GROUP				RECEIVED:	12/05/83	JA: KS			
8410487	K-82-1039	1512524499		108		ERWIN 3-32	JEFFERSON - SYCAMORE	1.8	UNION GAS SYSTEMS
8410488	K-82-1030	1512524500		108		ERWIN 4-32	JEFFERSON - SYCAMORE	13.1	UNION GAS SYSTEMS
8410477	K-83-0541	1512526131		103		GILLEN 2-B	JEFFERSON - SYCAMORE	2.4	UNION GAS SYSTEMS
8410464	K-83-0495	1500923143		103		GRACE WEAVER #1-3	OTIS-ALBERT	29.2	NORTHERN GAS PROD
8410486	K-82-1031	1512524501		108		INGMIRE 3-32	JEFFERSON SYCAMORE	5.4	UNION GAS SYSTEMS
8410435	K-83-0496	1514521040		102-2		NUCKOLLS "B" 1-15	BRYANT SE	7.3	NORTHERN NATURAL
8410490	K-82-1028	1512524504		108		WISE 6-5	JEFFERSON - SYCAMORE	0.0	UNION GAS SYSTEMS
8410489	K-82-1029	1512524505		108		WISE 7-5	JEFFERSON - SYCAMORE	2.3	UNION GAS SYSTEM
-BOW VALLEY PETROLEUM INC				RECEIVED:	12/05/83	JA: KS			
8410474	K-83-0572	1503320598		102-2		KANSAS UNIVERSITY 2-32	WILDCAT	109.0	MICHIGAN-WISCONSI
-BURK LEROY E				RECEIVED:	12/05/83	JA: KS			
8410441	K-83-0595	1512526304		102-2		BURK #11	COFFEYVILLE - CHERRYV	0.0	CITIES SERVICE CO
8410436	K-83-0440	1512524228		102-2		BURK #3	COFFEYVILLE - CHERRYV	21.9	CITIES SERVICE CO
8410442	K-83-0596	1512523728		102-2		BURK #5	COFFEYVILLE - CHERRYV	0.0	CITIES SERVICE CO
8410500	K-83-0439	1512525785		102-2		BURK #9	COFFEYVILLE - CHERRYV	21.9	CITIES SERVICE CO
-CENTENNIAL ENERGY CO				RECEIVED:	12/05/83	JA: KS			
8410450	K-83-0470	1518120124		108		BRINEY FARMS 2-22	GOODLAND	10.0	K N ENERGY INC
8410457	K-83-0468	1518120127		108		CEBULA #1-15	GOODLAND	10.0	K N ENERGY INC
8410451	K-83-0469	1518120220		108		WALLACE 1-16	GOODLAND	10.0	K N ENERGY INC
-CINCO EXPLORATION COMPANY				RECEIVED:	12/05/83	JA: KS			
8410471	K-83-0486	1509720899		102-2		FREDA DUNBAR #3	WILDCAT	91.3	PERMIAN CORP
-CITIES SERVICE OIL & GAS CORP				RECEIVED:	12/05/83	JA: KS			
8410460	K-83-0465	1507720879		103		GRIGSBY "A" #1	LITTLE SANDY CREEK	29.0	
-COASTAL OIL & GAS CORP				RECEIVED:	12/05/83	JA: KS			
8410461	K-83-0464	1512900000		108		CENTRAL LIFE 1-32	GREENWOOD	8.0	COLORADO INTERSTA
8410463	K-83-0462	1512900000		108		CRAVER 1-32	GREENWOOD	18.0	COLORADO INTERSTA
8410462	K-83-0463	1512900000		108		HEINTZ 1-31	GREENWOOD	9.0	COLORADO INTERSTA
-DECK OIL CO				RECEIVED:	12/05/83	JA: KS			
8410452	K-83-0528	1502500000		103		SMITH #1	SITKA	0.0	NORTHERN NATURAL
-DOME PETROLEUM CORP				RECEIVED:	12/05/83	JA: KS			
8410504	K-83-0008	1500720777		108		SCHIFF #1	N HARBAUGH	4.6	PANHANDLE EASTERN
-ENERGY GROUP INC				RECEIVED:	12/05/83	JA: KS			
8410431	K-83-0519	1518920581		103		DAVIS #1-27	WALKEMEYER	0.0	NORTHERN NATURAL
-F G HOLL				RECEIVED:	12/05/83	JA: KS			
8410470	K-83-0487	1504720517		103		HAWLEY #1-13	MASSEY	53.0	REPUBLIC NATURAL

BILLING CODE 6717-01-M

JD NO	JA DKT	API NO	D	SEC(1)	SEC(2)	WELL NAME	FIELD NAME	PROD	PURCHASER
-GRAVES DRILLING CO INC				RECEIVED:	12/05/83	JA: KS			
8410494	K-83-0537	1500720091		108		HAYNES #1	NC	29.1	PEOPLES NATURAL G
-HERITAGE EXPLORATION INC				RECEIVED:	12/05/83	JA: KS			
8410496	K-83-0534	1512525055		102-2		WEST POWELL 2B	CHERRYVALE - COFFEYVI	36.5	NORTHWEST CENTRAL
8410495	K-83-0535	1525125249		102-2		WEST POWELL 3B	CHERRYVALE - COFFEYVI	36.5	NORTHWEST CENTRAL
-HINKLE OIL COMPANY				RECEIVED:	12/05/83	JA: KS			
8410475	K-83-0567	1515121203		103		CARVER #1	IUKA-CARMI SW	91.0	CENTRAL STATES GA
-INTEGRATED ENERGY INC				RECEIVED:	12/05/83	JA: KS			
8410501	K-83-0167	1515520539		103		SOPER #2	FRIENDSHIP	36.5	PEOPLES NATURAL G
-J MARK RICHARDSON				RECEIVED:	12/05/83	JA: KS			
8410484	K-83-0479	1515121104		102-2		HARPER FARMS B #1	CARVER ROBBINS	45.0	PANHANDLE EASTERN
-JONES ROBERT & TAYLOR WILLIAM				RECEIVED:	12/05/83	JA: KS			
8410455	K-83-0524	1512525490		102-2		TAYLOR #1	CHERRYVALE COFFEYVILL	14.5	NORTHWEST CENTRAL
-KAISER-FRANCIS OIL COMPANY				RECEIVED:	12/05/83	JA: KS			
8410433	K-83-0501	1517500000		103		BLACK #1	IRIS	255.5	
-KBW OIL & GAS CO				RECEIVED:	12/05/83	JA: KS			
8410497	K-83-0530	1500721544		103		AUBLEY #1	WILDCAT	2.7	PEOPLES NATURAL G
8410483	K-83-0480	1500721515		103		DOHM #1	NW SHARON	16.0	PEOPLES NATURAL G
-L C G GAS CO				RECEIVED:	12/05/83	JA: KS			
8410491	K-82-1252	1509921783		108		JOHN WULF #1		18.3	H G HACKERLE CO I
8410492	K-82-1251	1509921765		108		MARVIN WULF #1	SW 1/4 NE 1/4 S13 T35	18.3	H E HACKERLE CO I
8410465	K-83-0490	1509921868		108		ZIEGLER #2	NE 1/4 S13 T35 R20E	3.7	H E HACKERLE CO I
-LEAR PETROLEUM EXPLORATION INC				RECEIVED:	12/05/83	JA: KS			
8410454	K-83-0525	1503320593		102-2		BIRD #1-32	BIRD SOUTH	53.0	MICHIGAN WISCONSI
8410453	K-83-0526	1503320595		102-2		NIELSON-UPTON #2-32	BIRD SOUTH	300.0	MICHIGAN WISCONSI
-MCGINNESS OIL COMPANY				RECEIVED:	12/05/83	JA: KS			
8410476	K-83-0542	1500721566		103		F OHLSON #1	HARDTNER	216.0	KANSAS GAS SUPPLY
-MIDWESTERN EXPLORATION CO				RECEIVED:	12/05/83	JA: KS			
8410498	K-83-0529	1512920648		103		GRIMWOOD 2-13	GREENWOOD GAS FIELD	60.0	COLORADO INTERSTA
-MOBIL OIL CORP				RECEIVED:	12/05/83	JA: KS			
8410439	K-83-0575	1518920615		103		HINSHAW ESTATE UNIT #2	PANOMA COUNCIL GROVE	36.0	NORTHWEST CENTRAL
-MOLZ OIL CO				RECEIVED:	12/05/83	JA: KS			
8410482	K-83-0481	1500721597		103		STERLING #1	STRANATHAN	30.0	KANSAS GAS SUPPLY
-NIELSON ENTERPRISES INC				RECEIVED:	12/05/83	JA: KS			
8410446	K-83-0476	1511920472		108		ADAMS 1-30	ADAMS RANCH	18.0	COLORADO INTERSTA
8410449	K-83-0473	1502320181		108		BURR #B-1	SO ST FRANCIS GAS ARE	8.0	PEOPLES NATURAL G
8410447	K-83-0475	1502320179		108		FRITZ #A-1	SO ST FRANCIS GAS ARE	4.0	PEOPLES NATURAL G
8410448	K-83-0474	1502320180		108		HARKINS #A-1	SO ST FRANCIS GAS ARE	5.0	PEOPLES NATURAL G
-NORTHERN NATURAL GAS PRODUCING CO				RECEIVED:	12/05/83	JA: KS			
8410459	K-83-0466	1505520522		103		BROWN #14 FARM WELL #15	PANOMA COUNCIL GROVE	52.1	NORTHERN NATURAL
8410472	K-83-0574	1518920638		103		THOMAS T HOLT UNIT WELL #2	HALKEMEYER LOWER MORR	112.5	NORTHERN NATURAL
-OIL PROPERTY MANAGEMENT INC				RECEIVED:	12/05/83	JA: KS			
8410456	K-83-0522	1515121004		103		POLLOCK #1	IUKA-CARMI	23.0	CENTRAL STATES GA
8410429	K-83-0521	1515121044		103		POLLOCK #2 "TWIN"	IUKA-CARMI	26.0	CENTRAL STATES GA
-OILWELL OPERATORS INC				RECEIVED:	12/05/83	JA: KS			
8410485	K-83-0478	1500721571		103		SPICER #1 NEW LEASE	CANEMA	200.0	PEOPLES NATURAL G
8410467	K-83-0489	1500721607		103		SPICER #2 NEW LEASE	CANEMA	144.0	PEOPLES NATURAL G
-R & D PETROLEUM				RECEIVED:	12/05/83	JA: KS			
8410503	K-83-0150	1515121166		103		GRIFFITH "B" #1	FRISBIE NE	120.0	CENTRAL STATES GA
-ROXANA CORP				RECEIVED:	12/05/83	JA: KS			
8410502	K-83-0166	1518521713		103		TURNER #6	CRISSMAN NORTH	27.0	CENTRAL STATES GA
-TEXAS ENERGIES INC				RECEIVED:	12/05/83	JA: KS			
8410468	K-83-0471	1500721578		102-4		HINZ 'C' 1-22	WILDCAT	18.0	REPUBLIC NATURAL
8410469	K-83-0472	1500721576		102-4		HOAGLAND 2-22	WILDCAT	28.0	REPUBLIC NATURAL
8410479	K-83-0485	1515121246		103		STOTTS 2-3	CARVER-ROBBINS	110.0	CENTRAL STATES GA
-TGT PETROLEUM CORPORATION				RECEIVED:	12/05/83	JA: KS			
8410466	K-83-0492	1509720946		103		VICKI #1	EINSEL	9.0	PANHANDLE EASTERN
-THE MAURICE L BROWN COMPANY				RECEIVED:	12/05/83	JA: KS			
8410432	K-83-0514	1509720932		103		YOST GAS UNIT #3	ALFORD NORTH	73.0	KANSAS GAS SUPPLY
-TOM KAT LTD				RECEIVED:	12/05/83	JA: KS			
8410440	K-83-0577	1504721079		103		CAREY #1	WILL C S/2 SE SE SE 2	15.0	CENTRAL STATES GA
-TXO PRODUCTION CORP				RECEIVED:	12/05/83	JA: KS			
8410480	K-83-0484	1509521344		102-2		ALBERS "B" #2	KOMAREK	360.0	DELHI CORP
8410478	K-83-0540	1509521359		102-2		ALBERS "C" #1	ST LEO	150.0	DELHI CORP
8410458	K-83-0467	1500720413		103		FINDLEY #1	SULLIVAN EAST	75.0	NORTHERN GAS PROD
8410493	K-83-0539	1509521332		103		KELLY #2	MAPLE GROVE	30.0	
8410481	K-83-0483	1500721510		102-2		LARSON "B" #1	BROOKS YOUNGER	150.0	
8410438	K-83-0569	1503310589		103		MCANINCH-GREGG #2	SHIMER	30.0	KANSAS GAS SUPPLY
8410437	K-83-0568	1509521361		102-2		NEISES #1	KOMAREK	150.0	DELHI CORP
**********									
LOUISIANA OFFICE OF CONSERVATION									
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-ADCO PRODUCING COMPANY INC				RECEIVED:	12/05/83	JA: LA			
8410339	82-1513	1710720407		102-4	103	PEARCE #3 LT MASS RA SU C	FOX LAKE	124.0	LOCUST RIDGE GAS
-AMOCO PRODUCTION CO				RECEIVED:	12/05/83	JA: LA			
8410397	83-1406	1770520107		103		S/L 862 #14	VERMILION BLOCK 14 FI	3000.0	TRUNKLINE GAS CO
-ARAPAHO PETROLEUM INCORPORATED				RECEIVED:	12/05/83	JA: LA			
8410424	83-0691	1701700000		108		WILBANKS #1	RODESSA	7.0	BRECKENRIDGE GASO
-ARCO OIL AND GAS COMPANY				RECEIVED:	12/05/83	JA: LA			
8410419	83-0712	1703100000		108		MAE FLETCHER #2 PETTIT SUE	LOGANSPORT (PETTIT)	19.0	SOUTHERN NATURAL
-ART MACHIN & ASSOCIATES INC				RECEIVED:	12/05/83	JA: LA			
8410405	83-1542	1711920408		103		WALKER #1 PET RA SUMN	NORTH SHONCALOO - RED	0.0	UNITED GAS PIPE L
-ASPEN EXPLORATION				RECEIVED:	12/05/83	JA: LA			
8410355	82-3313	1700121060		103		WINDSOR DAIGLE #1 WELL	CHURCH POINT FIELD	1014.0	MONTEREY PIPELINE
-BASS ENTERPRISES PRODUCTION CO				RECEIVED:	12/05/83	JA: LA			
8410338	83-1107	1706120279		102-4	103	R E ROBERSON #1 CV DAVIS RB SUS	MIDDLEFORK	110.0	UNITED GAS PIPELI
-BROWN JOEL B				RECEIVED:	12/05/83	JA: LA			
8410292	82-0228	1701723055		102-4		HOBBS #1 CV RA SUB	CADDO PINE ISLAND	1005.0	ARKANSAS LOUISIAN
-CALLON PETROLEUM COMPANY				RECEIVED:	12/05/83	JA: LA			
8410383	83-1174	1706320096		102-4		CROWN ZELLERBACH #3 WELL	LOCKHART CROSSING (WI	136.0	LOUISIANA INTRAST
8410332	83-0992	1706320104		102-4		CROWN ZELLERBACH #4 1ST WX RA SUM	LOCKHART CROSSING (WI	68.0	LOUISIANA INTRAST
8410347	83-0994	1706320109		102-4		CROWN ZELLERBACH #5 1ST WX RA SUR	LOCKHART CROSSING (WI	70.0	LOUISIANA INTRAST
8410333	83-0991	1706320098		102-4		I J FARRIS #1 1ST WX RA SUT	LOCKHART CROSSING (WI	68.0	LOUISIANA INTRAST
8410348	83-0993	1706320086		102-4		I P CO #3 1ST WX RA SUA	LOCKHART CROSSING (WI	126.0	SOUTHERN NATURAL
8410334	83-0990	1706320103		102-4		M I STEWART #1 1ST WX RA SUO	LOCKHART CROSSING (WI	106.0	LOUISIANA INTRAST
-CITIES SERVICE COMPANY				RECEIVED:	12/05/83	JA: LA			
8410296	82-3177	1702721053		102-4		GREER B #1	COLQUITT	210.0	ARKANSAS LOUISIAN
8410294	82-1074	1702720991		102-4		ODOM A-1 HA RB SUC	COLQUITT	506.0	
-CONOCO INC				RECEIVED:	12/05/83	JA: LA			
8410317	82-2249	1705320718		102-4		H A WILKINSON #1 VU A	EAST ROANOKE FIELD	1500.0	LOUISIANA GAS SYS
8410316	83-1177	1705320795		102-4		M W BRIESKE #1 HBY RA SUD	EAST ROANOKE FIELD	2000.0	LOUISIANA GAS SYS
8410331	83-1457	1705320779		102-4		S J LEJEUNE #1 HBY RA SUB	EAST ROANOKE FIELD	1500.0	LOUISIANA GAS SYS
-CRYSTAL OIL AND LAND COMPANY				RECEIVED:	12/05/83	JA: LA			
8410376	83-1330	1701724847		103		CLEMENTS "R" #4	NORTH MISSIONARY LAKE	32.1	ARKANSAS LOUISIAN

JD NO	JA DKT	API NO	D	SEC(1)	SEC(2)	WELL NAME	FIELD NAME	PROD	PURCHASER
8410315	83-1181	1704920195		102-4		DAVIS BROTHERS "D" #1	VERNON	1325.0	UNITED GAS PIPE L
8410343	83-1163	1701521900		102-4		FOSTER "B" #1-D CV RB SU49	ARKANA	12.8	ARKANSAS LOUISIAN
8410412	83-0979	1701521922		102-4		GEASLIN #1 SLI RB SUH	ARKANA	58.4	ARKANSAS LOUISIAN
8410410	83-0976	1701521781		102-4		INTL PAPER CO "I" #1 SLI RB SUA	ARKANA	40.2	ARKANSAS LOUISIAN
8410314	83-1180	1704920202		102-4		OXFORD #2 HOSS RA SUX	VERNON	930.8	UNITED GAS PIPE L
8410381	83-1537	1708120391		103		POSEY #1	GAHAGAN	83.4	LOUISIANA INTRAST
-DAVID CROW				RECEIVED:	12/05/83	JA: LA			
8410344	83-1162	1701718434		102-4		GRAVES "A" #1 SLI RC SU 92	CADDO-PINE ISLAND	0.0	ARKANSAS LOUISIAN
-DESCO OIL CO				RECEIVED:	12/05/83	JA: LA			
8410307	83-1521	1702321503		103		CUTLER #3 M-16 RA SUA	TWIN ISLAND	14.6	LOUISIANA RESOURC
-DESOTO OIL & GAS CORP				RECEIVED:	12/05/83	JA: LA			
8410420	83-0731	1703120455		108		ELEANOR SAMPLE SCOTT #1 #146239	GAY ISLAND	0.0	LOUISIANA INTRAST
8410386	83-1513	1703121905		103		SAMPLE SCOTT #2 SERIAL #180753	GAY ISLAND	0.0	LOUISIANA INTRAST
8410395	83-1512	1703121965		103		SAMPLE SCOTT #5 SERIAL #181603	GAY ISLAND	0.0	LOUISIANA INTRAST
-DIAMEX CO				RECEIVED:	12/05/83	JA: LA			
8410340	82-2229	1705320676		102-4		POWELL LUMBER COMPANY #1	EDNA 3583 (PERMITTED	75.0	TENNESSEE GAS PIP
-EDWIN L & BERRY R COX				RECEIVED:	12/05/83	JA: LA			
8410345	83-1161	1700120684		102-4		ARDOIN #2 ORTEGO A RB SUA	TEPETATE WEST	300.0	LOUISIANA GAS SYS
-EDWIN L COX				RECEIVED:	12/05/83	JA: LA			
8410346	83-1160	1700120780		102-4		HENSGENS #2 UMT-1 RB SUA	ELLIS	360.0	LOUISIANA GAS SYS
-EXCALIBUR RESOURCES INC				RECEIVED:	12/05/83	JA: LA			
8410394	83-1511	1701724494		103		EGAN-WEBB #2	CASPIANA	130.0	ARKANSAS LOUISIAN
8410391	83-1506	1703121659		103		LOWREY #3	RED RIVER - BULL BAYO	180.0	SABINE - DESOTO P
-EXCHANGE OIL & GAS CORPORATION				RECEIVED:	12/05/83	JA: LA			
8410384	83-1173	1705520240		102-4		DECLOUET #1 BOL MEX 3 RA SUB	NORTH MAURICE	2155.0	LOUISIANA INTRAST
-EXXON CORPORATION				RECEIVED:	12/05/83	JA: LA			
8410313	82-1244	1707520274		102-2		S L 6894 A 98	MAIN PASS BLOCK 74	15.0	UNITED GAS PIPE L
8410323	83-1468	1707523093		103		SL 1927 #67 SEP I-6 RA SU	SOUTHEAST PASS	100.0	TENNESSEE GAS PIP
8410320	83-1349	1707522450		103		SL 2090 #14 I5 R4A SUA	SOUTHEAST PASS	600.0	TENNESSEE GAS PIP
-FLAMINGO OIL & GAS INC				RECEIVED:	12/05/83	JA: LA			
8410368	83-1183	1702120977		102-4		GOUGH #1 WX RA SUG	PISTOL THICKET	0.0	LOUISIANA INTRAST
-FRANK HALE				RECEIVED:	12/05/83	JA: LA			
8410363	83-1322	1701724528		103		HINDSMAN PARKER B #2 SL1 RCSU 31	CADDO PINE ISLAND	220.0	ARKANSAS LOUISIAN
8410372	83-1327	1701724529		103		HINDSMAN PARKER B #3 SL1 RC SU 30	CADDO PINE ISLAND	220.0	ARKANSAS LOUISIAN
-FRONTIER EXPLORATION INC				RECEIVED:	12/05/83	JA: LA			
8410326	83-1501	1706900000		103		ARCO A LEASE 1	ASHLAND	214.0	UNITED GAS PIPE L
-GAS RESOURCES INC				RECEIVED:	12/05/83	JA: LA			
8410295	83-0354	1711123706		103		MANVILLE 748 #2	MONROE GAS	13.0	INC PIPELINE CO I
-GENERAL AMERICAN OIL COMPANY OF TEX				RECEIVED:	12/05/83	JA: LA			
8410312	82-2217	1702300000		103		CAMERON PARISH SCHOOL BOARD #28	JOHNSON BAYOU (K-3A S	400.0	TRANSCONTINENTAL
-GETTY OIL COMPANY				RECEIVED:	12/05/83	JA: LA			
8410302	83-1531	1703100000		103		PACE A #2 CV-RA-SUD	LOGANSPORT	0.0	TENNESSEE GAS PIP
-GOLDKING PRODUCTION COMPANY				RECEIVED:	12/05/83	JA: LA			
8410382	83-1175	1708720221		102-4		SL 9295 #1 7900 RB SUA	EAST STUARDS BLUFF	276.0	LOUISIANA INTRAST
8410416	83-1464	1703320170		103		TERRACE LAND CO #2-D	SIEGEN	81.0	UNITED GAS PIPELI
-GRACE PETROLEUM CORPORATION				RECEIVED:	12/05/83	JA: LA			
8410377	83-1533	1701724367		103		BAYLISS #1 HOSS RA SU FF	LONGWOOD	0.0	SOUTHWESTERN ELEC
8410398	83-1365	1706120340		103		STEWART #1	SIMSPORT	0.0	LOUISIANA GAS PUR
-GRAHAM EXPLORATION LTD DRILLING PAR				RECEIVED:	12/05/83	JA: LA			
8410369	83-1185	1705120575		102-4		MO PAC ALT #1 CIB 01 RB SUA	WESTWEGO	504.0	LOUISIANA GAS SER
-GRIGSBY PETROLEUM INC				RECEIVED:	12/05/83	JA: LA			
8410318	82-2273	1700121092		102-4		E L BERTRAND #1 #178099 RD SUA	IOTA	400.0	LOUISIANA GAS SYS
8410321	83-1502	1704920192		103		MS A MATHEWS #1 #180301 RA SUG	HODGE 4517	250.0	ARKANSAS LOUISIAN
-GUERNSEY PETROLEUM CORPORATION				RECEIVED:	12/05/83	JA: LA			
8410379	83-1535	1703121986		103		BISHOP #1 LAF RA SUG	RED RIVER BULL BAYOU	54.0	TEXAS EASTERN TRA
8410378	83-1534	1703121988		103		MARSHALL A CALHOUN #3 LAF RA SUS	RED RIVER BULL BAYOU	36.0	TEXAS EASTERN TRA
8410375	83-1333	1703121794		103		WANDA BEAM #1	WILDCAT	36.0	LOUISIANA INTRAST
-GULF OIL CORPORATION				RECEIVED:	12/05/83	JA: LA			
8410364	83-1526	1707523091		103		B L D 'D' #17	SOUTH PASS BLOCK 24	55.0	SOUTHERN NATURAL
8410360	83-1424	1707523069		103		BLD 'E' #163 VU 202	WEST BAY	88.0	TEXAS EASTERN TRA
8410310	83-1523	1707523028		103		BLD'E' 161 VU 62	WEST BAY FIELD	299.3	TEXAS EASTERN TRA
8410407	83-1544	1708920336		103		DELTA SECURITIES CO INC #134	BAYOU COUBA	47.5	TRANSCONTINENTAL
8410408	83-1545	1708920337		103		DELTA SECURITIES CORP INC #135	BAYOU COUBA	0.3	TRANSCONTINENTAL
8410309	83-1529	1701920989		103		FONTENOT #1-D CAM 1 RB SUA	SOUTH BELL CITY	507.0	TEXAS GAS TRANSMI
8410396	83-1420	1707523021		103		J G TIMOLAT 'C' #12	WEST BAY	20.0	TEXAS EASTERN TRA
8410304	83-1517	1705721512		103		S L 1772 #119	TIMBALIER BAY	108.0	TENNESSEE GAS PIP
8410351	83-1435	1707522777		103		S L 195 QQ #101-D Q-1 SUQ	WEST BLACK BAY FIELD	0.0	SOUTHERN NATURAL
8410414	83-1445	1707522844		103		S L 195 QQ WELL #318	QUARANTINE BAY FIELD	1.5	UNITED GAS PIPELI
8410365	83-1527	1707522935		103		S L 195 QQ WELL #323	QUARANTINE BAY FIELD	15.6	UNITED GAS PIPELI
8410328	83-1448	1707523006		103		S L 195 QQ WELL #326	QUARANTINE BAY FIELD	49.3	UNITED GAS PIPELI
8410327	83-1447	1707523032		103		S L 195 QQ WELL #86 MBLB N-1 RA SU	NORTH BLACK BAY	21.9	SOUTHERN NATURAL
8410370	83-1186	1707523148		102-4		S/L 195 'QQ' #338	QUARANTINE BAY FIELD	300.0	UNITED GAS PIPELI
-HADDOX PETROLEUM CORP				RECEIVED:	12/05/83	JA: LA			
8410428	83-0629	1711123045		108		MOBIL IP #5	MONROE	16.4	MID LOUISIANA GAS
-HARVEY BROYLES & MUNOCO CO				RECEIVED:	12/05/83	JA: LA			
8410356	83-1364	1707321948		103		G R CLEMENT #1 HOSS C RA SUE	CHENIERE CREEK	0.0	MANVILLE FOREST P
-HOGAN EXPLORATION INC				RECEIVED:	12/05/83	JA: LA			
8410367	83-1182	1702120968		102-4		GORDY #1 NEGLEY RA SUB	WELCOME HOME	35.0	LOUISIANA INTRAST
-JAMES CHARLIE G				RECEIVED:	12/05/83	JA: LA			
8410300	83-0988	1702120937		102-4		COLUMBIA HEIGHTS #1	WILDCAT	0.0	INTRA-STATE GAS C
8410335	83-0989	1702120896		102-4		E FINNEY CLAY #2	WILDCAT	0.0	LOUISIANA INTRAST
-JEEMS BAYOU PRODUCTION CORP				RECEIVED:	12/05/83	JA: LA			
8410390	83-1507	1708120446		103		DUPREE ROD RA	RED OAK LAKE 7644	83.3	LOUISIANA INTRAST
8410415	83-1446	1703122084		103		RIEMER CALHOUN B	BUFFALO BAYOU	146.0	MID-LOUISIANA GAS
-LEA EXPLORATION INC				RECEIVED:	12/05/83	JA: LA			
8410350	83-1436	1701120425		103		LONIX BOYER #1 VUA	EAST PERKINS	250.0	UNITED GAS PIPE L
-LOUISIANA LAND & EXPLORATION CO				RECEIVED:	12/05/83	JA: LA			
8410417	83-1465	1709720663		103		JOE BOUDREAUX #1	VELTIN	0.0	UNITED GAS PIPELI
-LUFFEY GAS CORP				RECEIVED:	12/05/83	JA: LA			
8410422	83-0632	1711123929		103		B J HAYES #1	MONROE	7.2	WEST MONROE GAS G
-M & M RENTALS				RECEIVED:	12/05/83	JA: LA			
8410341	83-1081	1707321958		103 108		A H JOHNSON #2	MONROE	9.0	PETRO LEWIS CORP
-MAJESTIC ENERGY CORP				RECEIVED:	12/05/83	JA: LA			
8410406	83-1543	1701521717		103		LOUIS KAUFMAN ET AL #1 CV RA SU 23	ELM GROVE	547.5	UNITED GAS PIPELI
-MALLARD DRILLING CORP				RECEIVED:	12/05/83	JA: LA			
8410400	83-1441	1708120480		103		CAMPBELL #1	GAHAGAN	0.0	LOUISIANA INTRAST
8410399	83-1440	1708120497		103		CAMPBELL #2 SERIAL #181005	GAHAGAN	0.0	LOUISIANA INTRAST
8410349	83-1437	1703122054		103		J BARNES #1	PLEASANT HILL	0.0	LOUISIANA INTRAST
8410413	83-1443	1708120494		103		RIVED #1	GAHAGAN	0.0	LOUISIANA INTRAST
8410401	83-1442	1708120498		103		STUART #001	GAHAGAN	0.0	LOUISIANA INTRAST
-MARATHON OIL COMPANY				RECEIVED:	12/05/83	JA: LA			
8410337	83-1352	1711920406		103		MDC GLEASON #3 CV JRS SU	COTTON VALLEY	401.5	UNITED GAS PIPE L
-MAY PETROLEUM INC				RECEIVED:	12/05/83	JA: LA			
8410389	83-1505	1703121911		103		LELA WILLIAMS "A" #1-D PSU-N	BETHANY LONGSTREET	182.5	ARKANSAS LOUISIAN

