THE BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY MARCH/APRIL 2017

OKLAHOMA COUNTY MEDICAL SOCIETY

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THE BULLETIN

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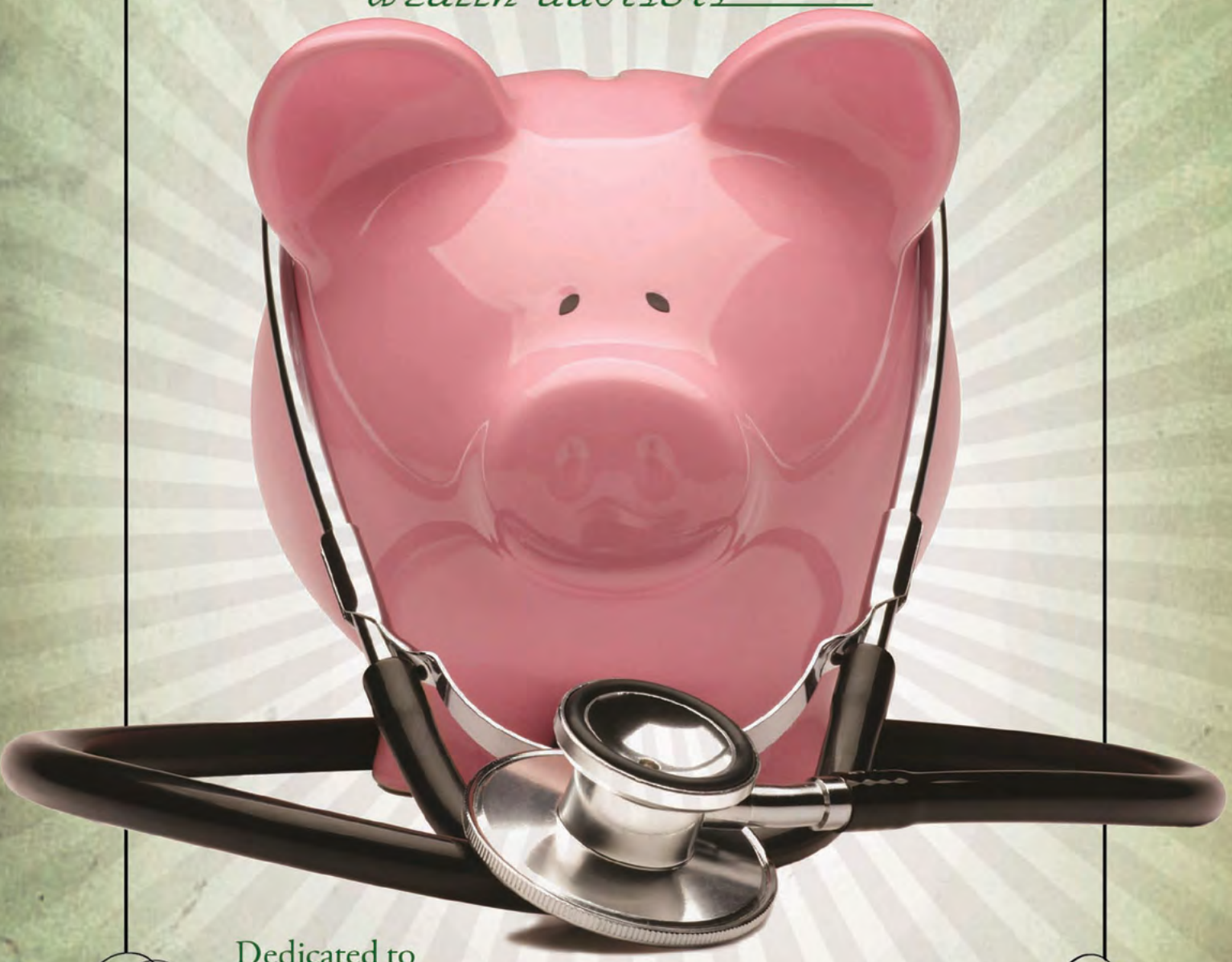
ABOUT THE COVER

Pictured on the cover is a word cloud prepared by Susan D'Antoni, a past president of the American Association of Medical Society Executives (AAMSE). Ms. D'Antoni is the current CEO of the Montgomery County Medical Society in Maryland.

The words are a combination of mission statements of those who attended the 2016 AAMSE County CEO meeting held in conjunction with AAMSE's Annual Conference in Baltimore. As Susan stated, "Not surprisingly, we are similar in many ways yet have important mission differences depending on the needs of our physicians and our communities. It's a neat way of representing the value we all bring through our organizations."

Wilshire-Pennington
wealth advisors



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PRESIDENT'S PAGE

DAVID L. HOLDEN, MD

Recently a representative of the Oklahoma State Medical Association presented OCMS with pertinent facts regarding the significant widespread budget constraints and the massive deficit the state of Oklahoma is now facing. More specifically, their information focused on the extensive cutbacks expected to take place in the medical arena and how these will impact medical care and medical practice in the future in Oklahoma. The details of these proposed changes are not always readily available to everyone and often do not garner nearly enough media attention. It was reported that health care reimbursement will continue to drop and may fall as much as twenty percent, which could lead to significant rationing of care in both the metropolitan and rural areas.

