BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY

JULY/AUGUST 2018

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OKLAHOMA COUNTY MEDICAL SOCIETY

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THE BULLETIN

July/August Volume 91 Number 4
Six Annual Publications • Circulation 1500

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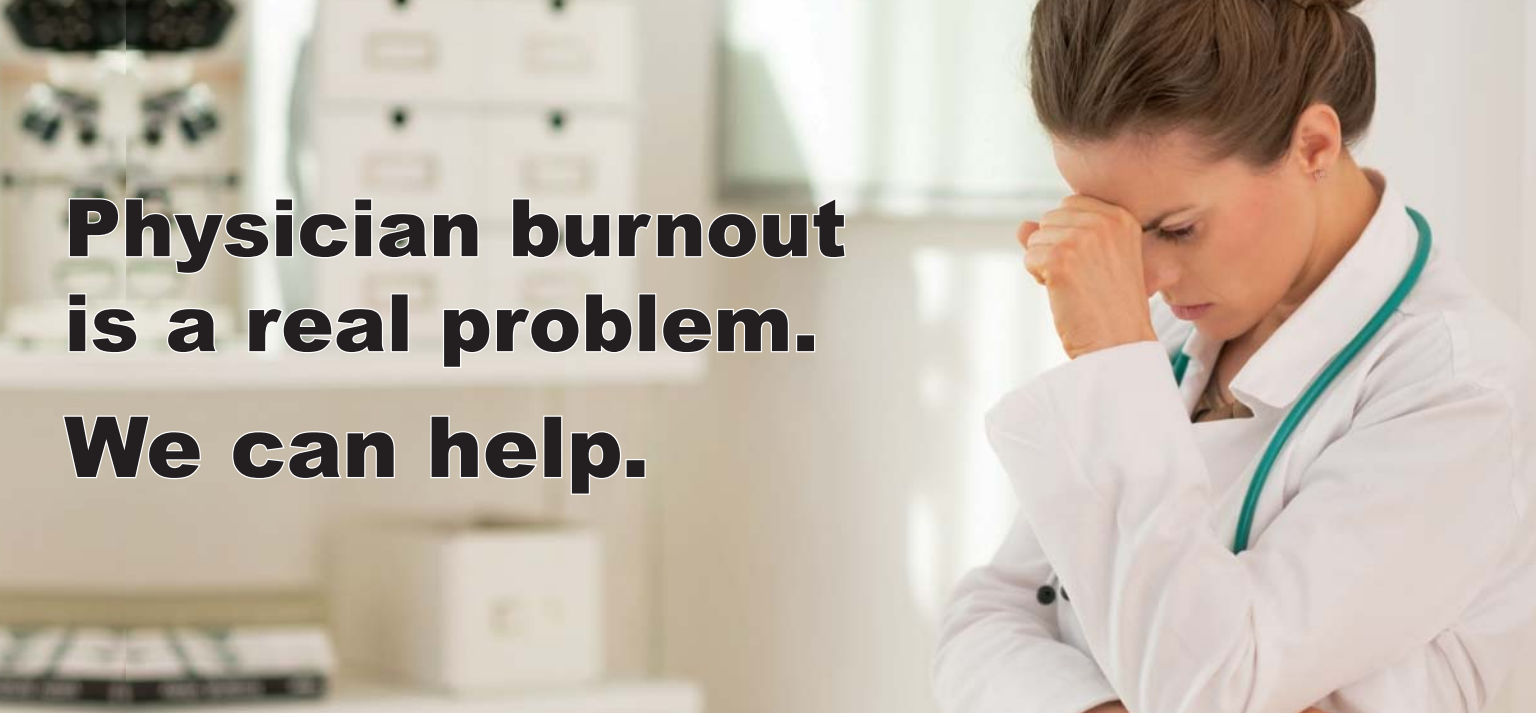

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- Create a better work/life balance
- Resolve issues with family and friends
- Develop strategies to deal with difficult patients or colleagues
- Cope more effectively with burnout
- Find ways to get your life back on track and thrive
- Deal with the constant-changing environment of medicine

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ABOUT THE COVER

In December, OCMS launched the Physician Wellness Program (PWP) to provide confidential counseling sessions to member physicians and residents. In the short time since the launch, the PWP has helped eight physicians in more than twenty sessions. Sessions are 100% confidential, with no electronic records, no insurance billing, and off-site at a private location.

Every day, physicians face major obstacles. Mandates, stress at home, increased clerical burdens, requirements, lost passion, burnout, stress at work, pressure, and so much more.

The goal is to help physicians:

- Address feelings of anxiety and depression
- Deal with the stress of litigation
- Create a better work/life balance
- Resolve issues with family and friends
- Develop strategies to deal with difficult patients or colleagues
- Cope more effectively with burnout
- Find ways to get your life back on track and thrive
- Deal with the constant-changing environment of medicine

Services are available by calling the psychologists' office directly and making an appointment. An answering service is available for after-hours calls. This program is convenient, with sessions at convenient times for the physician.

Physicians have higher rates of burnout and depressive symptoms. Your colleagues in Oklahoma County need your help to combat this public health issue. Recently, OCMS received funding that is contingents upon raising a minimum of $5000 in member donations. We need your help to continue to provide these lifechanging services for our members.

To learn more about the PWP, visit www.okcountymed. org/pwp. To make a tax-deductible contribution, visit www.okcountymed.org/donate. Funding for the program, in part, is provided by the Oklahoma State Medical Association Foundation.

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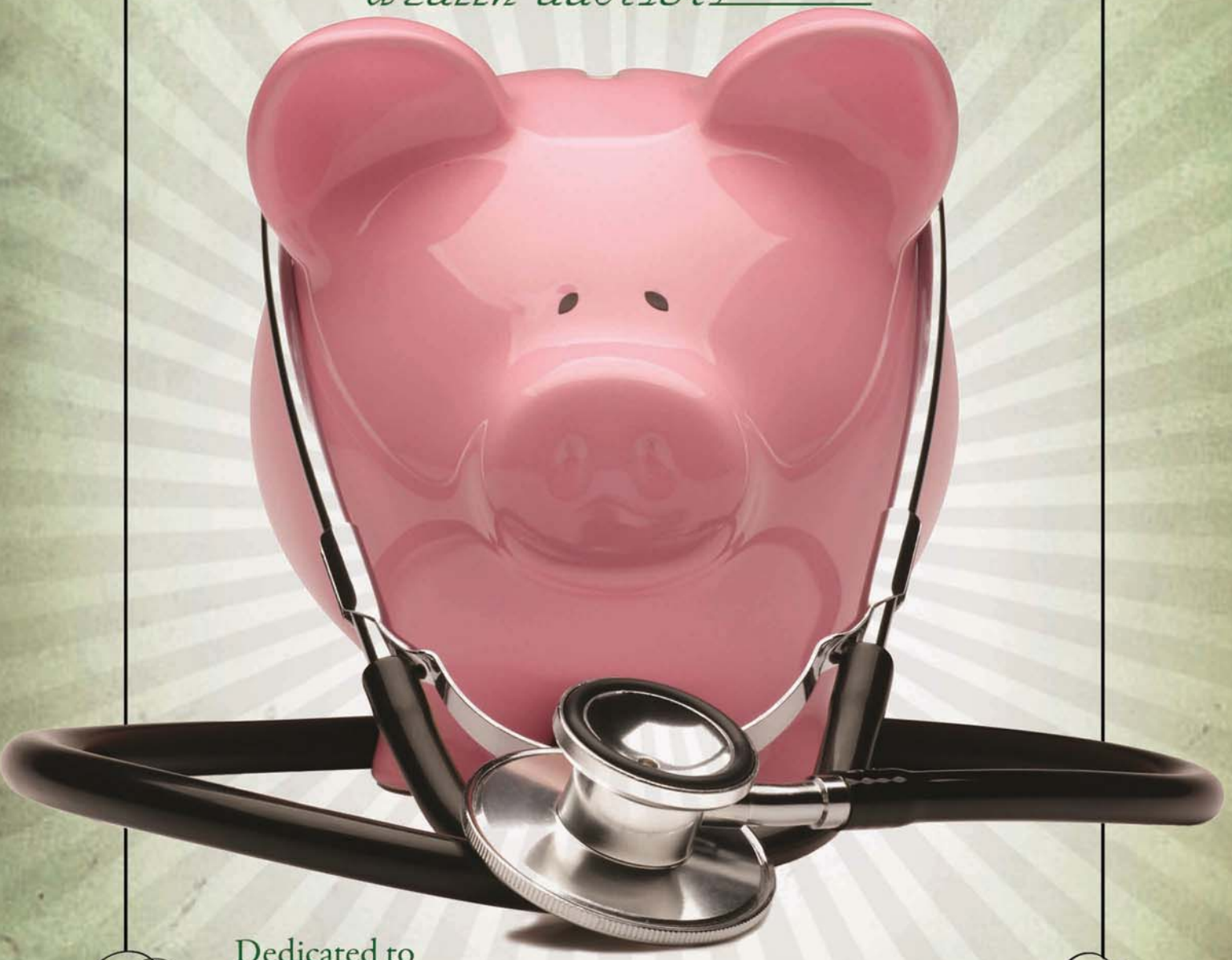

