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JANUARY 2012

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THE BULLETIN
The Oklahoma County Medical Society

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TABLE OF CONTENTS

About the Cover

Pictured on the cover of The Bulletin this month is the family of Tomás P. Owens, MD, the 112th President of the Oklahoma County Medical Society. Dr. Owens is the oldest of five children born to the late Thomas Owens, MD, recognized in Panamá as the "father of family medicine," and Criseida Saad de Owens, MD, a prominent neonatologist, medical journal editor and scholar. He graduated top of his class at both Colegio Javier high school (1979) and Facultad de Medicina-Univesidad de Panamá (1986). He served his tertiary care internship at Complejo Hospitalario Metropolitano C.S.S. (1986-1987) and his rural year as chief of interns at Sistema de Salud de Veraguas (1997-1988). He was resident and chief resident at OUHSC Family Medicine (1988-1991), where he was honored with the Clinical Excellence and Excellence in Teaching awards, and then completed a Geriatric Medicine fellowship at Mayo Clinic Department of Internal Medicine (1991-1993).

Dr. Owens returned to serve a dual appointment with OUHSC's Department of Family and Preventive Medicine and Department of Internal Medicine, becoming a founding member of the Geriatric Section at VAMC. He was inducted into Alpha Omega Alpha Honor Medical Society in 1994. He has been Associate Director of the Great Plains Family Medicine Residency Program at Integris Baptist Medical Center (IBMC) and Deaconess Hospital since 1995. He has remained active at the OU College of Medicine as their only pro-bono in-house preceptor for Clinical Medicine I. He has received several teaching awards and is Clinical Professor of Internal Medicine, Geriatric Medicine and Family & Preventive Medicine. He is also a Clinical Instructor at Mayo Clinic. Dr. Owens is the Chair of Family Medicine at IBMC since 1999 and served as President of the Oklahoma Academy of Family Physicians (2007-2008), where he continues to be a board member. He has represented Oklahoma as IMG Delegate at the American Academy of Family Physicians Congress (2006-2007 and 2111-2112). He is Secretary of the Integris Mental Health Board. A life-long learner, he has current ABFM certificates of added qualifications in geriatric medicine, adolescent medicine, sports medicine and hospice and palliative medicine, the only physician in the U.S. to have done so. He is also an AMDA certified medical director in long-term care. Through his son, he is involved in

scouting. He volunteers for the Integris Latino Initiative and the Latino Community Development Agency and serves as a speaker to many organizations in Oklahoma (Alzheimer's, Osher Lifelong Learning Institute and others) and beyond our borders. Tom's hobbies include reading, skiing, studying Oklahoma history, traveling and spending time with family. He wishes to someday go back to play tennis again.

His wife Tammy, youngest of five, a native of South Dakota, is an UCO-educated RN who was charge nurse at OU Medical Center when she met Tomás. She is currently a homemaker, tireless volunteer, and facilitator of multiple groups at their children's school. She is also a tremendous card player and handywoman who loves to spend time with family in South Dakota and Panamá. Also shown on the cover is their son Thomas, a National Merit Scholar, former drumline leader, team-soccer player and piano enthusiast, who is a freshman at the University of Oklahoma, and their daughter, Emily, show-choir performer, vocalist, National Honor Society president and Senior Class president at Edmond Memorial High School. They both feel their highest accomplishment has been to serve as royalty for the Swine Week fundraiser benefiting Oklahoma Children's Heart Center (2011) and Oklahoma Project Woman (2112). ❑

The Editor

In Memoriam

Richard W. Welch, MD

1942 - 2011

Letters

Dear Editor:

In the current (November 2011) issue is a piece on disparities in health care. The piece properly points out that members of minority groups often elect to receive care in hospitals which do not have the best records of performance. It cites southern, for profit hospitals as being disproportionately in this category. But this has been found true in New York hospitals and northern hospitals even before the modern Medicare performance measurers for heart attack, heart failure and pneumonia were set in place.[1],[2],[3] Some research ought to center on how and why these decisions are made. One suspects people feel comfortable in staying with people they know, convenience of visiting hours, and similar factors. Indeed, perhaps we shouldn't be surprised that disparities occur given the diversity of our country. ❑

William H. Hall, MD

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1 Rothenberg, BM, Pearson, T, Zwanziger, J, et al. Explaining Disparities in Access to High-Quality Cardiac Surgeons. AnnThor Surg 2004:78:18-25

