BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY
JUNE, 2010

THE BULLETIN
The Oklahoma County Medical Society

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About the Cover

The picture of the young lady on the cover of The Bulletin this month, as executed by William E. Hood Jr., MD is titled, "Mary." It won a first place award at the Oklahoma Art Guild Smallworks Show on August 6, 2009. The judge of the show commented, "This intriguing drawing of a young lady invites the viewer to wait patiently as her lips are poised to speak. What will she say? The drawing is soft, calm and inviting." The artistic medium is pencil with white charcoal highlights. Dr. Hood is a retired Obstetrician/Gynecologist who was for many years the Chief of Staff at Integris Baptist Medical Center. The physicians' lounge was dedicated to him. He continues to paint in his retirement and we are grateful to him for permission to reproduce this picture. ❑

The Editor

In Memoriam

Petre Nicolae Grozea, MD
1923 - 2010

Bulletin News

The next issue of the Bulletin will be published in September. As always, OCMS members are invited to submit articles, poetry or artwork for consideration for publication. The preferred format to receive them is email (llarason@o-c-m-s.org) but they may also be mailed to Suite 2, 313 NE 50th Street, Oklahoma City, OK 73105. To be considered for the September issue, we need to receive them by July 26. ❑

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President's Page

Larry A. Bookman, MD

Accomplishments and Future

There has been tremendous activity in medicine during the past few months. I have tried to keep up with all the events and the ebb and flow of the rhetoric coming from Washington, D.C. The passage of the federal health care reform bill is still being digested and analyzed. We will not know its complete effect until 2014 when it is completely phased in. What has become clear to me is that I have spent so much time and energy on federal changes, I have forgotten to communicate my most important mission, the accomplishments and future of our local medical society.

There are many established programs initiated by OCMS and its members that cause one to swell with pride. The Oklahoma Blood Institute, the dream of Dr. Don Rhinehart, has become a nationally recognized leader in its field and will soon move into a beautiful new building to continue its life saving work.

The Schools for Healthy Lifestyles, started by OCMS and mentored by many of our members, has named John R. Bozalis, MD as the first annual recipient of the Children's Wellness Award. Dr. Bozalis, the leader of SHL since its inception, states, "It is our desire that the Schools for Healthy Lifestyles will become an integral part of every student's life so they make healthy decisions for a lifetime. If we can accomplish this goal, we can impact the health of the entire state and beyond." For a state that ranks towards the bottom of most health parameters, educating our children on the importance of a healthy lifestyle will benefit our state well into the future.

The Health Alliance for the Uninsured, a more recent program, integrates the free clinics that serve the indigent and downtrodden

of our community. Dr. Murali Krishna, a past president of OCMS, has championed this cause and has created an organization envied by communities throughout the country.

Hospice of Oklahoma County and the trauma rotation for Oklahoma City are two more of the many important contributions this society has made to our community and the physicians that practice in Oklahoma county. In 2009, the most important tort reform ever passed in Oklahoma was spearheaded by members of the Oklahoma County Medical society. More recently, the delegates of the OCMS led the way in the passage of deunification of Oklahoma from the AMA. From now on, physicians who want to be members of OCMS/OSMA will not be required to join the AMA. At the recent state medical meeting, this bylaw change passed by a 96 percent to 4 percent margin.

New programs are being planned which will benefit the physicians of Oklahoma County. A new leadership college for selected physicians is being developed. Similar to a North Carolina program, the graduates will guarantee a continued stream of community and medical leaders coming from the Oklahoma County Medical Society.

These programs and many other issues benefit all of us. Yet, I frequently hear my colleagues say they don't want to "be involved" and they don't see any "benefit" from joining the OCMS/OSMA. As stated above, we live with the benefits every day. The excuse of not wanting to join the AMA is no longer an issue and there is no choice, all of us must be involved. Do not wait until next year or even next month, share this Bulletin with colleagues and invite them to join OCMS – and you – in getting involved and having a voice. As I said last month, "things are a changing", step up and have a voice in what those changes will be. ❑

There is so much good in the worst of us,
And so much bad in the best of us,
That it ill behoves any of us
To find fault with the rest of us.

Author Unknown

Remote Area Medical
Recruiting Volunteers for July Event

Remote Area Medical (RAM) Oklahoma, Inc. is recruiting licensed health professionals to provide free dental, vision and general medical care to more than 2,000 Oklahomans. The event will be July 9-11, 2010, at the Oklahoma State Fairgrounds. Approximately 30 hours of care will be provided during the weekend, beginning at 6:00 a.m. on Friday. Volunteers' time can be flexible, and they may work one, two or all three days.

Those wishing to volunteer can sign up at www.ramok.org/volunteer.

Physicians, physician assistants, specialists, dentists, hygienists, optometrists, ophthalmologists, nurses, EMTs, medical students and general volunteers are all needed. Volunteer health professionals will have tort protection under the Volunteer Professional Services Immunity Act. Breakfast and lunch will be provided each day by the Oklahoma Baptist Disaster Relief's mobile kitchen team.

Remote Area Medical, RAM Oklahoma's parent, is a volunteer medical care organization that uses volunteer health professionals to provide free health care on a first-come, first-served basis regardless of income. Based in Knoxville, Tennessee, it was formed in 1985 to air drop supplies and medical care to remote areas of Central and South America.

Oklahoma will be the sixth state to welcome RAM's **R**each Across **AM**erica program. The goal is to connect patients seen at this event with follow up care through Medicaid, InsureOklahoma, federally qualified health centers or free clinics.

Oklahoma sponsoring organizations include the Oklahoma County Medical Society, Health Alliance for the Uninsured, Variety Care, the Whitten-Newman Foundation, Docvia, the Oklahoma Academy of Family Physicians, the Oklahoma Dental Foundation, Oklahoma Baptist Disaster Relief, Wal-Mart, the Latino Community Development Agency, Crosstown Church, Bricktown Rotary, Oklahoma Families Coping with Cancer, and others. It was endorsed by the Oklahoma County Medical Society Community Health Committee.

