

BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY

NOVEMBER 2011



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THE BULLETIN

The Oklahoma County Medical Society

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TABLE OF CONTENTS

About the Cover	3
Operation Santa	3
In Memoriam	3
Another Study on P4P	4
2012 Board of Directors	4
President's Page	5
New Members	8
Pearl of the Month	9
Young Physicians	13
Be Happy	16
Financially Aware Children	17
Medicine Returns to its Roots?	19
In Memoriam	
Stanley F. McCampbell, MD	21
Drug Return Locations	22
Free Health Care Pamphlets	22
In Memoriam	
Floyd F. Miller, MD	23
HIV AIDS Reporting	24
Affordable Legal Services	24
Letter to the Editor	25
Law and Medicine	29
Advance Directives Report	31
Another Alarming Health Trend	32
Minority Patient Outcomes	33
Palliative Care	33
Director's Dialogue	35
Alliance	37
Subsidizing Junk Food?	38
Communicable Disease Surveillance	40
CME Information	41
Professional Registry	42

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About the Cover

The picture on the cover of The Bulletin this month is titled "Chamber Music" by the artist, Lisa Feldman. It was featured in the journal "Blood and Thunder, Musings on the Art of Medicine," published by the OU College of Medicine. Ms. Feldman has spent the last 30 years as a medical photographer and illustrator. She was diagnosed with Crohn's disease as a teenager and has lived with an ileostomy for 35 years. She has works exhibited in MoMa, Lincoln Center, Boca Raton, Florida and galleries in SoHo and Chelsea in New York City. She is a frequent collaborator with award winning playwright Bara Swain. We are indebted to her for this reproduction of her work. □

The Editor

Operation Santa

Operation Santa cards were mailed in October. This is your opportunity to help brighten a few very needy families' holidays.

Your OCMS Community Foundation Trustees voted to select families who live in Homeless Alliance-sponsored permanent supportive housing. Only very low-functioning parents with children under age 21 living in the home are eligible for such housing. "Our" families last year requested very basic gifts: winter clothing, including coats; bedding; kitchen utensils; even personal hygiene products. Your donations also allowed us to purchase some toys for the children as well as food for their holiday dinner along with staples such as cereal, pasta sauce, and soup.

Please give generously once again. If you didn't receive your card or would like to have another one sent, please call us at 702.0500. □

In Memoriam

Floyd F. Miller, MD
1930 - 2011

Robert Sukman, MD
1921 - 2011

Another Study on P4P

Researchers at the University of Melbourne's Melbourne Institute of Applied Economic and Social Research in Australia have found insufficient evidence to either support or refute the practice of using financial incentives to improve the quality of care. After reviewing all available data in a Cochrane Systematic Review, they found only seven appropriate studies, looking at very different schemes. "Poor study design led to substantial risk of bias in most studies," said Dr. Peter Sivey, who co-led the study. None of the studies addressed the ability to opt into or out of the incentive scheme or health plan. The seven studies looked at interventions covering a wide variety of health-related issues including smoking cessation, assessment of the quality of care, cervical screening, mammography screening, diabetes, childhood immunization, chlamydia screening, and appropriate asthma medication. Sivey said, "There is currently little rigorous evidence about whether financial incentives do improve the quality of primary health care, or of whether such an approach is cost-effective relative to other ways of improving the quality of care. There are ways of conducting high quality research that could find solid answers, and it is really important that we start collecting data that will address this critical issue." □

2012 Board of Directors

Members recently elected to serve on the 2012 Board of Directors are Doctors Don L. Wilber, Position 1; Paul J. Kanaly, Position 2; David C. Teague, Position 3; and Gary D. Riggs, Position 4.

The election for officers will be held at the OCMS Annual Meeting. Nominees are Thomas H. Flesher, III, MD, President-Elect; Julie Strebel Hager, MD, Vice President; and C. Douglas Folger, MD, Secretary-Treasurer. The Annual Meeting will be Monday, November 7, 2012, in the OSMA headquarters building, 313 NE 50th Street, Oklahoma City. The reception will begin at 6:00 p.m., dinner will follow at 6:30 p.m., and the program will begin at 7:00 p.m. □

President's Page



Robert N. Cooke, MD



Finding Support

I was sitting in my house not long ago and the phone rang. It was my son, a junior medical student. I could tell he was uneasy with something so we began to talk about his day. It started in the early morning with rounds that began before breakfast, a clinic all day with complicated patients to see and evaluate, no break for lunch, and then evening rounds where all the medical students were thoroughly “worked on” for not seeing their patients that afternoon despite the fact that they were in clinic with patients all day.

I felt all those feelings come crashing back into my mind as I recalled similar episodes from my medical school days. My first day on surgery was strenuous at best. A gentleman came through the ER with a small bowel obstruction. It was obvious he needed an operation but first he needed correction of his electrolytes, BUN and creatinine. The fact that it took until midnight was bad enough, but five hours later we were finished, just in time to make rounds for the day. Now, I can think of a lot of things that are fun and interesting, but I must admit that being on the end of a retractor all night isn’t one of them. Watching someone lyse adhesions for more than an hour is about as interesting as reading a Danielle Steele book while watching the Housewives of New York on television. It was frustrating. In fact, feelings of frustration still happen to this day with all physicians. There are just days when you feel like the Wicked Witch of the East wondering, “How did this house land on top of me?”

My son and I talked for a while and I suggested that he prepare for the next day and get to bed early. He was up at 4 a.m., made

INTEGRIS Health

BRINGING COMPASSION HOME



INTEGRIS EXPERTISE EXPANDS AGAIN

INTEGRIS Health has acquired Odyssey HealthCare of Oklahoma City, which includes hospice home care and inpatient services. Hospice of Oklahoma County, Inc. (an affiliate of INTEGRIS Health) will provide the services previously offered by Odyssey HealthCare of Oklahoma City in an effort to strengthen services.

The inpatient facility opened in 2006 and is located in northwest Oklahoma City. Caring for approximately 800 patients, the twelve-bed facility will be known as INTEGRIS Hospice House. This is Oklahoma's first licensed inpatient hospice facility, and the newest addition to INTEGRIS Health.

We are excited about the new addition to our family of healthcare services — and look forward to caring for more Oklahoma families by bringing compassion home. Hospice of Oklahoma County is certified by Medicare, and is one of an elite group to be accredited by The Joint Commission.

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his rounds with his team, helped with his cases and had a much better day. In fact, it was quite enjoyable. What a difference a day makes! Isn't that true for all of us?

