

THE BULLETIN

The Oklahoma County Medical Society

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About the Cover

The photo featured on the front cover is Larry A. Bookman, MD, the 110th President of the Oklahoma County Medical Society, his wife, Kathy, and their daughters, Jordan and Blair. A native Oklahoman, Dr. Bookman received his medical degree from the OU College of Medicine. He completed his Residency at the University of California, Irvine, in Long Beach. He entered private practice upon returning to Oklahoma in 1982 and, in 1994, established Digestive Disease Specialists in Oklahoma City, now the largest GI group in the state of Oklahoma. He served as president of DDSI for many years. With an interest in nutrition, he helped start the first home nutritional company in Oklahoma. He currently serves as Medical Director for INTEGRIS Home Health.

Dr. Bookman is an ardent supporter of community organizations, having served on the boards of directors of the Oklahoma Philharmonic and Lyric and as the co-chair of the 2008 Oklahoma Festival of the Arts.

Kathy Bookman is an active member of the Oklahoma County Medical Society Alliance and serves on the executive committee of the Oklahoma State Medical Association Alliance. Jordan, 23, a 2009 graduate of the University of Richmond in Virginia, currently works for a public relations firm in Dallas. Blair, 20, is a sophomore at Texas Christian University majoring in advertising and public relations. Dr. Bookman notes he also has two furry daughters, Annie and Sophie, his Cavalier King Charles Spaniels, who have helped build his character. □

Join Us at the Ball

Your invitation was mailed in early December - you should have made your reservations before Christmas ... but just in case you got caught up in year end festivities and forgot, don't despair: there's still time, although not much! Call 702-0500 today.

Larry A. Bookman MD, will be installed as the Society's 110th President on Saturday, January 16, 2010, at the Oklahoma City Golf and Country Club, 7000 NW Grand Boulevard. The social hour will begin at 6:30 pm, guests will be seated for dinner at 7:30 pm, and lively entertainment - The Wise Guys - will begin following the installation program. The dance floor will be open for those who feel energetic! □

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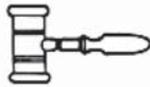
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President's Page



Larry A. Bookman, MD



Meeting the Future

As I begin to write my initial President's Page, I am overwhelmed by the complexity of medical health care reform and the magnitude of the possible changes on the horizon. I could spend every month's Page on this topic as it is ever changing or I could write a definitive statement as if I were omniscient. In truth, neither is accurate, nor does anyone have the definitive answer. We all would agree that reforms are necessary. Overall health costs must be controlled, while insuring all we can. The debt must be reduced but modern health care delivery, with all of its technical advancements, must be utilized. Patients should receive quality health care with respect, but physicians and health care providers must be respected as well.

On October 30, 2009, the final Medicare 2010 payment rules were published, confirming a 21.2 percent cut to Medicare physician fees. This is the largest payment cut ever after years of payment cuts to physicians. Access to care and choice of physician for seniors, baby boomers and military families is at serious risk. Is this how our government shows respect to its physicians? The SGR must be repealed and Congress must fulfill its obligation to America's seniors as they work to create new commitments to the American people through health reform.

Congressman Mike Rogers' (R-Michigan) opening statement on Health Care Reform quoted Abraham Lincoln: "You cannot make a weak man strong by making a strong man weak." Any health care reform must be done with respect for all sides and access to care must be maintained. Health care delivery must

remain strong while insuring those that *need* it are able to benefit from its availability.

Physicians must stand united and speak with a single voice to insure quality health care. I invite all the physicians of Oklahoma County to my inauguration on January 16, 2010. Take a moment and talk to me about your feelings and make your voice heard as I try to involve all physicians of this county to combine with the state to be heard nationally. Without your involvement, we have little political clout and will continue to be victims of health reform. United, we can and will be heard.

The solution is difficult, but if politics and personal agendas are set aside, I am confident an answer can be found. □

Alliance

Why Should Doctors Care?