Contact Tres Savage, Oklahoma native and RAM Oklahoma coordinator, to volunteer. Visit www.ramok.org/volunteer, call (405) 410-5411 or email Savage@ramok.org. ❑

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Volunteer Professional Services

Immunity Act Signed by Governor

R. Murali Krishna, MD

Physicians and other licensed providers now have immunity from civil liability while providing services to free clinic patients, regardless of where those services are performed. There is no enrollment process required, and the immunity for physicians is retroactive to November 2004. Other licensed professionals also are immune from civil liability, and most of them have coverage retroactive to November 2009.

On March 3, Governor Henry signed into law Senate Bill 2113 which, among other things, drastically simplified and strengthened the liability protections for volunteer physicians and other providers. This bill passed the House and Senate with an emergency clause, so it became effective on the Governor's signature. This legislation is the result of years of work by the Health Alliance for the Uninsured, the Oklahoma County Medical Society, the free clinics in Oklahoma County, and those planning for Oklahoma's first Remote Area Medical (RAM) event July 9-11 in OKC. This Senate Bill creating the "Volunteer Professional Services Immunity Act" provides immunity from civil liability for those providing care for free clinic patients in Oklahoma.

The statute provides, "Any volunteer professional or volunteer health practitioner and any organization that arranges for the care given by the volunteer professional shall be immune from liability in a civil action on the basis of any act or omission of the volunteer professional or volunteer health practitioner resulting in damage or injury…" The physician simply has to meet the following criteria to have the benefit of this protection. First, no compensation can be received by the provider for the care. Secondly, the patient must be seen in, or referred by, a free clinic. Third, the care provided must be done in good faith and within the scope of the professional license. Fourth, the care must be provided without "gross negligence or willful and wanton misconduct". This liability protection includes both active and retired physicians, as long as they are able to legally provide medically related services in Oklahoma. This liability protection also extends to most other licensed medical professionals, including RNs, Physician Assistants, Advanced Practice Nurses,

Physical and Occupational Therapists, Dentists, and almost every other type of licensed medical professional.

A Call To Action

Unlike previous forms of liability protection, there is no enrollment required to participate in this program. If you meet the requirements of the statute, you get the protection. There is no longer any requirement for the provider to verify the eligibility of the patient to receive the care, nor any requirement to inform the patient of the liability protection. Simply, as long as you meet the requirements outlined above, you are covered. Further, this coverage is retroactive to November 1, 2004, for physicians, and to November 1, 2009, for most others.

The need in Oklahoma County is great and we now enjoy the ability to volunteer our professional expertise without worry of being sued for helping. You are no longer placing your practice and assets at risk by extending help to others. The Health Alliance for the Uninsured is actively seeking volunteer providers, both in the clinics and to accept referrals for care in your office. Please consider volunteering just a few hours to help those in need of medical care in Oklahoma County. Visit the Health Alliance website at www.hauonline.org or call 702-0353 for more information on this program, or for volunteer opportunities. ❑

Help Free Clinic Patients

The Health Alliance helps match volunteer physicians and allied health care providers with free clinics. It is particularly focused on recruiting specialists to accept referrals of patients seen in the free clinics in Oklahoma County.

To volunteer your services, or to learn more about the possibilities, contact Pam Cross, Executive Director, at 702-0353 or email pam.cross@hauonline.org. ❑

Where there is charity and wisdom, there is neither fear no ignorance.
St. Francis of Assisi

Haiti Deployment Experience

David C. Teague, MD

"Today, we plan to get your leg fixed in surgery. We'll get that done so we can get you off the ship and back home as soon as possible." We related this presumably welcome information to our pleasant, gracious and grateful 27 year old female Haitian earthquake victim through one of the capable Red Cross volunteer French-Creole translators. We were a bit surprised that her response to the translator took so much time, for what else could she have to say but, "Great, thanks!"? Well, as it turned out, she responded quite succinctly given the gravity of the message. "Thank you, but I am in no hurry. My whole family has perished, and I have no home to go back to."

I was fortunate to be among a group of ten civilian orthopedic trauma surgeons asked to deploy to Haiti to assist our military colleagues aboard the US Naval Ship Comfort. We arrived three weeks after the earthquake, along with a team of about one hundred other volunteers, including anesthesiologists, CRNAs, ICU nurses, scrub personnel, and PACU nurses. The Comfort and its crew had been on site for about 10 days prior to our arrival, and they had already performed over 500 cases, working around the clock doing wound management, amputations, straightforward orthopedics and other service work like OMFS, neurosurgery, and general surgery. What remained to be dealt with were extremely complex pelvis, spine and extremity injuries in patients of all ages. Our team of experienced orthopedic trauma surgeons, dubbed the "Orthopedic Dream Team" by the crew, went immediately to work on the backlog of patients with the most severe injuries.

We performed over 150 complex orthopedic procedures during our two weeks on board. We initially worked around the clock in shifts to deal with the long list of patients awaiting surgery. The Comfort has twelve operating rooms, fully equipped ICUs, and ward capabilities for over 1,000 patients. It really is a floating hospital, fully capable of sophisticated care delivery. The military personnel on board, all of whom were called to duty on the ship with less than 72 hours' notice, were kind, energetic, compassionate toward the Haitian patients, and generally happy to be serving the Navy and their country in this fashion. At least one of these Naval surgeons, a fine, caring husband and father of

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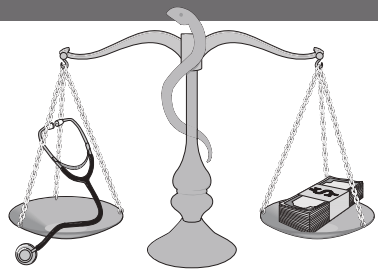

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three young children, received a needlestick exposure from one of the many HIV+ patients we cared for. Consider the sad cascade of life should he convert to HIV+ status as a result of performing his duty. We know his combat colleagues risk limb and life daily during the course of their military duty, but how often do we think of that similar risk for the medical corps?

