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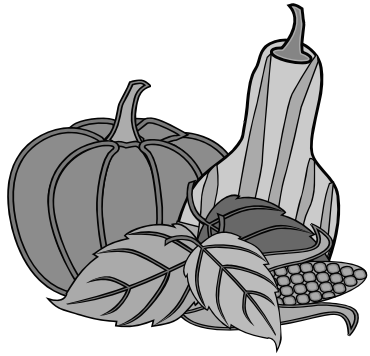

About The Cover

This sepia illustration of Gary G. Roberts, MD, was drawn by his friend William E. Hood, Jr., MD, in May of 2012. It was drawn from a photograph that was taken on New Year's Eve 2010. The drawing was made with dark umber and white Prismacolor pencil on Old Green Speckletone French paper. Dr. Roberts passed away in March 2012. ❑

New Members

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School of Medicine 2001

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Univ. of Oklahoma
2007

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Univ. of Oklahoma
2007

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Univ. of Oklahoma
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Deccan College of Med.
Science
Hyderabab, A P, India 1991

Chance Lee Matthiesen, MD
(RO)
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L200
Univ. of Oklahoma 2007

Betty S. Tsai, MD
(OTO)
825 N.E. 10th St., #4200
Baylor College of Medicine
2005

OCMS 2013 Board Members and Election of Officers

Election of 2013 OCMS Officers will occur at the Annual Membership Meeting on Monday, Nov. 5, 2012. Nominees are: Julie Strebel Hager, MD - President-Elect; C. Douglas Folger, MD - Vice President; and Don L. Wilber, MD - Secretary-Treasurer.

The OCMS Nominating Committee met recently and certified the election of Board Members and Delegates. The 2013 new Board members are: Joseph C. Broome, MD; J. Samuel Little, MD; Don P. Murray, MD; and Louis M. Chambers, MD. ❑

In Memoriam

Juan Francisco Correa Davila, MD
1922 – 2012

James E. Mays, Jr., MD
1927-2012

Barney Joe Limes, MD
1930-2012

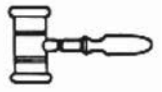
Ernest R. Daffer, MD
1930 – 2012

Jerry Lee Bressie, MD
1932-2012

C. Randall Jenkins, MD
1948 – 2012

Bruce C. Dunn, MD
1948 – 2012

President's Page



Tomás P. Owens, MD

The Oklahoma Justice Reinvestment Initiative

Nationally, Oklahoma has the 4th largest incarceration rate for males and 1st for females (Oklahoma rate is 129/100K vs. a national rate of 57/100K population). The average cost per inmate is $16,539 per year[1]. The incarceration of Oklahomans has a vast effect on the health of the population. Approximately 24,000 people are in prison in Oklahoma today.

Scores are mothers and fathers of minor children. Some have committed horrific crimes and must be separated from society permanently and irreversibly. Many have a violent streak and several others have been caught in a web of self-defeating behavior, inauspicious surroundings and drug use. Yet another large segment has mental health issues. The wisdom of long periods of internment for the latter individuals has been challenged. Moreover, general emphasis on the punitive or isolationist features of imprisonment is misguided, mostly based on the sensational exceptions and the experience with the most vicious and egregious criminals.

Rehabilitation and adequate treatment of mentally ill inmates will yield better outcomes for our state's health. Addicted and emotionally challenged prisoners, in spite of the Department of Corrections' best efforts, get exposed to influential malevolent characters in prison at a higher rate than they would have in the outside world. Many learn of atrocious behaviors that would have never occurred to them even at their precarious and dangerous neighborhoods. Exposing mentally challenged criminals to professional criminals can serve as a veritable "crime college."

Non-violent offenders in many instances need guidance, medication, psychotherapy and halfway houses to separate them from a life of crime, not an institution where they could inadvertently be taught more violent forms of interaction with the world or sometimes gain access to new and more dangerous drugs. There is a high rate of repeat offenses amongst many of the aforementioned criminals and the vicious cycle of re-offense/re-incarceration threatens to bankrupt the system and the state.

Poignantly, an ex-prisoner without dependents needs a minimum of $ 15,877 per year to sustain him or herself in Oklahoma County following release. That means gaining the skills and eventually holding an occupation that would pay at least that much as they arrive to the job market unprepared.

On Nov. 1, HB 3052, or the Oklahoma Justice Reinvestment Initiative, goes into effect. This effort, lead by retiring House Speaker Kris Steele, promises to make significant strides in helping resolve the aforesaid. As of today, 51% of those released from the penitentiary get no supervision. This new law will require *all* inmates to receive 9 months of supervision upon their release from prison. This is expected to reduce the rate of repeat offenders. On the other end, this law creates a grant program that will invest up to $40 million in 10 years for local law enforcement pre-emptive efforts against criminality.

The Oklahoma probations and parole service today supervises 34,000+ offenders at a mean cost of less than $2 per day/per individual. This new law orders inmates that violate their probation to be assigned to intermediate revocation facilities to receive treatment for any addiction or mental health issues, rather than immediately going back to prison[2]. The estimates are that this will save about $200 million over the next decade (with half of that to be reinvested in crime fighting programs).