JD NO	JA DKT	API NO	D	SEC(1)	SEC(2)	WELL NAME	FIELD NAME	PROD	PURCHASER
-MCRAE EXPLORATION INC				RECEIVED:	12/05/83	JA: LA			
8410409	83-1538	1702721025		103		BYRD #2 CV RA SU P	SUGAR CREEK	1500.0	LOUISIANA GAS INT
-MCRAE OIL CORP				RECEIVED:	12/05/83	JA: LA			
8410380	83-1536	1706120317		103		REED LUMBER CO #1 LCV RA SUY	TERRYVILLE	75.0	LOUISIANA GAS PUR
-MICH-LA OIL & GAS EXPLORATION				RECEIVED:	12/05/83	JA: LA			
8410392	83-1509	1703102202		102-3		MARTIN TIMBER CO #1	GROGAN	110.0	TENNESSEE GAS PIP
8410358	83-1428	1703121978		103		W T J RAMSEY ET AL #1	GROGAN	80.0	TENNESSEE GAS PIP
8410393	83-1510	1703122048		103		WALLACE #1	GROGAN	110.0	TENNESSEE GAS PIP
-MID LOUISIANA GAS COMPANY				RECEIVED:	12/05/83	JA: LA			
8410426	83-0611	1711123979		103		MLGC FEE GAS #1210	MONROE GAS FIELD	21.6	MID LOUISIANA GAS
8410427	83-0612	1711123971		103		MLGC FEE GAS #1212	MONROE GAS FIELD	21.6	MID LOUISIANA GAS
8410425	83-0610	1711123981		103		MLGC FEE GAS #1213	MONROE GAS FIELD	21.6	MID LOUISIANA GAS
-MITCHELL ENERGY CORPORATION				RECEIVED:	12/05/83	JA: LA			
8410411	83-0977	1704920133		102-4		T J GREEN #1 CV RA SUC	KELLEYS	250.0	LOUISIANA GAS PUR
-NRG RESOURCES INC				RECEIVED:	12/05/83	JA: LA			
8410306	83-1520	1701921118		103		CORBELLO #1	NORTHWEST CHALKLEY	180.0	TENNESSEE GAS PIP
-PENNZOIL PRODUCING COMPANY				RECEIVED:	12/05/83	JA: LA			
8410361	83-1421	1703121830		103		A M SMITH #1 HOSS SUNN	LOGANSPORT/TRAVIS PEA	500.0	DELHI GAS PIPELIN
8410362	83-1318	1703121822		103		HG ANTHONY A 1 HOSS RA SUC	SPIDER/HOSSTON	250.0	DELHI GAS PIPELIN
8410373	83-1325	1703121849		103		HG ANTHONY 1 HOSS SU QQ	LOGANSPORT-HOSSTON	100.0	DELHI GAS PIPELIN
-PETROFUNDS INC				RECEIVED:	12/05/83	JA: LA			
8410402	83-1539	1701320549		103		CONTINENTAL CAN CO #5 HOSS B SU C	WEST BRYCELAND	600.0	LOUISIANA GAS PUR
8410308	83-1523	1701320549		103		CONTINENTAL CAN CO #5-D HOSS A SU C	WEST BRYCELAND	600.0	LOUISIANA GAS PUR
-PHILLIPS PETROLEUM COMPANY				RECEIVED:	12/05/83	JA: LA			
8410301	83-1530	1701320531		103		STARK B #3 HOSS B RA SUNH	ADA	237.0	SOUTHWESTERN ELEC
-PICKENS CO INC				RECEIVED:	12/05/83	JA: LA			
8410421	83-0926	1705320650		102-4		M A LEBLANC #1 ID 168377	WEST TEPETATE	183.0	LOUISIANA GAS SYS
-PLACID OIL COMPANY				RECEIVED:	12/05/83	JA: LA			
8410387	83-1514	1710121311		103		SHADYSIDE #14 DB-1 RC SU J	PATTERSON	1095.0	TENNESSEE GAS PIP
-REALITOS ENERGY CORP				RECEIVED:	12/05/83	JA: LA			
8410329	83-1451	1703121752		103		WILLAMETTE #1 U HOSS RA SUY	BELLE BOWER	100.0	ARKANSAS LOUISIAN
-ROBERSON WELL SERVICE				RECEIVED:	12/05/83	JA: LA			
8410319	83-1082	1711123932		103 108		G A MCCORMICK #2	MONROE	9.0	PETRO LEWIS CORP
-SAMANTHA PETROLEUM CORP				RECEIVED:	12/05/83	JA: LA			
8410342	82-3442	1708120473		102-2 103		GUILLOT A-1	GAY ISLAND	50.0	UNITED GAS PIPE L
-SEVARG COMPANY INC				RECEIVED:	12/05/83	JA: LA			
8410330	83-1466	1709720717		103		WILSON COURVILLE #1	OPELOUSAS	350.0	FLORIDA GAS TRANS
-SHELL OFFSHORE INC				RECEIVED:	12/05/83	JA: LA			
8410324	83-1469	1772120362		103		SL 1008 #B-55 SPB 27 FLD N4A RA SU	SOUTH PASS BLOCK 27 F	6.0	TENNESSEE GAS PIP
8410366	83-1170	1770920231		102-4		SL 7870 #1 EI 18 S2 RC SU	EUGENE ISLAND BLOCK 1	0.0	MID-LOUISIANA GAS
8410404	83-1541	1772120285		103		SP 27 FLD SL 1012 #260	SOUTH PASS BLOCK 27 F	10.0	TENNESSEE GAS PIP
-SHELL OIL CO				RECEIVED:	12/05/83	JA: LA			
8410291	82-0615	1772120319		103		SL 1012 #295 SP 27 N4B RB SU	SOUTH PASS BLOCK 27 F	7.0	TENNESSEE GAS PIP
-SPIRIT PETROLEUM				RECEIVED:	12/05/83	JA: LA			
8410423	83-0679	1702120890		102-4		MIXON #1 (180748) L WX RA SUI	WELCOME HOME	100.0	LOUISIANA INTRAST
-STONE PETROLEUM CORP				RECEIVED:	12/05/83	JA: LA			
8410293	82-2538	1705721960		102-4		LATERRE #1 RB SUA	GOLDEN MEADOW	1570.0	
-SUN EXPLORATION & PRODUCTION CO				RECEIVED:	12/05/83	JA: LA			
8410325	83-1470	1700121200		103		HAYES B #4 EGAN CAM RC SU	EGAN	66.0	TRANSCONTINENTAL
-SUPERIOR OIL CO				RECEIVED:	12/05/83	JA: LA			
8410418	83-1463	1711321058		103		A S LAPOINT #1 15850' RA SUA	KAPLAN	300.0	
8410388	83-1515	1710922606		103		R W BUCKLEY UNIT 10 #3	FOUR ISLE COME	1000.0	UNITED GAS PIPELI
8410336	83-1361	1704721605		103		SCHWING L & S CO #75	BAYOU BLEU	1.0	DOW INTRASTATE GA
8410374	83-1324	1704720661		103		SCHWING L & S CO #81	BAYOU BLEU	25.0	DOW INTRASTATE GA
-TEXACO INC				RECEIVED:	12/05/83	JA: LA			
8410299	82-1241	1710121183		102-4		BAL SU WKL #53	BATEMAN LAKE	2071.0	CITY OF MORGAN CI
-TEXAS GAS EXPLORATION CORP				RECEIVED:	12/05/83	JA: LA			
8410354	83-1432	1705120570		103		STATE LEASE 7016 #1A	SATURDAY ISLAND	212.0	SUGAR BOWL GAS CO
-THE DOW CHEMICAL COMPANY				RECEIVED:	12/05/83	JA: LA			
8410311	83-1524	1709900547		103		IBERVILLE #1 H RA SUA	HAPPYTOWN	17.0	
8410303	83-1532	1709920682		103		WILLIAMS INC "A" #1 L PLAN P4 RA	BAYOU LONG	400.0	
-TIPCO				RECEIVED:	12/05/83	JA: LA			
8410357	83-1430	1772720078		103		STATE LEASE 2220 #48	ELOI BAY	8.0	SOUTHERN NATURAL
8410353	83-1433	1772720084		103		STATE LEASE 2220 #52-D	ELOI BAY	13.0	SOUTHERN NATURAL
8410352	83-1434	1772720098		103		STATE LEASE 2220 #54	ELOI BAY	51.0	SOUTHERN NATURAL
8410359	83-1425	1772720100		103		STATE LEASE 2220 #55	ELOI BAY	44.0	SOUTHERN NATURAL
-TWIN CITY GAS				RECEIVED:	12/05/83	JA: LA			
8410297	83-0376	1707321942		103		WOMACK #1	MONROE	0.0	IMC PIPELINE CO I
-TXO PRODUCTION CORP				RECEIVED:	12/05/83	JA: LA			
8410371	83-0987	1704920132		102-4		MARTIN "FF" #1	CLAY	24.8	ARKANSAS-LOUISIAN
8410322	83-1503	1701724607		103		WERNER SAWMILL #1 CV D RA SUPP	GREENWOOD-WASKOM	485.8	UNITED GAS PIPE L
8410298	83-0390	1706120337		102-4		YOUNG "L" #1	RUSTON	1053.0	DELHI GAS PIPELIN
-W B MCCARTER JR INC				RECEIVED:	12/05/83	JA: LA			
8410385	83-1178	1705320595		102-4		R J HINE ESTATE #1	ROGERS GULLY FIELD	61.2	UNITED GAS PIPELI
-WEAVER OIL AND GAS CORPORATION				RECEIVED:	12/05/83	JA: LA			
8410305	83-1518	1770320086		103		STATE LEASE 6289 #1	EAST CAMERON BLOCK 4	1460.0	LOUISIANA RESOURC
-WILLIAMSON & SMITHERMAN				RECEIVED:	12/05/83	JA: LA			
8410403	83-1540	1711920380		103		MCGINTY #1 SN 179472	SIBLEY FIELD	100.0	UNITED GAS PIPE L
**********									
** DEPARTMENT OF THE INTERIOR, BUREAU OF LAND MANAGEMENT, ALBUQUERQUE,NM									
**********									
-AMOCO PRODUCTION CO				RECEIVED:	11/28/83	JA: NM 4			
8409524	NM-1254-83PB	3004511687		108-PB		GALLEGOS CANYON UNIT #2U	BASIN	0.0	EL PASO NATURAL G

[FR Doc. 84-751 Filed 1-11-84; 8:45 am]

BILLING CODE 6717-01-C

[Vol. 1036]

Determinations by Jurisdictional Agencies Under the Natural Gas Policy Act of 1978

Issued: January 6, 1984.

The following notices of determination were received from the indicated jurisdictional agencies by the Federal Energy Regulatory Commission pursuant to the Natural Gas Policy Act of 1978 and 18 CFR 274.104. Negative determinations are indicated by a "D" before the section code. Estimated annual production (PROD) is in million cubic feet (MMCF).

The applications for determination are available for inspection except to the extent such material is confidential under 18 CFR 275.206, at the Commission's Division of Public Information, Room 1000, 825 North Capitol St., Washington, D.C. Persons objecting to any of these determinations may, in accordance with 18 CFR 275.203 and 275.204, file a protest with the Commission within fifteen days after publication of notice in the **Federal Register.**

Source data from the Form 121 for this and all previous notices is available on magnetic tape from the National Technical Information Service (NTIS). For information, contact Stuart Weisman (NTIS) at (703) 487–4808, 5285 Port Royal Rd, Springfield, Va 22161.

Categories within each NGPA section are indicated by the following codes:

Section 102–1: New OCS lease
102–2: New Well (2.5 Mile rule)
102–3: New Well (1000 Ft rule)
102–4: New onshore reservoir
102–5: New resevoir on old OCS lease
Section 107–DP: 15,000 feet or deeper
107–GB: Geopressured brine
107–CS: Coal Seams
107–DV: Devonian Shale
107–PE: Production enhancement
107–TF: New tight formation
107–RT: Recompletion tight formation
Section 108: Stripper well
108–SA: Seasonally affected
108–ER: Enhanced recovery
108–PB: Pressure buildup

Kenneth F. Plumb,
Secretary.

NOTICE OF DETERMINATIONS

ISSUED JANUARY 6, 1984

JD NO	JA DKT	API NO	D	SEC(1)	SEC(2)	WELL NAME	FIELD NAME	PROD	PURCHASER
TEXAS RAILROAD COMMISSION									
-ADA OIL EXPLORATION CORP				RECEIVED:	12/05/83	JA: TX			
8410591	F-03-069742	4205100000		102-2		JOHN NEWMAN #10	GIDDINGS (AUSTIN CHAL	0.0	PHILLIPS PETROLEU
8410610	F-03-071594	4205100000		102-2		WEST BIRCH CREEK PARK #5	GIDDINGS	0.0	PHILLIPS PETROLEU
8410635	F-03-072150	4205100000		102-2		WEST BIRCH CREEK PARK #7	GIDDINGS	0.0	PHILLIPS PETROLEU
-ADOBE OIL & GAS CORPORATION				RECEIVED:	12/05/83	JA: TX			
8410679	F-7B-074074	4225332649		103		D L BRISTON #4	MINTER	12.0	
-AMOCO PRODUCTION CO				RECEIVED:	12/05/83	JA: TX			
8410762	F-8A-075301	4221933880		103		ELLWOOD "A" #151	SNYER	0.0	AMOCO PRODUCTION
8410761	F-8A-075300	4221933881		103		ELLWOOD "A" #152	SNYER	0.0	AMOCO PRODUCTION
8410765	F-8A-075304	4221933884		103		ELLWOOD "A" #156	SNYER	0.0	AMOCO PRODUCTION
8410802	F-8A-075402	4221934010		103		LEVELLAND UNIT #791	LEVELLAND	77.5	AMOCO PRODUCTION
8410800	F-8A-075400	4221934008		103		LEVELLAND UNIT #793	LEVELLAND	74.0	AMOCO PRODUCTION
8410801	F-8A-075401	4221924012		103		LEVELLAND UNIT #794	LEVELLAND	101.0	AMOCO PRODUCTION
8410804	F-8A-075404	4221933960		103		MAY MONTGOMERY UNIT #74	LEVELLAND	37.0	AMOCO PRODUCTION
8410803	F-8A-075403	4221933959		103		MAY MONTGOMERY UNIT #80	LEVELLAND	33.1	AMOCO PRODUCTION
8410799	F-8A-075399	4221933956		103		MAY MONTGOMERY UNIT #83	LEVELLAND	26.0	AMOCO PRODUCTION
8410760	F-8A-075299	4221933961		103		MAY MONTGOMERY UNIT #84	LEVELLAND	91.0	AMOCO PRODUCTION
8410759	F-8A-075298	4221933955		103		MAY MONTGOMERY UNIT #85	LEVELLAND	35.2	AMOCO PRODUCTION
8410763	F-8A-075302	4221933890		103		W G FRAZIER #132	SLAUGHTER	0.0	AMOCO PRODUCTION
8410798	F-8A-075398	4221933892		103		W G FRAZIER UT #133	SLAUGHTER	0.2	AMOCO PRODUCTION
-ARCO OIL AND GAS COMPANY				RECEIVED:	12/05/83	JA: TX			
8410641	F-04-072291	4221531347		102-4		MACBEAN UNIT #1	MERCEDES (7500) PROFD	20.0	TENNESSEE GAS PIP
-AUDAX ENERGY CORP				RECEIVED:	12/05/83	JA: TX			
8410721	F-08-074959	4200333568		103		BROWN "12" #5	FUHRMAN-MASCHO	9.1	PHILLIPS PETROLEU
-BEST PETROLEUM EXPLORATION INC				RECEIVED:	12/05/83	JA: TX			
8410729	F-09-075157	4223735286		103		RITA "B" #1 (OIL)	DEARING (CADDO)	45.0	LONE STAR GAS CO
-BILL FENN INC				RECEIVED:	12/05/83	JA: TX			
8410628	F-03-071899	4228731411		102-4		SUSIE B NO 1 RRC ID #N/A	GIDDINGS (AUSTIN CHAL	0.0	PERRY PIPELINE CO
-BILL FORNEY INC				RECEIVED:	12/05/83	JA: TX			
8410690	F-02-072269	4225530650		102-4		J H SPURLOCK #1	SOUTHWEST MCDASKILL	160.0	ELIZABETHTOWN G/S
-BIRDWELL BAKER				RECEIVED:	12/05/83	JA: TX			
8410669	F-03-073825	4247130244		102-4		CENTRAL COAL & COKE #2	MORGAS EAST (JACKSON	50.0	MORGAS CO
-BORGER WELDING INC				RECEIVED:	12/05/83	JA: TX			
8410707	F-10-074510	4206500000		103		O'NEAL #1	PANHANDLE CARSON	50.0	GETTY OIL CO
-BRC PETROLEUM INC				RECEIVED:	12/05/83	JA: TX			
8410578	F-03-066907	4207100000		102-4		W L PATTILLO #1	PROPOSED TURTLE BAY (	0.0	UNITED TEXAS TRAN
-BUFFTON OIL & GAS INC				RECEIVED:	12/05/83	JA: TX			
8410609	F-09-071472	4223700000		103		POLK-PATTON #3	BOOMSVILLE BEND (CONG	182.5	LONE STAR GAS CO
-BURK ROYALTY CO				RECEIVED:	12/05/83	JA: TX			
8410692	F-10-07424	4235731254		103	107-TF	B F SCHULTZ #2	PERRYTON W (CLEVELAND	0.0	NORTHERN NATURAL
-C F LAWRENCE & ASSOC INC				RECEIVED:	12/05/83	JA: TX			
8410723	F-08-074968	4237134431		103		MCMURTRY #13	LEHN-APCO	0.0	APACHE GAS CORP
-C R GOBER				RECEIVED:	12/05/83	JA: TX			
8410659	F-7B-073499	4244733395		102-4		R C LITTLE #1	KINGS CREEK (MISS)	3.0	HST GATHERING CO
8410658	F-7B-07349	4244700000		102-4		R C LITTLE #2	KINGS CREEK (CADDO)	0.0	HST GATHERING CO
-CABOT PETROLEUM CORP				RECEIVED:	12/05/83	JA: TX			

BILLING CODE 6717-01-M

JD NO	JA DKT	API NO	D	SEC(1)	SEC(2)	WELL NAME	FIELD NAME	PROD	PURCHASER
8410737	F-10-075242	4239330922		103		LOWE #50-A-2	LEDRICK RANCH S (UPPE	82.0	TRANSWESTERN PIPE
8410736	F-7C-075234	4241331284		103		WHITTEN "A" #2 (106759)	ELDORADO (CANYON)	44.0	FARMLAND INDUSTRI
-CADDO CORP				RECEIVED:	12/05/83	JA: TX			
8410731	F-7B-075206	4215131649		103		J F DOZIER #2	SYLVESTER (STRAIN)	27.4	PALO DURO PIPELIN
-CARLSON PETROLEUM CO				RECEIVED:	12/05/83	JA: TX			
8410554	F-06-056278	4240131455		102-2		KANGERGA #1	MINDEN W (TRAVIS PEAK	109.0	TEXAS UTILITIES F
-CENTURY ENERGY INC				RECEIVED:	12/05/83	JA: TX			
8410587	F-01-069565	4250700000		103		LORA LYLES #3		2263.0	ESPERANZA TRANSMI
8410599	F-01-070670	4250731954		103		LORA LYLES #4	ESCONDIDO	44.5	ESPERANZA TRANSMI
-CHAMPLIN PETROLEUM COMPANY				RECEIVED:	12/05/83	JA: TX			
8410558	F-7C-058935	4210533242		107-TF		P C PERNER "199" #1	PERNER RANCH (DEVONIA	3564.0	PRODUCERS GAS CO
-CHARLES E HANNON				RECEIVED:	12/05/83	JA: TX			
8410694	F-08-07428	4232900000		108		L C JONES A-1	SPRABERRY	5.0	PHILLIPS PETROLEU
-CHESAPEAKE BAY GAS GATH & CROCKETT				RECEIVED:	12/05/83	JA: TX			
8410656	F-7C-073318	4210524386		103	107-TF	ADAMS #4-153	ADAMS-BAGGETT FIELD	90.0	DETROIT-TEXAS GAS
-CHEVRON U S A INC				RECEIVED:	12/05/83	JA: TX			
8410825	F-08-075486	4222733011		103		W L FOSTER 1 #72	IATAN EAST HOWARD	18.3	GETTY OIL CO
8410820	F-08-075479	4222733065		103		W L FOSTER 1 #76	IATAN EAST HOWARD	6.6	GETTY OIL CO
8410821	F-08-075480	4233532530		103		W L FOSTER 1 #77	IATAN EAST HOWARD	5.8	GETTY OIL CO
8410822	F-08-075481	4233532529		103		W L FOSTER 1 #79	IATAN EAST HOWARD	5.5	GETTY OIL CO
8410823	F-08-075482	4222733157		103		W L FOSTER 1 #80	IATAN EAST HOWARD	5.8	GETTY OIL CO
8410824	F-08-075485	4233532464		103		W L FOSTER 5 #17R	IATAN EAST HOWARD	9.1	GETTY OIL CO
-CITIES SERVICE OIL & GAS CORP				RECEIVED:	12/05/83	JA: TX			
8410677	F-06-074031	4231597501		108		BELCHER #1	RODESSA (HILL SOUTH)	0.0	BRECKENRIDGE GASO
8410758	F-8A-075296	4216532595		103		WEST SEMINOLE SAN ANDRES UNIT #809	SEMINOLE WEST	38.0	CITIES SERVICE CO
-COMANCHE INVESTMENTS				RECEIVED:	12/05/83	JA: TX			
8410667	F-7B-073764	4213335084		102-4	103	BIG MIKE "C" #1	DAVENPORT (RANGER M)	130.0	LONE STAR GAS CO
8410808	F-7B-075445	4213335112		103		C E LOURANCE #1	EASTLAND COUNTY REGUL	11.3	LONE STAR GAS CO
-CONOCO INC				RECEIVED:	12/05/83	JA: TX			
8410722	F-7C-074962	4210534507		103		C T HARRIS - 12 #1 ID	ESCONDIDO N W	365.0	
8410618	F-8A-071629	4216931600		102-4	103	CITIZENS NATL BANK OF LUBBOCK #13	HUNTLEY EAST/SAN ANDR	400.0	MID PLAINS PETROC
8410697	F-08-074317	4238931410		102-4	103	HUCKABEE #1	JEGS BURNER (DELAWARE	51.8	EL PASO NATURAL G
8410608	F-8A-071455	4216900000		102-4		HUNTLEY EAST SAN ANDRES UNIT #33	HUNTLEY EAST (SAN AND	887.0	MID PLAINS PETROC
8410617	F-8A-071628	4216900000		102-4	103	HUNTLEY EAST SAN ANDRES UNIT #53	HUNTLEY EAST (SAN AND	40.0	MID PLAINS PETROC
8410616	F-8A-071627	4216900000		102-4	103	HUNTLEY EAST SAN ANDRES UNIT #54	HUNTLEY EAST (SAN AND	400.0	MID PLAINS PETROC
8410615	F-8A-071626	4216931153		102-4	103	HUNTLEY EAST SAN ANDRES UNIT #55	HUNTLEY EAST (SAN AND	400.0	MID PLAINS PETROC
8410614	F-8A-071625	4216900000		102-4	103	HUNTLEY EAST SAN ANDRES UNIT #57	HUNTLEY EAST (SAN AND	400.0	MID PLAINS PETROC
8410613	F-8A-071624	4216931199		102-4	103	HUNTLEY EAST SAN ANDRES UNIT #58	HUNTLEY EAST (SAN AND	400.0	MID PLAINS PETROC
8410612	F-8A-071623	4216931536		102-4	103	HUNTLEY EAST SAN ANDRES UNIT #59	HUNTLEY EAST (SAN AND	400.0	MID PLAINS PETROC
8410611	F-8A-071622	4216931758		102-4	103	HUNTLEY EAST SAN ANDRES UNIT #60	HUNTLEY EAST (SAN AND	400.0	MID PLAINS PETROC
8410623	F-8A-071641	4216931753		102-4	103	HUNTLEY EAST SAN ANDRES UNIT #63	HUNTLEY EAST (SAN AND	400.0	MID PLAINS PETROC
8410622	F-8A-071640	4216931752		102-4	103	HUNTLEY EAST SAN ANDRES UNIT #64	HUNTLEY EAST (SAN AND	400.0	MID PLAINS PETROC
8410621	F-8A-071638	4216931948		102-4	103	HUNTLEY EAST SAN ANDRES UNIT #66	HUNTLEY EAST (SAN AND	400.0	MID PLAINS PETROC
8410620	F-8A-071637	4216931942		102-4	103	HUNTLEY EAST SAN ANDRES UNIT #67	HUNTLEY EAST (SAN AND	400.0	MID PLAINS PETROC
8410619	F-8A-071636	4216931941		102-4	103	HUNTLEY EAST SAN ANDRES UNIT #68	HUNTLEY EAST (SAN AND	400.0	MID PLAINS PETROC
8410755	F-08-075291	4213533092		108		WIGHT "187" #2 ID 25220	NORTH COWDEN	3.4	AMOCO PRODUCTION
8410757	F-08-075293	4213500000		108		WIGHT UNIT #64 ID 20661	NORTH COWDEN	4.5	AMOCO PRODUCTION
8410756	F-08-075292	4213531789		108		WIGHT UNIT #35 ID 20661	NORTH COWDEN	0.4	AMOCO PRODUCTION
-CORPUS CHRISTI OIL AND GAS CO				RECEIVED:	12/05/83	JA: TX			
8410715	F-04-074810	4270330301		102-4		STATE TRACT 691-L SW/4 WELL #3-L	BLOCK 691-L (5350') F	0.0	HOUSTON PIPELIN
-COTTON PETROLEUM CORPORATION				RECEIVED:	12/05/83	JA: TX			
8410585	F-10-069335	4239300000		108-PB		R D MILLS #1	R D MILLS-ATOKA	0.0	MICHIGAN-WISCONSI
-CROMERA OIL & GAS CO				RECEIVED:	12/05/83	JA: TX			
8410738	F-7B-075244	4241735288		102-4		JOHN SEDWICK #15	CROMERA (MORAN)	2.4	MASSEN PETROLEUM
-CRYSTAL OIL AND LAND COMPANY				RECEIVED:	12/05/83	JA: TX			
8410691	F-06-074237	4206730429		102-4		BLANCHARD #1	RODESSA	1.1	BRECKENRIDGE GASO
-DANIEL OIL COMPANY				RECEIVED:	12/05/83	JA: TX			
8410633	F-01-072082	4231131719		102-4	103	EVE #1	SAN CAJA S W (BLOCK 8	0.0	ENJET INC
-DAVID A SCHLACHTER OIL & GAS				RECEIVED:	12/05/83	JA: TX			
8410584	F-06-069026	4242330644		102-4		W L ONEAL #3	CHAPEL HILL (TRAVIS P	12.8	ETEXAS PRODUCERS
-DELTA OIL & GAS CO				RECEIVED:	12/05/83	JA: TX			
8410663	F-7B-073566	4242900000		108		BLANCHE WINSTON RRC #14840	STEPHENS COUNTY REGUL	0.0	LONE STAR GAS CO
-DIEKEMPER RAY J JR				RECEIVED:	12/05/83	JA: TX			
8410632	F-8A-072072	4216900000		102-4	103	NORTHWEST GARZA UNIT #209 I D 61053	GARZA	1.1	MID PLAINS PETROC
8410631	F-8A-072059	4216900000		102-4	103	NORTHWEST GARZA UNIT #407 I D 61053	GARZA	1.1	MID PLAINS PETROC
8410630	F-8A-072047	4216900000		102-4		NORTHWEST GARZA UNIT #705T ID 61053	GARZA	1.1	MID PLAINS PETROC
-DISCOVERY OPERATING INC				RECEIVED:	12/05/83	JA: TX			
8410675	F-8A-073938	4231732712		103		LAUDERDALE #1	ACKERLY (DEAN SAND)	0.0	TEXACO INC
-ECHO PRODUCTION INC				RECEIVED:	12/05/83	JA: TX			
8410739	F-09-075246	4250300000		102-4		CEARLEY #2	FRANK (4200)	0.0	SOUTHWESTERN GAS
-EL PASO EXPLORATION CO				RECEIVED:	12/05/83	JA: TX			
8410547	F-10-052824	4221131217		108-PB		MEEK #1	BUFFALO WALLOW	0.0	EL PASO NATURAL G
-EL PASO NATURAL GAS COMPANY				RECEIVED:	12/05/83	JA: TX			
8410535	F-10-041791	4217923689		108-PB		BARNES #2	PANHANDLE WEST	0.0	EL PASO NATURAL G
8410572	F-10-064107	4217923691		108-PB		BEASLEY #2	PANHANDLE WEST	0.0	EL PASO NATURAL G
8410529	F-10-036504	4208726022		108-PB		BETENBOUGH #2	PANHANDLE EAST	0.0	EL PASO NATURAL G
8410549	F-10-053982	4208726026		108-PB		BETENBOUGH A#4	PANHANDLE EAST	0.0	EL PASO NATURAL G
8410581	F-10-067613	4208726028		108-PB		BETENBOUGH B #1	PANHANDLE EAST	0.0	EL PASO NATURAL G
8410565	F-7C-062007	4217923696		108-PB		CALLAHAM #1	PANHANDLE WEST	0.0	EL PASO NATURAL G
8410544	F-10-049577	4221130262		108-PB		CAMPBELL #1	S E MENDOTA-UPPER MOR	0.0	EL PASO NATURAL G
8410520	F-10-022715	4221130555		108-PB		CHANDLER #1	VIKING - MORROW UPPER	0.0	EL PASO NATURAL G
8410510	F-7C-002531	4243530142		108-PB		COLLIER SHURLEY 18 #6	SAWYER-CANYON	0.0	EL PASO NATURAL G
8410534	F-10-041022	4217923699		108-PB		COUSINS #1	PANHANDLE WEST	0.0	EL PASO NATURAL G
8410541	F-10-047501	4217923702		108-PB		DARSEY #2	PANHANDLE WEST	0.0	EL PASO NATURAL G
8410532	F-7C-038781	4243519207		108-PB		DEBERRY A #2	SONORA-CANYON UPPER	0.0	EL PASO NATURAL G
8410513	F-7C-003276	4243519209		108-PB		DEBERRY A #4	SONORA - CANYON UPPER	0.0	EL PASO NATURAL G
8410512	F-7C-003115	4243500000		108-PB		DEBERRY A #7	SONORA-CANYON UPPER	0.0	EL PASO NATURAL G
8410569	F-7C-062723	4243530702		108-PB		DEBERRY A #8	SONORA-CANYON UPPER	0.0	EL PASO NATURAL G
8410560	F-7C-059278	4243519203		108-PB		DEBERRY-BOYETT UNIT #1	SONORA-CANYON UPPER	0.0	EL PASO NATURAL G
8410526	F-7C-033032	4243530555		108-PB		DEBERRY-BOYETT UNIT #2	SONORA-CANYON UPPER	0.0	EL PASO NATURAL G
8410518	F-7C-018052	4243531003		108-PB		HALBERT #3	SONORA - CANYON UPPER	0.0	EL PASO NATURAL G
8410627	F-10-071872	4248326095		108-PB		HALL A #1	PANHANDLE EAST	0.0	EL PASO NATURAL G
8410552	F-10-054499	4217923711		108-PB		HANNER X #1	PANHANDLE WEST	0.0	EL PASO NATURAL G
8410551	F-10-054313	4217923712		108-PB		HERRINGTON #1	PANHANDLE WEST	0.0	EL PASO NATURAL G
8410521	F-10-023815	4217923720		108-PB		HOWARD #1	PANHANDLE WEST	0.0	EL PASO NATURAL G
8410556	F-10-058236	4217923728		108-PB		JOHNSTON #1	PANHANDLE WEST	0.0	EL PASO NATURAL G
8410582	F-10-067614	4208726119		108-PB		KNOLL B #1		0.0	EL PASO NATURAL G
8410517	F-10-013291	4217923731		108-PB		KROUCH #1	PANHANDLE WEST	0.0	EL PASO NATURAL G
8410550	F-10-053984	4208726155		108-PB		LUTES A #1	PANHANDLE EAST	0.0	EL PASO NATURAL G
8410548	F-10-052827	4217923735		108-PB		MAGEE #1	PANHANDLE WEST	0.0	EL PASO NATURAL G
8410566	F-10-062009	4248326160		108-PB		MAGNOLIA A #2	PANHANDLE EAST	0.0	EL PASO NATURAL G
8410538	F-7C-045746	4243519213		108-PB		MARTIN #1	SONORA-CANYON UPPER	0.0	EL PASO NATURAL G
8410524	F-10-029850	4208726179		108-PB		MCDOWELL #5	PANHANDLE EAST	0.0	EL PASO NATURAL G
8410562	F-10-060460	4208726180		108-PB		MCDOWELL #6	PANHANDLE EAST	0.0	EL PASO NATURAL G

