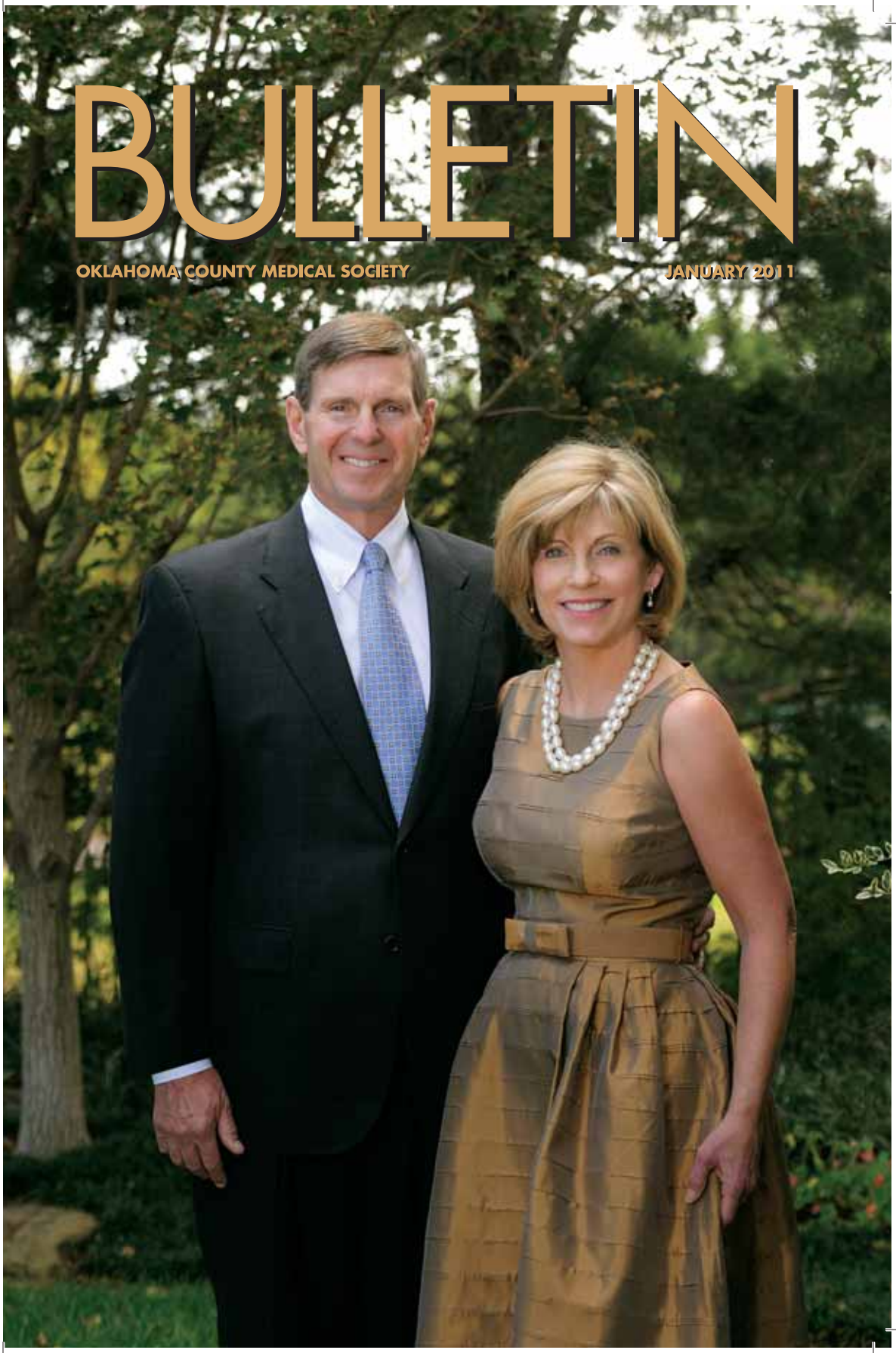
BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY

JANUARY 2011



THE BULLETIN
The Oklahoma County Medical Society

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About the Cover

The photo featured on the cover is Robert N. Cooke, MD, the 111th President of the Oklahoma County Medical Society, and his lovely wife, Diane. Dr. Cooke completed his undergraduate degree at Centenary College in Shreveport, Louisiana, graduating in 1973. He received his medical degree from the OU College of Medicine in 1980 and completed his internship and residency at the Oklahoma Health Center. He has been a general surgeon in private practice in Oklahoma City since then. He is an avid sports fan who can be found on the golf course on most days off, either at the game or firmly ensconced in front of the TV on OU football days, and at many Thunder basketball games. Bob and Diane have three sons: Everette, an attorney in Los Angeles; Jeff, a coordinator in the MGM Studio Film Library in Los Angeles; and Tommy, a second-year medical student at the OU College of Medicine and the student representative to the OCMS Board of Directors. Diane, who served as president of the OCMS Alliance in 1992, is a dietician in private practice in Oklahoma City. Dr. Cooke's father, Everette, a general surgeon, and his mother, Betty, were actively involved with the medical community in Oklahoma City for more than 40 years. Two of their six sons became physicians. In addition to Bob, their son Richard is a radiologist, also in Oklahoma City. ❑

Celebrate our 111th in 2011!

OCMS will inaugurate its 111th President in 2011 – what a momentous occasion! Robert N. Cooke, MD will be inducted during the Inaugural Dinner on January 15 at the Quail Creek Golf & Country Club. The Wise Guys will provide lively music for dancing or listening. Come join us, but get your reservations in by January 7. Invitations were mailed to home addresses in mid-December. Call 702-0500 if you did not receive yours. ❑

Each new day is a blank page in the diary of your life.
The secret of success is in turning that diary into the best story you possibly can.

Douglas Pagels
A Wonderful Resolution for the New Year!

Statewide Stroke Conference

OKLAHOMA STRIKES BACK AGAINST STROKE

5th Annual Evidence-Based Statewide Stroke Conference

Saturday, February 26, 2011
7:30 am – 4:30 pm
Moore-Norman Technology Center
13301 S. Penn
Oklahoma City, Oklahoma 73170

Who should attend? Physicians (emergency, neurology, primary care, hospitalists, interventionists, cardiology – any physician involved with care of stroke patients); nurses (emergency, critical care, stroke coordinators and stroke or neuro nurses, nurse educators, rehab, public health or community health nurses); EMS personnel; PT, OT & SLP; and hospital pharmacists, as well as other healthcare providers who work with stroke in Oklahoma.

