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The Oklahoma County Medical Society

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About the Cover

The wood carvings pictured on the cover of the Bulletin this month are reproduced by permission of Mr. and Mrs. Loyd Brown who purchased them in a handicraft market in La Paz, Bolivia, the highest of the world's capital cities 11,800 feet above sea level. The figures were made by artisans of a native ethnic people, the Aymara from the Altiplano (high plateau) near La Paz. Bolivia is 55% indigenous (primarily Aymara and Quechua). The Aymara's ceremonial dress is hand woven with yarn produced from their herds of sheep, llama and alpaca. The yarn, dyed using colors produced from extracts of local plants and fruits, is hand spun. The cloth is woven, according to Mr. Brown, on homemade hand looms. During most of the Spanish colonial period, this territory was called "Upper Peru" and was under the authority of the Viceroy of Lima. Independence was proclaimed in 1809 and on August 6, 1825, the republic was established and named for Simon Bolivar. In pre-Columbian Bolivia a major civilization had been developed by the Tiwanaku which exerted influence over a wide area of South America from A.D. 250 to 750. Their great art was weaving. The Tiwanaku produced ponchos, caps and other costume pieces that are instantly recognizable. ❑

In Memoriam

David J. Chesler, MD
1920 – 2009

George H. Jennings, MD
1925 - 2009

Leon N. Gilbert, Jr., MD
1918 – 2009

James C. Spalding, MD
1925 – 2009

President's Page

Teresa M. Shavney, MD

Health Care Reform

"Health care reform" continues to monopolize the daily news and the physicians lounge conversations. Opinions differ. No one is really sure what the different bills contain. I do know the bound copy of HR3200 is six inches tall.

What does health care reform really mean? Reports are that the majority of Americans are happy with their health care. It seems that most of the debate centers around access to care and cost. Who among us doesn't think a sick person should receive appropriate, timely and quality care? Who among us doesn't think they already do these things for their own patients?

Current bills (as of this writing) do not adequately address Medicare's sustainable growth rate (SGR) formula. Lest we forget, physicians are facing a 21 percent Medicare payment cut on January 1, 2010. A recent poll by the AMA, AARP, and American Nurses Association found that nearly 90 percent of people age 50 and older are concerned that the current formula threatens their access to care. Repealing this formula is critical to ensure access to care.

Tort reform remains an issue. None of these bills adopt real reform such as caps on non-economic damages and attorneys' fees. On September 17, President Obama instructed Kathleen Sebelius, Secretary of Health & Human Services, to "announce within 30 days that HHS will make available demonstration grants to states, localities, and health systems for the development, implementation, and evaluation of alternatives to our current medical liability system…" Did you know Secretary Sebelius served as director of the Kansas Trial Lawyers Association from 1978-1986?

It is no secret there is a shortage of primary care physicians. Those who think universal coverage would equate to universal access should read an article in the Boston Herald from September 15. A survey by the Massachusetts Medical Society reveals that 40 percent of family medical physicians and 56 percent of internal medicine physicians are not accepting new patients. The average wait time to see a primary care physician is 44 days.

The rhetoric is heating up. Links to summaries of the various bills are on the OSMA home page, www.okmed.org. ***Talk with your patients, friends and families. Encourage them to do their own research. Make your views known to our elected representatives. This is our profession, our livelihood. We cannot let it be changed without our permission.*** ❑

An optimist is a person who starts a new diet on Thanksgiving Day.
Irv Kupcinet

Dean's Page

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

Health care reform is on everyone's mind. No matter what one's personal opinion is, there is a pervasive notion among many if not most of our citizens that health care in this country has reached a state of being at a tipping point with its costs out of control. Some of this is driven by political hyperbole, but who among us could convincingly argue that we have a truly *efficient* health care "system" in this country or that we have a rational payment system for health care? After the August Congressional recess, President Obama began an all out campaign to get his health care agenda in front of Americans. Various forms of legislation are now on the table — some thoughtful, some not so thoughtful.

Some have suggested that if we just improved medical education and residency training we would address the nation's health care problems. That's a naïve notion, even though I agree that we can and should make additional improvements in our education programs. Some ask, "Why don't medical schools "compel" more medical students to choose primary care as a path?" No matter how hard we work to support primary care within the academic medicine community, our efforts will be undermined if the health care reimbursement system continues to undervalue primary care financially compared to specialists who perform procedures. And while we may be able to improve residency training in new ways, there still are not enough residency positions in the U.S. to allow future growth in the physician workforce (which has to be an element of addressing health care needs for the future). The proposed Resident Physician Shortage

Reduction Act of 2009 would increase by 15 percent the number of residency training slots supported by Medicare and offers hope for addressing this issue.