2 Oberman, A and Cutter, G Issues in the Natural History and Treatment of Coronary Heart Disease in Black Populations: Surgical Treatment. AmHeartJ 1984;108:688-694

3 Werner, RM, Asch, DA, and Polsky, D The Unintended Consequences of Coronary Artery Bypass Graft Report Cards. Circulation 2005;111L1257-1263

New Member Holiday Reception

Joni and Dr. Tom Flesher hosted the OCMS Board of Directors and the OCMS Alliance Board of Directors reception for new members. Their beautiful home is warm and inviting and full of holiday treasures. What a lovely evening it was! Dr. Flesher will serve as President-Elect this year. ❑

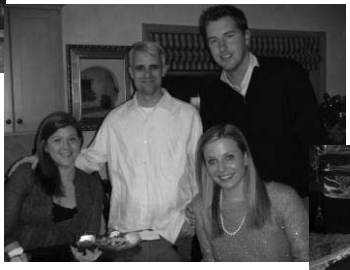












alliance


Kathy Bookman

At this time of year, most Alliances around the country are preparing to "*Pass the Torch*" to the next leadership team and many Presidents and Presidents-Elect are reflecting on what has been accomplished and what is yet to be.

I am honored to serve as the Alliance President for 2012. I am also honored to serve with an excellent board and outstanding committee chairs who will make this journey with me. I appreciate their willingness to serve and lend their support.

Help us celebrate the hard work done by Donna Parker and the current board and extend a warm welcome to the newly appointed Board. Please mark your calendars:

OCMS Alliance
Leadership Installation Ceremony
Thursday, January 12, 2012
11:30 am
The Blue Room, State Capitol

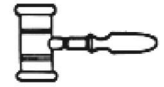
Congratulations to Dr. Tomás Owens, the in-coming OCMS President. Please celebrate with him at the OCMS Inaugural on Saturday, January 14. Dr. Bob Cooke, out-going President, has been a tremendous support to the Alliance and I would like to take this opportunity to extend a personal thank you on behalf of our organization.

Membership will be a strong focus this year! We will continue to work hard to recruit new members to our Alliance. The Leadership Installation Ceremony is a great place to start. Extend an invitation to a potential new member to attend this fun event with you, and spend some time enjoying our beautiful State Capitol.

It is a privilege to serve you this year and I look forward to working with you as your OCMSA President. ❑

Kathy Bookman

President's Page



Tomás P. Owens, MD

Unity

In essentials, unity; in differences, liberty; in all things, charity.
Philipp Melanchthon, 1497-1560

It is with humble disposition that I try to fill the shoes of the hard-working, honest, devoted and visionary leaders that preceded me. Drs. Krishna, Cannon, McCaffree, Shavney, Bookman and Cooke, and those who served before, have brought honor and great accomplishment to our society. What a time to be an OCMS member! The Health Alliance for the Uninsured has grown at such brisk pace that their physical office outgrew our building capacity. The trauma/emergency call distribution system has saved countless lives in the OKC metro. Hospice of Oklahoma County (now Integris Hospice) and the Oklahoma Blood Institute are thriving. The Open Arms Clinic, begun in partnership with Deaconess Hospital and residents from the Great Plains program to serve uninsured patients, is in its 18th year of operation. Now in its second year, our Leadership Academy is motivating a whole new cadre of young physicians. An informal gathering of the membership during the spring has reinvigorated the ranks. We remain committed to participating in the Susan G. Komen Walk for the Cure and, last month, we awarded the first OCMS scholarship for medical students. These are all OCMS initiatives that have made a huge difference in the lives of Oklahomans.

Our members had to seek harmony to produce these laudable goals. As we keep on influencing health policy and being the voice of organized medicine in Oklahoma County, we must remain in

accord. We will continue to face potentially divisive issues and it is essential that our organization works in unison.

Congruity is essential to our success. The give and take of a forum of ideas should eventually settle into a negotiated solution for all involved.

Nuances of our objectives can differ, yet they should have a common underpinning in our desire to serve humankind.

The next year has to continue to be one of cooperation with our colleagues in Tulsa and rural counties and the OSMA.

Unity should extend to those who are not yet members or have fallen from our ranks. Belonging is essential to our development; we are obliged to grow our membership.

We need to carry on in making our positions known by the community at large and persist in our efforts to highlight our central tenets. A doctor is, after all, a teacher. We must strive to educate ourselves in the challenges facing our profession, the influences wielded by government and private sector, the directions devised by insurers and the consequences inherent to all of those. These will definitely affect us financially and professionally; yet in the end, that matters not. Rather, the key is how they forever alter the life of our patients, for, as well described by William Mayo: *the best interest of the patient is the only interest to be considered*.

