THE BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY

MAY/JUNE 2014

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THE BULLETIN

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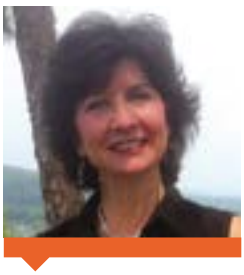

DR. LINDA WORLEY

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ABOUT THE COVER

The watercolor artist for the cover is Floyd Gibson. This piece, "Springtime Nomads," was used for the 2010 Festival of the Arts gift poster. We selected this painting because it shows the actual Festival of the Arts and the 'energy' it generates for downtown Oklahoma City.

The 2014 festival was held April 22-27. This 'rite of spring' has been sponsored by the Arts Council of Oklahoma City for 48 years. The 2014 festival was sponsored by Devon Energy and Chesapeake Energy, and was held at the Festival Plaza and the Myriad Botanical Gardens.

Each year, the festival attracts more than 750,000 people over six days. This year's 144 artists came from all over the United States. The festival features visual arts, performing arts, culinary arts, art for children and a talent show for children in grades K-12. Event co-chairs for 2014 were Charley Cohn and Kathy Bookman.

IN MEMORIAM

Pamela Parrish, MD
1921-2014

OKLAHOMA COUNTY MEDICAL SOCIETY

PRESIDENT'S PAGE

By Julie Strebel Hager, MD

Winston Churchill said, "The farther back you can look, the farther forward you are likely to see." As the environment of medicine changes due to the Affordable Care Act, new business models, and the team approach in delivering patient care, I've maintained that the practice of medicine is still the same. The sense of pride and humility we derive from creating bonds with the patients who entrust their health to us is as present today as it was in days gone by.

At a recent board meeting, we were honored to be visited by Chad Williams, Director of the Research Division at the Oklahoma Historical Society. He was there to present a letter to the OCMS board that was recovered from the Century Chest. The Century Chest is a time capsule buried in April 1913 at a downtown OKC church. It was unearthed in April 2013 and chronicled the events of the day, predictions and correspondence. Business, medicine, law, Indian relations, religion, and culture were just a few aspects represented in those buried treasures. The letter he presented to us was written by the Oklahoma County Medical Association in 1913 and addressed to the physicians one century later. The letter was opened by our immediate Past President, Thomas H. Flesher III, MD, at a recent board meeting. As you will note, the letter was signed by his grandfather, who was OCMS President 100 years ago. You can see the letter on page 12.

Also included in this edition of the Bulletin is another letter from the Century Chest, this one from Lee Riely, MD, forecasting what he thought medicine would look like in 2013. Dr. Riely was President of OCMS in 1909 and served as a faculty member in the first medical school in Indian Territory, Epworth University, which eventually merged with the University of Oklahoma College of Medicine. His insight is remarkable. You can read his prophecies starting on page 12.

The Century Chest will become a permanent exhibit at the Oklahoma Historical Society museum and opened April 22, 2014. Take some time to visit this view of the past.

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DEAN'S PAGE

By M. Dewayne Andrews, MD, MACP

On Saturday, March 8, the 2014 Bridges to Access Conference was held on the OU Health Sciences Center campus. This conference is organized and promoted by the OU Community Health Alliance. The Community Health Alliance is an inter-professional campus student organization that was developed several years ago by College of Medicine students and quickly expanded to include students in other colleges at the HSC (Dentistry, Nursing, Pharmacy, Allied Health, and Public Health). The College of Medicine and the College of Public Health are key contributors and sponsors for the conference with important participation by the State Health Department and other organizations.

It's encouraging to see the concern and energy manifested by the students as they put together this program each year. Elaine Stageberg, medical student, served as the conference chair for 2014. This year their speakers included Steven Schroeder, MD, former president of the Robert Wood Johnson Foundation, now distinguished professor of Health & Health Care, Division of General Internal Medicine at the University of California San Francisco; David Kendrick, MD, chair of the medical informatics program based at the Tulsa School of Community Medicine campus of the College of Medicine; Dale Bratzler, DO, chief quality officer for OU Physicians and associate dean of the College of Public Health; and Sarah-Anne Schumann, MD, associate professor of Family Medicine at the Tulsa campus.

Dr. Schroeder focused on improving the health of Oklahomans and emphasized the role of smoking and the great importance of tobacco cessation programs and health care access issues. Dr. Kendrick reviewed the complex and uncoordinated infrastructure for health care, then showed glimpses of the future in terms of how modern technology (including the power of health information exchange systems) may help us manage individual and population health and potentially increase access to health care. Dr. Bratzler focused on how we measure the quality of health care, and showed us that the quality of health care in many areas may not be as good as we like to think. He demonstrated how accountability and transparency will increase and affect our future practice. He emphasized that we are "at the intersection of cost, quality, and accountability" in U.S. health care. Lastly, Dr. Schumann reminded students that health and

Continues on page 8 …

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health care do not exist in isolation and emphasized how early childhood education and the integrity of the family unit have significant impact on promoting good health practices and outcomes. She also emphasized the cultural aspects of health care.

I was asked to make summary and closing remarks for the conference. After emphasizing the key points raised by each of the speakers, I reminded students that other important issues will have to be addressed, including: the physician workforce shortage, the implications of telemedicine and telehealth, the "for profit" mentality and some of the perverse incentives that exist in American health care, the advancing costs of the Medicare program with an aging population, how will Oklahoma and other states deal with the Medicaid-covered population, and the personal responsibility issues for those receiving health care. Health care professions students are studying and learning in a "system" that is undergoing great foment, change, looming change, and faces many unknowns. This can be anxiety provoking and intimidating, but it is also challenging and exciting. These students have a chance to participate in re-making American health care and fulfilling all of the promise it holds. Let's hope they and we are successful in this vitally important task for our nation!

MEMBER NEWS

DR. CANNON

Joins Oklahoma Workers' Compensation Commission

Jay P. Cannon, MD, was recently named medical director of the Oklahoma Workers' Compensation Commission. He is working with administrative law judges on independent medical examinations and vocational rehabilitation orders, and assists staff and individuals filing claims who have medical questions.

Dr. Cannon served as medical director, associate chief of staff, and clinical professor at the OU Health Sciences Center. He also served as chief of staff of the Oklahoma City Veterans Administration Hospital, and as chief of staff at Integris Baptist Medical Center. He served as president of OCMS in 2007.

Leadership Academy

Graduates of the 2013-14 Leadership Academy were recognized at the group's final meeting in March. Front row. left to right: Amy Bankhead, OCMS Alliance; Elizabeth Jett, MD; Steven Brantley, MD; Betty Tsai, MD; Julie Thompson, MD; Julie Strebel Hager, MD, OCMS President; and Larry Bookman, MD, Academy Advisor. Back row, left to right: Benjamin Pitman, MD; Tabitha Danley, DO; Savannah Stumph, DO; and Ashley Weedn, MD.