According to the Kaiser Family Foundation Health Tracking Poll taken in mid-August 2009, the features Americans considered most important in the health care reform debate include (1) helping those who can't afford health care insurance by expanding Medicaid and offering financial help to qualified families, (2) protecting consumers by requiring insurance companies to cover everyone and stopping them from dropping people or increasing their rates when they become sick, (3) strengthening prevention programs, and (4) reining in the costs of health care by changing the way doctors and hospitals deliver care and are paid. Physicians will also ask what about tort reform? As of October, tort reform is not in any of the major health care reform bills proposed. This could become a bargaining chip in some of the negotiations that will go on in the Senate and House.

Health care reform is vying for the nation's attention at the same time that the economy remains worrisome and federal expenditures are already projecting huge deficits for the next decade. Huge challenges to be sure – challenges that will need all of our collective wisdom to find an answer. ❑

Pearl of the Month

S. Sandy Sanbar, MD, PhD, JD, FCLM
Chairman, American Board of Legal Medicine
Adjunct Professor Medical Jurisprudence, TUN
President, American Board of Medical Malpractice
Past President, American College of Legal Medicine

The Pearl of the month column by Dr. Johnny B. Roy has been most successful over the years it has been published. When Dr. Roy graciously asked me to contribute to his column, I researched medical-surgical pearls Online and came up with Dr. Michael Ross's Medical Pearls of Wisdom.[1] They are straight to the point one liners and short statements that have been around serving physicians well for many years. Here are some of those medical, surgical and medical-legal pearls:

- Choose your spouse carefully. From this one decision will come 90% of your happiness or misery.
- Too much time with your practice – you lose your spouse. Too much time with your spouse – you lose your practice. Find the balance or you lose your mind.
- If you love your license, don't love your patient.
- If all else fails, look at and talk to the patient.
- Listen to the patient; he's telling you the diagnosis.
- Chest pain gets admitted or definably diagnosed.
- All surgeries are not created equal.
- Nice Docs get sued less.
- Medically and legally there are two kinds of physicians, those who have been sued – and those who will get sued.

1 http://medicalpearlsofwisdom.com/Surgery/MiscSurgical.html

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- Being a knowledgeable doctor is good, being a knowledgeable and personable doctor is great.
- If you do procedures in your office, not only have code equipment available but several times a year have code drills, like the fire drills in school. This will give the coding patient a fighting chance.
- Faster Surgery is usually better surgery, if you don't blow it.
- Beware the new procedure – the learning curve and the attorneys.
- Beware of and repeat the lab report or test that falls outside of expected values.
- You don't stop bleeding by looking at it!
- In active bleeding situations better to give too much blood than too little.
- In the eyes of the legal system – if you did not document it, you did not say it or do it.
- Before you do something, especially something new, ask yourself this question: What would I say to the Judge?
- Have a system in place which will track patients with specific problems so they will not fall through the cracks and get lost, to surface again in court or in the morgue.
- Aggravating a patient with a small dollar bill can initiate a large dollar law suit.
- Go out of your way to protect your assets. ❑

Membership Meeting

OCMS members will have an opportunity at the November membership meeting to help initiate the new headquarters, catch up with old friends and make new ones, vote on OCMS 2010 officers, and learn what the City Council has proposed for the new MAPS initiative.

The meeting will be Monday, November 16, 2009, in the new OSMA headquarters building, 313 N.E. 50th Street. The reception will begin at 6:00 p.m., dinner will be served at 6:30 p.m., and the program will begin at 7:00 p.m. Mayor Mick Cornett will be the featured speaker. As always, there will be an opportunity for questions at the end of his presentation.