The Comfort is a hospital ship that deploys to areas of military conflict when needed as well as to areas of natural disaster when requested. This ship is not a typical gray hull military ship. Instead, it is a striking, huge white hull ship with large red crosses emblazoned on the hull and bridge. It was anchored in the bay off Port au Prince and was a tremendous resource in the response to the earthquake that so devastated that city and region. Given the magnitude of the destruction and the staggering numbers of dead and injured, perhaps its more important role was the symbolic affirmation of our country's response to the disaster that befell our neighbors. It was truly a beacon of hope constantly in view of the locals all around Port au Prince.

The devastation on the island is difficult to process. The chances that the makeshift tent cities—for the more fortunate—and cardboard shelters survive the coming rainy season—imagine a Category IV hurricane coursing across the island during the upcoming hurricane season—well, those chances seem exceedingly slim. These people truly need the world's help. We found the patients to be generally stoic, tough, dignified, grateful, and accepting of our explanations and recommendations. Interestingly, we encountered virtually no obese patients. The patients' relatively ubiquitous thin body habitus greatly facilitated our ability to perform complex reconstructions at three and four weeks out from injury, especially in those patients requiring extensive surgical exposures about the hip and pelvis.

Patients were transported to the Comfort by either helicopter or boat. One of the critical care trauma surgeons assigned to the ship directed triage efforts and decisions. The many medical treatment facilities on the island provided initial and ongoing care to the vast majority of victims. However, early on in the response, these facilities could not safely perform extensive surgical procedures that required blood products, truly sterile environments, intraoperative imaging, and sophisticated internal fixation devices. Thus victims in need of this level of intervention,

at least the ones fortunate enough to access care, were either airlifted out of Haiti or brought to the Comfort. Once patients were aboard the ship, we made every effort to deliver definitive care that would necessitate as little supervised aftercare as possible. Robust discharge planning efforts were constantly ongoing, and patients were returned to a variety of settings on the island, including non-governmental treatment facilities, refugee villages and private homes. By the time we left the ship, patient census was down to about 100 from a high of near 500.

My trip was facilitated by many, and I am grateful for the opportunity. The leadership of the OU College of Medicine and OU Physicians were most supportive and readily endorsed this chance for OU Medicine to make a contribution to the Haiti relief efforts. My partners willingly covered my patient care and administrative duties here, and their support and esprit de corps inspire me still. My family unfailingly supports my work that often results in professional duties trumping some personal pursuits, and I recognize what a gift that attitude represents. Finally, we've heard again recently about the "Oklahoma Standard" of disaster response. I was honored to represent our medical community and our state in this current response, and I routinely drew strength and inspiration from the examples set in Oklahoma City in response to the Murrah Building bombing of April 19, 1995. ❑

Dr. Teague is a Professor and Don H. O'Donoghue Chairman, Department of Orthopedic Surgery, OU College of Medicine

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Peace is the work of justice indirectly,
in so far as justice removes the obstacles to peace;
but it is the work of charity (love) directly,
since charity, according to its very notion, causes peace.

St. Thomas Aquinas

50-YEAR PHYSICIANS

The Oklahoma County Medical Society and the OCMS Alliance honored members who are celebrating fifty years in medicine at the April Membership Meeting. One of the honorees, Donald R. Carter, MD, presented the program, "History of Surgery in Oklahoma."

Donald R. Carter, MD

(l-r, seated) Drs. Donald Carter, William Hall, Glen Hallum, Philip Maguire, Loy Donna Markland, and Stanley Muenzler
(l-r standing) Drs. S. Sandy Sanbar, Edward A. Shadid, Stephen Tkach, Marion C. Wagnon and James Worley

Your Community Needs to Hear Your Voice

Lynn Mitchell, MD, MPH

Is it possible we might practice even better medicine if we looked beyond our practices?

I know that's a tall order. At a recent meeting of one of the Oklahoma Health Care Authority's medical advisory groups, one physician mentioned that the burdens of the health care system on physicians are always increasing, but no one seems to have an interest in developing ways to make our profession easier.

As state Medicaid director, I have a unique perspective on Oklahomans' health. I often can see the forest more than the trees. I see the collective good of SoonerCare's patient-centered medical home structure that affords members continuity of care and the benefits of an ongoing relationship with their primary care provider. I see the numbers that show our efforts to reduce unnecessary Emergency Department visits and manage chronic illnesses are having positive results. I meet regularly with the physicians who are dealing with critical funding issues for their practices while still trying to meet the needs of our members who are children, pregnant, aged, blind, and have disabilities. I see their great skill and their compassion as they try to meet patients' needs where they are.

One of our responsibilities at the Oklahoma Health Care Authority is to provide additional resources to help providers improve their practices, whether it's through adopting electronic health records or more efficient systems for handling patients with multiple chronic health problems.

But because I see the numbers, I also see that we might serve our patients even more by looking beyond the walls of our clinics, hospitals and offices and reaching out to the community.

I serve as chair of the Oklahoma County Medical Society's Community Health Committee. Members of our committee have been meeting with city councils and school boards to try to work within their processes to advocate for cleaner air. We stress to these local groups how important it is for children

and adolescents to live in a tobacco-free environment 24 hours a day, seven days a week. We are urging all schools, parks and recreational facilities to go smoke-free.

The Oklahoma Youth Tobacco survey for 2009 showed that more than a fifth of our state's high school students are smokers, along with 6.5 percent of middle-schoolers. Both of those rates had decreased significantly from the 2007 survey, and we need to continue to educate our children about what smoking can mean for their current and future health.