Is it that time already? What time? The 2010 Oklahoma Legislative Session is rapidly approaching and OCMS, working with OSMA and the Patients First Coalition, is preparing for a potential Billion (yes with a B) dollar revenue shortfall for the state budget. Why should OCMS members care about the revenue shortfall for Oklahoma? There are many reasons why the doctors in Oklahoma should be concerned, with the primary reason being the drastic budget cuts at the Oklahoma Health Care Authority, the Department of Mental Health and Substance Abuse Services, the Department of Human Services and the Oklahoma State Department of Health that are sure to follow. These cuts will take place in fiscal year 2010, especially beginning July 1, 2010. The budget will also dominate the debate at the state capitol regardless of political affiliation because of the tremendous impact on medicine, education, public safety, transportation – and the list goes on. The budget shortfall will so dominate the legislature that many other issues will be placed on the “back burner.” Issues that medicine considers important to include – creating the “indemnity fund” for the tort reform legislation passed in 2009 and addressing public health issues – will be a challenge for us to enact.

In addition to the serious budget shortfall, 2010 is an election year in which the top three statewide elected officials, (Governor, Lieutenant



Diana Hampton, MD

Governor and Attorney General), will have no incumbent running for office. Doctors must make their voice heard early in these campaigns. The good news is that OCMS members have a great opportunity to engage in the political process and make a positive difference for medicine. The time for medicine to stop playing defense and get on the offense is now! We must step up to the plate and engage in the political process to elect state representatives, senators and state-wide elected officials who are "medicine friendly." *Writing a check, writing a letter, phoning, emailing or making a personal visit to an elected official can make a tremendous difference.* Personal relationships are critical to the successful outcome of our agenda. Please **join us for Medicine Day at the state capitol on Wednesday, February 24, 2010** and make your voice heard!

In closing, 2010 is going to be an exciting year of politics with many twists and turns as usual. The legislature will have a tough year of balancing the budget and we must increase our involvement to prevent that balancing act from adversely affecting the practice of medicine and our patients. □



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Important OCMS News

The transition to 2010 has barely begun, but already there is important news to share with OCMS members.

Membership Meetings

Please mark your calendars now - and save the dates! Although meeting notices will be mailed, we know our members are incredibly busy people so we want to make sure you have these dates well in advance. There will be four Membership Meetings, as usual. They will be February 15, April 26, September 27, and November 15, 2010.

Membership Directory

The 2010 Directory will be published this month. One complimentary copy will be mailed to each OCMS member. Additional copies will be available to members at \$10 each and to nonmembers and the public for \$20 each. Although at this time we can't project when, plans are underway to make it available on the Society's webpage.

The Bulletin

The new year also is ushering in a revised publishing schedule for the *Bulletin*. We will now be printing January, March, June, September, November and December issues. Beginning with the November, 2009 issue, each issue will also be available on our webpage; they will be archived for future reference.

Please note that these changes have not altered one important aspect of the publication: We still welcome letters to the editor, articles, poems and art for consideration by the Editor.

OSMA Annual Meeting

The OSMA Annual House of Delegates Meeting will be Saturday, April 17, 2010, at the Reed Center in Midwest City. At least one important issue will be considered: *whether to, once again, become a "unified state,"* which requires membership in AMA in order to be a member of OCMS and OSMA. Long-time members may recall that Delegates rescinded that requirement for a trial period of three years. Without action by Delegates at the 2010 Annual Meeting, the unified status requirement will automatically be reinstated with the 2011 dues year. *If you would like to serve as a Delegate to the Annual Meeting, call the OCMS office (702-0500) or email llarason@o-c-m-s.org.*

OCMS member Dr. K.A. Mehta will be installed at the OSMA Inaugural Dinner. Watch for your invitation and help welcome him to office! □

Director's

DIALOGUE

*Every new beginning
comes from some other beginning's end.*

Seneca, 5 BC - 65 AD

Roman dramatist, philosopher and politician

Happy New Year! Many of us make those dreaded New Year's Resolutions as each year begins anew. My experience has been that mine do not last very long. By January 1st, the holiday festivities and visions of sugar plums seem months – not weeks – in the past. Even if I am not successful in keeping the promises I make to myself, the act of beginning the year with a blank slate is met with anticipation and some degree of excitement.

2010 is no different. The year will begin with a focus of recruiting younger physicians to organized medicine in Oklahoma County. Approximately 17 percent of the Society's active, dues-paying membership is composed of physicians under the age of 45. Considering that 36 percent are over the age of 60, it becomes apparent that the Society cannot continue to exist without reversing the dwindling membership numbers. OCMS leadership has made a commitment to develop and implement strategies to increase membership numbers, and those will be shared with you in future publications.

