New England
HOSPITAL ENGINEERS SOCIETY
Newsletter

FALL 1991

NEW LIFE FOR OLD HOSPITAL EQUIPMENT

Old hospital equipment gets new life abroad to save lives

In the summer of 1969, Victor Sologaistoa was a 17 year old, fresh from Guatemala, camping in Bostons Symphony Hall subway station while futilely trying to reach a man whose name he had been given.

He hardly seemed a candidate to join Kay Barney and Thomas Magliocchetti in forming the American Medical Resources Foundation, which last year sent more than $1 million worth of donated medical gear to poor countries and helped many to leapfrog to more modern medical care.

Sologaistoa had come to the United States with his mothers blessing and little else. He, his brother and a friend had the telephone number of a man who could help him. But the man lived in a boarding house, with a phone in a hallway. Numerous times Sologaistoa, who spoke only Spanish, reached someone who only spoke English. For two days, the three boys searched for Beacon Street. By night, they would return to the station and sleep on benches. Finally, they made contact.

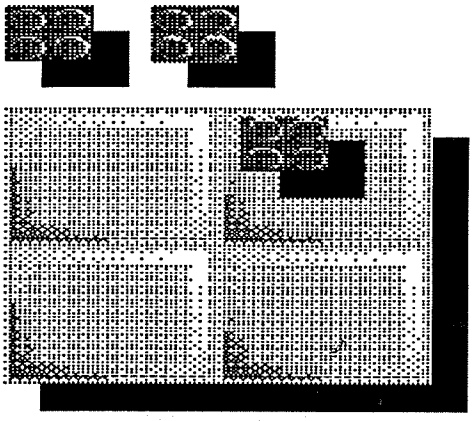
Sologaistoa, now manager of clinical engineering at Roger Williams General Hospital, smiled when he recalled his introduction to New England. For us, it was an adventure, he said.

(Continued on page 7 ,LIFE)

AHA SALARY SURVEY SHOWS INCREASES OUTPACE INFLATION AND NET MARGINS

During 1990, the average salaries for all health care staff increased at a greater percentage than both the rate of inflation and the financial performance of hospitals (Health Facilities Management, September 1991, pages 14-20). The average salary of the top executive in the facilities management department was $67,000 with the salary range directly dependant upon bed size. For hospitals under 100 beds the top executive salaries were 24% less than average while institutions with greater than 500 beds had salaries 23% higher than average. Other salary averages were $50,300 for Plant Engineering and $53,500 for Plant Operations. Incentive pay or bonuses were not unusual with 37% of institutions offering these programs. The average bonus for these programs was 12% for the top executive in the facilities management department. The article indicated the future trends will show compensation increases based more on the bonuses for performance improvements.

Abstracted by the editor



There is still time to sign up for the:

1991 NEHES FALL SEMINAR

OCTOBER 22-25
NEWPORT MARRIOTT,
NEWPORT, RHODE ISLAND

This years Seminar was designed by the American Hospital Association (AHA) and the New England Hospital Engineers Society. It is intended to promote better patient care through this continuing education program.

The Program Speaker will be ***William Koffel, President, Koffel Associates Inc., (Fire Protection Engineer, AHA).***

The one and a half day seminar will cover the use of the NFPA 1991 Life Safety Code, with special emphasis on New and Existing Health Care Occupancies.

A Certificate of Attendance will be presented to all seminar attendees after the Round Table Discussion on Friday, October 25, 1991.

REGISTRATION

NEHES Members	$125.00
Non-members	150.00
Guest Program	30.00

Registration Fees cover all breakfasts, lunches, Theme Dinner & Formal Dinner, plus all refreshments during Seminar breaks.

Registration should be addressed to:
WOMEN & INFANTS HOSPITAL
Attn: Tom Borden
101 Dudley Street
Providence, RI 02905-2499
Tele. No. (401) 274-1100

Late registration will be held at the Marriott Hotel (3rd floor) from 5:00 P.M. on Tuesday, October 22, 1991.

Theme Dinner will be a Clambake, (Wed. Eve.). Formal Dinner has a choice of: Prime Rib or Swordfish.