JD NO	JA DKT	API NO	D	SEC(1)	SEC(2)	WELL NAME	FIELD NAME	PROD	PURCHASER
8410527	F-7C-033181	4243519221		108-PB		MECKEL #5	SONORA-CANYON UPPER	0.0	EL PASO NATURAL G
8410537	F-7C-042712	4243530316		108-PB		MECKEL #7	SONORA-CANYON UPPER	0.0	EL PASO NATURAL G
8410555	F-10-057622	4248326201		108-PB		NELSON #1	PANHANDLE EAST	0.0	EL PASO NATURAL G
8410626	F-10-071854	4208726203		108-PB		NEWKIRK #2	PANHANDLE EAST	0.0	EL PASO NATURAL G
8410531	F-10-037519	4217923744		108-PB		REEVES #1	PANHANDLE WEST	0.0	EL PASO NATURAL G
8410543	F-7C-049576	4243500000		108-PB		SIMMONS #1	SONORA CANYON UPPER	0.0	EL PASO NATURAL G
8410516	F-7C-009196	4243530557		108-PB		THOMSON C #4	SONORA - CANYON UPPER	0.0	EL PASO NATURAL G
8410525	F-7C-030872	4243519227		108-PB		THOMSON 62 #1	SONORA-CANYON UPPER	0.0	EL PASO NATURAL G
8410519	F-10-020926	4217923757		108-PB		WILSON #1	PANHANDLE WEST	0.0	EL PASO NATURAL G
8410539	F-10-047226	4208726316		108-PB		WISCHKAEMPER A #1	PANHANDLE EAST	0.0	EL PASO NATURAL G
-ENERGY RESERVES GROUP INC				RECEIVED:	12/05/83	JA: TX			
8410749	F-7C-075280	4208131139		103		J E CHAPPELL "A" #17	JAMESON (STRAWN)	10.8	UNION TEXAS PETRO
-ENERGY RESOURCES OIL & GAS CORP				RECEIVED:	12/05/83	JA: TX			
8410709	F-01-074628	4201331558		102-4		J T PESEK #1	JOURDANTON (ANACACHO)	275.0	REATA INDUSTRIAL
-ENSERCH EXPLORATION INC				RECEIVED:	12/05/83	JA: TX			
8410704	F-7B-074446	4242900000		103		J W STOUARD UNIT #3	IWADELL	0.0	
8410689	F-7B-074208	4236732577		103		J W STURDIVANT #3	SPRINGTOWN	0.0	
8410716	F-09-074837	4219730589		103		LOVE "20" UNIT 4	LOVE (MISSISSIPPIAN)	0.0	LONE STAR GAS CO
8410649	F-05-073147	4221330371		103		T H WALLACE #3	TRI-CITIES (TRAVIS PE	0.0	LONE STAR GAS CO
-ESENJAY PETROLEUM CORP				RECEIVED:	12/05/83	JA: TX			
8410598	F-04-070538	4224931668		103		AMELIA TORRANS #1	ALICE (STILLWELL 5340	500.0	VALLEY GAS TRANSM
-EVEREST MINERALS CORP				RECEIVED:	12/05/83	JA: TX			
8410570	F-03-062791	4228731314		102-2	103	DOROTHY SIMMANG WELL #2	GIDDINGS (AUSTIN CHAL	210.0	PHILLIPS PETROLEU
-EXCELSIOR OIL CORP				RECEIVED:	12/05/83	JA: TX			
8410829	F-06-075490	4240100000		103		WILLIE ANN LINER #1	DANVILLE (PETTIT LOWE	36.0	AMALGAMATED GAS P
-EXXON CO USA				RECEIVED:	12/05/83	JA: TX			
8410533	F-08-040326	4232900000		108-PB		MARY E TURNER D #5	AZALEA	0.0	
-EXXON CORPORATION				RECEIVED:	12/05/83	JA: TX			
8410810	F-06-075447	4207330534		103		CARTER STATE (NECHES CONS OU-15) #4	NECHES (WOODBINE)	36.5	UNITED GAS PIPELI
8410807	F-03-075443	4233930586		103		CONROE FIELD UNIT #1119	CONROE	325.0	MORAN UTILITIES C
8410805	F-06-075440	4207330513		103		HARRY LEE CARTER "C" #14	NECHES (WOODBINE)	36.5	UNITED GAS PIPELI
8410806	F-06-075442	4207330531		103		HARRY LEE CARTER "E" #6	NECHES (WOODBINE)	63.9	UNITED GAS PIPELI
8410655	F-08-073303	4210333186		103		JUDKINS GAS UNIT #2 WELL 279	SAND HILLS (JUDKINS)	51.0	EL PASO HYDROCARB
8410707	F-06-075124	4207330507		102-4	107-TF	P C PINKERTON JR #1	OVERTON	352.0	ARMCO STEEL CORP
8410717	F-06-074852	4234731017		103		SAM B HAYTER ESTATE #3	DOUGLASS W (TRAVIS PE	263.0	ARMCO STEEL CORP
8410657	F-04-073336	4204730954		103		SANTA FE RANCH 71 (ID PENDING)	SANTA FE EAST (I-05)	548.0	NATURAL GAS PIPEL
8410586	F-06-069477	4206330475		102-4		VERA MIDDLETON GAS UNIT #1 #1	REKLAW (TRAVIS PEAK)	570.0	ARMCO STEEL CORP
-FIRST TRIAD CORP				RECEIVED:	12/05/83	JA: TX			
8410695	F-7B-074300	4236732543		102-4		WOODRUFF-BLAIR #2 (GAS)	DENNIS WEST (STRAWN)	328.0	PARKER G'S INC
-FLYNN ENERGY CORP				RECEIVED:	12/05/83	JA: TX			
8410606	F-02-071368	4229700000		102-4		HERRING RANCH 67 #4	MAXINE EAST (6900)	489.0	UNITED TEXAS TRAN
-GETTY OIL COMPANY				RECEIVED:	12/05/83	JA: TX			
8410701	F-8A-074411	4207900000		108		SOUTHWEST LEVELLAND UNIT #48	LEVELLAND	2.0	CITIES OIL & GAS
-GLENN COPE				RECEIVED:	12/05/83	JA: TX			
8410794	F-10-075391	4208700000		103		MELVIN BAILEY #1	EAST PANHANDLE	0.0	HIGH PLAINS NATUR
-GOLDSTON OIL CORP				RECEIVED:	12/05/83	JA: TX			
8410720	F-01-074949	4231131865		102-4	103	T J MARTIN GAS UNIT #2 WELL #1-T	ROOS (1850')	73.0	TENNESSEE GAS PIP
-GREENWOOD INDUSTRIES INC				RECEIVED:	12/05/83	JA: TX			
8410583	F-7B-068364	4209331084		102-4		MOORE #2	MOORE (MARBLE FALLS)	2000.0	ENERGY PIPELINE C
-GULF OIL CORPORATION				RECEIVED:	12/05/83	JA: TX			
8410559	F-10-059225	4219530014		108-PB		BUCKNER BAPTIST #1	CLEMENTINE	0.0	NORTHERN NATURAL
8410542	F-10-049146	4219535319		108-PB		CLEMENTINE #1	CLEMENTINE	0.0	NORTHERN NATURAL
8410685	F-10-074127	4229530858		107-TF		HAROLD PEERY #3-766	PEERY (MARMATON)/CLEV	19.4	TRANSWESTERN PIPE
8410684	F-10-074126	4229531005		107-TF		HAROLD PEERY #4-766	PEERY (CLEVELAND)/CLE	17.5	TRANSWESTERN PIPE
8410687	F-10-074129	4229531004		107-TF		HAROLD PEERY #5-766	PEERY (CLEVELAND)/CLE	184.6	TRANSWESTERN PIPE
8410683	F-10-074125	4229531226		107-TF		HAROLD PEERY #6-766	PEERY (CLEVELAND)/CLE	93.5	TRANSWESTERN PIPE
8410682	F-10-074124	4229531211		107-TF		HAROLD PEERY #7-766	PEERY (CLEVELAND)/CLE	72.1	TRANSWESTERN PIPE
8410681	F-10-074123	4229531210		107-TF		HAROLD PEERY #8-766	PEERY (MARMATON)/(CLE	56.5	PHILLIPS PETROLEU
8410754	F-08-075287	4247532919		103		HUTCHINGS STOCK ASSN #1245	WARD-ESTES NORTH	8.0	CABOT CORP
8410753	F-08-075286	4247532845		103		HUTCHINGS STOCK ASSN #1246	WARD-ESTES NORTH	3.4	CABOT CORP
8410752	F-08-075285	4247532878		103		HUTCHINGS STOCK ASSN #1248	WARD-ESTES NORTH	9.6	CABOT CORP
8410571	F-08-063972	4238932143		103		J R F WOODS ET AL #1	HAMON NORTHWEST (DELA	50.0	TRANSWESTERN PIPE
8410676	F-08-073988	4210331500		103		J T MCELROY CONSOL #975	MCELROY	7.0	PHILLIPS PETROLEU
8410553	F-10-054816	4221130642		108-PB		JENKIE CAMPBELL #1-1	S W CANADIAN	0.0	TRANSWESTERN PIPE
8410653	F-09-073190	4223795041		108		NORTH RIGGS WELL #1	BOONSVILLE BEND CONGL	6.2	SOUTHWESTERN GAS
8410680	F-10-074122	4229531006		107-TF		PEARL WHEAT #2-765	PEERY (CLEVELAND)/CLE	179.4	TRANSWESTERN PIPE
8410686	F-10-074128	4229531209		107-TF		PEARL WHEAT #4-765	PEERY (CLEVELAND)/CLE	8.8	TRANSWESTERN PIPE
8410568	F-10-062158	4235760082		108-PB		R H HOLLAND A #1	FRANTZ	0.0	PANHANDLE-EASTERN
8410567	F-10-062153	4219535314		108-PB		W B BARNES #1	HANSFORD-UPPERMORROW	0.0	NORTHERN NATURAL
8410575	F-10-065570	4231130916		108-PB		W CAMPBELL #3-56	RED DEER CREEK	0.0	TRANSWESTERN PIPE
-HAMMAN OIL & REFINING CO				RECEIVED:	12/05/83	JA: TX			
8410594	F-03-069891	4208931310		102-4		CRANZ #1	STARR-LITE N (WILCOX	2.5	
8410573	F-03-064351	4207131303		102-4		WILCOX HEIRS #3	TRINITY RIVER DELTA (	182.5	UNITED TEXAS TRAN
-HANLEY PETROLEUM INC				RECEIVED:	12/05/83	JA: TX			
8410714	F-08-074793	4213534061		103		FOSTER "A" WELL #1	EDWARDS WEST (CANYON)	40.0	PHILLIPS PETROLEU
-HANSON MINERALS CO				RECEIVED:	12/05/83	JA: TX			
8410664	F-02-073640	4229733292		102-4		MEIDER GAS UNIT WELL #2	CODDAT (10,500')	1.1	PANHANDLE GAS CO
-HCW EXPLORATION INC				RECEIVED:	12/05/83	JA: TX			
8410814	F-09-075463	4223732410		108		CAMPBELL-WOOD #2 ID #086279	NEWPORT SOUTH (ATOKA	6.7	CITIES SERVICE CO
8410812	F-09-075460	4223732465		108		J D COLLIE #1 ID #082414	MARINA-MAG (CONGLOMER	11.4	SOUTHWESTERN GAS
8410813	F-09-075461	4223733478		108		LOYD CLAY #1 ID #021298	JACK COUNTY REGULAR	3.5	LONE STAR GAS CO
8410816	F-7B-075466	4236731962		108		MILO ANDERSON #1 ID #091455	RENO (CONGLOMERATE)	2.0	LONE STAR GAS CO
8410815	F-7B-075465	4236731384		108		ROBERT BRYANT #1 ID #087913	RENO (CONGLOMERATE)	3.5	LONE STAR GAS CO
-HERD PRODUCING CO & WESSELY				RECEIVED:	12/05/83	JA: TX			
8410665	F-05-073642	4229330667		103	107-TF	TRIPLE H RANCH GU NO 1 WELL #2	FARRAR (COTTON VALLEY	1506.0	TEXAS UTILITIES F
-HIGHLAND RESOURCES INC				RECEIVED:	12/05/83	JA: TX			
8410662	F-02-07352	4228531309		102-4	103	BRUSHY CREEK GAS UNIT WELL #7	BRUSHY CREEK (YEGUA 5	250.0	TEXAS EASTERN TRA
8410643	F-02-072403	4228531716		103		BRUSHY CREEK GAS UNIT WELL #8	BRUSHY CREEK (5150) F	100.0	TEXAS EASTERN TRA
-HOUSTON OIL & GAS CO INC				RECEIVED:	12/05/83	JA: TX			
8410791	F-7B-075374	4208333534		102-4		FAUBION #1 (19826)	HRUBETZ (ELLENBURGER)	1.0	UNION TEXAS PETRO
8410790	F-7B-075373	4239932789		102-4		FAUBION #2 (19826)	HRUBETZ (ELLENBURGER)	75.0	UNION TEXAS PETRO
8410789	F-7B-075372	4208333573		102-4		FAUBION #3 (19826)	HRUBETZ (ELLENBURGER)	43.0	UNION TEXAS PETRO
8410788	F-7B-075371	4239932788		102-4		ROSSON #1 (20077)	HRUBETZ (ELLENBURGER)	36.0	UNION TEXAS PETRO
-HPC INC				RECEIVED:	12/05/83	JA: TX			
8410564	F-02-061315	4228531361		102-4	103	HUGH R GOODRICH #1	LAVACA RIVER (1760')	39.0	TEXAS EASTERN TRA
-HRUBETZ OIL CO				RECEIVED:	12/05/83	JA: TX			
8410817	F-7B-075468	4208333590		102-4		LUCY GRAY #2	HRUBETZ (ELLEN)	0.5	LONE STAR GAS CO
8410818	F-7B-075469	4208333622		102-4		LUCY GRAY #3	HRUBETZ (ELLEN)	0.5	LONE STAR GAS CO
-J A WILBURN				RECEIVED:	12/05/83	JA: TX			
8410751	F-7B-075282	4215131457		103		E L OGDEN #1	CLAYTONVILLE (CANYON	15.0	TIPPERARY CORP
8410750	F-7B-075281	4215131462		103		L L STUART "C" #1	CLAYTONVILLE (CANYON	17.0	TIPPERARY CORP
-J M HUBER CORPORATION				RECEIVED:	12/05/83	JA: TX			
8410828	F-10-075489	4219530851		103		STEELE COLLARD "B" #2L	HANSFORD (MARMATON)	20.0	PHILLIPS PETROLEU
8410827	F-10-075488	4219530850		103		STEELE COLLARD "B" #3	HANSFORD (MARMATON)	20.0	PHILLIPS PETROLEU

JD NO	JA DKT	API NO	D	SEC(1)	SEC(2)	WELL NAME	FIELD NAME	FROD	PURCHASER
-J R HAMILTON				RECEIVED:	12/05/83	JA: TX			
8410670	F-04-073831	4213100000		102-4		OLVERA #4	J R (5500)	100.0	VALERO TRANSMISSI
-J-O'B OPERATING CO				RECEIVED:	12/05/83	JA: TX			
8410674	F-06-073937	4207330495		102-4		WOMACK-HERRING #1	PERCY WHEELER (TRAVIS	183.0	UNITED GAS PIPE L
-JAMES K ANDERSON INC				RECEIVED:	12/05/83	JA: TX			
8410696	F-7C-074309	4239932639		102-4		PITCHFORD-STATE #1	MELANIE A (JENNINGS S	800.0	UNION TEXAS PETRO
8410700	F-7B-074388	4244132397		102-4		SEARS "D" #1	E J NORTH (FRY)	200.0	UNION TEXAS PETRO
-JOHN L COX				RECEIVED:	12/05/83	JA: TX			
8410645	F-7C-072583	4246131579		103		DOLLIE #1 RRC 10256	SPRABERRY (TA)	10.0	PHILLIPS PETROLEU
8410772	F-08-075321	4217331419		103		GLENN RILEY #5	SPRABERRY (TA)	10.0	EL PASO NATURAL G
8410580	F-7C-067417	4238300000		103		ROCKEN B "70" #1	SPRABERRY (TA)	10.0	EL PASO NATURAL G
8410636	F-7C-072229	4238332584		103		ROCKER B "O" #2 RRC 05172	SPRABERRY (TA)	10.0	EL PASO NATURAL G
8410637	F-7C-072230	4238332585		103		ROCKER B "O" #21 RRC #05172	SPRABERRY (TA)	10.0	EL PASO NATURAL G
8410639	F-7C-072235	4238332591		103		ROCKER B "Q" #19 RRC #05289	SPRABERRY (TA)	10.0	EL PASO NATURAL G
8410638	F-7C-072234	4238332583		103		ROCKER B "T" #14 RRC #05416	SPRABERRY (TA)	10.0	EL PASO NATURAL G
8410589	F-7C-069663	4238332533		103		ROCKER B "117" #1	SPRABERRY (TA)	10.0	EL PASO NATURAL G
8410590	F-7C-069666	4238332531		103		ROCKER B "153" #1 RRC #10119	SPRABERRY (TA)	10.0	EL PASO NATURAL G
8410642	F-7C-072353	4238332576		103		ROCKER B "153" #2 RRC#10119	SPRABERRY (TREND AREA	10.0	EL PASO NATURAL G
-KAARI OIL CO				RECEIVED:	12/05/83	JA: TX			
8410741	F-10-075261	4206531455		103		W E COBB #3 (ID# 05414)	PANHANDLE CARSON	40.0	CABOT PIPELINE CO
-KATLACO OPERATING CO INC				RECEIVED:	12/05/83	JA: TX			
8410561	F-7B-060341	4213334074		108		GARL GORR #1 (18938)	KLEINER (LAKE SAND)	40.0	EL PASO HYDROCARB
-KORMAN OPERATING INC				RECEIVED:	12/05/83	JA: TX			
8410778	F-7C-075342	4232900000		108		VOLKMANN #1	WILHELM LANE W/STRAWN	11.0	SUN OIL CO
-L R SPRADLING				RECEIVED:	12/05/83	JA: TX			
8410706	F-10-074509	4206500000		103		O'NEAL #3	PANHANDLE CARSON COUN	50.0	GETTY OIL CO
-LACY & BYRD INC				RECEIVED:	12/05/83	JA: TX			
8410795	F-08-075392	4232931209		103		MACKEY #1 RRC #28367	PARKS (PENNSYLVANIAN)	48.0	MOBIL PRODUCING T
-LADD PETROLEUM CORPORATION				RECEIVED:	12/05/83	JA: TX			
8410699	F-7C-074366	4210534454		103	107-TF	S MILLSPAUGH #14-4	OZONA (CANYON SAND)	328.5	AMERICAN PIPELINE
-MALOUF ABRAHAM CO INC				RECEIVED:	12/05/83	JA: TX			
8410678	F-10-074044	4221131592		103		CAMPBELL #1 WELL	CANADIAN SW (GRANITE	0.0	MESTAR TRANSMISSI
-MARSHALL EXPLORATION INC				RECEIVED:	12/05/83	JA: TX			
8410688	F-03-074149	4231330453		102-4	103	M Y VICK #5	MADISONVILLE NE (GEOR	200.0	LONE STAR GAS CO
-MCCORD EXPLORATION				RECEIVED:	12/05/83	JA: TX			
8410595	F-04-069895	4240900000		102-4		ROUNTREE #2	PLYMOUTH FIELD	0.0	HOUSTON PIPELINE
-MCKENZIE OPERATING CO INC				RECEIVED:	12/05/83	JA: TX			
8410698	F-7B-074320	4236332622		102-4		WIGGINGTON #1	MINERAL WELLS S (CONG	125.0	SOUTHWESTERN GAS
-MCMURREY PETROLEUM INC				RECEIVED:	12/05/83	JA: TX			
8410602	F-03-071135	4204130937		102-4	103	BRIGHT SKY RANCH #3 ID #16490	KURTEN	0.0	FERGUSON CROSSING
8410693	F-03-074267	4204130980		102-4	103	CHEAPSIDE #1 RRC PERMIT NO 202034	BRYAN	0.0	VANGUARD PIPELI
8410673	F-03-073880	4204130926		102-4	103	TRANT #1 RRC LEASE NO 16739	BRYAN	0.0	
-MCR OIL CORP OF TEXAS				RECEIVED:	12/05/83	JA: TX			
8410605	F-10-071307	4221131575		103		STATE #3-156	CANADIAN S E (DOUGLAS	234.0	ARKANSAS LOUISIA
-MICHAEL F CUSACK				RECEIVED:	12/05/83	JA: TX			
8410603	F-04-071234	4213100000		103		DUVAL COUNTY RANCH CO 3-55	LOPEZ NORTH (COLE)	0.0	UNITED TEXAS TRAN
-MID-AMERICA PETROLEUM INC				RECEIVED:	12/05/83	JA: TX			
8410780	F-7C-075345	4238332263		103		JIM DIXON #6	SPRABERRY (TREND AREA	9.0	NORTHERN NATURAL
8410782	F-7C-075348	4238332278		103		SHAW #5	SPRABERRY (TREND AREA	9.5	NORTHERN NATURAL
8410784	F-7C-075352	4238332280		103		SHAW #6	SPRABERRY (TREND AREA	9.0	NORTHERN NATURAL
8410785	F-7C-075353	4238332279		103		SHAW #7	SPRABERRY (TREND AREA	13.0	NORTHERN NATURAL
8410781	F-7C-075347	4238332180		103		TURNER #5	SPRABERRY (TREND AREA	9.0	NORTHERN NATURAL
8410783	F-7C-075351	4238332181		103		TURNER #6	SPRABERRY (TREND AREA	9.0	NORTHERN NATURAL
-MITCHELL ENERGY CORPORATION				RECEIVED:	12/05/83	JA: TX			
8410725	F-8A-075046	4250132362		103		COOPER-SLOAN #1	SABLE (SAN ANDRES)	0.0	
8410557	F-09-058556	4223700000		108-PB		EUGENE MOSER #2	CRAFTON WEST	0.0	CITIES SERVICE GI
8410577	F-09-066238	4249732473		102-4	103	J D KARNES #7-L	NEWARK EAST (BARNETT	213.9	NATURAL GAS PIPEL
8410726	F-09-075047	4236732521		103		J M HART #2	BOONSVILLE (BEND CONG	294.6	LONE STAR GAS CO
8410740	F-09-075251	4249700000		108		JAMES D BENTLEY #2 049167	BOONSVILLE (BEND CONG	0.0	NATURAL GAS PIPEL
8410528	F-03-036061	4231300000		108-PB		JAMES LANG #1	MADISONVILLE	0.0	LONE STAR GAS CO
8410730	F-09-075164	4249732605		103		S R BAILEY #2	BOONSVILLE (BEND CONG	276.7	NATURAL GAS PIPEL
8410819	F-09-075472	4249732546		103		TARRANT CTY WATERBOARD #30 #17355	MORRIS (CONSOLIDATED	162.5	NATURAL GAS PIPEL
8410690	F-09-074230	4249732566		103		W S COLEMAN #2	BOONSVILLE (BEND CONG	170.9	NATURAL GAS PIPEL
-MOBIL PRDG TEXAS & NEW MEXICO INC				RECEIVED:	12/05/83	JA: TX			
8410563	F-7C-060795	4244300000		108-PB		BROWN MCNINCH EST #3	BROWN BASSETT	0.0	EL PASO NATURAL G
8410713	F-10-07478	4229531341		103		WILLIAM T BROWNLEE #4	KELLN (TONKAWA OIL)	9.1	PHILLIPS PETROLEU
-MONTERO OPERATING INC				RECEIVED:	12/05/83	JA: TX			
8410654	F-7C-073234	4235331463		103		JAMESON "A" #1	SILVER (CANYON)	0.0	SUN EXPLORATION &
-MORAN EXPLORATION INC				RECEIVED:	12/05/83	JA: TX			
8410719	F-7C-07492	4223531550		108		MAYER "A" WELL #1 RRC 03568	SPRABERRY (TREND /REA	0.7	NORTHERN NATURAL
8410718	F-7C-07492	4223530698		108		ROCKER B-105 WELL #1 RRC 73677	ELA SUGG (WOLFCAMP)	17.4	NORTHERN NATURAL
-MR OIL CO				RECEIVED:	12/05/83	JA: TX			
8410771	F-08-075316	4247532796		103		JOHNSON -B- #15	HARD-ESTES NORTH	19.0	WESTERN COUNTIES
-MWJ PRODUCING COMPANY				RECEIVED:	12/05/83	JA: TX			
8410668	F-08-073810	4217331217		103		TXL 27 "A" #2	SPRABERRY (TREND AREA	42.0	TEXACO INC
-NATURAL RESOURCES CORP				RECEIVED:	12/05/83	JA: TX			
8410733	F-03-075221	4208900000		107-PE		NRC HERDER #1 RRC NO 045739	EAST RAMSEY	0.0	AMOCO PRODUCTION
-NEWTON OIL & GAS CORP				RECEIVED:	12/05/83	JA: TX			
8410703	F-01-074428	4228330968		102-4		LYSSY #1	TRI BAR NORTH (OLMOS)	191.0	HOUSTON PIPE LINE
-NORTHERN NATURAL GAS PRODUCING CO				RECEIVED:	12/05/83	JA: TX			
8410576	F-10-066200	4206500000		108-PB		BURNETT SEC 80 #1080	PANHANDLE WEST	0.0	NORTHERN NATURAL
-NORTHRIDGE OIL CO				RECEIVED:	12/05/83	JA: TX			
8410779	F-09-075344	4207733130		103		BORGMAN "B" B-1	BLUE GROVE (CADDO)	6.0	FAGADAU ENERGY CO
8410769	F-09-075313	4223735258		102-4		LEASE #23385	BARFIELD (CONG)	26.0	TEXAS UTILITIES F
8410770	F-09-075314	4223735343		102-4		LEASE #23385	BARFIELD (CONG)	9.0	TEXAS UTILITIES F
-OLYMPIA OIL CO INC				RECEIVED:	12/05/83	JA: TX			
8410728	F-7B-075156	4208333364		102-4		HALE #1 (106767)	HRUBETZ (ELLENBURGER)	1277.0	UNION TEXAS PETRO
-PATTERSON PETROLEUM INC				RECEIVED:	12/05/83	JA: TX			
8410601	F-03-070821	4214931546		102-2		H D HAVEMANN #1	GIDDINGS (AUSTIN CHAL	420.0	PHILLIPS PETROLEU
8410647	F-03-073096	4214931491		102-2		T A EMBESI #1	GIDDINGS (AUSTIN CHAL	475.0	PHILLIPS PETROLEU
-PED OIL CORP				RECEIVED:	12/05/83	JA: TX			
8410625	F-7C-071800	4246100000		103		X B COX #2	SPRABERRY (TREND AREA	0.0	PHILLIPS PETROLEU
-PEND OREILLE OIL & GAS CO				RECEIVED:	12/05/83	JA: TX			
8410629	F-03-072011	4216730925		102-4		RUTH MARSHALL ET AL CU #1	SAN LEON	1460.0	HOUSTON LIGHTING
-PERRY OIL & GAS CO				RECEIVED:	12/05/83	JA: TX			
8410661	F-03-073511	4214931575		102-3		MATTHEW UNIT #1	GIDDINGS (AUSTIN CHAL	73.0	SOUTH CENTER GAS
-PETRO-MEGA INC				RECEIVED:	12/05/83	JA: TX			
8410787	F-7B-075369	4208333542		103		DANIELS #2 (19541)	WILLIAMS	23.0	UNION TEXAS PETRO
-PHILLIPS OIL CO				RECEIVED:	12/05/83	JA: TX			
8410644	F-06-072415	4242330665		103		BISHOP MOSELEY #2	CHAPEL HILL N E (TRAV	120.0	ETEXAS PRODUCERS
-PHILLIPS PETROLEUM COMPANY				RECEIVED:	12/05/83	JA: TX			
8410776	F-08-075327	4249531274		108		BASH #13 (16091)	KEYSTONE (COLBY)	6.0	SID RICHARDSON GA
8410773	F-08-075323	4200304520		108		EMBAR-B #22 (08769)	GOLDSMITH (5600)	24.0	EL PASO NATURAL G
8410774	F-08-075324	4200304521		108		EMBAR-B #23 (08769)	GOLDSMITH (5600)	22.0	EL PASO NATURAL G

JD NO	JA DKT	API NO	D	SEC(1)	SEC(2)	WELL NAME	FIELD NAME	PROD	PURCHASER
8410766	F-10-075307	4234100000		108		JOANNA #2	PANHANDLE WEST	0.0	EL PASO NATURAL G
8410511	F-10-002739	4221100000		108-PB		JONES N #2	FELDMAN - CHEROKEE	0.0	PANHANDLE EASTERN
8410777	F-08-075328	4249503453		108		MCCABE F P #6 (21555)	HALLEY	3.0	EL PASO NATURAL G
8410767	F-10-075308	4223300000		108		POOL R L #1	PANHANDLE WEST	0.0	EL PASO NATURAL G
8410775	F-08-075326	4249510859		108		UNIVERSITY LANDS-R #1 (42188)	WAR-WINK (5085 DELAWA	21.0	EL PASO NATURAL G
-PIONEER PRODUCTION CORPORATION				RECEIVED:	12/05/83	JA: TX			
8410596	F-10-070498	4239300000		102-4	103	GILL #2-32R	GILL FIELD	0.0	WESTAR TRANSMISSI
8410514	F-10-007077	4229500000		108-PB		JOE BARTON #1	MAMMOTH CREEK NORTH	0.0	NORTHERN NATURAL
8410546	F-10-052244	4229500000		108-PB		MUGG ESTATE #1	MAMMOTH CREEK NORTH	0.0	NORTHERN NATURAL
8410536	F-10-041791	4229500000		108-PB		REDELSPERGER #1	MAMMOTH CREEK NORTH	0.0	NORTHERN NATURAL
8410515	F-10-007079	4229500000		108-PB		SCHULTZ UNIT #1	MAMMOTH CREEK - NORTH	0.0	NORTHERN NATURAL
-PITTS ENERGY CO				RECEIVED:	12/05/83	JA: TX			
8410724	F-08-074996	4231732711		103		BURCHETT #1	SPRABERRY (TREND AREA	13.1	PHILLIPS PETROLEU
-QUANICO OIL & GAS INC				RECEIVED:	12/05/83	JA: TX			
8410604	F-7B-071297	4204933530		102-4		J W ADAMS #1	TRICKHAM (CAPPS)	7.3	EL PASO HYDROCARB
8410660	F-7B-073495	4204933609		102-4		J W ADAMS #2	TRICKHAM (CAPPS)	7.3	EL PASO HYDROCARB
-R A W ENERGY CORP				RECEIVED:	12/05/83	JA: TX			
8410671	F-7B-073851	4236732507		102-4		G WARD-AIRPORT #1	MINERAL WELLS S (STRA	250 0	SOUTHWESTERN GAS
8410702	F-7B-074417	4236732423		102-4		WILEY "A" #1-B	DICEY S (STRAWN)	100.0	TEXAS UTILITIES F
-REATA OIL & GAS CORP				RECEIVED:	12/05/83	JA: TX			
8410574	F-03-065513	4231330412		102-4		MARY C BRADFORD #1	MADISONVILLE W (GEORG	3.0	LONE STAR GAS CO
-REUBEN B KNIGHT				RECEIVED:	12/05/83	JA: TX			
8410768	F-09-075312	4249731234		108		J R SINGLETON #1	BOONESVILLE (BEND CON	20.0	NATURAL GAS PIPEL
-RICHARDS PRODUCING CO				RECEIVED:	12/05/83	JA: TX			
8410710	F-03-074652	4232131274		103		DYKES & SWANSON #1	SUGAR VALLEY N (UNION	100.0	HOUSTON PIPE LINE
-ROSE O E				RECEIVED:	12/05/83	JA: TX			
8410735	F-7B-075227	4213300000		108		M L WOODS #2 (037199)	EASTLAND COUNTY REGUL	243.0	LONE STAR GAS CO
-RUTHERFORD OIL CORP				RECEIVED:	12/05/83	JA: TX			
8410811	F-03-07545	4236130464		102-4		NELDA C STARK #2	PEVETO (9,600)	730.0	TEJAS GAS CORP
-SANTA FE ENERGY PRODUCTS CO				RECEIVED:	12/05/83	JA: TX			
8410796	F-06-075394	4222530463		102-2		EASTHAM STATE FARM #2	EASTHAM STATE FARM (G	500 0	SOUTH TEXAS GATHE
8410797	F-03-075395	4214931536		102-2		MATTINGLY #1	GIDDINGS (AUSTIN CHAL	140.0	
-SCANDRILL INC				RECEIVED:	12/05/83	JA: TX			
8410624	F-09-071661	4223735325		102-4		KILLEN #3	POSELAND (ATOKA CONGL	159.9	LONE STAR GAS CO
-SOUTHLAND ROYALTY CO				RECEIVED:	12/05/83	JA: TX			
8410522	F-7C-025359	4243500000		108-PB		B M HALBERT #2	SONORA - CANYON (REEF	0.0	EL PASO NATURAL G
8410505	F-7C-000284	4210530216		108-PB		CLEGG 1-83	OZONA	0.0	NORTHERN NATURAL
8410506	F-7C-000291	4210530215		108-PB		DOLLYE COATES 1-69 #1	OZONA	0.0	NORTHERN NATURAL
8410530	F-7C-036652	4210500000		108-PB		IRA CARSON #2-54	OZONA	0.0	NORTHERN NATURAL
8410523	F-7C-025360	4210500000		108-PB		MOODY ESTATE #1-53	OZONA	0.0	NORTHERN NATURAL
8410507	F-7C-000297	4243500000		108-PB		SHURLEY B-1	SHURLEY RANCH CANYON	0.0	EL PASO NATURAL G
8410509	F-7C-000299	4216530226		108-PB		ZIPP RANCH 1-34 #1	OZONA	0.0	NORTHERN NATURAL
8410508	F-7C-000298	4210530229		108-PB		ZIPP RANCH 2-34 #1	OZON	0.0	NORTHERN NATURAL
-STEVE STAMPER				RECEIVED:	12/05/83	JA: TX			
8410793	F-09-075384	4223700000		103		T D WILLIAMS #1	JACK COUNTY REGULAR	47 0	
-SUN EXPL. & PROD. CO. - HOUSTON				RECEIVED:	12/05/83	JA: TX			
8410826	F-7C-075487	4210534188		103		UNIVERSITY "D" #15	FARMER (SAN ANDRES)	7.0	J L DAVIS
-SUN EXPLORATION & PRODUCTION @O				RECEIVED:	12/05/83	JA: TX			
8410764	F-8A-075303	4221933850		103		CENTRAL LEVELLAND UNIT #279	LEVELLAND	8 0	AMOCO PRODUCTION
8410540	F-7C-047488	4210500000		108-PB		COX #1-22	OZONA CANYON SAND	0 0	NORTHERN NATURAL
8410708	F-04-074568	4242700000		108		I V MONTALVO -A- #9L	SUN	15.0	TRANSCONTINENTAL
8410732	F-7B-075218	4215131185		103		PEARCE HOLLAND #2	PARDUE	7 0	
-SUPERIOR OIL CO				RECEIVED:	12/05/83	JA: TX			
8410634	F-03-072105	4228731372		102-2	103	SHELLY BRANCH UNIT #3 WELL #2	GIDDINGS (AUSTIN CHAL	116.0	PERRY PIPELINE CO
-TAUBERT STEED GUNN & MEDDERS				RECEIVED:	12/05/83	JA: TX			
8410712	F-8A-074737	4226931150		102-4		S B BURNETT ESTATE "NA" 34	ANNE TANDY (STRAWN 54	17.0	LONE STAR GAS CO
-TED TRUE INC				RECEIVED:	12/05/83	JA: TX			
8410652	F-10-073171	4234130965		103		BRENT 65-5	PANHANDLE MOORE COUNT	0.0	HOUSTON PIPE LINE
8410651	F-10-073169	4234130962		103		BRENT 65-7	PANHANDLE MOORE COUNT	0.0	HOUSTON PIPE LINE
8410650	F-10-073168	4234130963		103		BRENT 65-8	PANHANDLE MOORE COUNT	0.0	HOUSTON PIPE LINE
-TELSTAR CORP				RECEIVED:	12/05/83	JA: TX			
8410711	F-7B-074716	4236732562		102-4		RICHARDS #1 ID NUMBER APPLIED FOR	DENNIS WEST (STRAWN)	65 0	TEXAS UTILITIES F
-TEXACO INC				RECEIVED:	12/05/83	JA: TX			
8410648	F-08-073144	4243131343		102-4		STERLING "I" FEE #5	CONGER SW	318 3	VALERO TRANSMISSI
8410646	F-8A-072951	4216532598		103		WHARTON UNIT #132	HARRIS	1.5	PHILLIPS PETROLEU
-TEXAS INTERNATIONAL PET CORP				RECEIVED:	12/05/83	JA: TX			
8410588	F-03-069650	4205131489		102-2		BOHACEK #3	BIG "A" TAYLOR FIELD	0.0	CLAJON GAS CO
-THOMPSON J CLEO & JAMES CLEO JR				RECEIVED:	12/05/83	JA: TX			
8410705	F-7C-074486	4210534583		102-4	107-TF	UNIVERSITY 31-30E #2	UNIVERSITY 31 (STRAWN	300.0	
-TRACY OIL INC				RECEIVED:	12/05/83	JA: TX			
8410742	F-10-075265	4217931370		103		HOLT #2 (ID# 05419)	PANHANDLE GRAY	47.0	CITIES SERVICE CO
-TUCKER DRILLING COMPANY INC				RECEIVED:	12/05/83	JA: TX			
8410579	F-7C-067316	4243500000		108-PB		COLLIER SHURLEY #4	SAWYER (CANYON)	15.0	EL PASO NATURAL G
8410809	F-7C-07544	4223532139		102-2	103	MAGRUDER #3	ROCK PEN (CANYON)	164.3	
8410545	F-7C-049816	4243500000		108-PB		NED DUNBAR #7	SAWYER (CANYON)	15 0	EL PASO NATURAL G
-TXO PRODUCTION CORP				RECEIVED:	12/05/83	JA: TX			
8410597	F-02-070532	4223931866		102-4		BLANKENSHIP G U 4	MORALES	0.0	DELHI GAS PIPELIN
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-U S OPERATING INC				RECEIVED:	12/05/83	JA: TX			
8410593	F-03-069801	4228731331		102-2		JOAN #2 RRC ID # NA	GIDDINGS (AUSTIN CHAL	0.0	PERRY PIPELINE CO
-VOLVO PETROLEUM INC				RECEIVED:	12/05/83	JA: TX			
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-WARREN PETR CO A DIV OF GULF OIL CO				RECEIVED:	12/05/83	JA: TX			
8410786	F-08-075367	4210333219		103		P J LEA ETAL (TR A) #152	LEA (SAN ANDRES)	50.9	EL PASO NATURAL G
-WILLIAM MOSS PROPERTIES INC				RECEIVED:	12/05/83	JA: TX			
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-WILSON ENERGY INC				RECEIVED:	12/05/83	JA: TX			
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8410748	F-7C-075273	4210533332		108		UNIVERSITY 2 "A" #1	FARMER (SAN ANDRES)	1.0	J L DAVIS
8410747	F-7C-075272	4210533282		108		UNIVERSITY 2 "A" #4	FARMER (SAN ANDRES)	1.0	J L DAVIS
8410744	F-7C-075269	4210500000		108		UNIVERSITY [illegible] #1	FARMER (SAN ANDRES)	1.0	J L DAVIS
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-WY-VEL CORP				RECEIVED:	12/05/83	JA: TX			
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8410734	F-10-075223	4223331603		103		SOUTHLAND (04341) #17	PANHANDLE	16.8	PHILLIPS PETROLEU
-ZERO CORP OF TEXAS				RECEIVED:	12/05/83	JA: TX			
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Thursday
January 12, 1984

Part III

Department of Health and Human Services

Office of the Secretary

45 CFR Part 84

Nondiscrimination on the Basis of Handicap; Procedures and Guidelines Relating to Health Care for Handicapped Infants; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

45 CFR Part 84

Nondiscrimination on the Basis of Handicap; Procedures and Guidelines Relating to Health Care for Handicapped Infants

AGENCY: Office of the Secretary, HHS.

ACTION: Final rules.

SUMMARY: These are final rules on procedures and guidelines relating to nondiscrimination on the basis of handicap in connection with health care for handicapped infants. These rules are issued under the authority of section 504 of the Rehabilitation Act of 1973, which prohibits discrimination on the basis of handicap in programs and activities receiving Federal financial assistance.

EFFECTIVE DATE: February 13, 1984.

FOR FURTHER INFORMATION CONTACT: Susan Shaloub, Office for Civil Rights, Department of Health and Human Services, 330 Independence Avenue, SW., Room 5514, Washington, D.C. 20201; telephone (202) 245–6585. TDD No. (202) 472–2916.

SUPPLEMENTARY INFORMATION:

I. Synopsis

These rules are the product of a careful analysis of nearly 17,000 comments submitted to the Department during the comment period provided by the proposed rules of July 5, 1983. On the basis of this analysis, the Department has made significant modifications to the proposed rules. These modifications are designed to establish a framework under which the substantial controversy that has attended the Department's efforts to strengthen enforcement of section 504 in this area can be replaced by a more cooperative effort involving the Federal Government, the medical community, private advocacy groups and state governments.

These final rules continue the Department's efforts to put in place an effective mechanism for enforcing section 504 in connection with health care for handicapped infants.

But they also initiate new efforts to make unnecessary the use of those Federal enforcement mechanisms by encouraging hospitals to establish policies and procedures to implement the principle that treatment decisions for handicapped infants be based on reasonable medical judgments, and medically beneficial treatment not be withheld solely on the basis of an infant's present or anticipated mental or physical impairments.