Also, the proposal and passing of new House Bill 1013, soon to be heard in committee, would mean quite significant changes to medical practice as we have always known it. This Bill will expand the perimeters of nurse practitioners to such an extensive degree that they would be able to practice without the supervision and participation of physicians. In my opinion, completely removing the physician from this equation would only serve to increase risk to the patient and place complete responsibility for his care solely on the nurse practitioner. The reason for this Bill, is the legislature feels compelled to address the doctor shortage in Oklahoma and to increase the low patient care ratio, which does need addressing.

The irony for the legislators, is the double edged sword which will be facing them if these bills are enacted. In point of fact, it can easily be argued these proposed changes would not attract more physicians to rural areas and may by necessity even lower the overall access to doctors. In summary, nurse practitioners continue to be an essential and successful part of the health care team and delivery system. It would be wise for legislators to heed mythology's parable of "The Sword of Damocles" which in my opinion, will be looming over all of us if the long term effects of these changes to the health care system are not carefully considered.

UPDATE ON HB 1013

Don L. Wilber, MD

I am writing to express my strong opposition to HB 1013. The bill would allow nurse practitioners to have independent practice without any form of physician supervision. Current law requiring physician supervision was put in place to protect patient safety, which should always be the first consideration. Please consider the following:

- Nurses are a vital part of the health care team, but they simply do not possess the same level of training and clinical expertise as a medical doctor, who will have more than 10,000 hours of clinical training before he/she finishes a residency program.
- This bill will not significantly help rural health access as purported by its opponents. Physicians, nurses and health care providers of all types go where the patients are which is in urban areas. To improve rural health care, we must work to recruit physicians and a variety of health care providers to those areas.
- Even if nurse practitioners did suddenly flow into rural areas, it should not be acceptable to create a two-tier health care system, in which rural citizens receive a lesser standard of care.
- Advocates of the bill say 21 states allow independent practice. However, many states' laws are not nearly so expansive as this. For example, six states only allow independent practice after a certain number of hours or years of practice under physician supervision. Other states restrict nurse practitioners ability to prescribe Schedule II narcotics. The simple fact is that HB 1013 would give Oklahoma one of the most open-ended, expansive laws in the nation.
- At a time when we already have a crisis of addiction to opioids and other powerful drugs, it makes no sense to allow hundreds of new practitioners to prescribe dangerous Schedule II drugs.

Certainly, we can and need to do more to promote health care in not only rural areas but urban areas. This bill will not accomplish that goal and will almost certainly have unintended consequences that are detrimental to the safety and wellbeing of Oklahoma patients. Please contact your representative and ask them to vote No on House Bill 1013. In the event the vote happens around the time of publishing, you can visit this link for updates https://www.votervoice.net/OKMED/campaigns/49836/respond.

Goodbye DR. DEWAYNE ANDREWS

HANNA SAADAH, MD

Doctor, Teacher, Mentor, Author, Leader, Administrator, Musician

Editor's Note: In February, M. Dewayne Andrews retired after serving forty years as a medical school faculty member, fifteen of those as the executive dean of the University of Oklahoma College of Medicine.

After a two-score service span
Of quiet competence, the man
Exits the labor-laden life
Moves to the other side of strife
Where piano, quietude, and wife
Await him with a gentler plan.
Lord John Dalberg-Acton's adage:
Great men are almost always bad men
Exempts the kind, competent few, like you
Who with humble grace have served their hour
Un-attired, un-Champagned by power.
Perhaps, goodbye is not the proper word
Welcome from the front is more in order
Doctor, teacher, mentor, leader
Author, and administrator
All bow to your inner music
Where committees, boards, and meetings
Are replaced with nature's greetings
Where grave responsibilities
Replaced with possibilities
Help you hark with heightened ears
Nature's sounds and tunes and tears.
From friends and colleagues of two score and more
When you will walk through life's revolving door
A grateful thank-you and a warm embrace
For all the years you spent, holding the place.

IN MEMORIAM

HENRY J. PEARCE, MD
1931-2016

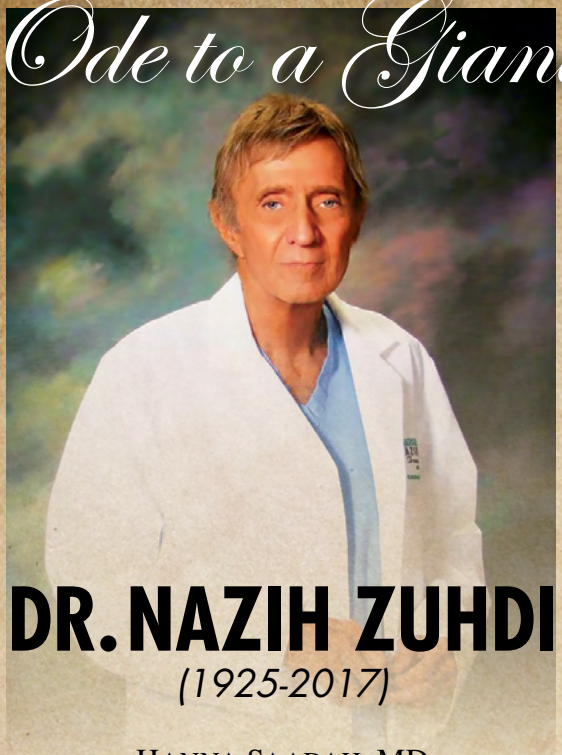
SURINDER KUMAR BHATIA, MD
1939-2017

ROBERT SMALL, MD
1927-2017

NAZIH ZUHDI, MD
1925-2017

LLOYD OWENS, MD
1924-2017

Ode to a Giant



DR. NAZIH ZUHDI
(1925-2017)

HANNA SAADAH, MD

A man came to offer condolences, surprised to have outlived his doctor.