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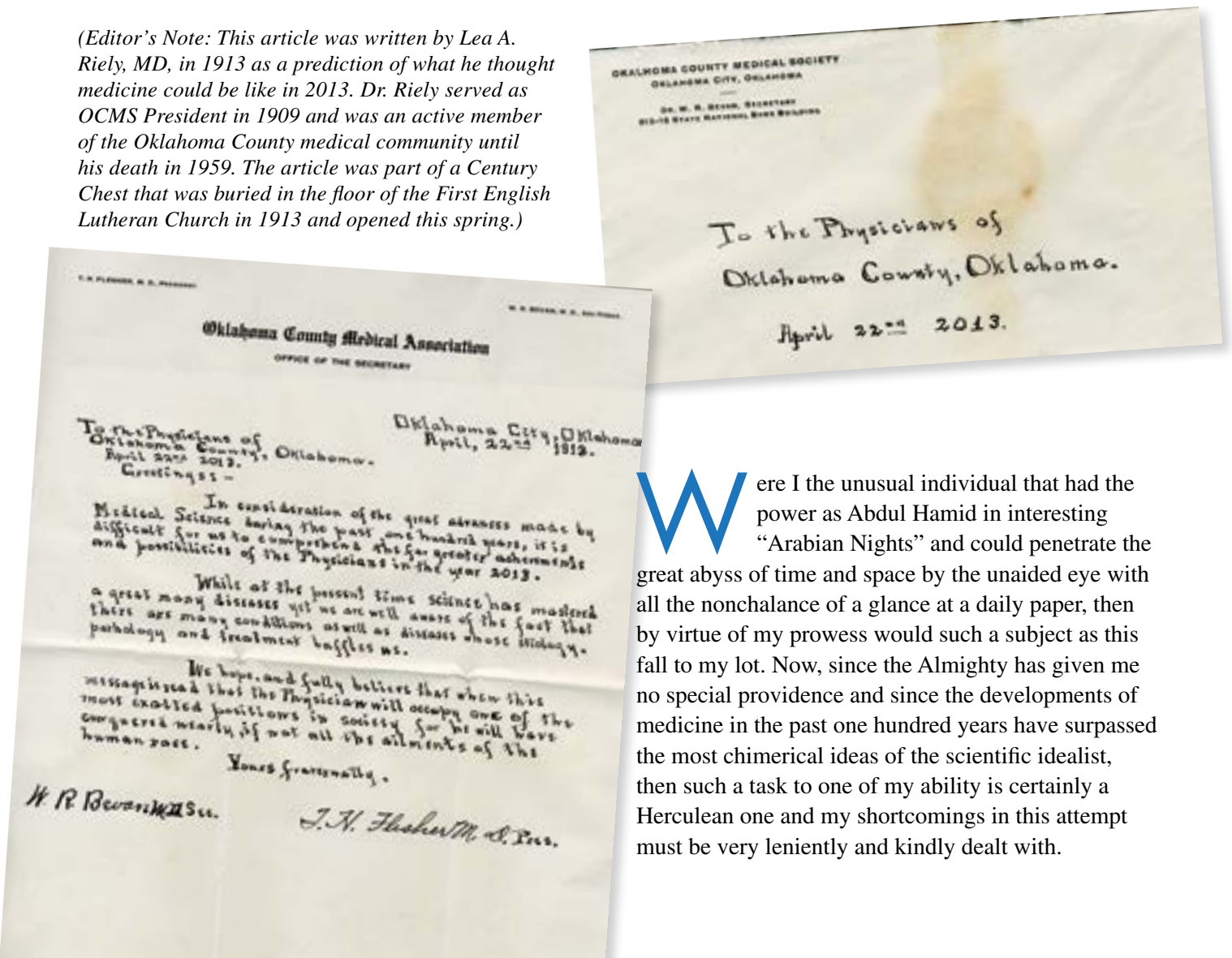
A group of 50-year physicians were honored at the OCMS Membership Meeting in February. Front row, left to right: Henry J. Pearce, MD; James A. Pederson, MD; and Paul E. Massad, MD. Back row, left to right: Carl Rubenstein, MD; Jerry D. Renfroe, MD; and Paul Silverstein, MD.

50-Year Physicians

1913 Conception of Medicine in TWO THOUSAND AND THIRTEEN

BY LEA A. RIELY, MD

(Editor's Note: This article was written by Lea A. Riely, MD, in 1913 as a prediction of what he thought medicine could be like in 2013. Dr. Riely served as OCMS President in 1909 and was an active member of the Oklahoma County medical community until his death in 1959. The article was part of a Century Chest that was buried in the floor of the First English Lutheran Church in 1913 and opened this spring.)



OKLAHOMA COUNTY MEDICAL SOCIETY
OKLAHOMA CITY, OKLAHOMA

To the Physicians of
Oklahoma County, Oklahoma.
April 22nd 2013.

Oklahoma County Medical Association
OFFICE OF THE SECRETARY

Oklahoma City, Oklahoma
April, 22nd 1913.

To the Physicians of
Oklahoma County, Oklahoma.
April 22nd 2013.
Greetings -

In consideration of the great advances made by Medical Science during the past one hundred years, it is difficult for us to comprehend the far greater achievements and possibilities of the Physicians in the year 2013.

While at the present time science has mastered a great many diseases yet we are well aware of the fact that there are many conditions as well as diseases whose etiology, pathology and treatment baffles us.

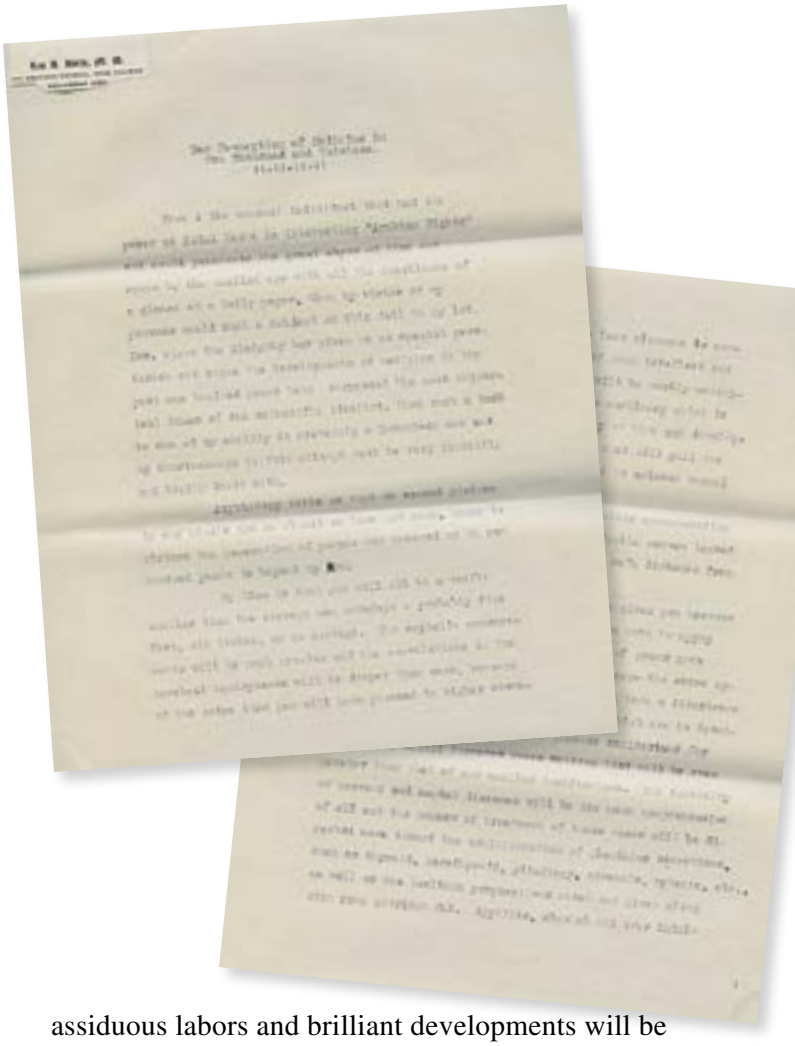
We hope, and fully believe that when this message is read that the Physician will occupy one of the most exalted positions in society for he will have conquered nearly, if not all the ailments of the human race.