In seeking to forge a cooperative approach, the Department is encouraged by the recent development of "Principles of Treatment of Disabled Infants" by the following major medical and disability organizations: American academy of Pediatrics, National Association of Children's Hospitals and Related Institutions, Association for Retarded Citizens, Down's Syndrome Congress, Spina Bifida Association of America, American Coalition of Citizens with Disabilities, The Association for the Severely Handicapped, American Association on Mental Deficiency, and American Association of University Affiliated Programs for the Developmentally Disabled. Announced November 29, 1983, in Washington, D.C., these principles state:

> When medical care is clearly beneficial, it should always be provided. * * * Considerations such as anticipated or actual limited potential of an individual and present or future lack of available community resources are irrelevant and must not determine the decisions concerning medical care. The individual's medical condition should be the sole focus of the decision. These are very strict standards.
>
> It is ethically and legally justified to withhold medical or surgical procedures which are clearly futile and will only prolong the act of dying. However, supportive care should be provided, including sustenance as medically indicated and relief of pain and suffering. The needs of the dying person should be respected. The family also should be supported in its grieving.
>
> In case where it is uncertain whether medical treatment will be beneficial, a person's disability must not be the basis for a decision to withhold treatment. * * * When doubt exists at any time about whether to treat, a presumption always should be in favor of treatment.

In the issuance of these final rules, the Department seeks to build upon the spirit of cooperation underlying this landmark statement of principles. The major elements of the final rules are as follows:

First, the Department adopts the recommendation of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research that the Federal government encourage hospitals to establish review procedures concerning life and death decisions affecting seriously ill newborns. The rules include a model Infant Care Review Committee to assist hospitals in this effort.

Second, the rules require the posting in hospitals of an informational notice regarding the legal rights of handicapped infants. The notice requirements have been revised to permit hospitals to highlight their own policies and internal review procedures, in addition to the federal law and government contact points.

Third, the rules require that state child protective services agencies have established procedures for applying their own state laws protecting children from medical neglect.

Fourth, the appendix to the rules sets forth interpretative guidelines for applying the law in these cases. These guidelines restate the Department's interpretation that section 504 requires that health care providers not withhold nourishment or medically beneficial treatment from a handicapped infant solely on the basis of present or anticipated physical or mental impairments, but it does not interfere with reasonable medical judgments, nor require the provision of futile treatments.

Fifth, the appendix to the rules sets forth guidelines for HHS investigations of alleged civil rights violations relating to health care for handicapped infants. These guidelines provide for the participation of hospital Infant Care Review Committees, the avoidance of unnecessary investigations, the involvement of qualified medical consultants, and the protection of confidential information.

The Department hopes the issuance of these rules, which become effective in 30 days, will end the controversy that has surrounded their development. But more importantly, it is hoped the rules will foster a new process of cooperative efforts and sensible approaches to advance the principle that life and death medical treatment decisions be based on informed judgments of medical benefits and risks, and not on stereotypes and prejudices against handicapped persons.

II. Background

On April 30, 1982, President Reagan instructed the Secretary of Health and Human Services:

> to notify health care providers of the applicability of section 504 of the Rehabilitation Act of 1973 to the treatment of handicapped patients. That law forbids recipients of federal funds from withholding from handicapped citizens, simply because they are handicapped, any benefit or service that would ordinarily be provided to persons without handicaps. Regulations under this law specifically prohibit hospitals and other providers of health services receiving federal assistance from discriminating against the handicapped.
>
> * * * * *
>
> Our nation's commitment to equal protection of the law will have little meaning

if we deny such protection to those who have not been blessed with the same physical or mental gifts we too often take for granted. I support federal laws prohibiting discrimination against the handicapped, and remain determined that such laws will be vigorously enforced.

The President's instructions followed reports of the death, in Bloomington, Indiana, of an infant with Down's syndrome, from whom available surgical treatment to repair a detached esophagus was withheld.

On May 18, 1982, HHS issued to approximately 7,000 hospitals a notice stating:

> Under section 504 it is unlawful for a recipient of federal financial assistance to withhold from a handicapped infant nutritional sustenance or medical or surgical treatment required to correct a life-threatening condition if: (1) the withholding is based on the fact that the infant is handicapped; (2) the handicap does not render the treatment or nutritional sustenance medically contraindicated.

Soon after this notice, the HHS Office for Civil Rights (OCR) established expedited investigative procedures to deal with any case of a suspected discriminatory withholding of lifesustaining nourishment or medical treatment from a handicapped infant.

On March 7, 1983, HHS issued, with a scheduled effective date of March 22, 1983, an interim final rule requiring recipient hospitals to post "in a conspicuous place" in pertinent wards a notice advising of the applicability of section 504 and the availability of a telephone "hotline" to report suspected violations of the law.

On April 14, 1983, the Honorable Gerhard Gesell, United States District Judge for the District of Columbia, declared the interim final rule invalid on the grounds that it was "arbitrary and capricious" and that there was inadequate justification for waiving a public comment period prior to issuance of the regulation. *American Academy of Pediatrics* v. *Heckler*, 561 F. Supp. 395 (D.D.C. 1983). Judge Gesell declined to order the Department to discontinue use of the hotline.

On July 5, 1983, HHS issued a proposed rule in which the notice requirement was revised; provisions were added concerning state child protective service agencies; an appendix of standards and examples was added; and a 60-day comment period was provided. 48 FR 30846.

The Department received 16,739 comments, of which 16,331 (97.5%) supported the proposed rule, and 408 (2.5%) opposed it. Other aggregate descriptions are:

—Of 322 nurses, 314 (97.5%) supported, and 8 (2.5%) opposed it.
—Of 141 pediatricians or newborn care specialists, 39 (27.7%) favored, and 102 (72.3%) opposed it.
—Of 253 physicians, not including pediatricians or newborn care specialists, 140 (55.3%) favored, and 113 (44.7%) opposed it.
—Of 137 comments from hospital officials and medical, hospital, nursing and other health related association, 31 (22.6%) supported and 106 (77.4%) opposed it.
—Of 77 comments from associations representing the handicapped, all supported the proposed rule.
—Of 100 parents of handicapped persons, 95 (95%) supported and 5 (5%) opposed it.

In addition to the written comments received, a number of meetings were held after issuance of the proposed rule with representatives of interested groups. The principal HHS officials involved in these meetings were the Under Secretary and the Surgeon General. Minutes of these meetings were kept and have been included in the public comment file.

Every comment was read and analyzed. Readers determined whether the commenter was in favor of, or opposed to, the proposed rule and identified particular points made by the commenter. The decisions made by the Department in connection with the rule are based not on the volume of comments advancing any point, but on thorough consideration of the merits of the comments submitted.

III. Provisions of the Final Rules

A. INFANT CARE REVIEW COMMITTEES

The March 1983 report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research included the following recommendation:

> The Commission concludes that hospitals that care for seriously ill newborns should have explicit policies on decisionmaking procedures in cases involving life-sustaining treatment for these infants. . . . Such policies should provide for internal review whenever parents and the attending physician decide that life-sustaining therapy should be foregone. . . .
>
> Such a review could serve several functions and the review mechanism may vary accordingly. First, it can verify that the best information available is being used. Second, it can confirm the propriety of a decision that providers and parents have reached or confirm that the range of discretion accorded to the parents is appropriate. Third, it can resolve disputes among those involved in a decision, if necessary, by siding with one party or another in a dispute. Finally, it can refer cases to public agencies (child protection services, probate courts, or prosecuting attorneys) when appropriate.

In response to a question included in the preamble, the Department received many comments regarding hospital review boards. Many commenters who expressed opposition to the rule, particularly health care providers, expressed a strong preference for the hospital review board approach over the proposed rule or any implementation or enforcement of section 504. Others opposed hospital review boards, particularly as an alternative to the proposed rule and existing HHS procedures.

The American Academy of Pediatrics, which submitted the most detailed proposal, suggested, as an alternative to the proposed rule, that all hospitals, as a condition of participation in the Medicare program (not as a requirement of section 504), establish a review committee. Under this proposal (also endorsed by the National Association of Children's Hospitals and Related Institutions, and in concept, the American Hospital Association) the committee would have three functions: (1) To develop hospital policies and guidelines for management of specific types of diagnoses; (2) to monitor adherence through retrospective record review; and (3) to review, on an emergency basis, specific cases when the withholding of life-sustaining treatment is being considered. When the committee disagreed with a parental or physician decision to withhold treatment, the case would be referred to the appropriate court or child protective agency, and treatment would be continued pending a decision. Committee membership would include a hospital administrator, a representative of a disability group, a lay community member, a member of the hospital's medical staff, and a practicing nurse.

Among the arguments advanced in favor of the creation of hospital review boards, as a substitute for the approach set forth in the proposed rule, were:

(a) They would represent a cooperative approach between the government and the health care community, rather than a confrontational approach.

(b) They would provide a vehicle by which facility "self-evaluations" can be conducted.

(c) They would assure an indepth review by persons of varied perspectives of individual, complex cases involving critically ill infants.

(d) They would provide a mechanism for ensuring that hospitals, physicians

and parents are informed of the most recent medical information concerning treatment of handicapped infants and of community services, counselling, parent support groups, and such alternative care options as adoption, foster care, and other out-of-home placements.

(e) They would lead to the involvement of child protective agencies and of the courts where it is indicated that the interests of the child are not being served.

Many commenters who expressed support for the proposed rule also expressed strong opposition to the alternative approach of hospital review boards because:

(a) Such boards cannot replace State and federal government responsibilities to protect the rights of citizens. The use of review boards would not assure that all individuals with disabilities would receive nondiscriminatory treatment as guaranteed by section 504.

(b) Such boards are virtually untested as a viable mechanism to protect handicapped infants from discriminatory practices.

A number of commenters, including the American Medical Association, the Catholic Health Association, the Federation of American Hospitals, the American College of Hospital Administrators, the American College of Physicians, the American Nurses Association, and other medical groups, expressed support for the concept of review boards, but opposed any mandate that review boards be established. The AMA added:

> While we do not support federal intervention in treatment decisions concerning seriously ill newborns, the attention brought about by the government's action should provide a continued stimulus to develop mechanisms to deal with these sensitive matters without the intrusion of the federal government into an area where it does not belong.

Response

The Department believes there is much merit in many of the comments submitted both in favor of, and in opposition to, utilization of hospital review boards to assist in the development of standard policies and protocols and to review individual cases. The Department's conclusions are as follows.

First, the Department believes review committees cannot be given an exclusive role in reviewing medical decisions concerning the withholding or withdrawal of medical or surgical treatments from handicapped infants, and thus, cannot accept the proposal of hospital review boards as a *substitute* for mechanisms to enforce section 504.

The Department does not seek to take over medical decisionmaking regarding health care for handicapped infants. HHS agrees that the best decisionmakers are generally the parents and the physicians directly involved. However, there is, and must be, a framework within which the decisionmakers, the parents and physicians, operate.

That framework is established by laws. With respect to health care professionals providing services under programs or activities receiving federal financial assistance, the framework includes section 504, which prohibits discrimination on the basis of handicap in programs or activities receiving Federal financial assistance. With respect to parents, the laws are state laws establishing limitations on parental authority. With respect to both the federal law and the respective state laws, each specifically provides implementation mechanisms involving government agencies.

The fundamental issue involved in deciding whether review boards should be a substitute for enforcement of section 504 is whether the legal framework within which the decisionmaking parents and physicians are supposed to function (and generally do function) will be utilized.

Under the proposal that review boards act in lieu of government, whether physicians or hospital review boards adhere to the principles of section 504 would be determined by those physicians and boards alone. Whether parents, physicians, or review boards adhere to state laws on the limitations of parental authority would be decided by the same physicians and boards. Whether they ever utilize the implementation schemes established by law to ensure that those principles are adhered to would also be decided by those parents, physicians, and review boards.

The Department concludes that the essential element of this alternative proposal—that it separates the process from the established legal framework governing decisionmaking by parents and physicians, with no meaningful provision to ensure that they function in accord with this framework—makes the proposal unacceptable as a substitute for the proposed rule. This alternative proposal simply does not provide sufficient safeguards that the requirements of section 504 will be met. Because section 504 is applicable to the provision of health care services to handicapped infants in programs and activities receiving Federal financial assistance, the Department believes it would not be justifiable for the Department to refrain from exercising a regulatory role to enforce the statute.

Second, the Department concludes that, although unacceptable as a substitute, review boards can be very valuable. The Department agrees with the rationale of the President's Commission and many commenters that input from a committee that includes individuals with medical expertise and people with non-medical perspectives and that is guided by proper standards and protocols can be very helpful in bringing about informed, enlightened and fair decisionmaking regarding these difficult issues. The Department, therefore, adopts the recommendation of the President's Commission that the government encourage establishment of hospital review boards.

Third, the Department concludes that the creation of hospital review boards should not be mandated by the Federal government. The Department agrees with the President's Commission that because review boards are "largely untried", they are not so demonstrably effective as to justify making them mandatory for nearly 7,000 hospitals nationwide. Also, there would be very substantial practical problems in seeking to enforce such a mandate with respect to so many hospitals. To make such a mandate viable, it would have to be accompanied by detailed standards on how to organize and operate the committee. The Department agrees with the President's Commission that flexibility is needed for each hospital to consider the best approach for itself. For example, the review board procedures may be unnecessary for small or rural hospitals that rarely encounter cases involving severely impaired newborns and that handle such cases by immediately transferring the infant to the appropriate specialty hospital.

In addition, in view of the strong opposition by major medical organizations to mandatory committees, there would likely be protracted legal proceedings challenging the regulation, whether adopted pursuant to section 504 or pursuant to authority under the Social Security Act to establish conditions of participation and standards for the Medicare and Medicaid programs.

For these reasons, the Department has concluded that Infant Care Review Committees should be encouraged, but not mandated by the federal government.

Fourth, the Department concludes that the establishment of review boards will be facilitated by the development of a model committee. Therefore, § 84.55(f) of the rules sets forth a model Infant Care Review Committee (ICRC). This model

calls for broad representation and significant involvement of the ICRC in developing standard policies and protocols for the hospital and in promptly reviewing specific cases. The model is based sustantially on comments submitted by the American Academy of Pediatrics.

The Department has revised the Academy's model somewhat to underscore that the purpose of the ICRC is to advance the basic principles embodied in section 504, the recommendations of the President's Commission and the landmark "Principles of Treatment of Disabled Infants." The Department has also revised the Academy's model to provide, in connection with review of specific cases, for the designation of one member of the ICRC as "special advocate" for the infant. While recognizing that all members of the ICRC should be advocates for the best interests of the infant, the role of the special advocate will be to ensure that all considerations in favor of the provisions of life-sustaining treatment are fully evaluated and considered. As the President's Commission stated, "it is all too easy to undervalue the lives of handicapped infants." The special advocate feature of the model ICRC provides a mechanism to counteract this tendency.

This model is also consistent with the recommendations of the President's Commission and the comments of the American Hospital Association and other medical organizations. The Department also acknowledges the comment of the American Medical Association that the government's actions provide "a continued stimulus" for the medical community "to develop mechanisms to deal with these sensitive matters." HHS strongly encourages medical organizations to follow through on their suggestions and provide all possible assistance to their member institutions and medical professionals in establishing and operating these ICRC's.

B. INFORMATIONAL NOTICE

The proposed rules required that recipient hospitals post "in a conspicuous place in each nurse's station" of appropriate wards a notice stating:

DISCRIMINATORY FAILURE TO FEED AND CARE FOR HANDICAPPED INFANTS IN THIS FACILITY IS PROHIBITED BY FEDERAL LAW.

* * * * *

Any person having knowledge that a handicapped infant is being discriminatory denied food or customary medical care should immediately contact:

Handicapped Infant Hotline

* * * * *

Failure to feed and care for infants may also violate the criminal and civil laws of your state.

A number of commenters expressed a concern that the posting of the required notice would itself have a disruptive effect on the provision of health care to newborn infants by creating the impression to an infant's parents, already in a very stressful situation, that the physician, nursing staff, and hospital should not be trusted to provide proper care to their child. In connection with this point, the Catholic Health Association suggested that hospitals be permitted to use an alternative notice allowing the hospital to state its agreement with the policy of nondiscrimination and indicate the appropriate hospital contact person. Another comment suggested alternatives to posting, such as placing the notice on the admitting document or on consent forms used by the hospital.

Some commenters considered the wording of the notice very ambiguous in its references to "discriminatory failure" and "customary medical care" and in its failure to make reference to futile treatments, deference to legitimate medical judgments, the nonapplicability of section 504 to parental decisions, and many distinctions and nuances relating to the applicability of section 504 in this context.

Other criticisms were that the words "should immediately contact" improperly implied a legal obligation to report; the reference to "this facility" implied prior misconduct by that facility; and the reference to violations of "the criminal and civil laws of your state" is inappropriate because it does not relate to the purpose of the notice to inform people about civil rights protections.

A number of commenters suggested additions to the notice, including: a reference to the sanctions for noncompliance; express inclusion of handicapped infants born alive after abortions; reference to physical, mental, or emotional abuse or injury or withholding of fluids, oxygen, medications, warmth, and routine nursing care; and a statement that callers are not required to identify themselves.

Other commenters urged that hospitals be required to notify HHS that the notice has been posted.

Response

In an effort to accommodate many of these concerns, the Department has made a number of changes regarding the wording of the informational notice and the locations where it is to be posted. However, the Department remains convinced of the need for a notice to advise individuals in a position to know about potentially discriminatory conduct of the requirements of the law and of the mechanisms available to report suspected violations expeditiously so that, should a violation be occurring, corrective action can be taken in time to save the infant's life.

In many other contexts of civil rights enforcement and enforcement of scores of other statutes, speed is not essential because the victim of discrimination can be essentially "made whole" through reinstatement in a job, admission to a school or hospital, retroactive benefit payments, or the like. However, in the context of life and death medical decisions, the matter must be handled with the utmost urgency. For this reason, the Department continues to believe that it is essential to meaningful implementation of the requirements of section 504 to have a mechanism for immediate reports of suspected violations.

However, the Department has concluded that it can, without detracting from this overriding objective, eliminate the unintended adverse effects of the notice many commenters perceived. Therefore, the informational notice requirements set forth in § 84.55(b) reflect significant modifications from those set forth in the proposed rules.

First, the Department has adopted the suggestion of the Catholic Health Association that hospitals be permitted to post a notice reflecting that the hospital's policy is consistent with the nondiscrimination requirements of section 504 and that the hospital also has a mechanism to review suspected noncompliance with this policy. This change eliminates any perception that the notice implies improper conduct by the hospital.

The only requirement contained in the rule for the use of this notice (identified in the regulation as "Notice A") is that the content of the notice be truthful as it relates to that hospital. To be truthful, the hospital must have a policy that nourishment and medically beneficial treatment, as determined with respect for reasonable medical judgments, should not be withheld from handicapped infants solely on the basis of their present or anticipated mental or physical impairments. Furthermore, the hospital must have a procedure for review of treatment deliberations and decisions concerning health care for handicapped infants. Also, so that potential callers will be assured that the hospital's procedures will be

implemented in good faith, the hospital's policies must provide for the confidentiality of the identity of, and prohibitions of retaliation against, potential callers who, in good faith and nonmaliciously, provide information about possible noncompliance. A hospital need not, in order to post Notice A, have an Infant Care Review Committee in conformance with the model ICRC, nor forego management prerogatives with respect to anyone who might abuse the hospital's procedures by, for example, willfully making false or malicious calls. Hospitals for which the content of "Notice A" is not truthful must post the notice identified as "Notice B."

Second, the requirement regarding the location where copies of the notice must be posted has been changed. Consistent with the Department's intent to target the notice to nurses and other health care professionals, the proposed rule required that the notice be posted at the nurses' stations of appropriate wards, rather than more generally in the wards as had been stated in the March interim final rule. In view of the concern expressed by a number of commenters that posting in the nurses' stations would continue to make the notice conspicuous to distressed parents, the final rules do not require that copies of the notice be posted at nurses' stations. Rather, the notice is to be posted at any location(s) where nurses and other medical professionals who are engaged in providing health care related services to infants will be aware of the content of the notice. Locations such as locker rooms and lounge areas will suffice as long as placement in these locations ensures that the appropriate personnel will see the notice. Under these circumstances the notice would not have to be posted at nurse's stations or any other location where posting would have adverse effects on parents. The number of copies which must be posted in the hospital is similarly determined on the basis of ensuring that the appropriate personnel will see it.

Third, in view of this more specific targeting, the size of the notice has been reduced from the 8½ x 11 inches requirement in the proposed rule (and the 17 x 14 inch notices distributed in connection with the March rule) to 5 x 7 inches.

Fourth, the wording of the informational notice has been revised in connection with the language which attempts to convey in simple terms the basic protection of the law. The new language reflects the law's deference to reasonable medical judgments, refers to "medically beneficial treatment" and clarifies that the concept of handicapped discrimination relates to decisions made solely on the basis of present or anticipated mental or physical impairments. The reference in the text of the notice and elsewhere in the rules to "present or anticipated mental or physical impairments" is based on the definition of "handicapped person" in existing regulations, 45 CFR 84.3(j). The Department believes this phrase conveys a better understanding than use of the word "handicap."

The Department has also changed the heading of the notice to eliminate what many perceived to be a negative statement. The revised notice adopts the same heading, "Principles of Treatment of Disabled Infants", adopted by the coalition of leading disability and medical organizations in their landmark statement of principles.

In seeking to compose the wording of the notice, the Department has sought to set forth a simple, understandable, and accurate description of the requirement of the law. To a significant degree, the application of section 504 in this context defies a simple and precise restatement. The wording of the notice, however, does not establish a legally mandated rule of conduct; it merely conveys information. In recognition of the impossibility of setting forth a statement that covers all possible dimensions and nuances of the statute, the notice advises that callers may obtain further information by calling the designated contact points.

The Department believes this statement resolves many of the concerns regarding ambiguity of the prior version of the notice without becoming so cumbersome and complicated that it confuses more than it informs.

Concerning other comments, the Department is not adopting the suggestion that hospitals be required to notify HHS that the notice has been posted. There are insufficient benefits accruing from establishing a mechanism for checking off approximately 7,000 unverified notifications of posting to justify the administrative burden on the Department and recipients.

In addition, consistent with the objective of targeting the notice to nurses and other medical professionals, and in view of concerns about frightening parents, the Department is not adopting the suggestion that the nondiscrimination notice be required on hospital admission or consent forms. However, the Department encourages hospitals and Infant Care Review Committees to consider seriously developing some written information for parents with respect to hospital policies and procedures in connection with this issue. Such information could include an explanation of rights and responsibilities of parents, infants, and hospitals, the operation of the ICRC, available social services, and other pertinent information.

The Department is also not adopting numerous suggestions for additions to the notice because they are unnecessary and would make the notice cumbersome and possibly confusing. Statements concerning the existence of sanctions for noncompliance, the applicability of section 504 to infants born alive after abortions, the lawfulness of withholding futile treatments, and the applicability of section 504 to a wide range of aspects of medical care are all quite correct, but their inclusion in the notice is unnecessary.

The Department is not adopting the suggestion that the notice state that callers are not required to identify themselves. Although the Department will take appropriate follow-up action on anonymous calls that convey credible and specific information, the Department does not wish to encourage callers to remain anonymous because there is great value in having the ability to recontact the complainant as the inquiry or investigation progresses. The Department believes the statements contained in the notice regarding confidentiality of the identity of callers and prohibitions against retaliation are adequate to overcome the understandable reluctance a sincere potential complainant may have.

Finally, although the statement is correct, the Department adopts the suggestion that the reference to violations of state criminal and civil laws be deleted because it is unnecessary and potentially inflammatory.

C. RESPONSIBILITIES OF CHILD PROTECTIVE SERVICES AGENCIES

A number of commenters addressed the provision of the proposed rule requiring that state child protective services agencies establish and maintain written methods of administration and procedures to ensure full utilization of their authorities pursuant to state law to prevent instances of medical neglect of handicapped infants.

Several child protective services agencies and their representatives opposed this provision. As stated by the National Council of State Public Welfare Administrators:

> While the NCSPWA agrees there is a need to establish additional protections for infants born with handicapping conditions. * * * we

believe the child protective services agency is not, as a rule, the appropriate authority to establish standards for medical treatment, to police the medical profession, or to make the kinds of medical/ethical judgments required in this area.

The State of Nebraska Department of Public Welfare expressed support for increased involvement of state child protective services agencies:

> We feel that the agency with primary responsibility for investigation and enforcement of this law should be the State Protective Services Agency. We further would suggest that hospital administration be charged with the responsibility for reporting any possible violations of this law to the State Protective Services Agency. * * * The State Protective Services Agency should be responsible for reporting to the Office of Civil Rights the results of any actions taken as a result of the report. * * *

Some commenters urged deletion of the requirement that state agencies report cases to OCR because it conflicts with the confidentiality requirements of state child abuse and neglect statutes and presents an unnecessary administrative burden. Other commenters suggested that this requirement be expanded to require reports to OCR at each step of an agency's investigation. Other commenters suggested that state child protective services agencies be required to involve state protection and advocacy systems for the developmentally disabled in all of its activities related to this issue.

Response

Section G, below, includes a discussion of the applicability of section 504 in cases where a refusal to provide medically beneficial treatment is a result, not of decisions by a health care provider, but of decisions by parents. As explained in that section, it is the responsibility of the hospital in such a case to report the circumstances to the state child protective services agency. If that agency receives Federal financial assistance in its child protective services program, it may not fail, solely on the basis of the infant's present or anticipated physical or mental impairments, to utilize its full authority pursuant to state law to protect the infant. Although there are some variations among state child protective statutes, all have the following basic elements: a requirement that health care providers report suspected cases of child abuse or neglect, including medical neglect; a mechanism for timely receipt of such reports; a process for administrative inquiry and investigation to determine the facts; and the authority and responsibility to seek an appropriate court order to remedy the apparent abuse and neglect, if it is found to exist.

Consistent with the applicability of section 504 to child protective services agencies and with the typical elements of state child protective statutes, the proposed rule included a subsection requiring that, within 60 days of the effective date, "each recipient state child protective services agency shall establish and maintain written methods of administration and procedures to assure that the agency utilizes its full authority pursuant to state law to prevent instances of medical neglect of handicapped infants."

This provision was modeled after an existing provision in the Department's regulation implementing title VI of the Civil Rights Act of 1964, 45 CFR 80.4(b), which requires all continuing state programs to have "such methods of administration for the program as are found by the responsible department official to give reasonable assurance" of compliance.

The proposed rule went on to specify several elements which must be included in the agency's methods of administration and procedures. Four of these elements precisely mirror the common fundamental components of state child protective statutes.

The proposed rule also called for immediate notification to the Department of each report of suspected medical neglect of a handicapped infant, the steps taken by the agency to investigate such report, and the agency's final disposition of such report. This requirement was also based upon an existing regulation, 45 CFR 80.6(b), which requires compliance reports "in such form and containing such information" as the Department may require. Therefore, the proposed rule's requirement for notification to OCR is simply a specification of a type of compliance report the Department deems necessary to monitor the recipient's compliance.

With respect to the comments concerning the potential conflict between this notification requirement and the confidentiality provisions of state child abuse and neglect statutes, this provision is entirely consistent with existing regulatory requirements of recipient child protective services agencies under 45 CFR 80.6(c), which includes the statement: "Asserted considerations of privacy or confidentiality may not operate to bar the Department from evaluating or seeking to enforce compliance with this part."

In addition, HHS regulations requiring, as a condition of receiving Federal funds, state child protective services agencies to protect the confidentiality of child abuse and neglect information also make clear that HHS and the Comptroller General of the United States must have access to documents and other records "pertinent to the HHS grant." 45 CFR 1340.14, 74.24.

The Department has not adopted the suggestion that more detailed requirements be established for state child protective services agencies because the requirements should be flexible enough to be easily incorporated into existing agency procedures.

Section 84.55(c)(1) of the final rules adopts the corresponding provision of the proposed rules without substantive change. In summary, it simply restates existing section 504 responsibilities of recipient state child protective services agencies; requires standard procedures to assure compliance (as has been long required for continuing state programs under title VI); specifies the basic elements of those procedures (which precisely mirror the standard components of state statutes); and specifies a form of compliance reports required under existing agency responsibilities. Consistent with the Department's investigative guidelines, § 84.55(c)(2) encourages state agencies to involve Infant Care Review Committees in connection with the agencies' actions pursuant to its state law and procedures.

D. EXPEDITED ACCESS TO RECORDS

The final rules create a limited exception to the Department's existing regulations pertaining to access to sources of information. The existing regulation, 45 CFR 80.6(c), made applicable to section 504 cases by 45 CFR 84.61, states:

> Each recipient shall permit access by the responsible Department official or his designees during *normal business hours* to such of its books, records, accounts, and other sources of information, and its facilities as may be pertinent to ascertain compliance with this part. (Emphasis supplied.)

The proposed rules included a modification to specify that access to pertinent records and facilities of a recipient "shall not be limited to normal business hours when, in the judgment of the responsible Department official, immediate access is necessary to protect the life or health of a handicapped individual." The final rules adopt this change in § 84.55(d).

A number of commenters expressed support for this provision as essential to efforts to save lives. Others objected on the grounds that investigations are

highly disruptive, the OCR officials are not qualified to make a judgment regarding the degree of danger to the life or health of a handicapped individual and that the rule should specify circumstances warranting access and procedures applicable to investigations after normal business hours.

Response

The Department views this as a minor, technical clarification. Access to recipient facilities and sources of information is required by existing regulations and is essential for the Department to carry out its statutory obligation to determine whether recipients are in compliance with civil rights laws. The provision in existing regulations regarding "normal business hours" is nothing more than a recognition that many recipients conduct their federally assisted programs and activities only during those hours.

The furnishing of inpatient medical services, however, is not a 9:00 a.m. to 5:00 p.m., Monday through Friday undertaking. Rather, the "normal business hours" for nurseries and neonatal intensive care units are 24 hours a day, seven days a week. The Department, therefore, has the authority to seek pertinent records at any time even in the absence of this revision. Nonetheless, the Department adopts this change to clarify its authority and recipients' obligations. The objections expressed regarding this provision are substantially the same as objections to investigative procedures generally, and are discussed in section H, below.

This modification makes clear where the circumstances indicate a risk of imminent, irrevocable harm due to suspected noncompliance, the Department will, as it must, initiate immediate action to determine compliance.

E. EXPEDITED ACTION TO EFFECT COMPLIANCE

The final rules include a slight revision to existing regulatory procedures concerning remedies for noncompliance. Existing regulations, 45 CFR 80.8(a) and (d) (made applicable to section 504 cases by 45 CFR 84.61), provide:

> If there appears to be a failure or a threatened failure to comply with this regulation . . . compliance with this part may be effected by the suspension or termination of or refusal to grant or to continue Federal financial assistance or by any other means authorized by law. Such other means may include . . . a reference to the Department of Justice with a recommendation that appropriate proceedings be brought to enforce any rights of the United States under any law of the United States. . . or any assurance or other contractual undertaking. . . .
>
> * * * * *
>
> No action to effect compliance by any other means authorized by law shall be taken until (1) the responsible Department official has determined compliance cannot be secured by voluntary means, (2) the recipient or other person has been notified of its failure to comply and of the action to be taken to effect compliance, and (3) the expiration of at least 10 days from the mailing of such notice to the recipient or other person.

The proposed rule included a provision that the normal requirement of providing 10-days notice "shall not apply when, in the judgment of the responsible Department official, immediate remedial action is necessary to protect the life or health of a handicapped individual." The final rule, in § 84.55(e), adopts this revision.

A number of commenters expressed support for this provision as essential to efforts to save lives; others objected because the rule did not identify standards for waiving the 10-day notice or alternate procedure to be followed.

Response

The Department considers this a minor, technical change. The 10-day notice was designed to facilitate pursuit of informal compliance in circumstances where noncompliance did not imminently threaten lives. The failure to provide nourishment or treatment to a handicapped infant, however, may have such a consequence.

As a matter of legal interpretation, the Department believes the normal 10-day notice rule would, even absent the proposed change, be inapplicable in a case where the government seeks a temporary restraining order to sustain the life of a handicapped infant in imminent danger of death. Such actions would often be for the purpose of preserving the status quo, such as by continuing the provision of nourishment and routine care, pending a more definitive determination of compliance or noncompliance with section 504, rather than "to effect compliance" following a determination of noncompliance. In addition, the Department believes federal judges would be appropriately loathe to allow minor procedural technicalities to defeat totally the accomplishment of the statutory purpose. Nonetheless, the Department proposed this limited exception to the normal 10-day notice rule to clarify its authorities and corresponding recipient responsibilities.

The determination of the need to waive the 10-day notice will be made in accordance with the standard investigative procedures, explained in section H, below. Concerning alternate notice procedures, the final rule provides that oral or written notice will be provided as soon as practicable.

F. GUIDELINES RELATING TO HEALTH CARE FOR HANDICAPPED INFANTS

Most of the comments submitted during the comment period dealt with issues well beyond the specific provisions of the proposed rules, such as the applicability of section 504 to this subject matter and the Department's section 504 enforcement process.

Like the proposed rules, the final rules contain four discrete requirements applicable to recipients of Federal financial assistance. First, hospitals must post an informational notice. Second, the normal 10-day notice before initiating action to effect compliance can be waived when immediate action is necessary. Third, access by the Department to pertinent records and facilities can be obtained after "normal business hours" when immediate access in necessary. Fourth, state child protective services agencies must establish procedures to utilize their full authority under state law to prevent medical neglect of handicapped infants.

To bring these specific provisions further back into focus, it is useful to note what the final rules, like the proposed rules, do *not* do. They do not establish the applicability of section 504 to the provision of health care to handicapped infants. The applicability of section 504 is already established by the statute and the existing HHS regulations. They do not establish the authority or procedures of HHS to investigate reports of suspected noncompliance with section 504. Authority and procedures are already established by the statute, existing regulations and administrative practices. They do not establish a toll-free telephone number, which has been established and is in operation. Although most of the controversy concerning the rules relates to the broader issues, the mandatory aspects of the final rules deal only with several discrete points.

Nonetheless, many of the comments relating to the broader issues were highly relevant and valuable. Other comments on the broader issues reflected a lack of understanding of how the Department interprets the applicability of section 504 in this area and the Department's compliance procedures. To clarify these issues, the final rules include an appendix, which sets forth guidelines relating to health

care for handicapped infants. This appendix includes interpretative guidelines relating to the applicability of section 504 and guidelines for HHS investigations in this area. These guidelines do not independently establish rules of conduct or substantive rights and responsibilities, which are established by the statute and existing regulations. The Department will apply these guidelines flexibly to take into account the circumstances presented in each case regarding both the determination of compliance or noncompliance and the conduct of the investigation. These guidelines are set forth as an appendix to the final rules simply to assist recipients and the public in understanding the Department's general interpretations and procedures. This appendix becomes a part of the permanent Code of Federal Regulations.

G. INTERPRETATIVE GUIDELINES RELATING TO THE APPLICABILITY OF SECTION 504

Medically Beneficial Treatment

As stated in the preamble to the proposed rules, the Department interprets section 504 as requiring that medically beneficial treatment not be withheld, solely on the basis of handicap, from a handicapped infant.

Three of the questions on which the July 5 notice of proposed rulemaking specifically solicited comments concerned the issue of medically beneficial treatment as the standard to guide treatment decisions, including further explanations that would assist health care providers and the public in understanding the requirements of Section 504, implications concerning cost and the allocation of medical resources, and the impact of perceived economic, emotional and marital effects on parents.