Still beating in his chest was the heart, which Dr. Zuhdi had transplanted in 1986.

Giants begin alone, their mighty vision
Reaches beyond their placid time and place;
They work with urgency and with precision
To bring the future in with hurried pace.
Giants descend into the world unseen
And spread in all directions, east and west
To water with ideas fresh and green
And help the ordinary reach their best.
In every one of us a giant hides
Yet only few dare let their giant grow
But those who do are ones who ride the tides
And liberate our lives to ebb and flow.
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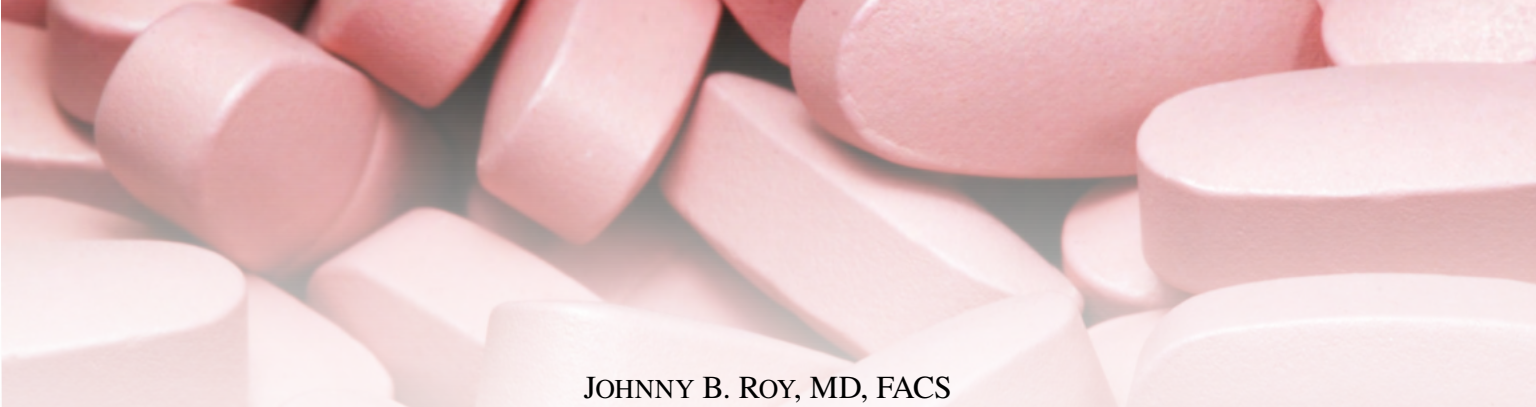
THE PEARL

FEMALE SEXUAL DYSFUNCTION

An Update



JOHNNY B. ROY, MD, FACS

Ever since Viagra, a successful male sexual enhancement drug was greenlighted by the FDA in 1998, efforts were directed towards discovering a comparable drug for women. Sexual dysfunction has been known to be more prevalent in women than men. Forty-three percent of women experienced sexual dysfunction in contrast to thirty-one percent of men.

Male sexual dysfunction (MSD) entails mostly performance- tumescence - difficulties. In contrast to female sexual dysfunction (FSD), it Involves mostly desire & arousal.

Four categories describe FSD:

- Hypoactive sexual desire disorder (affects one in ten women)
- Sexual arousal disorder
- Female orgasmic disorder
- Sexual pain disorder (dyspareunia)

Management of FSD was basically limited to cognitive behavior & psychological therapy. This has been laborious, expensive and time-consuming, besides the outcome has not been satisfactory. Pharmacologic treatment with estrogen enhances libido, besides increasing blood flow to genitalia and improves lubrication. Testosterone is libidinal to both men and women, and has been prescribed in appropriate dosing.

Another drug, Osphena, is approved for painful sex (dyspareunia). It is an estrogen agonist and antagonist. As an agonist, it lubricates the vagina, as an antagonist, it acts as Tamoxflen for treating breast cancer but with its other side effects application of vaginal cream is safer and more practical.

A year ago, the FDA approved the drug Flibanserin (Addyl). which made sensation headlines as the 'female' or 'pink' Viagra.

"To recap, Viagra is a performance drug by increasing blood flow to the male organ and cauces an erection, while Addyi stimulates a woman's higher center. The later enhances the release of dopamine and nor-epinephrine and decreases serotonin release. The latter is the inhibitor of sexual desire and interest.

Interest and desire for sexual activity are and have always been the first human sexual responses followed by arousal and orgasm.

Fhbanserin, upon its release, has certain restrictions and side effects. It is prescribed only to physicians who are certified (taken a test) and a pharmacist would need to confirm certification before dispensing it. Side effects include nausea, dizziness, low blood pressure, user has to abstain from alcohol and the drug reacts with anti-fungal medications.

The drug can be summed up as a libido enhancer!

Personal authors' comment: The core of sexual satisfaction has more to do with a stable, considerate and affable relationship.