Have you ever wanted to refer to a back issue of *The Bulletin* but can't seem to locate it? *The Bulletin* is now online and will be archived from the November 2009 issue forward. Visit the Society's website – <http://o-c-m-s.org> – and click the Bulletin button. Members will notice an additional change for the Society's official publication this year. Instead of 10 months, *The Bulletin* will be published six months annually. This difficult decision was approved by the Board of Directors due to budgetary constraints.

The 2010 Physician Directory will also be affected by a budget decision. Active, dues-paying members are accustomed to receiving two complimentary directories each year, with retired members receiving one directory. In early February, the number of complimentary copies furnished to regular members will be



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decreased one. Retired members will not be affected. OCMS members can purchase additional directories for \$10 each, a 50 percent savings over the price charged to the general public or non-members. Plans are underway to place the directory online to provide access to physicians, their staff members or the public at no charge.

The recession has affected the Society in much the same way each of you have felt the tightening of finances. Expenses have increased, while dues-paying members have decreased. Sound familiar? But you can be assured the Oklahoma County Medical Society continues its commitment to providing membership services while maintaining fiscal responsibility. These new beginnings do not signify "some other beginning's end" but a sound approach to ensure the Society is a viable organization for future generations of physicians and this community. □

Jana Timberlake, CAE, Executive Director

New Members



Gregory L. Blair, MD
(IM)
1000 N. Lee
University of Oklahoma 1993



Brett A. Germany, MD
(EM)
4300 W. Memorial - ER Dept
University of Oklahoma 1998



Gary M. Lawrence, MD
(FM)
1919 E. Memorial
University of Oklahoma 1980



Brent A. Mefford, MD
(EM)
4300 W. Memorial - ER Dept
University of Oklahoma 2004



Jeffrey G. Reames, MD
(EM)
4300 W. Memorial - ER Dept
University of Oklahoma 1989



Kenneth A. Seres, MD
(IM GE)
3366 NW Expressway, #380
University of Oklahoma 2001



Saundra S. Spruiell, DO
(Phlebology)
13820 Wireless Way
Oklahoma State Univ. 1988



Jennifer L. Strelbel, MD
(OBG)
4200 W. Memorial Rd., #201
University of Oklahoma 2005

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Electronic Medical Records

Planning the Selection Process - Part 1

Joe Denney, RN

In this article, I will focus on planning your selection process. As in the past, I continue to focus on proper planning to help increase your chances of a successful EMR implementation. Jumping into an EMR without consideration of all the things specific to your practice is a recipe for disaster. Vendors will tell you how easy their products are to set up and use, but the reality is that over half of EMR implementations fail, usually due either to poor planning, poor communication, or poor project management.

Assuming you have completed the pre-planning activities outlined in last month's article, you are now ready to begin developing specific criteria you will use to evaluate several EMR products. Focusing on usability, how to get data into and out of your system, hidden costs, and developing your own selection matrix will go a long way to maximizing the value of your time spent evaluating EMR products. Armed with a good knowledge of what *you* need, you can make vendors answer questions important to you.

Usability is, arguably, the most important factor in choosing an EMR. You will be interacting with the software more than anyone, and it **MUST** be a system you can quickly input information into and get information from. Reducing the number of clicks, the amount of typing, and the number of screens you have to navigate through to do your job is critical. The longer a task takes to complete in your EMR, the less time you will have to do something else, such as spend with your patient or your family. Develop a list of three or four of your most common tasks and document those tasks. Then, when you are having a vendor demonstration, ask the vendor to perform those tasks. Note how long it takes to do them, as well as how many clicks of the mouse it takes, how much free text typing has to be done, how many screens are opened and closed during the task, and whether or not you can quickly find the information you need to complete the task. Examples of this include writing a new prescription for a patient and authorizing a refill of an existing medication. Develop

a “standard” patient visit with some common issues and an order for a lab test and have the vendor show you how long that process takes, again keeping in mind some of the metrics discussed above. Request a demonstration on scheduling a patient, both for a follow up after a visit and for a new patient on the phone. Have your administrative staff develop a couple of use cases of their own and keep notes of the metrics above. Always keep in mind that clinical ease of use trumps administrative ease of use, because provider billable time is more valuable than administrative time, since administrative time is generally cheaper per hour than clinical time.