We also have partnered with different groups to discuss appropriate monitoring of the availability of alcohol to children and teenagers. We now have "social host" ordinances to discourage adults from supplying alcohol to youths in Edmond, Midwest City and Oklahoma City, but we are still trying to persuade other cities to adopt them. Particular targets are Arcadia, Del City, Nichols Hills, Bethany, Warr Acres, Choctaw, Harrah and Jones.

Whatever else may have changed in medicine, yours is still the most trusted voice when it comes to matters of health and medical advice. Your opinion carries weight and garners attention. Let me encourage you, my fellow physicians, to reach out beyond your comfort zone to address these community issues that can have a critical role in your patients' health. People will listen. ❑

As state Medicaid director at the Oklahoma Health Care Authority, Lynn Mitchell, MD, MPH, oversees health care programs for almost 700,000 low-income Oklahomans, mainly children. She serves on the executive committee of the National Association of State Medicaid Directors and chairs its Pharmacy Technical Advisory Group. In her spare time, she regularly volunteers on medical mission trips. As of June 1, she will be moving to the Oklahoma State Department of Health, where she will serve as deputy commissioner of prevention and preparedness services and chief medical officer.

Happiness is like a butterfly which, when pursued, is always beyond our grasp, but, if you will sit down quietly, may alight upon you.

Nathaniel Hawthorne

The Disruptive Physician

H. T. Kurkjian, MD

Dr. J. woke up in a good mood that morning. He had had only one call from the hospital that night. It was a nurse informing him that the patient had not gone to sleep yet. Now, at 1:30 a.m., she wanted to know if giving him the PRN at HS sleeping pill would be too late since the hour of sleep had already passed. Dr. J. had learned over the years not to argue with the nurse; otherwise, he could lose his sleep for the rest of the night.

He got up at six o'clock, showered, shaved, drank a cup of coffee and went to a seven o'clock meeting. There were only three physicians at that meeting and about ten non-physicians. Most of the agenda was for rubber-stamping what non-physicians had already decided. They were proposing to add another form to the patient chart. Dr. J. raised his hand in disagreement. However, he was overwhelmed and overturned. He looked around. One physician was doodling on the top sheet of the massive handout. The other was checking a message on his I-phone. Just then, his beeper went off. He had to excuse himself and go outside the room. It was surgery, telling him that his first patient had had breakfast. So the case had to be canceled. He knew his office had the patient the day before. He asked outpatient surgery nurses if they had called the patient the evening before. After talking to three different people, he could not get an answer. The whole schedule now had to be changed. He went back into the meeting room. The meeting was almost over, with only 25 percent of the agenda covered. The carefully crafted proposals in the voluminous handout came to a vote. Everything passed.

Dr. J. proceeded to surgery. First, he went to the outpatient surgery holding. The nurse taking care of his patient cheerfully told him that the history and physical were not on the chart. Dr. J. complained that he had dictated that the night before. Dr. J. picked up the phone, dialed 0, and asked the operator to connect him with Medical Records. The operator did not understand what Medical Records was. After some discussion, the operator realized that the doctor was talking about the Health Care Information department. His dictation could not be located. For damage control, he decided to manually write

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another H and P. He then proceeded to talk with the patient and family, and asked the family to wait for him in the waiting room so he could talk to them after surgery. He also talked to the nurse in holding, to make sure the family waited for him.

During surgery, Dr. J. asked for a special number six catheter for his procedure. However, the nurse told him that the specific size catheter was not available. So Dr. J. was forced to use a different catheter, hoping this would not compromise the procedure. He was upset, but he knew talking to the nurse in the room was not going to do any good. After the procedure was over, he talked to the supervisor about the incident. The supervisor promptly checked her computer and told him that they had not reordered that specific catheter because it was used only once during the previous year. Dr. J. went to the waiting room to talk to family. They were nowhere to be found. Dr. J. went to the other waiting room. The family was not there, either. After surgery, he went to the office to start seeing his patients. His beeper went off. It was the nurse from the post-op area, wanting to know why he had not talked to the family.

Dr. J. had had a very rough day, not unlike other days. So he picked up the phone, called the Surgery supervisor and the Nursing supervisor. All he got were recorded messages that told him they were either at a meeting or on another line. He left a detailed description of all his complaints in their voice mails.

A week later, the surgery supervisors, the nursing director, and the vice president had a meeting. Their conclusion: Dr. J. was a ***Disruptive Physician.*** ❑

Dr. Kurkjian is a urologist and long time member of the OCMS.

Diabetes Wellness Project

Beverly Caviness, RN, BSN

Diabetes affects one in 10 people in the state of Oklahoma. In 2007 there were over 6,000 hospital admissions in the state due to diabetes. Diabetes is challenging to manage if one has insurance but, without insurance, even the basic technology (glucose monitor and strips) is unavailable for disease management.

The Diabetes Wellness Project (DWP) was created to serve the uninsured and materially poor through a partnership with the Health Alliance for the Uninsured, Mercy Health Center, and the free clinics. The goals of the project are to provide patients with skills in medical management, nutrition, fitness, and coping. It is designed to treat the patient as a whole: body, mind, and spirit.

The team of educators for DWP is Glenda Bronson RN CDE, Diane Moore RD/LD, Jaime Hargus RD/LD, Lisa Thompson personal trainer, and Beverly Caviness RN BSN, project coordinator.

Beginning in February 2008, the project has been presented nine times, reaching 140 people. The process begins with a pre-assessment that includes measurements of height, weight, blood pressure, Hemoglobin A1c (A1c), cholesterol and a pre-test of diabetes knowledge. A brief medical history, foot assessment and an assessment of readiness to change habits are also completed.

Data collected from the 140 participants, at the three-month assessment, reveals an overall decrease in A1c of 63 percent of patients, weight loss of 45 percent of patients, decrease in cholesterol of 65 percent of patients, and 71 percent decrease in blood pressure of patients. We have had many successes, but one that stands out is a patient who was admitted to the hospital every three to four months in severe Ketoacidosis. The patient hasn't been admitted to the hospital since graduation from the project, nine months ago.