I still remember almost being overwhelmed with the amount of material there is to learn as a medical student and resident. Indeed, there is much to learn and keep current on once you are in practice. There is a reason it takes so long to become a physician. Not only is there a lot to learn but this knowledge then must be applied to patients. Many times diagnosing and treating people can be straightforward. At times it can be quite difficult. It is hard for those outside the profession to understand that, but I see it every day. Any physician occasionally finds a patient that is a challenge to diagnose and treat. As advanced as we feel we are, there are still ailments that are difficult to identify and treat successfully. Yet, there are some outside the profession who expect everything to be perfect. All we can do is utilize the knowledge that we have and apply it in the best and most efficacious manner possible. I have seen this over and over again in my career here in Oklahoma County.

When I read articles, visit with physicians from other areas, and attend meetings, I realize that the medical care delivered here is exemplary. Many fine physicians in the county treat patients every day. Are there times when there is frustration? Sure. Are there patients whose outcomes are not as good as we would like? Of course. There is one thing I do know, and that is there are times when the old medical school feelings creep back into my mind. I'm a surgeon and certainly don't know everything.

These feelings are eased by the fact that I know I can pick up the phone or contact a colleague in this county and get good, sound advice and consultation. What a privilege it is to be a physician in this county.

I hope everyone has a fantastic Thanksgiving and holiday season and, by the way, if you're frustrated or need a break from work, read one of those Steele books or watch some reality show. That will snap you back into reality! □

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Og Mandino (1923 - 1996)

New Members



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(GS)
3400 NW Expressway
University of Oklahoma
2004



Samantha J. Ganick, MD
(U)
PO Box 26901, BMSB 357
University of Oklahoma
2006



Bret R. Haymore, MD
(IM AI)
1810 E. Memorial Rd.
Pennsylvania State
College of Medicine 2002



Mohammad F. Khan, MD
(IM) 1110 N. Lee
J.J.M. Medical College, Rajiv
Gandhi U. Health Sciences,
Davangere, Karnataka 1963



Joseph W. King, III, MD
(OBG)
820 W. 15th St.
Meharry Medical College
School of Medicine, Nashville 1981



Troy E. Major, III, DO
(OTO)
535 NW 9th St., #300
U. of Health Sciences, C. of Osteo-
pathic Medicine, Kansas City 2000



Gregory M. Metz, MD
(AI IM)
750 NE 13th
University of Oklahoma
2004



Joshua R. Payne, MD
(EM)
4300 W. Memorial Rd. - ER Dept.
University of Oklahoma
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Shahan A. Stutes, MD
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Pearl of the Month



Anureet Bajaj, MD

Pressure Sores

As a plastic surgeon, one of my least favorite consults is that for a pressure sore. Unfortunately, the consulting services don't always understand why I don't want to operate right away and why, frequently, I don't recommend surgery at all. The etiology of a pressure sore is multifactorial, and its appropriate treatment requires a multidisciplinary approach to be successful and to minimize recurrence risk.

Frequently, the consult for treatment of a pressure sore is made when "it is getting worse." When a pressure sore "is getting worse," it is the wrong time to operate. At this stage, we need to evaluate why it is "getting worse" or why it even occurred in the first place; then we need to address those reasons. Before a patient is a surgical candidate for the closure of a pressure sore, there needs to be consistent improvement in the wound and correction of the factors that led to its development.

So how does a pressure sore develop? At the most basic level, pressure sores occur from pressure over bony prominences leading to tissue ischemia and necrosis. Muscle has the least tolerance to ischemia; skin can tolerate ischemia for up to 12 hours. Therefore, the damage that is visible by skin breakdown is the tip of the iceberg. Because the deeper tissues are the most susceptible to pressure necrosis, the commonly used staging system is irrelevant. (In the traditional staging system, stage I is intact skin with impending ulceration; stage II is partial thickness loss of skin; stage III is extension into subcutaneous tissue; and stage IV is full thickness loss with extension into muscle, bone, tendon, or joint capsule.)

However, the more fundamental problem in the development of a pressure sore is the other issues associated with these patients. Many of these patients have multiple comorbidities and difficult social situations; these comorbidities frequently include diabetes mellitus, chronic renal disease, poor nutritional status, low BMI, anemia, vitamin deficiencies, and severe physical debilitation. Not all of these factors are within our control, but we have to optimize the ones that are.

Recurrence rates as high as 90 percent have been reported for pressure sores. To minimize recurrence risk, we have to eliminate the factors that caused the pressure sore before we can consider surgical treatment with a flap. If those factors aren't eliminated, a flap will provide temporary closure, which will then break down and create an even larger wound than the initial pressure sore. The treatment of these issues includes both medical and surgical management, but, as you will see, the medical issues predominate.

Some things that we can do to minimize complication rate and decrease the risk of recurrence include:

1. Eradicate bony infection. Failure to eradicate bone infection will lead to a high recurrence rate. Wound swabs are not an appropriate means of obtaining cultures; these typically only represent surface contaminants. The best way to diagnose osteomyelitis involves a bone biopsy. Appropriate treatment will include debridement of all nonviable tissue and antibiotic therapy.
2. Debride adequately. Before any wound can begin to heal, all necrotic tissue has to be debrided.
3. Ensure that nutrition is optimized. Poor nutritional status, including low albumin and pre-albumin, contributes to poor wound healing. I was trained to require a normal pre-albumin level prior to surgery and an albumin level >3.5 for normal wound healing.
4. Have the patient quit smoking. Most plastic surgeons aggressively discourage their patients from smoking. The main concern with smoking is the wound healing complications related to tissue ischemia caused by the nicotine.
5. The patient needs to have a bowel and bladder regimen in place. The moisture from urinary and fecal soilage will contribute to wound maceration. Also, fecal contamination will contribute to wound infections. To adequately treat this problem, some patients may require a colostomy.

6. Muscle spasms, contractures, and skeletal abnormalities need to be adequately controlled and treated. Not only can the shear forces contribute to the development of the pressure sore, but they can also contribute to post-operative wound breakdown; and contractures and skeletal abnormalities will lead to development of more pressure sores if not appropriately addressed with splinting and padding.
7. The next step is to correct poor social situations; this will include ensuring that the patient has appropriate care and equipment including mattresses, wheelchair cushions, etc. The problem that I have found is that some of these may not be covered by insurance plans or patients can't afford them. Once the patient has the appropriate supplies, the patient then also needs to have an aggressive pressure relieving regimen – this can include relieving pressure once every 30 minutes when sitting for prolonged periods or being turned frequently if lying down. The minimal recommendation is that pressure needs to be relieved for 5 minutes every 2 hours. The patient and the family will also need to be educated on prevention. Lack of compliance with these issues will lead to recurrence.
8. The patient and his/her family have to understand that the recovery process following surgery is long and treatment is expensive. The patient may need to be hospitalized for several weeks because an initial sitting program may not begin for at least 3-6 weeks following surgery. And once the patient is discharged from the hospital, the family may have to provide assistance and support to the patient.

Many pressure sores will begin to heal following the institution of these measures. In particular, sacral pressure sores that develop in the ambulatory patient suffering from long or short term disability will frequently heal completely, making surgical closure unnecessary.