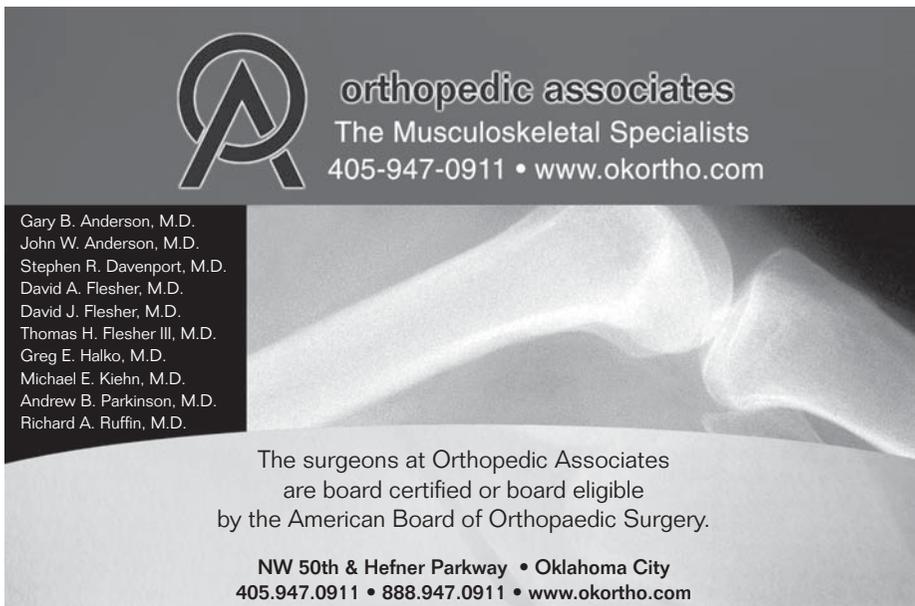
How will you get data into your system? This is a big factor in the success of your EMR project because if you can start on your live date with up-to-date information in your system, your experience will be more positive. Can your PM software export data? How much will this cost, or can you do an export yourself? Can the potential EMR software import data? What format does this data need to be in? What is the estimated cost for this import? Bringing information in from the PM system should provide you with a full patient listing, including demographic information and a basic level of information regarding the billing and diagnosis codes for this patient. Can your potential EMR import information from lab providers on your patients? How about pulling your patients’ information from SureScripts or other e-prescribing resources? Asking questions about where you can import information from and how much it will cost are all factors that will weigh on your final EMR decision. The other issue to consider is how to get clinical information captured in your paper records into the EMR. Scanning the paper chart into the EMR is a common solution, and one that typically is poorly thought out. It’s much faster to keep the paper chart handy and refer to it for historical information than to page through screen after screen of barely legible scans, looking for the one thing you need. Having *relevant* extraction done by an MA/LPN or even your RN before the visit is a solution that can be successful, if you think the process through. What information do you need for every visit, and what information is not essential? How far back should the extraction go? If Mrs. Smith is here for a visit after an abnormal breast self-exam, is information regarding her varicose

veins from three years ago really needed? Delegate as much as you can, and always remember your paper charts are historical records you can refer to, although you aren't going to be updating them any longer.

In the next issue I'll continue this topic, and give you some online resources to help you plan your selection process and develop your own selection matrix, so you can compare apples to apples. □

Controlling Diabetes

The December "On the Road to Health" posted by the Oklahoma City-County Health Department cites a study which studied 3,234 overweight and obese adults with elevated blood sugar levels. Researchers assigned the adult patients to one of three treatment groups: lifestyle changes, metformin, or placebo group. The metformin group experienced an 18 percent reduction in their rate of developing diabetes compared with those in the placebo group. Not surprisingly, the lifestyle group experienced a 34 percent reduction compared with the placebo group. □



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Prevention Key to Health Reform

Poll Results

A recent public opinion survey found that 71 percent of Americans favor an increased investment in disease prevention and that disease prevention is one of the most popular components of health reform. Forty-four percent of Americans strongly favor investing more in prevention.

In the poll, investing in disease prevention received majority support from across the political spectrum (85 percent of Democrats, 59 percent of Republicans, and 68 percent of Independents) and across the country (72 percent in the Northeast, 73 percent in the South, 71 percent in the West, and 69 percent in the Midwest).

By nearly a three-to-one margin (70 percent to 24 percent), respondents believed prevention will save – rather than cost – money. Sixty percent believed investing in prevention is worth it at a cost of \$34 billion out of the \$900 billion total proposed health reform spending proposals. Sixty-five percent of Americans said they would either be more likely to support a member of Congress who votes for the proposal to invest in prevention or that it would make no difference to their vote.