Presenters and topics include:

- Dr. David Lee Gordon - Stroke Center at OUHSC - Urgent Identification and Treatment of Stroke, Stroke Sub-Types, and "Unstrokes"
- Dr. Harold Adams, Jr., - Stroke Center at University of Iowa. - Emergent Stroke in the Emergency Room
- Dr. Anne Alexandrov – University of Birmingham Stroke Center - Tough Calls in tPA Decision Making - Case Presentations
- Amy Carte, RN – Oklahoma State Dept of Health – www.StrokeisnotOK.com (Website for Stroke Education, Information and Resources for Oklahoma)
- Dr. Charles Morgan – INTEGRIS Vascular Neurologist - Case Presentations
- Dr. Kevin Kelly – INTEGRIS Neurosurgeon - Neurosurgical Rescue of Malignant Stroke - When do you Need a Neurosurgeon?
- Dr. Joseph Broderick, University of Cincinnati Deptartment of Neurology - New Guidelines for Medical Management of Hemorrhage

Registration fee for entire conference (including lunch) is $20 – seating is limited to first 350 participants. To register, call the INTEGRIS Healthline at 405-951-2277. For more information, contact Briton Segler, 405-644-6965. ❑

President's Page

Robert N. Cooke, MD

Let's Work as One

It's my privilege to be your President for the next year. I am humbled and honored to continue working for the good of our patients and the physicians of the Oklahoma County Medical Society. Since I have been on the Board, past Presidents Murali Krishna, Jay Cannon, Bob McCaffree, Teresa Shavney and Larry Bookman have done a remarkable job in leading our Society. They have initiated and supported many programs. These include beginning the Health Alliance for the Uninsured, developing a metropolitan hospital rotational call system for Oklahoma County, starting a Leadership Academy to help develop the future leaders of our Society, and developing strategies to help our members cope with all the changes in healthcare today. Of course, there are many members who have contributed by being on the Board, serving on committees, or giving their time for free clinics and caring for those patients from those clinics. We owe them all our gratitude. Their work will ultimately benefit you as well as your patients. None of this could have been accomplished without the wonderful staff we have in place. Many thanks to Jana Timberlake, Linda Larason, and Ashley Merritt for their endless efforts and assistance. When you get the opportunity, let them know how much you appreciate them.

Our focus over the last year has been to attract new members to the Society. Never has there been a more important time for physicians to come together as one. With all the changes in the healthcare environment, I believe it is time to put aside some of our differences and work together for the common good. In the end, this will mean continued access to quality medical care for

our patients. It doesn't really matter if you are a solo practitioner, in group practice, employed, or in the university setting. Whether we own a facility or practice in one of our fine hospitals, as physicians we are still here for the common good. It is our duty to help see that the changes we are experiencing are just and in the best interests of the public, physicians and, hence, our patients' access to quality medical care. Let's all get behind the effort and that, in my view, starts with your membership in the OCMS. It's no secret we need dues to run the machine but it is vitally important, and I would welcome your comments and covet your participation.

Please encourage your colleagues and partners who are not members to consider joining. We would be happy to call and visit with them. In the meantime, the staff and I are always available for your comments and suggestions. This is your Society and we value your input.

In closing, I'd like to encourage all of our members to make a special effort on the legislative front. We have a significant chance this year to have meaningful tort reform. A call or visit with your state representative and senator would go a long way in helping to accomplish this. If you need help in identifying them or need their phone numbers or addresses, we can help. Just let us know. There are many other state issues to be addressed, including worker's compensation and scope of practice. We, along with the OSMA, can help keep you informed as these issues arise. Work as one. There's an old song by the Brotherhood of Man (yes, I looked it up on ITunes) that could never be more apropos – United We Stand, Divided We Fall. Those words ring true today. ❑

New Member

Abbas Raza, MD
(IM GE)
3366 NW Expr., #380
Sind Medical College
U. of Karachi,Pakistan 1985

Restore Local Control

Michelle Terronez

Oklahoma's health ranking is 49th out of 50 states, and smoking continues to be the leading cause of preventable death in Oklahoma. Smoking costs our state nearly $2.9 billion and 6,000 lives each year. There are many local groups in the state working to change these statistics by curbing the smoking initiation of youth as well as trying to decrease the prevalence of current smokers. While there is positive work being done, these proactive groups are, unfortunately, facing an uphill battle that only one other state in the United States is up against. *Oklahoma and Tennessee are the only two states in the nation that prohibit communities from adopting any local ordinance on tobacco that is stronger than the state law*. This barrier is greatly hindering progress and it is costing Oklahoma about 16 lives every day.

In the late 1980s, local communities such as Edmond and Tulsa were exploring the option of adding smoke-free ordinances to improve the health of their citizens. The tobacco industry realized that they would not be successful in battling these ordinances on a local level and, therefore, decided to act aggressively at the state level. At the urging of the tobacco industry lobbyists in 1986, the Oklahoma State Legislature passed preemptive state laws. Those laws were intensified in 1994 to make Oklahoma's preemption laws among the strongest in the country. There have been many attempts over the years to repeal these laws but, unfortunately, they have been rendered unsuccessful.

The tobacco industry continues to market its products in our state to addict "replacement smokers," and local communities are stuck with their hands tied, unable to limit marketing to children or prevent secondhand smoke exposure. While looking across the nation, many of the state laws surrounding tobacco prevention started with local ordinances being passed and support gradually building across the state. This shows the importance of having local communities involved. Restoring local rights is a vital step toward improving tobacco control efforts in our state, which will have a direct effect on health.

There are many groups across the state working to restore the rights of local communities with regards to tobacco. These groups, including the Oklahoma State Department of Health, Oklahoma City-County and Tulsa Health Departments, Greater OKC Chamber, Oklahoma Municipal League, and many others, are joining forces to combat the opposition of the tobacco industry and its allies at the State Capitol this

(Cont'd on page 35)

In Memoriam

Galen Patchel Robbins, MD

1928 –2010

The Oklahoma medical community lost an innovator, early adopter and change agent with the passing of Galen Robbins, MD, on November 14, 2010. Galen, who grew up in Pauls Valley, Oklahoma, was strongly influenced in Socratic critical thinking by his grandfather Patchel and father Welker Robbins. He was notorious for using those skills in interacting with individuals and creating/developing multiple medical and personal projects.