For paraplegic and non-ambulatory patients, discussion of surgical intervention can begin once these measures have been put into action. The surgery for pressure sores needs to be well-planned pre-operatively, intra-operatively, and post-operatively. Failure to follow through on proper pre-operative preparation will guarantee post-operative care failure. □

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Young Physicians



Thy Nguyen, MD

My Sincerest Thanks

I am thirty-eight years old and the thought of dying makes me quite uncomfortable. I don't think I am different from others my age. I completed my fellowship and, like my classmates, I am in the early stages of my career. Similar to them, I am preoccupied with building my practice and feeling comfortable in my craft. However, as an oncologist this thought of dying meets me on a far too regular basis and so I struggle with this more often than I desire.

Let me say this before I go on, I am not a scholar nor have I practiced medicine long enough to feel that I own any expertise on this topic. I am simply a physician trying to come to terms with the thought of dying in order to help my own patients with their journey. At the same time, I still have the feeling of invincibility that I am somehow going to cheat death for a very long time.

Currently in my sixth year of private practice, I have been blessed with incredibly generous patients who have taught me about acceptance, grace, and unyielding strength. In addition to this, they have also taught me about the process of dying and have allowed me to share with them in this most private passage. Many of us have our own beliefs and values. Certain religions tell us that if we live a good life on this earth our reward shall be ascension into our heaven – regardless of what that is to each of us. Although we believe this, how many of us are truly ready to

meet with this end? So how am I able to discuss dying with a patient when I have so many questions and doubts about it myself?

Amazingly, it is the patient that helps me with this process. Each time I have a discussion with a patient about exhausting our therapeutic options, the conversation turns to what I call “switching gears.” We are not giving up but we are now on a different path, one which has a predictable ending. Though these conversations are not pleasant, I try to approach them with honesty and openness. The emotions and responses from my patients have overwhelmed me and, in turn, helped me become a better physician.

There was one patient I had treated for about two years for metastatic colon cancer. We had shared in the happiness of a good scan and had sat quietly after a bad one. When the time came that I did not feel I could offer her any further chemotherapy, I spoke to her about comfort care and what that would entail. I still remember the words she told me. “Dr. Nguyen, it doesn’t matter what happens because either way I will be a winner.” I sat there looking at her with a puzzled face so she explained that if she was to somehow improve from a functional status and resume chemo, she would have more time with her children and grandchildren. If not, then she would be reunited with her loved ones that she had lost. Either way, she would be a winner. Occasionally on Friday mornings, I think about her as that was her regular appointment time and I still remember those words.

Perhaps death for my patients is easier to accept when there are few regrets. One patient told me that she knew we had tried everything and she was grateful for the extra time she had with her family. She said that although the chemotherapy made her sick it gave her hope. This hope is what she really needed in order to work through her grief and gave her strength to prepare not only herself but her three sons for her death. Before leaving my office that day, she thanked me for my care and for being her doctor. I spoke to her regularly after she was placed on hospice and, about a day before she passed, I called her but she was no longer able to speak. It was my turn to thank her for allowing me

to be her doctor and trusting me. It was truly humbling when her family asked me to speak at her funeral and I am so grateful that I was able to share what her strength had meant to me.

I am a Vietnamese-American and my patient was a Vietnam Veteran who had been a prisoner of war and diagnosed with quite severe posttraumatic stress disorder. (No I am not joking.) Imagine the look on his face when I walked in and had to tell him about his diagnosis of lung cancer. He did not want chemotherapy but was willing to try radiation therapy. Though our first meeting was awkward, over the course of the next few months he would come to appointments to talk and in many cases would remind me that death was not something he feared. I appreciated his frankness and even though I thought he could handle the chemotherapy, I accepted his wishes. He frequently wore a cap to his visits and it was one that would always make me laugh. After he passed, his wife brought his cap and gave it to me. I still have the cap on my bookshelf and smile when I look at it.

I am not comfortable with death. For whatever good I have done in my life, I have been blessed with the two most amazing children. Perhaps when you become a parent your wishes simplify. My greatest wish in life is to live long enough to raise my two children to adulthood. It sounds pretty simple but true. I am constantly reminded that if we appreciate death then somehow we may not take living for granted. So for my patients who are still fighting their battle here and for those that have perhaps won a greater battle somewhere else, I offer my sincerest thanks. □



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And because having preceded you in death
He will have taught you to value life more deeply.

Be happy because
You will grow
Wiser with grief
Nobler with loss
Humbler with gratitude
More generous with your love
And less wasteful with your time.

Be happy because
When it's your turn to die
You will relinquish your space
Bequeath your assets
Let go of your memories
Return all that you had received
And leave life as clean as when you entered it.

Be happy because
By re-joining mother earth
You will have made others happy
Because it wasn't they who died
And because by preceding them in death
You will have taught them to value life more deeply.

Hanna Saadah, MD

*I believe that imagination is stronger than knowledge – myth is
more potent than history – dreams are more powerful
than facts – hope always triumphs over experience –
laughter is the cure for grief – love is stronger than death.*

Robert Fulgham, The Storyteller's Creed

Financially Aware Children

Raising children to be well rounded and socially responsible is a goal my wife and I have with our 4 children (ages 12, 10, 8, and 7). We believe our values can be taught and expressed in the way we operate financially. Before I dive into this topic, I want to be upfront and let you know that my wife and I have had some successes and some failures in applying these ideas. Much of our “discussion” is based on our upbringing. My father was a pastor and missionary and my wife’s father was a banker. This leads to very different beliefs about how to apply these decisions for our children. I am sure your children/grandchildren are just as different, individually, as ours and what works for one doesn’t necessarily work for another. Bottom line, we are still a long way from having financially aware children. Fortunately, there are several helpful books on this topic. As you think about some of these ideas, be flexible and ask questions to understand the child’s perspective. For example, when my daughter asks for a stuffed animal, my thought is that she wants another toy. My wife (great to be married to a social worker) finds out more by asking questions and discovers that my daughter thought it would help her go to sleep at night and she wanted the comfort of a friend.

When to start teaching your children/grandchildren the value of a dollar?

Very young children can understand some basic concepts. Typically, this occurs around the arrival of the “Tooth Fairy” or the grandparents giving money as a birthday present. Sometimes, the Tooth Fairy brings a quarter to some children and a five dollar bill to others. This can be an excellent opportunity to talk to your children/grandchildren about your values and the basic concepts of saving (piggy bank).

Tell them stories!

Young children love to hear stories and many family values are passed down in the stories we tell. I tell them about my first job as a 12 year old paper boy paying for my clothes and mowing lawns for extra money. I want them to know that their mother and I struggled financially. I tell them stories about the tiny apartment we lived in with blankets draped over computer boxes as nightstands and two twin beds pushed together while

their mother was working at the hospital and I was working as an analyst. Share with your children/grandchildren stories and intertwine hardships or successes involving money and the family values your parents or grandparents taught. It comes across much better in a story rather than a lecture.