Nearly two-thirds of Americans rank investing in prevention between an eight and 10 on a scale of zero to ten, where zero means not at all an important health care priority and 10 means very important. Prevention is the second highest proposal tested, after prohibiting insurance companies from denying coverage because of age, medical history, or pre-existing conditions. Other proposals tested included providing tax credits to small businesses and requiring all businesses to provide health care for their employees or contribute to a fund to help pay for their coverage.

The poll, which reflects the responses from 1,008 registered voters, was conducted by Greenberg Quinlan Rosner Research and Public Opinion Strategies from November 2 to 5, 2009, and is available at www.healthyamericans.org. The margin of error was +/- 3.1 percent.

The survey was funded by the Trust for America's Health and the Robert Wood Johnson Foundation. □

End of Life Issues

Bill Truels, MD

I was sitting in the surgery lounge, sipping on coffee and donuts, waiting for my gallbladder case to start, when Herb walked in, looking somewhat disheveled and forlorn.

"You look down and out, Herb," I began. "Here, have some coffee - that'll cheer you up."

"Thanks, Dr. Truewater," Herb replied. "But I'll need more than coffee to cheer me up."

"What's the problem?" I asked.

"I'm dealing with end of life issues, Truewater."

"Aren't we all," I replied. "You know, the heart surgeon, Jim Hardy, used to park his Lexus at the first parking spot at Holy Christian every morning 'cause he was always the first one to get here every day. Now that he's retired, some young buck parks there every day with his new Hummer - it just doesn't seem right."

"Changing times, Dr. Truewater - nothing is static," Herb commented. "But I've got more serious problems than that. It seems that I've flunked my final exam."

"What final exam? I thought you were all through taking those pesky board recertification exams."

"Well, you know I've got prostate cancer, and I've had chronic pain," Herb replied.

"Yes, I'm sorry you have to go through that, Herb," I said.

"I took this tourist package they offer to Switzerland," Herb continued.

"Sounds like a fun trip," I answered, "a good way to cheer up and get a new perspective on life."

"Not exactly, Dr. Truewater," Herb countered. "You see, it's a one way trip - they call it an End of Life venture. You go to Switzerland, see all the usual sites, then you tell them your End of Life issues on your final exam, and for a mere \$3,000 tour package, you get euthanized, and they spread your ashes over beautiful Lake Geneva."

"Herb, I didn't know things were so serious. I'm shocked, shocked that you would consider such a thing. We're talking

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death here, and you're only 75. Besides, the hospital never threw your farewell party."

"We'll, I just took stock of everything," Herb answered forlornly. "For one thing, I'm tired of paying my life insurance premiums out of my social security income. I'd like to see that money go to my kids - I've been paying for fifteen years, but if I quit paying now they'll cancel my insurance.

"And I'm tired of all these government threats to cut my reimbursements by 20 percent to help pay for national health care. That 20 percent represents my profit margin, once I finish paying my malpractice premiums.

"And I'm fed up with all these government audits - I just had to send them 2,000 pages of medical records so they could see if I'm coding my procedures correctly. They want to see if I've got enough 'bullet points' in my progress notes to justify a \$30 visit.

"Well, I'm sorry to hear that, Herb," I sympathized. "But I'm glad you decided against euthanasia in Switzerland and came back."

"It wasn't my decision," Herb replied. "You see, I flunked my final exam."

"You flunked your final exam?" I asked.

"Herb, you always finished at the top of the class on your exams. What happened? Did they ask you a bunch of anatomy questions?"

"Well, they asked me what my end-of-life issues were and I told them I had prostate cancer and I was having a lot of pain."

"That sounds pretty convincing to me," I said.

"They said prostate cancer wasn't serious enough," Herb replied. "They said breast cancer was more acceptable, because it was more serious.

"Then I told them I was depressed about all the changes in health care and they said, 'Welcome to socialism!' They weren't very sympathetic for a euthanasia clinic. I mean, they were turning down CEOs of large companies, politicians, department chairmen, hospital administrators, you name it."

"Well, I'm sorry to hear you were rejected, Herb," I replied. "But I'm glad to have you back among us in the doctor's lounge."

"Thanks, Dr. Truewater," Herb answered. "But you want to

know the worst part?"