Our county Society could not function without our fantastic staff, Jana Timberlake, Linda Larason and Ashley Merritt, who have put forth much more than their share of effort. They are a true example of cohesion and I'm looking forward to sharing this challenging journey with them.

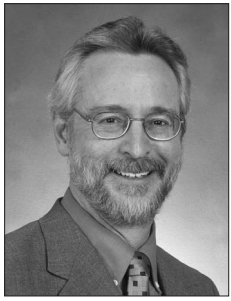
This year will bring, yet again, SGR issues and potential cuts, access to healthcare concerns and further implementation and/or changes in the Affordable Care Act. To top that off, it is an election year. We shall be forceful yet collegial, true to our principles yet mutually respectful. In following Rowan Williams words, "I value unity because I believe we learn truth from each other in this process."

Please text or email me with your thoughts throughout the year. I will make every effort to listen, to seek the sage advice of my colleagues and address your concerns to best of my ability.

"Individuality or Unity?
I say there's room for both."
Brian Celio

Have a Happy New Year! ❑

Pearl of the Month



William G. Reiner, MD

The Use – and Misuse – of Psychotropic Medications in Children and Adolescents

In the world of child psychiatry, it has been said that children are either sad, glad, mad, bad, anxious, or broken. (Some might add other appellations, for nonclinical situations). From an illness and impairment standpoint, most of these conditions are either poorly treated or not treated at all by psychotropic medications, with notable exceptions including depression ("sad"), anxiety, and attention deficit hyperactivity disorder (ADHD -- sometimes the "bad"). The use and misuse of psychotropic medications in children, therefore, is of great clinical concern to us as physicians.

This discussion will be limited to the stimulants and the antipsychotics, both very commonly used. First, "stimulants" is a misnomer. Most psychotropic medications stimulate some central nervous system physiological process or receptor molecule, although a few are true depressants. Selective serotonin reuptake inhibitors are, for example, stimulants. Depressants include the opiates, alcohol, and benzodiazepines. Here the term "stimulants" will be used in its common representation as the various forms of methylphenidate (Ritalin, Concerta, and so forth) and the various clinical forms of amphetamines (dextroamphetamine, amphetamine salt mixtures, and so forth).

Second, antipsychotics are a diverse group of medications fairly specific in their intention but not necessarily in their pharmacological actions. That is, antipsychotics treat the signs and symptoms of psychotic conditions. They generally function – at least, largely – by

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stimulating certain dopamine receptors, and in particular the D2 receptors. Although the older or so-called typical antipsychotics have more dopaminergic effects than other receptor-system effects, the newer or atypical antipsychotics are more "shotgun" medications. They are dopaminergic, catecholaminergic, antihistaminic, serotonergic, and muscarinergic. We have only weak understanding of most of these effects, even less about the interaction of these effects (the "shotgun" aspect). They are, however, administered to children and adolescents not infrequently.

From mechanisms we can move to risks of these psychotropics. The stimulants, and in particular methylphenidate, have been studied for decades with multiple research methods in multiple laboratory and real-world settings. With rare exception, studies have repeatedly shown that methylphenidate and, perhaps to a lesser degree, the clinical amphetamines are remarkably well tolerated, have few clinically important side effects, and have a very low risk profile. The "much ado" about abuse, especially in the media, rarely states but actually means the use of these medications without prescription – that is, students obtaining them from a friend or other illegal source, generally for the purpose of studying for exams or other educational needs.

In stark contrast, the atypical antipsychotics have a very high risk profile including but not limited to adverse neuromotor effects, metabolic syndrome, dyskinesia and withdrawal dyskinesia, neuroleptic malignant syndrome, prolactin changes with its physiological side effects, QT interval inhibition with possible fatal consequences, and (with clozapine) myocarditis. Other side effects include sedation and somnolence. More to the point, in the rapidly developing brain of the child and young adolescent the multiple-receptor system developmental effects of these medications are generally unknown. Neuronal pruning, synaptic extension and loss, and metabolic changes are very active in these ages. So just what are these drugs doing to this developing brain?

These points are important because psychotropic medications are so commonly used in behavioral modification treatment plans. Unfortunately, only the stimulants have consistently shown a clinically significant behavioral modification profile, specifically for hyperactivity and inattentiveness. Other behaviors – such as oppositional and defiant behaviors – are much less likely to be targeted successfully.