Among commenters supporting the standard of providing medically beneficial treatment was the Down's Syndrome Congress:

> Some children may be unwanted by their parents. . . . The Down's Syndrome Congress does not seek to judge those parents who do not feel that they can adequately parent because of the handicap. Rather, we seek to make available those adoption homes that want children who have Down's syndrome.

Also typical of comments in support of the standard of providing medically beneficial treatment was the comment of the Association for Retarded Citizens:

> No quality of life or other such considerations are acceptable to the ARC. Although we are primarily a parent organization and many ARC members have had significant difficulty (financial, emotional, etc.) raising their mentally retarded child, we come down strongly on the side of the child.
>
> Available medical and other technology is not able to fully predict the future capacity of most mentally retarded children, especially in the first days and weeks of life. Our members can cite numerous examples of improper and wrong advice given to them by physicians about the future capacities of their children.

A number of commenters argued that the medically beneficial treatment standard is inappropriate. For example, the Department received the following comment from a Texas physician:

> [N]ot only is the "very strict standard" advocated by the President's Commission "not being uniformly followed," [as stated in the HHS July 5 NPRM] it is probably close to *uniformly not* being followed. The "very strict standard" the Secretary of Health and Human Services is trying to foist on the medical community is contrary to the usual practices of that community. (Emphasis in original.)

Similarly, the following comment was submitted by an Alabama physician:

> Recently I have treated a 13-month old black child who has congenital heart disease, spastic encephalopathy, vomiting, repeated bouts of bilateral pneumonia, internal squint of the left eye, and mental deficiency. He is one of the thousands of children who are the victims of the neonatal intensive care units located in every medical center. He was born premature, weighing two pounds and ten ounces. With modern treatment and instruments he survived. These children have no future and are a terrible burden on their parents and this nation.
>
> * * * What good is it treating these premature babies? Will it not be better if they are left to die? * * * We are compounding our problems by bringing into life thousands of congenitally sick babies which nature has rejected.

A number of commenters, particularly medical organizations, suggested different articulations of standards. For example, the American Medical Association combines a number of notions in articulating the standard to be applied, including consideration of "quality of life", and deference to parental decisions unless there is "convincing evidence to the contrary." The full text of the AMA position is as follows:

> QUALITY OF LIFE. In the making of decisions for the treatment of seriously deformed newborns or persons who are severely deteriorated victims of injury, illness or advanced age, the primary consideration should be what is best for the individual patient and not the avoidance of a burden to the family or to society. Quality of life is a factor to be considered in determining what is best for the individual. Life should be cherished despite disabilities and handicaps, except when prolongation would be inhumane and unconscionable. Under these circumstances, withholding or removing life supporting means is ethical provided that the normal care given an individual who is ill is not discontinued. In desperate situations involving newborns, the advice and judgment of the physician should be readily available, but the decision whether to exert maximal efforts to sustain life should be the choice of the parents. The parents should be told the options, expected benefits, risks and limits of any proposed care; how the potential for human relationships is affected by the infant's condition; and relevant information and answers to their questions. The presumption is that the love which parents usually have for their children will be dominant in the decisions which they make in determining what is in the best interest of their children. It is to be expected that parents will act unselfishly, particularly where life itself is at stake. Unless there is convincing evidence to the contrary, parental authority should be respected.

Another articulation of standards, submitted by the Biomedical Ethics Committee of the University of Minnesota Hospitals, includes the following ethical principles:

> When the burden of treatment lacks compensating benefit or treatment is futile, the parent(s) and attending physician need not continue or pursue it.
>
> Therapies lack compensating benefit when: (a) they serve merely to prolong the dying process; (b) the infant suffers from intolerable, intractable pain, which cannot be alleviated by medical treatment; (c) the infant will be unable to participate even minimally in human experience.

Probably the most poignant comments regarding the standard which should be applied relating to the provision of medical care to handicapped infants were submitted by parents of handicapped children. Of 100 commenters who identified themselves as parents of handicapped persons, 95 supported the proposed rule and five opposed it. From a Montana mother:

> My daughter Keough was born in November 1980 with Down's syndrome and a host of birth defects in her digestive system similar to Baby Doe's problems * * * Twenty minutes after her birth our then pediatrician offered to let her starve in the hospital nursery * * *
>
> * * * * *
>
> * * * There are times when I am getting up for the tenth time during the night to suction my daughter's trach tube so she can breathe that I would give anything not to have to deal with the situation, but I will never regret having her as part of the family.

From a mother and father, both physicians, in California:

> [A]s the parents of an eight-year-old boy with Down's Syndrome, who suffers from marked retardation and a severe cardio-pulmonary condition, we do appreciate both the deep anguish and the countless joys that derive from caring for and caring about a

severely handicapped child. There is no limit set on the strength, the growth and the fulfillment that his love continues to bring us every day For his sake and for the sake of all the handicapped newborn, it is urgent that safeguards be enacted. Let merciful caring, not mercy-killing, be our answer to their needs.

Another dimension of the comments concerning the interpretation of section 504 as requiring that medically beneficial treatment not be withheld solely on the basis of handicap relates to the difficulty of determining the "medically beneficial treatment." As stated by the Children's Hospital of Boston:

[The NPRM] states that the denial of treatment where there is no medical benefit to the individual would not be discriminatory because the individual would not be a "qualified handicapped person" within the meaning of section 504. . [A problem with this analysis is that] it relies on outcome which cannot always be predicted or, even if predicted is not always accurate, may be affected by other factors, and may not even be known for an indeterminate time. If section 504 is to provide guidance in treatment situations, its applicability should be known at the outset. Otherwise staff will be subjected to an after-the-fact scrutiny which may well be inaccurate and oppressive.

Another comment regarding the role of medical judgements was submitted by presiding Judge John G. Baker, Monroe Superior Court, Division III, the Judge who decided the Bloomingtom Infant Doe case:

The question in the Infant Doe case was, when parents are confronted with two competent medical opinions, one suggesting that corrective surgery may be appropriate and the other suggesting that corrective surgery and extraordinary measures would only be futile acts, does the law allow the parents to select which medical course to follow? It was the decision of the Indiana Court that the law provided the parents with the responsibility of choosing which medical course to follow without governmental intervention.

Response

The Department's position remains unchanged. Section 504 provides:

No otherwise qualified handicapped individual shall, solely by reason of his handicap, be excluded from participation, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance. . .

The statute defines a "handicapped individual" as:

Any person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, . or (iii) is regarded as having such an impairment.

A key issue in applying section 504 in any context is that the handicapped individual who is allegedly excluded from participation in, denied the benefits of, or subject to discrimination under a federally assisted program or activity be "otherwise qualified" to participate in, or benefit from, the program or activity, in spite of his or her handicap. In the context of receiving medical care, the ability to benefit for a handicapped person is the ability to benefit medically from treatment or services. If the handicapped person is able to benefit medically from the treatment or service, in spite of the person's present or anticipated physical or mental impairments, the individual is "otherwise qualified" to receive that treatment or service, and it may not be denied solely on the basis of the handicap.

Therefore, the analytical framework under the statute for applying section 504 in the context of health care for handicapped infants is that health care providers may not, solely on the basis of present or anticipated physical or mental impairments of an infant, withhold treatment or nourishment from the infant who, in spite of such impairments, will medically benefit from the treatment or nourishment.

Not only is this analytical framework directed by the statute, the Department believes the medically beneficial treatment standard is the appropriate guiding principle for providing health care services to handicapped infants. The Department agrees with the President's Commission that "it is all too easy to undervalue the lives of handicapped infants," and that it is "imperative to counteract this" by excluding "consideration of the negative effects of an impaired child's life on other persons" and to treat handicapped infants "no less vigorously than their healthy peers."

The Department also agrees with the essential principle contained in the joint statement of November 29, 1983, by the coalition of medical groups and disability organizations, including the American Academy of Pediatrics, the National Association of Children's Hospitals and Related Institutions, the association for Retarded Citizens, the Spina Bifida Association of America, and others:

When medical care is clearly beneficial, it should always be provided. . . . The individual's medical condition should be the sole focus of the decision.

Consistent with the recommendations of the President's Commission and the principles agreed to by the coalition of medical and disability groups, paragraphs (1), (2) and (3) of section (a) of the appendix state the basic interpretative guidelines of the Department for applying section 504 in this context. These interpretative guidelines make clear that health care providers may not, solely on the basis of present or anticipated physical or mental impairments of an infant, withhold treatment or nourishment from the infant, who, in spite of such impairments, will medically benefit from the treatment or nourishment. They also made clear that futile treatments or treatments that will do no more than temporarily prolong the act of dying of a terminally ill infant are not required by section 504, and that, in determining whether certain possible treatments will be medically beneficial to an infant, reasonable medical judgments in selecting among alternative courses of treatment will be respected. The principle of respecting reasonable medical judgments reflects the Department's recognition that in many cases the process of medical decisionmaking is not mechanical and precise. Analyses of medical risks, medical benefits, possible outcomes, complications, and the like require experience and judgments. Most of all, they must be specifically based on the actual circumstances presented in any given case. The statutory framework does not provide for, nor will the Department seek to engage in, second-guessing of reasonable medical judgments regarding medically beneficial care.

The principle of respecting reasonable medical judgments in the context of applying section 504 is also consistent with analogous case law. For example, the Supreme Court has made it clear that the application of constitutional protections do not interfere with *bona fide* medical judgments so as to authorize a court "to specify which of several professionally acceptable [treatment] choices should have been made." *Youngberg* v. *Romeo*, 457 U.S. 307, 321 (1982).

However, the Department also recognizes that not every opinion expressed by a doctor automatically qualifies as a reasonable medical judgment. For example, a doctor's opinion that available corrective surgery to save the life of a Down's syndrome infant should be withheld is contrary to the opinion of the President's Commission and comments submitted to the Department by the American Academy of Pediatrics, the National Association of Children's Hospitals and Related Institutions, and other medical organizations. It is not within the

bounds of reasonable medical judgment and is not entitled to deference.

Parental Decisions

A number of commenters argued that the Department's analysis of section 504's applicability fails to take into account the lack of authority hospitals and physicians have to perform treatment to which the parents have not consented. Some commenters expressed a belief that the Department purports to require physicians and hospitals unilaterally to overrule parental decisions. As stated by the American Medical Association:

> If section 504 is applied as the Department claims it should be, physicians and hospitals will be required to treat a handicapped infant in all cases, regardless of parental consent, for fear of sanctions allegedly authorized by section 504.

Similarly, the National Asssociation of Children's Hospitals and Related Institutions stated:

> Nor does the rule recognize that, in lieu of indications to the contrary, decisions of care of the infant made by these parents, based on their determination of the child's best interest, are theirs to make, a right and responsibility assigned to them universally by state statute. . . .

Also in connection with the issue of a recipient's section 504 responsibilities in cases where parents refuse to consent to medically beneficial treatment, a number of commenters criticized a statement included in the Department's May 18 notice to health care providers that:

> Health Care providers should not aid a decision by the infant's parents or guardian to withhold treatment or nourishment discriminatorily by allowing the infant to remain in the institution.

The criticism was that to discharge the infant, as the statement implied the hospital should do, would be unlikely to advance the objective of assuring that the infant receive medically beneficial treatment.

Response

The Department's position has been, and continues to be, that the lack of parental consent does have an impact on a recipient hospital's section 504 responsibilities, but that the lack of parental consent to provide particular treatment does not remove from hospitals the obligation to operate other aspects of their program without discrimination.

Although the need may not arise frequently, it is an accepted part of the operation of hospitals to contest the denial of parental consent when such a decision is not in the best interest of a child. Most hospitals have established procedures to petition courts to order medical care when parents do not provide consent for treatment that is medically needed and appropriate.

In addition to the internal hospital procedures, state laws generally establish responsibilities of health care professionals where treatment is being withheld because of improper denial of parental consent. Health care professionals are generally required by state law to report cases of abuse, neglect, or other threats to a child's health. These laws, whether explicitly or implicitly, include the denial of needed medical treatment as an event requiring reporting.

The requirement that health care providers report instances of improper denial of medical care is no less a part of their program than is the provision of care itself. Both arise from the recipients's program of administering to the medical interests of its patients. Section 504 prohibits discrimination on the basis of handicap in the operation of federally assisted programs and activities. Thus, a recipient that, as a matter of practice or law, reports to State authorities the withholding of needed medical treatment from an infant may not deny the same service or benefit to a qualified handicapped infant because the infant is handicapped.

Section 504 applies only to programs or activities receiving federal financial assistance; it does not apply to decisions made by parents. Where a non-treatment decision, no matter how discriminatory, is made by parents, rather than by the hospital, section 504 does not mandate that the hospital unilaterally overrule the parental decision and provide treatment notwithstanding the lack of consent. But it does require that recipient hospitals not fail, on the basis of handicap, to report the apparently improper parental decision to the appropriate State authorities, or to seek judicial review itself, so as to trigger the system provided by State law to determine whether the parental decision should be honored. Action by hospitals to seek judicial review is not uncommon in cases where, for example, parents have objected on religious grounds to a medically necessary blood transfusion for their child.

The Department agrees with the criticism of the sentence in the May 18, 1982 notice. This statement reflected a recognition by the Department that section 504 does not require hospitals unilaterally to overrule parental decisions, and that hospitals cannot provide treatment without parental consent. The point should have been better stated that a recipient hospital may not blindly implement improper and discriminatory parental decisions. Rather, the hospital should resort to the system provided by state law to determine whether a parental decision should be implemented.

Therefore, the proper analysis of the applicability of section 504 in cases where the failure to provide medically indicated treatment is due to a lack of parental consent is that a recipient hospital is not required to seek to unilaterally overrule the parents, but it must adhere to the standard practice, as required by state law, to make a report to the state agency charged under state law with responsibility to initiate the determination as to whether the parental decision was proper, or to seek judicial review itself. This interpretative guideline is set forth in section (a)(4) of the appendix.

Rather than representing an improper Federal government attempt to "question and overturn the decisions of parents concerning their children's medical treatment," the Department is simply requiring that the long-standing requirements and mechanisms of *state* law for defining the limits of parental authority not be rendered, through discriminatory actions of recipient hospitals, *de facto* inoperative.

Examples

The July 5 proposed rule was accompanied by an appendix explaining the manner in which section 504 applies to the provision of health care services to handicapped infants and providing several examples of its applicability to particular factual situations. A number of commenters criticized statements contained in that appendix. Criticisms and comments were as follows: (a) Use of phrases such as "futile therapies", "services generally provided", and "dubious medical benefit" are ambiguous. (b) The characterization of the infants with intracranial hemorrhage as analogous to anencephaly is incorrect. Intracranial hemorrhages vary greatly in severity, and are generally treatable and treated. (c) The American Society for Parenteral and Enteral Nutrition stated that although there are no circumstances justifying "withholding oral feeding through a working digestive tract in any patient capable of digesting food, in whole or in part," there may be "limited circumstances" in which not providing nourishment through intravenous means "may be appropriate." (d) The appendix does not indicate the appropriate care for infants who have conditions with prognoses worse than Down's syndrome

but less severe than anencephaly, such as Trisomy 18, Trisomy 13, Holoprosencephaly, Hydranencephaly, Cornelia de Lange Syndrome, and many others.

(e) "It would be impossible to develop a complete list of handicaps to which the regulations apply. The limited ability to predict outcomes, and the rapid changes in diagnostic and therapeutic modalities make such a goal wholly impracticable."

Response

The application of constitutional and statutory civil rights protections in scores of contexts is difficult. A glance at the Supreme Court's docket confirms this, as every year difficult issues are presented to the Court for resolution. These cases often produce split decisions and multiple opinions.

Therefore, it is to be expected that definitive statements on various dimensions of the applicability of the handicapped discrimination law in connection with health care for handicapped infants, a subject no less difficult than many other aspects of civil rights law, would be few. The imprudence of seeking to speculate on the outcome of applying section 504 in a wide variety of specific factual circumstances was underscored by some of the comments received.

Keeping in mind the utility of providing some examples to assist in understanding the analytical framework of the statute, but also the need to allow individualized attention to specific factual circumstances, the guidelines included in the appendix (section (a)(5)) set forth examples dealing with Down's syndrome, spina bifida, anencephaly, and extreme prematurity.

The Department agrees with the comment that it would be impossible to establish a specific list of all handicapping conditions and the proper treatment in each case. None of the commenters who perceived ambiguities had convincing answers to the questions they raised.

It is appropriate that the law (and thus the government) does not prospectively and unequivocally answer every hypothetical question. In many cases, the law, like medical treatment, can only be applied on a case-by-case basis with a full appreciation for the facts presented.

But it is also appropriate that the law and government have an analytical framework for approaching the issue and a procedural framework for seeking, in coöperation with the medical community and advocacy groups, to narrow the "gray area." The final rules seek to do no more, and importantly, no less.

H. GUIDELINES FOR HHS INVESTIGATIONS RELATING TO HEALTH CARE FOR HANDICAPPED INFANTS

Conduct of Investigations

The July 5 notice of proposed rulemaking solicited comments on HHS investigative procedures. A number of commenters argued that OCR complaint investigations are highly disruptive. The primary concerns expressed in this regard were:

(a) Due to the complexity of the subject matter, there are many erroneous complaints, either by well-intentioned, but ill-informed, persons or by disgruntled employees.

(b) Anonymous calls are not reliable.

(c) Investigations monopolize the time of physicians, nurses and other hospital staff, and make medical records, while under review by OCR investigators, unavailable.

(d) Investigations carry with them the potential for sensational media coverage, which can unjustly damage the good reputations of parents, hospitals and health care professionals.

(e) The presence of OCR investigators is likely to frighten other infants' parents who will assume that, because investigators are present, the hospital must be guilty of improper conduct.

Response

Although some potential for inconvenience or disruption exists in connection with any type of law enforcement investigation, because of the traumatic circumstances of an infant's illness, the potential for sensationalistic media coverage, and other factors, the Department is very sensitive to the special nature of "Infant Doe" investigations. As HHS has gained experience in conducting these investigations, revisions to investigative procedures have been implemented to minimize any disruptive effects. It is the policy of the Department to do everything possible, consistent with its statutory obligation to investigate effectively all complaints of violations of section 504, to minimize any disruptions that may be caused by OCR investigations.

OCR has made adjustments to investigative procedures. It now undertakes a careful screening of complaints in an effort to avoid unnecessary on-site investigations. This screening consists of immediately initiating a preliminary inquiry with the hospital to obtain information regarding the infant in question. The information initially received from the complainant and that received from the hospital is then evaluated to determine whether there is a need for an on-site investigation. Particular factors taken into account are the source of the complainant's information (first-hand knowledge, overheard a discussion, etc.), the complainant's position to have reliable information (a nurse in the ward where the infant is being treated, a friend of a friend, etc.), the specificity of the information provided by the complainant and hospital, whether there is any indication of a lack of parental consent for the provision of all medically beneficial treatment, the analysis of the ICRC, whether the hospital is cooperative in connection with the inquiry, and other pertinent factors.

None of these factors considered in evaluating the information provided by the complainant and the hospital is, by itself, determinative. For example, the Department prefers that the complainant provide his or her name. Not only does it corroborate that the complainant takes the matter seriously and reflects some degree of confidence the complainant has in the accuracy of the information being conveyed, having the complainant's name also permits follow-up communications to seek clarification of the information gathered. However, the Department recognizes that a complainant may not be willing to provide his or her name due to fear of retaliation, and that anonymity does not necessarily suggest that the complaint is not valid, particularly if the specificity of the information provided and other factors support the credibility of the complaint. Therefore, the determination as to whether an on-site investigation is needed is made on the totality of the information available to OCR from the complainant, the hospital, and any other source consulted (such as an OCR medical consultant and the state child protective services agency).

HHS believes this procedure, if hospitals cooperate in its implementation, can avoid unnecessary on-site investigations, which inherently have a potential for some inconvenience. Although hospital officials may be properly reluctant to provide information over the telephone, they can confirm the credentials of the OCR investigator making the telephone contact by calling the toll-free telephone number to verify that the caller is, in fact, an OCR investigator.

Where, as a result of this preliminary inquiry, there appears to be no need for an immediate on-site investigation, none will be conducted. However, to assure

that HHS is adequately meeting its statutory responsibility, where there is a significant question as to compliance with section 504, doubt will be resolved in favor of initiating an on-site investigation.

This preliminary inquiry process is undertaken by OCR in an effort to accommodate the special circumstances presented in connection with "Infant Doe" complaints. This procedure should not be construed as suggesting that the Department believes there are any limitations to its legal authority to investigate all complaints or to otherwise collect information regarding recipient compliance in accordance with the Department's existing section 504 regulations. Nor does this preliminary inquiry process establish any legally enforceable procedural right or precondition to the conduct of on-site investigations.

When on-site investigations are conducted, OCR's procedures minimize any potential inconvenience or disruption. Every effort is made, consistent with the need to obtain prompt information, to accommodate the busy schedules of health care professionals to avoid diverting them from their important duties. Similarly, OCR has never had a problem working out access to medical records to avoid their being unavailable to health care professionals who also need access to them.

With respect to media interest, OCR has a firm policy of providing no comment to the press on the details of any open investigation. HHS believes organizations or individual complainants concerned about proper patient care should be extremely sensitive to threats to proper care inherent in making premature and unsupported comments to the media. Similarly, the media should be attentive to OCR's admonition, regularly given in response to media questions, that the fact that an investigation is being conducted does not imply that an allegation is true.

Section (b)(1) through (5) of the appendix spell out the basic guidelines, including the preliminary inquiry process, applicable to HHS investigations in this area. These guidelines make specific reference to the role of Infant Care Review Committees. Whenever a hospital has an ICRC, established and operated substantially in accordance with the suggested model, the Department will consult closely with the ICRC in connection with a preliminary inquiry or investigation and will give careful consideration to the analysis and recommendations of the ICRC.

The Department believes OCR procedures, including the initial inquiry process, minimize the potential for disruption. HHS will, on the basis of further experience gained, such as with ICRCS, continue to evaluate its procedures consistent with the policy of effective enforcement with a minimum of disruption. The Department also notes that there is probably an irreducible level of inconvenience associated with any effort to provide safeguards to prevent the fatal consequences of discriminatory decisions. It must be recognized, however, that the risks of a certain amount of inconvenience or disruption are significantly preferable to the risks of tragic loss of life due to discriminatory decisionmaking.

Use of Medical Consultants

Another concern expressed by commenters relates to the qualifications of the individuals involved in the administrative fact finding process to evaluate correctly the medical circumstances present in any particular case. For example:

> The Alabama Hospital Association strongly feels that the [investigative] team should be comprised of highly trained and licensed medical personnel. Under no circumstances should anyone less than licensed medical personnel be allowed to intrude in this area of medical decisionmaking and impose alternative judgments or conclusions.

The Spina Bifida Association of America made a similar comment from a different perspective:

> The key to effective enforcement is securing an independent medical examination of children allegedly being denied treatment, by a physician or medical team both skilled in modern treatment techniques *and* committed to the equal treatment principle. Such physicians do exist, particularly at expertise centers that have specialized in the care of children with spina bifida. The only way to ensure effective enforcement is to give disability rights groups like SBAA the ability to recommend *which* expertise centers and expert consultants are used by the regional OCR offices to conduct the independent medical examinations.

Response

HHS agrees that OCR investigators do not have the medical expertise to make independent judgements concerning difficult medical issues. For this reason, the Office for Civil Rights has made arrangements with qualified physicians to serve as medical consultants to OCR in "Infant Doe" investigations. This process is noted in section(b)(6) of the appendix.

The role of the OCR medical consultants is to provide OCR with an analysis of the medical issues present in any particular case, and an opinion as to whether medically beneficial treatment was provided. Based on this analysis, OCR makes a determination as to whether any medically beneficial treatment may have been discriminatorily denied solely on the basis of the infant's handicap.

The extent of the involvement of the OCR medical consultant has varied depending upon the circumstances of particular cases. In all cases the OCR medical consultant reviews the pertinent medical records. In some cases the OCR medical consultant and the attending physician have discussed a case by telephone. HHS believes the experience to date with OCR medical consultants demonstrates the effectiveness of their involvement. HHS is aware of no case in which a recipient has challenged the quality of the medical consultant's evaluation or the OCR findings based upon it.

It is important that all interested groups understand the precise and limited role of the OCR medical consultants. Their function is *not* to take over the medical management of particular cases, to conduct a personal, independent examination of the infant, to make independent treatment recommendations to parents, or to otherwise engage in any direct practice of medicine concerning the infant.

The Department has no authority to compel unilaterally an independent medical examination of a child who is the subject of a section 504 complaint. Under applicable requirements of law, physicians may not practice medicine on an infant patient without the consent of the parents or an order of a court of competent jurisdiction.

In any given case, any of a wide variety of circumstances may be present regarding the actions of parents and health care providers. Regardless of the circumstances, the first step is to determine the facts. Only if the facts demonstrate that there is a need for governmental action can that action be pursued. A court will only issue an order if there is a showing of a need for the order, such as evidence that the hospital *is* out of compliance with section 504 or showing that the parents *are* medically neglecting the infant. Such a showing cannot be made on the basis of the bare allegations of a complaint or without a determination of the facts.

OCR's function in an investigation is to determine the facts, and the function of the medical consultant is to assist OCR in this effort. The process of determining the facts typically involves a review of medical records and

discussions with health care providers involved. The OCR medical consultants assist in this process by providing identification and expert analysis of the medical issues involved. These consultants do not, and may not under applicable law, take over the medical management of the case.

With respect to the suggestion that HHS give disability groups the opportunity to recommend qualified physicians to serve as OCR medical consultants, the Department would welcome such suggestions from all interested groups.

The Department is unable to commit itself to having a medical consultant participate in person in every on-site investigation. However, the guidelines contained in the appendix state that, to the extent practicable, the OCR medical consultant will discuss the case with the hospital's ICRC or appropriate medical personnel by telephone.

Prompt Report of Investigative Findings

Another complaint made by a number of commenters regarding OCR enforcement procedures concerns the sometimes lengthy delay between completion of the on-site investigation and receipt by the hospital of notification of the outcome of the investigation. Commenters expressed concern that, particularly in connection with investigations that may have attracted local media attention, where the OCR investigation found no evidence of a violation, the hospital should have the ability to reassure the public promptly that it was involved in no improper activity.

Response

The point is well taken. Office for Civil Rights procedures pertaining to all investigations require that before the office makes an official finding, whether it is of compliance or noncompliance, a thorough record is compiled and reviewed by supervisory officials. Experience in connection with "Infant Doe" cases is that formal findings have been made in less time than is typical in connection with other civil rights investigations. However, there is generally a need for careful review by an OCR medical consultant, an HHS attorney, and supervisory officials.

The Department recognizes that there are special circumstances in connection with Infant Doe cases, and is instituting a special notification to recipient hospitals in cases where an emergency on-site investigation has been conducted. As a matter of practice, on-site investigation of complaints alleging that an infant's life is in peril due to the discriminatory withholding of medically beneficial care are conducted immediately for the primary purpose of determining whether there is a need to ask the Department of Justice to seek immediate injunctive relief to compel compliance with section 504. Generally, during the course of the investigation, when sufficient information has been obtained and discussed with the OCR medical consultant, a decision is made on whether there is such a need.

The new procedure is that, when a decision is made that there is no need to make an immediate referral to the Justice Department, the recipient hospital will be immediately notified of that decision. The investigator will, if still on-site, personally notify hospital officials. A letter to the same effect will then promptly be sent by OCR. This letter will notify the recipient hospital of the decision made concerning immediate referral to the Justice Department. It will not provide a formal finding concerning the investigation, which cannot be made until all information is analyzed and reviewed. (It may be, for example, that, although there is no emergency requiring immediate legal action by the Justice Department, there is, or was, noncompliance.)

The Department believes this immediate notification procedure, stated in section (b)(7) of the appendix, will provide a basis for the hospital to assure the press and public that OCR's initial conclusion in connection with the investigation is that no infant is in imminent peril due to discriminatory withholding of medically beneficial treatment.

Confidentiality of Records

A number of commenters criticized the enforcement process on the grounds that it infringes on the confidentiality of the physician-parent relationship and the privacy of medical records. Some of these commenters referred to the confidentiality requirements of state law and professional ethical standards.

As stated by the Federation of American Hospitals:

> The physician may be required to inform the parents that anything they may say or decide must be disclosed to federal or state authorities if an investigation results. [P]arents will find that they have a choice between sharing vital information and counseling with their physician and having their thoughts and emotions revealed to a stranger or, alternatively, withholding information.

A suggestion for an additional confidentiality safeguard, submitted by the director of nursing of a Butte, Montana hospital, was to limit review of records to one investigator, on-site, with no copies made.

Response

HHS believes there is no sound legal basis to challenge the Department's right to access to medical records for the purpose of determining compliance with section 504, and that adequate safeguards exist to protect the confidentiality of records obtained by OCR in the course of civil rights investigations.

With respect to legal authority, a state law, such as one restricting access to certain records, cannot, under the Supremacy Clause of the United States Constitution, be used to prevent accomplishment of the full congressional purpose of a Federal law. Similarly, standards of particular professional groups may not frustrate or defeat a Federal statutory duty.

Section 504 establishes certain responsibilities of recipients and authorizes and directs Federal agencies to enforce the law. Existing regulations, 45 CFR 80.6(c) (made applicable to section 504 by 45 CFR 84.61), require:

> Each recipient shall permit access by the responsible Department official or his designee during normal business hours to such of its books, records, accounts, and other sources of information, and its facilities as may be pertinent to ascertain compliance with this Part. . . . Asserted considerations of privacy or confidentiality may not operate to bar the Department from evaluating or seeking to enforce compliance with this Part. Information of a confidential nature obtained in connection with compliance evaluation or enforcement shall not be disclosed except where necessary in formal enforcement proceedings or where otherwise required by law.

The requirement that recipients provide access to records necessary to determine compliance is essential to accomplishment of the congressional purpose in enacting section 504.

HHS has adequate safeguards to protect the confidentiality of medical records obtained during the course of a section 504 investigation. In addition to the regulatory provision (quoted above) protecting confidentiality, OCR does not release confidential information in connection with any Freedom of Information Act request. Nondisclosure is permitted under that Act for records, the release of which would consititute a clearly unwarranted invasion of personal privacy. As further protection, OCR permits deletion of the patient's and parents' names and other indentifying information to the extent deletion will not impede OCR's ability to determine compliance.

The argument that the possibility that investigators will seek access to a medical file will cause parents to withhold vital information from the infant's physician is not persuasive. Courts and legislatures have repeatedly rejected arguments that exceptions to the principle of confidentiality of medical records and the physician-patient privilege would result in the withholding of information necessary to facilitate proper treatment. There are many established exceptions in the law to the principle of doctor-patient confidentiality in connection with criminal and civil proceedings where the effective administration of justice requires access to information in medical records or provided to physicians. It is also noteworthy in this regard that the Federal Rules of Evidence do not include an express doctor-patient privilege.

With respect to the suggestions for additional safeguards submitted by a commenter, OCR has in some cases been able to limit review of records to one individual at the hospital, without the need to obtain copies. However, no assurances can be made that OCR can meet its responsibility to conduct a thorough investigation under these conditions. Also, in many cases it may be preferable for the hospital to send OCR the pertinent records (with identifying information deleted), perhaps avoiding the need for any on-site investigation.

IV. Related HHS Activities

HHS has undertaken several other initiatives in cooperation with the medical community and disability organizations to improve the delivery of health care services to handicapped infants. Recently, a contact was awarded by the Office of Human Development Services, HHS to the John F. Kennedy Institute in Baltimore to develop a model for a working nationwide referral network for the developmentally disabled. Such a network, using today's sophisticated technology, will make it possible for the physician, parents, or care-takers of a developmentally disabled individual to query a single source for information about that disability and pinpoint the best or most appropriate places to get help any where in the country for that individual.

Under the terms of this award, the strong features of two important information systems are to be combined and regionalized. One is a data retrieval system for the particular use of practicing physicians. The other is accessible by the general public. The data base for the physician-oriented system was developed by the Kennedy Institute in Baltimore, using data supplied by the 38 HHS supported university-affiliated facilities around the country. The American Medical Association has a contract with the Kennedy Institute to include the Institute's data as an additional offering of the A.M.A.'s nationwide medical information network, or "MINET." It is available to every "MINET" subscriber who has a desk-top computer and a telephone.

This enterprise pulls together government, the private nonprofit sector, and organized medicine, in this case, the A.M.A., to make information available to physicians concerning access to specialized care for their patients and as well as to a broad variety of support services in the community.

The more consumer-oriented data system is now functioning in South Carolina to benefit the citizens of that state. The system carries information on access to care and community support services within the state. Any individual or family member can gain access to the system merely by dialing a toll-free "800" number.

The Kennedy Institute has an excellent concept of how such a network will function. Under the contract recently awarded, it is hoped the South Carolina Model will be expanded to seven other states in the region. The next step should then be to extend the system nationally and thus make available to all citizens the best information and the most appropriate resources relative to handicapping conditions.

The availability of such a resource should do much to take the insecurity out of one effort to rally support services for the handicapped newborn.

In addition to this nationwide referral network, HHS and the Department of Education, in cooperation with the coalition of medical and disability organizations who signed the "Principles of Treatment of Disabled Infants," are organizing an effort to develop teaching models for health care professionals on improving infant care, aiding the decision-making process and use of the nationwide referral network.

The Department believes that informational and educational efforts of this kind are also of great importance in advancing the principles underlying the final rules.

V. Additional Analysis of Comments

Section III above includes an explanation of the provisions of the final rules, including an analysis of pertinent comments submitted to the Department during the comment period on the proposed rules. This section is an analysis of other comments not directly related to specific provisions of the final rules.

A. LEGAL ISSUES

A significant number of commenters addressed legal issues relating to the application of section 504 to matters concerning health care for handicapped infants.

Statutory Construction of Section 504

A number of commenters argued that, as a matter of statutory construction, section 504 of the Rehabilitation Act of 1973 is inapplicable to matters concerning health care for handicapped infants. The arguments advanced by these commenters were:

(a) The statute does not specifically mention handicapped infants, and the statutory definition of "handicapped individual" should be construed as inapplicable to infants because its reference to substantial limitations on major life activities has no application to infants since all infants are dependent on the efforts of others for performance of all external life activities.

(b) The legislative history makes no mention of handicapped infants and indicates that the primary focus of Congress in enacting the Rehabilitation Act was matters relating to vocational rehabilitation, rather than medical matters; and although the statutory definition of handicapped individual was amended in 1974 to broaden its scope beyond vocational rehabilitation, including access to services such as medical care, there was no indication that the statute, as amended, was intended to cover medical judgments about the type of treatment given any handicapped individual. As stated by one commenter:

> There is not even a hint in the legislative history of the Act or its amendments that would indicate Congressional intent to apply section 504 to medical treatment of severely handicapped infants. Rather, it is clear that Congress intended the Act to foster fruitful and independent living for handicapped individuals.

(c) The rulemaking history of the Department's section 504 regulations reveals previous HHS interpretations that section 504 is inapplicable.

Response

The Department's position remains unchanged. Section 504 clearly applies to matters concerning the provision of health care to handicapped infants, and nothing in the legislative history of the statute or rulemaking history of the

Department's regulations suggests a credible interpretation to the contrary.