HOTEL ACCOMMODATIONS

We have made arrangements with the Newport Marriott to reserve a block of rooms. Please make your reservations early to assure that you will have a room. Reservations must be made directly to the Marriott (800) 228-9290.

1991 NFPA ANNUAL MEETING

The Codes and Standards Review Committee of the Health Care Section discussed code changes and their effect on the Health Care Industry in NFPA 45, 88A, 424M, 1581 & 13. These codes were voted for acceptance at this meeting. The committee discussed comment 45-1 (exception No.1) appendix note. This comment was accepted in principle by the Technical Committee. The Health Care Section felt the appendix note led to confusion in establishing when NFPA 99 is the applicable code and when NFPA 45 is the applicable code. A motion, presented by the Health Care Section, to delete the appendix note was defeated during the general assembly voting. There were no other concerns with the codes that were being adopted during this meeting.

NFPA 1, The Fire Prevention Code was withdrawn from the adoption process at this annual meeting due to significant changes in the documents scope and the extensive number of public comments This document will be submitted for the approval process at the 1992 annual meeting . NFPA 1 is presently a document for the prevention of fire and explosion in existing buildings. With the proposed revisions, the document has taken on an added scope that is in direct conflict with NFPA 101 and the existing model building codes. This new scope would create a fourth code that is between the fire prevention and model building codes. The driving force to change this code comes from the fire officials. The new proposal will be printed in the TCR 1992, and public comment will be taken during the summer 1991. Because this document has been withdrawn from this annual meeting cycle, all 365 original public comments are now void. All comments must be resubmitted on the new document. Is it necessary to further complicate the system with another code? Many are resistant to this approach and are encouraging the fire officials and building inspectors to combine forces before the Certificate of Occupancy is issued.

A joint education session, between the Fire Service and Health Care Sections, provided insight into the differences of fire fighting and the command decision process when fire strikes in a health care setting. The panelists emphasized prior training, and the local fire department familiarity with normal hospital operations and the building, were the most important factors in successfully fighting a hospital fire. A lengthy study done by the Veterans Administration on this subject suggests several key decisions need to be made before fire strikes. The FIRST PRIORITY in their opinion is to get water on the fire (attacking the fire verses rescue). There were many other useful points in this report. If you are interested I have copies.

A second educational program dealt with the risk of exposure to AIDS from patients to fire fighters and EMTs. Dr. William Dornette presented a brief outline on the development of AIDS and described what makes AIDS incurable with present technology and then described the precautions necessary to protect the fire fighter or EMT. Several times the universal precautions procedures were outlined with an emphasis on full face shields. All body fluids from all subjects have the potential to infect the fire fighter or EMT.

The Health Care Section business meeting was comprised of reports from standing committees and elected officials . A special award was presented to Pete Gregor by NFPA for his work in the Health Care Section Information Room.

A code update of interest is the revision to NFPA 101 by comment 12-442 (1990 TCR), which required smoke detectors in patients rooms annunciated at the nurses station and quick response sprinkler heads in patients rooms in new health care construction. This amendment was voted and approved at the fall general assembly meeting. However, the amendment was not supported by the Technical Committee. The Standards Council viewed the eight vote margin that this bill passed by and the lack of Technical Committee support as insufficient technical consensus to require a smoke detector in new construction patients rooms. *Therefore, the 1991 addition of 101 does not require smoke detectors in sleeping rooms in new health care construction. Quick response sprinkler heads are still required. This Standards Council action has been appealed to the Board of Directors and, as yet, no decision has been rendered.*

NFPA 70 is up for review at the next annual meeting. The public comment period ends November 1, 1991. The documents that will be adopted at the Fall 1991 meeting are: NFPA 69 Explosion Prevention Systems, NFPA 91 Blower and Exhaust Systems, NFPA 101M Alternative Approaches to Life Safety, NFPA 220 Types of Building Construction, NFPA 600 Private Fire Brigades and NFPA 1961 Fire Hose.

Norman Welch,
Springfield (VT) Hospital
NFPA Liaison

NEW ENGLAND STATES REPORTS

Massachusetts Report

On August 1, 1991, a joint meeting was held of the Middlemac and Boston Hospital Plant Engineers Club. The meeting was held at the Lahey Clinic and there were 10 members in attendance. Although the attendance was small, the meeting went over very well. I believe a lot of ideas were exchanged. I was disappointed that other clubs did not participate, however there is always next year. After the meeting, I took the group on a tour of the Lahey Clinic. I would like to acknowledge the following members for attending.