As reported by The Oklahoman, the challenge now will be to have all parties – prosecutors, judges, law enforcement and mental health groups - actively participate in the working group. It is not only what is right by those with mental illness and addiction, but is also the fiscally responsible and the medically ethical thing to do. In

addition, whole generations of children on the outside depend on the success of this endeavor.

Independent Transportation Network

The ITN working group has now met with all major hospital providers in the county and has started to visit with the civic/ philanthropic departments of several of the major Oklahoma City corporations. We have received unanimous support.

OCMS has provided the initial costs and the OCMS Community Foundation has become the fiscal agent for the start up of the newly minted ITN Central Oklahoma.

OCMS will host ITN for the first few years. A Steering Committee will be constituted this month and we expect a launch in the next month. ❑

References:
1.http://www.doc.state.ok.us/newsroom/publications/did_you_know.htm
2. http://newsok.com/buy-in-necessary-for-oklahoma-justice-reform-bill-to-succeed/article/3712691

Holy Days of Eastern Orthodox Christianity

Paul Massad, MD

(Editor's note: This is the first in a series of Bulletin articles written by OCMS members describing the holy days and celebrations of their religions.)

Let me introduce you to the Liturgical Calendar of Eastern Orthodox Christianity. The ecclesiastical year begins Sept. 1. In the same way a metronome helps keep the rhythm musically, the Liturgical Calendar keeps the pace and rhythm of the liturgical life of the Eastern Church throughout the year.

Before discussing the Liturgical Calendar itself, I must mention the secular calendar. In 1582 Pope Gregory XIII modified the Julian calendar's use of leap years in order for the calendar more accurately to coincide with the spring equinox. March 21 had been the date of the spring equinox since the First Ecumenical Council in Nicea in A.D. 325. In 1582, a 10-day shift was needed for March 21 to once again coincide with the spring equinox. The shift was made and the Gregorian calendar was created.

At first only the four Catholic countries of the West adopted the new calendar. Eventually Protestant countries also adopted Gregory's calendar. It was not until the 20th century that Russia and Greece adopted the Gregorian calendar, which today is the predominant international civil calendar.

By the 20th century, a 13-day adjustment was required between the Old Julian and the New Gregorian calendars. Some of the Eastern Orthodox churches did not accept using the New Gregorian calendar for their Liturgical Calendar. Therefore, within Eastern Orthodox Christianity there are New Calendar churches and there are Old Calendar churches.

There are two kinds of feasts in the Eastern Orthodox Liturgical Calendar: Fixed and Movable. Fixed Feasts are feasts occurring on the same date each year (such as Christmas). Movable Feasts are feasts that occur on a different date each year (such as Easter).

All Eastern Orthodox churches celebrate the Movable Feasts on the same day each year. But those churches using the Old

Julian calendar celebrate the Fix Feasts 13 days after those Orthodox churches using the New Gregorian calendar.

Pascha (Easter), the Feast of all Feasts, is a Movable Feast. All Eastern Orthodox Christians celebrate Pascha on the first Sunday following the first full moon after the spring equinox (March 21) *provided the Jewish feast of Passover has been completed*. Since the Crucifixion and Resurrection occurred at the Jewish Passover, Eastern Christianity does not celebrate Pascha before the Jewish Passover. This is why the date for the Eastern Orthodox Pascha sometimes is several weeks after Western Easter.

In addition to Pascha, which is above all feasts, there are Twelve Great Feasts celebrated by Eastern Orthodox Christians. Three of these are movable and are based on Pascha:

- Palm Sunday (the Sunday before Pascha)
- the Ascension (40 days after Pascha)
- Pentecost (50 days after Pascha)

The remaining Great Feasts are Fixed Feasts and are celebrated 13 days apart depending on which civil calendar is used:

- The Nativity of the Virgin Mary (8 September)
- The Elevation of the Holy Cross (14 September)
- The Presentation of the Virgin Mary (21 November)
- The Nativity of the Lord (25 December)
- The Theophany (Epiphany) of the Lord (6 January)
- The Presentation of the Lord (2 February)
- The Annunciation (25 March)
- The Transfiguration (6 August)
- The Dormition (Falling Asleep) of the Virgin Mary (15 August)

Orthodox Christian worship involves the five senses. There is music to be sung and heard; incense that is smelled; blessed bread to be held, tasted and eaten; and colorful icons to be seen. Additionally, our special feast days may include distributing fresh basil sprigs (the Elevation of the Cross), cups of blessed water (Theophany) or ripe grapes (the Transfiguration).

We also remember the saints on the day of their falling asleep. For example, the feast day for St. Nicholas of Myra, in what is today Turkey, is Dec. 6. St. Nicholas was a major figure at the First Ecumenical Council in A.D. 325 in Nicea. He is also the patron saint of children. Before going to bed, children would place their shoes in a certain place in hopes of finding goodies in them in the morning. Somehow in the West his feast day was celebrated later and later in the month until it eventually bumped into the Feast of the Nativity of our Lord. That's why Santa Claus is now part of Christmas.