Section 504 provides:

> No otherwise qualified handicapped individual . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. . . .

The statute defines a "handicapped individual" as

> any person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, . . . or (iii) is regarded as having such an impairment.

An infant is a person. If an infant has a physical or mental impairment which substantially limits major life activities, or is regarded as having such an impairment, the infant is a "handicapped individual" within the meaning of the law. If a hospital engages in a program or activity which provides medical services to infants and if that program or activity receives Federal financial assistance, it is a "program or activity receiving Federal financial assistance" within the meaning of the law.

If an infant who is a "handicapped individual" is "otherwise qualified" to receive the benefits of a medical services program or activity receiving Federal financial assistance, and is denied, solely by reason of his handicap, the benefits of those medical services, that infant is within the protection of section 504.

A key issue, therefore, in applying section 504 in any context is that the handicapped individual who was allegedly excluded from participation in, denied the benefit of, or subjected to discrimination under, a federally assisted program or activity be "otherwise qualified" to participate in, or benefit from, the program or activity. To be "otherwise qualified," the handicapped individual must, in spite of his or her present or anticipated physical or mental impairment, be able to meet the essential requirements for participation in the program or activity.

In the context of receiving medical care, the ability to benefit for a handicapped person is the ability to benefit medically from treatment or services. If the handicapped person is able to benefit medically from the treatment or service, in spite of the person's handicap, the individual is "otherwise qualified" to receive that treatment or service, and it may not be denied solely on the basis of the handicap.

Therefore, the analytical framework under the statute for applying section 504 in the context of health care for handicapped infants is that medically beneficial treatment and services not be withheld from a handicapped infant solely on the basis of the handicap.

The legislative history makes clear that by enacting section 504 Congress intended to eliminate all of the "many forms of potential discrimination" against handicapped people through "the establishment of a broad governmental policy." S. Rep. No. 1297, 93d Cong., 2d Sess. 38 (1974). The statute applies to all federally funded programs or activities, specifically including those that provide "health services." *Id.*

The rulemaking history related to the 1977 promulgation of the Department's section 504 regulations explained that the Department was not seeking to regulate with respect to the highly controversial issue of the rights of institutionalized persons to receive treatment for the condition which led to their institutionalization. Additionally, the regulation specifies that the provision of health care services generally to handicapped persons is a matter covered by the Act and the Department's rules. 45 CFR 84.52.

It is difficult to understand the theory of statutory construction that would distinguish the provision of health care services to qualified handicapped infants from the provision of other federally assisted benefits and services to qualified handicapped individuals.

The Department cannot subscribe to the theory that the definition of "handicapped individual" should be construed as inapplicable to infants because infants are dependent upon others for all major life activities. This argument appears to be based on a much too narrow view of what constitutes "major life activities." The Department's section 504 regulations define "major life activities" at 45 CFR 84.3 (j)(2)(ii), as: "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." Infants undertake at least some of these major life activities from the moment of birth.

Moreover, if this is the theory, the Department is unaware of the basis to be used in determining at what age the protections of section 504 would begin to apply.

In summary, the Department can find no clue in any bit of legal analysis or rational policy analysis to commend the notion that there is or should be a distinction in the application of section 504 based on the age of the handicapped individual.

It appears the real basis for the contention that section 504 is inapplicable in this context is that medical care is involved, rather than what some may perceive as much less complicated matters like distributing welfare benefits, developing transportation systems, administering housing programs, delivering social services, providing educational services, making employment decisions, and the like.

The Department agrees that matters relating to the provision of medical care are in some ways different from other aspects of applying section 504. For one thing, the consequences of discriminatory treatment may be much higher—a matter of life and death. Also, the analysis involved in determining whether discrimination exists may, in some cases, be much more subtle and difficult. But one aspect that appears the same in all applications of section 504 is that decisions regarding whether handicapped persons will receive the services and benefits of programs and activities receiving Federal financial assistance are sometimes made, not on the basis of the individual's actual qualifications for, and ability to benefit from, those activities, but rather on stereotypes and prejudices concerning the limitations on major life activities faced by handicapped persons. Section 504 was enacted to eliminate these considerations from such decisions. And although the section 504 analysis may be more subtle (at least in some cases), it is an anomalous and bizarre theory that section 504 can properly be used to require that a ramp be built in a hospital to assure that handicapped persons not be denied access to medical services solely on the basis of their handicaps, but that statute may not properly be used to prevent the intentional act of allowing other handicapped persons to die in that hospital, solely because of their handicaps. The Department cannot subscribe to this theory.

In summary, the Department's position is unchanged. Section 504 clearly applies to the provision of health care for handicapped infants.

Separating the "Handicap" from the Condition Requiring Treatment

A number of commenters expressed views that the section 504 analysis summarized above is incapable of application in many or most cases because the handicapping condition and the condition requiring treatment are one and the same. This fact, the commentors argue, results in an inability to separate "medical judgments" from judgments relating to social, emotional,

economic, or other non-medical issues, concerning which unreasonable prejudices have often caused discrimination against handicapped individuals.

Response

Although perhaps subtle, the analysis required by the statutory framework is just as applicable in a case where the handicapping condition and the condition requiring treatment are the same as it is to the "simpler" case where two distinct conditions are involved.

In the "simple" case involving two distinct conditions, such as Down's syndrome and an intestinal obstruction, the Down' syndrome does not present a medical contraindication to surgical correction of the intestinal obstruction. There is no valid medical reason (assuming no other condications) for treating the Down's syndrome infant differently than an infant with the same intestinal obstruction and no Down's syndrome.

The same analysis applies where the handicapping condition and the condition to be treated are the same. In such a case the "handicap" is the physical or mental impairment the infant has or will have (or "is regarded as having") *after* completion of the treatment under consideration. In the case of an infant born with myelomeningocele, for example, the treatment which must be considered is surgery to close the protruding sac to prevent infection and other potentially fatal consequences. The "handicap" is the physical and/or mental impairment the infant is regarded as likely to have in future life. To the extent the myelomeningocele itself or other complications (such as respiratory problems, infection, anesthetic risk, or other factors) present, in the exercise of reasonable medical judgement, contraindications to the surgery, the infant is not able to benefit, in spite of his or her handicap, from the surgery. However, if the surgery would be medically beneficial, in that it would be likely, in the exercise of reasonable medical judgment, to bring about its intended result of avoiding infection or other fatal consequences, then failure to perform the surgery because of the anticipated impairments in future life offends section 504, as the withholding of surgery is *because* of the handicap and *in spite of* the infant's being qualified to receive the surgery.

In both the Down's syndrome and myelomeningocele examples, this analytical framework accomplishes precisely what Congress intended in enacting section 504: to overcome stereotypes and prejudices against handicapped persons who are, in spite of their handicaps, able to participate in, and benefit from, activities and services supported by Federal funds.

All of this is not to say that application of this analytical framework in every case will be easy. Nonetheless, in spite of the difficulties which may arise in case-by-case applications, the analytical framework focusing on the provision of medically beneficial treatment to handicapped infants is the correct one under the statute, and is capable of application.

Applicability of Section 504 When Hospital Is Incapable of Providing Treatment

A number of commenters questioned the applicability of section 504 in cases where the hospital, due to lack of sophisticated equipment, medical specialists, or other factors, is incapable of providing the treatment needed by a particular infant. These commenters appeared to suggest that the Department would find such a hospital to be in violation of section 504 because it did not provide the medically beneficial treatment it was unable to provide.

Response

The answer on the applicability of the law in such a case is as clear as the applicability of common sense. Common sense indicates that if a patient needs treatment which a hospital cannot provide, the hospital will try to refer the patient to a facility that can provide it. If the patient is handicapped, the common sense response is the same. The failure of the hospital to itself provide the treatment is not "on the basis of the handicap"; rather, nontreatment is based on the fact that the hospital is incapable of providing the treatment.

Similarly, if the medically indicated course of action for any individual with a condition the facility is incapable of treating is to arrange for that individual to be transferred to a facility where the treatment can be provided, then this transfer cannot be denied to a qualified handicapped person (one who will benefit medically from it) on the basis of the person's handicap.

Responsibilities of Hospitals as Opposed to Physicians

Another challenge to the Department's application of section 504 to health care for handicapped infants was submitted by the Federation of American Hospitals:

> . . . A hospital cannot practice medicine. In fact, many state laws prohibit and punish the unauthorized practice of medicine. Nevertheless, the proposed rules place the responsibility for the physician's decision on the hospital. Moreover, assuming that discrimination on the basis of handicap exists, it is *not* discrimination on the part of the hospital, it is the discrimination of the physician and/or parents who are not recipients of federal financial assistance as that term is defined under the Rehabilitation Act. Therefore, insofar as they apply to hospitals, not physicians and parents, the proposed rules are also totally misdirected.

Response

The Department disagrees with the comment's implications that the law in any way requires hospitals to engage in the unauthorized practice of medicine, and that hospitals have no authority to prohibit discrimination by physicians.

It is the Department's view that a hospital has the authority to condition a physician's staff membership or renewal of membership on an agreement to abide by the hospital's policy of nondiscrimination. Indeed, the Department's conditions for hospital participation in the Medicare program require that a hospital have "an effective governing body legally responsible for the conduct of the hospital as an institution." 42 CFR 405.1021. Those conditions also require that a hospital have:

> a medical staff organized under bylaws approved by the governing body, and responsible to the governing body of the hospital for the quality of all medical care provided patients in the hospital and for the ethical and professional practices of its members.

42 CFR 405.1023.

Under those conditions the medical staff is also "responsible for support of . . . hospital policies." 42 CFR 405.1023(a). Standards set forth in the accreditation manual for hospitals, published by the Joint Commission on Accreditation of Hospitals, also recognize the responsibility of the governing body to adopt and approve bylaws consistent with all applicable laws and regulations. The accreditation manual also emphasizes that the governing body has the responsibility for the conduct of the hospital's operation and that the medical staff is responsible to the governing body.

It is the Department's position therefore that a hospital has the right to establish and implement a policy of nondiscrimination among its employees and medical staff, and that this does not constitute an unauthorized practice of medicine by the institution.

Applicability of Section 504 to Adults

Several commenters raised the issue whether section 504 would also be applicable to issues relating to medical care provided to adults. For example,

the Department received the following comment from a doctor in San Antonio, Texas:

As a doctor who practices on adult patients, what I find most worrisome about this whole sorry affair is that the reasoning behind the proposed rules applies at least as well to adults as to infants with congential defects. Should every patient, no matter how old or ill, be forced to receive the "benefits" of cardiopulmonary resuscitation? Should a ninety-year-old man with a stroke which has caused him to develop pneumonia be subjected to weeks on a respirator in hopes of getting him well enough to go to a nursing home, where the same basic problem is sure to lead to another bout of pneumonia? Should a senile, combative eighty-year-old lady with a breast mass have a biopsy and mastectomy? Certainly a stroke and senility are handicaps if Down's syndrome is.

Response

Although section 504 is, of course, applicable to issues relating to health care provided to adults, the unique issues relating to health care for handicapped infants significantly affect the application of the law and justify the special procedures established by the final rules.

The special needs of infants and minors have long been recognized by most states, as its evidenced by the enactment of child abuse and neglect statutes. These statutes, in most instances, specifically reference the failure to provide necessary medical care to minors as constituting child abuse or neglect, and establish special remedial authorities.

In contrast, most adult patients are viewed by courts as being competent to give or withhold consent regarding medical treatment for themselves. In the case of adults incapable of making decisions, due to senility, mental retardation, or the like, courts have applied the "substituted judgment" doctrine to try to ascertain the incompetent patient's own wishes through available evidence and by asking what a reasonable person in the patient's situation would do.

The circumstances which give rise to the special procedures established by every state to protect children are the same circumstances which give rise to the special procedures established by the final rules to apply section 504 to matters relating to health care for handicapped infants.

Limitations on Obligations Imposed By Section 504

A number of commenters called attention to judicial decisions indicating limitations on the extent to which section 504 mandates that recipients of Federal financial assistance undertake substantial changes in their programs or activities.

As stated by the American Academy of Pediatrics:

Case law interpreting section 504 suggests the existence of limitations beyond which the statute cannot reach, giving rise to the question of whether HHS' rule would impose on providers unwarranted affirmative action burdens. In *Southeastern Community College v. Davis*, 442 U.S. 397 (1979), the Supreme Court considered the claims of a licensed practical nurse that her denial of admission to a college nursing program on the basis of her hearing disability violated section 504. The college had determined that Davis's impairment was such that, even with a hearing aid, she would be unable to participate fully in the program and function effectively as a nurse. According to the plaintiff, however, the college should not have taken her handicap into account in determining whether she was "otherwise qualified" for the program, but, rather, should have confined its inquiry to her academic and technical qualifications. The Court rejected this argument, finding that section 504 "by its terms does not compel educational institutions to disregard the disabilities of handicapped individuals. . . ." 442 U.S. at 405.

Davis argued further that HHS regulations implementing section 504 required that the nursing program be modified to accommodate her, to which the Court replied:

If these regulations were to require substantial adjustment in existing programs beyond those necessary to eliminate discrimination against otherwise qualified individuals, they would do more than clarify the meaning of § 504. Instead, they would constitute an unauthorized extension of the obligations imposed by that statute. *Id.* at 410. . . .

Response

The only affirmative step required of recipient hospitals by the final rules is to post an informational notice. As explained in the preamble, the Department has sought to tailor the notice, with respect to both its wording and the locations for its posting, so as to avoid any disruptive or administratively burdensome effects. The posting of notices to advise individuals of protections provided by Federal laws is very common in connection with a wide range of civil rights, health and safety, consumer protection, labor standards, and other Federal laws. The posting of this notice cannot be credibly argued to constitute the kind of excessive regulation prohibited by the *Davis* doctrine.

The other provisions of the final rule which affect hospitals, the clarification regarding access to records and the narrow exception to the ten-day notice rule, similarly impose no appreciable administrative burdens on hospitals. The provision of the final rules relating to state child protective services agencies also, as explained in the preamble, imposes no significant burdens.

The case-by-case application of section 504 and existing regulations, entirely separate from any mandatory provision of the final rules, is, of course, subject to the *Davis* limitations. However, as clearly evidenced by the guidelines set forth in the appendix to the final rules, these limitations have been fully complied with in connection with the Department's interpretations of the application of section 504 and in its enforcement processes.

Section 504, as the *Davis* decision recognized, requires the operation of a recipient's program in a nondiscriminatory fashion. The Department's interpretations and procedures applicable in this context require no more. The guidelines in the appendix make clear the Department interprets section 504 as not requiring the provision of futile treatments and as respecting reasonable medical judgments. Further, they make clear that investigative procedures have been specially crafted to avoid substantial administrative burdens. The basis of the Supreme Court's decision in *Davis* was that because the Court found it unlikely that the plaintiff could benefit ultimately from the nursing program, the college's refusal to make substantial modifications to its educational program to accomodate the plaintiff was not discriminatory. The appendix guidelines make clear that the Department's interpretation of section 504 in this context carefully adheres to this ability to benefit requirement.

The *Davis* decision did not authorize the evasion of section 504 obligations under the guise that adhering to the nondiscrimination mandate may require some attention. However the courts ultimately refine the doctrine that there are limitations on the scope of section 504, it is the Department's firm position that those limitations are in no way touched by the mandatory requirements of the final rules, nor will they be touched by case-by-case application of the law consistent with the guidelines set forth in the appendix to the final rules.

Medicare and Medicaid as "Federal Financial Assistance"

A number of commenters also disputed the Department's legal authority for the rules on the grounds that participation by hospitals in the Medicare and Medicaid programs did not bring them within the coverage of section 504 on the grounds that Medicare and Medicaid are not

"Federal financial assistance" within the meaning of the Act.

Response

The Department's position, consistently held since the Medicare and Medicaid programs were originally enacted in 1965, that Medicare Part A payments to hospitals and Medicaid constitute Federal financial assistance for purposes of applicability of Title VI of the Civil Rights Act of 1964 and the nondiscrimination statutes modeled after it, including section 504, is unchanged.

Because the rules do not specifically refer to the Medicare or Medicaid programs, the validity of the rule is not dependent upon the Department's long-standing interpretation. However, hospital officials who believe their hospitals are not subject to these civil rights laws may wish to inform themselves of the Department's position and the substantial legal support for it.

The Department's position has been clear, unequivocal, and consistent. The appendix to the Department's title VI regulations lists Medicare and Medicaid as programs of Federal financial assistance. 45 CFR Part 80, Appendix A, Part 1, No. 121, and Part 2, No. 30. The appendix to HHS's section 504 regulations makes clear HHS's interpretation that the scope of jurisdiction of section 504 is the same as that for title VI. 45 CFR Part 84, Appendix A, Subpart A, No. 2.

The legislative history of the Medicare statute makes clear that Medicare payments to hospitals were intended to constitute Federal financial assistance for purposes of the applicability of title VI of the Civil Rights Act, and thus section 504 as well. Speaking on the floor of the Senate in support of the Medicare bill, Senators Ribicoff and Hart stated unequivocally that title VI was applicable to hospitals participating in Medicare. Senator Ribicoff: "[H]ospitals and other institutions have . . . to abide by Title VI of the Civil Rights Act." 111 Cong. Rec. 15803 (1965). Senator Hart:

> In addition to the new economic independence it will create, I am hopeful that the bill will promote first class citizenship in another fashion also. We decided last year, and wrote into law, that federal tax dollars collected from all the people may not be used to provide benefits to institutions or agencies which discriminate on the grounds of race, color, or national origin. This principle will, of course, apply to hospital and extended care and home health services provided under the social security systems, and *will require institutions and agencies furnishing these services to abide by Title VI of the Civil Rights Act of 1964.* Id. at 15813 [emphasis supplied].

In addition, the legislative history of the Civil Rights Act supports this position. In the most complete analysis of title VI contained in the House Judiciary Committee's Report, the additional views of seven supporters of the legislation, uncontroverted in any section of the report, specifically made reference to the predecessor program to Medicaid and clearly stated congressional policy underlying title VI:

> In a related fashion, racial discrimination has been found to exist in vendor payment programs for medical care of public assistance recipients. Hospitals, nursing homes, and clinics in all parts of the country participate in these programs and, in some, Negro recipients have received less than equal advantage.
>
> * * * * *
>
> In every essential of life, American citizens are affected by programs of Federal financial assistance. Through these programs, medical care, food, employment, education, and welfare are supplied to those in need. For the government, then, to permit the extension of such assistance to be carried on in a racially discriminatory manner is to violate the precepts of democracy and undermine the foundations of government.

H.R. Rep. No. 914, 88th Cong. 2d Sess. (Additional Views on H.R. 7152 of Hon. William M. McCulloch, et al.).

Courts which have dealt with this issue have found Medicare and Medicaid to constitute Federal financial assistance for purposes of establishing civil rights jurisdiction. A recent such case is *United States* v. *Baylor University Medical Center*, 564 F. Supp. 1495 (N.D. Tex. 1983). Citing HHS regulations indicating that Medicare and Medicaid are Federal financial assistance, case law in which courts "have had little difficulty" in finding that they are Federal financial assistance, the legislative history of the Medicare statute, long-standing agency interpretation, and the broad construction which must be given to remedial civil rights statutes, the court found that Medicare and Medicaid are Federal financial assistance for purposes of section 504 coverage. The court also specifically rejected the medical center's argument that Medicare and Medicaid payments are exempt from the definition of "Federal financial assistance" on the grounds of being under contracts of insurance. The Court distinguished insurance programs, by noting that Medicare is funded by mandatory taxes and Medicaid by general revenues, rather than through a system of risk-based premiums.

Other cases supporting the position that Medicare and Medicaid payments are Federal financial assistance are *NAACP* v. *Wilmington Medical Center*, 657 F.2d 1332 (3d Cir. 1981) (the court noted its jurisdiction was based on the hospital's receipt of Medicare and Medicaid funding); *United States* v. *Cabrini Medical Center*, 497 F. Supp. 95, 96, n.1 (S.D.N.Y. 1980); *Cook* v. *Oschner*, No. 70–1969 (E.D. La., Feb. 12, 1979) (the defendants' argument that Medicare and Medicaid payments did not constitute Federal financial assistance was rejected by the district court during pre-trial motions); *Flora* v. *Moore*, 461 F. Supp. 1104, 1115 (N.D. Miss 1978); and *Bob Jones University* v. *Johnson*, 396 F. Supp. 597 (D.S.C. 1974), *aff'd.*, 529 F.2d 514 (4th Cir. 1975) (court held that VA benefits to students constituted Federal financial assistance to the university and noted their similarity to Medicaid).

The basic congressional policy underlying title VI, section 504 and related statutes is that federally funded programs and services are to be administered in a nondiscriminatory fashion. The Medicare and Medicaid programs were established for the purpose of providing medical service to people who otherwise might not be financially able to obtain them. The argument that somehow these federally assisted medical services were not intended to be within the reach of the nondiscrimination rule is clearly contrary to the basic congressional policy. Underscoring this is the fact that HHS spends billions of dollars annually for health care services to the aged, disabled, and poor, and virtually all hospitals participate in these programs. According to data of the Health Care Financing Administration (HCFA), HHS, of approximately 6,930 hospitals, 6,737 participate in Medicare and virtually the same number in Medicaid. In fiscal year 1982, total hospital costs in the United States were $136 billion. Of this, $47.9 billion were HCFA expenditures ($36.3 billion, Medicare, $11.6 billion, Medicaid). Approximately 36 percent of all hospital costs in the United States are financed through the Medicare and Medicaid programs. *See HCFA Statistics* (Publication No. 03155, Sept. 1983).

It should also be noted that there are no persuasive arguments for distinguishing Medicaid and Medicare on the question of whether they constitute Federal financial assistance to hospitals. Although Federal Medicaid funds flow through the states, the states' relationship to the hospitals in Medicaid is essentially the same as that of the Federal government to the hospitals in Medicare. HHS regulations for both title VI and section 504 specify that recipients of Federal financial assistance include all subrecipients

which receive funds from a recipient. 45 CFR 80.13(i), 84.3(f).

In addition, Medicare and Medicaid cannot be considered procurement contracts for purposes of the statutory exemption from civil rights jurisdiction in connection with such contracts. Unlike the relationship that exists under procurement contracts, health care providers promise only that if they serve an eligible beneficiary of the program, they will look to the government for payment of all but specified items. In addition, under Medicare and Medicaid the level of services is determined by providers who are not acting as agents for the government and are not discharging an obligation the government has assumed. Rather they are—with Federal assistance—engaging in activities they have long performed. In this respect Medicare and Medicaid payments are indistinguishable from grants to pay the costs of medical services. Indeed, those payments often cover medical costs of indigent patients that hospitals would otherwise be required to absorb pursuant to their other legal obligations. In contrast, under a procurement contract the government acts on its own account as a consumer of goods, such as typewriters and paper clips, or services, such as hotel accommodations and rental car services for traveling employees. The level of services under procurement contracts is determined by the government and not, as under Medicaid or Medicare, by the provider.

Furthermore, the Medicare and Medicaid programs do not fall within the statutory exemption from the definition of Federal financial assistance for any payments pursuant to "a contract of insurance or guaranty," 42 U.S.C. 2000 d–1, 2000 d–4 (title VI); 45 CFR 84.3(h) (section 504). The principal object of the Medicare and Medicaid programs is to provide service. Medicare and Medicaid programs cannot properly be characterized as, or analogized to, a contract of insurance. Benefits under these programs are not measured by any fixed premium paid by the beneficiary to the government; the government reimburses for the reasonable cost incurred by the provider in rendering services. Missing from both reimbursement plans is that essential element of insurance—the assumption of risk. The Medicare and Medicaid programs do not purport to indemnify for nonpayment by the beneficiary. The hospital, in becoming a provider of services under these programs, agrees to look to the government for payment and to accept the reimbursement from the government as full payment, except for the deductible and coinsurance. The beneficiary does not incur any obligation to pay for those services which are covered by the agreement between the provider and the government.

Nor do Medicare and Medicaid constitute contracts of guaranty. Essential to a definition of a contract of guaranty is a primary obligation on the part of the individual for whom the guaranty is given. A contract of guaranty is a promise to pay or an assumption of performance of some duty upon the failure of another who is primarily obligated in the first instance. In contrast, the reimbursement provisions of the Medicare and Medicaid programs are not activated by the failure of the individual recipient to pay for the medical services covered by agreement between the government and the hospital.

It is the absence of these elements which distinguishes Medicare and Medicaid from programs that Congress intended to be excluded under the contract of insurance or guaranty exception, such as mortgage guarantees under FHA or VA and depositors' insurance under FDIC, where the role of the government is clearly as an insurer or guarantor and Federal monies are involved only if the private party does not meet his or her obligation. It is also noteworthy that the American Hospital Association apparently concluded in 1966, when Medicare was instituted, that hospitals receiving Medicare were recipients of Federal financial assistance for title VI purposes. The AHA solicited and printed in its journal a question and answer article prepared by the former Department of Health, Education and Welfare to help hospitals understand what they were required to do to comply with title VI to receive Medicare funds. *See* "Hospitals and Title VI of the Civil Rights Act of 1964, Questions and Answers," *Hospitals*, June 1, 1966. Also, pursuant to 45 CFR 84.5, hospitals which participate in the Medicare and Medicaid programs have submitted assurances to HHS that they would comply with section 504 and the applicable regulations.

Accordingly, as demonstrated by this brief summary of points in support of the Department's long-standing position, hospitals which participate in the Medicare and Medicaid programs are recipients of Federal financial assistance for the purpose of establishing section 504 jurisdiction.

"Program or Activity" Receiving Federal Financial Assistance

Another argument presented by some commenters to dispute the legal authority for the proposed rule is that even if Medicare and Medicaid are "Federal financial assistance," they are not "a program or activity" which provides medical care to handicapped infants. The argument appears to be that, purportedly following the analysis of the government's brief to the Supreme Court in the pending case of *Grove City College* v. *Bell*, 687 F.2d 684 (3d Cir. 1982), *cert. granted*, 51 USLW 3611, February 22, 1983 (#82–792), the "program or activity" which receives Federal financial assistance in the form of Medicare and Medicaid payments to a hospital is the fiscal accounting office of the hospital.

As stated by the American Academy of Pediatrics:

> . . . to the extent, then, that the government believes that Title IX cannot extend beyond the financial aid office, is difficult to understand how section 504 could extend to nurseries, maternity wards, and neonatal intensive care units simply because the medical expenses of primarily elderly Medicare beneficiaries are reimbursed in the accounting office.

Response

The Department believes this argument is without merit. The position advanced by the government in *Grove City* is that in determining what constitutes the Federally assisted program, it is necessary to examine both the nature of the Federal program and the organizational practices of the recipient institutions. *Grove City* involves the Basic Education Opportunity Grants program (BEOG), in which grants are made to students and used by the students to pay for tuition, fees, room and board. The recipient institutions operate financial aid programs under the direction of a financial aid office, with a separate budget and a specific purpose, to provide financial aid to students who otherwise could not afford to attend the college. BEOG's are one component of the college's financial aid program. In view of the nature of the Federal BEOG program and the organizational practices of colleges, it is the college's financial aid program that receives the Federal assistance. Although, conceivably, an effort could be undertaken to "trace" the "ripple effects" of the BEOG money throughout the college, the government's position in *Grove City* is that this is not what Congress intended in enacting the program specificity requirement in the applicable civil right statutes.

The circumstances involved in connection with Medicare and Medicaid reimbursements to hospitals are entirely

different from those involved in BEOG's and colleges. Rather than providing assistance to a general financial aid program operated by the recipient, Medicare and Medicaid payments to hospitals are primarily for particular medical services provided to particular patients who received services in particular units of the hospital. It is services provided to particular beneficiaries by the hospital's operating room, x-ray department, laboratory, pediatrics ward, or other organizational units that give rise to the Federal reimbursements. In addition, the hospital's organizational and accounting practices provide for Federal reimbursement for a proportionate share of administrative costs, housekeeping, depreciation of physical plant, and other general expenses, all specifically itemized and specifically eligible for reimbursement.

Also unlike colleges, "tracing" Medicare and Medicaid reimbursements within hospitals is not dependent upon looking for "ripple effects" of the Federal funds. Rather, it is the specific identification of actual services and costs which gives rise to reimbursements based specifically thereon.

Therefore, the Federally assisted program of a hospital is not, as a commenter suggested, the accounting office of the hospital, any more than the Federally assisted program of a college is the accounting office or comptroller. An examination of the applicable Federal programs and the recipient's organizational practices makes clear that the issues presented in the *Grove City* case, and the positions taken by the government in that case, do not undermine the legal basis for the final rules or the application of section 504 to health care for handicapped infants.

It should also be noted that whatever subtleties or twists are ultimately associated with the interpretation of "program or activity," the final rules specifically accommodate the program specificity requirement pertaining to the posting of the informational notice as applicable to each recipient that provides health care services to infants "in programs or activities receiving Federal financial assistance." If, on the basis of the Supreme Court's eventual decision in *Grove City* or other factors, limitations evolve on what programs or activities of hospitals are covered by section 504, those limitations will be accommodated by the text of the rules.

Services vs. Employment as Jurisdictional Limitation

The Federation of American Hospitals advanced another argument in behalf of the proposition that the Department has no legal authority to issue the final rules. The Federation commented:

> The Rehabilitation Act of 1973 (Pub. L. 93–112) does *not* apply to hospitals. Federal circuit courts of appeal which squarely address the issue uniformly hold that the Act does *not* apply to hospitals as recipients of Medicaid or Medicare funds. These courts have held that the Rehabilitation Act applies to recipients of federal financial assistance if, and only if, that assistance has the primary objective of providing employment.
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> In *United States* v. *Cabrini*, 639 F.2d 908 (2d Cir. 1981), the Court . . . [held] that the Office for Civil Rights was not authorized to investigate a complaint by a hospital employee that he was discharged for mental disability. . . . *Tragesar v. Libbie Rehabilitation Center, Inc.*, 590 F.2d 87, 89 (4th Cir. 1978), *cert. den'd*, 442 U.S. 947; *Scanlon v. Atascadero State Hospital*, 677 F.2d 1271, 1272 (9th Cir. 1981); see, also, *Carmi v. Metropolitan St. Louis Sewer District*, 620 F.2d 672, 674–675 (8th Cir. 1980), *cert. den'd*, 101 S. Ct. 249 (1980) . . .
>
> As there is no legal authority supporting the proposition that the Rehabilitation Act of 1973 applies to hospitals receiving Medicare and Medicaid funds since the primary objective of those programs is *not* employment; the proposed rules must be withdrawn.

Response

The Federation's legal argument is incorrect. The *Tragesar/Carmi/Cabrini Scanlon* line of cases holds that section 504 does not provide jurisdiction *over employment practices of recipients* unless the Federal financial assistance has the primary objective of providing employment. These cases held that section 505(a)(2) of the Rehabilitation Act, making the "remedies, procedures, and rights set forth in title VI of the Civil Rights Act of 1964" applicable to section 504, incorporated the restriction in section 604 of the Civil Rights Act of 1964, which makes title VI inapplicable to employment practices unless the Federal financial assistance has the primary objective of providing employment. Two circuit courts have recently held that the reference to title VI procedures in section 505 did not intend to incorporate the employment restriction. *Jones* v. *Metropolitan Atlanta Rapid Transit Authority*, 681 F.2d 1376 (11th Cir. 1982), *petition for cert. pending*, No. 82–1159 (filed January 11, 1983); *LeStrange* v. *Consolidated Rail Corporation*, 687 F.2d 767 (3d Cir. 1982), *cert. granted*. The Supreme Court is expected to decide this issue during its present term.

Regardless of the merits of that issue, it has no relevance to the final rules. No case has held, as none could based on the clear statutory language and congressional intent of section 504, that section 504 applies only to a very narrow segment of employment practices, and has no applicability to the provision of services and benefits under programs and activities receiving Federal financial assistance.

B. ENFORCEMENT PROCESSES

A prior section of this preamble discusses investigative procedures of the Department applicable in the context of health care for handicapped infants and an analysis of related comments. This section discusses other comments pertinent to this issue.

Sanction for Non-Compliance

A number of commenters stated objections to the sanction for non-compliance, termination of Federal financial assistance. The basic thrust of these comments was that termination of all or a portion of a hospital's Federal financial assistance would be unfair in the context of difficult treatment decisions, later judged by HHS to be in non-compliance with section 504. As stated by the American Hospital Association:

> The penalty for even inadvertent violation would be severe. The Department asserts authority and threatens to terminate all federal financial assistance that the individual or institution may be receiving. Moreover, the threat of such penalties may encourage physicians and others to refuse to participate in programs funded by the Federal government, particularly those supporting specialized treatment facilities for the newborn. In cases where the institution depends for operation on significant federal funds unrelated to handicaps, this policy may, for example, cause the closing of neonatal units to avoid the risk of losing federal funds. Such a result could reduce access to needed care for many infants who could be helped with safe, timely and effective treatment.

Response

It is correct that under the law, non-compliance with section 504 can result in termination of Federal financial assistance to the particular program or activity, or part thereof, in which the noncompliance has been found. However, the existing procedural and legal requirements applicable to any action to terminate Federal financial assistance are more than adequate to protect against an unfair result.

The Rehabilitation Act provides, in section 505(a)(2), that the remedies, procedures and rights set forth in title VI of the Civil Rights Act of 1964 shall be applicable to actions to enforce section 504. These title VI procedures provide substantial due process protections.

First, before Federal financial assistance can be terminated, the

recipient must have an opportunity for a hearing before a court or administrative law judge, who must expressly find that there has been a failure to comply with the law or applicable regulations.

Second, before Federal financial assistance can be terminated, their must be a finding that compliance cannot be secured by voluntary means. Therefore, a recipient that has been found to have violated section 504 in connection with the health care provided to a handicapped infant will not lose its Federal funding unless it refuses to adopt the standards or procedures necessary to prevent future noncompliance.

Third, in any case, the burden of proof that there has been noncompliance and that it cannot be corrected by voluntary means is on the government. The standards for this determination are those set forth in the appendix to the final rules which includes the guideline regarding deference to reasonable medical judgments.

Fourth, the Department's regulations provide for appeal of adverse administrative law judge decisions to the Department's Civil Rights Reviewing Authority, which is independent from the Office for Civil Rights. Recipients may then seek review by the Secretary of the decisions of the Reviewing Authority. Further, the Department's final decision is subject to judicial review.

Therefore, there is no basis for an assertion that Federal financial assistance can be precipitously terminated on the basis of some subjective determinations by a handful of bureaucrats. In fact, due primarily to the statutory requirement that recipients be given full opportunity to voluntarily comply, the chance, based on all prior governmental experience under title VI and the statutes modeled after it, that any recipient will actually lose its Federal financial assistance is rather remote.