OCMS
OKLAHOMA COUNTY MEDICAL SOCIETY

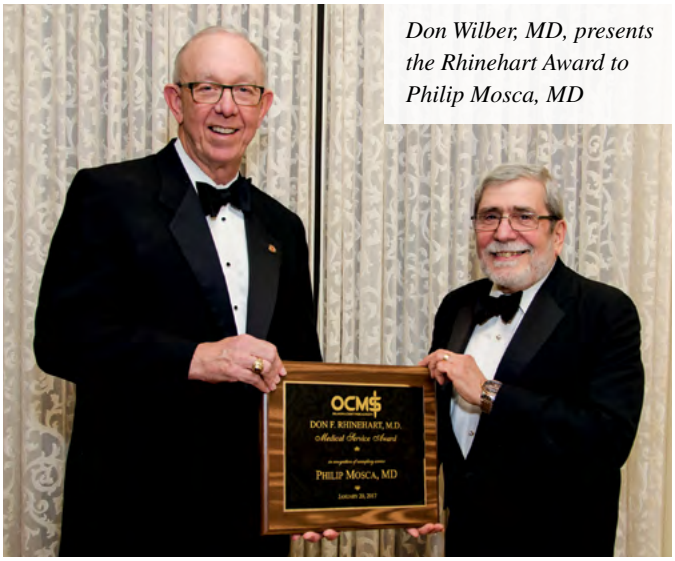
2017 Inauguration Ceremony

Don Wilber, MD – OCMS Immediate Past-President passes the gavel to David Holden, MD

David L. Holden, MD, was inaugurated as the 117th President of the Oklahoma County Medical Society on January 20, 2017 at the Oklahoma City Golf and Country Club at the OCMS Inaugural Dinner. Also honored was the Don F. Rhinehart Community Service Award Recipient, Philip Mosca, MD. The event had more than 250 supporters of Oklahoma County Medical Society, including physicians and partners.

Above: OCMS Past-President, Doug Fogler, MD, served as emcee.

Left: OCMS Officers: Sam Dahr, MD – President-Elect; Lisa J. Wasemiller-Smith, MD – Secretary-Treasurer; David Holden, MD, President; R. Kevin Moore, MD – Vice-President.



Don Wilber, MD, presents the Rhinehart Award to Philip Mosca, MD

Don Wilber, MD – OCMS Immediate Past-President receives his plaque from OCMS Past President Doug Folger, MD

Right: Members of the OCMS Leadership Academy, from left to right: Eric Yee, MD; Ryan Wicks, MD; Felicia Allard, MD; Pooja Singhal, MD; Amgad Haleem, MD.

Below: Holden Family Back row: Dr. David Holden, Amanda Holden, John David Holden and Rachel Holden Front row: Linda Holden and Lee Holden, DVM

Below: Members of the OCMS Board of Directors, from left to right: Elizabeth Jett, MD; Ralph Shadid, MD; Lisa J. Wasemiller-Smith, MD; R. Kevin Moore, MD; David Holden, MD; Don L. Wilber, MD; Anureet Bajaj, MD; Sam Dahr, MD

A LETTER FROM alliance

As we begin a new Alliance year, we welcome several new faces to our Board of Directors. Maria Abbott, Sandy Beall, Nicole Cook, Dinah L'Heureux, Traci Walton, Margo Ward and Tessa Wicks join returning board members: Amy Bankhead (Ex-Officio), Deanna Carey (Treasurer-Elect), Angela Chambers, Stacie Evans, Karen Gunderson (Treasurer), Berna Goetzinger, Barbara Jett, Stephanie Kazenske, Rick Knapp, Joan Larson, Natasha Neumann (President-Elect), Jeary Seikel (Secretary), Paula Scott, Jennifer Tortorici, Anita Verma and Mucki Wright.

We are gearing up for a busy and exciting year. The date for our 2017 Kitchen Tour has been set for Sunday, October 22nd. The committee, under the guidance of Chair Deanna Carey and Co-chair Nicole Cook, has already been reviewing grant applications and working on securing sponsors. Our Community Service Team is likewise busy setting up volunteer activities for the year. All of our volunteering is with non-profit groups with health –related needs. Our first volunteer day will be in mid-March at the Regional Food Bank.

As always, we appreciate the support of the OCMS. If your spouse is not already a member of the Alliance, we would love to have him/her join us. The OCMSA generally meets once a month (except during the summer months) and our meetings are varied in topics, locations and activities. What do we do? All of our activities and meetings are focused on promoting health and wellness in our community, assisting non-profits with health–related needs, supporting each other, our spouses and their practices, and the medical community in general. Dues are $80 which includes both County and State Alliance membership. Information can be found on our website at www.ocmsalliance.org or we can be reached at ocmsalliance@gmail.com.

Regards,
Cara Falcon
OCMSA President

Chiles Redux

It is not certain where chiles originated but most botanists believe that they first grew in Bolivia some 8000 years ago. Chiles are known to be one of the earliest domesticated plants, grown not only for food but also for medicinal and ritual purposes.

Peppers, red peppers, bell peppers – call them what you like but they are properly called chiles. The word chile though spelled in different ways comes from the Nahuatl or Aztec word for red. A good deal of this name confusion can be attributed to Christopher Columbus.

Columbus set out across the oceans to find a new source of spices. Spices at that time having the value of silver. Unfortunately, he caused years of confusion. He went west thinking he was headed for India.

He did find a new spice - chiles. But he thought they were a type of black pepper, piper nigrum, when in reality they belonged to an entirely new species, capsicum. Hundreds of years later thanks to Columbus we still call them peppers (and we still call our indigenous population Indians).