"What's that?" I asked.

"The End of Life tour package only includes a one way ticket to Switzerland. I had to pay \$1,500 for a no-discount one-way ticket back to Oklahoma City!" □

Helping Smokers Quit

What Works Best?

You want your patients to quit smoking. But what works best to help them kick the habit?

To determine the effectiveness of prescription and over the counter medications, researchers at the University of Wisconsin-Madison studied over 1,500 smokers who wanted to quit. The smokers were randomly assigned to receive different medications or no medication for up to three months. They found that people taking the nicotine patch plus the nicotine lozenge had the best success. About 40 percent of them were still smoke-free six months after their quit date. About 33 percent of patients remained smoke-free when they'd taken other medications, like the nicotine patch or nicotine lozenge alone, the prescription drug bupropion (Zyban), or a combination of the nicotine lozenge plus bupropion. Only 22 percent of those taking no medications were still smoke-free at six months. The researchers didn't look at other common quit-smoking aids, including nasal sprays, inhalers and nicotine gum. They also didn't evaluate the medication varenicline (Chantix) because it hadn't yet been approved by the U.S. Food and Drug Administration when the study began. The study was funded by the NIH. □



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Law and Medicine

The Physician-Patient Relationship

S. Sandy Sanbar, MD, PhD, JD, FCLM

Chairman, American Board of Legal Medicine

Adjunct Professor Medical Jurisprudence, TUN

The presence of an established relationship between the physician and the patient is a legal prerequisite to a medical malpractice lawsuit. The relationship represents a consensual contract, which may be express or implied, under which a patient seeks medical assistance and a physician or other medical professional agrees to render such treatment.

In public places, the physician has *no duty* to help another person who is ill, even though the person may die without assistance. Generally no duty is created where the physician provides professional medical services to third parties *without* treatment, such as independent medical examinations for insurance companies, informal consultations, so-called *curb side consults*, and telephone calls, where advice is given without reviewing records or examining the patient. Usually physicians have no duty to non-patients. *Merely listening* to another physician's description of a patient's problem, and then offering an opinion is not enough to create a duty where there is no agreement to treat and only informal assistance is provided. A *non-viable fetus* is not a person within the meaning of the Wrongful Death Act, and hence may not sue.

The independent medical examining physician who is retained by a third party for examination only and not treatment (e.g. pre-employment exam) owes no duty to an examinee. Because the physician acts for a third party and does not undertake to treat, he/she would not be liable for any alleged damages resulting from any conclusions the independent medical examiner (IME) reaches or reports. But, the IME physician has a *limited* physician-patient relationship with the examinee that can give rise to a medical malpractice claim based upon a limited duty to exercise professional care. The IME physician has a limited duty to perform an examination in a manner so as not to cause physical injury to the examinee. Additionally, a claim of ordinary negligence could exist against any healthcare provider, including IME physicians, for ordinary negligence, where an injury occurs

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INTEGRIS Health has acquired Odyssey HealthCare of Oklahoma City, which includes hospice home care and inpatient services. Hospice of Oklahoma County, Inc. (an affiliate of INTEGRIS Health) will provide the services previously offered by Odyssey HealthCare of Oklahoma City in an effort to strengthen services.

The inpatient facility opened in 2006 and is located in northwest Oklahoma City. Caring for approximately 800 patients, the twelve-bed facility will be known as INTEGRIS Hospice House. This is Oklahoma's first licensed inpatient hospice facility, and the newest addition to INTEGRIS Health.

We are excited about the new addition to our family of healthcare services – and look forward to caring for more Oklahoma families by bringing compassion home. Hospice of Oklahoma County is certified by Medicare, and is one of an elite group to be accredited by The Joint Commission.

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under circumstances not directly related to exercise of professional services. Finally, an immediate family member within a "zone of danger" may recover for severe mental disturbance caused from witnessing a negligently inflicted or threatened serious injury to the patient.

The physician-patient relationship is created by: (1) Accepting a person as a patient; (2) Undertaking to examine *and* treat a patient; or (3) Agreeing to be "on call" or be available to provide medical care. On-call cases may represent a *spectrum* of involvement. Mere *on-call status alone* is not enough to create an implied consent to a physician-patient relationship. If, however, a physician is *on-call and a discussion* takes place regarding the patient's symptoms, diagnosis, and treatment, a physician-patient relationship has been held to exist.