Yours fraternally.

W. R. Beverly M. D. Sec.

J. N. Fisher M. D. Pres.

Were I the unusual individual that had the power as Abdul Hamid in interesting "Arabian Nights" and could penetrate the great abyss of time and space by the unaided eye with all the nonchalance of a glance at a daily paper, then by virtue of my prowess would such a subject as this fall to my lot. Now, since the Almighty has given me no special providence and since the developments of medicine in the past one hundred years have surpassed the most chimerical ideas of the scientific idealist, then such a task to one of my ability is certainly a Herculean one and my shortcomings in this attempt must be very leniently and kindly dealt with.



Psychology tells us that we cannot picture in our mind's eye an object that we have not seen, hence to picture the generation of people who succeed us in one hundred years is beyond my ken.

My idea is that you will all be a trifle smaller than the average man nowadays – probably five feet, six inches, as an average. The cephalic measurements will be much greater and the convolutions in the cerebral hemispheres will be deeper than ours, because of the extra time you will have pursued in higher education. Your physical being will be less vigorous to compensate for the extra development of your intellect and the fact also that your hard work will be mostly accomplished by dexterous and almost human machinery which is bound to be developed in this century of time and development. Yours will be the master mind that will pull the lever or push the button for much that is arduous manual labor at present.

This will cause strain in ocular accommodation which will occasion the presence of a double convex lenses in front of all your eyes to keep you a safe distance from the object to be seen.

The complimentary terms I have given you because of your unusual developments mean that you have to apply yourselves the harder and make two blades of grass grow where only one grows in this generation; hence the extra application and nervous tension expended will have a disastrous effect and the new psychoses and neuroses which are to develop will be legion. You will have immense sanitoriums for nervous and mental diseases whose waiting list will be even greater than that of our smaller institutions. The specialty of nervous and mental diseases will be the most comprehensive of all and the manner of treatment of these cases will be directed more toward the administration of glandular secretions, such as thyroid, parathyroid, pituitary, adrenals, splenic, etc., as well as the lecithin preparations which are given along with some nutrient fat. Syphilis, alcohol and overindulgence in animal pleasures will play a smaller etiological role than does the mental or nervous factor in mechanical and scientific applications. So the price of your assiduous labors and brilliant developments will be paid for by a great toll on your nervous integrity.

The greatest advantage you will have over us is the change brought about by government insurance which, when that occurs, means that all physicians will become government employees with plenary powers to regulate and impose severe penalty on all acts which violate the strict sanitary laws which are then in vogue.

The individual, being a ward of the government, when sick must so conduct his business and maintain his premises as to minimize his chances of harboring any infections or contagious diseases. The amount of water per capita in daily consumption will be sufficient to keep all cities immaculate. Typhoid fever will be known to you only as a matter of medical history, not being described in your textbooks then but fully elucidated in the musty volumes of second hand book stores. You will read that in the time of your fathers a genuine crusade had been waged against this

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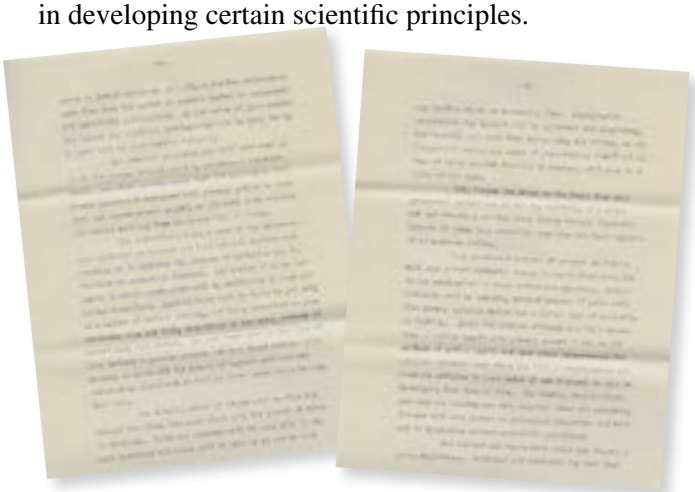
disease in which all the ejecta of typhoid patients was cremated or sterilized so that no other cases could develop from them.

The drinking water of cities will be fine and brought from long distances where only the purest of water is obtained. Wells and cisterns will be used only in *(words cut off)* and these will be made so as not to have any surface water contaminating them. Prophylactic vaccination for typhoid will be universal and compulsory. The housefly will have been driven away and killed, so the disease, not having any means of perpetuating itself and no ways of being carried from one to another, will soon be a thing of the past.

Col. Gorgas has shown on the Canal Zone what government control can do for the morbidity of a place and has brought a country which France thought impossible because of miasm to a morbidity less than the best regulated of American cities.

This government control of general sanitation will mean a most wonderful change in man's expectancy due to the eradication of acute infectious troubles. Infant mortality will be markedly reduced because of purer milk from purely hygienic dairies and a better idea of scientific feeding. Among the Cabinet officers will be a Secretary of Public Health with plenary powers to act on all matters of public health and have great laboratories for original research work along the line of prophylactic and curative medicine in such cases of new diseases as will be developing from time to time. The brainy, well-equipped men over the country who have original ideas and promising futures will have access to government properties and will aid in developing certain scientific principles.



One hundred and twenty-five years ago, Jenner, a young Englishman, developed and expounded the fact that English dairy maids with cow-pox did not develop smallpox, while everyone else did when exposed. It was a hard thing then to realize that such a thing then was or ever could be possible. Wright of London now comes forward with the opsonic theory, wherein the serum and white cells are able to combat the invading germs better by the injection of dead germs. Now the soldiers of the American and English armies are almost to a man vaccinated with the dead germs of the typhoid fever and the dreadful scourge of this disease has been almost eliminated.