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PRESIDENT'S PAGE

Sam S. Dahr, MD

When the high costs of the U.S. health care system are compared to European countries, pundits from across the political spectrum often point to higher incomes among U.S. physicians. If U.S. physicians were only reimbursed akin to their European counterparts, health care costs in the U.S. would be more reasonable …

Wrong! The March 13th edition of JAMA features a very technical economic analysis of health care spending in the U.S. vs. other high-income countries[1], accompanied by a secondary analysis by Ezekiel J. Emanuel, M.D., Ph.D.[2] I would encourage you to read Dr. Emanuel's essay. An oncologist by training, he is currently a health care policy professor at the University of Pennsylvania. He and Bob Kocher, M.D. (now at Venrock, the venture capital firm of the Rockefeller family) were high level aides in the Obama White House and essentially wrote the Affordable Care Act. One brother is Rahm Emmanuel, mayor of Chicago, and the other brother is Ari Emmanuel, famous Hollywood talent agent on whom the HBO show Entourage was based.

Anyway, enough fun trivia. The point is that Dr. Emanuel does come from the more liberal end of the spectrum and is not necessarily a defender of physician incomes. However, his analysis of the drivers of high health care costs in the U.S. is quite compelling. First of all, he points out that costs are prices multiplied by volume. Yes, U.S. physicians do earn more than European physicians e.g. the "price" of a physician is higher. However, the number (e.g. "volume") of U.S. physicians is lower than comparable European countries. The U.S. features 2.6 physicians per 1000 citizens compared to 4.1 per 1000 in Germany and 4.2 per 1000 in Sweden. Thus, Emanuel points out that the per capita costs of paying physicians is identical or very close to European countries. The higher incomes of U.S. physicians do not make much difference with regards to high costs of health care in the U.S. versus Europe.

What are the drivers of the difference? Again, utilizing this price times volume methodology and then dividing per capita, Dr. Emanuel calculates that drug prices account for 18% of the difference in health care spending between the U.S. and Germany and 34% of the difference with Sweden. A second major driver is high-price, high-volume procedures such as angioplasty, knee replacement, cesarean deliveries, spine surgery, hysterectomy, and prostatectomy. For about twenty-five of these procedures, both the volumes and the prices in the U.S. are high, accounting for 20% of the per capita cost difference between the U.S. and European countries. A third driver is imaging, explaining about 7% of the per capita cost difference. A fourth area is administrative costs, likely accounting for around 13% of the per capita cost difference.

Continues on page 6 …

REMINDER

Ballots will be mailed on or before September 15. See our list of nominees on pages 20-21.

YOUR **VOTE** COUNTS!

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 Continued from page 5 ...

Obviously, we have a long way to go here in the U.S. with regards to reducing the costs of our health care system. No society in the history of humankind has enjoyed unlimited resources; spending in one area may crowd out worthwhile spending in another. As folks on the front lines, we as physicians must offer insight and analysis to help tackle the problem. However, when the pundits go on TV or write a column blaming physician income, we are certainly entitled to defend our hard-earned careers.

.....

Moving from the policy viewpoint at 35,000 feet to the ground level, the other day I had a nice conversation with a patient that reminded me of the lifelong ambition and sacrifice that characterize our profession. This 66 year old patient came in for a diabetic fundus checkup, and the retina looked good, and the conversation turned towards his overall health. Let's just say "Mr. Jones" voiced a strong preference for being on this earth for a good many years to come. His baby girl was born when he was fifty and is now a 16 year old varsity athlete at a local high school with a 4.5 GPA. Her plan is to attend VoTech during summer, earn her LPN by the time she graduates high school, and then work as an LPN part time and pay her way through college and subsequently go to medical school and be a doctor. I must humbly say my pathway was easier, but this story reminded me of the aspiration, drive, and ambition that it takes to reach for a career as a physician. A physician career is earned. Collectively we can say our colleagues' accomplishments humble us every day, and I think this 16 year old student will one day as well.

[1] Papanicolas I, Woskie LR, Jha AK. Health care spending in the United States and other high-income countries. JAMA. 2018;319(10):1024-1039.

[2] Emanuel EJ. The real cost of the US health care system. JAMA. 2018;319(10):983-985.

EARLY MEMBERSHIP RENEWAL OPPORTUNITY

Why am I receiving a bill?

Some members expressed concern about many professional memberships being billed late in the calendar year, resulting in financial hardships. Other members found it difficult to renew or join in the middle of an academic year.

What is the dues cycle?

The dues cycle remains the same - January 1-December 31.

Can I still pay with Easy Pay?

Yes. Easy pay can be split into three montly payments.

When is the due date?

Members will be dropped from membership if payment for the 2019 dues are not received by March 1, 2019. The change in billing is a convenient option for those who prefer to renew earlier.

Is the price changing?

No.

Questions? Contact Eldona Wright
ewright@okcountymed.org;
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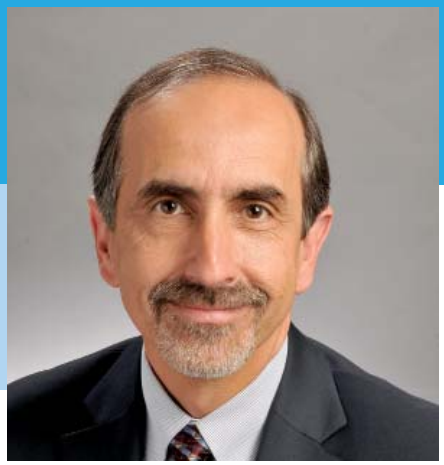
DEAN'S PAGE

John P. Zubialde, MD
Interim Executive Dean and Professor,
Family and Preventive Medicine
University of Oklahoma College of Medicine



In contrast to the last issue of The Bulletin, where Dr. Russell Postier authored his final Dean's Page, this is my first while serving as Interim Executive Dean of the University of Oklahoma College of Medicine, effective July 1. Similar to my two predecessors, I have dedicated most of my career to the College of Medicine which, for me, began in 1991 when I joined the faculty. It is with distinct pleasure that I commit to the role and responsibilities of this important position as the search proceeds for the next Executive Dean.