The physician's *duty* arises from a *special relationship* beyond just being there, examining third parties, mere listening or just being on call. Whether a special relationship exists to create a medical professional duty to another person is a *question of law* for the judge to decide. If the court determines that a defendant physician owes *no* duty to the plaintiff, summary dismissal is proper. But, if the court determines that a medical professional duty does exist, the nature and extent of the duty is generally for the *jury* to decide.

In determining whether to impose a duty, the Judge evaluates four factors: (1) The relationship between the parties; (2) The foreseeability of harm; (3) The burden on the defendant in imposing a duty; and (4) The nature of the risk of harm from the conduct complained of in the malpractice lawsuit.

Generally, there is no duty to protect *third persons* against the *criminal acts* of a patient. But when a patient communicates a threat of physical violence against a reasonably identifiable third person, this triggers a mental health professional's duty to act to protect the third party. Third-party communications do not appear to be sufficient to trigger the duty. A common-law duty might survive where a foreseeable danger is made known during the course of the patient's treatment. Hospitals have been held to owe a duty of care to a patient's family to take reasonable measures to prevent foreseeable harm. A special relationship must be sufficiently strong to require a defendant to take action to benefit the injured party. □

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On Professionalism

Healing Authority and Physician Professionalism

S. Sandy Sanbar, MD, PhD, JD, FCLM

Chairman, American Board of Legal Medicine

Adjunct Professor Medical Jurisprudence, TUN

The “*healing authority*” of physicians is based on scientific medical knowledge and expertise, and it dates back to the Oath of Hippocrates. The Oath demands “ethical” integrity on the part of physicians. The Oath enjoins the physician healer to a duty and service that is beneficent, in the best interests of the patient, coupled with a declaration of respect for human life under all circumstances. The physician is enjoined from taking advantage of or exploiting the patient-physician relationship, including any sexual relationship. Thus, the physician avoids discrimination, preserves confidentiality, is truthful and altruistic, suppresses self-interests for the welfare of others, refers and consults with colleagues when needed, adheres to medical lifelong learning, maintains a high level of the patient-physician relationship, and sanctions and censures incompetent physicians. Physicians use the healing authority to act as an intermediary between the patient and a body of knowledge, which generally is not possessed by the patient or society. The physician’s healing authority, which is based on expert medical scientific knowledge, benefits the patients but renders them vulnerable to its potential abuse.

Physician professionalism is generally regarded as a separate and distinct concept from the physician healing authority. Healing authority imposes duties, while professionalism generally denotes standards. Physician professionalism is an ideal toward which “healers” must always strive. The basic principles of physician professionalism emphasize factual knowledge, procedural competence, and technical advances as well as the humanistic qualities of professionalism. Physician professionalism stemmed from the societal creation of the concept of professions in the guilds of the Middle Ages. It represents a dynamic covenant between society and the medical profession, which is constantly evolving to meet the changing societal medical needs, e.g. H1N1,



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The physician's ability or authority to practice is granted through state licensure. The state acts in the best interest of society and the patient. Physician professionalism is influenced by both environmental and personal factors, including physician well being. If the physician fails to meet the needs and expectations of society, the privileges granted can be suspended or taken away altogether by the State Medical Licensing Board. Medical societies and associations at all levels, including hospital medical staff organizations, have also developed programs to meet societal needs, interface with government and corporations, aid in self-regulating and self-disciplining and serve the vital function of preserving the integrity of the medical profession.

The basis for the trust in the patient-physician relationship is physician professionalism. Trust is at the heart of the physician-patient relationship and the core of the medical profession. It is predicated on the integrity of both the individual physician and the profession as a whole. Physicians earn patient trust by their conduct, behavior, personal beliefs, values, attitudes and ideas when interacting with patients and society. Physician professionalism denotes a core set of values which represent the sum total of education from childhood to postgraduate medical training and serve as the infrastructure for the trust that is absolutely necessary to the patient-physician relationship. The goal of the patient-physician relationship is healing. The physician always acts in the best interest of the sick patient who is vulnerable and in constant need for reassurance. □