But the highlight of the Orthodox Christian's year is Holy Pascha (Easter). We begin our journey to the Empty Tomb four Sundays before the 40 days of Great Lent, which begins with Forgiveness Vespers. Great Lent is filled with fasting and extra services during the week. Great Lent ends on Lazarus Saturday, which is the day before Palm Sunday. With Lazarus Saturday and Palm Sunday we now enter into the daily services of Holy Week.

Three nights are given to the Bridegroom Services. Wednesday night is Holy Unction, the anointing with oil, and praying for the sick. Thursday morning is the Last Supper. Thursday night is the Crucifixion. Friday afternoon Christ is taken down from the Cross. Friday night is the Lamentation Service and the Burial of Christ.

Following an all-night vigil we gather Saturday morning at the tomb. At midnight on Saturday night we gather outside the doors of the church to hear the shout of the Resurrection. We enter the church joyfully singing the Troparion of the Resurrection, which we will sing for the next 40 days. We sing it in three languages, English, Greek and Arabic:

Christ is risen from the dead.

O Christ is risen from the dead.

Trampling down death by death,

An upon those in the tombs

Bestowing life.

Please contact any of the Orthodox Christian churches in the Oklahoma City area for information regarding their services this holiday season: St. Elijah Orthodox Church (OKC), St. George Orthodox Church (OKC), St. Mary Orthodox Church (Jones), Holy Ascension Orthodox Church (Norman), and St. James Orthodox Church (Stillwater).

May you have a blessed and very Merry Christmas. And may God grant you many years! ❑

Legal Guide for Senior Citizens

The Oklahoma Bar Association (OBA) Young Lawyers Division has recently revised the Senior Citizens Handbook. It discusses situations that are common to seniors, such as writing wills or handling finances, and explains how to deal with them. It is available online at **www.okbar.org/public/brochures**. Printed copies are available through the OBA at (405) 416-7000. Shipping is $5 for five or fewer copies. ❑

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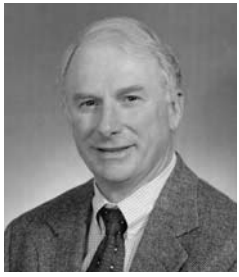
Pearl of the Month



James R. Couch, Jr., MD

Medication Overuse Headache

Medication Overuse Headache (MOH) is a problem of major significance for societies all over the world. It is a condition with insidious onset variable progression and can produce a great deal of intermittent disability for the sufferer.

For the most part, MOH arises out of intermittent frequent or Chronic Daily Headache (CDH) with migraine or a combination of migraine and tension-type headache features. In epidemiologic studies from America, Europe, Africa and Asia, CDH is seen in 2-5% of the population in general. MOH occurs in 20-50% of this group or up to 1% of the population. MOH contributes significantly to the overuse of medically prescribed opiates seen today.

With the syndrome of MOH, the patient often has a background of infrequent migraine (<10 days/month) and begins to have acceleration of the headache frequency into a pattern of CDH defined as headache occurring ≥15 days/month. The headaches typically have a pattern of "big" and "little" headaches, with the "big" headaches occurring from 1-2/month to 15-20/month. The "big" headaches are usually rated at 8+/10, and "little" headaches at 2-5/10. With the "big" headaches the patients usually go to bed or are at minimal activity. The "big" headaches usually have features of migraine while the "little" headaches are more like tension or possible migraine in character. With the "little" headaches, the patient can continue to function at 50% or more of "usual" activity.

The patient is usually given a symptomatic medication (SM) for the headache and achieves a significant degree of relief. Initially the SM works well but with frequent ongoing use its efficacy wanes, resulting in increasing use of the SM to achieve pain relief. Despite increasing use of the SM, the intensity of the *headache problem,* in terms of frequency and intensity of the headache, gradually worsens resulting in further increase in SM usage. At this point, attempts to stop the SM result in severe and prolonged headache, which sustains the cycle. To diagnose MOH, the pattern of SM overuse must be present for at least 3 months and may have been ongoing for several years.

The SMs that are associated with MOH (MOH agents) include major and minor narcotics (including hydrocodone and oxycodone), butalbital and other short acting barbiturates, all triptans, and over-the-counter analgesics with combinations of aspirin and acetaminophen (such as Excedrin). Whether aspirin, acetaminophen or ibuprofen used as single agents can precipitate MOH is debated.

To diagnose MOH it is necessary to establish:

1. The underlying headache is a primary type of headache and not secondary to another disease process.
2. There is a pattern of consistent overuse of an SM of one of the types noted above. For triptans or narcotics this would constitute usage ≥10 days/month or analgesics ≥15 days/month and this overuse has been present for at least 3 months.

Treatment of MOH, for the best results, requires discontinuation of the MOH agent. There are multiple ways to achieve this, varying from gradual limitation of use with discontinuation by tapering the MOH agent over several weeks to immediate discontinuation and dealing with the subsequent headaches.