The antipsychotics, on the other hand, have a miniscule research record in terms of behavioral modification. Certainly, they target behaviors related to psychosis. But psychotic conditions in children

are rare. (Bipolar disorder is a psychotic condition and is uncommon or rare in children). Antipsychotics do not target other behaviors in any meaningful or reliable research or clinically demonstrated manner. Although there is some positive effect on aggression in specific cases (perhaps most likely to be found in so-called mixed affective states), few well-controlled studies have demonstrated other behavioral improvements. Aggression itself must be carefully defined. Care must be taken not to see aggression in a singular sense when it may be a part of a larger, treatable syndrome such as depression.

Children can be very difficult. Sad and anxious children and those with a true syndrome of ADHD may be the most easily treated. Psychotic children (including the glad, that is manic, children) often respond well to the atypical antipsychotics. However, children who are mad or bad – oppositional, defiant, naughty – and have correspondingly poor relationships with their caregiver are generally not well treated by medication at all.

In these cases parent effectiveness training is generally more valuable than any other approach. There is generally more success in working with the parents than with the children directly. The physician can be an important part of a clinical family-development process. With the potential to develop a relationship both with the child and with the parents, the physician is in the unique position of observing while participating in the care and treatment for both. Parental education is likely to be far more valuable than medication and with far less risk. On the other hand, for children who are "broken" – that is, children who have a bad or damaged brain – both the physician and the parents along with the child are going to need outside consultation and education. Again, medications are very unlikely to be of primary benefit.

In conclusion, care must be taken to treat appropriately and not over-treat children with behavioral problems. When medication is considered, it is most effective for ADHD, affective disorders, and psychotic conditions. Behavioral problems deserve behavioral modification approaches that begin first with education of the parents. ❑

Dr. Reiner is a Professor of Urology and Pediatric Urology, Adjunct Professor of Psychiatry and Child and Adolescent Psychiatry, University of Oklahoma Health Sciences Center, Oklahoma City OK

Director's

DIALOGUE

Most of my articles begin with a quote, but this one will be all quotes ... just a little food for thought. Hope your holiday season was joyous and you are looking forward to a great 2012!

When was the last time you did something for the first time?
Sally Edwards

New habits make new horizons.
Glenville Kleiser

What the New Year brings to you will depend a great deal on what you bring to the new year.
Vern McLellan

Year's end is neither an end nor a beginning but a going on, with all the wisdom that experience can instill in us.
Hal Borland

One resolution I have made, and try always to keep, is this: To rise above the little things.
John Burroughs

May all your troubles last as long as your New Year's resolutions.
Joey Adams

My personal favorite: "Many years ago I resolved to never bother with New Year's resolutions, and I've stuck with it ever since." Dave Beard

Happy New Year!

Jana Timberlake, Executive Director

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Riders on the Storm

Troy A. Tortorici,MD and Jennifer Tortorici

When my wife, Jennifer, was diagnosed with Type I diabetes 10 years ago, we thought our world was coming to an end. Through the maze of treatment and support, she became well acquainted with the JDRF (Juvenile Diabetes Research Foundation). She began volunteering for the organization at the local chapter. This subsequently led to increased participation in fundraising activities including the walk to cure diabetes and the annual gala.

Years ago, we began bicycling on weekends as a form of exercise. Through the JDRF network, Jennifer was introduced to the local JDRF cycling group, Riders on the Storm. We were invited to join. As a non-competitive group, it raises funds and awareness of type I diabetes through the Ride to Cure Diabetes. The Ride, composed of hundreds of cyclists throughout the U.S. helps raise money for the JDRF. Needless to say, we accepted, but didn't fully realize what we had gotten ourselves into.

Of the cycling venues arranged by the JDRF, the team chose to ride in Death Valley, California – a 105-mile ride in the desert! The longest ride we had done at this point was 10 miles around Lake Hefner, complete with multiple stops and numerous complaints about how tired we were.

The challenge was two fold. First, we had to commit to raising $4,000 each to be part of the team. That task proved formidable, but in the end we raised over $9,000 between us, thanks to our many supportive and generous friends. Our team of 12 riders raised over $60,000 collectively! Teams from across the nation that participated in the Death Valley venue raised over $1.2 million collectively!