Barry Movitz
Framingham Union Hospital
Bob Bornstein
Leonard Morse Hospital
John Anderson
New England Baptist Hospital
Jim Baker
Symmes Hospital
David Martin
Emerson Hospital
Bruce McCoy
Youville Hospital
Gus Basque
Hale Hospital
David Hathaway
Mt. Auburn Hospital
George Hawley
Hebrew Rehabilitation

On June 24, 1991, St. Johns Hospital in Lowell experienced a gas explosion in their boiler room. Cause of the mishap is still under investigation.

June was the month for two J.C.A.H.O. inspections:
South Shore Hospital
Haverhill Municipal Hospital

September was the month for J.C.A.H.O. inspection for the Symmes Hospital in Arlington.

Membership status for the state is still a top priority and recently I sent out letters to all Hospitals in the Commonwealth directed to the CEOs to ask that their engineer become a member. Results to date have been gratifying.

Leonard Morse Hospital, in Natick, and Framingham Union Hospital are in the process of merging.

MILESTONES/TRANSITIONS

It is with deep regret that I have received notice on the passing of the following members:

Mr. Bernie Dowd, Director of Plant Operations, Worcester County Hospital Association, some time in mid-May.

Mr. Daniel Maxwell, Chief Engineer, Nantucket Cottage Hospital, on June 14, 1991.

Respectfully submitted,
Terry Ringer,
Mass Rep. for NEHES

New Hampshire Report

The New Hampshire Society held meetings on May 16, 1991 and on August 2, 1991 held the annual dinner cruise. This year was aboard the Isle of Shores cruise lines departing from Portsmouth Harbor.

1. Both Jack Berger and Barney Bolton came to the May meeting and supplied moral and monetary support to the N.H. group.

2. The education program for this meeting consisted of a presentation by the N.H. Safety Council. The program was informative.

3. Some of the members toured the new Mary Hitchcock Hospital in June. No formal meeting was held.

4. Preparations for the 92 Fall Seminar, Sheraton Portsmouth, are going well. Both Hotel and seminar dates are set. Vender lists are being updated constantly and a floor plan for booth layout is being prepared.

5. The September meeting is scheduled to be held at Speare Memorial Hospital in Plymouth, N.H. on Thursday the 15th.

Respectfully Submitted
Stephen Shaw
N.H. Representative

Rhode Island Report

The last meeting of the Rhode Island Hospital Engineers took place at Womens and Infants Hospital on Friday, May 31, 1991. Our guest speakers were Harold E. Wight, P.E. and Tony Mesa, both from Nash Engineering Company. Their interesting topics of discussion were:

1. NFPA 1990-99 Code Changes, as they pertain to Medical Compressed Air & Vacuum Systems
2. Medical Compressed Air Quality
3. Alarm Requirements
4. Dew Point Monitoring Requirements
5. Methods to Achieve NFPA System and Air Quality Requirements
6. Types of Vacuum/Compressor Medical Air Systems Currently available to the hospital engineer

Our sincere thanks to the Nash Engineering Company for their presentation.

The next meeting of the Rhode Island Chapter will take place at Women and Infants on Friday, September 27, 1991 at 11:30 A.M. Hosting the meeting will be Gale Associates, Inc. Their subject will be Underground Storage Tanks (UST) - Removal, Replacement and Closure Issues and will relate not only the engineering concerns but the Rhode Island procedures that govern such projects, as well. Dr. Irwin Silverstein will discuss the engineering needs associated with UST projects. Saverio Mancieri, a Sanitary Engineer and the UST Coordinator for the Rhode Island Department of Environmental Management will discuss the Rhode Island and Federal Regulations governing USTs.

Tom Galligan will be supplied with additional tapes to review for the NEHES Library.

Again, may I suggest another Career Development Bulletin similar to the one by Jack Berger in December, 1988 when he was Chariman of Career Development. My personal interest is in the pay scales of Hospital Engineers, their Assistants, and their Secretaries or Office Coordinators.