Galen graduated from DePaul University and then earned an MD and Master's Degree in Biochemistry from Northwestern University by age 21. He spent a year in Korea with the CIA before marrying Bobbie in London, England. He then did fellowships in Hematology at the Tufts New England Center Hospital in Boston and in Cardiology at Baylor University in Houston.

He moved to Oklahoma City in 1959 and co-founded the Cardiovascular Clinic with William Best Thompson, MD. Galen was fascinated with science, technology and how to improve patient care. A major endeavor was the development of an electronic medical record with office support in the late 1960s that was decades ahead of most other efforts. He worked on computer interpretations and electronic transmission of electrocardiograms. He was instrumental in establishing inpatient and outpatient diagnostic nuclear cardiology testing and an outpatient joint venture diagnostic cardiac catheterization laboratory. Galen was a member of the team that did the first heart transplant with Nazih Zuhdi, MD, at INTEGRIS Baptist Medical Center in 1985.

Galen was a Clinical Professor of Medicine at the University of Oklahoma School of Medicine. He was Governor of the

Oklahoma Chapter of the American College of Cardiology. He received many Certificates of Merit for his contributions to the Computer Applications Committee of the ACC. He was a long-time Board of Directors member of the Oklahoma Medical Research Foundation. One of the committees he chaired was the Technology and Transfer Committee. He received the OMRF Board of Director's Distinguished Service Award.

Galen was on the Board of Directors of American Fidelity Insurance Company and was Medical Director for over 26 years. He was a Board member of Nomadix/Flir Corporation, an innovative technology company. He was on numerous other Boards and influenced even more.

After retiring from clinical practice in 1997, he turned his energies to refining and further developing his scientific and technology efforts in ranching/farming, furniture making, fly fishing and fly rod creation, and restoration of antique horse-drawn carriages and sleighs.

Galen influenced almost everyone with whom he came in contact. He encouraged many individuals who had the great fortune to have close contact. Not only has he left a medical community and patients the better for his dedication, insight, and drive, but he has left a family with wide and varied gifts and interests (like Galen): his wife of 57 years Bobbie, five children and nine grandchildren. I will miss and be forever grateful for my friend, mentor and former partner ❑.

W. H. "Bud" Oehlert, MD, MMM

SGR Cut Delayed One Year

On December 9, 2010, Congress took final action on the Medicare and Medicaid Extenders Act of 2010, approving a 12-month reprieve from the 25 percent Medicare physician payment cut that had been scheduled to take effect on January 1. The act also includes funds to enable Medicare contractors to reprocess claims for physician services affected by provisions of the health care reform act, retroactive to January 1, 2010. ❑

Dean's Page

M. DEWAYNE ANDREWS, MD
Executive Dean
University of Oklahoma College of Medicine

How well is the OU College of Medicine meeting its missions? To gain some insight into how we might answer this question, I asked Jon Brightbill, Assistant Dean for Administration, to summarize for us some interesting data he monitors. Mr. Brightbill's comments follow.

Recently the Association of American Medical Colleges developed a tool that enables medical schools to benchmark themselves against each other in terms of some of the primary missions of medical schools: (1) provide high quality medical education, (2) graduate a workforce that addresses the priority needs of the nation, (3) prepare a diverse physician workforce, (4) foster advancement of medical discovery, (5) prepare physicians to fulfill the needs of the community, and (6) graduate a medical school class with manageable debt. We also have data from sources other than the management tool. Space limitations allow me to highlight only some of the results for our College of Medicine and how those results compare to 125 other medical schools nationwide.

How well is the College educating its students? Let's look at the results from the latest cycle of the USMLE exams which all medical students take. For the Step 1 exam, 91% of our students passed on the first attempt compared to 92% nationally, and 100% of our students who had to repeat the exam passed compared to 79% nationwide. For the Step 2 exam, 99% of our students passed compared to 97% nationwide.

For the cohort of OU College of Medicine graduates from 1995 through 1999, there were 720 graduates of whom 37.9% are now in primary care (places us at the 55th percentile nationwide). There

are also 118 of those graduates practicing in rural areas, which is the highest number from any medical school for that five-year cohort. If one looks at OU College of Medicine graduates from 1995 through 2004, those who became faculty at any medical school at any time comprised 13.9% of the cohort with a national average of 17.8%.

In terms of diversity, the College attempts to recruit students of diverse background; however, our success is modest. For the five-year cohort of graduates from 2003 through 2008, only 1.3% were African-American and 2.7% were Hispanic. Our lack of success here is in part secondary to the paucity of scholarship funds we have available. Of importance, 8.1% of graduates were Native American placing us first among U.S. medical schools in this dimension. With respect to faculty we had 34% who are women at the end of 2008; this has increased to 42% at the beginning of 2011.

If one looks at the cost of attendance for a 2009 graduate, we are at the 55th percentile among all medical schools. We are also at the 55th percentile with respect to average debt of indebted graduates ($137,543).

These are just a few of the areas in which we can compare our results to those of other medical schools. The most important information that can be taken away is that the College of Medicine is doing well in many areas related to the goals of our nation and our state in providing quality medical education. The key is not to let ourselves become complacent with the successes we have. There are other areas in which we need to improve. We must maintain and grow the many positives and work hard to raise those areas in which we can improve. We are committed to those tasks. ❑

Celebrating 50 Years in Medicine

The first membership meeting of the year will honor OCMS members who are celebrating 50 years in medicine in 2011. The meeting will be February 21 and will be held in the OSMA building at 313 NE 50th Street, Oklahoma City. The reception will begin at 6:30 p.m., dinner will be served at 7:00 p.m., and the program will begin around 7:30 p.m. Further details will be mailed with the meeting notices. ❑

Pearl of the Month

Tomás P. Owens, MD
Chair, Family Medicine
INTEGRIS Baptist Medical Center

Pay 4 Performance: A great idea or an ill-advised ploy?

Let me submit to you that the answer is: *yes*.

On the surface, it sounds as American as apple pie: Reward Those Who Perform Better. Have the providers compete for excellence while patients get better outcomes. The devil is in the details, though. What is better? Who decides? Do markers really signify excellence on the part of the clinician? Does the fulfillment of said guidelines really change outcomes? Which outcomes are we measuring?