The discontinuation must be coupled with a plan to manage this headache. Typically this requires use of a preventative antimigraine agent (PAM) along with another type of SM to help with acute pain. For the PAM, I prefer a tricyclic antidepressant such as amitriptyline with either topiramate or sodium valproate

as alternate choices. For the SM in the outpatient withdrawal setting, an NSAID such as ibuprofen or ketoprofen combined with 25 -50 mg of hydroxyzine or promethazine may provide adequate relief. Doses of amitriptyline of 100-200 mg/day may be required for initial management and can be tapered later.

For the more severe case, hospitalization with use of intravenous dihydroergotamine may be required to initiate the withdrawal. In this situation, the SM is withdrawn immediately, dihydroergotamine is used to control the acute headache and the PAM is initiated at the same time.

After the acute or gradual withdrawal of the MOH agent, the patient and physician must still deal with the underlying *headache problem* that produced the MOH.

Complete return to the pre-MOH status may take up to 6 months, and the patient needs adequate follow-up and access to the physician during this period. Ongoing use of PAM is usually always necessary as well as close monitoring of any SM agent used to help the patient. Recidivism to the use of the MOH agent is common and may occur in 33-50% of patients. A physician who is caring and willing to continue to help the patient when he/she "falls off the wagon" is absolutely necessary.

The final note is that MOH is often a partially iatrogenic problem that may result from physicians not monitoring the patient's medication usage and request for prescription refills. ***The best treatment for MOH is prevention of occurrence!*** ❑

OCMS Inaugural Dinner Jan. 18

The OCMS Inaugural Dinner will be Friday, Jan. 18, 2013, at the Oklahoma City Golf & Country Club. Dr. Thomas H. Flesher III will be installed as the 113th President of the Society. The Straight Shooter Band will provide lively entertainment. Mark your calendar, save the date, and watch your home mail for the invitation with details. They will be mailed immediately after Christmas. ❑

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D. Wade Christensen, JD[1], J. Clay Christensen, JD[2], L. Nazette Zuhdi, JD, LLM[3], Adam W. Christensen[4], JD, MBA, Blake Christensen, DO, and S. Sandy Sanbar, MD, PhD, JD[5]

The Patient Protection and Affordable Care Act (PPACA) was signed into law by President Barack Obama on March 23, 2010. It created the Medicare Shared Savings (MSS) program[1]. The MSS program promotes accountability for a patient population, coordinates items and services under part A and B; and encourages investment in infrastructure and redesigned care processes for the purpose of providing high quality and efficient service delivery. In 2011, the Centers for Medicare & Medicaid Services (CMS), which is one of the HHS agencies, issued the rule that established Accountable Care Organizations (ACOs)[2].

The ACO initiative is a doctor-hospital partnership which heavily emphasizes integration through technology. The goals or benchmarks of ACOs are the provision of good quality care to Medicare beneficiaries, the reduction of waste when rendering medical services, and ultimately the containment of health care cost. The doctors and hospitals will jointly be accountable for the health of their patients. They are expected to utilize meaningfully the use of electronic medical records and to effectively coordinate care among all providers, and are discouraged from repeating tests on patients.

The ACO providers contractually agree to manage all of the health care needs of a minimum of 5,000 Medicare beneficiaries for at least three years. They are given strong incentives to cooperate and save money by avoiding unnecessary tests and

(Continued on page 20)

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procedures. They will get paid more in bonuses for keeping their patients healthy and out of the hospital.

On the other hand, the ACOs may have to pay a penalty if they do not meet performance and savings benchmarks. And patients in ACOs would still be free to see doctors of their choice outside the network without paying more. In this regard, ACOs differ from HMOs (Health Maintenance Organizations) where patients do not have that choice. In an attempt to become integrated systems, U.S. hospital systems have been buying up physician practices in hopes of becoming ACOs that directly employ the majority of their physicians.

The novel idea of the ACO doctor-hospital partnership has raised some important legal concerns, including (1) anti-trust and anti-fraud laws, (2) novel contracts between doctors and hospitals, (3) direct liability of ACOs for integrated system failure or improper integration of care, failure to properly credential and re-credential physicians, and failure to properly train or oversee personnel, vicarious liability extending to both old and new duties which are based on general corporate and agency law principles, (4) liability for independent contractors under the theory of apparent authority, or ostensible agency, (5) liability of primary care physicians for any system breakdown, even at a third-party level, (6) ACO liability caused by self-insurance which protects physicians as long as the system remains financially stable, (7) malpractice claims resulting from incentivizing physicians to not repeat tests or not to refer patients for needed treatment, delay some admissions or discharge patients prematurely, (8) the standard of care for ACOs may be higher than the prevailing standard because the physician may have to explain why he or she did not follow the ACO application, assessment and individualized care plan, and (9) when providing informed consent, physicians should ascertain that the patient comprehends the alternative therapies presented and their risks in order to make an ***informed choice***; patient understanding is pivotal in the informed consent process.

An ACO should put the beneficiary and family at the center of all its activities, honor individual preferences, values, backgrounds, resources, and skills, and should thoroughly engage people in shared decision-making about diagnostic and therapeutic options. This is referred to as **patient engagement,** *(continued on page 22)*

The homeless are the responsibility of those of us who have homes. We cannot blame their destiny, entirely, upon them. They are the products of their times, doing the best they can with what they have been vouchsafed. Poverty is a social disease whose roots lie in genetic dysfunctions, traumatic childhoods, fractured families, deficient education, and enabling environments. If we cannot preserve the dignity of our poor, we stand to lose our own.