OCR Investigations at Strong Memorial Hospital and Vanderbilt University Hospital

In support of criticisms of OCR investigations, a number of commenters cited reports of hospitals which were subjects of OCR investigations at the time the interim final rule was put into effect in March. As stated by the American Hospital Association:

> The mischief of the federal hotline enforcement machanism was illustrated graphically during the short life of the March rule by the occurrances at Vanderbilt University Hospital in Nashville and Strong Memorial Hospital in Rochester, NY. In the Vanderbilt case, an anonymous hotline caller alleged that ten named children at the hospital were not being fed or given proper medical care. A federal "Baby Doe squad" (consisting of lay officials from the regional and national staffs of the Office of Civil Rights and a hired neonatologist) arrived at the hospital that evening and met with the attending physicians for each of the children, the chief of pediatrics, the chief pediatric resident, and the associate director for nursing, after which the neonatologist examined each child. On the following day, the investigative team examined medical records and interviewed nursing staff, hospital administrators, and the chief of pediatrics.
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> [The investigation] resulted in the delayed discharge of one patient, delayed the transporting of children to scheduled surgery, necessitated the re-ordering of laboratory reports, diverted nurses from patient assignments, delayed nursing shift reports, and consumed, in total, substantial amounts of professional time that otherwise would have been devoted to the care of patients, including the infants who were the subjects of the investigation.
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> The Strong Memorial experience was strikingly similar and even more disturbing. An unidentified hotline caller, whose only information concerning the case apparently came from a newspaper report, triggered an investigation regarding the treatment of conjoined twins in that facility. An identically constituted investigative squad arrived at the hospital, though without any statement of investigative authority or written requests for hospital records. The hospital complied nonetheless with the investigators' requests, only to have the team disagree as to which of them was entitled to the information. The neonatologist member of the team subsequently departed upon learning that the investigators had failed to obtain the parents' consent to examine the infants.
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> The effects of the investigation in this case went well beyond the diversion of patient care resources and delays in treatment. The parents of the conjoined infants were subjected to substantial undesired publicity. Parents of other critically-ill children were led by this publicity and the lack of clarification from federal investigators to become apprehensive about the adequacy of care provided at Strong Memorial. Before the investigation concluded, one family removed its seriously-ill child from the facility prior to the completion of treatment, on the belief that the hospital was intentionally harming children.

Response

The Department strongly disputes the accounts of these investigations provided by personnel affiliated with the two hospitals. The reports referenced by commenters appear to be based upon affidavits prepared in connection with litigation initiated by the American Hospital Association challenging the implementation of the March interim final rule. Contrary to these reports, both of these investigations were conducted very expeditiously and professionally, and every effort was made to minimize any disruption to the hospitals. In addition, during the course of these investigations (and prior to their being raised in the litigation), officials of neither hospital complained to OCR regarding the conduct of the investigations, nor, in either case, did hospital personnel complain to OCR personnel that the investigations were causing significant disruptions to the patient care activities of the hospital.

With respect to the Strong Memorial Hospital case, the following are the pertinent facts of the investigation:

a. On the morning of March 29, 1983 (seven days after the effective date of the interim final rule), a complaint was received on the hotline about conjoined infants recently born at Strong Memorial Hospital in Rochester, New York.

b. An investigative team consisting of one investigator from the Washington Office and two from the New York Regional Office was sent to the site to investigate. The team arrived at approximately 4:30 p.m. Arrangements were made to have a medical consultant also travel to the site.

c. The team met with a hospital administrative officer and the attending physician. The attending physician reviewed the infants' condition and status. He mentioned that there was a no-resuscitation order in effect for the twins, should cardiac arrest occur.

d. The attending physician told OCR that the parents were concerned about publicity. OCR assured him that OCR would not discuss the case with the media or otherwise publicize OCR's investigation.

e. The OCR team made no request to interview other staff at that time. The administrator produced a copy of the medical records. The Washington Office investigator received it and said it would not be necessary to produce another copy for the Regional Office. Throughout the investigation, the administrator and attending physician were cooperative and helpful. The attending physician asked the team leader to tell the OCR medical consultant that he could be called late and would be glad to come to the hospital and meet with him, show him the medical records, and let him view the infant. The administrator asked to be called when the medical consultant arrived. The OCR team left the hospital at about 7:30 p.m.

f. The OCR medical consultant arrived in Rochester about 9:15 p.m. and met with the investigative team. Apparently based on a misimpression of his role, the consultant stated he would not review

the records or go to the hospital to meet with the physician or view the infants unless the parents consented.

g. On the morning of March 30, 1983, the OCR team and the OCR medical consultant had a telephone conversation with the administrator. He said that he wished the OCR team would not return to the hospital because that investigation was receiving publicity. The team leader decided there was no need to return to the hospital.

h. In summary, the investigative team was on site only three hours in the late afternoon and early evening of March 29.

With respect to Vanderbilt University Hospital, following are the pertinent facts of the case:

a. OCR received a hotline telephone call at 11:45 a.m. on March 23, 1983 (the day after the effective date of the interim final rule), alleging that ten infants at Vanderbilt University Hospital were not receiving treatment and/or nourishment.

b. From 9:30 p.m. to 11:45 p.m. on March 23, 1983, the OCR investigative team, consisting of two investigators from the Atlanta Regional Office, one from the Washington Office, and the OCR medical consultant, met with various members of the hospital staff to discuss the current status of the ten infants.

c. After this meeting, from midnight until 12:30 a.m., the OCR medical consultant physically viewed the infants on the regularly scheduled "rounds" in the company of the Chief Pediatric Resident and the Chief of Pediatrics.

d. From 8:00 a.m. until 2:45 p.m. on March 24, 1983, the OCR investigators and medical consultant reviewed the available medical records of the ten children. Medical records were given to OCR in groups of four and retrieved as needed by the Associate Director of Nursing and other members of the Vanderbilt staff. The Associate Director of Nursing and the hospital staff members were very cooperative, and at no time did they indicate to the investigative team that the review of records was causing any problem. In only one instance did they indicate they needed a chart, and OCR immediately relinquished it. That chart was not subsequently made available for review that day, but a copy of it was mailed to OCR.f

e. All records were reviewed with the understanding that if they were needed for patient care they would be retrieved. Computer printouts detailing the admitting diagnosis, age, physician assigned to the case, service area, and the date of admission or transfer for all ten children were given to the OCR team. The Associate Director of Nursing stated that this printout was readily available because the information was kept on-line for billing purposes and this would not interfere with patient care. The bedside charts were copied and given to OCR at the end of day because they were needed for patient care.

f. Following the OCR review of the medical records, from approximately 2:45 p.m. to 4:00 p.m. on March 24, 1983, the OCR team interviewed the available nurses who were involved in the primary care of the infants. Five nurses were interviewed for approximately 10 to 15 minutes each. The selection of the nurses was left to the discretion of the Associate Director of Nursing; she scheduled them so that patient care would not be disrupted.

g. At no time did the Chief of Pediatrics or Associate Director of Nursing indicate that the OCR investigation was placing patients in jeopardy.

h. The hospital staff asked the OCR team for a preliminary statement of findings. The team leader responded that OCR investigators are not authorized to make findings during an investigation. An investigative report would have to be prepared following the investigation, and this would have to be reviewed before the agency could issue findings.

i. The total time spent on-site to investigate the circumstances relating to all ten infants was approximately eleven hours. The total time occupied of the two Vanderbilt doctors directly involved was seven and one-half hours. Every effort was made to minimize any disruption, and at no time during the investigation did hospital personnel complain to OCR that the investigation was disrupting patient care.

Therefore, contrary to the reports of hospital officials, prepared to support litigation against the Department, these investigations were conducted professionally and every effort was make to minimize any disruptions.

Concerning the report that, according to a hospital official, one family withdrew a seriously ill patient from the Strong Memorial Hospital before completion of treatment due to fears that the hospital was intentionally harming children, caused by their reading of local newspaper accounts of the investigation, the report provided no further details, and the department has no basis to confirm the event or the motivations for it. However, the firm policy of not commenting to the media regarding an open investigation was adhered to strictly in the Strong Memorial Hospital case. Media attention was not provoked by OCR, nor did OCR make any statement to the media which could have implied any belief by OCR that the allegations of the complaint were substantiated.

Danger of Overtreatment

Several Commenters expressed the concern that the existence of OCR's enforcement process would cause hospitals and health care professionals to "overtreat" an infant. An example of this is a case in which the attending physician or physicians have concluded on the basis of reasonable medical judgment that treatment would be futile, but, due to a fear that an OCR investigation might come to a contrary conclusion, nevertheless provide futile treatment, which, while prolonging the process of dying, causes suffering to the infant and severe distress to the infant's parents. In connection with adverse ramifications of overtreatment, attention was called to the experiences of one family, as presented in a recent book, *The Long Dying of Baby Andrew* (Little, Brown and Co., Boston, 1983).

Response

The Department believes that whatever the dangers are that physician misjudgments will lead to "overtreatment" of infants, those dangers are not increased by the existence of section 504 or the determination of the Department to see that it is effectively enforced. As indicated above, section 504 does not require that futile treatments, which will do no more than prolong the act of dying, be provided. Moreover, OCR decisions concerning compliance or noncompliance with section 504, informed by the expert evaluation of qualified medical consultants, do not interfere with reasonable medical judgments. Also, in any case, reviewing whether certain care was medically indicated and denied on the basis of the infant's handicap, there are extensive due process protections to assure accuracy of fact finding. Furthermore, even where there is an ultimate finding, after exhaustion of all due process rights, of noncompliance of section 504, no sanction can be implemented unless the recipient hospital refuses to adopt procedures to bring it into compliance.

The Department agrees that in a "close case" it may be prudent to preserve the status quo pending additional consideration regarding whether certain possible treatments are medically indicated, whether that additional consideration is by specialists at the hospital, by medical professionals at a more specialized facility, by some internal hospital

review board, or by some state or federal agency. In such a case, the usual practice in most hospitals likely would be to continue life-sustaining care until the appropriate analysis has been secured.

C. ALTERNATIVE APPROACHES

In addition to proposals discussed in the preamble concerning establishment of Infant Care Review Committees, the Department received other suggested alternative approaches.

AMA Proposal: Further Study Prior to Action

The American Medical Association proposed that, rather than adopting any regulation, the Department should initiate a study to include: compilation of data on the incidences of each type of severe impairment in newborns and of successful treatment, unsuccessful treatment and nontreatment in each category; identification of the issues involved in medical management and of mechanisms currently used by hospitals and states; determination of the availability of facilities, financial resources, and public and private social services; and an assessment of the impact of the various alternative means of responding to situations involving severely impaired newborns, including such factors as the ongoing treatment of newborns, the families of severely impaired newborns, the operation of health care facilities, the confidentiality of patient-physician relationship, the malpractice and disciplinary risks of health care providers, the availability of facilities and resources, and the costs of care.

Response

The AMA's proposal for an elaborate study prior to taking any action concerning this matter is not acceptable to the Department. The Department does not believe it is necessary—or in some respects, even possible—to generate definitive data, information or conclusions on many of the issues identified in the AMA's study proposal.

Much of the data the AMA proposes be compiled concerning the incidence rates of every classification and degree of serious impairment, of respective modes of treatment, of rates of success, nonsuccess and nontreatment, and of issues, mechanisms, resources and costs is probably impossible to compile. These matters are the subject of an entire discipline of medical practice and study To suggest that a government study will somehow generate conclusive information on these issues appears naive at best

The call for a study of the resources available and the costs of care for newborns appears aimed at identifying an aggregate cost to society of putting into practice the principle of providing all handicapped infants with medically beneficial treatment. Because there are no reliable data available on the extent to which handicapped infants are now denied medically beneficial treatment, it would apear impossible to develop even reasonable guesses regarding aggregate costs. Of course, in the overall context of all health care expenditures in the United States, the costs are certain to be relatively small.

In question 6 included in the preamble to the July 5 proposed rule the Department sought input on this cost issue by asking for "examples of cases where medically indicated treatment would, but for the legal requirements of section 504, be withheld." No information was submitted to the Department in response to this question which provides a basis for meaningful cost projections. Although the AMA did not address the issue, other major medical organizations who commented on the cost issue indicated that cost should not be a determinative factor in deciding upon treatment for seriously impaired newborns.

The Department agrees there is utility in assessing the impact of various alternative means of addressing and responding to situations involving severely impaired newborns. Much of this preamble focuses on precisely this issue. Although the AMA did not identify the "various alternative means" it believes to exist to deal with this issue, based on the comments received by the Department, there would appear to be three major approaches: (1) Enforcement of section 504 (hereinafter "the section 504 approach"); (2) review by hospital review boards, such as Infant Care Review Committees (hereinafter "ICRC approach"); and (3) the traditional doctor-parent approach.

Concerning impact on treatment of newborns, the section 504 approach is most directly focused on the provision of medically beneficial treatment. The ICRC approach would be organized to have this as its objective, but lacks a mechanism to assure this as a relatively uniform result among thousands of hospitals. The connection between actual practice and this objective appears most potentially attenuated under the traditional doctor-parent approach, under which there are many thousands of individual decisionmaking units.

With respect to the impact on families to the extent some parents would not consent to medically beneficial treatment, the traditional doctor-parent approach would appear least likely, given the lack of a mechanism to facilitate uniformity, to resort to the system provided by State law to review the propriety of parental decisions. The ICRC approach appears more likely, and the section 504 approach most likely, to produce this result in that they incorporate standards that the lack of parental consent for medically beneficial treatment must be brought to the attention of the appropriate state agencies.

Concerning the impact on the operation of health care facilities, the traditional doctor-parent approach would appear to have the least impact because the facilities have no formalized involvement in the decisionmaking process. Both the section 504 approach and the ICRC aproach would likely result in greater involvement of the health care facility.

With respect to the confidentiality of patient-physician relationships, the traditional physician-parent approach is most protective of confidentiality in that it does not provide for the sharing of information with others. Both the section 504 approach and ICRC approach involve the sharing of information with others, but both incorporate adequate confidentiality safeguards.

With respect to the impact on malpractice and disciplinary risks (assuming that by disciplinary risks, the AMA is referring to revocation of medical licenses, or the like) of health care providers, to the extent physicians have malpractice or disciplinary vulnerabilites relating to incorrect diagnoses or inadequate knowledge of prevailing medical judgments regarding indicated treatments, approaches which facilitate the avoidance of failure to provide medically indicated treatment would appear to reduce those vulnerabilities. Because none of the approaches involve doctors or hospitals overruling parental decisions, and because reports to State agencies of suspected instances of neglect of children are immunized by state law from legal vulnerability, none appear to increase malpractice or disciplinary risks in the context of actions which would be taken when parents refuse consent for medically beneficial treatment.

With respect to the impact on costs, available resources, and available facilities, to the extent the different approaches affect the likelihood that handicapped infants will receive medically indicated treatment, these factors will be correspondingly affected

However, the Department is unaware of any data base for quantifying these factors.

In summary, the Department believes adequate information is on the record to provide a basis for prudent and informed decisions on this issue. Regarding several of the issues raised by the AMA proposal, the Department agrees there would be advantages in having more detailed information and data. However, obtaining more definitive information on some of these issues is impracticable or impossible due to the lack of a reliable data base and a viable methodology to obtain better data. Therefore, the Department believes there would be very little to be gained from another government study of this issue.

D. FACTUAL BASIS FOR FINAL RULES

NPRM Explanation

A number of commenters challenged the Department's factual basis for the proposed rule, as set forth in the July 5 notice of proposed rulemaking. The points argued in support of the position that the factual basis did not provide a sufficient foundation for the regulation were:

(a) Judge Gesell questioned the factual basis for the March 7 rule.

(b) The 1973 article by Drs. Duff and Campbell of the Yale New-Haven Hospital documenting that of 299 consecutive deaths occurring in that special care nursery, 45 (14%) were related to withholding treatment, cited in the preamble to the proposed rule, was too old to be reliable.

(c) The several specific cases cited in the preamble had various probativity defects.

(d) The 1977 article reporting the results of a survey of pediatricians suggesting discriminatory attitudes was outdated, not statistically valid, and otherwise lacked current probative value.

(e) The findings of the report of the President's Commission for Study of Ethical Problems in Medicine and Biomedical and Behavioral Research entitled *Deciding to Forego Life-Sustaining Treatment* contradict the Department's factual basis.

(f) Because "discrimination against the handicapped in the delivery of health care services does not only involve handicapped newborns," there is "no compelling rationale for a set of rules targeted solely at this population."

Response

The Department continues to believe that a substantial factual basis exists for the proposed rule. First, it should be noted that Judge Gesell, although he found many relevant factors to have been inadequately considered in connection with issuance of the March 7 rule, did not find the factual basis inadequate to support "undertaking a regulatory approach to the problem of how newborns should be treated in government-financed hospitals."

Second, the arguments that the well-documented Duff and Campbell study is outdated are based on the personal opinions of several commenters. These personal opinions, although in some cases those of highly-respected medical professionals, were not backed up by any empirical data even remotely resembling the very detailed evidence of the Duff and Campbell study.

Third, the conclusion of the President's Commission that decision-making about seriously ill newborns "usually adheres" to proper standards cannot be fairly represented as evidence that handicapped newborns should be exempt from basic protections of the law prohibiting discrimination on the basis of the handicap.

Fourth, regardless of the caveats concerning the age of particular cases or the lack of a conclusive finding of illegal discrimination, the several specific cases cited in the preamble to the proposed rule support the proposition that handicapped infants may be subjected to unlawful discrimination.

Fifth, in the absence of any empirical studies or data to bolster their personal opinions, the commenters who suggested that the results, published in 1977, of the survey of pediatricians' attitudes are outdated are not convincing. The article, "Ethical Issues in Pediatric Surgery: A National Survey of Pediatricians and Pediatric Surgeons," 60 *Pediatrics* 588, reported the results of a survey of 400 members of the Surgical Section of the American Academy of Pediatrics and an additional 308 chairpersons of teaching departments of pediatrics and chiefs of divisions of neonatology and genetics in departments of pediatrics. Responses were received from 267 of the former group (66.8%) and 190 of the latter (61.7%). Responses were anonymous. Among the results of the survey were:

—76.8% of the pediatric surgeons and 49.5% of the pediatricians said they would "acquiesce in parents' decision to refuse consent for surgery in a newborn with intestinal atresia if the infant also had Down's syndrome."

—23.6% of pediatric surgeons and 13.2% of pediatricians would *encourage* parents to refuse consent for treatment of a newborn with intestinal atresia and Down's syndrome. Only 3.4% of pediatric surgeons and 15.8% of pediatricians would get a court order directing surgery if the parents refused.

—63.3% of the pediatric surgeons and 42.6% of the pediatricians said in cases of infants with duodenal atresia and Down's syndrome, where they "accept parental withholding of lifesaving surgery," they would also "stop all supportive treatment including intravenous fluids and nasal gastric suction."

—62% of all respondents who believe that children with Down's syndrome "are capable of being useful and bringing love and happiness into the home" would nevertheless acquiesce in parents' decisions not to allow surgery for the atresia. Only 7% who so believe indicate that they would go to court to require surgery.

Sixth, there is no requirement in law or policy for the government to prove the magnitude of illegality before establishing basic mechanisms to allow for effective enforcement of a clearly applicable statute.

Evidence of Problems Submitted by Commenters

Additional evidence of the risk that handicapped infants may be subjected to discrimination was submitted by commenters. For example, the Spina Bifida Association of America stated:

> Unfortunately, the SBAA has direct experience of cases in which this principle [of nondiscrimination] has not been followed—instances in which children with spina bifida have been initially denied appropriate treatment. Pediatric neurosurgeon Dr. David McClone of Chicago Children's Memorial Hospital, a member of SBAA's Professional Advisory Committee, has found that 5% of the children with spina bifida referred to him have been victims of treatment denial. Most of these cases, he believes, resulted from ignorance of current therapies and their impressive outcomes.

The Department received a number of comments from practicing nurses regarding the problem and need for the proposed rule. For example, from a Lexington, Kentucky, nurse:

> I am a registered nurse and have worked in the labor and delivery area, newborn nursery and intensive care nursery. . . . I think the average American would be shocked at the decisions that are made regarding "non-perfect" infants. I have personally heard physicians and nurses talk to new parents about their child and persuade the parents to "let the child die and therefore end its suffering"—which really meant "let us starve your child to death"—that is certainly not a humane way to "let a child die."

A nurse in Boca Raton, Florida wrote:

> I am an RN with a speciality in maternal-child health. In the past few years I have had to witness the deaths of innocent children in hospitals where a decision was

made not to continue with medical care and assistance.

Another nurse wrote:

As a nurse (RN) in a neonatal ICU, I feel compelled to write and voice my support of the "Baby Doe rule" now proposed. . . . Many doctors and nurses openly support withholding or withdrawing medical care. . . . Due to the ethics of the medical director of the unit, this has only been done once or twice to my knowledge. I would report any cases of neglect I knew of if this number and service were available. . . . An outside third party is needed to police the cases. Please allow some method of reporting and investigating these babies' cases to be available.

From a nurse in San Diego, California came the following comment:

[A]s a practicing registered nurse myself, I believe such regulations permit nurses and staff to act in a patient's best interest—life itself!—without fear of harrassment and possible job loss.

In addition, some commenters who opposed the proposed rule appeared to acknowledge that there is a risk that handicapped infants will not receive medically beneficial treatment. For example, the American Society of Law and Medicine, a national, nonprofit professional association, stated:

There can be no question that some decisions to end life-sustaining care for newborns have been made inappropriately, even if the frequency of this problem has not been established.

Another example of this is the comment by the chairman of the division of pediatrics of a hospital in Illinois:

We are acutely aware that handicapped individuals (*not* must handicapped newborns) are systematically discriminated against in our society. We are also acutely aware that we, like virtually all members of our society, are guilty of having prejudicial beliefs and attitudes about the handicapped. That pediatricians and other health care providers have acted on these negative beliefs and attitudes should come as no surprise. That parents, at least in the initial phase of their relationship with a handicapped newborn, should wish to be spared what is perceived as a burden or even wish that the infant had never been born should come as no shock.

* * * * *

We wholeheartedly agree that in the past these obviously critically important decisions have not been accorded the degree of reflection and care they are due. Given the wide range of possible technological interventions now possible; given the changing conception of the appropriate role of physician and parents in such decisions; and given the need for public accountability for such decisions—we support the idea that the manner in which such decisions have been made in the past needs critical re-examination.

Another example is the comment of the American Academy of Pediatrics:

The traditional method of a single physician making such judgment [regarding treatment], without exposure to other persons having additional facts, experience, and points of view, may lead to decisions, which, in retrospect, cannot be justified.

Response

The Department believes these comments provide additional support for the Department's conclusions that available evidence indicates there are cases in which handicapped infants are at risk of having life-sustaining, nourishment or medically beneficial treatment withheld solely on the basis of their present or anticipated physical or mental impairments, and that this evidence constitutes a substantial foundation for the establishment of basic procedural mechanisms to facilitate enforcement of section 504.

OCR Investigations to Date

Another argument made by a number of commenters to support criticisms of the adequacy of the factual basis for the proposed rule was that the experience of the Office for Civil Rights to date in connection with section 504 enforcement activities relating to health care for handicapped infants indicate there is no significant evidence of a problem that the rule could reasonably be designed to deal with. As stated by the American Hospital Association:

The total absence of verifiable violations, notwithstanding hundreds of hotline calls, also compels the conclusion that either this mechanism is not an effective means to meet any alleged need or, as we believe to be the case, the violations that have been described are not occurring. In either case, a federal regulation is unnecessary.

Response

Rather than support the argument that there is no need for section 504 applicability or enforcement in connection with health care for handicapped infants, the OCR experience to date provides additional evidence that the assumption that handicapped infants will receive medically beneficial treatment is not always justified.

First, it must be noted that the vast majority of the several hundred calls made to the Department were not for the purpose of reporting suspected violations of section 504. Rather, the vast majority of calls were for administrative purposes, such as hospital officials asking questions about the provisions of the March interim final rule, individuals acting on their apparent curiosity to see if anyone would answer the telephone, and other peripheral matters. It should also be noted that the Department's experience under the interim final rule does not provide an adequate basis to make conclusive judgements in any direction because the rule was only in effect for about three weeks, from March 22 until April 14, the day Judge Gesell declared it invalid.

Following is a summary of the Infant Doe cases handled to date, and current as of December 1, 1983.

1. *Bloomington, Indiana.* Investigation into April 1982, death of infant with Down's syndrome and esophageal atresia from whom surgery was withheld on the instructions of the parents. An investigation, delayed due to difficulties in obtaining information sealed by court order, has been conducted. Final administrative action has not yet been taken.

2. *Robinson, Illinois.* May 14, 1982 complaint that hospital (at the parents' request) failed to perform necessary surgery on an infant born with myelomeningocele. Prompt on-site investigation was conducted, involving OCR, the Justice Department and the state child protective services agency. The parents refused consent for surgery; the hospital referred the matter to state authorities, who accepted custody of the infant and arranged for surgery and adoption. The care provided to the infant while these actions were taken was in compliance with section 504. Finding: no violation.

3. *Madison, Wisconsin.* May 7, 1982, complaint that two infant survivors of abortions may have been denied treatment. On-site investigation revealed that two infants, of 26 and 22 weeks gestation, were born alive following abortions; life-saving procedures were applied: neither infant could survive due to extreme prematurity. Finding: no violation.

4. *Kettering, Ohio.* July 26, 1982, complaint that an infant with spina bifida and hydrocephalus was not being treated. Immediate on-site investigation revealed that surgery to correct the spina bifida condition was not performed immediately because the infant had medical complications. Surgery was performed after the infant's condition stabilized. The hospital provided all proper treatment. Finding: no violation.

5. *Barrington, Illinois.* September 17, 1982, complaint that a multi-handicapped infant was not receiving needed treatment. Immediate on-site investigation determined that given the nature and severity of the problems, there were no procedures or services which could have been provided which might have changed or otherwise

influenced the outcome for this infant, who died for days after birth. Finding: no violation.

6. *New Haven, Connecticut.* October 12, 1982, complaint (referred from the Department of Justice) that hospital engaged in a pattern and practice of denying medical treatment to handicapped infants. The complaint was included in a compliance review, already in progress. The investigation has been expanded to include several cases involving other Connecticut hospitals. The investigation, which has included review of hundreds of medical files, has not been completed.

7. *Tulsa, Oklahoma.* December 7, 1982, complaint that a baby was being deliberately dehydrated. Immediate on-site investigation determined that the infant had hydranencephaly (complete or almost complete absence of cerebral hemispheres) and transposition of the great vessels (reversal of main vessels into heart); notwithstanding all proper care, the severity of the anomalies made the prognosis very pessimistic. Finding: no violation.

8. *Duarte, California.* January 10, 1983, complaint that the hospital denied the complainant's son admission to the hospital for a bone marrow transplant solely because of his handicapping condition, Down's syndrome. An investigation has been conducted. Administrative action has not been completed.

9. *Austin, Texas.* January 17, 1983, complaint that newborn babies with serious birth defects have not received proper care. An investigation has been conducted. Administrative action has not been completed.

10. *Lansing, Michigan.* January 24, 1983, complaint that a handicapped infant born to a surrogate mother was treated for a streptococci infection over the objections of the father who had told the hospital not to care for the child. OCR inquiry determined the hospital took immediate steps to obtain an appropriate court order to assure that needed treatment was provided, notwithstanding objections from the father. Finding: no violation.

11. *San Antonio, Texas.* March 2, 1983, complaint that deaths of a number of infants at two hospitals may have been related to discriminatory withholding of care. OCR investigation postponed at request of District Attorney assisting in grand jury criminal investigation.

12. *Houston, Texas.* March 10, 1983, complaint that five infants were denied proper care in a neonatal intensive care unit. The investigation has not been completed.

13. *Jackson, Michigan.* March 14, 1983, complaint from a mother that her son, who had Down's syndrome, died as a result of improper treatment. An investigation has been conducted. Administrative action not completed.

14. *Odessa, Texas.* March 18, 1983, hotline complaint that the hospital had failed to provide adequate medical care to a premature infant who died in 1982. On-site investigation and review of medical records by OCR medical consultant found that the infant, born March 18, 1982, after a 25–26-week gestation period, suffered from extreme immaturity, and died March 20, 1982. Finding: no violation.

15. *Nashville, Tennessee.* March 22, 1983, hotline complaint that an infant had been denied sustenance for three days. Immediate contact revealed the infant was not a patient at the facility and the alleged attending physician was not a member of the attending or resident medical staff. This was verified by the patient census data, the facility's physician roster, and contact with the county medical society. This case was administratively closed due to an insufficient complaint.

16. *Nashville, Tennessee.* March 22, 1983, anonumous hotline complaint that 10 childern were not receiving adequate medical treatment. Immediate on-site investigation, including an OCR medical consultant, determined that no child was in imminent danger; all children were receiving nutritional sustenance; and all children were receiving proper care. Finding: no violation.

17. *Fayette, Alabama.* March 22, 1983, anonymous hotline complaint that a handicapped infant was denied nourishment and allowed to die in an Alabama hospital in December 1982. The caller could provide no other information. Investigation has been conducted. Administrative action awaiting report from medical consultant.

18. *Waxahachie, Texas.* March 23, 1983, anonymous hotline complaint that between Christmas and February, a premature infant was denied treatment and allowed to die at a hospital in Texas. An investigation has been conducted. Administrative action not yet completed.

19. *Baltimore, Maryland.* March 23, 1983, hotline complaint that a premature infant was not being provided nourishment and heat. An immediate on-site investigation determined that the infant, weight 1 lb., ½ ounce at birth, was previable; the infant died several hours after birth; the infant had no congenital malformations or anomalies. Final administrative action on this case has not yet been taken.

20. *Newark, New Jersey.* March 27, 1983, anonmous hotline complaint that a premature infant, born as a result of a third trimester abortion, was not receiving adequate care. Immediate on-site investigation reveled that the premature infant weighed about 700 grams, and showed few signs of life. The infant was aggressively resuscitated, placed on intravenous feeding, and provided other life supporting treatment. Appropriate care was being provided. Finding: no violation.

21. *Rochester, New York.* March 29, 1983, hotline complaint that Siamese twin infants were being denied treatment. Immediate on-site investigation determined that a team specialists examined the infants and concluded the conjoined female infant would not survive any attempt to separate them. Full intensive care was provided. The infants were placed on a respirator and given antibiotics, fluid and the necessary nutrition. At the time of the on-site, March 29, 1983, it was determined that there was no basis for seeking emergency remedial action. Final administrative action has not yet been completed.

22. *Seattle., Washington.* March 30, 1983, hotline complaint that an infant was being denied food and water and would not live much longer than a day or two. The caller had no identifying or other information. Immediate on-site inquiry determined there were no infants at the facility meeting the description of the complaint. The case was administratively closed due to insufficient complaint.

23. *Miami, Florida.* April 4, 1983, hotline complaint alleging (based upon information in the newspaper) parents of a premature infant and the attending physician decided not to allow the infant to be resuscitated. Immediate inquiry determined the infant had died prior to receipt of the complaint. The premature infant had multiple catastrophic conditions, including complete liquefaction of the brain. Final administrative action awaiting report of medical consultant.

24. *Decatur, Alabama.* April 6, 1983, hotline complaint from a parent that her child's condition was misdiagnosed by a particular physician during a 2½ year period. Inquiry determined that the child suffers from food allergies; the prognosis is excellent, the child at one time was believed, apparently erroneously, to be retarded. This case was administratively closed because the inquiry failed to reveal ilnformation suggesting a possible violation of section 504.

25. *Melrose Park, Illinois.* April 8, 1983, anonymous hotlilne complaint. The caller provided no details concerning the infant's condition or treatment.

Immediate telephone inquiry discovered no information to suggest a section 504 violation. This case was administratively closed due to an insufficient complaint.

26. *Charlotte, North Carolina.* April 10, 1983, hotline complaint that a premature infant died in July 1979 due to withholding of treatment. The caller could not provide any other information. Due to the length of time since the alleged discriminatory act and the lack of specific information, this case was administratively closed due to an insufficient complaint.

27. *Hyde Park, New York.* April 13, 1983, anonymous hotline complaint that the hospital would have let a baby with Down's syndrome die if the parents had not been aggressive and insisted on care being provided. The caller could provide no identifying information. This case was administratively closed due to an insufficient complaint.

28. *Coquille, Oregon.* April 13, 1983, hotline complaint that parents of a handicapped infant and the attending physician were going to withhold all treatment. Immediate on-site investigation, including medical consultant's review of medical records, determined the infant had a severe congenital central nervous system defect incompatible with life and not amenable to surgical correction; hospital provided supportive care and attempted to provide fluid orally, but did not attempt to provide intravenous fluids or arrange immediate transfer to a tertiary level neonatal intensive care unit for more specialized evaluations. The OCR medical consultant and the specialists at the tertiary care facility to which the infant was transferred three days after birth concluded that no course of treatment which was available would have avoided imminent death of this infant; the most that could have been expected from more aggressive care would have been to prolong the act of dying. The infant died 10 days after birth. Finding: no violation.

29. *Athens, Tennessee.* April 18, 1983, anonymous hotline complaint that an infant born at 28 weeks gestation was denied treatment and nourishment and allowed to die at a Tennessee hospital. The caller could give no identifying information. Investigation has been conducted. Administrative action awaiting report of medical consultant.

30. *Shreveport, Louisiana.* April 20, 1983, hotline complaint that a particular physician at the hospital certified three infants born alive as stillborn and refused to provide care to another infant. Investigation, including medical consultant review, found no medically beneficial treatment was withheld. Finding: no violation.

31. *Dayton, Ohio.* April 29, 1983, anonymous hotline complaint that an infant, identity unknown, weighing one pound and eight ounces was denied treatment and died. Inquiry revealed the deceased infant was premature (22 weeks gestation) and immature (organs were not developed); the infant had no anomalies; the hospital attempted to administer oxygen but the lungs were too small to function; no medically beneficial treatment was withheld. This case was administratively closed due to the lack of information suggesting possible violation of section 504.

32. *Los Angeles, California.* May 17, 1983, complaint that infant, believed stillborn, lived several hours and may not have received proper care. Administrative action has not been completed.

33. *Daytona Beach, Florida.* May 19, 1983, hotline complaint that an infant with spina bifida may not be receiving medical treatment. Immediate contact with hospital and state agency and prompt on-site investigation indicated that the parents did not consent to surgery for the infant; on May 18, eight days after birth, the state agency obtained a court order to provide surgery, which was performed May 22, 1983. An investigation has been conducted. Administrative action awaits report of medical consultant.

34. *Baton Rouge, Louisiana.* May 23, 1983, hotline complaint that medical services were denied a premature infant, who died soon after birth. Investigation has been conducted. Administrative action has not been completed.

35. *Colorado Springs, Colorado.* June 21, 1983, hotline complaint from a nurse that an infant with myelomeningocele and paralyzed vocal chords was being denied necessary surgery. Immediate on-site investigation indicated substantial uncertainty on whether treatment for the myelomeningocele would be provided immediately; physicians were providing nutrition and supportive care and were awaiting the results of several tests on the infant. During the afternoon, hospital personnel were advised that an on-site investigation would be initiated that evening; that the state child protective services agency would be asked to also investigate; and that OCR would notify the Justice Department of the investigation. Also during the afternoon, the OCR medical consultant discussed the case with the attending physician. That evening corrective surgery was performed on the myelomeningocele. Investigation, including review by medical consultant, determined that no medically beneficial treatment was withheld on the basis of the infant's handicap. Finding: no violation.

36. *Brooklyn, New York.* June 23, 1983, complaint that premature infant who died in 1981 did not receive proper care. An investigation was conducted. Administrative action awaits report of medical consultant.