The address of an honorary member, David O. Elliott is as follows:

David O. Elliott
Chief of Engineering Services
Department of Corrections,
State of CT
90 Brainard Road
Hartford, CT 06114

It is with great sorrow that I inform you of the passing of Edmund Fazzi, a member of NEHES and the Rhode Island Hospital Engineers. He was Manager of Services, Bradley Hospital, East Providence.

My sincere thanks to Terry Ringer for the letter encouraging attendance at the Fall Seminar in Newport, Rhode Island. This is what it takes to make our gathering successful.

Fall Seminar Update:
The flyers will be mailed to our membership this week. Registrations for the Education Program, NFPA 101, the Spouse/Guest Program, and the Hotel Accommodations will be enclosed.

I have received confirmation from the University of Rhode Island of both the selection of the Engineering Student for our Scholarship Award and the attendance at our Formal Dinner by the student and professor for the acceptance of the award.

Thanks to the involvement of Ovid Bordeianu the catering meals and entertainment are all set.

The Spouse/Guest Program was completed by Marie Slover.

Tom Borden, Vendor Coordinator, sold the last of our fifty-five (55) booths on Tuesday, September 3rd. He is now verifying the electrical needs, gift presentations (if any), and attendance at meals of all vendors. My sincere thanks to Tom for his work and the vendors for their quick and willing response.

During all of this, I must mention the extra work performance by my Office Coordinator, Peg Davis. Typing, filing, and answering the telephone was just an additional chore done without fanfare.

If you have the chance and deal with the participating vendors, please extend a thank you. Additional gifts have been donated by some of them.

Again, I suggest the New Hampshire Fall Seminar Chairman be given copies of all of my reports.

Respectfully Submitted
Ken Boyer
Rhode Island Rep.

Vermont Report

VHES MEETING 8/29/91
Brattleboro Memorial Hospital

Hosts: Lindsay Caroll - Assistant Director Plant Services
Ronald Gauvin - Director Plant Services

Present: J. Lawson, K. Pease, W. Perry, N. Welch, M. Paine, R. Williams & R. Forsell

Introduction to new CEO at Brattleboro Memorial Hospital, Brian Mitteer.

Tim Borda, CFO, discussed the Medicare program. He indicated if it was eliminated, hospitals could reduce their charges by 45%.

Some recent legislative health care payment activity was mentioned. Bills related to total control of health care costs including S-127 Cheryl Rivers were discussed. He noted hospitals could be a strong lobby if employees are kept informed. Single payer/or single payment schemes were also discussed. One comment referenced insurance carrier requirements for payment information adds 29% to cost. Tom estimates in 4-5 years we will be under a controlled health care delivery system. He hopes that Washington does not run it.

Jim Lawson, former NEHES President, presented a talk entiled: Planning Ahead. Jim discussed the critical need to make planning a priority. Should facility questions come up, plant engineers are more familiar with the facility and needs than outside experts. Engineers need to market themselves to administration.

The NEHES annual meeting in Newport R.I. was discussed. It was indicated a wonderful spouse program is planned. Members were urged to attend this excellent professional seminar.

Ray Forsell of TSP discussed the success of the power quality monitoring and analysis program performed by TSP. The service has identified several problems with electrical power distribution systems and, in some cases, put the onus back on the equipment manufacturers due to verification of power within specification. A second topic presented by Ray was infrared thermography. The needs, costs and potential for shared use of such a device was addressed. TSP will be doing a survey of needs and costs for VHES.

The next VHES meeting was planned for September 13th, 1:30pm, at the Stratton Mountain Lodge in conjunction with the Vermont Hospital Association Meeting.

VHES Meeting 9/13/91
Stratton Mountain Vermont

Present: J. Lawson, W. Perry, N. Welch, T. Clark, J. Gosselin, M. Cappello, L. Carroll, & T. Manning

Norm Welch, Chairman VHES - Springfield Hospital, discussed an update to OSHA requirements for hazardous materials related to a recent conference he attended.

Members were again urged to attend the NEHES annual seminar and the brochure was discussed. It was noted the 1993 seminar would be held in Vermont.