This line of treatment will be more in vogue in your day than ours and the children of your time will have prophylactic doses of the bacteria of scarlet fever, tuberculosis, syphilis, measles and pertussis, as the children of our day are vaccinated against variola.

When you have succeeded in giving prophylactic or immunizing doses to people for tuberculosis and syphilis and can show results to any degree of certainty then you will have compulsory vaccinations for these diseases and a most wonderful decrease in mortality, and most everyone will live to the psalmist's allotted three score years and ten. Your eleemosyary and penal institutions will be decimated. This saving of your public moneys can be then diverted to development of scientific principles in behalf of the state's welfare.

Your most brilliant avenue of work will come from the better understanding of serums developed from lower animals and injected into human beings for most of your ills, and will be your chief source of therapeutics. This will supplant the many mixtures now set forth by the National Formulary and give results quickly in supposedly self-limited and long drawn out complaints. The question of anaphylaxis will be known well so that these sudden and unpleasant reactions will be of the very rarest occurrence.

Along with the work on serums will be the understanding of the workings of different strains of live and dead bacteria, as well as their filtrates. These will be used more in the prophylaxis than in treatment, except for chronic inflammatory troubles. The results obtained from vaccines will be even more brilliant than from serum and then possibilities are greater.

Cancer and all malignant growths will have been found to result from microbic origin and then it will be a matter of possibly some serum to relieve inroads on healthy tissue and restore these to normal condition, relieving old age of many of its horrors.

Were I to sleep one hundred years and on awakening seek out some large hospital (for in those days the hospital will be the place for all sick people) in which to attend a surgical clinic, I would find the methods changed some little as to technique. The operator would show cases of brain surgery and his operative findings would prove what masters of diagnostic skill they had attained. The inner recesses of the brain could be invaded with impunity and with accuracy. After having been shown several cases of brain surgery we would then be shown some cases of heart or lung surgery where stenosed valves were cut and their proper functions obtained. Fibrous adhesions and atelectatic lungs would be deftly handled so as to restore their normal function. The transplanting of various glandular organs from lower animals would wind up the clinic. The surgeon would tell us that since the more scientific study of medicine from research work wonderful inroads had been made on all branches of surgery and that all acute inflammatory conditions were not operable cases because of the vaccine and serum treatments then in vogue. Appendicitis would not then be known, because in the evolutionary process the appendix will have disappeared.

On going to the obstetrical wards, I would find that all women were confined in these large hospitals and that Caesarian section was performed much more frequently than forceps deliveries, with almost an absence of infant mortality, while the mother's life was not jeopardized at all.

The method of obtunding the sensibilities was mostly by local measures with either nitrous oxide or some similar gas to begin with.

In this Utopian dream of a century later I am sure the practice of medicine will be at a very high standard, that quacks and charlatans will be unknown and everyone's work will bear the scrutiny of the limelight. Every physician must be a graduate of the state schools where the various phases of practice are studied. Mental medicine will be one of the specialties and massage will be properly carried

on by those trained in such art. Electricity will be used for diagnostic and therapeutic measures. X-ray will have simplified diagnosis so as to be a constant accompaniment of every diagnostician in his work.

Skin reactions and agglutinations will still further make our work more accurate and medicine will veritably be a science, and every disease will have accurate laboratory findings which will be more accurate than our Waserman reactions of this age and day.

The physician will have charge of a certain number of people whose duty it is to keep them well, as well as to cure their infirmities. The number of specialists will not be any more, if as many as now. The man who commands the biggest attention will be the bacteriologist. The nicest phase of your system of medicine will be that you are paid by the state and will not have to have the many trials and vexations with which the physician of today is bothered in collecting his bills.

We hope that our ideal both as to physician and people will be realized and that they will have risen by this century of research until nothing could be impossible for them to accomplish and may my ashes rest in peace among such a cultured people where peace and prosperity, friendship and love universally abounds.

Lea A. Riely, MD - Oklahoma City, Oklahoma

NEWS

Laura Emamian: 2014 OCMS Medical Student Scholarship Winner

Laura Emamian, a third-year medical student at the OU College of Medicine, was recently named the 2014 Medical Student Scholarship winner by the Oklahoma County Medical Society through the OCMS Community Foundation. The $10,000 scholarship will go toward her fourth-year tuition.

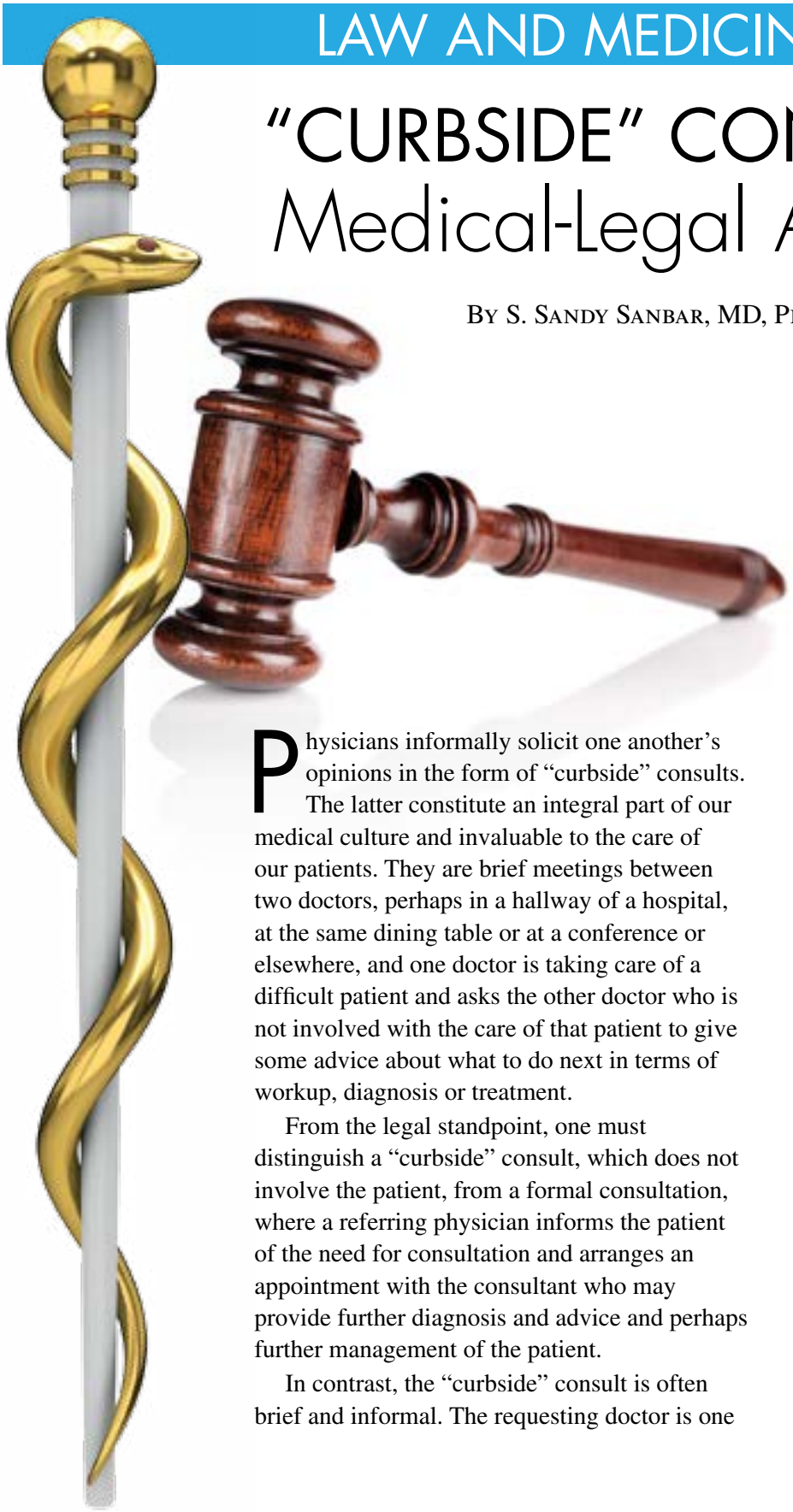
Laura was born and raised in Oklahoma. She graduated from Baylor University magna cum laude in 2009 in 3½ years with a bachelor's degree in health sciences. She earned a master's degree in global health and public policy at the University of Edinburgh in Scotland, returning to Oklahoma to attend medical school. She plans to focus on pediatrics in her medical practice and advocating for policies that will improve health outcomes for children.