Health Care Industry Remains Healthy

Although many industries have suffered during the past decade, the health-care industry has nearly tripled its profits, according to data compiled by MarketWatch and reported by Tennessean.com. On average, the companies experienced sales growth of 160 percent and increased profits of 175 percent. Translated to dollars, that equals projected net income of \$94 billion on more than \$1 trillion gross revenue. The analysis included the past ten years' financial reports and Wall street estimates - or, if available, final results - for fiscal year 2009 of 52 of the 53 health-care companies included in the Standard & Poors 500. The nine groups that comprise the health-care sector include biotech, health-care services, hospitals, insurers, medical-device makers, medical suppliers, benefits managers, pharmaceutical makers and drug distributors. □

**Oklahoma City-County Health Department
Epidemiology Program
Communicable Disease Surveillance**

COMMONLY REPORTED DISEASES	Monthly			YTD Totals [^]	
	Nov'09	Nov'08	Oct'09	Nov'09	Nov'08
Campylobacter infection	5	16	5	85	121
Cryptosporidiosis	3	1	1	15	34
E. coli 0157:H7	1	0	1	9	5
Ehrlichiosis	0	0	0	7	6
Giardiasis	0	8	4	39	32
Haemophilus influenzae Type B	0	0	0	0	1
Haemophilus influenzae Invasive	1	0	0	14	15
Hepatitis A	0	0	0	4	7
Hepatitis B*	12	20	11	160	223
Hepatitis C *	15	9	11	235	273
Legionellosis	0	0	1	3	2
Lyme disease	0	0	0	5	11
Malaria	0	0	0	0	1
Measles	0	0	0	0	0
Mumps	0	0	0	2	0
Neisseria Meningitis	1	2	1	4	7
Pertussis	4	2	0	22	13
Pneumococcal infection	1	0	1	14	15
Rabies (Animal)	0	0	0	0	0
Rocky Mtn. Spotted Fever (RMSF)	0	1	0	28	31
Rubella	0	0	0	0	1
Salmonellosis	4	16	4	102	161
Shigellosis	10	7	10	149	57
Tuberculosis	27	68	57	738	1013
ATS Class II (+PPD only)					
Tuberculosis	3	4	1	16	26
ATS Class III (new active cases)					
Tularemia	0	0	1	1	2
Typhoid fever	0	0	0	1	1
RARELY REPORTED DISEASES/Conditions:					
West Nile Virus Disease	1	0	0	5	6
Pediatric Influenza Death	0	0	2	3	2
Influenza, Hospitalization or Death	38	0	163	252	0
Influenza, Novel Virus	0	0	15	65	45
Strep A Invasive	0	3	2	33	2
Listeriosis	0	0	0	2	1
Yersinia (not plague)	0	0	0	0	0

* - *Over reported* (includes acute and chronic)

[^] *YTD - Year To Date Totals*

STDs/HIV - *Not available from the OSDH, HIV/STD Division*

Not reportable ⁺

CME Information

For information concerning CME offerings, please refer to the following list of organizations:

Community-based Primary Health Care CME Program

Sponsored by Central Oklahoma Integrated
Network Systems, Inc. (COINS)
Contact: Deborah Ferguson
Telephone: (405) 524-8100 ext 103

Deaconess Hospital

Contact: Yvonne Curtright
CME Coordinator
Telephone: 604-4979

Deaconess Hospital

Tuesday CME Program
Contact: Denise Menefee
Medical Library
Telephone: 604-4524

Integris Baptist Medical Center

Contact: Marilyn Fick
Medical Education
Office
Telephone: 949-3284

Integris Southwest Medical Center

Contact: Marilyn Fick
CME Coordinator
Telephone: 949-3284

Mercy Health Center

Contact: Debbie Stanila
CME Coordinator
Telephone: 752-3806

Midwest Regional Medical Center

Contact: Carolyn Hill
Medical Staff Services
Coordinator
Telephone: 610-8011

Oklahoma Academy of Family Physicians Choice CME Program

Contact: Sue Hinrichs
Director of
Communications
Telephone: 842-0484
E-Mail: hinrichs@okafp.org
Website: www.okafp.org

OUHSC-Irwin H. Brown Office of Continuing Medical Education

Contact: Letricia Harris or
Kathleen Shumate
Telephone: 271-2350
Check the homepage for the latest CME
offerings:
<http://cme.ouhsc.edu>

St. Anthony Hospital

Contact: Lisa Hutts
CME Coordinator
Telephone: 272-6358

Orthopaedic & Reconstruction Research Foundation

Contact: Kristi Kenney
CME Program Director
or Tiffany Sullivan
Executive Director
Telephone: 631-2601

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