Coach Stoops gets paid differentiating incentives for winning the Big 12, reaching a BCS bowl, reaching the National Championship and winning it. Why should it be different for us? Because there are colossal differences. First, the only similarity: like us, he depends on others to achieve success; after all, it is the young men who play the actual contests who win. But, unlike him, we can't determine the number of hours of practice, the number of repetitions done. We can't select which patients to play and which to trade or suspend. Our game plans are not gospel; they don't have to be followed. We don't get to bench patients. It has to be recognized that pay 4 performance is actually "pay for patients' performance." And, recruitment is an essential part of success. But if we decided to take a proactive approach in this regard (recruiting only all-American patients) it would be devastating for medical care.

The mandate to use "quality metrics" as part of Medicare payments has shown that in many cases "the quality measures have been hastily adopted, only to be proven wrong and even potentially dangerous to patients"[1]. Of interest is data from an academically affiliated internal medicine practice[2]. An expert panel found that in 94 percent of cases a deviation from a "national guideline" by the physician was clearly appropriate for the individual patient and only inappropriate in three percent of cases, at most. The ACCORD study showed that a reduction of HbA1C from 7.0 mg percent to 6.0 mg percent may actually be deleterious to patients and the New Zealand Intensive Care Society Clinical Trials Group found that tighter control of glycemia in the ICU can actually be deadly.

Although most variables in biology are of the quantitative continuous type (e.g., blood pressure, HbA1c), the adjudication of adequacy is done via categorical, discrete variable allocation, i.e. more than x is good, less than x is bad. A clinician that helps 100 patients reduce their HbA1c from 14 to 8.5 will get a worse "grade" than one that kept 98 patients at the 14 level, but dropped two from 7.1 to 6.0 – and ironically may have hurt them in the process (see above). I agree entirely with Dr. Ofri at NYU School of Medicine: "Doctors who actually practice medicine — as opposed to those who develop many of these benchmarks — know that these statistics cannot possibly capture the totality of what it means to take good care of your patients. They merely measure what is easy to measure"[11].

How about quality measures of hospitals? An article in the Archives of Surgery suggests that "much of the data available on the Hospital Compare site may not help patients make better decisions." Most measures did not correlate with actual mortality: "They expected [the measures] to be closely tied to patient outcomes, and were instead surprised to find that hospitals [with high compliance rates] don't have correspondingly lower rates of mortality, or complications"[6], and, when actual mortality is measured, it is impossible to interpret, as patients are very difficult to compare at different settings. Importantly, these experiments in measuring the unmeasurable could have the effect of encouraging hospitals not to accept the sickest patients in order to get better ratings. This would certainly worsen outcomes.

Paying for performance has the unintended consequence of producing lower payments to practices dealing with the underserved and "medically vulnerable" communities, to the tune of $7,100 per year, at a time when primary care is being encouraged, thus making disparities worse[3]. A 2003 RAND study found that the average American patient receives only 55 percent of recommended care; yet in a follow-up study where P4P incentives were used, some "measures" of quality were improved but no evidence of any "positive major improvement in patient outcomes" was found. "This result casts doubt on … P4P as a transformative mechanism for improving health care"[4].

A study published in April 2010 found no evidence of any quality-of-care improvement after P4P incentives were put in place in two "safety-net" settings in the northeast. Curiously, the non-incentivized quality measures increased during the study period. The providers concluded that energy devoted to P4P goals interfered with caring for "complex underserved patients[5]."

The UK has the Quality of Outcomes Framework (QoF). This program has "actually increased costs … mostly because the government ... had underestimated the extent to which doctors were already delivering high quality primary care[5]." No improvement in actual patient outcomes has been seen. Among the putative reasons for this failure: illness-centered guidelines offer "incentives for targets rather than understanding medical conditions," and the fact that professionalism embodies judgment, nuance, constant decision making and directional change and adjustments, that, at its core, is the "antithesis" of "target" reaching.

The problem is one of expecting too much of a very early process. The fact is that measuring performance is a dauntingly multifarious process. Short-term adherence to certain intermediate goals (such as HbA1C measures) may not bear the fruit of an improved hard ultimate goal, such as mortality-deferral, and that "set in stone" marker (pun intended) may not even be the best in assessing success. "Better health outcomes" as a construct of improved quality-of-life or human well-being is what actually matters, yet is elusive to compute[7].

Now comes the Accountable Care Organization (ACO), set to launch in January 2012. At its heart this will link payments to quality with a focus on prevention, early diagnosis and chronic

disease management[9]. The Patient Centered Medical Home, which I reviewed in previous issues of The Bulletin, will be an ideal venue to exercise this process. It is imperative that a thoughtful measuring system is used. The bottom line is that outcomes are not as "inextricably linked to doctors" as it appears[8]. Patient characteristics are essential (to the seasoned clinician this is just stating the obvious). The concern, which Clemens Hong, MD stated best, is that "Fee-for-service has already driven physicians away from primary care. If we don't address patient differences, we may do the same thing with pay-for-performance [10]."

"There isn't a simple formula for distinguishing good doctors from second-rate ones, nor will there ever be[11]." In the final analysis, "a good doctor exercises sound clinical judgment by consulting expert guidelines and assessing ongoing research, but then decides what is quality care for the individual patient. And what is best sometimes deviates from the norms."[1] ❑

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2. http://www.ahrq.gov/research/jul10/0710RA4.htm "Frequency of inappropriate medical exceptions to quality measures," by Stephen D. Persell, MD, MPH, Nancy C. Dolan, MD, Elisha M. Friesema, BA, et al February 16, 2010, Annals of Internal Medicine 152(4), pp. 225-231.
3. http://content.healthaffairs.org/cgi/content/abstract/hlthaff.26.3.w405 Will Pay-For-Performance And Quality Reporting Affect Health Care Disparities? Lawrence P. Casalino, Arthur Elster, Andy Eisenberg, Evelyn Lewis, John Montgomery and Diana Ramos
4. Mullen, Kathleen, Richard Frank and Meredith Rosenthal "Can You Get What You Pay For? Pay-For-Performance and the Quality of Healthcare Providers." The RAND Journal of Economics, (2010) Vol. 41, No. 1, p. 64-91.
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6. http://archsurg.ama-assn.org/cgi/content/short/145/10/999 Hospital Process Compliance and Surgical Outcomes in Medicare Beneficiaries Lauren H. Nicholas, PhD; Nicholas H. Osborne, MD; John D. Birkmeyer, MD; Justin B. Dimick, MD, MPH Arch Surg. 2010;145(10):999-1004. doi:10.1001/archsurg.2010.191
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8. http://jama.ama-assn.org/content/304/10/1107.full Relationship Between Patient Panel Characteristics and Primary Care Physician Clinical Performance Rankings Clemens S. Hong et al JAMA. 2010;304(10):1107-1113.
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(Cont"d on page 27)