The next and more significant challenge was the physical training to do the ride. We began our training in March. We first transitioned from our large, heavy, and clunky mountain bikes to lightweight, streamlined road bikes. We went from wearing sneakers to real cycling shoes that clip onto special pedals. We

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went from riding around Lake Hefner to routes that involved highway shoulders and semi tractor-trailers blazing by us. We began to look, talk, and act like real cyclists, not weekend warriors who have no clue what they are doing. Yes, we even wore cycling outfits complete with special padded cycling shorts and riding jerseys! It was exciting to see our progress as we continued to train. In spite of the record-breaking heat and wind this past spring and summer, we continued to train. We entered many "t-shirt rides" which are organized rides on most weekends in the spring and summer all around the state, such as the Red Bud Classic and the Road Kill Rally in Ardmore, OK. The benefits of riding in a "t-shirt ride" are rest areas stocked with drinks, snacks, and restrooms. We felt right at home with the cycling community. Come to think of it, I don't think Jennifer has ever had to change a flat tire because the cyclists are so quick to help! By September, we had advanced to long endurance rides and weekly totals of 100-150 miles, all for a great cause.

By October, our time to depart for Death Valley, CA had finally come. There was good news and bad news. The good news was that the wind would be light. The bad news was that during the few days we were there, a heat wave would occur. A heat wave in Death Valley is never a good thing. On the day of the ride, the temperature was a record breaking 111 degrees. Since we were so far below sea level on the desert floor, some parts of the route reached 120 degrees. The scenery was unbelievable. Although Death Valley could be construed as a barren desolate wasteland, it was one of the most breathtakingly beautiful places we have ever seen.

We plan on being a part of the Ride to Cure Diabetes again for 2012. Our cycling teammates have become part of our extended family. Each person on our team has been affected by type 1 diabetes in some way; either they have a child, family member, spouse, or friend – or they, themselves – have type 1 diabetes. We are always looking to add to our team. You do not have to be an advanced rider and you do not have to be willing to ride on the highway. Our team will train and teach you how to properly ride and maintain your bike. Riding is exciting and exhilarating, especially when it is for a great cause. ❑

Save the Date

The first membership meeting of the new year will be Monday, February 27, 2012, in the OSMA headquarters building, 313 NE 50th Street. The reception will begin at 6:00 pm and dinner will be served at 6:30 pm. Watch your mail for program details, but mark your calendar now and save the date! ❑

Nursing Shortage Averted?

Perhaps a downward trend in nursing school enrollment has been reversed, news@JAMA reported on December 5. There were 190,000 full-time-equivalent nurses ages 23-26 in 1979; by 1991 that number had plunged to 110,000. It continued to decline during the following decade. However, a 62 percent increase between 2002 and 2009 brought the number from 102,000 to 165,000. If this trend continues, the projected shortage by 2030 may be averted. ❑

Where Memories Go

Hanna Saadah, MD

You and I
And all the secret seeds we sowed
And all the flowers we hatched to sprout
That none will ever hear about, or see
But you and me.

Do you not wish to see
That time's cashiers
Collect the years
And hand us memories instead;
Do you not wish to see
That love is memory fed
And like a child—sleeps, dreams, and fears
While dreamless time devours the hours
And never goes to bed.

You asked me once
With sunrise in your eyes
What happens to the snow?
Whereto do rivers flow?
Where will our memories go?
Do you not wish to see
That after you and me
Our memories swan south
And cry across the sky
Without a mouth.

Like song makes singer
And singer makes song
Like death is ever weak
And life is ever strong
Like blooms grow out of rocks
And dead seeds are raised by rain
Memories subside to sleep
Then come around again.

Do you not wish to see
We are the fore and after
Heirs to life's past
Seeds to life's future
Sharers of our planet's azure breath
Fuelers to her cycles of life and death
(Which fester and burn, hunger and yearn)
Patrons of her ever-whispering memory urn. ❑

Bioterrorism Experiment

The flu destroys civilization! A possible future headline, assuming someone surfaces to write it.