We are presently working with the OU School of Nursing to apply for a NIH grant to research the effectiveness of a modified format of DWP for this target population. ❑

Ms. Caviness, chronic disease nurse for the Health Alliance for the Uninsured, assisted with development of Quality Guideline suggestions for Oklahoma City free clinics. Her previous experience is in case management, cardiac cath lab, emergency medicine, radiology, and the breast care center. She is a retired radiologic technologist.

Informed Consent
DNA Research and DNA Patents

S. Sandy Sanbar, MD, PhD, JD, FCLM[1]

Medicine has become more personalized. Genetic tests are used to diagnose diseases and to determine which medicine is best for which patient. Federally funded research requires "informed consent" from subjects to ensure that they understand the risks and benefits before they participate in research that carries physical risks, such as experimental drug trials or surgery. Do DNA researchers have a responsibility to communicate the "range of personal information" that can be gleaned from DNA at a time when the DNA sample is being collected? The rights of research subjects can be violated when they are not fully informed about how their DNA might be used, particularly where medical research takes advantage of a vulnerable population. The individual who gives DNA for research on a specific disease should be the one to give consent to use that DNA for other disorders.

Informed Consent for DNA Research[2]

In 1990, members of the Havasupai Indian Tribe, who live amid turquoise waterfalls and red cliffs deep in the Grand Canyon, had given DNA blood samples to Arizona State University researchers to investigate genetic clues to the tribe's devastating rate of diabetes. Beginning in the 1960s, an extraordinarily high incidence of Type 2 diabetes led to amputations, even among the younger members, and forced many to leave the canyon for dialysis. In 1997, upon learning that the blood samples had been used to study many other things, including mental illness and theories of the tribe's geographical origins, 41 tribe members sued the university. The Havasupai Indian Tribe issued a "banishment order" to keep the university employees from setting foot on their reservation, an ancient punishment for what the tribe regarded as a genetic-era betrayal.

The DNA researchers stated that they had obtained permission for wider-ranging genetic studies. The university spent $1.7 million fighting lawsuits by tribe members. In

2010, in an effort to "remedy the wrong that was done," the university's Board of Regents agreed to: (1) pay $700,000 to 41 of the tribe's members, (b) return the blood samples and (c) provide other forms of assistance to the impoverished Havasupai. The Havasupai settlement appears to be the first payment to individuals who said their DNA was misused.

DNA Patents[3]

About 20 percent of human genes have been patented, and multibillion-dollar industries have been built atop the intellectual property rights that the patents grant. Federal U.S. District Court Judge Robert Sweet struck down several patents on two genes, BRCA1 and BRCA2, whose mutations have been linked to breast and ovarian cancer. If upheld, the decision could affect patents covering thousands of human genes and reshape the law of intellectual property. Myriad Genetics sells a test costing more than $3,000 that looks for mutations in BRCA1 and BRCA2 genes to determine if a woman is at a high risk of getting breast cancer and ovarian cancer. Plaintiffs asserted that (1) Myriad had a monopoly on the test, conferred by the gene patents, which kept prices

high and prevented women from obtaining a confirmatory test from another laboratory; (2) Genes are products of nature which fall outside the realm of things that can be patented, and (3) the patents stifle research and innovation and limit testing options. Defendants claimed that the work of isolating the DNA from the body transforms it and makes it patentable; such patents have been granted for decades.

Judge Sweet ruled that the patents were "improperly granted" because they involved a "law of nature." He stated that isolating a gene does not make it patentable. This is a "lawyer's trick" that circumvents the prohibition on the direct patenting of the DNA in human bodies but which, in practice, reaches the same result. The human genome was discovered, not created. Genes have an endless amount of information that begs for further discovery. Gene patents place unacceptable barriers to the free exchange of ideas. The decision opens up things. It is good for patients, patient care, science and scientists. We await the decision of the U.S. Court of Appeals.

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[1] Dr. Sanbar is a Board Certified Legal Medicine Specialist and Chairman of the American Board of Legal Medicine; Adjunct Professor of Medical Education, Office of the Dean, University of Oklahoma College of Medicine; Adjunct Professor of Medical Jurisprudence, Touro University Nevada; Past President & Ex-Officio Member of the American College of Legal Medicine.

[2] Indian Tribe Wins Fight to Limit Research of Its DNA - http://www.nytimes.com/2010/04/22/us/22dna.html?ref=us

[3] ASSOCIATION FOR MOLECULAR PATHOLOGY,ET AL.,Plaintiffs, v. OPINION, UNITED STATES PATENT AND TRADEMARK OFFICE, ET AL., Defendants - http://www.aclu.org/files/assets/2010-3-29-AMPvUSPTO-Opinion.pdf

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Three things are necessary for the salvation of man:
to know what he ought to believe;
to know what he ought to desire;
and to know what he ought to do.
St. Thomas Aquinas

Alliance


Donna Parker

This year is the 85th Birthday of the Alliance in Oklahoma County. The key to our longevity has been the ability of our members to adapt to an ever-changing environment. This 85th birthday year marks the beginning of a significant period of change for our Alliance. There is much to talk about!

This year we begin a purposeful time of reflection and improvement. Membership retention and recruitment are our highest priority. As we Baby Boomers retire, Gen X and Gen Y are taking our places. Our future membership has arrived! It's time to get acquainted!

They are physicians' spouses who juggle family needs as well as their own careers and goals. They are likely to move in and out of the work force as needed to accommodate their children and outside interests. They want an organization that is "high tech" in form and function, and which provides an innovative environment for them to share their creativity and ideas. They are hard working and success-oriented, so they demand fun and friendships while doing what is meaningful to them. And volunteering is among the activities that they value the most! How cool is that?