Please note that the new location is the second building west of Lincoln Boulevard, on the north side of the street. Enter through the southwest door. ❑

Medical Revenues Fall

Revenue in medical practices declined in 2008 for the first time in several years, according to the MGMA Cost Survey: 2009 Reports Based on 2008 Data. Multispecialty group practices saw a 1.9 percent decrease in total medical revenue. While each medical specialty's cost and revenue drivers are unique, falling revenues may be attributable to a decline in patient volume, indicated by a 9.9 percent drop in the number of procedures and an 11.3 percent slump in the number of patients from 2006 to 2008. Additionally, bad debt in multispecialty group practices from fee-for-service charges increased 13 percent from 2006 to 2008, suggesting that patients may be having a harder time paying their medical bills. The data indicate that total operating cost increased 54 percent in multispecialty group practices in the past 10 years, while total medical revenue increased 46 percent. Overall cost increases were due to a variety of factors, including increases in drug supply costs, support staff costs and professional liability fees.

In 2008, multispecialty practices reduced overhead expenses 1.4 percent, largely by cutting support staff costs by 1.5 percent – the first decline in several years. Support staff costs make up 32 percent of medical practice expenses. Support staff includes general administrative, accounting, information technology and maintenance employees. Interestingly, while medical groups reduced support staff costs, their total worker count remained constant, indicating that employees may have gone without raises, bonuses or perhaps even suffered pay cuts.

The survey for single specialty practices also revealed trends distinct to specialty practices. OB/GYN and gastroenterology practices experienced decreases in total medical revenue after operating costs. Cardiology, family practice, anesthesiology, pediatrics, orthopedic surgery and urology groups fared better, reporting increases.

For the first time, the report this year includes legal and consulting fees in medical practices, new benchmarks for procedures and charges, and expanded data and analysis for integrated delivery systems. ❑

EMR in Real Life

Joe Denney, MCSE, RN

Rather than talk about big picture EMR stuff, I'd like to talk about some of the reality of EMR. Like most things, there are things to like and dislike about any EMR. Many of the things to dislike aren't often discussed by those selling EMR, and the things to like are often minimized by those who are EMR proponents.

Things not to like about EMRs are generally grouped into two categories: ease of use and process changes. No currently available EMR is truly easy to use. Some are certainly better than others, but given the huge amount of data to be captured and considered and the number of possible variables, the bottom line is that these systems are incredibly complex. That said, vendors should be doing a much better job of implementing user interface design to make inputting, reviewing, and extracting the data in an EMR easier. Non-standard navigation tools, way too many mouse clicks to accomplish a task, not using Windows standard keyboard navigation tools, and too much data in too little an area can overwhelm the new user, regardless of their level of computer savvy. I have been in the IT field for over 15 years professionally, and every time I look at a new EMR, I have to learn again how to do very simple things such as move around the screen. Usability is a big factor in selection of an EMR, and in my upcoming column on EMR selection I'll spend more time on how to evaluate and factor usability into your decision.

Another thing not to like about EMRs is that to successfully implement and use an EMR requires changes in most of the processes you and your staff perform every day. While a formal workflow and process study and documentation project is often beyond the time and financial means of a single physician or small group, a structured look at what practices will change is certainly a good idea. This self-evaluation process can be as simple as having your staff sit down and make notes on what happens to patient information now, from the time the patient calls to schedule an appointment through the time when the patient checks out, and what happens to the information regarding things that have to be done by an outside party such as labs, diagnostic tests and referrals. Once completed, think about how those processes will change with your fully implemented EMR. In a future article on

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EMR implementation I'll go into more detail, but suffice it to say this process requires time and money that vendors typically don't spend a lot of time explaining.

Fortunately, there are also things to like about EMRs. Once fully and properly implemented, an EMR can save the physician time in doing repetitive tasks. A correctly set up system will enable you to generate standard order sets with a few clicks, handle refill requests quickly, order standard tests and labs with minimum times, and help you fully document every encounter to maximize your revenue. Your EMR can help you increase revenue by giving the insurance companies the information required to approve your claim, rather than deny based on incomplete or incorrectly coded information. The ability of an EMR to correctly capture the diagnosis and the complexity of the encounter to justify the level of the CPT submitted can decrease your initial rejection rate and increase your average per- encounter revenue. Another way a well done EMR can increase your revenue is by letting you identify patients who should receive preventive care and encourage those patients to come in for that care. Use your EMR to encourage medically appropriate preventive treatments for your patients. This type of reporting and marketing is potentially a big benefit to your bottom line.

Always being able to find patient charts, being able to read the notes and being able to quickly share information are other huge benefits of an EMR. Think about how much staff time is spent in pulling, refiling, updating and looking for charts every day. While on a per-chart basis this may not be much, when you multiply that by the number of charts that are handled daily, this is another area where an EMR shines.