The Daily Mail UK reported in late November 2011 that a group of scientists is trying to publish research on creating such a potent flu virus. It is allegedly a "genetically tweaked version of the H5N1 bird flu strain, but is far more infectious and could pass easily between millions of people at a time." Only five mutations to the avian virus rendered it "sufficient to make it spread far more easily." Anticipating a media storm, Virologist Ron Fouchier, the lead researcher on the team, has hired an adviser to help craft a communication plan. Although admitting the strain is "one of the most dangerous viruses you can make," Fouchier is determined to publish a paper describing how it was done. Understandably, some in the scientific community are less than enthusiastic about seeing this research published. Fouchier is at the Erasmus Medical Centre in the Netherlands. ❑

Performance Measurement Rule

On December 5, the Centers for Medicare & Medicaid Services (CMS) published its final rule regarding the "Availability of Medicare Data for Performance Measurement." The Affordable Care Act (ACA) authorizes the release of standardized extracts of Medicare claims data under parts A, B, and D to "qualified entities" for the performance evaluation of providers and suppliers. These entities will then make performance reports publicly available. This data will be provided to qualified entities beginning January 1, 2012. Qualified entities approved at the beginning of the program will be provided with calendar year data for 2009 and 2010, and from the first two quarters of 2011. Thereafter, CMS will provide quarterly data updates on a rolling basis.

The final rule is very detailed and complex and the AMA is continuing to analyze it to better determine the impact on physicians. An in-depth comparison of the provisions in the final rule and the AMA position will be available when complete.

During the drafting of the legislation in the ACA, the AMA secured a number of safeguards in the ACA provisions, including requirements that enable physicians to review, appeal and correct errors in the reports prior to publication. On August 8, 2011, the AMA coordinated a comment letter with 81 physician organizations to CMS responding to the proposed rule and urging the agency to carefully develop a final rule in which qualified entities: (i) meet each of the requirements secured in the data release provision, as set forth in the ACA; (ii) produce public reports that are valid, meaningful, actionable, and user-friendly; and (iii) participate in a reporting program that is standardized and streamlined to minimize administrative burden and allow comparable results. The letter acknowledged CMS's efforts to implement the safeguards outlined in the ACA data release provision, but also expressed the need for the agency to move toward standardization of many elements qualified entities will use in developing and releasing public quality performance reports, e.g. measure specifications, risk-adjustment and attribution methodologies.

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The AMA supports the use of physician data when it improves the quality of patient care, promotes the efficient use of resources in care delivery, preserves access to care, and provides accurate physician performance assessments. In the final rule, however, CMS has eased some of the proposed requirements a qualified entity must meet to receive Medicare data. This may benefit highly qualified research efforts, but also poses greater risk of public release of poorly analyzed data. Although the AMA aggressively urged CMS to begin moving toward standardizing elements qualified entities will use in developing and releasing public reports, CMS has made no move in this direction in the final rule. These factors increase the risk of multiple entities obtaining Medicare data in a single geographic area, and each of these entities could use different methodologies in analyzing the data, thereby resulting in a proliferation of physician performance reports that are conflicting, inaccurate, and not meaningful for patients and physicians. We do not yet know how serious this problem will be, as this will depend on implementation of the program. The AMA will aggressively work to urge the Administration to monitor the program and to modify it if qualified entities release misleading or confusing performance reports.

The AMA also believes CMS should strengthen the appeals process for physicians requesting error correction in a public report. CMS has maintained in the final rule the proposal that qualified entities must publicly release performance reports, regardless of whether there are outstanding, unresolved physician appeals. The AMA advocates that a qualified entity should only display the provider's name and indicate that the results are still pending in the event of an ongoing appeal. We also believe CMS or an independent third party should assist in settling unresolved appeals.

If you have questions or need additional information, contact Terri Marchioro, Director of Federal Relations at the AMA, 312.464.5271 or terri.marchiori@ama-assn.org. ❑

Preventing Childhood Obesity

What Really Works?

After reviewing 55 prevention studies mostly targeting children ages 6 to 12, Australian researchers suggest only very broad strategies to prevent children from becoming obese, according to an article in the Boston Globe. They suggest a school curriculum that includes healthy eating, physical activity, and body image discussions; increased time for gym, and movement activities built into English, science, or math classes; improved nutrition in school lunches emphasizing less saturated fat and calories and more fruits, vegetables, and whole grains; creating an environment that makes it easy for kids to choose healthful foods and be active throughout the day; support for teachers and other staff trying to implement new strategies; and support for parents trying to encourage their kids to eat more nutritiously and spend less time staring at computers, TV, and other screens. The researchers note that many interventions unsurprisingly produce better results in young children, since "parents have more influence." The study was published by the Cochrane Collaboration on December 7. The report is available online at

http://www.cochrane.org/features/evidence-shows-how-childhood-obesity-can-be-prevented. ❑

Electronic Informed Consent

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Diplomate, American Board of Legal Medicine
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Oklahoma City, OK