Norm read a statement thanking the group for the honor of chairing VHES with special note to the assistance of Wayne Parry of Mt. Ascutney. The nominating committee presented candidates Mark Cappello - Copley, Chairman, Robert Cummings - Northeastern VT, Vice Chairman and Dana Swenson-Medical Center, Sec/Treas. The candidates were approved for their posts.

A fine technical presentation was made by Robert Megerdichian of Computer Aided Facilities Management of Cambridge, MA following the business meeting.

Respectfully submitted by
Tobey Clark
Univ. of Vermont/TSP

MEETINGS/SEMINARS/ PUBLICATIONS

Complying with the Americans with Disabilities Act (ADA): **A Guide for Health Care Facilities**, October 24-25 - Arlington, VA, November 18-19 - Chicago, IL, December 9-10 - Philadelphia, PA, Sponsored by AHA, $350 ASHE Members

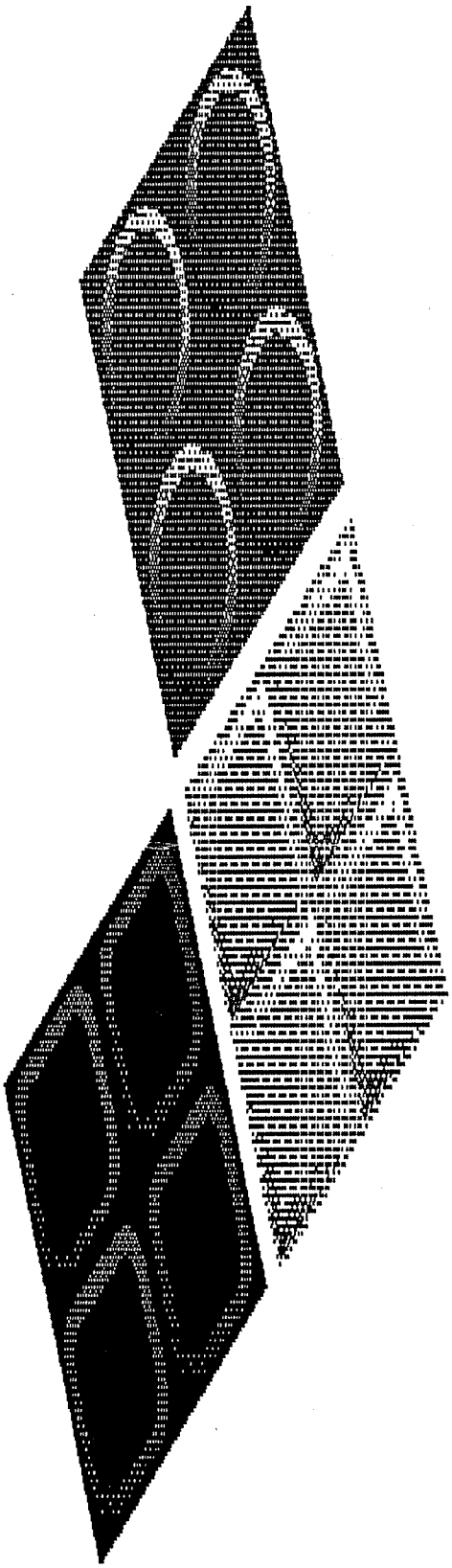
Safe Medical Devices Act of 1990, November 5 - Boston, MA, Sponsored by AAMI, (703) 525-4890, $200 AAMI members

Safe Medical Devices Act - Final Regulations, December 11 - Lake Placid, NY, Sponsored by the Technical Services Program, Univ. of Vermont, (802) 656-3255, Free for TSP member hospital staff, $125 for others

Preventing Occupational Exposures, (Publication), JCAHO, (708) 916-5800, $30

Effective Health Care Facilities Management, (Publication), AHA, (800) AHA-2626, $49.95 ASHE members

Safety Guide for Health Care Institutions, (Publication), AHA, (800) AHA-2626, $35.00 ASHE members



Viewpoint

Hospitals need to treat engineers as professionals, part of the team

By Norman Johnson

Facilities with major building and environmental problems often have one thing in common: Their engineering departments are nothing more than fire brigades running from one emergency to the next.