Allowance?

Older children/grandchildren can handle responsibilities such as an allowance. The three main opinions I have heard regarding allowances are: allowance without expectations, allowance based on chores, and no allowance. There are many factors to consider such as the child's age, why it's given, and what it's for (clothes, toys, lunches, entertainment, etc). An allowance can be a great teaching and learning experience. Your child/grandchild can learn about setting up a budget, the benefits of delayed gratification, and learning to be more self-sufficient. It can be viewed as a mini economy within the home.

These years are also very important in teaching a sense of charity and commitment to the community at large. This can be done using a three-bucket model of having the allowance divided into portions devoted to savings, spending, and charity. It can reinforce the idea that money can have many purposes and can be made to work in many ways, not just for spending. This can help children/grandchildren grow up with a sense of

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purpose, empathy, and awareness of others. For example, we try to involve our kids in tithing at church and in our family tithing decisions. We involve the kids by volunteering with those we financially support and in selecting different projects for micro lending. We use an online non-profit organization with a mission to make interest free loans around the

world called Kiva. We meet as a family and collectively select different groups around the world to support in their businesses (for as little as \$25).

As the children/grandchildren age, other concepts can be learned, including advanced budgeting, goals with the money (college, car, trips, etc.) and definitely starting a Roth IRA (investing). It is also a good idea to help the child/grandchild earn a good credit score. This will help them get a lower mortgage rate, lower insurance premiums and many other financial benefits.

Allow the child/grandchild to take ownership of the financial decision. For example, for the past several years when we go out to eat, we give our children a choice: They could have a soda or they could have \$1. It saves me more than a \$1 and allows them to “earn” a \$1 while making a healthy decision. Not all my kids do this all the time and we respect their decision.

It is not just about the money. Teaching your children/grandchildren to be financially aware is a process of learning responsible habits. It is a tool you can use to help raise the next generation of well-rounded and socially responsible members of our community. □

R. Todd Owens, CFA
President & Portfolio Manager
Baker Asset Management, LLC

*In early childhood you may lay the foundation of poverty or riches,
industry or idleness, good or evil,
by the habits to which you train your children.
Teach them right habits then, and their future life is safe.*

Lydia Sigourney

Medicine Returns to its Roots?

After a dog bit a large chunk of a Swedish woman's face from her upper lip to her eye, physicians at Skåne University Hospital reached into history for a solution to reconstruct her face, the Daily Telegraph reported in September. The woman's relatives had saved the torn flesh on ice as she was rushed to the hospital. “The most important thing was to get blood into the torn off body part, which we managed to do within an hour of the start of the operation,” specialist Jens Larsson said – with the aide of 358 blood sucking leeches. □

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In Memoriam



Stanley R. McCampbell, MD **1925 – 2011**

Dr. Stanley R. McCampbell went to meet our Lord on September 23, 2001. He was born in Nashville, Tennessee in 1925. He attended public schools, graduating from Classen high school. He went to Vanderbilt University, did postgraduate work on the East coast and served in the Navy. Stanley began his practice of internal medicine in Oklahoma City in 1957. I knew him while he practiced at St. Anthony hospital, where I was a pathologist. We collaborated on a number of cases, reviewing laboratory work and deciding on various studies to confirm diagnoses. I learned during this time that he was a very astute physician. It seemed there were three things important in his life: his family, his church and tennis! He helped organize the Medical Tennis Society, and had a lot of stories about doctors he met playing tennis. He believed you could make a pretty good judgment about people after working with them on various committees. He said people were the same everywhere and wanted the same basic things. During these years, he served as president of the County and State Medical societies. While president of the Oklahoma Academy of Medicine, he and Bill Snoddy sponsored me for membership. At that time it was an honor to become a member and indicated you were at a high level of competency in your specialty. As a result of these associations I gained respect for Dr. McCampbell and feel that he was a pillar of the medical community. He will be missed by patients, family and friends.

Theodore Violet, MD
(Continued on page 39)

Drug Return Locations

The Oklahoma Bureau of Narcotics and Dangerous Drugs has established a number of drug return locations throughout the state for safe disposal of unused prescription drugs. Syringes, liquids and inhalers are strictly prohibited. The drop off boxes, which look like street-corner mailboxes painted white, are available for the citizens of the state, not for use by businesses such as hospitals, doctor's offices, or pharmacies, to dispose of controlled dangerous substances. The secure boxes are in the office lobbies and are unmanned. There are no forms to complete, no questions to answer. Disposing of the medications is as easy as mailing a letter. Locations in Oklahoma County include the following:

- Edmond Police Department, 23 East 1st Street, Edmond
- Moore Police Department, 117 E. Main Street, Moore
- Bureau of Narcotics, 440 NE 39th Street, Oklahoma City
- Oklahoma County Sheriff's Office, 8029 SE 29th, Midwest City
- Oklahoma County Sheriff's Office, 3700-A NW 206th, Edmond
- Oklahoma County Sheriff's Office, 201 N. Shartel, Oklahoma City

Go to http://www.ok.gov/obnidd/Take_Back/index.html and click on Take Back Container Locations to view the list for all sites in the state. □

Free Health Care Pamphlets

The Agency for Healthcare Research and Quality (AHRQ) is offering six additional free Spanish-language, easy-to-understand pamphlets on six health-related topics. They are:

- Benefits and Risks of Certain Heart Medications
- Managing Pain from a Broken Hip
- Treatment Options for Rotator Cuff Tears
- Depression after Brain Injury
- Understanding Radiotherapy for Head and Neck Cancer
- Human Growth Hormone for Children with Cystic Fibrosis

AHRQ now offers 23 publications in Spanish. They are available online at

<http://effectivehealthcare.ahrq.gov/index.cfm/guides-for-patients-and-consumers/informacion-en-espanol/> □

In Memoriam



Floyd F. Miller, MD

1930 - 2011

The House of Medicine lost a great friend August 1st when Floyd Miller passed away at the age of 81. Floyd's roots were sprouted firmly in rural Oklahoma, having been born and raised, and attending school in Skiatook. His competitive spirit may have been created early at home since he was youngest of four children. He demonstrated his competitiveness in high school on the basketball court, baseball diamond, and in the classroom by graduating as the Valedictorian in 1947. His academic prowess continued in college, where he graduated from The University of Oklahoma with honors, and advanced on to OU College of Medicine, where he graduated at the top of his class in 1956. Floyd served his country as an officer in the Air Force. His chosen specialty was Allergy, which he practiced in Tulsa 40 years before retiring. He also enjoyed teaching his specialty as a Clinical Staff member of the OU Health Sciences Center.

