THE BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY NOVEMBER/DECEMBER 2015

ASSOCIATION OF AMERICAN INDIAN PHYSICIANS HOMECOMING 2015
ANNUAL MEETING AND NATIONAL HEALTH CONFERENCE

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ABOUT THE COVER

Painting: *"Flying Eagle with Indian Pipe"*
The "Pipe of Peace" is well known among Native American People; two or more sit and discuss things; the Pipe is smoked; the wishes, desires and Prayers are carried Heaven-ward to the Great Creator by way of the Spirit Eagle as he carries the smoke upward. The colors red, white and black are brought forth; as in the Eagle's feathers; turquoise is an additional prized stone feature. **Artist:** Colleen A. Barker, who is a registered member of the Snoqualmie Indian Tribe.

This image was the poster for the 44th Annual Meeting and National Health Conference of The Association of American Indian Physicians (AAIP). AAIP was founded in 1971 by Dr. Everett Rhoades as an educational, scientific, and charitable non-profit corporation. At the time of its founding, AAIP's primary goal is to improve the health of American Indian and Alaska Natives. Its mission is: "to pursue excellence in Native American health care by promoting education in the medical disciplines, honoring traditional healing principles and restoring the balance of mind, body, and spirit."

AAIP seeks to accomplish its mission by offering educational programs, services and activities that motivate American Indian and Alaska Native students to remain in the academic pipeline and to pursue a career in the health professions and/or biomedical research. AAIP also provides leadership in various health care arenas affecting American Indians and Alaska Natives such as cancer, diabetes mellitus, HIV/AIDS, domestic violence, and drug use.

Outgoing Executive Director Margaret Knight, a member of the Pueblo of Laguna, began her career at the Association of American Indian Physicians in 1987 and held the Executive Director position from 1995 to 2015. During Ms. Knight's tenure, AAIP successfully administered federal grants and contracts totaling more than $25 million and implemented and managed 22 public health and career initiative programs. Incoming Executive Director Polly Olsen, a member of the Yakama tribe, has over 14 years of experience in academia and healthcare. She was the Director of Community Relations at the University of Washington where she worked with tribal communities and academic institutions.

James W. Hampton, MD, Chickasaw, longtime Oklahoma City oncologist and AAIP member is stepping down from his Editor-in-Chief role of The Bulletin, a post he has held since January 1983. Within the AAIP, Dr. Hampton was named Indian Physician of the Year twice and was President of AAIP twice. OCMS extends a magnitude of thanks to Dr. Hampton for his longtime support of OCMS publications.

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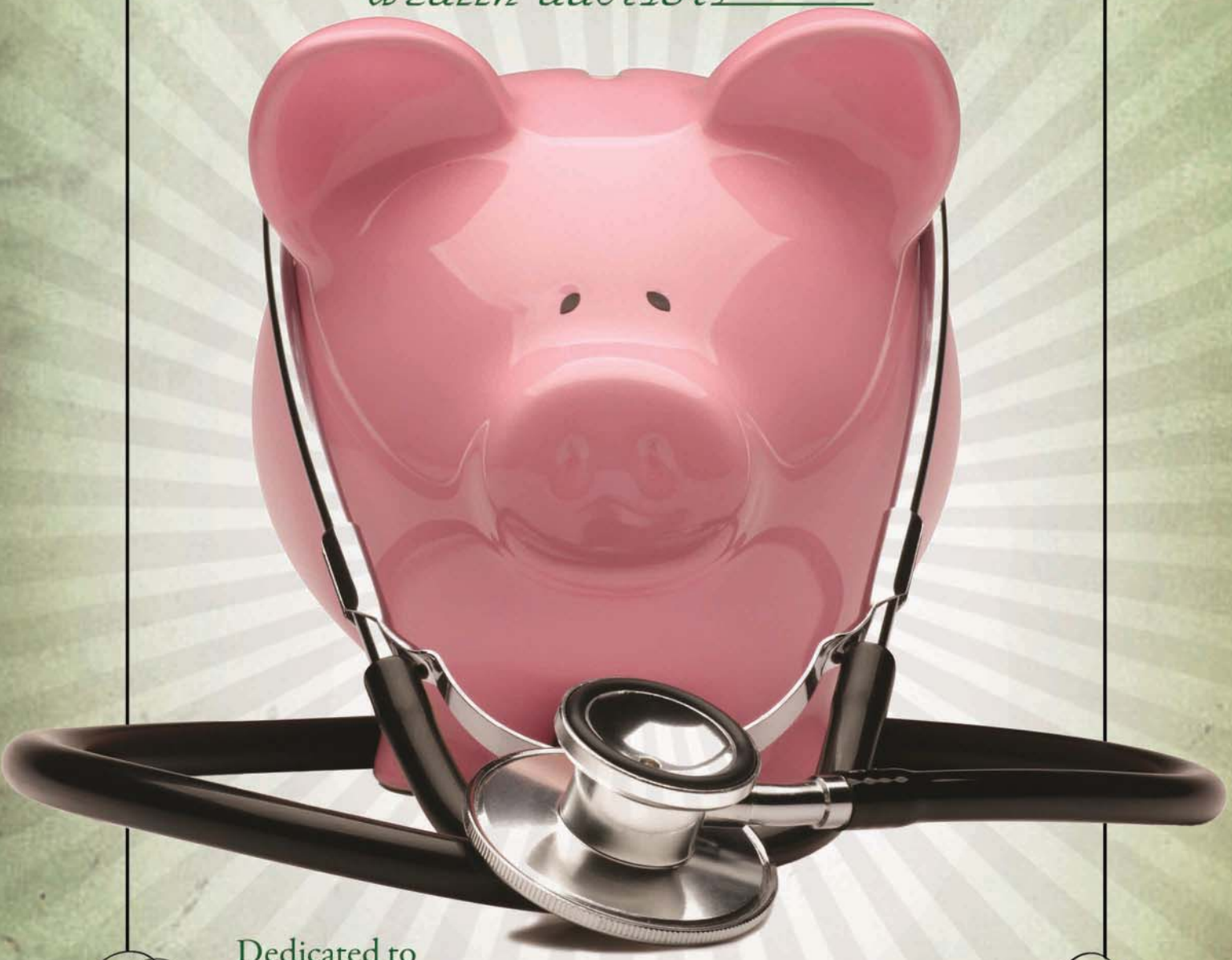