Retiring Student Debt

The National Health Service Corps (NHSC) is a Federal program that helps physicians deal with their student debt while addressing the current shortage of primary care practitioners. The NHSC repays student loans in exchange for service in rural or urban communities that have a shortage of primary medical, behavioral health and dental care workers. There are currently 1,900 physicians serving in the NHSC. The NHSC recently announced the opening of its 2011 loan repayment program, which includes several changes authorized by provisions in the Affordable Care Act.

NHSC members may now receive up to $60,000 in loan repayment for a full-time, two-year service commitment and up to $170,000 for a full-time, five-year service commitment. They also have the option to completely eliminate their educational loan debt with additional years of service. The program now offers three options for fulfilling the service obligation: A two-year, full-time contract, a four-year, half-time contract, and a two-year, half-time contract. The service obligation for clinical practice hours has been updated to include a 20 percent credit for teaching and a 50 percent credit for instruction at a Teaching Health Center. Prospective Corps members can also complete their application entirely online, available at NHSC.hrsa.gov. ❑

Director's

DIALOGUE

We will open the book. Its pages are blank.
We are going to put words on them ourselves.
The book is called Opportunity, and its first chapter is
New Year's Day
Edith Lovejoy Pierce

Another holiday season has come and gone and a new year has begun. 2011 will be a year of change and opportunity for this organization. Many outcomes from the OCMS Board of Directors' retreat last November will chart this organization on a new course and demonstrate our continued viability.

The first session of the OCMS Leadership Academy was successful. Participants are scheduled to hear presentations about the political process and media relations-public speaking during the second session on January 29th. Oklahoma State Medical Association lobbyists, Pat Hall and Jim Dunlap, are slated to discuss the legislative process with their own brand of wit and humor. Jane Braden, a senior account executive with the public relations firm The Gooden Group, will present the second portion of the session titled Media Relations and Public Speaking. Ms. Braden was a medical reporter for KOCO-Channel 5 in Oklahoma City for 16 years, from 1982 to 1997.

The purpose of the Leadership Academy is to orient and train OCMS members for future leadership positions at county, state and potentially national levels. Academy topics throughout the spring months will include board leadership, parliamentary procedure, business and cultural community involvement, and organized medicine. Plans are to include the commencement ceremony as part of the OSMA annual meeting in April 2011. The Society owes a debt of gratitude to Dr. Larry Bookman and Frank Merrick for their contributions to this endeavor.

A physician family event is being planned for mid-April at the Harn Homestead. Many younger physicians have expressed their interest in an event they can share with their children. There will be food, music, dancing, and children's activities. This special event will appeal to young and old alike. Be sure to look for an announcement in the mail and do not miss this spring event.

There are plans during this year for the Society to have a presence on Facebook, the social media site that had more than 500 million active users as of July 2010. I do not currently have a personal Facebook page but have made the decision that if 500 million people are finding a beneficial use for it, I need to forge ahead or be left behind. Many of my friends created their own Facebook page to learn what was going on in the lives of their grandchildren. Wow, how times have changed!

The Senior Physicians Group continues to be active with quarterly meetings and special interest events. All OCMS members who are 60+ years of age who are not participating with this group will have an opportunity later this month to attend a "Sweetheart Dance" at a local dance studio. For a modest price, you and your spouse or guest can enjoy the wine and hors d'oeuvres while brushing up on your dance techniques. Look for your invitation in the mail and don't miss this opportunity to socialize with your colleagues.

Here's to another year that is certain to be filled with surprises – and how we react to them is our decision. I will leave you with some food for thought as this new year stretches out before us.

It Depends on Us...

Another year lies before us like an unwritten page,
an unspent coin, an unwalked road. The pages we will read,
what treasures will be gained in exchange for time,
or what we find along the way,
will largely depend on us.

Esther Baldwin York

Happy New Year! ❑

Jana Timberlake, CAE, Executive Director

PAIN: Fifth Vital Sign

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

For centuries, blood pressure, pulse, respiration and temperature have been regarded as the basic four "vital signs" which provide a simple, baseline compass to determine if a patient is ill. Pain is often regarded as the 5th "vital sign." "Pain" should be described as acute or chronic; mild, moderate or severe; neuropathic or nociceptive. Pain affects mood, activity, appetite, sleep, hygiene, and the ability to focus and concentrate, all of which impact the quality of life.

Pain scales are useful diagnostic and therapeutic indicators when determining efficacy of therapeutic modalities. In unconscious patients or those requiring respirators who are unable to speak, pain is determined by closely monitoring the patient's other four vital signs as well as behaviors such as their level of agitation, irritation, and restlessness. The pediatric pain scale is comprised of six pictures with facial expressions, the 1st being a happy expression and the 6th describing a grimacing face suffering from intolerable pain. In conscious adult patients, the subjective pain level may be "objectively" measured by using a scale of 0 and 10, with the number 0 meaning "no pain" and a score of 10 representing the worst pain imaginable.

The physician who is treating the patient with controlled drugs should also note whether the patient knows about or has received Complementary Pain Therapies, such as Acupuncture, TENS, Manipulative & Physical therapy, Biofeedback, Psychological counseling, and spiritual interventions.

The Federation of State Medical Boards "Model Guidelines for the Use of Controlled Substances for the Treatment of Pain", which has been adopted by most States, distills safe opioid prescribing into seven concise principles – namely,

- Patient evaluation including the establishment of a physician-patient relationship;
- Treatment plan that is tailored to the patient's medical condition;
- Informed consent & agreement for treatment;
- Periodic review of the pain treatment with assessment of Clinical Outcome, be it beneficial or not;

- Consultation with pain specialist when needed;
- Medical Records should provide adequate documentation, and
- Compliance with Controlled Substances Laws and Regulations.