Floyd donated countless hours of his time volunteering for community service and medical organizations. Not only did he agree to serve on boards, he very frequently took the leadership role of numerous societies and organizations. Space allows only a partial listing of these. Floyd served as President of the Tulsa County Medical Society, Oklahoma State Medical Association, and OU College of Medicine Alumni Association. He received awards from many of the organizations in appreciation and recognition of his service and accomplishments. All the while he was doing the above, Floyd Miller served as a Founding Member of the Board of the Physicians Liability Insurance Company of Oklahoma for 24 years, the last eight serving as Chairman and President of PLICO until his retirement from medicine in 2004 at the age of 74.

(Continued on page 39)

HIV AIDS Reporting

Terrainia Harris and Amber Rose

The Oklahoma State Department of Health (OSDH) Surveillance and Analysis Division of the HIV/STD Service is committed to maintaining the most accurate and updated records of HIV and AIDS morbidities in the state. In order to ensure the accuracy of demographic information and risk factor ascertainment, the surveillance division is educating Oklahoma health care providers on adherence to the OSDH Board of Health disease reporting rules.

It is essential that health care providers report morbidities, in addition to any lab reporting, because of the specific patient history (demographics and risk factors) needed. Also, the OSDH requests that all health care providers complete a report on new patients who relocate to Oklahoma with a previous HIV/AIDS history. A report should also be completed when a patient is reclassified from a HIV case to an AIDS case by a provider. For your convenience, reports can be mailed to:

Oklahoma State Department of Health
HIV/STD Service - Surveillance Division
1000 NE 10th, MD 0308
Oklahoma City, Oklahoma 73117

For more information about reporting HIV/AIDS cases or to order Adult or Pediatric HIV/AIDS Case Report Forms (CDC 50.42A) and/or postage-paid envelopes, please feel free to contact Amber Rose by email at Amberr@health.ok.gov or by phone at 405.271.4636 or Terrainia Harris by email at Terrainia@health.ok.gov or by phone at 405.271.4636. □

Affordable Legal Services Available

The Senior Law Resource Center's attorneys provide free information and affordable assistance with basic estate and incapacity planning, probate, adult guardianship, and other elder law issues. They have no income or age requirements.

Call (405) 528-0858 or email info@senior-law.org for more information. □

Letter to the Editor

September 26, 2011

RE: Oklahoma Health Care Authority
Cesarean Section Quality Initiative

Dear Editor,

The Oklahoma Health Care Authority appreciates Dr. Larry Kincheloe's opinions in the September issue of the County's journal, *Bulletin*, with regard to our Cesarean Section Quality Initiative. He raises some legitimate concerns and his angst with this program is clearly palpable. However, Dr. Kincheloe's letter has numerous misconceptions which we feel compelled to address.

Dr. Kincheloe's first misconception is found in the title of his letter, "39 week OHCA proposal." The OHCA has never advanced a 39 week proposal. There are no "Medicaid rules" that refer to gestational age. The agency has specifically addressed a desire to reduce the number of primary Cesarean sections that have no medical indication. Based on the medical literature, approximately 4 to 30 percent of all primary C-sections in this country have no medical indication. After recent review of the agency's claims data, we noted that 12 percent of the pregnant SoonerCare population had primary Cesareans without a medical indication. In real numbers, this means that about 3,000 women per year insured by SoonerCare (Oklahoma Medicaid) have primary Cesarean sections when documentation does not support that mode of delivery. In all of the agency's discussions with providers prior to the initiation of this program, the discussions have focused on Cesarean sections only. There has not been a single time that the Agency addressed gestational age. Dr. Kincheloe's reference to the 39 week project is one that has been promoted by the Oklahoma Hospital Association and the OU Office of Perinatal Education, Every Week Counts, and mirrors the American College of Obstetrics and Gynecology guidelines. That project does target the reduction of deliveries prior to 39 weeks but it is separate and distinctly different from our Cesarean Section project. The OHCA was aware of the program's development and endorses it but did not participate in its implementation. We would refer

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Dr. Kincheloe to those institutions' representatives for further information on their program.

Dr. Kincheloe then inaccurately mentions on three separate occasions that the OHCA will deny payment to physicians and hospitals. The agency has never stated that it would deny reimbursement. A delivery will always be a compensable service. The statement that the OHCA has made is that reimbursement for a primary Cesarean section might be reduced to the vaginal delivery rate if there is inadequate documentation to support medical necessity. In this case, the reduction in reimbursement from a Cesarean delivery rate to a vaginal rate is quite minimal for a physician.

Dr. Kincheloe is quick to report that Texas Medicaid has recently implemented a change in their reimbursement for deliveries <39 weeks. He is correct on this point. That is the Texas plan. However, the program implemented in Texas bears no resemblance to the quality initiative program in Oklahoma.

Dr. Kincheloe again inaccurately notes that there is a panel of six physicians who will review medical records. The OHCA is in the process of employing an obstetrician to assist the agency with this program. The agency understands that review of the obstetrical record by an obstetrician is important.

Finally, let us address a concern of Dr. Kincheloe's which is very real and probably deserves much more attention than we can justifiably give it today, namely the need for tort reform. As physicians who practiced in Oklahoma, we can empathize with Dr. Kincheloe's desire for some sort of reform. We don't believe any physician in this state disagrees that Oklahoma is long overdue for this. Perhaps now would be a good time to take up this fight again, but this issue has nothing to do with the OHCA Quality Initiative.

The agency's focus is first and foremost the mother and her baby. As best as we can, the agency wants to promote both the short-term and long-term good health of each patient. With a rate of 2.7 percent, Oklahoma ranks last in the country in the number of VBACs (Vaginal Birth after Cesarean Section). Therefore, in general, in our state, if a young woman has a Cesarean section, she will likely continue to have operative deliveries with her subsequent pregnancies, along with all the potential problems associated with major abdominal surgery. These potential risks to her health cannot be overlooked nor can the potential risks to

her newborn. Infants born by Cesarean section have a high rate of admission to the Neonatal Intensive Care Unit, a higher incidence of respiratory distress, more early-onset feeding problems, longer hospital stays, longer duration of IV antibiotic administration, etc.

The agency does not desire to omit all Cesarean sections. There is certainly a place for those which are medically necessary, such as cases with placenta previa, placental abruption, breech presentation, to name a few. We do, however, want to focus on reducing the number of those primary sections that have no medical indication. With the help of providers, we believe we can achieve that end and promote a healthier population. □

Sylvia Lopez, MD

Medical Director

J. Paul Keenan, MD

Chief Medical Officer



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Errors, Malpractice Risk and Judge-Directed Negotiation

S. Sandy Sanbar, MD, PhD, JD, FCLM
Of Counsel, Health Law Section
Christensen Law Group, PLLC

Medical errors remain staggering. One out of every seven hospitalized Medicare beneficiaries is seriously harmed in the course of his or her medical care, and less serious harm is equally common.¹ About one in three patients will encounter some kind of mistake during a hospital stay. Almost 50 percent of these episodes were found to be preventable. One in 20 hospitalized patients develops a healthcare-related infection. Reducing harmful hospital stays by 40 percent over the next three years will prevent 1.8 million injuries and will avert 60,000 inpatient deaths. The annual cost of measurable medical errors that harm patients was estimated to be \$17.1 billion in 2008.² The first three errors were bed sores, postoperative infections and post-laminectomy syndrome.