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OCMS
OKLAHOMA COUNTY MEDICAL SOCIETY

PRESIDENT'S PAGE

By C. Douglas Folger, MD

In the January-February 2015 BULLETIN President's page, I discussed the disturbing annual downward trend since 2010 in the number of dues paying members in our Oklahoma County Medical Society. I'm sorry to report that the membership declined another 10% in 2015. Your OCMS Board has been busy this year working on a plan that will hopefully reverse this unwanted trend. Let me share our present plan.

The Board felt that it would be of utmost importance to understand the views of our county physicians regarding the present day practice of medicine before we could formulate a specific recruitment plan. We felt it was especially important to understand the views of our young physicians. Shapard Research was selected to interview a group of physicians less than forty years of age from multiple integrated group practices in Oklahoma County. Some of the physicians interviewed were members of the OCMS and OSMA, and some were not. After compiling the results of 18 interviews, Shapard was able to identify a number of common themes. The attitude of most of the employed physicians of integrated systems is that they enjoy regular office hours, are not required to make many administrative decisions, and are not bogged down with many practice related headaches. They tend to define the medical community as the campus of their system, and tend not to have regular communication with physicians outside of their system. Most of the non-members are not familiar with either the OCMS or the OSMA. They are unaware of our impact. Not understanding what they would be paying for, the dues are perceived as being far too expensive.

Our OCMS staff has spent countless hours identifying close to forty sizeable group practices in Oklahoma County that are composed of both OCMS member and non-member physicians. As a pilot effort, the Board has identified a handful of group practices that we feel would provide a good opportunity for us to encourage OCMS physicians in the groups to aid in the recruitment of non-members in their groups. Representatives of the OCMS Board will meet with OCMS member physician leaders in the pilot group-practices to discuss the specific benefits of OCMS membership. We will then ask them to help us recruit their non-members to join our organization. If we are successful in our recruiting efforts in the pilot groups, we will expand the plan more widely. Benefits of membership talking points will include: legislative advocacy, leadership development through the OCMS Leadership Academy, professional education opportunities, free physician legal advice, the Bulletin and e-News, job postings, DocBookMD membership, OSMA Health, PLICO, OHPP, and various community volunteer opportunities. Our tremendous support to the Oklahoma County community will also be emphasized by mentioning entities created by the OCMS, including the Oklahoma Blood Institute, EMSA, Hospice of Oklahoma County, Open Arms Clinic, Schools for Healthy Lifestyles, Health Alliance for the Uninsured, and Independent Transportation Network of Central Oklahoma.

There have been 2 recent decisions that will lead to a decrease in the cost burden of OCMS/OSMA dues. The OCMS is now offering one half off annual dues for members who recruit a new member and a full one year refund of dues for recruiting 2 new members. The new members will pay only one half dues for the first year. This program applies only to OCMS dues. The details are explained in a flier included in your annual dues statement. In view of the recent sale of PLICO, the OSMA held a specially called House of Delegates' meeting in late September to rescind the $25 dues increase for 2016 that had been approved in the April House of Delegates' meeting. My hope is that significant further decreases in OCMS/OSMA dues will occur in years to come.

I would once again like to call on you, who have benefited over the years from OCMS membership, to join in the recruitment of new members. The larger our membership, the stronger our voice will be, the greater our power will be, and the more likely we will be able to carry out our mission of "being the leading advocate to improve the health of our citizens and to enhance, nurture, and improve the well-being of our physicians."