Homeless

Hanna Saadah, MD

Of earth, I am a wondering breath of mud
I lost my home, my land, and sold my blood
When it is hot I find a shady spot
When cold, so not to freeze, I walk a lot.

I eat what I can find or people give
I sleep on benches—in the streets I live
No place is safe, I cannot rest nor hope
I dwell with knifings, alcohol, and dope.

Born of the social ills of this, our time
Sickened by illness, tragedy, and crime
Condemned by genes and childhood, not to thrive
I do my best—I manage to survive.

I am a scar upon my marble race
It has begotten, now it has to face.

(Law and Medicine continued ftrom page 20)'

which allows the patient to assess the merits of various treatment options in the context of his or her values and convictions. The ACO standards may indeed be stricter than the prevailing informed consent standards. Physicians may be liable for lack of ***informed choice*** for failure on the part of the physician to demonstrate that a patient understood all reasonable alternatives and made decisions accordingly. ❑

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[1] http://edocket.access.gpo.gov/2011/pdf/2011-7880.pdf

[2] http://www.cms.gov/sharedsavingsprogram

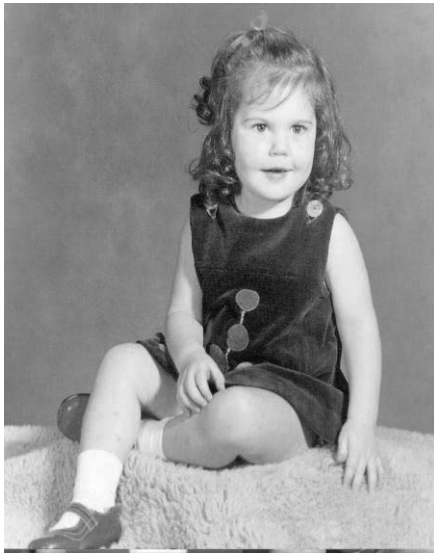
If I summon up those memories that have left me with an enduring savor, if I draw up the balance sheet of the hours in my life that have truly counted, surely I find only those that no wealth could have procured me.

Antoine de Saint-Exupéry
Wind, Sand and Stars

Valerie
The Story of a Foster Child

John A. Blaschke MD

In 1969 my wife and I became foster parents for the Oklahoma Department of Human Service (DHS).Our three older children were in college or on their own and the three younger were in high school. A story in our local paper about the number of abused, neglected or abandoned children in our state and the pressing need for more foster parents caught my wife's eye. Possibly the nearness of an empty nest in our lives motivated her interest. In fact, however, ever since our earliest dates my dear wife manifested special concern for children in need.



Valerie, age 3

Ruth made the usual inquiries, was interviewed by several and made plans to become involved in foster care. I was in agreement with the plan but not enthusiastic. In my view six children were enough responsibility. The social worker that interviewed me sensed my moderation and indicated that it would not be acceptable if I were not committed. Ruth's unhappy face appeared in my mind and hastily I agreed to be fully involved.

For the next 29 years a parade of injured, neglected, abused, and sometimes sexually abused children came to our home.

Every race, color and ethnic group was represented. Many stayed a few weeks. One little boy stayed six years. One brother and sister came for two separate stays. DHS records indicate that 184 children were in our care for varying periods in those 29 years.

The events, circumstances and stories of these children could break your heart. People asked us if we experienced a sense of loss when the children were either returned to their parent(s) or adopted. Of course we did, but all the social workers emphasized to us the necessity of hiding our tears and acting enthusiastically about how great an event was about to happen to an anxious child.

Perhaps in narrating the story of Valerie I can convey a portrait of the problems that necessitate foster care, the impact on the child, and the tug on our hearts when they left. Val came to us at about 18 months of age. The worker did not give us any details other than Val was a bedwetter and had been punished by her mother to such a degree that the neighbors complained to DHS. The plan was to arrange counseling for the mother and after some period of time Val would be returned to her mother.

Val was an adorable baby girl. Dark curly hair and a cupid face that always reminded me of the advertisements for Campbell's soup, which depicted twin girls like Val. She learned to talk, play, laugh, and eat everything normal for a child of that age. She did have trouble learning bladder control but she would always say, "Sorry." We had other children at the time, a small Sioux Indian boy, and another girl about 4 years of age. I have a photo of them on our bed, dressed in colorful sleepers; they are incredibly beautiful as they look at the camera. Incomprehensible to most is the idea that these lovely creations of God's purpose could be deliberately injured.

After a year or so the day came for Val to go home. My wife had made a cute blue velvet dress for her. We had a cake, balloons and two of our own children to the farewell party. I took pictures and even now I marvel what a sweet child she had become for us.