Malpractice risk in specialties was reported in 2011 by Jena et al³ who analyzed malpractice data from 1991 through 2005 for 40,916 physicians (233,738 physician-years of coverage) in 25 specialties. During that period, 7.4 percent of all physicians had a malpractice claim, with 1.6 percent having a claim leading to a payment. Hence, 78 percent of all claims did not result in payments to claimants. The annual claims for specialties ranged from 19.1 per cent in neurosurgery, 18.9 per cent in thoracic-cardiovascular surgery, and 15.3 per cent in general surgery to 5.2 per cent in family medicine, 3.1 per cent in pediatrics, and 2.6 per cent in psychiatry. The mean indemnity payment was \$274,887, and the median was \$111,749. Mean payments ranged from \$117,832 for dermatology to \$520,923 for pediatrics. By the age of 65 years, 99 per cent of physicians in high-risk specialties and 75 per cent of physicians in low-risk specialties had faced a malpractice claim.

Medical malpractice lawsuits are often protracted, winding and emotionally draining, with staggering cost. Often physicians

develop a medical malpractice litigation stress syndrome leading to dire consequences. Malpractice cases can go on for years with little judicial involvement. Judges find it difficult to control malpractice lawsuits during the pretrial phase when both parties are solidifying their positions, which substantially drives up legal expenses. Settlement conferences occur late in trial and often represent pro forma exercises.

Judge-directed negotiation is novel. Started in the Bronx, NY under a \$3 million federal grant, early settlement occurs at the beginning soon after the lawsuit is filed. This represents a major cultural change in malpractice cases, which are placed before a judge with better than average medical knowledge.⁴ The judge directs the negotiations, utilizes a variety of techniques/strategies, including frequent conferencing with representatives of the opposing parties, and pushes for an early settlement. The lawyers from both sides meet at a table in the judge's chambers. Evidence is presented to the medically knowledgeable judge in the absence of the parties and the public. The judge focuses on bringing about settlements long before the malpractice cases move toward trials. Thus, the crucial ingredient is getting judges involved earlier, more often, and personally active in pushing for settlements, which curbs liability expenses. This approach to claims settlement forces the parties to evaluate their case and look at the strengths and weaknesses very early. This approach may potentially bypass years of court battles, limit legal costs, avoid excessive jury awards, decrease physician and patient litigation stress and, importantly, provide injured patients with early compensation, without lengthy appeals. □

¹ AHRQ. First, do no harm: improving health quality and patient safety. Testimony of Carolyn Clancy before the Senate Health, Education, Labor and Pensions Committee. May 5, 2011. Available at: <http://www.ahrq.gov/news/test050511.htm>

² The \$17.1 billion problem: The annual cost of measurable medical errors. *Health Affairs*, April 2011. Available at: <http://content.healthaffairs.org/content/30/4.toc>

³ N Engl J Med 2011;365:629-36.

⁴ Glaberson W. To curb malpractice costs, judges jump in early. The New York Times. June 12, 2011. Available at: <http://www.nytimes.com/2011/06/13/nyregion/to-curb-malpractice-costs-judges-jump-in-early.html>

Advance Directives Report


Medicare patients with advance directives specifying limits in treatment who lived in regions with higher levels of end-of-life spending were less likely to have an in-hospital death, averaged significantly lower end-of-life Medicare spending and had significantly greater odds of hospice use than decedents without advance directives in these regions, according to a study in the October 5 issue of JAMA. Patients living in low spending regions were more likely to have a treatment-limiting advance directive than those who lived in high-spending regions (42 percent vs. 36 percent). In high-spending regions, adjusted spending on patients with a treatment-limiting advance directive was \$33,933, whereas adjusted spending for patients without an advance directive was \$39,518 (difference, -\$5,585). Having a treatment-limiting advance directive was not associated with differences in aggregate end-of-life spending for decedents in low- and medium-spending regions. In high-spending regions, patients without an advance directive had a 47 percent adjusted probability of in-hospital death, whereas those with an advance directive had a 38 percent probability of in-hospital death. Advance directives were associated with higher adjusted probabilities of hospice use in high- and medium-spending regions, but not in low-spending regions. In the study, conducted at the University of Michigan, Ann Arbor, researchers collected survey data from the Health and Retirement Study for 3,302 Medicare beneficiaries who died between 1998 and 2007 linked to Medicare claims and the National Death Index. Various models examined associations between advance directives, end-of-life Medicare expenditures, and treatments by level of Medicare spending in the decedent's hospital referral region. The average age of the beneficiaries at death was 83 years; 56 percent were women. Regions were characterized by quartiles of end-of-life spending averaged across a 7-year period. Decedent's region intensity was determined by zip code of residence.

A second study, at the CIRO+, Centre of Expertise for Chronic Organ Failure, in the Netherlands, found that 38% of people with chronic conditions changed their preferences for CPR and/or mechanical ventilation in the year following cardiac arrest. The research analyzed 206 patients who had chronic obstructive

pulmonary disease (COPD), chronic heart failure or chronic renal failure but were in a stable condition when the study began. They monitored patients every four months for a year and assessed their preferences for CPR and mechanical ventilation.

The researchers also assessed a number of health and lifestyle factors, including presence of other diseases, hospital admission, health status, care dependency, mobility, depression and anxiety, in order to determine if these factors could be linked with changes in patients' preferences for life-sustaining treatments. The results also showed that patients were more likely to change their preferences if they experienced a change in health status, mobility, symptoms of anxiety and depression or marital status. The study was presented at the European Respiratory Society Annual Congress in Amsterdam in September. The study recommends that physicians encourage patients to review their advance directives frequently. □

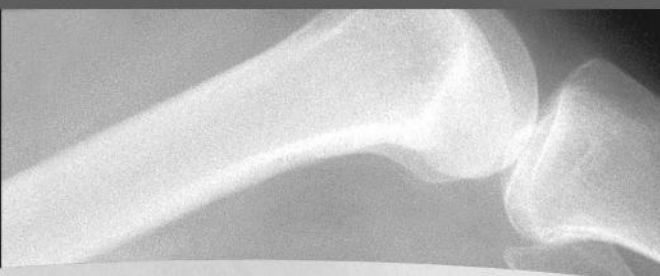
Editor's note: Advance directive forms are available on the Senior Law Resource Center's Website, <http://www.senior-law.org>. Scroll down and click on Advance Directive for Healthcare.