Amazingly within 100 years from the time Columbus brought chiles to Spain their cultivation had spread virtually worldwide. Tons of these fruit are grown today. They have become an extremely valuable crop all around the globe. Indeed, hundreds of acres of chiles are planted each year in America. One well know place is the Hatch ranch in New Mexico where a chile festival is held yearly.

Anchos in one place are mulatos in another. In parts of South America, the generic name for all chiles is Aji, which is also the name for a specific pepper. Even among experts, turmoil continues about the correct nomenclature within the species itself. Partly because the plant freely cross-fertilizes and because individual types are called by different names locally.

Among the hundreds of varieties of chiles are those with such colorful names as cascabel mirasol and chiltecpin. In 1950 the University of California at Davis classified them into five categories that include all types from Bell to Tabasco. They are: frutescens (such as tabascos), chinensens (habaneros), pubescens (rocotos) and annum (most common types).

The characteristic hotness in chiles is derived from the chemical capsaicin. It is generated by a single gene. This substance is produced by glands in the upper portion of the inner septum or placenta of the fruit. Although some is transferred to the seeds and the outer wall the percentage of this fiery chemical is almost 100 times greater in the inner parts.

Higher levels of capsaicin are found in the more narrow shouldered types than in the broader varieties (bell peppers lack the gene). Removing the so called “veins” or inner parts therefore results in less heat when ingested. In Mexico removing these parts is called “castration” and such chiles are called “capones”.

These capsaicinoids when broken down into their compounds such as dihydrocapsaicin can cause different sensations - some more burning others more piquancy. The products affect parts of the mouth differently such as the lips, tongue or pharynx.

Oddly capsaicin itself has no odor or flavor. The pungency and heat are based on five vanylic amides with various acid side chains. The heat varies from plant to plant even in chiles from the same plant Fortunately capsaicin is largely unaffected by cooking or freezing.

Flavor is not the same as heat and is related to carotenoids in the perecarp (flesh). Habaneros which we once thought were the hottest of all chiles, give a distinct, intense burn that is more flavorful but of shorter duration. The heat of jalapenos may be Jess severe but longer lasting. These differences are reverently described by “aficionados” in the same terms oenologists use - such as fruity, chocolate-like or smoky.

In an effort to make some sense out of this Wilber Scoville, a pharmacologist at Park-Davis company in l912 developed a scale of heat which

Continues on page 18 …

 Continued from page 17 ...

remains in use today. He called it the Organoleptic Test. The ratings are given in Scoville Units which once went from Oto 300,000 with Bell peppers at 0. But new varieties can go over 2 million units! New Mexico varieties are given values from 500 to 21000 with jalapenos at 2500 to 5000, tabasco at 30 to50,000, chiltecpins 50 to 100 000 and the well-respected habaneros are rated at a heaping 300 000. A new system simply called the Heat Scale rates chiles from 1 to 10.

But – and it is a big but – there are newer varieties of chiles that dwarf habanero's heat! To list just a few:

The Carolina Reaper was developed by an amateur by crossing Pakistani Naga and Habanero.

Compare these with the once King Habanero!

Pepper	Units
TRINIDAD BUTCH T	1,403,000
NAGA CHILE & NAGA VIPER	1,500,000
TRIDIDAD MORUGA	2,000,000
POT DOGLAH	1,000,000
BHUT JOLOKIA	1,400,000
CAROLINA REAPER	1,500,000

All manner of health benefits have been attributed to chiles. The ancient Mayans and Aztecs were well aware of these uses. Their nasal decongestant value is widely known. Some arthritis creams contain capsaicin and are reported to be helpful. It has been tried with some success on post-herpetic neuralgia. Plenty of chile lovers know the discomfort of"chiliproctitis". Not so well known is that during exploration of the New World sailors quickly learned of their value in preventing scurvy.

In 1937 a Hungarian physician, Alber Szent Georgi, was awarded the Nobel Prize for his discovery of vitamin C. He isolated vitamin C from paprika, the mainstay pepper of Hungry. Chiles contain more vitamin C per weight than oranges.

Why suffer the pain? Most chile lovers certainly aren't concerned with the medicinal value. Once again one must return to the main ingredient, capsaicin. This odd chemical causes the heart rate to increase, induces diaphoresis and salivation along with some pretty intense pain. Capsaicin stimulates pain receptors -neurotransmitters that indicate to the brain that something awful is happening. Somehow the brain perceives the pain, produces painkillers, endorphins, which themselves soon result in a feeling-of-well-being. Eating more chiles produces more endophorias. Other pungent-like foods may cause local burning but don't seem to cause the same physiologic response. Repeated exposure can reduce the response so that frequent users may find a reduction in the heat.

But chili eaters look for hotter ones to get that high or rush. Some say there is a Macho factor or point to psychological aspects such as the idea of non-dangerous fright which results in pain and then pleasure. Dairy products and sugar best relieve the heat Alcohol is less helpful since capsaicins are alcohol soluble.

Chiles, once confined to aficionados in the warmer climates, these gustatory delights Have rapidly moved northward. It is reported that picante sauce sales have exceeded those of ketchup. Moreover, it has even become part of the fashion of the day with bizarre chile adornments from jewelry and clothing to home decoration.

But true chili lovers pay no attention to such idleness they just continue to seek out "EL MAS PICOSO" the hottest chile!

WELCOME NEW MEMBERS!