As a medical student, Laura volunteers at local free clinics, community health fairs, and local schools. She is a member of OCMS/OSMA and the American Medical Association. She is married to Stewart Finlayson, whom she met while attending school in Scotland. They plan to live in Oklahoma City after she completes her residency training.

The Oklahoma County Medical Society takes applications for this scholarship in January from third-year medical students at the OU College of Medicine. Applicants must have been a resident of Oklahoma County for at least five years. This year's OCMS scholarship review committee included Drs. Doug Folger, Don Wilber, Anu Bajaj and Tomás Owens.

"CURBSIDE" CONSULTS: Medical-Legal Aspects

By S. Sandy Sanbar, MD, PhD, JD



Physicians informally solicit one another's opinions in the form of "curbside" consults. The latter constitute an integral part of our medical culture and invaluable to the care of our patients. They are brief meetings between two doctors, perhaps in a hallway of a hospital, at the same dining table or at a conference or elsewhere, and one doctor is taking care of a difficult patient and asks the other doctor who is not involved with the care of that patient to give some advice about what to do next in terms of workup, diagnosis or treatment.

From the legal standpoint, one must distinguish a "curbside" consult, which does not involve the patient, from a formal consultation, where a referring physician informs the patient of the need for consultation and arranges an appointment with the consultant who may provide further diagnosis and advice and perhaps further management of the patient.

In contrast, the "curbside" consult is often brief and informal. The requesting doctor is one in general medicine and the other is a specialist or another general physician or specialist who has had a similar case. In this brief conversation, the requesting doctor will attempt to present some of the facts (history, physical findings and labs) that the doctor can recall and present in a few minutes or less and then will wait for advice and suggestions made by the "curbside" consulting doctor. The patient is usually unidentified and the case is usually unknown by the "consultant." This activity is considered and performed as a "professional courtesy," a friendly and perhaps expected professional communication between two doctors, in which the "consultant" is not providing the advice for any fee and has no intent to provide direct management to the patient under discussion. The patient is unaware of the consultation and may not be told later.

The requesting physician may be motivated to ask for a "curbside" consult to obtain advice for no monetary charge

Story continues on page 22

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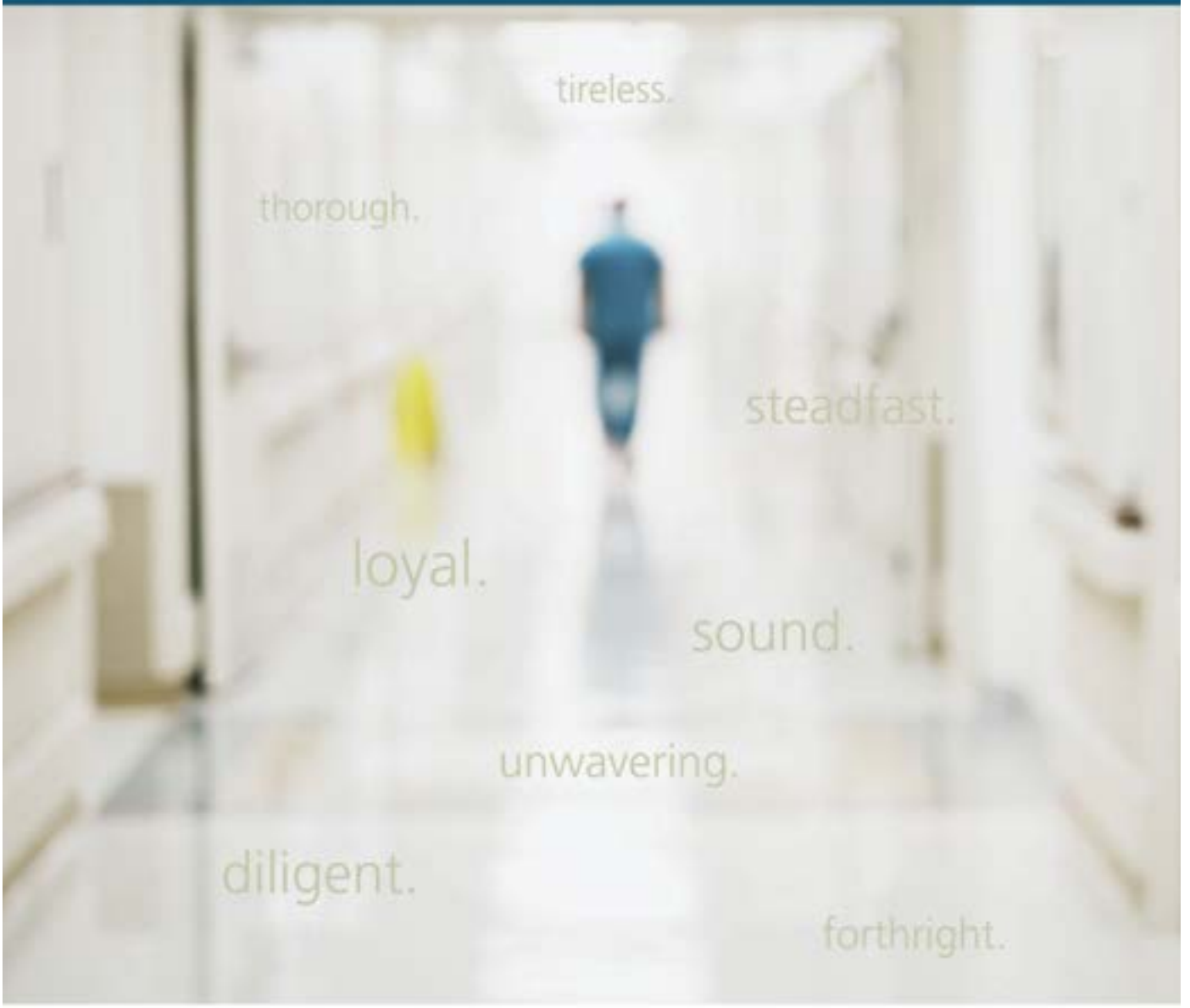