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Minority Patient Outcomes

The nation's lowest-quality, highest-cost institutions care for more than twice the proportion of elderly minority and poor patients as the nation's lowest-cost, highest-quality hospitals – and patients at the “worst” institutions are more likely than patients elsewhere to die of certain conditions, such as heart attacks and pneumonia. Researchers examining the associations among quality, costs and types of patients served in approximately 3,200 hospitals nationwide identified 122 “best” hospitals (those that were in the highest quartile of quality and lowest quartile of risk-adjusted costs) and 178 “worst” hospitals (those in the lowest quartile of quality and the highest quartile of costs). Elderly black people constituted nearly 15 percent of the patients in the worst hospitals compared to 6.8 percent in the best hospitals. Patients with myocardial infarction or pneumonia who were admitted to low-cost, low-quality hospitals or high-cost, low-quality hospitals were more likely to die (12-19 percent and 7-10 percent, respectively) than similar patients admitted to the best hospitals.

The worst hospitals were smaller than the best hospitals, were usually for-profit or public, and tended to be located in the South. The best hospitals were typically nonprofit institutions located in the Northeast region of the United States and were often equipped with cardiac intensive care units. The best hospitals also treated a higher proportion of Medicare patients than the worst hospitals.

“Agenda for Fighting Disparities,” by the Harvard School of Public Health, was published in the October 2011 issue of Health Affairs. The study was funded by The Commonwealth Fund; the Health Affairs October issue was supported by the Aetna Foundation. □

Palliative Care

A recent survey found that 1,568 (63 percent) of 2,489 hospitals surveyed had palliative care teams. Only hospitals with at least 50 beds were surveyed; smaller hospitals are less likely to have such specialized teams. The number of hospital-based programs has grown by 138 percent since 2000 – in mostly non-profit hospitals. They are less likely to be found in Southern hospitals. The hospice industry grew at a similar rate – mostly in for-profit companies. Oklahoma's results: 30 percent. One hundred percent of the District of Columbia's hospitals provide such care, as do 100 percent of hospitals surveyed in Vermont although hospitals too small to be included likely do not. The study was reported by the Kaiser Health News blog. □



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DIALOGUE

*Remember, if you ever need a helping hand,
you'll find one at the end of your arm...*

*As you grow older, you will discover that you have two hands,
one for helping yourself, the other for helping others.*

Audrey Hepburn

To me, Thanksgiving represents a family-oriented day focused on being grateful for both individual and collective blessings. Thanksgiving Day celebrations, minus the stress of Christmas, are among some of my best memories. Tradition meant we would arrive at my grandmother's house, and always be met with indescribable, scrumptious smells wafting from the kitchen. After a word of grace, everyone ate to their heart's content before sneaking a quick nap while pretending to watch the football game. If the weather was nice, the children would move outside to enjoy a game of their style of football and perhaps be coaxed to rake a few of the fall leaves blanketing the yard. Before going home for the evening, each family would take their share of leftovers...my favorite being the turkey sandwich on white bread with a smear of Miracle Whip.

Individuals who become physicians lend themselves a helping hand by undergoing many years of medical school and residency training. They learn to practice the "art" of medicine – and it is an art – no matter how many outside forces attempt to reduce physicians to "providers," try to supersede the physician-patient relationship, or mandate that a patient's disease can be pigeon-holed with everyone who is given the same diagnosis. Since they treat human bodies, and not something manufactured via an assembly line, no two people diagnosed with the same disease will have the same response to an identical treatment modality. It takes the knowledge and expertise of a physician to ascertain what might be the correct course of treatment for each patient.

One way physicians *lend their other hand* is treating all patients, regardless of their ability to pay. Many demonstrate their

altruism by accepting uninsured patients in their private office or by volunteering as primary care and specialty physicians at the Open Arms Clinic or other area free clinics. Many of the primary care physicians currently in the Open Arms rotation began working there 18 years ago when the doors first opened. Also vital to Open Arm's success are the specialty physicians who accept referrals ensuring that patients receive optimum care.

As an Open Arms Clinic co-sponsor, the Oklahoma County Medical Society maintains the rosters of both the primary care and the specialty physicians, schedules a primary care physician to work at the clinic and makes specialty referrals when needed. This system has worked well for 18 years, but now we have begun a new chapter. As of mid-October, Open Arms Clinic specialty referrals will be transferred to the Health Alliance for the Uninsured's Care Connection.

HAU, a successful project envisioned by former OCMS president, R. Murali Krishna, MD, is building the capacity to manage specialty referrals for its free clinic partners in a more efficient manner. The organization is also working to develop agreements with metro-area hospitals to provide a seamless process so that specialty physicians will need only to focus on the delivery of care with other ancillary services arranged through HAU. If you are a specialty physician who has not signed up, do so today by contacting the OCMS staff office, 702-0500.

I plan to demonstrate my gratitude during this Thanksgiving season and leave you with a final thought attributed to W. T. Purkiser, Christian theologian... "Not what we say about our blessings, but how we use them, is the true measure of our thanksgiving." And we are all blessed in some way! □

Jana Timberlake,
Executive Director

Happy Thanksgiving

alliance

The Fall Kick Off meeting was held September 21, and what a meeting it was! Held at the home of Terrie Hubbard, it was well attended and full of excitement.

Through the hard work and dedication of Lori Hill, Chair, and her wonderful Walk the Doc Committee, it was a day of celebration as a check for \$13,000 was presented to the staff of Schools for Healthy Lifestyles (SHL). Combined with the sponsorship efforts of the OCMS Board, we put on an event that made us all proud.

October was Breast Cancer Awareness month and, again, the Alliance and members of the OCMS joined forces to raise money for the Susan G. Komen Foundation, Race for the Cure on Saturday, October 15 in downtown Oklahoma City. By forming a Team, our efforts were stronger and our donation greater. It was a rewarding experience! Team Leaders were Suzanne Reynolds and Amy Bankhead.

November 16 will take the Alliance Members to Children's Hospital. Dr. Terry Stull, Chair of the Department of Pediatrics, will provide a tour of the facility. Children's Hospital is the *Leader in the Scope of Children's Medicine* and we are privileged to have them right here in Oklahoma.

The Alliance Holiday Auction will be held on December 2, chaired by Nina Massad. As a dynamic group, our members work hard to "give back" to our community. This auction is designed to celebrate those efforts as well as to celebrate the friendships within it.



Membership is open to all spouses of physicians. If you are not a member, we ask you to please become one. Email us at ocmsalliance@gmail.com or visit the Website, ocmsalliance.org, and leave us a message. We will be happy to assist you. □

Kathy Bookman, Co-President

Donna Parker, Co-President

Editor's note: Pictured in the photograph accompanying this article are (left to right) Donna Parker, Alliance Co-President; Barbara Jett, SHL board member; Lindsie Lemons, SHL staff; Jana Timberlake, Oklahoma County Medical Society Executive Director; Sherre James, SHL staff; and Lori Hill, Chair, Walk the Doc.