Cristina G. Arriens, MD, is a board-certified rheumatologist with OMRF. She also volunteers at OUHSC and the VA. She completed medical school and a fellowship at UT Southwestern, and an internship and residency with the University of New Mexico.

Cory D. Cross, MD, is a board-certified pulmonologist and critical care physician in Oklahoma City. He completed medical school at OU, as well as his internship and residency in internal medicine, and a pulmonary, critical care and sleep medicine residency with OU.

Gabriel M. Cuka, MD, is a board-certified psychiatrist with HOPE Community Services in Oklahoma City. He completed medical school at the University of Nebraska, internship at Creighton University and residency at Griffin Memorial Hospital in Norman.

Subrato J. Deb, MD, is board-certified in thoracic and general surgery, and is employed with OUHSC Department of Surgery. He completed medical school at the University of Maryland School of Medicine, a thoracic surgery fellowship with the Mayo Clinic School of Medicine, and general surgery residency and internship with the National Naval Medical Center.

Wesley A. Dickson, MD, is an anesthesiologist with Southern Plains Anesthesia Service. He completed medical school at OU.

C. Erick Kaufman, MD, is an internal medicine physician with OU. He completed medical school and his internship at OU, and residency at the Providence Portland Medical Center in Portland, Oregon.

Mikhail A. Lomize, DO, is a board-certified family medicine physician with Mark 5 Care Group. He completed medical school at A.T. Still University in Kirksville, Missouri. His fellowship and residency was with St. Anthony Hospital.

Benjamin I. Panter, MD, is a board-certified orthopedic surgeon with McBride Orthopedic Hospital. He completed medical school, residency and internship at OU.

Daniel R. Skelly, MD, is a board-certified anesthesiologist with Anesthesia Scheduling Services. He completed medical school and his residency at OU.

Ksenia Stark, MD, is a board-certified anesthesiologist with Affiliated Anesthesiologists in Oklahoma City. She completed medical school at the Rosaline Franklin University of Medicine and Science – Chicago Medical school. Her residency was with Beaumont Hospital in Royal Oak, Michigan.

Nathan I. Valentine, MD, is a family medicine physician with Variety Care. HE completed medical school at OU and residency at VIA Christi Regional Medical Center in Wichita.

OCMS
OKLAHOMA COUNTY MEDICAL SOCIETY

UNPROFESSIONAL CONDUCT

PART 1: PERJURY

S. SANDY SANBAR, MD, PHD,
JD, FCLM, DABLM, DABFM

This article is the first of a three-part series on unprofessional conduct. Part 2 will address medical fraud and abuse and part 3 will depict rogue doctors.

The majority of doctors are conscientious, descent, honest, truthful and professional. However, physicians generally avoid testifying against colleagues, in part because of great professional risk of being shunned as traitors and potentially lose income. Some doctors find it totally acceptable to conceal wrongdoing or medical errors when their referral business might be jeopardized. Others do not tell the truth under oath for sundry reasons and motivations, including selective recollections, biases, assumptions, testimony for personal gain, hidden agendas, and deliberate falsehood.

In 2016, a South Dakota surgeon, Lars Aanning, MD, admitted that he deliberately lied under oath 15 years previously during a malpractice trial to protect one of his partners. While on the witness stand, Dr. Aanning was asked whether he knew of any time when his partner's

work had been substandard. Despite knowledge that his partner's work had been substandard, his answer was, "No, never." In so doing, he "... accepted the defense mantra that no negligence or break of 'standard of care' had occurred, and that the surgeon had 'done everything right.'" That lie under oath haunted Dr. Aanning for years and he ultimately confessed publicly.

Under Oklahoma law, "whoever, in a trial, hearing, investigation, deposition, certification or declaration…makes…a statement under oath, affirmation or other legally binding assertion that the statement is true, when in fact the witness or declarant does not believe that the statement is true…is guilty of perjury".

Perjury is a serious criminal act that occurs when a person lies or makes statements that are not truthful while under oath, if it is discovered that they have lied. It may be much costlier than telling the "hurtful" truth. Anytime one lies under oath, including in an affidavit, legal charges for perjury may result, thereby necessitating the help of an experienced fraud defense attorney. Perjury results in the miscarriage of justice and corrupts the legal process by disrupting the legitimate discovery of truth.

Perjury is very rarely charged against anyone who testifies unless the offense is egregious. It is exceptionally difficult to show that someone intentionally lied about something. If one can provide irrefutable evidence that someone has lied under oath, he/she may have the right to ask that the person be held in contempt for perjury and he/she or the judge might notify the local criminal prosecutor of the event. But, many kinds of perjury may not be actionable.

If one chooses not to plead guilty at the outset, there are two defenses to a perjury charge. One can argue that the statement was not actually false, or that he/she believed the statement to be true when it was made. But the prosecutor may bring evidence proving that the accused was aware of the falsity of the statement.

Legal consequences of perjury include being convicted of a crime of dishonesty, and may range from having to spend time in jail, probation, or paying fines to the court. Additionally, the perjurer's ability to obtain employment or security clearance may be compromised. The penalty for perjury in Oklahoma City depends on the circumstances under which the false statement was made.

Grand Jury: Between two and 20 years in prison.

Oklahoma court of justice: Between one and 10 years in prison.

Any other circumstances: Five years in prison.