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Aspirations of Perfection

By Alex Raines, MD

Have you ever eaten an orange only to have it turn into a complete disaster? The peel doesn't want to separate from the fruit, the planes between the slices don't seem to exist, your hands are full of mush, and, before you know it, there's juice in places that should be dry. And after it all, you have yet to even taste the sweetness.

That became a reality for me the other day. As I was walking to the bathroom to get cleaned up, I crossed paths with one of my attending surgeons. We shared a laugh as I explained my blunder. He said, jokingly I hope, "Well, Dr. Raines, it sounds like you eat oranges the same way you operate."

As a general surgery resident, my mind started to wander as the proposed analogy was quite applicable to the training of our craft. And, in a much broader sense, it could be applied to medical residencies in general. Sometimes things don't go well despite our best intentions and efforts. Does that mean we're inadequate doctors?

July always marks a time of excitement and anxiety alike. The focus of the new transitions in residency usually lies with the fresh batch of medical students-turned-physicians. But, as graduated responsibility and increased autonomy are awarded to the more experienced residents, transitions apply to all residents. With that increased level of responsibility for all, certain amounts of success and frustration are equally inevitable. Victories of patient improvement, education, and enhanced efficiency are often balanced by less than desirable outcomes.

Medical trainees enter medicine with aspirations of perfection. We want to make every diagnosis, prevent every complication, and heal every patient. Anything resulting in less than these high standards makes us feel like failures. Especially demoralizing are the cases we seem to fumble, only to have a more experienced physician step in and save the day with seemingly little effort. These feelings of inadequacy can sometimes escalate to a feeling of fraud – a dolt masquerading in a long white coat. However, it is important that both the residents and those teaching them realize that every physician has walked those humbling steps out of a room where their best wasn't yet good enough. Perfection is a fleeting notion; we all continue to strive for it, getting closer and closer every day, only to realize that grabbing hold of it is impossible. This is true even for the most brilliant.

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THE PEARL

GAMBLING ADDICTION

By S. Sandy Sanbar, MD, PhD, JD

In 2014, it is estimated that some 200 million people bet more than $10 billion on the Super Bowl, arguably the biggest one-day betting event in the world. Gambling has become a major source of revenue for states that endeavor to plug gaping budget holes. What impact does gambling have on the health and welfare of state citizens?

An estimated 6 million Americans suffer from gambling addiction, which can lead to financial ruin, destroyed relationships, health problems and criminal activity. The number of patients struggling with gambling problems is growing. The ubiquitous nature of gambling is a major force driving the increase. Forty-three states, the District of Columbia, Puerto Rico, and the US Virgin Islands have lotteries, and 39 states allow some form of legalized electronic gaming, including traditional slot machines, video poker and bingo at Indian casinos, commercial casinos, racetracks, or other establishments.

In 2013, people placed 313,000 calls for help to the National Center for Responsible Gaming (NCRG) hotline (1-800-522-4700). This number has been steadily increasing at a rate of 10% per year for the past decade. The NCRG estimates that by 2018 100 million people will have a gambling account on their mobile phones.

In 1980, the Diagnostic and Statistical Manual of Mental Disorders (DSM) first included gambling as a disorder. It is a psychological impulse control behavioral problem. It is also referred to as "gambling addiction," "problem gambling," "pathological gambling," and "compulsive gambling." In 2013, the American Psychiatric Association (APA) recognized the severity of the gambling problem in its latest DSM-5 by placing it into a new category called "Addictions and Related Disorders," along with more commonly known substance-related addictions. Currently, individuals suffering from this affliction, and other impulse-related disorders, require treatment for their gambling addiction.

Gambling is no longer regarded as a merely financial or moral problem. It is an addiction, a chronic disorder that can contribute to depression, coronary heart disease, hypertension, disrupted sleep patterns, ulcers, and drug abuse. Gambling triggers a reward stimulus in the brains of problem gamblers similar to that experienced by individuals addicted to substances. Patients with gambling addiction have a need to gamble with increasing amounts of money to achieve the desired excitement. They exhibit restlessness or irritability when attempting to cut down or stop gambling. They

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to the patient. The requesting physician may repeat communication with the "curbside" consultant as a courteous follow-up report. The "curbside" consultant may be motivated to participate in hope of being considered by the referring physician for later formal care. However, if the requesting doctor may be looking for additional advice, repeated follow-up informal consults may not be appreciated by the consult doctor both out of concern for the proper care of the patient and for the consulting doctor's own financial interest.

At law, "curbside" consults have on some occasions led to malpractice actions taken upon the consulting doctor as well as the requesting doctor if serious problems in the patient's management occur. Laws defining malpractice issues in this form of consultation may vary from state to state. The consulting physician's name may have to be noted in the patient's medical records. The threat of malpractice may discourage such consultations. However, Oklahoma medical malpractice law generally requires the creation of a physician-patient relationship which is established by a face-to-face encounter.

Finally, federal HIPAA laws regarding privacy of patient's protected health information, identified by name or not, permit informing another individual who is not directly attending the patient for care or responsible for insurance payment.

In sum, "curbside" consults do raise ethical and legal obligations to patients, a sense of duty to colleagues, and the physician's own legal well-being, but they should occur as often as needed and to whatever degree that is necessary for proper patient care.[1]

1 *Legal Risks of "Curbside" Consults. Am J Cardiol, 2010 Jul 1;106(1) 135-8 Epub 2010 May 13.*

PAUL PATZKOWSKY, MD

By Charles E. Womack, MD

I met Dr. Pat as a medical student. He was an appointed doctor for the Santa Fe Railroad employees and my father worked for Santa Fe. My parents had seen Dr. Pat and told him about their son, the medical student. He expressed to them an interest in meeting me, so I made an appointment and met him during an office visit.

We became friends right from the beginning. He encouraged me in medicine and asked if I would like to shadow him at the hospital and scrub with him in surgery. At the time, I was working as an orderly at Deaconess Hospital, which was his primary hospital of practice.