These hospitals have a history of cutting back on engineering and other support services while giving more to services that provide healthcare. As a result, engineering becomes a hit-or-miss proposition; its delivery is fragmented, irregular and costlier than necessary.

Engineers must be seen as a vital part of the healthcare team. If hospitals want to provide excellent healthcare and do so more efficiently, the engineer must be seen as a professional, not just a good old "Mr. Fix-it."

For example, humidity has a profound effect on inpatients' health. Yet, in most hospitals, particularly those with weak engineering departments, the humidity controls and humidifiers aren't tested or serviced or, even worse, are disconnected.

Hospital engineers often have an identity problem. They're not just maintenance men. In many industries, untrained and unskilled handymen are given the title of engineer; after all, a fancier title costs less than a pay increase. The resulting confusion exposes the root of the problem.

This mislabeling has caused the quality of hospital facilities to deteriorate, even though technology provides ample opportunity for improvement. Some administrators think they'll save money by spending as little as possible for the engineering department; however, studies suggest that overall costs are lowest at hospitals that use the best available equipment and expertise.

Part of the problem is that the engineering department often works in obscurity; unless it can't keep up with work orders, requests for more resources aren't approved. But if an engineering department is strapped, planned maintenance is delayed to take care of emergencies, and this type of "breakdown maintenance" approach is more expensive in the long run.

Hospital engineering is more than just maintenance. In fact, if a facility's engineering department devotes more than 20% of its time and money to unscheduled work, the department isn't meeting quality standards for hospitals.

So, if hospital engineers aren't maintenance personnel, what should they be doing? Here are 10 responsibilities that should be part of their job descriptions:

- Ensure that the facility is designed to be safe and healthy.
- Ensure that the facility is operated in a safe and healthy manner.
- Know and understand the codes and standards of the various regulatory agencies that influence and control hospital operations.
- Understand and implement the best available technology in the care of medical devices and facilities.
- Test, qualify and improve the many complex, critical systems in the building.
- Train engineering department staff in the nuances of working in a hospital, such as disinfecting tools before use in sensitive areas, such as operating rooms.
- Provide quality assurance. Time and resources must be set aside to ensure that all systems perform as they should and that actions taken by the department have achieved the desired results.
- Exercise preventive maintenance. These programs do more than provide a proven economic benefit to hospitals; they improve healthcare and save lives.
- Foster communication. The hospital engineer needs to relate to all of the disciplines of the hospital and know what their problems are. He must be known to be receptive and responsive to problems.
- Respond promptly when notified of problems and correct them.

It's rarely the engineer's fault that he can't meet these responsibilities—doing so requires time and resources so the engineer can plan, evaluate and communicate. And time and resources are two commodities usually in short supply. The typical hospital engineer only has time enough to run from one problem to the next, and many don't have adequate clerical support or storage space to keep records.

Without sufficient resources, a hospital's engineering operation can't do the job expected by the regulators, the healthcare industry and consumers.

Ideally, an engineering department's time should be allocated close to the following percentages:

- Breakdown maintenance and preventive maintenance, each 20%.
- Communicating, engineering, quality assurance, supervision and training, each 10%.
- Planning and miscellaneous tasks, each 5%.

Another common mistake is that critical building project decisions in which the hospital engineer should be involved instead are coordinated by assistant administrators or administrative interns, who have more time. Hospitals often view building project management as a task for management, which relies on the architect and design engineer for technical expertise.

Unfortunately, few architects and design engineers are versed on environmental contamination control or the importance of equipment accessibility, and it's a rare administrator who takes into account adequate space for systems and support functions. If a hospital engineer doesn't keep the focus on constructing a healthy building, there's a risk the new facility could end up an unmaintainable, infectious nightmare.

It's not easy to find well-rounded, well-versed hospital engineers. In addition to having a fundamental understanding of a facility and its complex systems, he needs an intimate understanding of the skills needed to qualify, calibrate and maintain them. This comes from practical experience and an intense interest in the profession, not from textbooks.

Hospital engineers need exposure to other healthcare disciplines, must gain information through professional discourse and training and must read constantly to keep abreast of changes in codes, practices and technology.

Once this type of person is found, don't put him in the basement to wait for someone to report a burned-out light bulb. Realize he's a specialist that every hospital needs. A well-informed, enthusiastic engineer will save lives and reduce costs, if he's given the resources to do a professional job.