Eight months later the social worker brought Val to my office as an emergency. As I examined her I was first shocked, then outraged at the painful damage that Val had sustained for wetting her pants. She had three cigarette burns on the palm of

her right hand, two on the left. On the sole of the left foot two circular burn scars from a cigarette. She had bruises on her bottoms, arms and legs, and a cut on her forehead. Several denuded areas on her scalp where her hair had been pulled out. She whimpered and cringed when I first began to examine her, but her smile, when she recognized me, energized me. Foster parents were not supposed to become involved in the legal processes of the children but I wrote a detailed medical report to the presiding judge of the Juvenile Court. He told me later at a social event that my letter made clear the extent of her injuries, but it was also clear that I had taken it personally.

Val came back to us and stayed about a year. She finally learned bladder control and was as always a lovable, enjoyable and intelligent little girl who needed loving, caring parents on a permanent basis. Val's mother's rights were terminated and Val was adopted. We had another farewell party and I came home from my office to attend the party and see her off. Ruth and I had a few private tears. We never saw or heard anything about Val again. This is the primary unhappy aspect of foster care. Forty-two years ago Val left and even now, occasionally, Ruth and I wonder what happened in her life. Does she have children of her own? Is she good to them? Hopefully she will not remember the pain when the cigarettes burned her hands. Val will always occupy a special niche in our memories and hearts. ❑

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Her Journey Around the World

Tracy Senat

For Dr. Susan Chambers, life is a journey that has taken her around the world with World Neighbors, an international community development organization headquartered in Oklahoma City.

From the remotest villages in Africa and South America to places in between, Dr. Chambers takes her knowledge and experience out to help others find lasting solutions for their communities.

Dr. Chambers is an OB/GYN specialist in Oklahoma City, practicing at Lakeside Women's Hospital. She is married and has three children.

She also has volunteered with World Neighbors for 15 years and remains passionate about its mission to eliminate hunger, poverty and disease in the poorest, most isolated rural villages in Asia, Africa and Latin America.

Dr. Susan Chambers works with a traditional birth attendant in Mali during a World Neighbors journey.

World Neighbors was 'born' in 1951 from a sermon given at St. Luke's United Methodist Church by Dr. John Peters. This inspirational sermon served as the beginning of World Neighbors, which to date has helped transform the lives of more than 26 million people in 45 countries. Currently

around 500,000 people benefit from World Neighbors programs in 13 countries in Asia, Africa, Latin America and the Caribbean.

Dr. Chambers attends St. Luke's United Methodist Church, where she learned the history of World Neighbors and its beginnings there. About 15 years ago, she was invited to a talk at a friend's house on maternal health in Africa.

"That's what got me hooked, when I saw how World Neighbors works in the world," she said. "They truly do community development. They don't give people fish, they teach people how to fish for themselves. They give people tools that help them make long-lasting improvements in their communities."

Not long after, she went on a World Neighbors 'journey' to Ecuador.

"We call them 'journeys' at World Neighbors," she said. "We experience the whole community from health care to literacy training, agriculture, and savings and credit programs so we see the whole picture. It's a very holistic approach. We do not give away food or aid, we provide tools and training so people can improve their own communities."

After her trip to Ecuador, she joined the World Neighbors board and has been a part of their work since. In 2009, World Neighbors presented her with the prestigious Namasté award, which recognizes a person or family who symbolizes

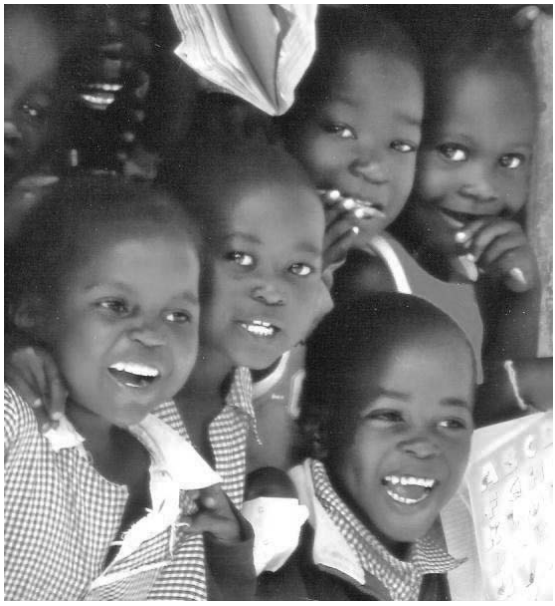
Dr. Chambers worked with this woman in Kenya who has HIV. World Neighbors' programs are helping this woman improve her life and that of her family and community with better plants and by teaching new growing and grafting techniques.

the qualities of the World Neighbors mission.

Dr. Chambers has now 'journeyed' to a number of countries around the world, some multiple times, including Ecuador, Mali, Guatemala, Kenya and Tanzania.

When Dr. Chambers journeyed to Mali in West Africa, only 10 percent of the country's roads were paved so it took days of travel to reach their remote village.

"That trip we slept in tents. There was a 'government health clinic' there but it had no electricity, no water, and used lanterns for light," she said. A midwife-type person was there to help women go through labor and give birth.



One night just before dinner ("just like at home!"), she was told that a woman was there to give birth after walking nine miles in labor with her family to get there.