OCMS BULLETIN

LONGTIME EDITOR RETIRES

Thirty-three years. That's how long James W. Hampton, MD, FACP has served as Editor-in-Chief of the Bulletin. He has reviewed reams of columns, selected artwork for countless covers, written numerous articles, and supported five OCMS Managing Editors as needed. We really needed him to respond to the occasional "hot" letter to the editor. This is the final issue on which his name will appear as Editor-in-Chief. Dr. Hampton is retiring from both his medical practice and the Bulletin at the end of the year.

Dr. Hampton has been a leader throughout his 50-year career in medicine. As an intern he recognized a form of cancer not previously described in the U.S. and saw his resulting paper on Waldenstrom's macroglobulinemia published in the New England Journal of Medicine. He helped initiate the Southwest Oncology Group, one of the National Cancer Institute's first cooperative research groups, whose work led to the development of new chemotherapy agents.

He was an early advocate of palliative care in Oklahoma, presenting a series of lectures at the Oklahoma Medical Research Foundation from 1971 to 1977. After meeting with Dame Cicely Saunders, the founder of hospice in England, Dr. Hampton persuaded the OCMS to lead development of Hospice of Oklahoma County, a non-profit hospice that continues today under the INTEGRIS umbrella.

A member of the Chickasaw Nation, inducted into the Chickasaw Hall of Fame in 2014, Dr. Hampton is one of only two Native American medical oncologists in the nation. Mayo Clinic's Spirit of Eagles fellowship is named in his honor. The American Cancer Society presented him their Humanitarian Award in 1999 for his service with the Intercultural Cancer Council and his advocacy for improved detection of cancer in these special populations.

He's a workaholic in the best sense of the term. He reads a broad range of literature. He edited his medical school yearbook. He writes poetry. He is a long time supporter of the Arts Council of Oklahoma City and other arts organizations throughout the City. Many of his original paintings and artworks hang in his office and examination rooms.

For such a distinguished and accomplished individual, he is humble and self-effacing. As a former Managing Editor of the Bulletin, I can honestly and enthusiastically say he is also a delight to work with.

Linda Larason

DEAN'S PAGE

By M. Dewayne Andrews, MD, MACP
Vice President for Health Affairs
Executive Dean, College of Medicine

Students beginning their medical studies at the OU College of Medicine arrive from many different undergraduate institutions across the country and many different backgrounds in their educational emphasis areas. As they come into medical school, students are swiftly and homogeneously immersed in the language of science and medicine and are caught up in acquiring facts, knowledge and clinical skills and acumen. Understanding the human body in health and illness is a complex undertaking that requires a great deal of study and devotion if one is to be successful.

In our College of Medicine, we support and incorporate the importance and place of humanities topics in the learning environment and culture of medical school education and training. Humanities can assist students in becoming more culturally sensitive. Humanities help students learn about the joys and tragedies of the human experience, about aspects of suffering and dying, and about personal interactions and professionalism.

How are humanities incorporated into the medical school environment? A few examples may be helpful. In the preclinical years, students may elect an "enrichment" course focused on humanities concentrating on literature and medicine, e.g., works of prose and poetry that present many compelling medical and life situations for discussion and analysis. Special interest groups have been organized for students, such as Music and Medicine. There have been dramatic plays dealing with important medical issues presented in a "reader's theater" format. Evening discussion groups with students and faculty have been utilized. And there is the literary journal Blood and Thunder, published by the College of Medicine annually, with the most recent edition issued this fall being the 15th anniversary edition.

Begun as a student-initiated project and outlet for the creative writing of local medical students and faculty, it has been quite interesting and rewarding to observe the evolution and growth of the Blood and Thunder journal over the past 15 years. This publication has increasingly attracted a regional, national and international audience. The monograph journal contains original works of poetry, prose, and visual arts – all products of the creative talent of medical students, faculty, other health care students and faculty, working health professionals, patients and family members, and community individuals and writers who are interested in this endeavor. Some of our talented medical students provide the impetus for soliciting contributions annually and organize and assemble the journal each year. They also make the final editorial judgments. We are proud of these students and congratulate them on their outstanding efforts for each volume published. In addition to its distribution to subscribers and donors, copies are distributed to all medical schools in the United States and Canada.

The humanities leaven the experience of our medical students and help us sensitize them to the important fundamental personal, family, ethical, and social issues confronting the modern physician.

Lastly, on behalf of the entire College of Medicine family of faculty, staff, residents, and students, we hope you and your family have a Happy Thanksgiving followed by a blessed, wonderful holiday season and a very Happy New Year!