Appropriate pain management is the treating physician's responsibility. Inappropriate treatment of pain includes four main categories: non-treatment, under-treatment, overtreatment, and continued use of ineffective treatments. Inappropriate treatment of pain is considered by the Oklahoma Medical Board (OMB) as a departure from standards of practice. Allegations of inappropriate pain treatment are investigated by the OMB. In doing so, the Board will refer to: current clinical knowledge, scientific research, medical practice guidelines, use of pharmacologic and non-pharmacologic modalities, and expert review (e.g. by Board Certified Pain Management Specialists). Inappropriate pain treatment may result from Physicians' lack of knowledge about pain management and fears of investigation or sanction by federal, state and local agencies.

The Physician who is treating pain should be able to determine whether the patient's pain medications are causing tolerance, physical dependence, addiction, or pseudo-addiction. And, the physician should be vigilant to possible substance abuse by the patient.

At the Federal level, the Drug Enforcement Administration (DEA) is the Federal Regulatory agency that administers federal laws, maintains opioid records, registers health professionals, sets quotas, and enforces violations of the Controlled Substances Act (CSA). The CSA was upheld by the U.S. Supreme Court in U.S. v. Moore, 423 U.S.122 (1975). The Court stated that if physicians have licenses from the DEA, they can be prosecuted "when their activities fall outside the usual course of medical practices." At the State level, the Attorney General may prosecute criminal activity of Physician offenders, and the State Medical Board and the Oklahoma Health Care Authority may impose severe civil sanctions.

Medical offices or facilities which utilize controlled substances for pain management should adopt a "Clinic Policy" regarding the Use of Controlled Substances that is committed to improving the quality of and access to appropriate pain care; avoiding

under-treatment; and addressing concerns about abuse and diversion of controlled substances. Such Clinic Policy provides the physicians and clinic staff with a template regarding the appropriate management of pain in compliance with applicable state and federal laws and regulations. ❑

Save the Date

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Patient Safety 104

The American Medical Association (AMA) is holding the webinar "Patient Safety 104: High-Reliability Safety: Applications to Healthcare" on January 19 at 1:00 pm EST. AMA PRA Category 1 Credit (TM) will be available.

The webinar will feature Gregg Bendrick, MD, MPH, Chief Medical Officer at the NASA Dryden Flight Research Center, Edwards Air Force Base, California. Over the years, NASA has had well-publicized successes (and failures). By applying these lessons learned from its own experiences, NASA has made safety an integral part of its culture.

All physicians, nurses, health professionals, students, educators, and patient safety experts, are encouraged to participate. The cost is $79 per site for AMA members and $99 per site for nonmembers.

You may register online by logging on to http://eo2.commpartners.com/users/ama/session.php?id=4881.

For questions about this webinar, contact Fred Donini-Lenhoff at (312) 464-4635 or fred.lenhoff@ama-assn.org. ❑

alliance

Lori W. Hill
guest author

Mark your calendars for Saturday, May 7, 2011! The first ever **Walk the Doc** (**WTD**) has been scheduled and we need *you*, your family and your medical staff there!

What in the world is Walk the Doc, you ask? Our official WTD Mission Statement states: "*Walk the Doc is a fun physician walk and family recreational event scheduled for 9:00 a.m. Saturday morning, May 7, 2011, at Lake Hefner Stars and Stripes Park, for the primary purpose of raising awareness of the problems that a sedentary lifestyle and obesity cause our community and especially our children. Co-sponsored by the Oklahoma County Medical Society and the OCMS Alliance, our goal is to demonstrate the commitment of our local physicians and their spouses to health and well being for themselves, their families and the community in which they serve.*"

We are especially looking forward to the camaraderie with our families, children, grandchildren, and dogs at Stars & Stripes Park on a beautiful May morning. Having a great time "with a purpose" is our plan, including lots of activities for adults and children, such as music, food, kites, and face painting. We will begin the walk around the park at 10 AM, at which time participants and family members can choose if they want to walk one loop for 1 mile, or 3 loops for a 5K. Celebrations and awards will follow the walk.

Besides the health benefits, what are the benefits of **Walk the Doc?** We feel there are many, such as the following:

WTD is a professional event that will promote name recognition for both of our organizations, and provide a venue to promote our purpose and mission and to raise funds for one of our important causes, *Schools for Healthy Lifestyles.*

WTD is an opportunity for existing members to become more familiar and involved with OCMS and the Alliance, with a commitment of only a few hours.

WTD is a highly visible public event to attract new physicians and spouses to join the OCMS and the Alliance.

WTD will allow physicians and their spouses to participate in the event without sacrificing their important family weekend time with each other and their children.

WTD will provide a new marketing opportunity to reach younger physicians and their spouses through popular social networking sites such as Facebook and Twitter.

In addition, we feel an important goal is to help promote and enhance physician unity on a local level amidst a time of uncertainty in medicine on a national level. If ever there was a time to become involved with an organization entirely and uniquely devoted to the medical family, it is NOW!

How can you help? First, we need your commitment and *participation*! We will soon have a pre-registration form on both the OCMS and the OCMSA websites. Although our current plan is not to charge an entry fee, we will need to know how many of you plan to participate and we will be hoping for voluntary donations.

In addition, we need *Sponsors*, such as hospitals, cardiology groups, orthopedic groups, drug reps, athletic apparel stores, fitness equipment stores, health food stores, and nutritionists, just to name a few ideas. We need vendors and complimentary **give-a-ways**, such as T-shirts, food, pedometers, water bottles, and dog bandanas. And we need **printing** donations for our brochures, route maps, and promotional banners.

Please contact me if you or your spouse have any ideas or comments, or would like to help with planning for exciting, ground-breaking opportunity for our two organizations. My phone number is 843-9858 and my email is loriwhill@cox.net.

Let's make Oklahoma County's health a priority with **Walk the Doc**! ❑

Lori W. Hill, Community Outreach Chair

(Cont'd from page 18)

10. http://www.nytimes.com/2010/10/01/health/01chen.html?_r=1 Pauline W. Chen, M.D Paying Doctors for Patient Performance" September 30 2010. New York Times
11. Quality Measures and the Individual Physician, Danielle Ofri, MD, PhD. N Engl J Med 363;7 August 12, 2010

LIVING ARTIFACTS

Bill Truels, MD

I was sitting in the surgery lounge, munching on a cookie, waiting for my anesthesiologist to finish an earlier case, when Herb Krackle walked into the lounge.