Dr. Pat was one of the last of the primary care physicians who did a full range of surgery. His training after medical school consisted of three years of surgery residency. He 'left' the surgery program when he told the head of the department that he wanted to practice Family Medicine and Surgery. This revelation did not set well with the chief of the department and Paul gave up a general surgery career for family practice.

He loved surgery and was an excellent surgeon. He taught me many things in general surgery that I incorporated into my practice. We helped each other on many cases through the years.

I worked as an orderly from 7 am to 3 pm and Dr. Pat would schedule his surgery cases after office hours. I scrubbed with him on many cases while in medical school. What a thrill for a medical student! One afternoon while I waited for him, the head O.R. nurse asked me into her office. She proceeded to tell me I could no longer scrub with Dr. Pat. The reasons were obscure and I was devastated. When he arrived to the surgery dressing room and saw me NOT dressed in my scrubs as usual, he asked why. When I told him what had happened, he was furious. He told me to get ready for surgery and he would be back. He returned shortly and said he 'had taken care of the issue and it would never happen again.' It never did.

In 1974, I entered the U.S. Army as a general medical officer. I served one year in South Korea and one year at Ft. Sill. At this time, Dr. Pat and Dr. McLendon had left their old clinic and were heading in separate directions. Dr. Pat asked me to dinner a few nights before I left for Korea. He told me he had something to show me after dinner. It was the artist's rendering of a new medical clinic to be built at 2915 Pine Ridge Road, on property owned by Dr. Pat adjacent to his restaurant, The Wine Cellar. He said it would take another two years before the clinic would be ready to open. That would be the exact time I would be leaving the Army for private practice.

Story continues on page 30

AN UNEXPECTED SURGERY

By David W. Foerster, MD

Sports car racing is a most unusual avocation for a plastic surgeon. However, for a 17-year period I was mesmerized by the excitement and glory before finally coming to realize that it wasn't a very smart thing to be doing! I drove mainly for the Datsun (Nissan now) dealer in Midwest City and later for Alfa Romeo where I had the dealership in Oklahoma City.

Sometime in the spring of 1968, I read about a new race held near Roswell, NM, at the Bottomless Lakes State Park. It was named "Los Ocho Millas" or The Eight Miles and covered a natural road course through a three-mile stretch of the park's valley, and then five miles through the low surrounding mountains, and then down into the valley.

The article was written by a TR-3 (Triumph sports car) driver who was very proud of the fact he had averaged 90 mph on a few laps of the Regional (Amateur) race. I certainly was impressed as the TR-3 was in the same class as was my Datsun 1600 sports car.

At that time, the U.S. was divided into eight regions and New Mexico was in the Southwest division as was Oklahoma (also Texas, Kansas and Arkansas). So when a Regional-National (semi-pro) race was scheduled that summer at Bottomless Lakes we decided to go.

Arriving early on Saturday morning and after tech inspection, all drivers were piled onto a flat-bed truck and driven around the course at a slow speed. My impression was how in the world did that TR-3 go so fast, as the course was twisty through the mountains and a little so even in the valley.

We were then allowed to practice (for only a few laps due to time restrictions) and like most National drivers I used the Regional race that afternoon for more practice time.

After practice Sunday morning, we were timed and gridded by lap times. My Datsun was in the F production race and we were combined with the faster D production cars. This was often done to reduce the number of races and to be sure all classes were fitted into the time schedule. There were about eight FP and eight DP cars, which made a reasonable overall number for the spectators.

I was gridded fourth with three DP cars in front of me and the rest of the pack behind based on practice lap times.

When the green flag dropped and the race began through the valley, the three DP cars began to stretch out from me so that the third DP car (an Alfa Romeo) was about 100 to 150 yards ahead of me as he entered the first turn into the mountains.

It was then that disaster struck. He apparently entered too fast, went off the narrow two-lane road, hit some rocks, and did a 360 flip in the air, crashing down right side up. He was slumped over and the back

end of the car was on fire from slopped-out gasoline. The corner crew threw a red flag to stop the race just as I passed them and stopped behind the injured driver. He was obviously unconscious but there was no time for evaluation because of the fire. I jerked his seat harness loose, pulled him out of the car and dragged and lifted him to the opposite side of the road. He had a heart beat but was totally unable to breathe. Nothing was in his mouth and I couldn't compress his chest (CPR was not yet known). The corner crew had put out the fire and I yelled at them to bring me the sharpest pocket knife they had. I grasped his trachea beneath the larynx and cut between the cartilage. I told the corner chief to cut the end of a ballpoint pen and give it to me. I slipped it into his trachea and then by compressing his rib cage I was able to get an exchange of air. About that time the track ambulance had arrived and they had a tracheotomy set which I put into place and attached a Bougie bag which made the aeration process much easier. He was then taken to the Roswell hospital. Many days later we learned that he had had a very high cervical laceration of his spinal cord (a deceleration snap from the impact that flipped his car) causing complete quadriplegia and knocking out his respiratory capacity. Mercifully he died that evening.

After the ambulance left and not knowing the final disposition of the driver, the chief steward brought all the cars back to the start/finish line and told us to line up as we were when the race was stopped. I lined up in the Number 3 spot at which time the chief steward came running over and told me I had to start last! I said, "Why in the world are you doing this?" and he said, "Because you ran through the red flag." I implored that I did this to aid the stricken driver but to no avail, as he said rules are rules with no exception. Needless to say, I was furious so I drove like a possessed demon (in spite of what had happened earlier), began turning lap times over 100 mph, beat all the FP cars and most of the DP cars.

Later that year, at the national meeting of the Sport Car Club of America, I was given a huge trophy for my sportsmanship and performance far beyond the call of duty. I wonder what that chief steward thought when he found that out? Perhaps he realized the whole organization was giving him a one-finger salute!

The tragedy that happened that hot and dusty afternoon was far more significant than arguments and trophies. Eventually natural road races were eliminated and racing was confined to airport courses or carefully constructed road courses with emphasis on driver safety. Although this helped considerably, there is still risk when cars are driven at the limit of adhesion, but as long as there are cars, there will be drivers willing to take that chance.

DIRECTOR'S DIALOGUE

By JanaTimberlake, Executive Director

"History never looks like history when you are living through it."

– John W. Gardner, American novelist

The Century Chest Exhibit, now on display at the Oklahoma Historical Society, has special significance to the Oklahoma County Medical Society. A letter from the Society, signed by Thomas H. Flesher, MD, 1913 OCMS President (and grandfather of our Immediate Past-President Thomas H. Flesher, III, MD), and a prediction of how medicine could evolve in the next 100 years by Lea A. Riely, MD, were included with items buried in the chest and sealed in a basement floor of the First English Lutheran Church on April 22, 1913, not to be opened for 100 years. If you have not seen the exhibit that opened recently, you are encouraged to see the historical items that will give you a glimpse of Oklahoma in 1913.