37. *Atlanta, Georgia.* June 27, 1983, hotline complaint that an infant, identity unknown, born with multiple anomalies was in a life-threatening situation because the doctors were planning to cease treatment of the infant. On-site investigation, June 28, indicated the premature infant, who weighed 950 grams at birth, received aggressive treatment, but the prognosis was not optimistic. At the time of the on-site investigation, it was determined there was no basis to seek emergency remedial action. Final administrative action is awaiting written report from medical consultant.

38. *Medford, Oregon.* July 7, 1983, anonymous hotline complaint that two infants died in 1982 because of improper medical treatment. The investigation has not been completed.

39. *Pinehurst, North Carolina.* July 21, 1983, hotline complaint that a three-week old infant with spina bifida and hydrocephalus would not live if surgical treatment was not provided. Immediate inquiry determined the appropriate surgery was performed July 8, 1983. Final administrative action has not been concluded.

40. *San Francisco, California.* August 2, 1983, hotline complaint that an infant with a cleft palate and heart defect was allowed to die at a California hospital in May 1979. The caller stated that a malpractice lawsuit is pending. The investigation has not been completed.

41. *Falls Church, Virginia.* August 9, 1983, hotline complaint that a baby, identity unknown, with possible brain damage, no ears or eyes, would not be given nourishment. A meeting with hospital officials failed to identify an infant meeting the description given by the complainant. An infant with somewhat similar circumstances was described; no information concerning this infant suggested a lack of appropriate care. Complainant refused to accept OCR calls seeking further information. This case was administratively closed due to an insufficient complaint.

42. *Wichita, Kansas.* August 11, 1983, complaint that infant whose body was discovered at incinerator site may have been denied proper treatment. An investigation has been conducted.

Administrative action has not been completed.

43. *Lincoln, Nebraska.* August 25, 1983, hotline complaint that two premature infants did not receive appropriate care and died. The investigation has not been completed.

44. *Boynton Beach, Florida.* September 20, 1983, hotline complaint that two handicapped infants were allowed to die immediately following birth. The investigation has not been completed.

45. *Norfolk, Virginia.* September 21, 1983, complaint that infant born alive following an abortion was not being fed or treated. Inquiry determined infant died September 20, 1983. Final administrative action has not been completed.

46. *Boise, Idaho.* September 30, 1983, hotline complaint that an abandoned premature infant with no brain tissue might be withdrawn from life support. Immediate inquiry determined the State child protective services agency had obtained custody of the infant and had no plans to discontinue life support. Final administrative action has not been completed.

47. *Philadelphia, Pennsylvania.* October 16, 1983, hotline complaint that infant, age approximately six weeks, with spina bifida, who received surgery, was not receiving appropriate follow-up care. Inquiry initiated October 16. Decision made that circumstances did not suggest need for immediate remedial action. Final administrative action has not been completed.

48. *Long Island, New York.* October 19, 1983, complaint, based on newspaper article, that infant with spina bifida not receiving surgery due to refusal of parents to consent; legal proceedings has been initiated in State court. Inquiry initiated October 19. On October 27, HHS asked Department of Justice to commence legal action to overcome refusal of hospital to permit review of pertinent records. On November 2, legal action was commenced. On November 17, district court ruled against the government. Appeal filed November 18.

49. *Phoenix, Arizona.* November 7, 1983 anonymous hotline complaint that infant with spina bifida and other conditions not receiving surgery. Immediate inquiry initiated; records obtained; OCR medical consultant discussed case with attending physician and hospital review committee. Decision made not to refer case to Justice Department for emergency remedial action. Final administrative action not yet completed.

The Department believes three of these cases demonstrate the utility of the procedural mechanisms called for in the final rules. In the Robinson, Illinois case (listed as case 2, above), for example, the involvement of the state child protective services agency, working in cooperation with HHS and the Justice Department, was the most important element in bringing about corrective surgery for the infant. The state agency received a report from the hospital administrator pursuant to the state child protective services statute. Had there been no governmental involvement in the case, the outcome might have been much less favorable. Media reports one year later indicate the child's development was proceeding very well, with leg braces adequately compensating for the child's impairment.

In the Daytona Beach, Florida case (listed as case 33, above), action by the state child protective services agency, like that called for in the final rules, brought about needed corrective surgery. Without this action, the infant might have died or suffered more severe impairments.

In the Colorado Springs, Colorado case (listed as case 35, above) the prompt involvement of HHS, acting upon a complaint from a nurse, may have contributed to the decision to provide corrective surgery. Because the decisionmaking process was in progress at the time the OCR inquiry began, it is impossible to say the surgery would not have been provided without this involvement. However, the involvement of OCR and the OCR medical consultant was cooperatively received by the hospital and apparently constructive.

Although no case has resulted in a finding of discriminatory withholding of medical care, the Department believes these cases provide additional documentation of the need for governmental involvement and the appropriateness of the procedures established by the final rules.

E. OTHER ISSUES

Self-Evaluation

Among the questions on which the July 5 notice of proposed rulemaking solicited comments was question 1:

> Should recipients providing health care services to infants be required to perform a self-evaluation, pursuant to 45 CFR 84.6(c)(1), with respect to their policies and practices concerning health services to handicapped infants?

A number of commenters expressed support for this requirement. Some commenters expressed the view that self-evaluations would be helpful and should be conducted, but they should not be a federal regulatory mandate. Some commenters suggested that if this were to be a requirement, it should be through mechanisms other than section 504, such as voluntary accreditation standards or Medicare conditions of participation.

Some commenters opposed a self-evaluation requirement on the grounds it would likely be unproductive. For example:

> Americans United for Life is skeptical of any approach to the enforcement of section 504 that relies on the cooperation of those being regulated. Encouraging hospitals to perform "*self*-evaluation" is not likely to lead to *accurate* evaluation.

Response

The Department has not adopted a self-evaluation requirement as part of the final rules. The Department believes this function will be most effectively carried out in connection with the activities of Infant Care Review Committees encouraged by the final rules, and therefore will not seek to impose uniform standards for self-evaluations.

Information to Parents

Among the questions on which the July 5 notice of proposed rulemaking solicited comments was question 2:

> Should such recipients be required to identify for parents of handicapped infants born in their facilities those public and private agencies in the geographical vicinity that provide services to handicapped infants?

A great many commenters expressed support for such a requirement on the ground that before parents are put into a position of having to make very difficult decisions concerning care for their handicapped child, the parents should be aware of the health and social services agencies and organizations and parental support groups available in the community. Other commenters opposed this requirement. Some commenters expressed the view that hospitals should provide this information as part of their own policies and procedures, but that it would be counterproductive to seek to impose rigid, uniform regulatory requirements in this regard.

Among those supporting such a requirement was the Spina Bifida Association of America (SBAA):

> The SBAA strongly supports such a requirement; it might be the most important influential aspect of the entire regulation.
>
> Parents of a newborn spina bifida child are expected to make rational life and death decisions when what was expected to be a joyous time has instead become an occasion for confronting the concerns of the unknown. The decisions must be made quickly and under great stress. Dr. Rosalyn Darling, a member of SBAA's Professional Advisory Committee, has written that decisions are often made by physicians and individuals who have very little contact with the

disabled community; consequently, decisions concerning treatment are often "stacked" against the newborn with a problem. Parents naturally turn to their physician for guidance, but he or she may have only outdated and unwarrantedly pessimistic information about spina bifida. Even if the physician is well-informed about the available treatment, he or she is rarely aware of the supportive services in the community or equipped to give the support and counselling that others who have gone through the same experience can't provide.

Clearly, new parents of a disabled child need the names of agencies and support groups available to assist the family unit. Other parents who have gone through the same situation can then share their knowledge of the disability and its treatment and give comfort and assistance.

The American Speech-Language-Hearing Association, which represents 39,000 speech-language pathologists and audiologists nationwide, stated:

[P]arents and physicians are largely unaware of what educational, habilitative, and rehabilitative services are available for handicapped children, how much success handicapped children receiving these services can have, the obligation of states to educate handicapped children, the extent of research now going on regarding handicapped children, and other federal, state and local governmental commitments to the handicapped. Unfortunately, physicians have all that they can do to maintain currency with medical information and are, therefore, frequently ill-informed as to what can be done for handicapped infants. . . .

* * * * *

. . . Recipients should be required to provide complete information to the parent about the appropriate handicap. This would include not only identification of public and private agencies that provide services to handicapped infants, but (1) detailed information on the handicap itself; (2) discussion of the educational and rehabilitation potential; (3) discussion of alternative care options such as foster homes, adoption, etc.; (4) identification of parent support groups; and (5) discussion of expectations for a self-sufficient future life. In providing the required information the recipient should use individuals knowledgeable about the handicap, including professionals, associations and parents of handicapped children. For example, the American Speech-Language-Hearing Association and its consumer affiliate, the National Association of Hearing and Speech Action (NAHSA) maintains a Help line (800-638-8255) that can be used to obtain information on (1) speech-language pathology and audiology services available in any area of the United States, (2) speech, language and hearing disorders, and (3) other agencies serving the communicatively handicapped. NAHSA provides informational brochures. . . . Many professional associations have similar documents that would be helpful to recipients.

Among those opposing a requirement that recipients provide information to parents was Georgetown University Hospital, Washington, D.C. As an alternative, the hospital proposed:

DHHS should undertake the responsibility of providing a federal office charged with the task of identifying for parents of handicapped children those public and private agencies in the geographical vicinity of the parent's residence that provide service of handicapped infants, and for providing the necessary financial assistance to acquire such services. Hospitals should be required to furnish parents with a telephone number, and/or address of this federal office.

Response

The Department believes it is extremely important for parents of handicapped newborn infants to receive detailed information on the availability of health and social services for handicapped children in the communities. However, the Department has concluded the most effective way to advance this goal is not through an attempt to impose detailed regulatory requirements that would be very difficult to monitor and enforce.

Rather, the Department has undertaken several initiatives, discussed above in the preamble, to improve the furnishing of information to parents. In addition, this should be a central focus of the activities of the Infant Care Review Committees, which, under the model set forth in the final rules, include participation by representatives of disability groups or disability experts.

VI. Regulatory Information

Severability

It is the Secretary's intent that should any subsection, paragraph, clause, or provision of this rule be declared by a court of competent jurisdiction to be invalid, the remainder of the rule, not expressly so declared invalid, shall continue in effect.

Regulatory Impact Analysis

This proposed rule has been reviewed under Executive Order 12291. It is not a major rule as defined by the Order because it does not have an effect on the economy of $100 million or more or meet the other definitional criteria contained in the Order, and thus does not require a regulatory impact analysis.

Regulatory Flexibility Analysis

The Regulatory Flexibility Act (Pub. L. 96-354) requires the Federal government to anticipate and reduce the impact of rules and paperwork requirements on small businesses and other small entities. For each rule with a "significant impact on a substantial number of small entities" an analysis must be prepared describing the rule's impact on small entities.

The Secretary certifies that the final rules do not have a significant impact on a substantial number of small entities. As it relates to hospitals, the primary requirement of the final rules is to post an informational notice, which has no significant impact on the hospitals. The requirements concerning expedited access to records and expedited action to effect compliance also, as explained above, have no significant impact. Requirements in the final rules relating to state child protective services agencies have no substantial impact on those agencies, because those requirements, as explained above, are fully consistent with normal procedures of those agencies and existing regulatory requirements.

Matters addressed in the guidelines included in the final rules are not requirements of the rules. They reflect interpretations and procedures of the Department pursuant to the statute, existing regulations, and existing procedures.

Therefore, a regulatory flexibility analysis is not required.

Paperwork Reduction Act

Section 84.55(c) of the final rules contains information collection requirements. These requirements were submitted to the Office of Management and Budget for review under section 3504(h) of the Paperwork Reduction Act of 1980, and approved for use through September 30, 1986. The OMB No. is 0990-0114.

Department of Justice Review

Pursuant to Executive Order 12250, these final rules have been reviewed and approved by the Department of Justice.

List of Subjects in 45 CFR Part 84

Civil rights, Education of handicapped, Handicapped, Physically handicapped.

Dated: December 30, 1983.

Approved:

Margaret M. Heckler,

Secretary.

PART 84—[AMENDED]

The authority citation for Part 84 is as follows:

Authority: Sec. 504, Rehabilitation Act of 1973, Pub. L. 93-112, 87 Stat. 394 (29 U.S.C. 794974); sec. 111(a), Rehabilitation Act Amendments of 1974, Pub. L. 93-516, 88 Stat. 1619 (29 U.S.C. 706); sec. 606, Education of the Handicapped Act (20 U.S.C. 1405), as amended by Pub. L. 94-142, 89 Stat. 795; sec. 321, Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and

Rehabilitation Act of 1970, 84 Stat. 182 (42 U.S.C. 4581), as amended; sec. 497, Drug Abuse Office and Treatment Act of 1972, 86 Stat. 78 (21 U.S.C. 1174), as amended.

For the reasons set forth in the preamble:

1. 45 CFR Part 84 is amended by inserting after § 84.54 the following new § 84.55:

§ 84.55 Procedures relating to health care for handicapped infants.

(a) *Infant Care Review Committees.* The Department encourages each recipient health care provider that provides health care services to infants in programs receiving Federal financial assistance to establish an Infant Care Review Committee (ICRC) to assist the provider in delivering health care and related services to infants and in complying with this part. The purpose of the committee is to assist the health care provider in the development of standards, policies and procedures for providing treatment to handicapped infants and in making decisions concerning medically beneficial treatment in specific cases. While the Department recognizes the value of ICRC's in assuring appropriate medical care to infants, such committees are not required by this section. An ICRC should be composed of individuals representing a broad range of perspectives, and should include a practicing physician, a representative of a disability organization, a practicing nurse, and other individuals. A suggested model ICRC is set forth in paragraph (f) of this section.

(b) *Posting of informational notice.* (1) Each recipient health care provider that provides health care services to infants in programs or activities receiving Federal financial assistance shall post and keep posted in appropriate places an informational notice.

(2) The notice must be posted at location(s) where nurses and other medical professionals who are engaged in providing health care and related services to infants will see it. To the extent it does not impair accomplishment of the requirement that copies of the notice be posted where such personnel will see it, the notice need not be posted in area(s) where parents of infant patients will see it.

(3) Each health care provider for which the content of the following notice (identified as Notice A) is truthful may use Notice A. For the content of the notice to be truthful: (i) The provider must have a policy consistent with that stated in the notice; (ii) the provider must have a procedure for review of treatment deliberations and decisions to which the notice applies, such as (but not limited to) an Infant Care Review Committee; and (iii) the statements concerning the identity of callers and retaliation are truthful.

Notice A:

PRINCIPLES OF TREATMENT OF DISABLED INFANTS

It is the policy of this hospital, consistent with Federal law, that, nourishment and medically beneficial treatment (as determined with respect for reasonable medical judgments) should not be withheld from handicapped infants solely on the basis of their present or anticipated mental or physical impairments.

This Federal law, section 504 of the Rehabilitation Act of 1973, prohibits discrimination on the basis of handicap in programs or activities receiving Federal financial assistance. For further information, or to report suspected noncompliance, call:

[Identify designated hospital contact point and telephone number] or

[Identify appropriate child protective services agency and telephone number] or

U.S. Department of Health and Human Services (HHS): 800–368–1019 (Toll-free; available 24 hours a day; TDD capability).

The identity of callers will be held confidential. Retaliation by this hospital against any person for providing information about possible noncompliance is prohibited by this hospital and Federal regulations.

(4) Health care providers other than those described in paragraph (b)(3) of this section must post the following notice (identified as Notice B):

Notice B:

PRINCIPLES OF TREATMENT OF DISABLED INFANTS

Federal law prohibits discrimination on the basis of handicap. Under this law, nourishment and medically beneficial treatment (as determined with respect for reasonable medical judgments) should not be withheld from handicapped infants solely on the basis of their present or anticipated mental or physical impairments.

This Federal law, section 504 of the Rehabilitation Act of 1973, applies to programs or activities receiving Federal financial assistance. For further information, or to report suspected noncompliance, call:

[Identify appropriate child protective services agency and telephone number] or

U.S. Department of Health and Human Services (HHS): 800–368–1019 (Toll-free; available 24 hours a day: TDD capability)

The identity of callers will be held confidential. Federal regulations prohibit retaliation by this hospital against any person who provides information about possible violations.

(5) The notice may be no smaller than 5 by 7 inches, and the type size no smaller than that generally used for similar internal communications to staff. The recipient must insert the specified information on the notice it selects. Recipient hospitals in Washington, D.C. must list 863–0100 as the telephone number for HHS. No other alterations may be made to the notice. Copies of the notices may be obtained from the Department of Health and Human Services upon request, or the recipient may produce its own notices in conformance with the specified wording.

(c) *Responsibilities of recipient state child protective services agencies.* (1) Within 60 days of the effective date of this section, each recipient state child protective services agency shall establish and maintain in written form methods of administration and procedures to assure that the agency utilizes its full authority pursuant to state law to prevent instances of unlawful medical neglect of handicapped infants. These methods of administration and procedures shall include:

(i) A requirement that health care providers report on a timely basis to the state agency circumstances which they determine to constitute known or suspected instances of unlawful medical neglect of handicapped infants;

(ii) A method by which the state agency can receive reports of suspected unlawful medical neglect of handicapped infants from health care providers, other individuals, and the Department on a timely basis;

(iii) Immediate review of reports of suspected unlawful medical neglect of handicapped infants and, where appropriate, on-site investigation of such reports;

(iv) Provision of child protective services to such medically neglected handicapped infants, including, where appropriate, seeking a timely court order to compel the provision of necessary nourishment and medical treatment; and

(v) Timely notification to the responsible Department official of each report of suspected unlawful medical neglect involving the withholding, solely on the basis of present or anticipated physical or mental impairments, of treatment or nourishment from a handicapped infant who, in spite of such impairments, will medically benefit from the treatment or nourishment, the steps taken by the state agency to investigate such report, and the state agency's final disposition of such report.

(2) Whenever a hospital at which an infant who is the subject of a report of suspected unlawful medical neglect is being treated has an Infant Care Review Committee (ICRC) the Department encourages the state child protective services agency to consult with the ICRC in carrying out the state agency's authorities under its state law and methods of administration. In developing its methods of

administration and procedures, the Department encourages child protective services agencies to adopt guidelines for investigations similar to those of the Department regarding the involvement of ICRC's.

(The provisions of § 84.55(c) have been approved by the Office of Management and Budget pursuant to the Paperwork Reduction Act. The OMB No. is 0990–0114.)

(d) *Expedited access to records.* Access to pertient records and facilities of a recipient pursuant to 45 CFR 80.6(c) (made applicable to this part by 45 CFR 84.61) shall not be limited to normal business hours when, in the judgment of the responsible Department official, immediate access is necessary to protect the life or health of a handicapped individual.

(e) *Expedited action to affect compliance.* The requirement of 45 CFR 80.8(d)(3) pertaining to notice to recipients prior to the initiation of action to effect compliance (made applicable to this part by 45 CFR 84.61) shall not apply when, in the judgment of the responsible Department official, immediate action to effect compliance is necessary to protect the life or health of a handicapped individual. In such cases the recipient will, as soon as practicable, be given oral or written notice of its failure to comply, of the action to be taken to effect compliance, and its continuing opportunity to comply voluntarily.

(f) *Model Infant Care Review Committee.* Recipient health care providers wishing to establish Infant Care Review Committees should consider adoption of the following model. This model is advisory. Recipient health care providers are not required to establish a review committee or, if one is established, to adhere to this model. In seeking to determine compliance with this part, as it relates to health care for handicapped infants, by health care providers that have an ICRC established and operated substantially in accordance with this model, the Department will, to the extent possible, consult with the ICRC.

(1) *Establishment and purpose.* (i) The hospital establishes an Infant Care Review Committee (ICRC) or joins with one or more other hospitals to create a joint ICRC. The establishing document will state that the ICRC is for the purpose of facilitating the development and implementation of standards, policies and procedures designed to assure that, while respecting reasonable medical judgments, treatment and nourishment not be withheld, solely on the basis of present or anticipated physical or mental impairments, from handicapped infants who, in spite of such impairments, will benefit medically from the treatment or nourishment.

(ii) The activities of the ICRC will be guided by the following principles:

(A) The interpretative guidelines of the Department relating to the applicability of this part to health care for handicapped infants.

(B) As stated in the "Principles of Treatment of Disabled Infants" of the coalition of major medical and disability organizations, including the American Academy of Pediatrics, National Association of Children's Hospitals and Related Institutions, Association for Retarded Citizens, Down's Syndrome Congress, Spina Bifida Association, and others:

> When medical care is clearly beneficial, it should always be provided. When appropriate medical care is not available, arrangements should be made to transfer the infant to an appropriate medical facility. Consideration such as anticipated or actual limited potential of an individual and present or future lack of available community resources are irrelevant and must not determine the decisions concerning medical care. The individual's medical condition should be the sole focus of the decision. These are very strict standards.
>
> It is ethically and legally justified to withhold medical or surgical procedures which are clearly futile and will only prolong the act of dying. However, supportive care should be provided, including sustenance as medically indicated and relief of pain and suffering. The needs of the dying person should be respected. The family also should be supported in its grieving.
>
> In cases where it is uncertain whether medical treatment will be beneficial, a person's disability must not be the basis for a decision to withhold treatment. At all times during the process when decisions are being made about the benefit or futility of medical treatment, the person should be cared for in the medically most appropriate ways. When doubt exists at any time about whether to treat, a presumption always should be in favor of treatment.

(C) As stated by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research:

> This [standard for providing medically beneficial treatment] is a very strict standard in that it excludes consideration of the negative effects of an impaired child's life on other persons, including parents, siblings, and society. Although abiding by this standard may be difficult in specific cases, it is all too easy to undervalue the lives of handicapped infants; the Commission finds it imperative to counteract this by treating them no less vigorously than their healthy peers or than older children with similar handicaps would be treated.

(iii) The ICRC will carry out its purposes by:

(A) Recommending institutional policies concerning the withholding or withdrawal of medical or surgical treatments to infants, including guidelines for ICRC action for specific categories of life-threatening conditions affecting infants;

(B) Providing advice in specific cases when decisions are being considered to withhold or withdraw from infant life-sustaining medical or surgical treatment; and

(C) Reviewing retrospectively on a regular basis infant medical records in situations in which life-sustaining medical or surgical treatment has been withheld or withdrawn.

(2) *Organization and staffing.* The ICRC will consist of at least 7 members and include the following:

(i) A practicing physician (e.g., a pediatrician, a neonatologist, or a pediatric surgeon),

(ii) A practicing nurse,

(iii) A hospital administrator,

(iv) A representative of the legal profession,

(v) A representative of a disability group, or a developmental disability expert,

(vi) A lay community member, and

(vii) A member of a facility's organized medical staff, who shall serve as chairperson.

In connection with review of specific cases, one member of the ICRC shall be designated to act as "special advocate" for the infant, as provided in paragraph (f)(3)(ii)(E) of the section. The hospital will provide staff support for the ICRC, including legal counsel. The ICRC will meet on a regular basis, or as required below in connection with review of specific cases. It shall adopt or recommend to the appropriate hospital official or body such administrative policies as terms of office and quorum requirements. The ICRC will recommend procedures to ensure that both hospital personnel and patient families are fully informed of the existence and functions of the ICRC and its availability on a 24-hour basis.

(3) *Operation of ICRC*—(i) *Prospective policy development.* (A) The ICRC will develop and recommend for adoption by the hospital institutional policies concerning the withholding or withdrawal of medical treatment for infants with life-threatening conditions. These will include guidelines for management of specific types of cases or diagnoses, for example, Down's syndrome and spina bifida, and procedures to be followed in such recurring circumstances as, for example, brain death and parental refusal to consent to life-saving treatment. The

hospital, upon recommendation of the ICRC, may require attending physicians to notify the ICRC of the presence in the facility of an infant with a diagnosis specified by the ICRC, e.g., Down's syndrome and spina bifida.

(B) In recommending these policies and guidelines, the ICRC will consult with medical and other authorities on issues involving disabled individuals, e.g., neonatologists, pediatric surgeons, county and city agencies which provide services for the disabled, and disability advocacy organizations. It will also consult with appropriate committees of the medical staff, to ensure that the ICRC policies and guidelines build on existing staff by-laws, rules and regulations concerning consultations and staff membership requirements. The ICRC will also inform and educate hospital staff on the policies and guidelines it develops.

(ii) *Review of specific cases.* In addition to regularly scheduled meetings, interim ICRC meetings will take place under specified circumstances to permit review of individual cases. The hospital will, to the extent possible, require in each case that life-sustaining treatment be continued, until the ICRC can review the case and provide advice.

(A) Interim ICRC meetings will be convened within 24 hours (or less if indicated) when there is disagreement between the family of an infant and the infant's physician as to the withholding or withdrawal of treatment, when a preliminary decision to withhold or withdraw life-sustaining treatment has been made in certain categories of cases identified by the ICRC, when there is disagreement between members of the hospital's medical and/or nursing staffs, or when otherwise appropriate.

(B) Such interim ICRC meetings will take place upon the request of any member of the ICRC or hospital staff or parent or guardian of the infant. The ICRC will have procedures to preserve the confidentiality of the identity of persons making such requests, and such persons shall be protected from reprisal. When appropriate, the ICRC or a designated member will inform the requesting individual of the ICRC's recommendation.

(C) The ICRC may provide for telephone and other forms of review when the timing and nature of the case, as identified in policies developed by the ICRC, make the convening of an interim meeting impracticable.

(D) Interim meetings will be open to the affected parties. The ICRC will ensure that the interests of the parents, the physician, and the child are fully considered; that family members have been fully informed of the patient's condition and prognosis; that they have been provided with a listing which describes the services furnished by parent support groups and public and private agencies in the geographic vicinity to infants with conditions such as that before the ICRC; and that the ICRC will facilitate their access to such services and groups.

(E) To ensure a comprehensive evaluation of all options and factors pertinent to the committee's deliberations, the chairperson will designate one member of the ICRC to act, in connection with that specific case, as special advocate for the infant. The special advocate will seek to ensure that all considerations in favor of the provision of life-sustaining treatment are fully evaluated and considered by the ICRC.

(F) In cases in which there is disagreement on treatment between a physician and an infant's family, and the family wishes to continue life-sustaining treatment, the family's wishes will be carried out, for as long as the family wishes, unless such treatment is medically contraindicated. When there is physician/family disagreement and the family refuses consent to life-sustaining treatment, and the ICRC, after due deliberation, agrees with the family, the ICRC will recommend that the treatment be withheld. When there is physician/family disagreement and the family refuses consent, but the ICRC disagrees with the family, the ICRC will recommend to the hospital board or appropriate official that the case be referred immediately to an appropriate court or child protective agency, and every effort shall be made to continue treatment, preserve the status quo, and prevent worsening of the infant's condition until such time as the court or agency renders a decision or takes other appropriate action. The ICRC will also follow this procedure in cases in which the family and physician agree that life-sustaining treatment should be withheld or withdrawn, but the ICRC disagrees.

(iii) *Retrospective record review.* The ICRC, at its regularly-scheduled meeting, will review all records involving withholding or termination of medical or surgical treatment to infants consistent with hospital policies developed by the ICRC, unless the case was previously before the ICRC pursuant to paragraph (f)(3)(ii) of this section. If the ICRC finds that a deviation was made from the institutional policies in a given case, it shall conduct a review and report the findings to appropriate hospital personnel for appropriate action.

(4) *Records.* The ICRC will maintain records of all of its deliberations and summary descriptions of specific cases considered and the disposition of those cases. Such records will be kept in accordance with institutional policies on confidentiality of medical information. They will be made available to appropriate government agencies, or upon court order, or as otherwise required by law.

Amendment to Table of Contents

2. The table of contents to 45 CFR Part 84 is amended by striking the designation of "84.55–84.60 [Reserved]" and by inserting in lieu thereof, the following:

Sec.
84.55 Procedures relating to health care for handicapped infants.
84.56–84.60 [Reserved]

3. 45 CFR Part 84 is amended by inserting after Appendix B the following new appendix:

Appendix C—Guidelines Relating to Health Care for Handicapped Infants.

(a) *Interpretative guidelines relating to the applicability of this part to health care for handicapped infants.* The following are interpretative guidelines of the Department set forth here to assist recipients and the public in understanding the Department's interpretation of section 504 and the regulations contained in this part as applied to matters concerning health care for handicapped infants. These interpretative guidelines are illustrative; they do not independently establish rules of conduct.

(1) With respect to programs and activities receiving Federal financial assistance, health care providers may not, solely on the basis of present or anticipated physical or mental impairments of an infant, withhold treatment or nourishment from the infant who, in spite of such impairments, will medically benefit from the treatment or nourishment.

(2) Futile treatment or treatment that will do no more than temporarily prolong the act of dying of a terminally ill infant is not considered treatment that will medically benefit the infant.

(3) In determining whether certain possible treatments will be medically beneficial to an infant, reasonable medical judgments in selecting among alternative courses of treatment will be respected.

(4) Section 504 and the provisions of this part are not applicable to parents (who are not recipients of Federal financial assistance). However, each recipient health care provider must in all aspects of its health care programs receiving Federal financial assistance provide health care and related services in a manner consistent with the requirements of section 504 and this part. Such aspects includes decisions on whether to report, as required by State law or otherwise, to the appropriate child protective services agency a suspected instance of medical neglect of a child, or to take other

action to seek review or parental decisions to withhold consent for medically indicated treatment. Whenever parents make a decision to withhold consent for medically beneficial treatment or nourishment, such recipient providers may not, solely on the basis of the infant's present or anticipated future mental or physical impairments, fail to follow applicable procedures on reporting such incidents to the child protective services agency or to seek judicial review.

(5) The following are examples of applying these interpretative guidelines. These examples are stated in the context of decisions made by recipient health care providers. Were these decisions made by parents, the guideline stated in section (a)(4) would apply. These examples assume no facts or complications other than those stated. Because every case must be examined on its individual facts, these are merely illustrative examples to assist in understanding the framework for applying the nondiscrimination requirements of section 504 and this part.

(i) Withholding of medically beneficial surgery to correct an intestinal obstruction in an infant with Down's Syndrome when the withholding is based upon the anticipated future mental retardation of the infant and there are no medical contraindications to the surgery that would other wise justify withholding the surgery would constitute a discriminatory act, violative of section 504.

(ii) Withholding of treatment for medically correctable physical anomalies in children born with spina bifida when such denial is based on anticipated mental impairment paralysis or incontinence of the infant, rather than on reasonable medical judgments that treatment would be futile, too unlikely of success given complications in the particular case, or otherwise not of medical benefit to the infant, would constitute a discriminatory act, violative of section 504.

(iii) Withholding of medical treatment for an infant born with anencephaly, who will inevitably die within a short period of time, would not constitute a discriminatory act because the treatment would be futile and do no more than temporarily prolong the act of dying.

(iv) Withholding of certain potential treatments from a severely premature and low birth weight infant on the grounds of reasonable medical judgments concerning the improbability of success or risks of potential harm to the infant would not violate section 504.

(b) *Guidelines for HHS investigations relating to health care for handicapped infants.* The following are guidelines of the Department in conducting investigations relating to health care for handicapped infants. They are set forth here to assist recipients and the public in understanding applicable investigative procedures. These guidelines do not establish rules of conduct, create or affect legally enforceable rights of any person, or modify existing rights, authorities or responsibilities pursuant to this part. These guidelines reflect the Department's recognition of the special circumstances presented in connection with complaints of suspected life-threatening noncompliance with this part involving health care for handicapped infants. These guidelines do not apply to other investigations pursuant to this part, or other civil rights statutes and rules. Deviations from these guidelines may occur when, in the judgment of the responsible Department official, other action is necessary to protect the life or health of a handicapped infant.

(1) Unless impracticable, whenever the Department receives a complaint of suspected life-threatening noncompliance with this part in connection with health care for a handicapped infant in a program or activity receiving Federal financial assistance, HHS will immediately conduct a preliminary inquiry into the matter by initiating telephone contact with the recipient hospital to obtain information relating to the condition and treatment of the infant who is the subject of the complaint. The preliminary inquiry, which may include additional contact with the complainant and a requirement that pertinent records be provided to the Department, will generally be completed within 24 hours (or sooner if indicated) after receipt of the complaint.

(2) Unless impracticable, whenever a recipient hospital has an Infant Care Review Committee, established and operated substantially in accordance with the provisions of 45 CFR 84.55(f), the Department will, as part of its preliminary inquiry, solicit the information available to, and the analysis and recomendations of, the ICRC. Unless, in the judgment of the responsible Department official, other action is necessary to protect the life or health of a handicapped infant, prior to initiating an on-site investigation, the Department will await receipt of this information from the ICRC for 24 hours (or less if indicated) after receipt of the complaint. The Department may require a subsequent written report of the ICRC's findings, accompanied by pertinent records and documentation.

(3) On the basis of the information obtained during preliminary inquiry, including information provided by the hospital (including the hospital's ICRC, if any), information provided by the complainant, and all other information obtained, the Department will determine whether there is a need for an on-site investigation of the complaint. Whenever the Department determines that doubt remains that the recipient hospital or some other recipient is in compliance with this part or additional documentation is desired to substantiate a conclusion, the Department will initiate an on-site investigation or take some other appropriate action. Unless impracticable, prior to initiating an on-site investigation, the Department's medical consultant (referred to in paragraph 6) will contact the hospital's ICRC or appropriate medical personnel of the recipient hospital.

(4) In conducting on-site investigations, when a recipient hospital has an ICRC established and operated substantially in accordance with the provisions of 45 CFR 84.55(f), the investigation will begin with, or include at the earliest practicable time, a meeting with the ICRC or its designees. In all on-site investigations, the Department will make every effort to minimize any potential inconvenience or disruption, accommodate the schedules of health care professionals and avoid making medical records unavailable. The Department will also seek to coordinate its investigation with any related investigations by the state child protective services agency so as to minimize potential disruption.

(5) It is the policy of the Department to make no comment to the public or media regarding the substance of a pending preliminary inquiry or investigation.

(6) The Department will obtain the assistance of a qualified medical consultant to evaluate the medical information (including medical records) obtained in the course of a preliminary inquiry or investigation. The name, title and telephone number of the Department's medical consultant will be made available to the recipient hospital. The Department's medical consultant will, if appropriate, contact medical personnel of the recipient hospital in connection with the preliminary inquiry, investigation or medical consultant's evaluation. To the extent practicable, the medical consultant will be a specialist with respect to the condition of the infant who is the subject of the preliminary inquiry or investigation. The medical consultant may be an employee of the Department or another person who has agreed to serve, with or without compensation, in that capacity.

(7) The Department will advise the recipient hospital of its conclusions as soon as possible following the completion of a preliminary inquiry or investigation. Whenever final administrative findings following an investigation of a complaint of suspected life-threatening noncompliance cannot be made promptly, the Department will seek to notify the recipient and the complainant of the Department's decision on whether the matter will be immediately referred to the Department of Justice pursuant to 45 CFR 80.8

(8) Except as necessary to determine or effect compliance, the Department will (i) in conducting preliminary inquiries and investigations, permit information provided by the recipient hospital to the Department to be furnished without names or other identifying information relating to the infant and the infant's family; and (ii) to the extent permitted by law, safeguard the confidentiality of information obtained.

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