"Welcome, Herb!" I said. "I thought you were retired. What's happening?"

"I'm retired, Dr. Truewater," Herb began, "but I like to come back and visit every so often. I kind of miss the old stomping grounds."

"It doesn't seem that long ago that you were doing those plastic reconstructions for spina bifida patients," I said.

"That was ten years ago," Herb answered. "I've been fully retired five years now. By the way, what happened to the donuts they used to have in the surgery lounge. I see you're just munching on cookies these days."

"Conflict of interest," I answered.

"Conflict of interest?" Herb asked. "What do you mean?"

"Well, the Eli Lilly rep used to bring donuts on Monday morning until the federal government declared that this was a conflict of interest," I said. "The government was afraid if we ate a 15 cent donut from Eli Lilly for breakfast, we would be biased toward using Eli Lilly products. So now we eat cookies the hospital brings from the cafeteria."

"That's so silly," Herb answered. "After all those contributions the Congressmen receive from 'disinterested parties,' you'd think they'd let us have a 15 cent donut without arousing claims of favoritism."

"It's a brave new world," Herb added.

"I still remember the time you got mad about your surgery instruments," I began.

"That was at the old Presbyterian Hospital on 13th Street," Herb interrupted. "I tended to be a grouch in those days, and I complained to Nurse Martin for the umpteenth time about my surgical instruments. She just picked up the whole box of instruments, walked over to the window, opened the window, and calmly threw the instruments out the second floor window," he added.

"I think you started the feminist revolution all by yourself that day, Herb," I quipped.

"Yep, those were the good old days," Herb laughed. "I remember when this lounge was half this size," he added, as he looked around the newly expanded facility. "I guess they had to make room for all these new computers."

"Yes, they've done a nice job of renovating the old surgery lounge," I said. "With these new computers, we can dictate and sign our medical records while we're waiting for the next case to start."

"Progress," Herb replied cynically. "I remember when this hospital had a home for unwed mothers at the south end of the campus. Then they ran an adoption agency for the newborn babies. That was true compassion."

"Herb, you're going back fifty years," I replied. "Why, you probably knew the founding fathers of Holy Christian Hospital."

"As a matter of fact, I knew Dr. Spencer and Sister Coletta—nice, compassionate people," Herb answered. "But they were much older than me."

"That makes you sort of a living artifact, Herb" I quipped.

"A living artifact? Hmm. That reminds me of another Oklahoma story," Herb laughed. "You probably don't remember Jim Thorpe."

"Jim Thorpe? Of course I know about Jim Thorpe," I answered. "We studied him in Oklahoma history—Oklahoma's greatest athlete, an Olympic champion—he also competed in football, baseball, basketball, lacrosse and even ballroom dancing, and is heralded by the Sac and Fox Indians."

"But have you heard about the controversy?" Herb asked.

"What controversy?" I asked.

"Well, Jacobus Franciscus 'Jim' Thorpe is buried in Jim Thorpe, Pennsylvania. It seems that Jim grew up in the Sac and Fox nation in Oklahoma, and Jack Thorpe, his son, would like to bring his body back to Oklahoma, to be buried next to his family."

"But can they do that?" I asked.

"It seems that the Indians are declaring Jim Thorpe's remains to be an artifact and wish them to be removed to the reservation in Oklahoma, under the Native American Graves Protection and Repatriation Act," Herb stated.

"How long do you have to be dead to be declared an artifact?" I asked.

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"Jim Thorpe died in 1953—that would be 57 years," Herb answered. "But it doesn't have to be that long—you just declared me to be a living artifact!"

"I was joking," I quipped. "But think about the poor people in Jim Thorpe, Pennsylvania," I added. "They would have to rename the town."

"Let me think," Herb replied. "I guess they could rename it Joe Paterno, Pennsylvania. Have you seen Joe, lately? He's another living artifact—they call him 'Joe Pa'—one of the greatest living football coaches. I wouldn't be surprised if he helped forge the Liberty Bell!"

"That would be a great honor for Joe, to have a town renamed after him," I replied.

"Well, I've got to go start my case," I concluded. "It was nice of you to drop by, Herb—you're always welcome here, you know. It's like having a history lesson."

"I appreciate that, Dr. Truewater," Herb answered-- "even if I am a living artifact!" ❑

Frightening News for Retirees

Although the health reform law will reduce some health costs in retirement for many people, retirees will still need a significant amount of savings to cover out-of-pocket health expenses, according to a report released today by the nonpartisan Employee Benefit Research Institute (EBRI). Women will need more savings than men because they tend to live longer.

The study finds that men retiring in 2010 at age 65 will need from $65,000-$109,000 to cover health costs if they want a 50-50 chance of being able to have enough money; to improve the odds to 90 percent, they'll need $124,000-$211,000. Women retiring this year at age 65 will need between $88,000-$146,000 for a 50-50 change of having enough money, and $143,000-$242,000 for a 90 percent chance.

Those estimates are for Medicare beneficiaries age 65 and older. Younger retirees will, of course, need more.

The report, Funding Savings Needed for Health Expenses for Persons Eligible for Medicare, is online at www.ebri.org ❑

Ethics of Pain Management

S. Sandy Sanbar, MD, PhD, JD, and Chris Codding, MD

The American Academy of Pain Medicine stated in its Ethics Charter, adopted in December 2007, that "*The ethical imperative to provide relief from pain requires all physicians to apply themselves toward improvement in the following areas:*

- *assessment of the pain sufferer as a whole person, including all relevant biological, social, psychological, and spiritual dimensions pertaining to etiology and impact of pain;*
- *treatment of the person in pain with competence and compassion;*
- *education of professional colleagues, patients, the public, and policy-makers on the principles and methods of Pain Medicine;*
- *support of and/or participation in basic and clinical pain research;*
- *advocacy to ensure access to pain care and its continuous improvement."*[1]

Physicians have a core ethical obligation to treat patients with pain equitably and righteously to alleviate their suffering. In most medical matters, including pain management, ethics should take the lead and law follows. Some physicians are ambivalent, in denial, and harbor suspicion of the circumstances of patients in pain and of doctors who treat them.

Pain has become a public health crisis. Unrelieved pain adversely impacts enjoyment of human goods and values. Chronic pain is frightening, humiliating, and a difficult ordeal. Terrible, relentless pain is depressing and may be totally disabling personally and functionally, leading to withdrawal from family, friends and work.