The woman was laid down on a rickety metal table and labor was stimulated by the traditional method of pounding on her abdomen. Two hours later, the baby was born. The family then scrubbed the baby clean and "30 minutes after giving birth, the woman walked nine miles back home with her family and new baby."

Since so many poor countries have very high infant mortality rates, World Neighbors now runs a 'Traditional Birth Attendants' program that teaches community women ways to lessen the risks of birth. They are taught to wash their hands, to sterilize razor blades, and how to quickly recognize problems such as infection, bleeding and malpresentation.

"These women are very proud of this education, as most of them do not go to school," Dr. Chambers said. "They are empowered to help their community and, in return, their community supports them."

Even though World Neighbors travels into the 'tiniest, most remote' villages, the people they meet in those villages are wonderful, she said.

"The people we meet are great," she said. "They want to be good hosts, and they are very friendly and welcoming. They are just like us. They want the same things we do, like a better life for their children."

Dr. Chambers intends to keep working with World Neighbors for a long time.

"World Neighbors gets under your skin," she laughed. "It's just a great organization." ❑

PHYSICIANS:
ARE YOU SIGNED UP WITH THE HEALTH ALLIANCE FOR THE UNINSURED?

The Health Alliance for the Uninsured (HAU) is looking for physicians to donate their time and skills at HAU charitable clinics or to see a limited number of charitable clinic patients in their practices. All referrals are coordinated by HAU.

The HAU referral process makes it easy for you to participate:

- You establish the number of patients you will see.
- HAU arranges lab, pathology, x-ray and other imaging.
- HAU coordinates hospital services.
- Clinic data and notes are sent for your review.
- Patients are screened for eligibility.
- Patients are counseled that a missed appointment, without notice, removes the patient's eligibility.
- Patients return to the charitable clinic for follow-up and treatment of other health conditions.
- Liability protection for physicians that volunteer at free/charitable clinics and/or agree to accept referrals of free/charitable clinic patients is covered by recent state laws.

For more information or to sign up, please contact Beverly Caviness, RN, at 286-3343. ❑

Thankful for Family

Thanksgiving is quickly upon us. I get excited at the thought of our daughters coming home and us all being together. I then get even more nostalgic as I think about our Thanksgiving traditions and one in particular. Each year, those present at the Thanksgiving table take a moment to share and reflect upon life's blessings.

When the girls were young, we even experienced some giggles as they proudly and profoundly expressed they were thankful they had passed a test, a particular young man had noticed them, or they had gotten a special birthday gift.

As they have gotten older, the expressions of "thanksgiving" have become more mature and reflective. One Thanksgiving in particular, they revealed how happy they were to have us as their parents and for all the sacrifices we both had made to provide them with quality family time, a good education and lots of love and laughter. If you are a parent, you can appreciate what an amazing gift that statement is to receive even if you have to wait a few years to receive it!

As President of the OCMS Alliance, I also find myself reflective and nostalgic and realize that family comes in many forms. I have had the good fortune to be a member of the family of medicine and know so many of you. I hope we each realize the bond we have with one another is unique and truly special. We know what it is like to make sacrifices at home, at work, and within the community. We lead, celebrate, console and encourage one another.

Being a member of both the Oklahoma County Medical Society and the Alliance affords us an opportunity and platform

(Continued on page 33)

Director's

DIALOGUE

The unthankful heart... discovers no mercies;
but let the thankful heart sweep through the day
and, as the magnet finds the iron, so it will find,
in every hour, some heavenly blessings!

~Henry Ward Beecher

When is the last time you made a list of all the things that make you thankful? I tried listing and prioritizing mine recently. Soon after I began, it quickly became apparent that my reasons to be thankful were unending and the task impossible.

We are among the fortunate who do not worry about where the next meal will come from or having to decide whether to pay the rent, the utility bill or use those funds to purchase life-saving prescriptions. Many of us volunteer at charitable organizations that assist people in need such as the Food Bank, Infant Crisis Services, or our church's "meals on wheels" program. This gives us an opportunity to demonstrate our thanks by giving ourselves in service to others.

Recently, the OCMS Alliance did this by announcing its 2012 Kitchen Tour proceeds would be shared by two organizations providing service to others: Toby Keith's KID'S KORRAL and the YWCA Battered Women's Shelter.

The KID'S KORRAL concept was developed with the hope to make life easier for children undergoing cancer treatment at the OU Medical Center. It will open its doors in 2013 to provide a cost-free, convenient and comfortable home providing warmth and security to children receiving cancer treatment in Oklahoma and their families.

The YWCA has been known for its domestic violence outreach programs for more than 20 years and recently launched a $15 million capital fundraising campaign to better help victims break the cycle of abuse by building a larger emergency shelter for women and their children. Plans are for the current emergency shelter to become an enhanced extended-stay shelter.

(Continued on page 33)

(Alliance continued from page 31)

that no other organization can offer. I encourage each of you to *add to our family. Reach out* and share with others our visions and goals. Invite new physicians and spouses to dinner or special events, and introduce them to others.