Last year, in the November/December edition of The Bulletin, Dr. Postier wrote about the Stephenson Cancer Center at the University of Oklahoma Health Sciences Center submitting its application to attain National Cancer Institute (NCI) designation status. I am pleased to share with you that as of early May this year, the Stephenson Cancer Center did indeed receive the prestigious designation reserved for the top two percent of cancer centers in the country: A National Cancer Institute (NCI) Cancer Center. Because this is the only NCI-Designated Cancer Center in Oklahoma, Stephenson Cancer Center patients will now have access to new drugs, treatment options and clinical trials offered only at NCI-Designated Cancer Centers. Our citizens will have access to the highest standard of cancer care, right here in Oklahoma, thanks to the support of many stakeholders – including the Oklahoma State Legislature, the University Hospitals Authority and Trust, OU Medicine, the Oklahoma Tobacco Settlement Endowment Trust, the state's philanthropic community, the Chickasaw and Choctaw Nations, and the citizens of Oklahoma.

On August 14, we will welcome the incoming Class of 2022: The 137 new students to the Oklahoma City campus will begin their 3-day orientation to the medical school, the curriculum, and to the expectations we have of them upon beginning their medical education. Professionalism is emphasized on the first day during their participation in small group discussions "Case Studies in Professionalism." Their orientation activities culminate with two major events: First, the Anatomical Donor Luncheon during which students meet with family members of the individuals who donated their body for anatomical study. Over the years, this event has proven to be a special and sensitive experience for all concerned, and one that students and families truly enjoy.

Second, is the White Coat Ceremony: A well-established tradition in its twenty-first year and very meaningful experience for the students and their families, the new class is welcomed by the faculty, and Medical Student Council President into the medical school and to the fulfilling journey that awaits. Dr.

Continues on page 10 …

Greg Skuta, President and Chief Executive Officer of the Dean McGee Eye Institute; Edward L. Gaylord Professor and Chair, and Regents' Professor for the Department of Ophthalmology, University of Oklahoma College of Medicine, will be the keynote speaker. We are appreciative of The College of Medicine Alumni Association for providing breakfast and lunch as well as the stethoscopes and white coats for each student.

I look forward to sharing with you in future Dean's Pages, events and progress in the medical school on a variety of subjects and hope to further enhance the existing good relationships between the Oklahoma County Medical Society and the College of Medicine.

Editor's Note: Dr. Zubialde has provided leadership to the College of Medicine as Senior Associate Dean since 2015, while continuing to teach and deliver patient care in Family Medicine. Earlier, after having served as Program Director of the OU Family Medicine Residency program, Dr. Zubialde served as Associate Dean for Graduate Medical Education from 2000-2015 during which time he was also appointed as Adjunct Professor at Dartmouth Medical School due to his national work in the care of the complex patient and health systems innovation. Save for his undergraduate medical and residency experiences at the University of New Mexico School of Medicine, Albuquerque, and years serving in the United States Air Force (attaining the rank of Major) - as Chief of Family Medical Services at the USAF Clinic and Hospital at Tinker AFB, his academic career and clinical practice have been centered in the College of Medicine and Health Sciences Center.

Non-Opioid Treatment of Acute pain

S. Sandy Sanbar, MD, PhD, JD,* and
Blake Christensen, D.O. **

Physicians who treat acute pain are increasingly avoiding the use of opioids in order to minimize the high incidence of adverse effects such as nausea, vomiting, constipation, oversedation, and respiratory depression. Some patients (e.g. renal colic) are at extremely high risk for developing opioid dependence.

Instead, physicians are using nonopioid multimodal analgesic therapies to alleviate acute pain, facilitate the surgical recovery process, reduce side effects and improve patient satisfaction. They are turning toward the use of NSAIDs and COX-2 inhibitors, local anesthetics, steroids, antidepressants, anticonvulsants and other adjuvants, as well as nonpharmacologic analgesic techniques (Acupuncture and acupressure; transcutaneous (TENS) and percutaneous (PENS)

*Lecturer and CME Director, Western Institute of Legal Medicine, San Mateo, CA
**Anesthesiologist and Pain Management Specialist, Oklahoma City, OK

electrical nerve stimulation; Low-level laser therapy (LLLT) and high-intensity cold laser therapy; physical therapy, e.g. exercise, yoga, massage), and interventional procedures, e.g. trigger point injections, nerve blocks, and epidurals.

In ambulatory surgery, for example, rapid and short-acting local anesthetics for spinal anesthesia are potentially beneficial for day-case surgery in the older population because of shorter duration of the motor block, faster recovery, and less transient neurologic symptoms. Patients with renal colic pain who are treated only with intravenous ketorolac are almost twice as likely to be discharged from the ED in less than 3 hours versus patients who received only opioids. And, stone patients who receive narcotics only or a combination of opioids and ketorolac are two to four times more likely to be admitted to the hospital. The following are non-controlled drugs which may be used IV or IM to manage acute pain.

1. **Ketorolac tromethamine (Toradol)** is a nonsteroidal anti-inflammatory drug (NSAID) which has been effectively used intravenously (IV) or intramuscularly (IM) for decades to treat short-term postoperative moderate to severe pain. It is usually used before or after medical procedures or after surgery. It also helps to decrease swelling, pain, or fever. It is available in prefilled syringes and single-dose vials, 30 mg/ml, for IV push or IM administration q6hr; not to exceed 120 mg/day. Its use is limited to a 5-day treatment duration due to an increased risk of gastrointestinal (GI) bleeding. IV ketorolac may be more cost-effective than IV morphine. Ketorolac should not be used for mild or long-term painful conditions.
2. **Ibuprofen (Caldolor)**, an NSAID, is approved by the FDA for use as monotherapy or in combination with opioids to treat both mild to moderate pain and moderate to severe pain. Intravenous ibuprofen has been shown to be well tolerated and has significant opioid sparing effects during the postoperative period. The dosing for IV ibuprofen is 400 mg to 800 mg every 6 hours as necessary with a maximum of 3200 mg per day. The product must be diluted prior to administration and then infused over a period of 30 minutes. IV ibuprofen does not have a limit on duration of use. It is contraindicated for the treatment of perioperative pain in the setting of coronary artery bypass graft surgery.
3. **Diclofenac sodium**, an NSAID, is approved IV for management of mild-to-moderate pain and moderate-to-severe pain alone or in combination with opioid analgesics. The dose is 37.5 mg IV bolus injection infused over 15 seconds q6hr as needed, not to exceed 150 mg/day. It is used for a short duration and patients must be well hydrated prior to IV administration.
4. **Parecoxib sodium** is the first parenteral COX-2 inhibitor used for pain management licensed for postoperative pain. The analgesic efficacy of parecoxib sodium 20 and 40 mg, IV or IM, has been found to be similar to that of Ketorolac, 15 to 30 mg IV and 30 to 60 mg IM, and IV morphine 12 mg. It has an additive effect with morphine.
5. **Acetaminophen (Ofirmev; Propacetamol)** was approved in 2010 by the FDA for intravenous (IV) use in management of mild to moderate pain and moderate to severe pain with adjunctive opioid analgesics. It decreases opioid consumption

in major surgery by nearly one-third. The recommended IV dose of acetaminophen for patients weighing greater than 50 kg (110 lbs) is 1000 mg every 6 hours or 650 mg every 4 hours, with a maximum single dose of 1000 mg. For patients weighing under 50 kg, including children, the recommended IV dose is 15 mg/kg every 6 hours or 12.5 mg/kg every 4 hours to a maximum of 75 mg/kg per day. The most common side effects seen with IV acetaminophen are constipation, nausea, injection site pain, pruritus, and vomiting. Exceeding the recommended maximum dose of 4000 mg per day may potentially cause fatal hepatic injury.