When a physician makes a medical or surgical mistake, he/she should disclose the error and apologize. Additionally, the physician and the malpractice insurance should consider an early settlement offer for the medical error, thereby keeping such cases out of the courtroom. Expert medical witnesses should testify professionally and truthfully in accordance with the oath they take. Those who give untruthful testimony should not be tolerated by any malpractice insurer.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Dr. Filley


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BACK FROM HOSPICE

HANNA SAADAH, MD

Continues on page 26 …

"We had a great sex life, Doc."

"Had?"

"Last week, they put Earl on hospice."

Eldina's tears shivered on her cheeks. With long, smooth fingers, she reached for a tissue, and sighed, "We've had sixty great years. I'm just not ready to give him up."

"Tell me what happened? I had no idea he was that sick."

"When at his last physical you diagnosed prostate cancer and sent him to the urologist, his bone scan showed metastasis. They put him on Lupron, and he's been getting worse ever since."

"Getting worse? He had no symptoms when I referred him."

"You should see him now. You won't recognize him. His entire body aches. He has headaches. His eyes are failing. He's lost a lot of weight and is getting weaker by the day. Last night, he tried to turn in bed to…" she sighed. "He tried to..." she cried. "He tried to reach for me and couldn't," she sobbed. "We had a great sex life until they put him on Lupron."

"Is he still on Lupron?"

"He took his last shot three months ago. 'No more Lupron,' said the urologist. But, he continues to fail, and the hospice nurses keep trying to give him pain pills, which he refuses because they make him feel worse."

Eldina and Elmer were high school sweethearts sixty-two years ago, and were both eighteen when they got married. Tall, handsome, beautiful, and beaming with joy, they always came together for their annual examinations. Eldina, an accomplished pianist and piano teacher, year after year, in the privacy of the

examination room, would always extol their wonderful sex life:

"We started having sex when we were sixteen, Doc, and we haven't stopped, and don't intend to."

Elmer, on the other hand, a combat pilot who turned commercial after Vietnam, was too shy to mention their sexuality.

Throughout retirement, Eldina played the organ at church and Elmer taught Sunday school. Now, with all their personal and social activities suspended by illness, depression cried silent tears from behind Eldina's gaping eyes.

After the examination, as I embraced Eldina, she whispered into my ear, "Would you please see him."

I looked into her quivering eyes and asked, "As a friend?"

"No, as his doctor," she retorted, with reproachful firmness.

"Is he not happy with his hospice physician?"

"Dr. Maroon is very nice, but he doesn't give us hope."

"But, I don't think he's supposed to," I protested, "because that would be giving you false hope."

"What's he supposed to do then?"

"He's supposed to help Elmer die peacefully, with dignity, and without pain."

Eldina blanched when I said that, and her gaze fell down onto the examination room floor. While I stood there, aloft, alone, afar, suspended between the silent jaws of reality and the saving kiss of hope, her fallen gaze rose up again until it met mine. And then, with feathers in her voice, she asked the proverbial question:

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"Do you believe in miracles, Doctor?"

"Miracles? Yes, of course," I gasped. "Medical miracles happen every day," I acquiesced, not suspecting that I was being setup.

"In that case, come and see him, please. You've been our doctor and our friend for over thirty years, and we believe you can help."

In response, I smiled and tried to hide my inadequacy, but she saw through my veil of pretense and answered the question, which I dared not ask.

"We don't expect you to perform a miracle," she reassured. "God will do that for us, but it has to come through you. Elmer and I prayed about it last night and he was the one who told me that you are the only one who can give us hope. He said that, after he tried and tried to reach for me and couldn't."

I swayed and buckled under the mighty weight of responsibility. Mr. and Mrs. Rettung wanted me to perform a medical miracle on a dying man, a man that I had not seen for a year, a man who is on hospice. "I'll just visit him as a friend," I thought, trying to appease my angst. "That will help them both and ease the dying process." As I pondered my next move, with Eldina's expectant eyes fixated on mine, my nurse knocked on the door, poked her head into our silent stalemate, and announced, "Your next patient is ready."

Late that evening, after the usual phone calls and paperwork, I drove to the Rettung's home. Elmer greeted me with faint smile and feeble voice, "It's good to see you, Doc."

While Eldina stood like a statue in the middle of the room, I sat on Elmer's bed, held his hand, and listened:

Slowly, among gasps and groans, he told me his one-year saga. After his last physical exam, after I told him that he had a large prostate nodule, and after Dr. Stone, the urologist, told him that he had bony metastasis, he agreed to take Lupron. It was after the fourth shot that he began to ache in the hips and

shoulders. Weakness followed and he had trouble getting out of bed or standing up from a sitting position. He lost his appetite, lost lots of weight, and had trouble ambulating. Then the headaches came, and with them his vision began to fail. Scans showed widespread metastasis to his big bones and to his skull. Dr. Stone consulted Dr. Malin, the oncologist, and Dr. Ojo, the ophthalmologist. They offered him aggressive chemotherapy, but knowing that it could make him feel even worse, he refused. That was when they all agreed on hospice.

When he finished his story, Eldina, still standing like a statue in the middle of the room, chimed in with, "So, what do you think, Doc?"

Instead of answering her question, I palpated Elmer's temporal arteries. They were tender, and so were his shoulder and hip muscles. It was then, after I had make up my mind that Elmer was suffering form polymyalgia rheumatica with cranial arteritis—a condition not infrequently associated with cancer—that I began interrogating him:

"Have you had any recent blood work?"

"Not for three months," answered Eldina.

"Has anyone ever given you cortisone?"