Subsidizing Junk Food?

As we know, childhood obesity rates have tripled over the last three decades, with one in five kids aged 6-11 now obese. Many “culprits” have been named – fast foods, processed foods, sweetened drinks, TV ads aimed at kids – but a major player previously not identified is in the spotlight: farm subsidies.

A report recently released by the California Public Interest Research Group (CALPIRG), “Apples to Twinkies: Comparing Federal Subsidies of Fresh Produce and Junk Food,” revealed that between 1995 and 2010, American taxpayers spent over \$260 billion in agricultural subsidies. Most subsidies were paid to the country’s largest farming operations, to grow just a few commodity crops, including corn and soybeans – the ingredients used to manufacture high fructose corn syrup and vegetable oils used in a variety of junk food products. That’s right: Americans’ tax dollars are directly subsidizing junk food:

- Between 1995 and 2010, \$16.9 billion subsidized corn syrup, high fructose corn syrup, corn starch, and soy oils (which are often processed into hydrogenated vegetable oil).
- Since 1995 only \$262 million in direct subsidies supported the growing of apples – the only significant federal subsidy of fresh fruits or vegetables.
- If these subsidies had gone directly to consumers to purchase food, each of America’s 144 million taxpayers would have received \$7.36 to spend on junk food and 11 cents to buy apples – enough to buy 19 Twinkies but less than one-quarter of one Red Delicious apple each.

The report is available online:

<http://www.calpirg.org/home/reports/report-archives/health-care/health-care/apples-to-twinkies2>. □

(Continued from page 21)

Stanley R. McCampbell was a gentleman and a scholar. He and I shared many patients, and patients spoke fondly of him. Stanley was always dignified, friendly and usually had a funny story to tell. He held a great number of offices in the Medical community as well as in other organizations. One great interest was tennis and, in fact, he was one of the organizers of the American Medical Tennis Society. I never played tennis with him but would see him on the next court and must say he was a formidable player. He must have had a wall full of accolades. We frequently crossed paths in the hospital coffee room and went over the day's news. I always enjoyed seeing him. We both had farms in the eastern part of the county and spent some time talking about horses and such. We also went on some fine fishing trips! Stanley was a friend, a first-class member of the Medical community and will certainly be missed.

Requiescat in pace. □

Philip Maguire, MD

(Continued from page 23)

Even with his busy schedule, Floyd found time for family activities. He loved tennis, and even competed in doubles tournament tennis with his elder son for many years. In later years, he transferred his competitive spirit to playing golf with his friends at his favorite course until being curtailed by more recent medical issues.

Floyd is survived by Adeline, his wife of 58 years, and his sons Mike and Steve and their spouses, along with five grandchildren and three great grandchildren.

Floyd Miller was one of the most gentle, compassionate physicians I have ever met. However, when I saw him on many occasions advocating for physicians, he was as intense, passionate, and competitive as you would want to see. Floyd, I know you are in a better place now. I expect you are again competing on the golf course, and possibly even on the tennis court. Play well, my friend. □

Carl Hook, MD

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

COMMONLY REPORTED DISEASES	<i>Monthly</i>			<i>YTD Totals[^]</i>	
	Sept'11	Sept'10	Aug'11	Sept'11	Sept'10
Campylobacter infection	7	4	8	53	56
Chlamydial infection	N/A	N/A	N/A	N/A	N/A
Cryptosporidiosis	3	4	3	20	18
E. coli (STEC, EHEC)	0	3	1	8	10
Ehrlichiosis	0	0	2	2	1
Giardiasis	0	0	0	1	12
Gonorrhea	N/A	N/A	N/A	N/A	N/A
Haemophilus influenzae Type B	0	0	0	0	0
Haemophilus influenzae Invasive	0	0	1	9	21
Hepatitis A	0	0	1	2	3
Hepatitis B*	10	16	15	113	142
Hepatitis C *	20	22	14	142	165
HIV Infection	N/A	N/A	N/A	N/A	N/A
Lyme disease	0	0	2	4	10
Malaria	0	0	0	0	1
Measles	0	0	0	0	0
Mumps	0	0	0	1	0
Neisseria Meningitis	0	0	0	1	2
Pertussis	6	5	3	26	32
Pneumococcal infection Invasive	0	1	2	5	10
Rocky Mtn. Spotted Fever (RMSF)	18	8	14	88	25
Salmonellosis	9	22	38	103	104
Syphilis (primary/secondary)	N/A	N/A	N/A	N/A	N/A
Shigellosis	25	4	3	46	58
Tuberculosis ATS Class II (+PPD only)	39	57	76	419	485
Tuberculosis ATS Class III (new active)	4	3	3	25	20
Tularemia	0	0	0	1	2
Typhoid fever	0	0	0	1	1
RARELY REPORTED DISEASES/Conditions:					
West Nile Virus Disease	0	0	0	0	0
Pediatric Influenza Death	0	0	0	0	0
Influenza, Hospitalization or Death	0	0	0	237	13
Influenza, Novel Virus	0	0	0	0	0
Strep A Invasive	0	1	0	2	20
Legionella	0	1	0	3	4
Rubella	0	0	0	1	2
Listeriosis	3	0	0	3	1
Yersinia (not plague)	0	0	0	0	1
Dengue fever	0	0	0	0	1

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

[^] *YTD - Year To Date Totals*

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

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 System, Inc. (COINS)
Contact: Deborah Ferguson
Telephone: (405) 524-8100 ext. 103

Deaconess Hospital

Contact: Emily McEwen
CME Coordinator
Medical Library
Telephone: 604-4523

Integris Baptist Medical Center

Contact: Marilyn Fick
Medical Education
Office
Telephone: 949-3284

Integris Southwest Medical Center

Contact: Marilyn Fick
CME Coordinator
Telephone: 949-3284

Mercy Health Center

Contact: Debbie Stanila
CME Coordinator
Telephone: 752-3806

Midwest Regional Medical Center

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

Oklahoma Academy of Family Physicians Choice CME Program

Contact: Sue Hinrichs
Director of
Communications
Telephone: 842-0484
E-Mail: hinrichs@okaftp.org
Website: www.okaftp.org

OUHSC-Irwin H. Brown Office of Continuing Professional Development

Contact: Susie Dealy or
Myrna Rae Page
Telephone: 271-2350
Check the homepage for the latest
CME offerings:
<http://cme.ouhsc.edu>

St. Anthony Hospital

Contact: Lisa Hutts
CME Coordinator
Telephone: 272-6358

Orthopaedic & Reconstruction Research Foundation

Contact: Kristi Kenney
CME Program Director
or Tiffany Sullivan
Executive Director
Telephone: 631-2601

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