6. **Ketamine (Ketamine HCl, Ketalar)** IV was introduced commercially in 1970 as a rapidly acting, nonbarbiturate general anesthetic. It is a N-methyl-D-aspartate (NMDA) receptor antagonist. It is used extensively in the emergency department for procedural sedation and rapid sequence intubation. It may be a viable option for treatment of refractory cancer pain. When given as a single bolus, the analgesic effect of ketamine is short lived. The peak effect occurs in the first several minutes after administration with a typical duration of 10–15 minutes. After a dose of 15-20 mg intravenous ketamine, it can be followed immediately by continuous ketamine infusion at 20 mg/h for 1 hour for severe pain.
7. **Dextromethorphan IV** is a N-methyl-D-aspartate (NMDA) receptor antagonist. When used perioperatively, it reduces postoperative opioid consumption.
8. **Lidocaine IV** is a useful acute pain adjunct to achieve enhanced recovery after surgery outcomes. It is a potent anti-inflammatory, anti-hyperalgesic, and gastrointestinal pro-peristaltic drug. Patients with acute hyperalgesia may show particular benefit. The dose of i.v. lidocaine necessary for analgesia in the perioperative period is 1–2 mg kg−1 as an initial bolus followed by a continuous infusion of 0.5–3 mg kg−1 h−1.
9. **Exparel (bupivacaine liposomal)** is a long acting local anesthetic used to produce local analgesia for pre- or post-operative pain control for specific nerve blocks. It inhibits nerve impulse initiations and conduction by inhibiting sodium ion channels to stabilize neuronal cell membranes. It has proven to prolong the time to first opioid use after surgery by 14 hours.

In conclusion, physicians have now an array of non-opioid, non-controlled drugs for use IV, alone or in combination with opioids, to treat acute pain.

[1] http://dx.doi.org/10.1016/j.anclin.2017.01.006

[2] http://www.acepnow.com/article/non-opioid-pain-medications-consider-emergency-department-patients/?singlepage=1&theme=print-friendly

[3] Portis A, et al "Non-narcotic emergency management of renal colic improves length of stay and discharge rate" AUA 2018; Abstract MP02-18

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Dana Stone, MD

How often have we commiserated with colleagues, "We didn't learn anything about managing a business during medical school or residency." Yet as soon as we either start our own practice, join an existing practice, or sign an employment contract, we realize that some business knowledge is invaluable. Physicians learn quickly, so we tend to pick up knowledge as we navigate through our business dealings in our practices, with hospitals, and with other organizations. Usually more formal business training takes a back seat to our practice and continuing medical education, so I was intrigued by an opportunity put together by the Oklahoma State Medical Association and Oklahoma City University Meinders' School of Business.

This year several Oklahoma physicians and I were among the first participants in the new Master Certificate in Healthcare Practice management offered by OCU. The entire course of study covers five graduate-level courses that are taught using an on-line format over nine weeks each with a week break between courses to catch your breath. The course content closely adheres to existing courses taught in the Master's of Business Administration degree program at OCU, but with a more specific healthcare administration focus and application. Each student who completes the certificate can elect to complete seven remaining MBA courses and earn the full MBA degree.

The courses were chosen using the results of a 2015 survey of practicing medical practitioners from across the state of Oklahoma. They also align with knowledge and competencies recommended by national healthcare organizations. The classes include: 1) Effective leadership and communication, 2) Healthcare finance decision making, 3) Healthcare market strategy and patient satisfaction, 4) Strategic management of healthcare organizations, and 5) Medical law and regulation.

The leadership and communication course included personality assessment, self-evaluation, and goal-setting. We also had a great introduction to constructive, respectful negotiating techniques. We,

of course, learned how to read and interpret financial statements in our finance class. We also covered using financial information to help drive decisions to add or remove services for hospitals and practices. Market strategy reviewed various marketing approaches and the importance of evaluating the patient experience. We are completing the medical law and regulation course now, which touches on the vast amount of legislation and policy that determines how hospitals and doctors do their jobs. I appreciate the need for consultation with experts to help us avoid costly errors that can lead to heavy fines when we make key business decisions.

Each professor presented the material a little differently, but after some initial orientation to a distance-learning format, I think we all adapted to the new learning style. I found the coursework valuable and very interesting. Every instructor seemed very aware of our need to learn relevant and applicable information based on our healthcare focus. I found the reading and class participation projects meaningful and I didn't feel that we were assigned "busy-work" at any time. This is NOT done at your own pace – which I thought was for the best. You don't have the flexibility to complete the work when it's most convenient, but you also can't fall behind. There are weekly assignments that keep you moving through the material.

Each one of the courses either introduced new concepts or reinforced and strengthened my previous knowledge base. I recommend this healthcare management certificate to any medical professional who is interested in better understanding leadership, finance, and other aspects of healthcare management. I think this will help me manage my own business better and prepare for the challenges coming with the ever-changing future of healthcare. The next group of students will start August 6, 2018. You can contact OSMA for further information about scheduling and reduced OCU tuition for the certificate.

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IN MEMORIAM

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1943-2018

Garland Norman Porterfield, MD
1944-2018

Wesley Robert Mote, MD
1933-2016

Frank Wilson III, MD
1936-2018

Two Bits

Philip Maguire,MD

It was a warm, sunny day near the end of June. There was a small neighborhood grocery store down the street from us and alongside it was an ice dock. In those days people would buy a block of ice, usually around 25 pounds. The ice would be put in an actual ice box, and the ice went on a shelf inside. Those were days before refrigerators! A tray below the ice box collected the water as the ice melted. Also, ice men drove trucks through the neighborhoods and sold ice directly to homes.

Sometimes people put signs in the windows that indicated how many pounds of ice were requested. The signs were four sided with different numbers telling how much ice was wanted. We used to follow the ice trucks and pick up ice chips.

An old plumbing company was next to the ice dock. It had a wide, gravel driveway. In the front there was a gasoline pump with a glass top. I never saw anyone get gas from it. In back, there was a sort of warehouse shack. An old, faded sign painted on the side read Cardui. We didn't know what that was but someone told us it was a laxative. Well we thought that was pretty funny. Most days inside the shack a group of old men played cards, Pitch, I think.

When we went in the shack we could see dust motes riding on bright slats of sunshine coming through cracks in the wall. Inside there was always Grandpa Agnew and Mr Butler. Mr Butler had a funny walk so that one leg flared out as he came along. Mr. Leder, the owner of the plumbing company, would be there in bib overalls faded to almost white. He wore a billed-cap of the type baseball players wear. Old man Heenan was a regular in the group – he wore a coat and tie. They used a big wire-cable spool for a table and bad an odd assortment of chairs. The old guys would tell us to get on out of there and get about our business. But we did like to watch them while we could.

Back outside my brothers and I were sitting on the edge of the dock whiling away the summer day when one of us noticed a quarter, what we called "two bits" in those days. The quarter was down between the cracks. Of course, that got us all worked up. A quarter then would buy plenty. We spent lot of time trying to tease the coin up and out through a crack between the boards of the dock. No luck. We used all our engineering skills to no avail. Then we got the bright idea of going out to the street and digging a little tar from the hot pavement We put the tar on the end of a stick down through the crack and got the quarter!

Now flush, we went into the store and bought each of us a Sidewalk Sundae, one six-ounce Coca-Cola and a nickel bag of peanuts. We retired to the ice dock and started on our feast. Might as well have been *Haute Cuisine*. The peanuts were stale but we ate them anyway.

Three adventurous young boys on a warm summer day. Sure didn't take much to keep boys happy then. No electronic devices, no screens to mesmerize and music came from a radio. People had conversations and faced each other while they were talking.