IN MEMORIAM

Richard Shifrin, MD
1928-2015

D. Scott McMeekin, MD
1963-2015

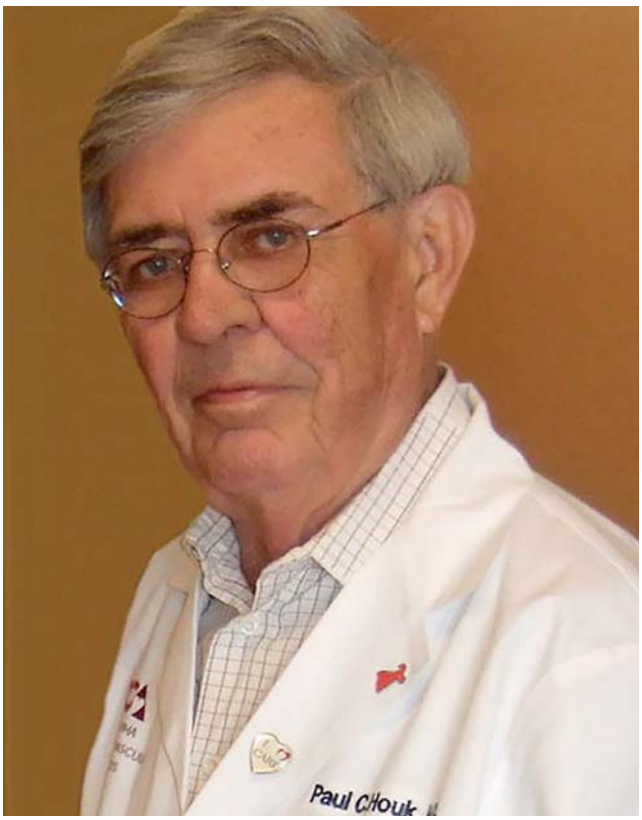
Donald L. Tutt, MD
1936-2015

Paul Cullison Houk, M.D.
May 27, 1933 - August 29, 2015

Paul Cullison Houk, M.D., a pioneer in the development and advancement of modern techniques for diagnosing and treating cardiovascular disease and founding member of the Robert M. Bird Society, died August 29 at 82 from pulmonary fibrosis. He practiced interventional cardiology for 50 years until his retirement in 2011.

As professor and Chief of Medicine at the Veterans Administration Hospital early in his career, Dr. Houk was widely respected as a role model for his ability to balance unyielding professionalism and clinical expertise with his responsibility to improve student performance. Dr. Houk's education and practice were inspired by his mentors, Dr. Stewart Wolf, Dr. Robert Bird and Dr. William Middleton. He also served on the National Board of the American Heart Association and President of the Oklahoma Chapter.

Dr. Houk was a research fellow in cardiovascular disease in 1965 when chosen as a National Institutes of Health Fellow to work with international researchers at the Sahlgrenske Academy of the University of Gothenburg in Sweden to further develop procedures and tools for heart catheterization and to bring these advancements back to the United States. The work by Dr. Houk and colleagues in Sweden was revolutionary and paved the way for balloon angioplasty including the introduction of the Swan-Ganz catheter and other life-saving procedures practiced today.



The Oklahoma native received a bachelor's degree from the University of Oklahoma and a medical degree from the OU College of Medicine in 1959, where he became a member of Alpha Omega Alpha scholastic fraternity as a junior. His first post-graduate year at the Kansas University Medical Center was followed by a residency in internal medicine at OU where he was chief resident in Medicine.

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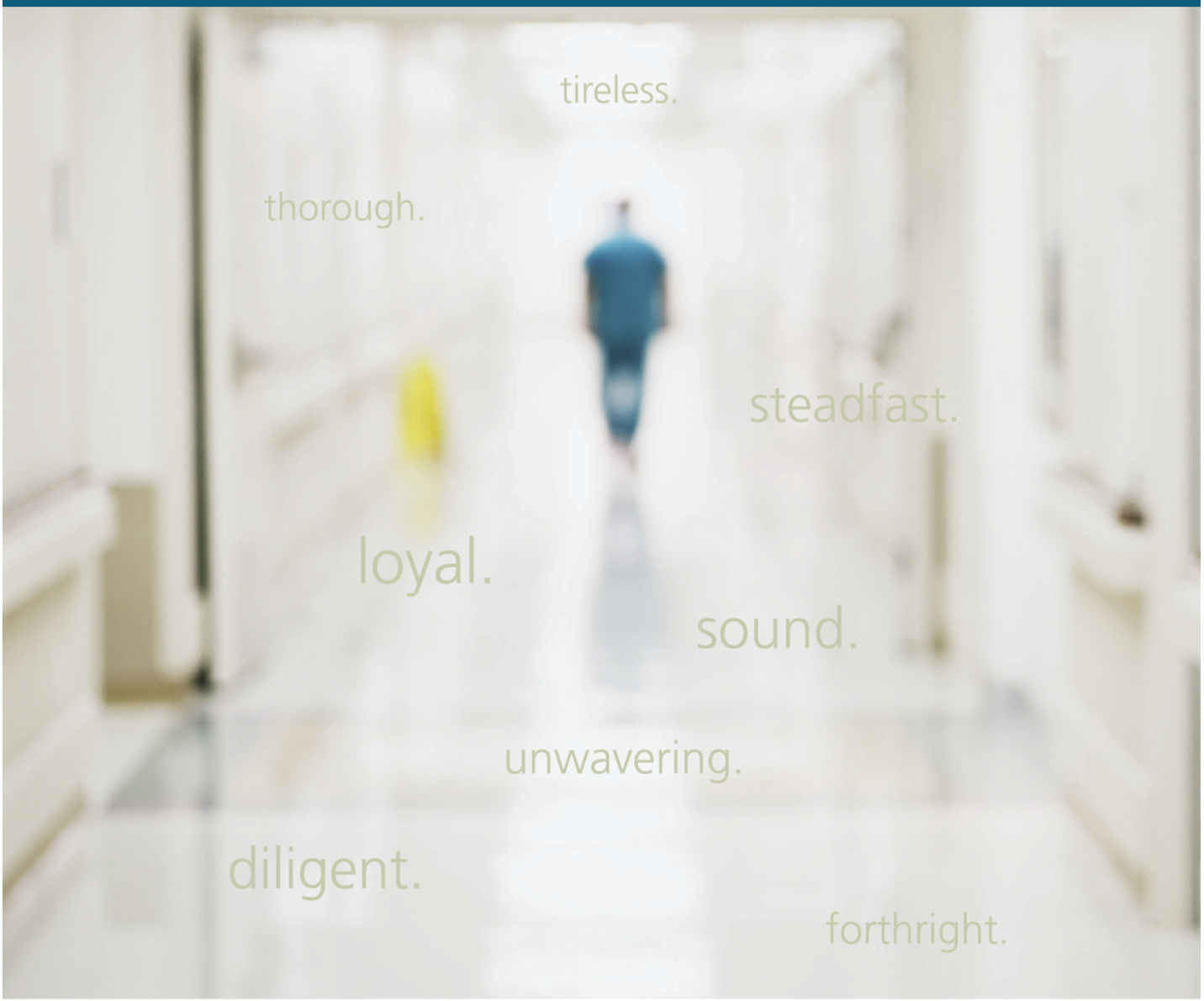