"No," answered Eldina…

******

Two weeks later, Elmer, walking bright and tall, came in for his appointment.

"Where's Eldina?" I quizzed.

"She's in Missouri, babysitting the grandkids."

"You look well," I added with a smile.

"That cortisone is a miracle, Doc. It didn't take but a few days before my strength began to return and my other aches to go away."

"How's your vision?"

"It's back to normal."

"And how's your appetite?"

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"I'm gaining my weight back."

Elmer, after some resistance to my insistence, started taking his Lupron injections again, which thrilled Dr. Stone. A few months later, Elmer and Eldina decided to move to Missouri to be closer to their children and grandchildren.

"What a miracle of life, what inveterate inseparableness, and what indomitable love," I thought as I handed them their charts, hugged them both, and bid them farewell. Of course, we promised to stay in touch, but we never did. We lost contact after they left, but they never left my mind. Year after year, their image would flash on my mental screen, as a most beautiful couple who defied age with love.

Four years after they had left Oklahoma to Missouri, I received a beautifully handwritten letter from Eldina. At first, I was afraid to open it because I was fearful of what it might hold within its folds. It lay on my desk for two days before I summoned enough courage to violate its sanctity:

Dear Dr. Hawi,

Elmer died in his sleep last month, and he never needed hospice. He was eighty-four, and just as sassy and handsome as when he was sixteen. We had four good years in Missouri, rich with love and family. And although his cancer weakened him, he continued to reach for me at night until the very end.

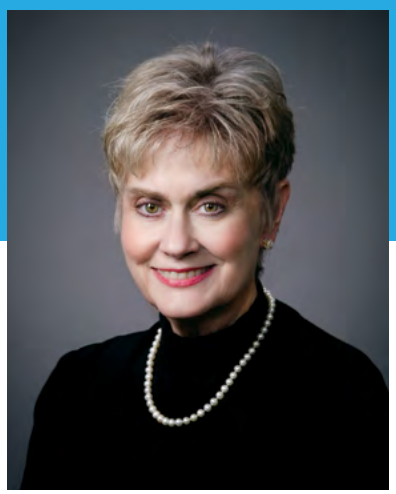
All his Sunday-school students came to the funeral. I played the organ, and the church choir sounded heavenly. We had been married for 66 years. Oh, how I miss him in my bones.

When, five years ago, you told us that medical miracles happen everyday, you gave us hope, and then God did the rest. Nevertheless, we were greatly disturbed when Medicare refused to pay for your lifesaving house call because doctors are not supposed to provide lifesaving treatments for patients dying on hospice.

May the Lord continue to perform his medical miracles through the hands of good doctors.

With love,
Eldina Rettung.

DIRECTOR'S DIALOGUE



"Patience is a virtue, and I'm learning patience. It's a tough lesson."

~Elon Musk

BY JANA TIMBERLAKE, EXECUTIVE DIRECTOR

The Oklahoma County Medical Society receives requests from the public for different types of assistance, many of which have been to help navigate the intricacies of the U.S. health care system. I can still hear the frustration in people's voices as they attempt to describe their experiences and then wait for an answer that will hopefully untangle the web of misunderstandings, delays, and sometimes denials for treatment coverage. Unexpectedly, I found myself needing help so I attempted to utilize the skills I have developed over several years!

My situation began by calling my pharmacy for a prescription refill. The pharmacy told me the prescription was required to have a preauthorization. That was the first red flag! After two weeks of attempting to understand and work through the process, permission was finally granted. At one point, I decided if I didn't laugh, I would cry, and that's when I could hear my Mother saying, "Keep your sense of humor – it will help lessen your frustration."

While my outcome was far different from what others experience, I felt the need to illuminate some of the reasons U.S. citizens are becoming disenchanted with health care. The insurance and pharmaceutical companies, whose lobbyists expend massive amounts of monies to lobby Congress, are a good start. According to a New York Times article by Gina Chon dated September 1, 2016, "...Drug makers doled out $240 million for lobbying purposes last year, according to the Center for Responsive Politics, making it the biggest spender. The insurance industry was second, at $157 million."

Something's gotta give! Insurance premiums are continuing to rise, and pharmaceutical prices are astronomical when compared to some of the same drugs purchased in England and Canada. According to an article in Tech Times, dated February 13, 2017, since the FDA gave their recent approval for the drug deflazacort

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for patients suffering from Duchenne muscular dystrophy, Marathon Pharmaceuticals "will offer the drug at a cost of about $89,000 per year, which is up to 70 times more expensive compared to its cost outside of the U.S." It is considered an orphan drug because a small number of people are diagnosed with this specific type of muscular dystrophy. But this is an old drug that is being sold at higher prices – not a new one that went through the research and development process...the reason often given for the high cost of drugs. To make matters worse, patients who were once able "to import the drug from abroad at a cost of about $1,200 per year" can no longer do so since it now has FDA approval for sale in the U.S.

While Congress needs to address these types of issues, pharmaceutical prices and insurance premiums will probably continue to rise as a result of the massive amounts of lobbying dollars paid to elected officials to pad their campaign coffers.

Yes, my experience was frustrating, but it pales in comparison to what occurs when many people attempt to navigate our complex health care system. At least I know where to start and which questions to ask. One thing is certain. This incident has given me a whole new meaning to the fervent prayer, "Oh God, grant me patience but please hurry up!" May we all learn the tough lesson of patience...and then practice it. Good luck!

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