Mr. Johnson is director of engineering with Viral Control Technology, a Tampa, Fla.-based research firm studying infection control. He's worked at several hospitals.

(LIFE, continued from page 1)

From dishwasher to therapist

That first summer, Sologaistoa worked odd jobs and washed dishes. He went to Guatemala for Christmas and thought he would never return to the United States. But shortly after the holidays, he decided to come back. He and his brother got jobs in the Boston Lying-in Hospital housekeeping department. Victor washed floors at night and went to school during the day. For two years, he took English lessons. He progressed to respiratory therapist.

Doctors regularly visited the hospital from South and Central America, and Sologaistoa often served as their interpreter. The visitors marveled at the advanced U.S. medical equipment. Sologaistoa, who had also learned to fix equipment, began to think that hospital equipment replaced by updated models could be reused. Because other hospitals were rarely interested in the outdated machinery, it often languished in storage or was discarded.

Every time the hospital discarded something, Sologaistoa rescued it. Then he had visiting doctors from South and Central America buy trunks to take the equipment home. Sologaistoa became a one-man organization, asking hospitals for equipment they no longer used. He spent vacations in remote areas to learn their medical needs. Often, he found hospitals that lacked even rudimentary tools to maintain and repair equipment.

In 1984, Sologaistoa joined the staff of Newton-Wellesley Hospital, which had a roomful of discarded equipment. Sologaistoa asked Thomas Magliocchetti, head of the hospitals biomedical engineering department about it. Magliocchetti, a University of Rhode Island graduate (and current NEHES member), began helping, and the pair enlisted donations from other hospitals.

Foundation formed in 1988

At a holiday gathering a few years ago, Magliocchettis father-in-law, Kay Barney, mentioned that he had read a hospital newsletter article about Sologaistoas work. Magliocchetti introduced his father-in-law to Sologaistoa.

In 1988, the trio formed the American Medical Resources Foundation of Lexington, Mass., a larger, more sophisticated version of the helping network Sologaistoa had started. Barney took early retirement as a Raytheon international program manager and transferred his management skills to Sologaistoas effort. As AMRF president, Barney began soliciting donations from friends. Richard Lee, chairman of EGI Warehouse, donated 25,000 square feet of space in his warehouse in Brockton, Mass. Nearly 100 hospitals, mainly in New England, have made donations, Barney said, and requests for help come from around the world.

Recipient hospitals dont have to pay for equipment but must pay the transportation costs. AMRF usually ships the donations in 40-foot crates, and transportation usually runs about $10,000.

The new equipment shipped last year to India, Guatemala, Angola, Turkey, Vietnam and elsewhere would cost about $7.5 million. The organization computes the values at about one-fifth of current retail prices.

AMRF has a volunteer cadre of professionals who repair and test equipment and travel abroad to show recipients how to set up and maintain the equipment.

Donations cover a broad range

Donations range from beds and wheelchairs to the sophisticated critical-care unit monitoring system that Roger Williams General Hospital has given to medical facilities in Guatemala and Brazil.

Roger Williams plans to open a new critical-care unit with new equipment. In September, Sologiastoa will go to Guatemala to help set up the equipment from Roger Williams and train personnel to use it. Sologaistoa and Magliocchetti came to Rhode Island and Roger Williams last year and have since spread the AMRF message. Sologaistoa lives in Middleboro, Mass., with his wife and four children. Magliocchetti lives in Wakefield and is director of technology and safety at Roger Williams.

Rhode Island Hospital and Miriam Hospital have also donated equipment to AMRF. The numerous requests and donations have prompted the former teenager whose introduction to the American Dream began in a Boston subway station to say: AMRF for me is a dream come true.

Submitted by Ken Boyer from an article
By S. Robert Chiappinelli
Reprinted from the Providence (RI) Sunday Journal, June 9,1991

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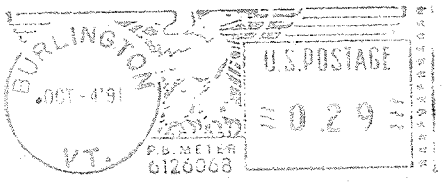

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