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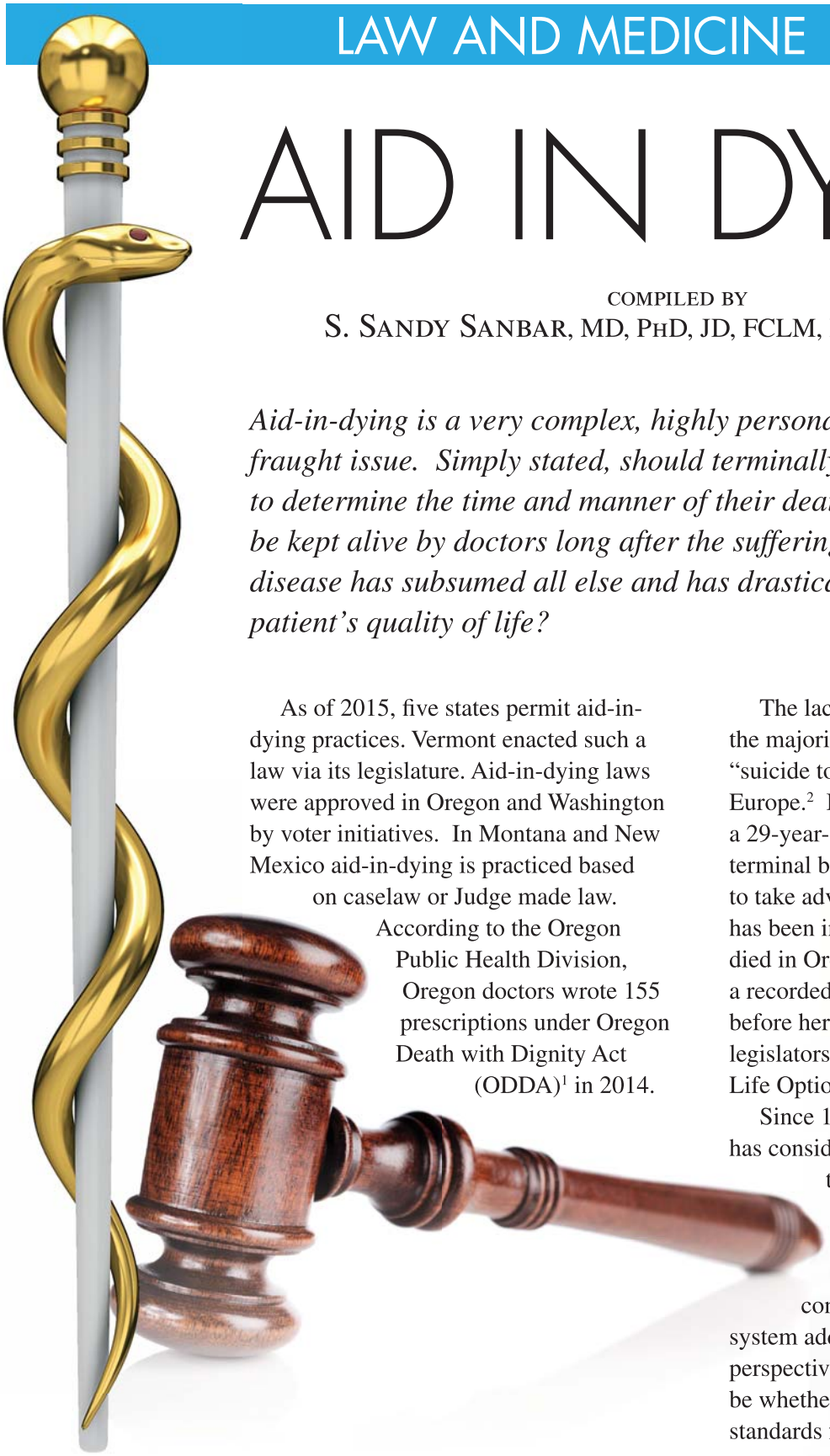
AID IN DYING