Physicians have been amazed at the number of Dr. Riely's predictions that were correct. Since the only thing I knew about Dr. Riely is that he served as the Society's president in 1909, I began to search for additional information. He was born in Indiana in 1874, graduated from the University of Louisville School of Medicine in 1898, was elected as a faculty member of Epworth University (the first medical school established in Indian Territory in 1904), and he remained an active member of organized medicine until his death in 1959. He served many years as a member of the Society's Board of Censors, overseeing new members accepted into this organization. In the September 1935 Bulletin article, H. Coulter Todd, MD, recalled his first society meeting:

"I well remember the first Oklahoma County Medical Society that I attended. We met in various offices of the members. This was in the year 1903, when our County organization was about two years old. There were eight or ten men present."

Dr. Todd also stated that Dr. Riely "presented one of two papers that were such splendid well written theses. I must tell my readers that after hearing these two excellent addresses my mental superiority complex or whatever it might have been had completely gone."

While searching for information about Dr. Riely, I read an editorial titled, "The Oklahoma County Medical Society 1907-1957" in the September 1957 Bulletin. Some of the article's highlights are below:

In 1907, the Society raised its dues to $6 per year and contributed $25 to buy a pair of storks for the zoological museum at Wheeler Park.

In 1919, the Society vigorously endorsed the national campaign against the misuse of narcotics, organized a venereal disease control board to function in cooperation with the state board of health, and appointed a committee to help in obtaining safe milk for Oklahoma County.

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YOUNG PHYSICIANS

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An associated lesson learned over time is that not all cases are equal. There are many cases that are seamless and straightforward, like a perfectly formed orange. The planes are obvious and the components need only the slightest effort to separate. Yet, sometimes we still manage to mangle and mush them. Experience, however, affords us the ability to make this scenario ever more rare. There are other cases, though, that are not so simple; the patient makeup isn't textbook and sometimes the fruit is downright rotten. Both extremes and everything in between will be experienced.

Total perfection is impossible for even the most dedicated and skilled. As difficult as this may be for a group of over-achievers to admit, this is an important reality that residents and their educators alike need to accept. This acceptance will facilitate more effective teaching and learning which will ultimately result in improved patient care. As long as we don't settle for mediocrity and we work hard to get better every day, we should hold our heads high even in the face of failure. We will never become perfect. But, that shouldn't keep us from trying!

THE PEARL

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have repeated unsuccessful attempts to control or stop gambling. About one out of five gambling addicts attempt suicide; a small number succeed.

Many gambling addicts are able to curb their addiction without professional help. Friends, family and loved ones can be very helpful, as are Gamblers Anonymous meetings, though not as readily available as Alcoholics Anonymous meetings. States provide less treatment money for gambling addiction than for substance abuse.

Primary care physicians can be instrumental in helping patients with gambling problems access treatment. They should hang an educational poster about problem gambling in the waiting area or the examination room to prompt a conversation. They should screen for gambling addiction, just as they do for substance abuse by asking their patients if they gamble. If so, ask if they have ever lied about how much they gamble. And ask if they ever felt the need to bet more and more money. If so, the doctor should refer the patient to a gambling problem therapist and/or provide the patient with the NCRG hotline (1-800-522-4700) to inquire about self-help resources and local counselors.

The US Food and Drug Administration has to-date not approved any pharmacologic treatments for gambling addiction. However, it is possible that some drug used to treat substance abuse, such as selective serotonin reuptake inhibitors and opioid receptor antagonists, which target reward pathways in the brain, may benefit some patients with gambling addiction.

Gambling addiction treatment helps people develop coping and refusal skills and address the underlying issues that lead them to gamble. The treatment often includes cognitive-behavioral therapy and participation in a 12-step program.

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Contact: Tracy Senat,
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OCMS
OKLAHOMA COUNTY MEDICAL SOCIETY

IN MEMORIAM

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"Do you have any plans for practice after your return?" he asked. "Would you like to practice with me? If so, pick out a suite in this new building and it will be yours." I said yes! No money. No buy in. Just a handshake. He let me pick the suite I wanted, which I was able to decorate and furnish as I wished. It was ready for me when I got out of the Army. We practiced together in that building for over 20 years.

Dr. Pat was dearly loved, even adored, by his patients. He would take as long with each patient as they needed, even an hour if necessary. He was hands on, passing out hugs when appropriate. Needless to say, he often ran late on his schedule, but patients rarely complained. In fact, they expected it! Patients often would wait to see him, rather than seeing the 'new' doctor without waiting. He knew everything about his patients' medical histories, their lives and their families.

Paul loved to laugh and joke. He actually threatened to 'spike' the punch at my wedding. Indeed, the church hostess told me later that a man tried to spike the punch, but she had intervened. I smiled to myself, knowing this would not have set well at Putnam City Baptist Church!

Paul loved the University of Oklahoma and OU football and would often offer me tickets to the football games. He loved to go to Lake Eufaula with family and friends to boat and fish. He loved his family and enjoyed life. Of course, he had his disappointments in life, but Paul always kept his word. He was a great mentor, friend and practice partner to me. His presence will be missed, but his memory lives on. Paul, we miss you.

THE BULLETIN

DIRECTOR'S DIALOGUE

Continued from page 27 …

After heated arguments, the annual dues were raised to $12.50 in 1920; and Oklahoma City's considerate mayor granted special traffic privileges to society members whose automobiles carried a uniform medical emblem. During that year, the society was host to the 800 members of the State Medical Association. A high point in the meeting was a symposium on the technique and indications for blood transfusion.

In 1923, the society was proud of its balance of $1,330.79 in the treasury but the members were more enthusiastic about the revolutionary treatment of diabetes with insulin and the new anesthetic called ethylene.

The editorial concluded, "Looking back over the brilliant history of our society, there is the usual tendency to assume that the younger generation is going to the dogs. We see the past as a process which culminates in ourselves and feel subconsciously that history will end when we die. Fifty years is a long time, longer than most men practice medicine, and the course of the County Society during this half century has been a good one. The current problems are probably no greater than those already met by our predecessors. Let us hope that the next fifty years of the County Society is equally successful."

The history made by the past leaders of this Society never looked like history while they were living through it. Victor Hugo once wrote, "What is history? An echo of the past in the future; a reflex from the future on the past." During the long, hot summer ahead, take some time to reflect on the past!

THE BULLETIN

THE POET'S SPOT

Our Bed

(Sonnet of an Aging Couple)

By Hanna Saadah, MD

A buoyant cloud of dreams suspends our bed
Your purring breaths sing poems in my ears
You kitten stretch then rearrange your head
And gaze through curtained eyelids at our years.

Your liquid skin invites my fingertips
I gaze and almost touch but then refrain
So near you are and yet your essence slips
Into the whispering darkness like the rain.

One day we will awaken, calm and cold
To find that we have grown abruptly old
And cheeks that once were apple-lush and tight
Will crawl like swarming ants into the night.

But youth remains a blossom in my mind
And love, alive, with joys youth cannot find.

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