Every physician is required by law to converse in understandable language directly with the patient when advising a treatment or procedure before signing an informed consent or, if refused, an informed refusal. The physician should ascertain that the patient comprehends the alternative therapies presented and their risks in order to make an informed choice. Documentation of the conversation is an important element of the consent process. Patients often receive a generic "consent-to-treat" document or a "fill-in-the-blank" document to sign, which is frequently unread, resulting in either under- or misinformation. The consent process is not a formality or a nuisance that serves to extend or delay the inevitable procedure. Consent is an essential part of medically preparing and rightly empowering patients to take ownership of their illness. The process ends with the physician's yielding to the patient's informed choice. Patient understanding is pivotal in the consent process.

In 2006, Issa et at investigated the satisfaction of urology patients with electronic informed consent. The authors found that 96 percent preferred the electronic process to a traditional paper-based informed consent process.[1]

In 2010, Fink et al[2] investigated independent factors that are associated with improved patient understanding of electronic informed consent. The authors concluded that:

1. Comprehension during computerized informed consent discussions may be limited in individuals with potential language difficulty due to ethnicity or education.

2. The total consent time was the strongest predictor of patient comprehension. The patient comprehension was maximized when informed consent took between 15 and 30 minutes.

3. The use of "teach-back" or "repeat-back" also significantly improved patient comprehension.

Electronic Health Records (EHRs} often incorporate electronic informed consent software to prepare detailed patient information packets aimed at educating patients about planned procedure. The packets are given to the patients before the scheduled elective procedure either on paper or electronically. They include comprehensive and easy to understand procedure-specific consent forms.

When the informed consent software is integrated into the HER, or practice management system, it relieves physicians from preparing a note describing completion of an informed consent discussion in the EHR. Physicians who obtain informed consent electronically do so at workstations, tablet computers, and mobile point-of-care devices which display the procedure-specific information and forms. That makes for efficient use of the doctor's time. Patients and their families who fully understand through excellent communication the complete range of complications that may result from a procedure ultimately helps minimize risk and reduce liability.

Patients sign the electronic informed consent with a retail-style digitized signature capture pad or by using the stylus on a tablet computer. Automated informed consent tools ensure that digitized images of signed consent forms are available to the operating room staff for the pre-procedure verification and for the time-out.

Electronic informed consent is best obtained in the physician's office, rather than the preoperative holding area. Informed consent software tools may provide both detailed pre-procedure instructions and comprehensive discharge instructions. Patients may take a detailed document home to review at their own pace with their family members. And every provider in an integrated health system may easily access and check the signed electronic informed consent form within a patient's EHR and answer questions that may arise. ❑

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[1] Issa MM, Setzer E, Charaf C, et al. Informed versus uninformed consent for prostate surgery: the value of electronic consents. J Urol. 2006;176:694-699

[2] Fink AS, Prochazka AV, Henderson WG, Bartenfeld D, Nyirenda C, Webb A, Berger DH, Itani K, Whitehill T, Edwards J, Wilson M, Karsonovich C, Parmelee P., **Predictors of comprehension during surgical informed consent.** J Am Coll Surg. 2010 Jun;210(6):919-26.

Organizations Collaborate to Reduce Inappropriate Use

Recognizing that patients often ask for tests and treatments that are not necessarily in their best interest, and physicians often struggle with decisions about prescribing tests and procedures as a way of covering all possible bases, the ABIM Foundation (Advancing Medical Professionalism to Improve Health Care) has joined with nine leading medical specialty societies to develop evidence-based lists of tests and procedures for patients and physicians to question as part of Choosing Wisely(TM). The goal of this campaign is to help physicians, patients and other health care stakeholders think and talk about overuse or misuse of health care resources in the United States.

Consumer Reports, the nation's leading expert, independent, nonprofit consumer organization, has also joined the campaign to provide resources for consumers and physicians to engage in these important conversations.

The campaign is part of the ABIM Foundation's goal of promoting wise choices by clinicians in order to improve health care outcomes, provide patient-centered care that avoids unnecessary and even harmful interventions and reduce the rapidly-expanding costs of the health care system. The lists of Five Things Physicians and Patients Should Question is modeled after the successful National Physicians Alliance (NPA) project titled "Five Things You Can Do in Your Practice," which was funded by the ABIM Foundation in 2009.