The key to living with and benefiting from an EMR in real life is to approach it with realistic expectations of what it will and won't do, and to understand the time and financial commitment it will take to make it work for you. Understanding both the challenges and the opportunities an EMR provides will let you maximize your return and minimize the pain involved in adding this tool to your practice. ❑

A thankful heart is not only the greatest virtue,
but the parent of all the other virtues.

Cicero

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What Patients Want And What They Need

Tomás P. Owens, MD

> *Professional competence is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served.*
>
> Epstein and Hundert[1]

One of the hardest parts of being a physician comes to the forefront when, due to innumerable reasons, we established that the "patient" is also a "client." True enough, but where does a true professional stand in the midst of this? As opposed to retail activity, in a professional relationship the client is not "always right." Maybe a better way to look at this is to say that the client may always be right, but our response to their "rightness" can be and many times *should* be, dissonant. The medical profession has maintained a position on the paternalistic end of this balance for the majority of our history: we decide what is best and focus our attention on promoting our agenda *to* the patient (maybe a start would simply be to *encourage* our goal *with* the patient). The stress arises when the patient's beliefs, wants or perceived needs are in juxtaposition with *our* scientific truths (understanding that sometimes those might be somewhat tainted by our cannons). Today, success in the patient-physician relationship is measured, in great part, by how cooperative and concordant this interaction is. In the final analysis, the sense of well-being derived from our interactions can be as valuable as the improvement of the chemical or clinical abnormality.

The ACGME[2], in their professionalism dictum, requires our resident physicians to demonstrate to patients: (1) respect, compassion, and integrity, (2) responsiveness that supersedes self-interest, (3) accountability which extends to society, (4) respect for their privacy and autonomy, (5) commitment to ethical principles, and (6) sensitivity and responsiveness to their culture, age, gender, and disabilities. The charter for medical professionalism[3,4] refers to three fundamental principles: *primacy of patient welfare, patient autonomy* and *social justice.*

The best interest of the patient is the only interest to be considered, said William Mayo, MD to the graduating class of 1910 at Rush Medical College. It is critical to pursue that maxim while realizing that the operating words are patient and interest: not whim, desires or wishes, but interest. Who is to decide what the best interest is, the professional or the individual? Should your financial advisor put all your money in a bankrupt car company stock because you, the client, demands that?

In other words, what to do when there is a conflict between patient welfare and patient autonomy? People come to us based on convictions that might be more or less righteous, and sometimes ill-informed, but strongly held beliefs they are nonetheless. As professionals, we are held to a much higher standard than any other people-related career and are duty-bound to juggle the inconsistencies while avowing to the patient the aforementioned sensitivity and understanding. Yet, we must also commit to competence, honesty, confidentiality, maintaining appropriate relations with patients, improving quality and access to care, a just distribution of finite resources, growing our scientific knowledge, managing conflicts of interest and upholding our responsibilities[4]. It is this commitment that should guide us on the aforesaid fracas. I, as most physicians, face this dilemma many times each day, as I get requests for antibiotics for viral illnesses, expensive diagnostic tests – fraught with potential risks – for symptoms that do not warrant them, narcotic prescriptions for unclear motives or work excuses for vacation forays — some situations easier (the latter) others less so (all the former).

Our patients (my preferred word) are indeed our clients and that is very fine. We must strive to improve their comfort, access, customer service (and heaven knows we have not done that well in those arenas). Nevertheless, we can not compromise our obligation to be their professional advisers, guides and true mentors through the maze of health care.

Give our patients what they *want*, when they *want* it vs. what they *need* when they *need* it? Our job is to promptly acquiesce in some instances and many times to redirect and negotiate, but to do either without ever compromising the integrity of our noble vocation. ❑

1) Epstein RM, Hundert EM. Defining and assessing professional competence. JAMA. 2002;287(2):226–235.

2) Accreditation Council for Graduate Medical Education, Outcome Project Common Program Requirements: General Competencies Approved by the ACGME Board February 13, 2007 http://www.acgme.org/outcome/comp/GeneralCompetenciesStandards21307.pdf

3) Kirk, LM Professionalism in medicine: definitions and considerations for teaching Proc (Bayl Univ Med Cent). 2007 January; 20(1): 13–16.