These new members will see our Alliance on into its Centennial year. Our job now is to get ready for them! We will learn, through the generous mentoring offered by our RPS/MSS Alliance friends, about creating short-term volunteer opportunities, forming teams to accomplish a shared job, designing flexible meetings that work around busy schedules, and e-volunteering. We will invest significant dollars to upgrade our web presence because we know that this is where future members will go to find us, and we will only be given one chance to make a good impression.

Our predecessors had to stretch and grow so that we would feel welcome in the Alliance, and we, too, will rise to this challenge and greet our new generation of members on their terms. Please give your time to the Alliance this year. Become a positive participant in this exciting season of change.

Consider it a birthday gift to an 85-year old friend… ❑

Donna Parker, President

Patients Invited to Report Adverse Medical Events

A new Website, developed by the Empowered Patient Coalition and Consumers Union's Safe Patient Project, is designed to allow patients to complete a survey about adverse medical events they experience. The survey includes 40 questions and asks for such details as the state where the error occurred, the type of health care provider involved, the procedure or treatment, factors contributing to the error, whether the patient considered legal action, and how the health care provider responded. Patients may submit the survey anonymously, if they choose. The coalition "plans to aggregate the information and use it to identify patterns that could lead to adverse medical events," according to an article in the April 26, 2010, edition of Modern Healthcare. The Website can be found at www.empoweredpatientcoalition.org/report-a-medical event. ❑

Cut Medication Errors

Medication errors are reduced seven-fold when doctors prescribe using an electronic system, according to a study conducted by physician-scientists at Weill Cornell Medical College and reported in the March 31, 2010, issue of Medicine & Health. Researchers compared the number and severity of errors between 15 providers who adopted e-prescribing and 15 who wrote prescriptions by hand at 12 community practices in the Hudson Valley area of New York.

The study found that two of every five handwritten prescriptions had errors such as incomplete directions or omitting the quantity. A few errors were more serious, including prescribing incorrect dosages. The error rate dropped to seven percent from 43 percent for the providers using e-prescribing. For those writing prescriptions by hand, the error rate increased slightly, from 37 to 38 percent.

Researchers noted that providers who adopted e-prescribing "used a commercial, stand-alone system that provides dosing recommendations and checks for drug-allergy interactions, drug-drug interactions and duplicate drugs." Electronic systems users also received technical assistance from a health information technology service provider.

The Agency for Healthcare Research and Quality supported the study. ❑

Director's

DIALOGUE

You can get assent to almost any proposition
so long as you are not going to do anything about it.
John Jay Chapman, 1862-1933

Will the flawed Medicare SGR formula *ever* be fixed? Congress continues to "kick the can" down the road as each deadline approaches to cut Medicare reimbursement rates – and sometimes, it is *after* the deadline. What is needed is a rational Medicare physician payment system that automatically keeps pace with the cost of running a medical practice and is backed by a fair, stable funding formula.

I suppose the individuals who wrote the provision in 1997 thought it was a good cost-containing measure to mandate cuts to physician payments whenever Medicare's spending rose above a certain level. Thus, the sustainable growth rate formula was born... but flawed – and now implementing a solution to the problem will be very costly, especially at a time of massive deficits.

What has not been addressed are the unintended consequences that will occur if the payment reductions are finally implemented. If these cuts, now at more than 21 percent, are eventually imposed on physicians, it will result in an access to care problem for senior citizens much like that experienced by many of the uninsured citizens in this country. Let's not forget all of the military families who will be impacted, along with Medicaid patients since the reimbursement for Medicaid is tied to Medicare rates. Physicians cannot take care of their patients at such a loss that they cannot afford to keep their doors open.

Congressional inaction on this subject reminds me of when I was younger and kept procrastinating about an unpleasant chore or homework assignment. My mother would suggest that sometimes the dread about doing something was much worse than actually addressing the issue and finally getting it behind me. I acknowledge that the cost of the "fix" will be enormous but

Congressional inaction is only heaping additional expense onto an already enormous price tag.

The Oklahoma County Medical Society joined with other state medical associations and county medical societies throughout the U.S. in the "Stop the Medicare Meltdown" Campaign. The goal was to obtain 1 million signatures on an electronic petition prior to June 1, 2010, and present these signatures to Congress urging them to finally fix the flawed SGR formula. Initiated by the Texas Medical Association, each state will be forwarded the total number individuals who signed the petition.

At the time of this publication, we will know if Congress decided to take action to fix the formula or agreed "not to do anything about it" once again. If you were a betting person, what would you put your money on?

Have a great summer! ❑

JanaTimberlake, CAE, Executive Director

End-of-Life Care Discussions Are in Patients' Best Interests

Scenario: What can doctors do to break down barriers to these kinds of talks?

It's incumbent upon physicians to help patients understand end-of-life care options, even though the coding and payment system for these discussions is lagging behind. Discussions about options have been shown to lessen depression, pain and anxiety for patients in their final days. A formal payment code would help in tracking such vital data.

Reply:

Recently proposed federal legislation on health reform would have allowed physicians to code and get paid for discussing end-of-life care options with patients. This idea was not welcomed; instead, it was met with alarm and bizarre misunderstanding -- the "death panel" inference and cries of "health care rationing." The provision has been removed from current reform bills.

The rationale behind the proposal was the assumption that allowing doctors to bill specifically for discussions about goals and advance directives for health care planning would motivate them to have those discussions. If this assumption is correct, then how do we convince the public that we are not trying to "pull the plug" on old people who get sick and are viewed by some as a drain on society's resources, but that advance planning discussions are in their best interest?

Paradoxically, the very idea that created the most furor about governmental coercion would have increased patient autonomy by guaranteeing everyone the right to discuss and set goals with their doctors about the kind of medical care they want as the end of life approaches. It would have placed informed decision-making about care directly in the hands of patients, where it belongs.

If we don't discuss with elderly patients their entitlement to the Medicare hospice benefit, for example, their decisions are not fully informed.