Blessings come in many forms. I consider the Alliance and OCMS a highlight of mine! ❑

Kathy Bookman, President
OCMS – Alliance

Please Join Us !

Alliance Holiday Auction -Wed. Dec. 5 - 11:30 am

Home of Dr. Diana Hampton

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www.ocmsalliance.org

(Director's Dialogue continued from page 32)

We applaud the Alliance for its giving spirit. The next time you see an Alliance member, please remember to thank her or him for the positive work their organization is doing in this community.

My father died when I was a young child, and my mother often found it difficult to make ends meet while raising my brothers and me. I am so thankful that family, friends and our community loved and supported us in ways beyond my imagination. Mother often reminded me to use the memory of these struggles for reasons to be thankful and to give in ways that will benefit others less fortunate.

Everyone has a story, and we all have reasons to give thanks. My hope is for each of you to have a wonderful Thanksgiving season with hearts brimming over in service to others – in other words, *pay it forward*. ❑

Jana Timberlake
Executive Director

Oklahoma County Medical Society

23rd Annual Operation Santa!

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Amount Enclosed $ _____

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Thank you!

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 CARELINK (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 Hospital OKC
Contact: May Harshbarger
CME Coordinator
Telephone: 752-3390

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 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: Susan Moore
CME Coordinator
Telephone: 272-6748

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

Help Improve the Bulletin

Do you have an interesting hobby? Do you write poetry? Are you an amateur photographer? Are you an artist? Do you volunteer on medical mission trips? Are you a mountain climber? Share your works and stories with your colleagues! The editorial staff welcomes – invites – your articles, poetry, letters and artwork for inclusion in the Bulletin. You may email them to tsenat@o-c-m-s.org or mail them to Tracy Senat, OCMS, Suite 2, 313 NE 50th Street, Oklahoma City, OK 73105. We look forward to hearing from you! ❑

Oklahoma City-County Health Department
Epidemiology Program
Communicable Disease Surveillance

COMMONLY REPORTED DISEASES	*Monthly*			*YTD Totals*	
	Aug'12	**Aug'11**	**July'12**	**Aug '12**	**Aug '11**
Campylobacter infection	9	8	10	41	46
Chlamydial infection	N/A	N/A	N/A	N/A	N/A
Cryptosporidiosis	1	3	3	18	17
E. coli (STEC, EHEC)	0	1	1	10	8
Ehrlichiosis	0	2	0	1	2
Giardiasis	0	0	0	0	1
Gonorrhea	N/A	N/A	N/A	N/A	N/A
Haemophilus influenzae Type B	0	0	0	0	0
Haemophilus influenzae Invasive	0	1	1	11	9
Hepatitis A	0	1	0	2	2
Hepatitis B*	0	15	8	89	103
Hepatitis C *	14	14	22	157	122
HIV Infection	N/A	N/A	N/A	N/A	N/A
Lyme disease	0	2	0	0	4
Malaria	0	0	1	5	0
Measles	0	0	0	0	0
Mumps	0	0	0	0	1
Neisseria Meningitis	0	0	0	0	1
Pertussis	0	3	0	10	20
Strep pneumo invasive, children <5yr	1	2	0	5	5
Rocky Mtn. Spotted Fever (RMSF)	0	14	0	4	70
Salmonellosis	8	38	17	67	94
Syphilis (primary/secondary	N/A	N/A	N/A	N/A	N/A
Shigellosis	1	3	3	77	21
Tuberculosis ATS Class II (+PPD only)	55	76	51	268	380
Tuberculosis ATS Class III (new active cases)	1	3	3	19	21
Tularemia	0	0	0	0	1
Typhoid fever	0	0	0	0	1
RARELY REPORTED DISEASES/Conditions:					
West Nile Virus Disease	18	0	11	50	0
Pediatric Influenza Death	0	0	0	0	0
Influenza, Hospitalization or Death	1	0	0	81	237
Influenza, Novel Virus	0	0	0	0	0
Strep A Invasive	0	0	0	0	2
Legionella	0	0	0	1	3
Rubella	0	0	0	0	1
Listeriosis	0	0	0	1	0
Yersinia (not plague)	0	0	0	0	0
Dengue fever	0	0	0	0	0

YTD totals are updated quarterly to reflect cases that have a reporting delay due to laboratory confirmation or symptom assessment.

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

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

***Beginning in June 2012, medical health record was transitioned to the electronic format PHIDDO.

Data for newly identified infections is not available at this time. OSDH is being consulted on obtaining data.

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OCMS Community Foundation Supports Community Projects

Three local charities will receive grant money this year from the OCMS Community Foundation. The organizations are the Health Alliance for the Uninsured, Hospice of Oklahoma County and Schools for Healthy Lifestyles. All of these organizations were started by OCMS members. Each will receive $2,000 to continue their important community work.

The Community Foundation also has chosen Katherine Shoush as the recipient for the 2012 Medical Student Scholarship. She will receive $10,000 to be used toward school costs. This is the second year the scholarship has been awarded.

Operation Santa, a longstanding OCMS holiday favorite, is back again this year. See Page 34 of this Bulletin for more information! ❑

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