4) Medical professionalism in the new millennium: a physician charter. Project of the ABIM Foundation, ACP–ASIM Foundation, and European Federation of Internal Medicine *AnnInternMed.*2002;136(3):243–6. http://www.annals.org/cgi/content/full/136/3/243

Dr. Owens, Chair of Family Medicine at INTEGRIS Baptist Medical Center (IBMC), is a Clinical Professor, Department of Internal Medicine, Adj. Department of Geriatric Medicine, Adj. and Department of Family and Preventive Medicine, OUHSC and is the Associate Director of the Great Plains Family Medicine Residency Program (IBMC and Deaconess Hospital Affiliated)

Alliance


Lu Garrison

Members Emeritus are special ladies who have served the Alliance in many capacities in the past, from president to board members. It is our pleasure each year to honor these women during our October meeting. We also enjoy hosting a Christmas Tea for them each year, where current board members have the opportunity to visit and learn and profit from their vast experience. This year the tea will be Wednesday, December 9, in my home.

I have truly been honored to serve as chair of this committee for a number of years. ❑

As we express our gratitude, we must never forget
that the highest appreciation is not to utter words, but to live by them.

John Fitzgerald Kennedy

Keep Pumping

Survival after cardiac arrest is directly related to the amount of time spent doing chest compressions during CPR, according to a study published online in the September 14 *Circulation* and reported by HealthDay. The study analyzed data from 506 patients after cardiac arrest at emergency medical centers between 2005 and 2007. Heart function returned to normal in 58 percent of cases when compression time was less than 20 percent. Normal function was restored in 79 percent of cases when compression time was 81 percent or more. Survival to hospital discharge was 12 percent when compression time was 20 percent or less and 25 percent when that time was 81 percent or more. Dr. Benjamin S. Abella, clinical research director of the University of Pennsylvania Center for Resuscitation Science and head of its department of emergency medicine, says we "believe that compressions at about 100 per minute and two inches of depth should be maintained while CPR is being delivered," until a pulse is restored or it is deemed futile. ❑

Judges as Gatekeepers of Medical Evidence

S. Sandy Sanbar, MD, PhD, JD, FCLM
Chairman, American Board of Legal Medicine
Adjunct Professor Medical Jurisprudence, TUN

In federal court, the Federal Rules of Evidence govern the introduction of all evidence at trial. In Oklahoma state courts, the Oklahoma Evidence Code, which was adapted from the Federal Rules, governs the admissibility of evidence. In 1993, the U.S. Supreme Court first outlined the ***scientific*** aspects of expert medical testimony in *Daubert*,[1] and further expounded in 1999.[2] In 2003, the Oklahoma Supreme Court adopted the *Daubert* approach,[3] which requires that a judge ensure that any and all scientific testimony or evidence is not only ***relevant*** to a fact in issue, but also ***reliable***. ***Relevant*** evidence tends to make the existence of any fact that is of consequence to the determination of the lawsuit more probable or less probable than it would be without the evidence. Medical evidence ***reliability*** is defined as the application of a scientific principle that produces consistent results. "If scientific, technical, or other specialized knowledge will assist the trier of fact (jury) to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise."[4]

Thus, Judges act as ***gatekeepers*** when admitting or denying expert testimony ***after*** analysis of the expert's knowledge, training and experience as it is relevant to the issues to be decided at trial. Judicial gate keeping is not based on a rigid test, but must be exercised with discretion when considering both the ***relevance and reliability*** of a physician's expertise in light of the issues presented. By allowing a physician to testify, the Judge is determining neither the ***credibility*** of that testimony nor the ***probative value*** that the testimony will carry with the Jury (trier of facts). Experts whose education, training, methods and conclusions are unsound risk exposure through the critical role of the cross-examination process. Jurors take such matters into consideration when deciding whether an expert's testimony is

credible.

Judges must also weigh or balance the probative value of relevant evidence against the likelihood that such evidence will ***unfairly prejudice or mislead a jury, confuse the issues or unduly waste time or delay the proceeding***. In such instances, the trial judge may exclude even relevant evidence. In determining whether ***relevant*** evidence should be excluded, the trial judge is granted a large amount of discretion, but with a strong presumption in favor of admitting the evidence.