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

Aid-in-dying is a very complex, highly personal and an emotionally fraught issue. Simply stated, should terminally ill patients be able to determine the time and manner of their deaths? Should a patient be kept alive by doctors long after the suffering caused by terminal disease has subsumed all else and has drastically reduced the patient's quality of life?

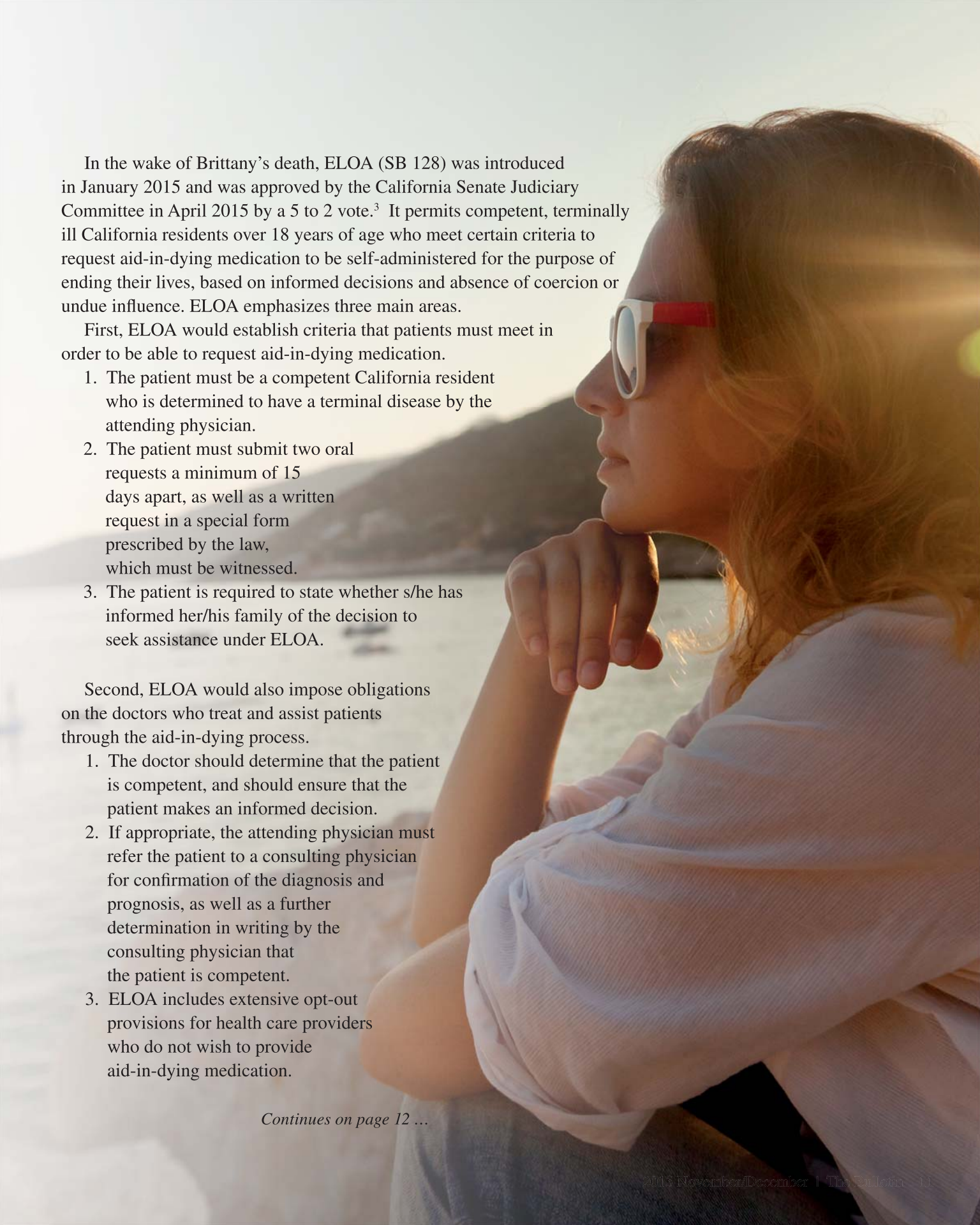


As of 2015, five states permit aid-in-dying practices. Vermont enacted such a law via its legislature. Aid-in-dying laws were approved in Oregon and Washington by voter initiatives. In Montana and New Mexico aid-in-dying is practiced based on caselaw or Judge made law.