There is considerable evidence that physicians and patients need to improve their communication about end-of-life care options. So often we wait until the patient is too ill to participate

fully in the decision-making. Survey after survey indicates that the majority of patients would like to have advance planning discussions but don't ever accomplish the goal.

What are some barriers? I think the foremost barrier is that many health care professionals believe that patients should initiate the conversation, while patients expect their practitioners to do so. Some patients think that physicians are not comfortable discussing end-of-life issues, and some physicians think that broaching the topic will frighten patients. It becomes a stand-off: Neither party initiates the conversation, and each waits for the other to do so.

Beyond this, practitioners report that they do not have the time for such conversations. This claim is the basis for the assumption that coding and payment for advance care planning would help physicians view it as a legitimate medical service and one worthy of the time spent.

But payment systems traditionally have rewarded technical skills more than communication skills. Medicare will pay for almost any medical procedure but it will not pay physicians or midlevel practitioners for having an emotionally demanding, personal and thoughtful discussion to prepare patients and families for the complex and delicate decisions surrounding the end of life.

And yet sitting down and having a frank discussion about end-of-life issues can be as life-changing for a patient as any billable medical intervention. Lance Armstrong has stated that, on the day he and his physician had the discussion about his metastatic testicular cancer, he "left home as one person and returned as another."

Partly as a result of current payment policy, those difficult, emotional conversations are not happening nearly as often, or as early, as they ought to. The average hospice stay is less than a month, yet it can take at least 60 to 90 days, sometimes longer, to develop rapport and help a patient and family through the process.

There are other recently reported facts that patients should know: The literature indicates that patients who stop all aggressive therapies actually may live longer -- an average of 29 days longer by one study -- than do those who continue aggressive care at the end of life. Moreover, a patient's being on hospice is associated with a significant reduction in the risk of death for that patient's care-giving spouse.

Death is not optional -- it is the largest geriatric syndrome. What is optional is how we experience life's last stages. Will we be at home, in the hospital or in a nursing home? Will we be in

pain or have our pain well-controlled? Will we be in an ICU or enrolled in hospice?

Most caring physicians will not avoid discussing these matters with patients who are facing serious illnesses simply because they cannot code for them. These discussions still take place all the time in physicians' offices, hospitals, nursing homes and hospice settings. That is part of being a compassionate and caring doctor.

In a time when hospice and palliative medicine has become the 21st official medical specialty, and the use of hospice has grown so that approximately 40% of all deaths in this country take place in hospice care, it seems that the coding and payment system is lagging behind what practitioners are actually doing.

That system may even be moving backward, as the Centers for Medicare & Medicaid Services has recently eliminated payment for the inpatient and outpatient consultation codes previously used by the palliative care consultant.

Most busy physicians are less likely to take adequate time to discuss advance directives with a younger healthy patient -- the very patient who might benefit the most from such discussions. It seems reasonable that creating a diagnosis code that would allow health care professionals to charge for these discussions certainly would encourage them to have the conversation with this healthy population. The public deserves to be informed and educated with truthful facts about end-of-life choices. How else can "informed consent" be considered to be truly "informed?"

We do not know for sure whether payment for advance care planning would reduce the cost for terminal care. But discussing care options with their physicians gives patients the opportunity to avoid overtreatment as well as undertreatment.

Another helpful spin-off of a formal code is the ability to track how often these discussions are happening. At this point, we have no useful data as to what discussions are occurring. If coding and payment are ineffective in promoting end-of-life discussions, we will need to find other strategies.

Why and how did the recent legislative proposal to reimburse advance care planning go so terribly wrong? We can speculate that being associated with a massive, controversial health care reform bill made the provision immediately suspect. The provision that Medicare would pay

for advance care planning discussions every five years was easily "misinterpreted" as something that must be done every five years, hence the "death panels."

Perhaps the time for acceptance of end-of-life discussions has just not come in our society; more likely, this provision became the pawn in a political game. Whatever the cause, we must now be alert to the distortions that lie ahead as health care legislation moves forward.

How do we best educate both health care professionals and the public about end-of-life care? How do we effectively communicate that this is more about ensuring patients' rights than about limiting care, hastening death or making more money? Most important, health care professionals must speak out on behalf of our patients and convince our legislators that advance care planning is in the public's best interest.

The good news is that the discussion has started. With our aging demographics and increasing demands on the health care system, it is bound to persist. Perhaps each time it arises, it will seem a little less threatening, and eventually a payment code for end-of-life discussions will become standard of care.

Jerry Old, MD, associate professor and geriatrics clerkship director, Kansas University School of Medicine, Wichita; community leader in the hospice movement

"End-of-life care discussions are in patients' best interests" by Jerry Olds, MD, first appeared in the March 15, 2010, edition of *AMNews,* Ethics Forum published by the American Medical Association. Reprinted with permission.

Ethics Forum *discusses questions on ethics and professionalism in medical practice. Readers are encouraged to submit questions and comments to* ***philip.perry@ama-assn.org*** *or to* ***Ethics Group****, AMA, 515 N. State Street, Chicago, IL 60654; fax 312-464-4613. Opinions in Ethics Forum reflect the view of the author and do not constitute official policy of the AMA.*

There are things that we don't want to happen but have to accept,
Things we don't want to know but have to learn,
And people we can't live without but have to let go.

Author Unknown

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Does Crime Pay?

We've always heard that crime doesn't pay, but a group of physicians in Memphis, Tennessee, have learned – to their frustration and dismay – that it may. Even though one of their partners pleaded guilty to 35 counts of federal fraud, he is still practicing medicine while the doctors who reported him are footing the bill for an internal investigation, writing off $300,000 in drugs and dealing with loss of income and a civil lawsuit.

The crimes? He diluted dosages of eye injection medicine and falsely billed Medicare for the amount of medicine – to the tune of $1.6 million. He then took the medicine and sold it, pocketing the money.

And his partners? They were initially told to reimburse Medicare the entire amount of fraudulent claims but have been able to secure a lesser payment amount. The FDA retained the stolen medicine as evidence and eventually returned it – after it had expired.