The scientific aspect of judicial gate keeping entails a more detailed analysis when considering the admission of expert testimony. Unlike fact witnesses, physician experts often testify and offer opinions on events to which they possess no first hand knowledge, based on expertise in an area that is not generally familiar to members of the public who serve as jurors. At law, s***cientific*** implies the grounding in the methods and procedures of science. ***Knowledge*** connotes more than subjective belief or unsupported speculation. The subject of the scientific testimony need not be known to a ***certainty*** before the evidence can be admitted, but an ***inference or assertion*** must be derived by the scientific method. In determining whether or not the inference or assertion is derived by the scientific method, a Judge must consider the following non-exhaustive list of factors:

1. Whether the methodology relied on by the expert can be (and has been) tested;
2. Whether the theory or technique has been subjected to peer review and publication;
3. The known or potential rate of error;
4. The existence and maintenance of standards controlling the technique's operation;
5. Whether the technique is "generally accepted" within the relevant scientific community (the *Frye test*).[5]

A physician witness is considered an expert based on his or her knowledge, skill, experience, training, or education. In some instances, however, practical experience alone is sufficient to consider a witness as an expert. An expert need not be board certified or even a specialist in a particular field of medicine to render an opinion about the standard of care applicable to that field. The expert need only be familiar with the relevant standard of care

for the medical problem or procedure at issue and be otherwise qualified to testify regarding the particular case. In *Ralston v. Smith & Nephew Richards, Inc.,*[6] a board certified orthopedic surgeon with expertise in oncology was ***not*** permitted to testify as an expert in a case involving left leg fracture after the patient received extensive treatment for cancer of the femur because of an admission that she was not an expert on intramedullary nailing. The Court excluded her testimony as required by *Daubert*.

On the other hand, Judges have permitted ***non-physicians*** to testify about a diagnosis where the witnesses' education, training, and experience demonstrate that the expert opinion will assist the jury. In *Gaines v. Comanche County Med. Hosp.,*[7] the Oklahoma Supreme Court held that the relevant experience, skill and training of a registered nurse with eighteen years of experience and a specialty in wound care was qualified to offer expert testimony as to the relevant standard of care for and treatment of decubitus ulcers. ❑

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1 *Daubert v. Merrill Dow Pharmaceuticals, Inc.,* 509 U.S. 579 (1993).

2 *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 119 S.Ct. 1167, 1175-1176 (1999).

3 *Christian v. Gray,* 2003 OK 10, 65 P.3d 591.

4 12 O.S.2001 § 2702

5 *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923).

6 275 F.3d 965 (10th Cir. 2001).

Director's

DIALOGUE

The longer I live, the more beautiful life becomes.
Frank Lloyd Wright

Frank Lloyd Wright knew something about beauty. His innovative architectural style embraced the natural environment, whether it was a residential or commercial structure. My favorite, Falling Water, is situated over a small waterfall and creek outside Pittsburgh, Pennsylvania. This structure was designed by Mr. Wright when he was 67 years old, and it has been referred to as a "near perfect" merger of architecture and nature.

Loss of youth does not mean an inactive life. As my dad aged, he equated his sharp mind with continuing to read, work crossword puzzles and engage with others. I recently attended the funeral of Ruth Russell Bozalis, a woman known by many of you. She was a past president of the OCMS Auxiliary (now Alliance) and the mother of one of this Society's past presidents, Dr. John Bozalis. Mrs. Bozalis loved to entertain, and her guests enjoyed a hospitality surpassed by no other hostess. She felt it was important to contribute to society and did so through her membership in numerous organizations. One of my favorite stories told at her funeral was of Mrs. Bozalis riding as her friend's automobile passenger on local outings. Her friend was 101. And between the two of them, they had almost 200 years of driving experience. As they would near a busy intersection, after looking either direction and noting it was all clear, Mrs. Bozalis would yell, "Charge!" She grew more beautiful as she aged. Anytime I saw her dining at a restaurant, she was "dressed to the nines" and ever so gracious when someone took a moment to say hello. Her vitality and love of life remained until her death at the age of 98.

A group of physicians, retired and non-retired, met recently to explore the establishment of an Oklahoma County Medical Society senior physicians' program. Each participant made

comments regarding his personal vision of what this group's focus should be. It quickly became apparent we should engage this age group as the amount of knowledge and experience among these physicians would be a major loss to society if left untapped. A consensus was reached that their purpose will be "to encourage connectedness among physicians who are retired or nearing retirement by sponsoring social, community and medical educational activities." More information about this group will be disseminated as it develops.