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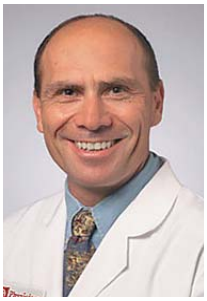
BOARD NOMINATIONS

POSITION 1

Janine E. Collinge, MD is a board-certified pediatric ophthalmologist who works as an assistant professor, soon to be associate professor, with the Dean McGee Eye Institute and the University of Oklahoma Health Science Center. She completed medical school at the University of Medicine and Dentistry of New Jersey, a fellowship with the Eugene and Marilyn Glick Eye Institute at the Indiana University Medical Center and residency at Georgetown University Hospital/Washington National Eye Center, where she served as chief resident. For her local contributions to pediatric ophthalmologic care, Dr. Collinge has been awarded as a member of the OK Gazette's "Forty Under 40." She has also received awards for resident education and feedback from the Dean McGee Eye Institute. Dr. Collinge completed the Oklahoma County Medical Society Leadership Academy in 2018 and is a member of various professional organizations. Dr. Collinge enjoys volunteering her medical expertise locally and abroad, and has presented many lectures, posters and workshops at local, regional and national conferences.



Morris R. Gessouroun, MD is a board certified pediatric critical care physician with OU Medicine. He completed medical school at the University of Maryland, a residency in Pediatrics and fellowship in Pediatric Critical Care with Children's Medical Center Dallas, and is currently the Children's Hospital Foundation Patricia Price Browne Professor of Pediatrics and Chairman of the Department of Pediatrics at OU College of Medicine. Dr. Gessouroun joined the OUHSC Department of Pediatrics as Associate Professor and assumed the responsibilities of Section Chief of Pediatric Critical Care and Medical Directorship of the Pediatric Intensive Care Unit at The Children's Hospital in 1990. He became Interim Chairman of Pediatrics in August 2016 and permanent Chairman in January 2018. Dr. Gessouroun has the distinction of having cared for all but one of the survivors of the daycare center at the Alfred P. Murrah building bombing as well as caring for all of the severely injured children from major urban tornadoes that struck the Oklahoma City metropolitan area. Originally from Maryland, he's a first generation American born to refugees from World War II Europe. He and his wife, Cindy, are active in community organizations across the metropolitan area.

POSITION 2

Chad Smith, MD, FACOG is a board certified OB/GYN. He attended the University of Oklahoma College of Medicine for Medical School and completed his Residency in Obstetrics and Gynecology at the University of Oklahoma Health Sciences Center. He spent seven years on faculty at the University of Oklahoma where he served as the Medical Director of Labor and Delivery and the Perinatal Patient Safety Director for OU Physicians. He joined Mercy Hospital Oklahoma City as the Vice Present of Medical Affairs in July 2017. He serves as the Medical Director for the Oklahoma Perinatal Quality Improvement Collaborative.

Savannah Stumph, DO is a board certified pediatrician with Mercy. She completed medical school at the OSU Center for Health Sciences College of Osteopathic Medicine, and residency at OU Tulsa. She has served on the OCMS Board of Directors in the past, and is eager to return to their service, as well as become more active with the OSMA. She is a physician representative in the Mercy in Schools partnership with Edmond Public Schools, and is the camp pediatrician and

serves on the Board of Directors of Camp DaKaNi. Dr. Stumph is particularly interested in legislative affairs, and recently co-founded the Deer Creek Parent Legislative Action Committee for her school district.

POSITION 3

Ryan Wicks, MD, FACS is a board certified general surgeon with INTEGRIS Baptist Medical Center. He received his medical degree from the University of Oklahoma College of Medicine where he graduated with Distinction in 2010 and completed his residency in general surgery in 2015. Wicks received the outstanding General Surgery Resident in Trauma award in 2014 and received the Aesculapian Award for teaching excellence from University of Oklahoma College of Medicine in 2015. He completed the OCMS Leadership Academy in 2017. He is originally from Tucson, Arizona and has undergraduate degrees from the University of Arizona.

Sumit Nanda, MD grew up in Norman, Oklahoma and attended Duke University School of Medicine and trained at the Wilmer Ophthalmological Institute at Johns Hopkins Hospital. After his vitreoretinal fellowship, he served on the faculty at Dean A. McGee Eye Institute at OU for nine years. He was nominated for the Aesculapian teaching award at the University of Oklahoma in 2001 and rose to the rank of Clinical Associate Professor. He founded Oklahoma Retinal Consultants at Integris Baptist Medical Center in 2002 and served as the Chairman of the department of Ophthalmology from 2006-2010. He served on the governing board of Foundation Surgery Center from 2011-2015. Dr. Nanda's wife, Sumeeta, has practiced Obstetrics/Gynecology at Integris Baptist Medical Center since 1998. They have three children ages 22, 20, and 14. He has served on the Casady Board of Visitors from 2008-2014. He has served on the board of the Hindu Temple of Oklahoma/India Cultural Foundation since 2014.

POSITION 4

Dr. Pooja Singhal, MD is a board certified Gastroenterologist at SSM Health/St. Anthony Hospital. She completed her medical school training at the University of Oklahoma Health Sciences Center and an internal medicine residency at Georgetown University Hospital in Washington, DC. Dr. Singhal received her fellowship training in gastroenterology at Georgetown as well, where she also served as Chief Resident and Chief Fellow. Dr. Singhal has received several awards and honors including National SCOPY award consecutively in 2016 & 2017 for raising Colon cancer awareness in Oklahoma, ACG train the trainee scholarship, AGA young delegates membership, Caring Star Award, and numerous scholarships. Dr. Singhal's clinical training and interests include Esophageal disorders, Inflammatory bowel disease, Irritable bowel syndrome, liver diseases and women's gastrointestinal health. She has lectured in the community on gastroenterological topics, as well as worldwide conferences.

Matthew Jared, MD is the Associate Chief Hospitalist at St. Anthony Hospital in Oklahoma City, OK. He has been working on improving opioid use and safety in the hospital with the Society of Hospital Medicine since 2015. Dr. Jared studied medicine at the University of Oklahoma Health Sciences Center and graduated in 2009. He completed residency at St. Anthony Hospital in Family Medicine in 2012, where he served as Chief Resident. Dr. Jared has worked with several quality improvement projects in the hospital including the Stroke Committee, Graduate Medical Education Executive Committee, Patient Quality and Safety Committee, and St. Anthony Reducing Adverse Drug Events from Opioids. Since starting practice, Dr. Jared has run an outpatient clinic, volunteered regularly at local free clinics and taught residents in the hospital. He is committed to using education and innovation to overcome the difficult tasks facing healthcare and physicians.

The official ballot will be mailed on or before September 15.

2018 Nominating Committee

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Don L. Wilber, MD – Vice-Chair
Serena Anderson, MD
Matt Atkins, MD
Tabitha Danley, DO
Randal Juengel, MD

Silhouettes

Hanna Saddah, MD

Whispers are shy kisses, I thought, as I watched the octogenarian couple snail on the dance floor, few steps behind the music, balancing one another with amorous caution, and clinging with frail arms that defied gravity. Their cheeks glowed with hushed joy, their lips gleamed with sunset smiles, and their eyes beamed like nightlights from behind their swooning eyelids.

Remote from the tenebrous ambiance of the restaurant's dance floor, my wife and I sat in an alcove while I watched geriatric love cling to life with defiant disregard of years and circumstance. And when the music leaped from tango to rock, and youth quaked the floor with jarring gyrations, their movement maintained its measured grace, echoing the siren tunes of their inner harmony, unaware of the surrounding bedlam.

Continues on page 24 ...

SILHOUETTES *Continued from page 23 ...*

"What are you looking at?" snapped my wife, a bit perturbed at my taciturn inattention.

"I'm watching this elderly couple dance."

"You must find them more interesting than me," she reproached, half-heartedly.

"Observe their buoyant reverie, their sublime emotional dimension, their defiant passion, and their cherished solitude as if they're here but not here, and with us but not with us."

"You and I were like that when we first met and fell in love," she lamented.

"We are still like that, darling, but only when alone."

"Are you too embarrassed to show intimacy in public places?" She challenged.

"A public display of emotion, after so many years of marriage, would seem unbecoming."