As part of Choosing Wisely, each participating specialty society will identify its own list of five common tests or procedures whose use in their profession should be discussed or questioned. The lists will be unveiled in April 2012. The societies were given the following parameters to develop the lists:

- Each item should be within the specialty's purview and control;
- Procedures should be used frequently and/or carry a significant cost; and
- There needs to be evidence to support each recommendation.

The Congressional Budget Office estimates that up to 30 percent of care delivered in America goes toward unnecessary tests, procedures, medical appointments, hospital stays and other services that may not improve people's health - and in fact may

actually cause harm. If current trends remain unchanged, the Centers for Medicare & Medicaid Services project U.S. health care spending will reach $4.3 trillion and account for 19.3 percent of the nation's gross domestic product by 2019.

First announced in March 2011, Choosing Wisely is part of a multi-year effort led by the ABIM Foundation to support and engage physicians in being better stewards of finite health care resources. It is part of the ABIM Foundation's long history of advancing medical professionalism and supporting similar initiatives. In 2002 the Foundation, along with the American College of Physicians Foundation and European Federation of Internal Medicine, authored Medical Professionalism in the New Millennium: A Physician Charter. The Physician Charter has as its fundamental principles the primacy of patient welfare, patient autonomy and social justice and articulates professional responsibilities of physicians, including a commitment to improving quality and access to care, advocating for a just and cost-effective distribution of finite resources and maintaining trust by managing conflicts of interest.

Organizations participating in Choosing Wisely include American Academy of Allergy, Asthma & Immunology, American Academy of Family Physicians, American College of Cardiology, American College of Physicians, American College of Radiology, American Gastroenterological Association, American Society of Clinical Oncology, American Society of Nephrology, American Society of Nuclear Cardiology, and Consumer Reports.

To learn more about Choosing Wisely visit www.ChoosingWisely.org. ❑

Urgent Care Clinics

Trying to ease the strain on emergency rooms, hospitals are adding urgent care centers, trying to boost admissions and contain the costs of delivering care. Duke Primary Care, North Carolina, has added five such centers as medical homes for patients. The Urgent Care Association of America says the number of urgent care clinics has grown from 8,000 in 2008 to more than 9,200 in 2011. They serve nearly 3 million patients each week. FierceHealthcare.com summarized the Kaiser Health News report and USA Today article. ❑

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 CARELINK (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 Professional Development
Contact: Susie Dealy or
Myrna Rae Page
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'11	Nov'10	Oct'11	Nov'11	Nov'10
Campylobacter infection	2	7	4	59	72
Chlamydial infection	N/A	N/A	N/A	N/A	N/A
Cryptosporidiosis	1	1	1	22	21
E. coli (STEC, EHEC)	0	1	0	8	16
Ehrlichiosis	0	0	0	2	1
Giardiasis	0	0	0	1	14
Gonorrhea	N/A	N/A	N/A	N/A	N/A
Haemophilus influenzae Type B	0	0	0	0	0
Haemophilus influenzae Invasive	0	1	1	10	22
Hepatitis A	0	0	0	2	3
Hepatitis B*	12	21	24	149	176
Hepatitis C *	16	19	24	182	198
HIV Infection	N/A	N/A	N/A	N/A	N/A
Lyme disease	0	0	1	5	10
Malaria	0	0	0	0	1
Measles	0	0	0	0	0
Mumps	0	0	0	1	0
Neisseria Meningitis	0	0	1	2	2
Pertussis	0	4	3	29	40
Pneumococcal infection Invasive	0	1	0	5	12
Rocky Mtn. Spotted Fever (RMSF)	0	0	9	97	33
Salmonellosis	6	8	19	128	127
Syphilis (primary/secondary	N/A	N/A	N/A	N/A	N/A
Shigellosis	10	5	44	100	67
Tuberculosis ATS Class II (+PPD only)	36	38	52	507	564
Tuberculosis ATS Class III (new active cases)	2	2	1	28	24
Tularemia	0	0	0	1	2
Typhoid fever	0	0	0	1	1
RARELY REPORTED DISEASES/Conditions:					
West Nile Virus Disease	0	0	0	0	0
Pediatric Influenza Death	0	0	0	0	0
Influenza, Hospitalization or Death	0	1	0	237	14
Influenza, Novel Virus	0	0	0	0	0
Strep A Invasive	0	0	0	2	21
Legionella	0	1	0	3	6
Rubella	0	0	0	1	3
Listeriosis	0	0	0	3	1
Yersinia (not plague)	0	0	0	0	1
Dengue fever	0	0	0	0	1

*** -** ***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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