One of the most poignant moments at this meeting was when a retired physician stated, "Growing old is an art. Since retirement, I have a greater understanding of life ... I learned there is more to life than practicing medicine." In the fast paced "instant" world in which we live, this physician has discovered the secret to enjoying a beautiful, fulfilling life as a person who chose to retire from the active practice of medicine ... but not from life!

May your life continue to grow more beautiful each day— and best wishes to each of you during this season of Thanksgiving. ❑

Jana Timberlake, Executive Director

Consumer Opinion of Mail Order Pharmacies

According to a non-scientific survey of just over 400 patients conducted by the National Community Pharmacists Association (NCPA), 48% of mail-order customers went without medications because of late delivery. Patients required by their health plan to use mail order experienced higher rates of late delivery (63%) than those who had a choice of pharmacy (28%). Nearly 85 percent of patients waiting for late delivery routinely bought the drugs at local pharmacies, in effect paying for the medications twice. Patients also complained of being forced to purchase a 90-day supply via mail, leaving them stuck with unusable medicine when doctors wrote new or different prescriptions two weeks later. To conduct the poll, patients completed – on a voluntary basis – an eight-question survey developed by NCPA officials that was displayed on counters. ❑

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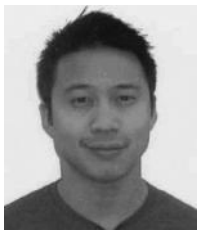

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Let us remember that, as much has been given us, much will be expected from us, and that true homage comes from the heart as well as from the lips, and shows itself in deeds.

Theodore Roosevelt

New Board Members

The Nominating Committee has certified the election of new board members and announced nominees for OCMS 2010 officer positions. Board members who will begin their three-year term in January are C. Douglas Folger, MD, D. Randel Allen, MD, Jerry D. Brindley, MD, and William J. Miller, MD. Candidates for officer positions are Robert N. Cooke, MD, President-Elect; Tomás Owens, MD, Vice President; and Thomas H. Flesher, III, MD, Secretary-Treasurer. Nominating Committee members were Drs. Bob McCaffree, Jay Cannon, David Hunter, and Mukesh Parekh. ❑

Oklahoma City-County Health Department
Epidemiology Program
Communicable Disease Surveillance partment

COMMONLY REPORTED DISEASES	*Monthly*			*YTD Totals^*	
	Sept'09	Sept'08	Aug'09	9/30/2009	9/30/2008
Campylobacter infection	12	22	13	75	92
Cryptosporidiosis	0	19	2	11	30
E. coli 0157:H7	0	2	2	7	5
Ehrlichiosis	2	0	1	7	5
Giardiasis	0	8	9	35	22
Haemophilus influenzae Type B	0	0	0	0	1
Haemophilus influenzae Invasive	2	1	1	13	13
Hepatitis A	0	0	0	4	6
Hepatitis B*	14	26	15	137	179
Hepatitis C *	20	10	19	209	241
Legionellosis	0	1	1	2	2
Lyme disease	0	2	1	5	11
Malaria	0	0	0	0	1
Measles	0	0	0	0	0
Mumps	1	0	0	2	0
Neisseria Meningitis	1	0	0	2	4
Pertussis	3	0	2	18	9
Pneumococcal infection	0	1	0	12	15
Rabies (Animal)	0	0	0	0	0
Rocky Mtn. Spotted Fever (RMSF)	1	4	4	28	26
Rubella	0	0	0	0	1
Salmonellosis	16	22	14	94	128
Shigellosis	21	5	21	129	45
Tuberculosis ATS Class II (+PPD only)	71	124	64	654	850
Tuberculosis ATS Class III (new active cases)	3	3	1	12	21
Tularemia	0	0	0	0	2
Typhoid fever	0	0	0	1	1
RARELY REPORTED DISEASES/Conditions:					
West Nile Virus Disease	1	2	1	4	6
Pediatric Influenza Death	0	0	0	1	2
Influenza, Hospitalization or Death	50	0	1	51	0
Influenza, Novel Virus	1	0	2	50	0
Strep A Invasive	1	1	4	31	42
Listeriosis	0	0	2	2	2
Yersinia (not plague)	0	0	0	0	1

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

^ *YTD - Year To Date Totals* **STDs/HIV - *Not available from the OSDH, HIV/STD Division***

CME Information

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

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

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

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

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

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

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

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

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

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

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

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

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Physicians interested in advertising in the Professional Registry should contact the Executive Office at 843-5619

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