"Are you suggesting that we wait till our eighties to behave like them?" She smiled.

"We have what they have, darling, but ours is no longer new, which is why it must remain private. They are in the spring of love and we, in its autumn. Their orchards are full of blossoms and ours, of ripe fruit."

"Do you know them?"

"The man was a patient."

"How about the woman?"

"I know of her, but this is the first time I see her."

"Are you going to tell me their story?"

"It would be a HIPAA violation."

"Tell it without names or records, Doctor," she sneered. "I can only see their silhouettes from here and would not recognize them if I were to see them again."

✪ ✪ ✪

The man [let's call him Adam] was married to a heavy-smoking, diabetic lady [let's call her Eve] who ignored medical advice, did not take her insulin as prescribed, and continued to smoke with nonchalant disregard of consequences. Adam complained about

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her every time he visited my office, but I was never able to influence Eve to take better care of her health. As they grew older, Adam became more depressed while Eve lost more weight and her lungs failed. Her visits to my office became more frequent and more cumbersome because of frailty, failure to thrive, and emphysema. But, in spite of failing health, two heart attacks, one stroke, several pneumonias, a foot amputation, and oxygen dependence, she managed to survive and laughed in my face each time I urged her to stop smoking. "I turn my oxygen off when I light up," was her favorite comeback.

Adam became a fulltime caregiver and had to delegate his business responsibilities to their two daughters because he could no longer leave Eve alone. He and I commiserated about Eve's decline and I had to augment his antidepressant to keep him functional.

❂ ❂ ❂

Two months before I retired, he called me at three in the morning, sobbing.

"Eve has just died," he cried. "She woke me up choking, clasped her chest, rolled her eyes, and turned blue. I did not try to resuscitate her because she did not wish to be resuscitated."

"Are you alone with her?"

"Yes, but our daughters are on their way and so is the police."

❂ ❂ ❂

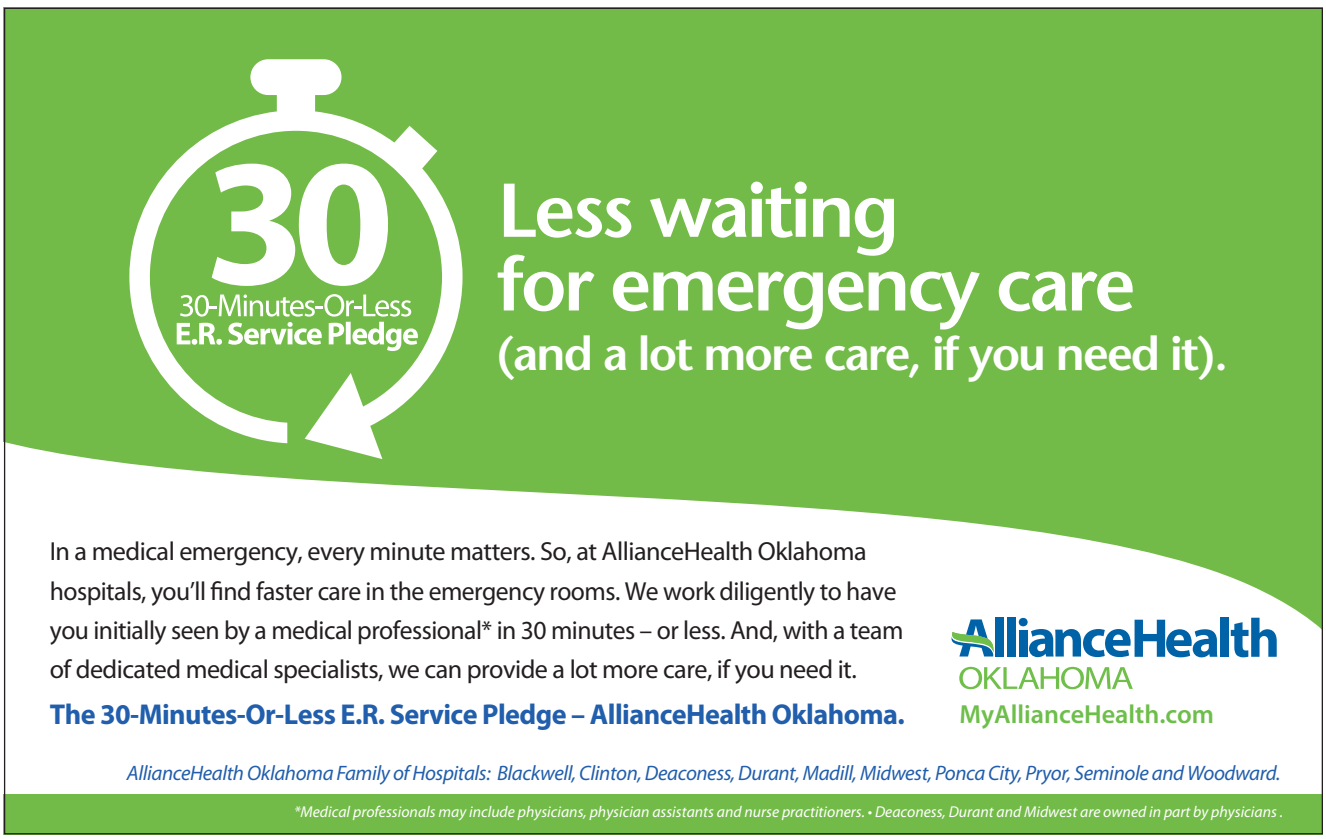
At the funeral, Adam was inconsolable. Instead of relief, he felt guilt for not having loved Eve enough during her final years.

"She was too much, Doctor, and drained my love and my patience. We were high-school sweethearts. Oh, you should have seen her when she was young and beautiful. I was the most envied groom of my generation."

❂ ❂ ❂

After the funeral, I did not see Adam for several months, but when he came for his annual exam, he told me that he was back to work and that his

Continues on page 26 …



daughters are staying on because he did not feel as capable and energetic at eighty-five as he did at seventy-five. He also mentioned that he had a love interest, a widow who had been their family friend since high-school days.

"We have been dating for a few weeks now and my daughters are appalled, but I don't care because I am happiest when I'm with her and feel profoundly alone without her."

"Do your daughters spend much time with you?"

"We're only together at the business. Since I've started dating [let's call her Helen], they seldom come home any more."

"Are you planning to marry her?"

"I would love to but she's against it. She believes that if we could keep our independence and not share children, we would be able to keep our relationship pure and free of interference. 'Children will harm our rare and precious love, whether they approve or not,' she insists. Like me, she had had a hard marriage and her children do not approve of us."

❂ ❂ ❂

Reviewing Adam's chart, after this heart-to-heart conversation, I noticed that he was not taking his mental-health medications.

"Why did you stop your antidepressants?" I asked, surprised.

"Because I no longer needed them."

"When did you realize that?"

"After my first date with Helen. I flew home like a bird, free to sing, free to live, and free to love. Love must revive youth because I feel young again. Are you happy for us, Doctor, or do you think that we're just old and silly children?"

"On the contrary, I'm awed and overjoyed. Don't let anyone take away the happiness you two have resurrected in each other. Life is short, happiness is even shorter, and resurrection is rare. You have been blessed with a second life. Live it to the fullest with God's blessings and remember this quatrain from Rupert Brooke:

" 'Now that we've done our best and worst, and parted,
I would fill my mind with thoughts that will not rend.
(Oh heart, I do not dare go empty hearted)
I'll think of Love in books, Love without end;' "

❂ ❂ ❂

On the way home, having told my wife the story of Adam and Eve, and of Adam and Helen, she said nothing for a long while and then abruptly asked:

"If I die before you do, could you fall in love again?"

"I would hope so," I replied without hesitation.

"Not me. I'd rather live alone and die alone."