The guilty party? Allowed to continue practicing medicine. The Tennessee Department of Health says, "There is no state law, nor is there any rule within the boards, for health professionals that automatically prompts action against a licensed health professional for a criminal conviction." The doctor's sentencing hearing was scheduled prior to publication of this Bulletin, so perhaps he is finally being held accountable. The Memphis Daily News initially reported this story; it was summarized in FierceHealth.com.

Guess Mom was right: Choose your friends – and partners – carefully. ❑

Streamline Medical Billing and Save

Researchers at Massachusetts General Hospital have found that 12.6 percent of submitted claims are rejected. Eighty-one percent of those are eventually paid, but only after a great deal of staff time and effort. In some cases, providers fail to collect because of the initial rejections. The researchers concluded that standardizing the billing system – using a single set of payment rules, a single claim form, and standard rules of submission – could not only reduce time spent by physicians and staff on billing by four and five hours weekly, respectively, but could also save physicians and their practices approximately $7 billion per year. ❑

OLDER DRIVER SAFETY GUIDE

Motor Vehicle Injuries a Leading Cause of Injury-Related Deaths in Seniors

To help protect the lives of older drivers and make our roads safer, the American Medical Association (AMA) has released a new Physician's Guide to Assessing and Counseling Older Drivers. Motor vehicle injuries are a leading cause of injury-related deaths in adults over 65. The fatality rate for drivers 85 years and older is nine times higher than the rate for drivers 25 to 69 years old.

The guide can help physicians address the driving safety of their older patients and better understand the public health issues involved. Topics covered include screening, assessing functional abilities, handling evaluations and referrals, conditions and medications that may impact driving, addressing safer driving, and counseling those who are no longer able to drive. A section with worksheets and resources for older patients and caregivers is also included.

Older drivers have a higher risk of traffic fatalities for two reasons: Drivers age 75 and older are involved in significantly more motor vehicle crashes per mile driven, and older drivers are considerably more fragile and more likely to suffer a fatal injury in the event of a crash than their younger counterparts.

The guide was developed by the AMA in cooperation with the National Highway Traffic Safety Administration (NHTSA). It is available online (www.ama-assn.org/go/olderdrivers) and physicians can order a free hard copy. Later this year, a Continuing Medical Education course for physicians will be offered on the AMA's Web site. ❑

Security Rule Guidance

The Office for Civil Rights has published a guide to assist physicians and provider organizations in identifying and implementing the most effective and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of electronic protected health information. The materials will be updated annually, as appropriate. The draft guidance is available on the DHHS Website:

http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/radraftguidanceintro.html

Oklahoma City-County Health Department
Epidemiology Program
Communicable Disease Surveillance

COMMONLY REPORTED DISEASES	*Monthly*			*YTD Totals^*	
	April'10	**April'09**	**March'10**	**April'10**	**April'09**
Campylobacter infection	4	9	4	15	19
Cryptosporidiosis	2	2	1	3	5
E. coli 0157:H7	0	0	0	0	0
Ehrlichiosis	0	1	0	0	1
Giardiasis	2	2	1	8	7
Haemophilus influenzae Type B	0	0	0	0	0
Haemophilus influenzae Invasive	2	0	5	12	6
Hepatitis A	0	0	0	1	2
Hepatitis B*	18	13	20	60	66
Hepatitis C *	29	8	17	73	95
Lyme disease	1	0	1	2	4
Malaria	0	0	0	1	0
Measles	0	0	0	0	0
Mumps	0	0	0	0	1
Neisseria Meningitis	0	0	0	1	1
Pertussis	0	4	4	5	11
Pneumococcal infection Invasive	4	3	3	7	7
Rocky Mtn. Spotted Fever (RMSF)	2	2	0	2	5
Salmonellosis	3	9	5	22	29
Shigellosis	8	14	10	40	37
Tuberculosis ATS Class II (+PPD only)	53	87	70	209	333
Tuberculosis ATS Class III (new active cases)	1	3	1	7	5
Tularemia	0	0	0	0	0
RARELY REPORTED DISEASES/Conditions:					
West Nile Virus Disease	0	0	0	0	0
Pediatric Influenza Death	0	0	0	0	1
Influenza, Hospitalization or Death	1	0	6	12	0
Influenza, Novel Virus	0	0	0	0	0
Strep A Invasive	3	8	1	14	23
Legionella	0	0	1	1	0
Rubella	1	0	1	2	0

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

^ ***YTD - Year To Date Totals***

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

CME Information

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

Community-based Primary Health Care CME Program
Sponsored by Central Oklahoma Integrated Network Systems, Inc. (COINS)
Contact: Deborah Ferguson
Telephone: (405) 524-8100 ext 103

Deaconess Hospital
Contact: Yvonne Curtright
CME Coordinator
Telephone: 604-4979

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

Integris Baptist Medical Center
Contact: Marilyn Fick
Medical Education
Office
Telephone: 949-3284

Integris Southwest Medical Center
Contact: Marilyn Fick
CME Coordinator
Telephone: 949-3284

Mercy Health Center
Contact: Debbie Stanila
CME Coordinator
Telephone: 752-3806

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

Oklahoma Academy of Family Physicians Choice CME Program
Contact: Sue Hinrichs
Director of Communications
Telephone: 842-0484
E-Mail: hinrichs@okafp.org
Website: www.okafp.org

OUHSC-Irwin H. Brown Office of Continuing Medical Education
Contact: Letricia Harris or Kathleen Shumate
Telephone: 271-2350
Check the homepage for the latest CME offerings:
http://cme.ouhsc.edu

St. Anthony Hospital
Contact: Lisa Hutts
CME Coordinator
Telephone: 272-6358

Orthopaedic & Reconstruction Research Foundation
Contact: Kristi Kenney
CME Program Director
or Tiffany Sullivan
Executive Director
Telephone: 631-2601

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