Care of pain patients has customarily been achieved by placing them into one of several broad categories – namely, acute pain, cancer pain, or chronic nonmalignant pain. Physicians who treat patients for pain of cancer or terminal illness generally confront no legal risk of medical board or DEA actions. Emergency departments tend to be hypervigilant about diversion of controlled substances, but they are neither significant sources of diverted drugs nor a prime target for investigation and prosecution. Nursing homes

[1] Source: http://www.painmed.org/files/ethics-charter.pdf last visited November 17, 2010.

tend to resist extensive reliance on pain medications that impact alertness, particularly in patients with dementia or other forms of mental confusion.

Physicians who are treating patients with pain should not allow patients to suffer, whether the treatment is provided institutionally or in the office-based practices. Concerns about diversion or addiction and fear of DEA action licensing board reviews should not lead physicians to avoid patients with chronic pain. Some physicians who do treat chronic pain patients with controlled substances may conservatively under-treat the pain to avoid agency reviews. Avoidance, neglect and under-treatment of pain patients are unethical and inappropriate in all medical practice settings. The financial costs of untreated pain are staggering.

From an ethical standpoint, the medical community and the public both should strive to improve access to appropriate, effective pain relief care for patients in pain. That improvement begins with professional medical ethics and the provision of equitable and righteous management to relieve pain. There should be adequate pain management training not only in medical schools but also while in practice. Physicians have a professional ethical duty to maintain their competencies and continue to learn about medicine in general and pain management in particular. Ultimately, it is critical that Physicians treat patients with pain professionally, righteously, competently and compassionately. ❑

Top 10 Health Hazards

The Economic Cycle Research Institute (ECRI), an independent group that evaluates medical devices and procedures, has issued its list of the 10 top healthcare technology hazards for 2011. They include, in order, Radiation Overdose and Other Dose Errors During Radiation Therapy; Alarm Hazards; Cross Contamination from Flexible Endoscopes; High Radiation Dose of CT Scans; Data Loss, System Incompatibilities and Other Health IT Complications; Tubing Misconnections; Oversedation During Use of PCA Infusion Pumps; Needlesticks and Other Sharps Injuries; Surgical Fires; and Defibrillator Failures in Emergency Resucitation Attempts. ❑

(Cont'd from page 9)

legislative session. In addition to these organizations, there are many grassroots efforts underway to educate all elected officials on this law.

For more information about restoring local rights, go to www.smokefreeoklahoma.com or contact the Oklahoma County Tobacco Use Prevention Coalition at 405-419-4247. The Coalition is a group of local volunteers with a passion for improving the health of Oklahoma County citizens through tobacco prevention policy and education.

If you feel strongly about the need to restore local rights, or any other issue of concern, contact your state legislators. Elected officials want and need to hear the concerns of their constituents, and it is vital that they hear these concerns early in the session so they can represent their community with votes. There is no wrong way to contact your legislator; however the most recommended methods are handwritten letters, phone calls, and face-to-face meetings. To learn who your state legislators are, go to http://www.lsb.state.ok.us/. ❑

Ms. Terronez is a Tobacco Use Prevention Coalition Coordinator with the Oklahoma City County Health Department.

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 System, Inc. (COINS)
Contact: Deborah Ferguson
Telephone: (405) 524-8100 ext. 103

Deaconess Hospital
Contact: Emily McEwen
CME Coordinator
Medical Library
Telephone: 604-4523

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

Oklahoma City-County Health Department
Epidemiology Program
Communicable Disease Surveillance

COMMONLY REPORTED DISEASES	*Monthly*			*YTD Totals^*	
	Nov'10	Nov'09	Oct'10	Nov'10	Nov'09
Campylobacter infection	7	5	9	72	85
Chlamydial infection	N/A	N/A	N/A	N/A	N/A
Cryptosporidiosis	1	3	2	21	15
E. coli 0157:H7	1	1	5	16	9
Ehrlichiosis	0	0	0	1	7
Giardiasis	0	0	2	14	39
Gonorrhea	N/A	N/A	N/A	N/A	N/A
Haemophilus influenzae Type B	0	0	0	0	0
Haemophilus influenzae Invasive	1	1	0	22	14
Hepatitis A	0	0	0	3	4
Hepatitis B*	21	12	13	176	160
Hepatitis C *	19	15	14	198	235
HIV Infection	N/A	N/A	N/A	N/A	N/A
Lyme disease	0	0	0	10	5
Malaria	0	0	0	1	0
Measles	0	0	0	0	0
Mumps	0	0	0	0	2
Neisseria Meningitis	0	1	0	2	4
Pertussis	4	4	4	40	22
Pneumococcal infection Invasive	1	1	1	12	14
Rocky Mtn. Spotted Fever (RMSF)	0	0	8	33	28
Salmonellosis	8	4	15	127	102
Syphilis (primary/secondary	N/A	N/A	N/A	N/A	N/A
Shigellosis	5	10	4	67	149
Tuberculosis ATS Class II (+PPD only)	38	27	41	564	738
Tuberculosis ATS Class III (new active cases)	2	3	2	24	16
Tularemia	0	0	0	2	1
Typhoid fever	0	0	0	1	1
RARELY REPORTED DISEASES/Conditions:					
West Nile Virus Disease	0	1	0	0	5
Pediatric Influenza Death	0	0	0	0	3
Influenza, Hospitalization or Death	1	38	0	14	252
Influenza, Novel Virus	0	0	0	0	65
Strep A Invasive	0	0	1	21	33
Legionella	1	0	1	6	3
Rubella	0	0	1	3	0
Listeriosis	0	0	0	1	2
Yersinia (not plague)	0	0	0	1	0
Dengue fever	0	0	0	1	0

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

^ *YTD - Year To Date Totals*

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

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OKLAHOMA CITY, OK 73105-1830

• • • •

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Oklahoma Tobacco Helpline

1-800 QUIT-NOW • 1-800 784-8669

- ***free information on quitting tobacco***
- ***one-to-one proactive telephone counseling***
- ***referrals to local cessation programs and services (dependent on availability)***

OKLAHOMA COUNTY MEDICAL SOCIETY
313 N.E. 50TH ST., SUITE 2
OKLAHOMA CITY, OK 73105-1830

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