"Please do not say that, darling. Do not make promises you should not keep. Romance, which is love laced with desire—the desire to unite bodies, souls, days, nights, and lives—is one of the few meaningful passions that can rejuvenate old age. Saying no to that kind of love is a betrayal of life, not a betrayal of the deceased spouse. Romance will help us die while feeling new instead of old. All the other loves of family and friends cannot do that for us. Dying while feeling aged prevents us from celebrating the ends of our lives, whereas dying while feeling youthful helps us die with joy in our hearts, that sublime joy of having found romance again."

"This has been too much for one evening," she sighed as she wiped off a tear. "I don't want to talk about old age and death anymore. Let's just hold hands be quiet until we get home."

❂ ❂ ❂

At home, in bed, with the lights off, and still holding hands, my wife whispered, "What are you thinking?"

"I'm thinking of what Gibran said about love in The Prophet. I've never really understood that one line until tonight."

"What line? What did he say?"

"He said, 'When you love you should not say, God is in my heart, but rather, I am in the heart of God.' "

"And what did he mean by all that?"

"He meant that to know God we must love because Love is what brings us unto God."

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PART 1: OPIOID LAWSUITS – MANUFACTURERS AND DISTRIBUTORS

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

This is a three-part series on opioid lawsuits. Part 1 deals with opioid actions against manufacturers and distributors. Part 2 addresses opioid prescription lawsuits against healthcare providers. Part 3 reviews proposed solutions to the current opioid crises by federal, state and local goverments, medical organizations, consumer advocates and the public.

Like Big Tobacco, states and cities have recently begun fighting the worst opioid epidemic in U.S. history by suing the multibillion-dollar drug companies, including both the manufacturers and distributors that market and distribute dangerous opioid medications for pain. About two-thirds of the 64,000 people that died of drug overdoses in 2016 were linked to legally prescribed opioids.

Hundreds of lawsuits have already been filed across the U.S. against opioid makers and distributors. For example, in 2007, Purdue Pharma paid a penalty more than $630 million for misleading marketing.

In 2017, McKesson agreed to pay a $150 million settlement to the Department of Justice for failing to report suspicious orders of pharmaceutical drugs, particularly opioids. In 2008, McKesson paid an over $13 million fine for similar violations.

Mississippi, Oklahoma, Missouri, New Hampshire, and other states as well as local jurisdictions filed lawsuits. Kentucky previously settled with Purdue (for $24 million) and Janssen (for nearly $16 million) in cases alleging misleading marketing.

In May 2017, the Ohio Attorney General filed a lawsuit against Purdue Pharma L.P., The Frederick Company, Inc., Teva Pharmaceutical Industries,Ltd., Cephalon, Inc., Johnson & Johnson, and several other companies, alleging that defendants:

(a) Used Multiple Avenues To Disseminate False And Deceptive Statements About Opioids;

(b) Marketing Scheme Misrepresented The Risks And Benefits Of Opioids;

(c) Targeted Susceptible Prescribers And Vulnerable Patient Populations;

(d) Knew That Their Marketing Of Opioids Was False And Deceptive, They Fraudulently Concealed Their Misconduct;

(e) Deceptive Marketing Scheme Has Fueled The Opioid Epidemic And Devastated Ohio Communities;

(f) Unlawful Opioid Promotion And Scheme Has Caused Substantial Economic Injury To State Agencies; and

(g) Their Fraudulent Marketing Has Led To Record Profits.

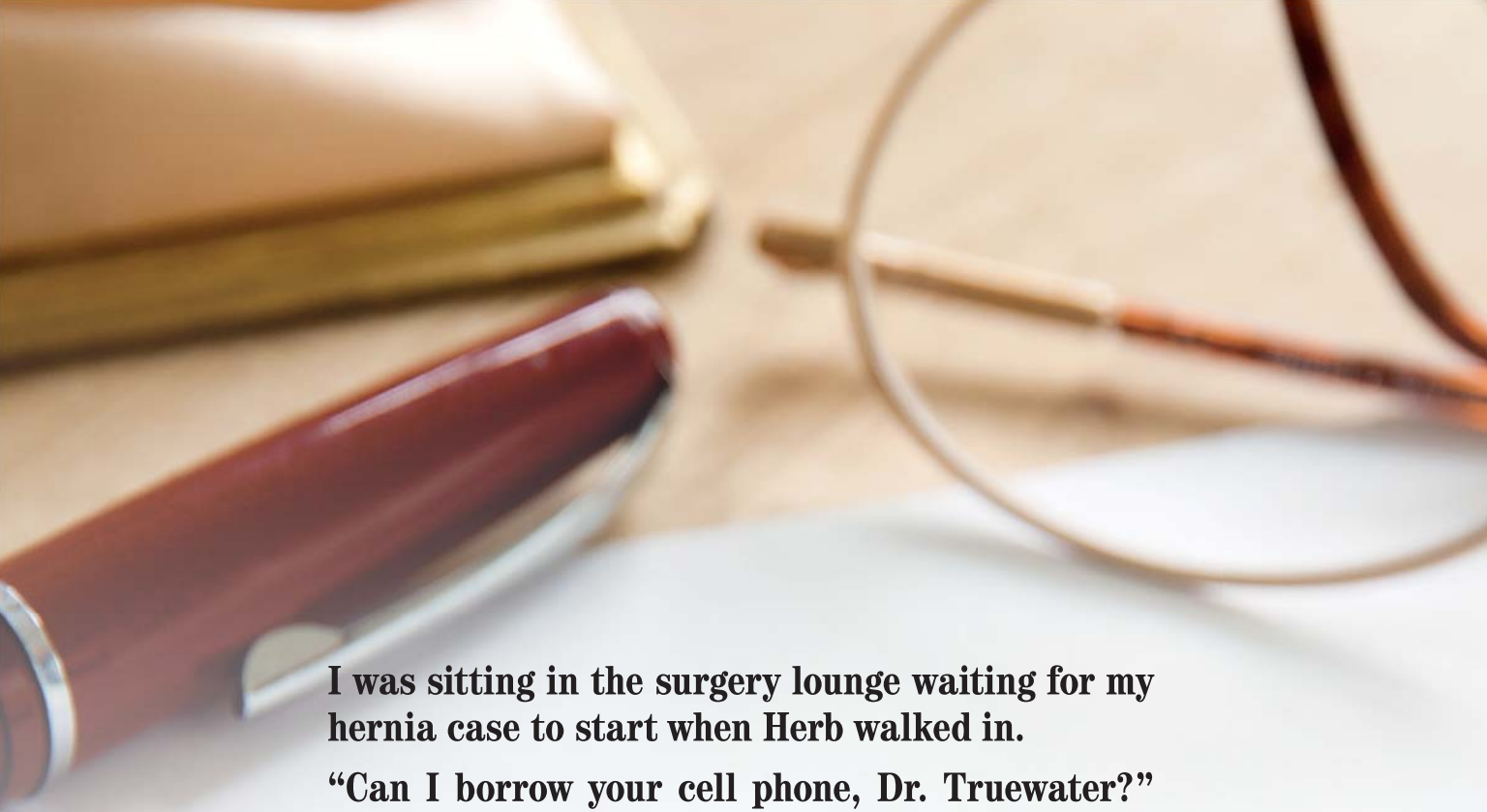
In January, 2018, Mayor Bill de Blasio announced that New York City is suing manufacturers and distributors of opioids in an effort to recoup some of the costs associated with the deadly epidemic.

In May 2018, U.S. state attorneys general of Nevada, Texas, Florida, North Carolina, North Dakota and Tennessee alleged that Purdue Pharma LP, maker of OxyContin, violated state consumer protection laws by falsely denying or downplaying the addiction risk while overstating the benefits of opioids. The company was accused of fueling a national opioid epidemic by deceptively marketing its opioids to generate billions of dollars in income. It encouraged doctors to overprescribe the pills and persuaded patients to think the pills were safe and effective.