According to the Oregon Public Health Division, Oregon doctors wrote 155 prescriptions under Oregon Death with Dignity Act (ODDA)[1] in 2014.

The lack of aid-in-dying laws in the majority of states has encouraged "suicide tourism" mostly to Mexico and Europe.[2] In 2014, Brittany Maynard, a 29-year-old Californian who had terminal brain cancer, moved to Oregon to take advantage of the ODDA, which has been in effect there since 1994. She died in Oregon in November, 2014. In a recorded plea made several weeks before her death, she urged California legislators to enact the California End of Life Options Act (ELOA).

Since 1995, the California legislature has considered aid-in-dying bills six times prior to 2015. The repeated attempts to pass a bill in California probably reflect a larger societal concern for how the healthcare system addresses death. From a legal perspective, the most critical issue may be whether a given bill provides clear standards for providers to follow.



In the wake of Brittany's death, ELOA (SB 128) was introduced in January 2015 and was approved by the California Senate Judiciary Committee in April 2015 by a 5 to 2 vote.[3] It permits competent, terminally ill California residents over 18 years of age who meet certain criteria to request aid-in-dying medication to be self-administered for the purpose of ending their lives, based on informed decisions and absence of coercion or undue influence. ELOA emphasizes three main areas.

First, ELOA would establish criteria that patients must meet in order to be able to request aid-in-dying medication.

1. The patient must be a competent California resident who is determined to have a terminal disease by the attending physician.
2. The patient must submit two oral requests a minimum of 15 days apart, as well as a written request in a special form prescribed by the law, which must be witnessed.
3. The patient is required to state whether s/he has informed her/his family of the decision to seek assistance under ELOA.

Second, ELOA would also impose obligations on the doctors who treat and assist patients through the aid-in-dying process.

1. The doctor should determine that the patient is competent, and should ensure that the patient makes an informed decision.
2. If appropriate, the attending physician must refer the patient to a consulting physician for confirmation of the diagnosis and prognosis, as well as a further determination in writing by the consulting physician that the patient is competent.
3. ELOA includes extensive opt-out provisions for health care providers who do not wish to provide aid-in-dying medication.

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Third, ELOA would not create unintended consequences for legal fields including insurance law, criminal law, and medical licensure.

1. Altering or forging a request for aid-in-dying medication is a felony if done with the intent of causing someone's death.
2. Complying with ELOA's provisions will not constitute "suicide," "assisted suicide," "mercy killing," or anything else under the law other than compliance with ELOA.
3. ELOA imposes rigorous documentation requirements on the attending and consulting physicians.
4. No contract could require a person to seek aid-in-dying medication, and no provision in a contract, will or other agreement is permitted to have any effect on a decision to request or withdraw a request for ELOA assistance.
5. Requesting ELOA assistance cannot be the sole basis for the appointment of a guardian or a conservator of a patient.
6. ELOA bans insurance companies from considering use of ELOA in a number of ways, such as in determining the value of a life insurance policy on death, or in selling or issuing policies in the first place.
7. ELOA mandates that the cause of death documented on the patient's death certificate must be her/his underlying terminal disease.

If enacted in California, ELOA would be legally valid. In Gonzales v. Oregon, the United States Supreme Court upheld ODDA against a challenge by the Bush Administration. The Court held that Attorney General Ashcroft had attempted to "effect a radical shift of authority from the States to the Federal Government to define general standards of medical practice in every locality," and overturned the interpretive rule. The Drug Enforcement Administration was not authorized to "displace the states as the primary regulators of the medical profession, or to override a state's determination as to what constitutes legitimate medical practice."

However, there are professional medical ethical concerns such as doing harm to patients and a potential to undermine trust in the physician-patient relationship if the patients feel that physicians will direct them to ELOA rather than more difficult courses of treatment and pain relief. Some patients may feel pressured or coerced to seek aid-in-dying medication, particularly if the patient feels s/he is a burden to loved ones. The right to fatal, life-ending medications could possibly become an expectation, and ultimately a duty, fueled by those members of society whose existence is expensive or otherwise could be considered burdensome.

[1] *https://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-outreach/upload/Oregon-Death-with-Dignity-Act-Guidebook.pdf*

[2] *Sanbar, S. S., Suicide Tourism, The Bulletin, January/February, 88(1):14, 2015.*

[3] *http://www.deathwithdignity.org/2015/04/09/california-senate-judiciary-committee-passes-sb-128-end-of-life-option-act#sthash.P9G2Kb7j.dpuf*

WELCOME NEW MEMBERS!