In May 2018, Florida sued Endo Pharmaceuticals Inc, Allergan, units of Johnson & Johnson and Teva Pharmaceutical Industries, and Mallinckrodt, as well as drug distributors AmerisourceBergen Corp, Cardinal Health Inc and McKesson Corp. Opioid distributors supplied an inordinate amount of opioids, even when they should have known they were going to people who were misusing the drugs. They allegedly violated the law by letting opioids proliferate.

Manufacturers and distributors argue in defense that they merely manufacture and sell opioids, respectively. They have no direct contact with patients and their oipoids cause mainly pseudo-addiction and not addiction. Furthermore, pharmacists dispense the opioids. The latter are legally prescribed by doctors who are considered “Learned Intermediaries”. Pharmacists and doctors have always known that opioids are addictive and have numerous side effects which may lead to overdose and death. For centuries, it has been commonly known by the public that opiates/opioids are addictive. Finally, the manufacturers and distributors argue that patients receive informed consent from the doctors and enter into treatment agreements for opioids in an attempt to prevent catastrophic outcomes. And, many individuals resort to illicit and highly addictive opioid drugs which lead to overdose and death.

The Big Question is: Are doctors and other health care providers also positioned in the path of what is seemingly a “Perfect Opioid Malpractice Lawsuit Storm”? Part 2 will address the myriad opioid prescription actions against healthcare providers.



I was sitting in the surgery lounge waiting for my hernia case to start when Herb walked in.

"Can I borrow your cell phone, Dr. Truewater?" Herb asked. "I left my phone in the car."

"Sure, Herb," I replied, as I pulled the phone out of my scrub pants pocket.

"I need to call Sherm Adkins," Herb added.

"You can look Sherm up in my phone directory," I said.

When Herb finished his call, he stared down at my phone directory. "You've still got Dr. Straylo and Dr. Jameson in your directory," Herb noted. "They both died years ago."

'TIL DEATH DO US PART

Bill Truels, md

"I know," I replied. "I just hate to delete people out of my phone directory. I knew both docs for over twenty years. They sent me a lot of patients."

"It's not like they're going to call you anymore," Herb quipped.

"Well, if they did, I'd be really surprised," I joked. "I might ask them what heaven is like," I added.

"I'm not sure Dr. Straylo made it to heaven," Herb quipped. "He had a real mean streak in him – cost him a divorce, you know."

"Maybe he's spending a little more time in purgatory – he was Catholic, you know."

"That's one thing about being Baptist," Herb added. "You don't spend time in purgatory – either you make it to heaven or you don't!"

"What's that you're reading?" Herb asked. "It looks serious."

"It is serious," I said. "I just got these documents from my estate planning lawyer. We've got a family trust set up, in case Maggie and I both die."

"What do you mean, 'in case you die'? Don't you know everybody dies?" Herb asked.

"Of course I know everybody dies, Herb. For God's sake I'm a doctor!"

"Doctors are in denial about death," Herb added. "They think everybody dies except them – that's why they became a doctor – to defeat death!"

"Let's just say that doctors try to prevent death as long as possible – to delay death," I added. "That's what modern medicine is all about- to find ways to keep people healthy as long as possible- to improve the quality of life."

"Maybe that's why doctors find it so difficult to pull the plug," Herb added.

"Pull the plug?" I asked.

"You know, to end life support. Doctors don't like to end life support and provide comfort care – basically, you're admitting defeat," Herb replied.

"And doctors don't like to admit defeat."

"That's true," I replied. "When I was a resident, no one liked to follow Dr. Emory on the call schedule.

"Why's that?" Herb asked.

"Well, Dr. Emory never wanted anyone to die on his shift. So he would do everything possible to keep them alive during his shift. If you followed Dr. Emory on the call schedule, you were ready for a pretty stressful day."

"Well, doctors are perfectionists," Herb answered. "And death represents our failure at perfection and eternal life on earth."

"I suppose so," I replied.

"I think doctors need to stop denying death. As a start, I'm going to remove those deceased names from my phone directory!"

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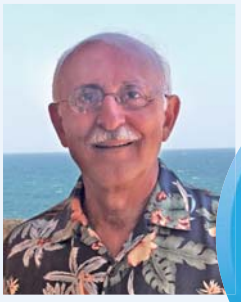


THE POET'S SPOT

Graduation—Songbirds taking their first flight out of the nest, new orchards bearing their first fruits, long spring after many long winters, a ship's maiden voyage, sailing into the unknown, with a cargo of hope.

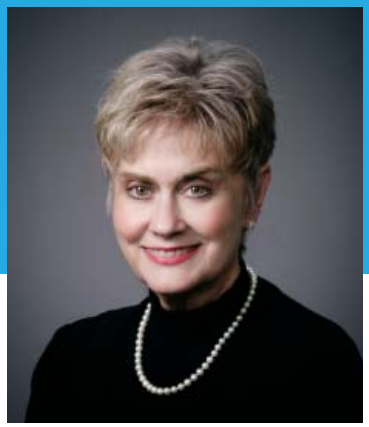
Graduation

(Sonnet 107)

When beauty blossoms on the lips of youth
Glowing with joy at nature's twin-birth truth:
The nest when first with hungry mouth you sing
Next love explodes and youth is on the wing.
Four seasons are your life, in spring you grow
In summer flaunt your fruits upon the bough
In autumn mellow with the yellow leaves
In winter warm your days with quiet eves.
But, from your spring, you cannot see the fall—
With visions green and passions that enthrall,
Your branching mind, which reaches for the sky
Can only see the glorious stars on high.
Dare spread your wings, set mind and spirit free
Love passionately and youth will ever be.

Hanna Saddah, MD

DIRECTOR'S DIALOGUE



"Freedom has never been free."

~ Medgar Evers

By Jana Timberlake,
Executive Director

On the 4th of July – Independence Day – Americans celebrate with parades, waving flags, patriotic music, cookouts and firecrackers. We also focus on the constitutional freedoms granted to us by America's founding fathers. This democracy has been the greatest and most successful experiment in history.

However, not everyone was granted those freedoms without paying the greatest price a person can pay. Medgar Evers, a civil rights activist in Mississippi and the first state field secretary of the NAACP, realized that freedom wasn't free. He was murdered for his efforts to organize voter-registrations and investigating crimes against blacks. From his death, legislation was supported that eventually became the Civil Rights Act of 1964.

Abraham Lincoln is credited with saying, "America will never be destroyed from the outside. If we falter and lose our freedoms, it will be because we destroyed ourselves." Sometimes I fear our country is on the cusp of destroying itself. The mere lack of civility in our discourse with one another is frightening. What happens when cultural norms are set aside? It seems everyone is choosing sides and arguing who is right or wrong. When in reality, we probably agree on more than we actually disagree...if only we would listen.

The United States has been a beacon of light – hope – to the world. Our "greatest export to the world" according to Senator Robert Byrd, are "our ideals of freedom, set forth and realized in our Constitution." Our humanity towards the sick and poor is unsurpassed. Remember the words most often associated with the Statue of Liberty, "give me your tired, your poor, your huddled masses yearning to breathe free." The world looks to us – the United States – to set the example for others to follow.

The quote below, by President Barack Obama, speaks to my soul about the meaning of freedom:

"We, the people, recognize that we have
responsibilities as well as rights,
that our destinies are bound together;
that a freedom which only asks
what's in it for me, a freedom without a
commitment to others, a freedom
without love or charity or duty or patriotism,
is unworthy of our founding ideals,
and those who died in their defense."

My minister talks about the luminous web that binds all of us together. But most importantly, Dr. Meyers reminds us that "if one of us doesn't matter, then none of us matter."

Enjoy your 4th of July holiday with a little reflection ... while listening to John Philip Sousa!

It's not about giving up hope, but about

living each day to the fullest.

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