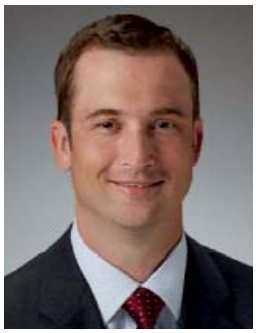
Broselow

Fong

King

Parekh

Schwartz



Wicks

Blake D. Christensen, DO, is an anesthesiologist in Oklahoma City. He completed medical school at Oklahoma State University College of Osteopathic Medicine, an internship at St. Anthony Hospital, residency at the University of Oklahoma and a fellowship at the John H. Stroger, Jr. Hospital of Cook County in Interventional Pain Management.

Andrew M. Broselow, MD, is a board-certified OB/GYN in Oklahoma City. He completed medical school at the Texas Tech University Health Sciences Center School of Medicine, an internship and residency at the John Peter Smith Hospital in Fort Worth (OB/GYN).

Judy Fong, MD, is an OB/GYN in Oklahoma City. She completed medical school at St. George's University School of Medicine, interned at North Shore University Hospital and completed residency at Hofstra-North Shore LIJ School of Medicine at North Shore University (OB/GYN).

Lauren King, MD, is a Hematopathologist at OUHSC. She completed medical school at the University of Tennessee Health Science Center, an internship in General Surgery and residency in pathology and AP/CP at the University of Tennessee Health Science Center and fellowship at the Houston Methodist Hospital.

Nimish M. Parekh, MD, is an OB/GYN in Oklahoma City. He is a graduate of the University of Oklahoma College of Medicine, completed an internship at North Shore University Hospital and residency at Hofstra-North Shore LIJ School of Medicine at North Shore University (OB/GYN).

Catherine E. Porter, MD, is a board-certified neurologist in Oklahoma City. She completed medical school at the University of Oklahoma College of Medicine and residency at SUNY-Buffalo.

Lauren H. Schwartz, MD, is a board-certified psychiatrist in Oklahoma City. She completed medical school and residency at the University of Oklahoma College of Medicine.

Ryan F. Wicks, MD, is a general surgeon in Oklahoma City. He completed medical school at the University of Oklahoma College of Medicine, and completed internship and residency at the OUHSC Department of Surgery.

Sarah Yoakam, MD, practices Integrative Medicine in Oklahoma City. She completed medical school at the University of Oklahoma College of Medicine, completed internship at OUHSC-Tulsa, and completed a fellowship in integrative medicine at the University of Arizona.

THE BULLETIN

OCMS
OKLAHOMA COUNTY MEDICAL SOCIETY

Please plan to attend the annual OCMS Presidential Inaugural Dinner on Friday, Jan. 22, 2016, to honor our 2016 president, Don L. Wilber, MD.

The event will include dinner, awards and recognition, and dancing afterwards at the Oklahoma Golf & Country Club. Dress is black-tie optional. Tickets are $95 each and may be paid online at www.o-c-m-s.org or by check. Dinner guests may order a vegetarian and/or a gluten-free meal in advance.

If your organization is interested in sponsoring an inaugural table, please call Alison Williams at 702-0500.

Invitations to this special event will be mailed to all members in early December with an RSVP card.

SAVE THE DATE

JUNIOR LEAGUE BRINGS AMERICA'S TOUGHEST TRAINER TO OKLAHOMA CITY

The Junior League of Oklahoma City recently initiated its new five-year health focus. As part of that initiative, the organization is bringing a new health-related event to Oklahoma City called Speaker in the City.

Personal trainer, entrepreneur and best-selling author Jillian Michaels will be the featured speaker at the inaugural event taking place Jan.31, 2016, at 2 p.m. at The Civic Center Music Hall in downtown Oklahoma City.

Perhaps considered one of the most inspiring people on television through her role as trainer, wellness expert and life coach on her hit TV shows and regular TV appearances, Michaels has created a brand name for herself. Every week she motivates millions in every form of media from TV to publishing to her Web site and daily e-newsletter.

"We are so excited to offer this new, motivational health event to the public," said Alexis Lux, Speaker in the City Chair for the Junior League. "Jillian Michaels captured our hearts each week as she pushed contestants to be their best self on the Biggest Loser. And we know she will do the same with our guests at Speaker in the City."

As a motivator and role model, Michaels has a unique connection with her audience that stems from her own personal journey toward wellness. Before becoming a big media success, Michaels struggled with her own weight. She was determined to reach her goals – and through dedication and hard work, she did.

"We hope to motivate Oklahoma City residents to take charge of their own mental and physical wellbeing, and then encourage their friends and family to do the same," Lux said.

Speaker in the City is open to the public. Individual tickets are available starting at $35 and go on sale mid-November at The Civic Center Music Hall box office. Tickets to a VIP reception and photo opportunity with Michaels are only $200. Proceeds from the event will be reinvested in the Oklahoma City community through a number of the League's health-focused community projects.

JUNIOR LEAGUE OF OKLAHOMA CITY

Women building better communities

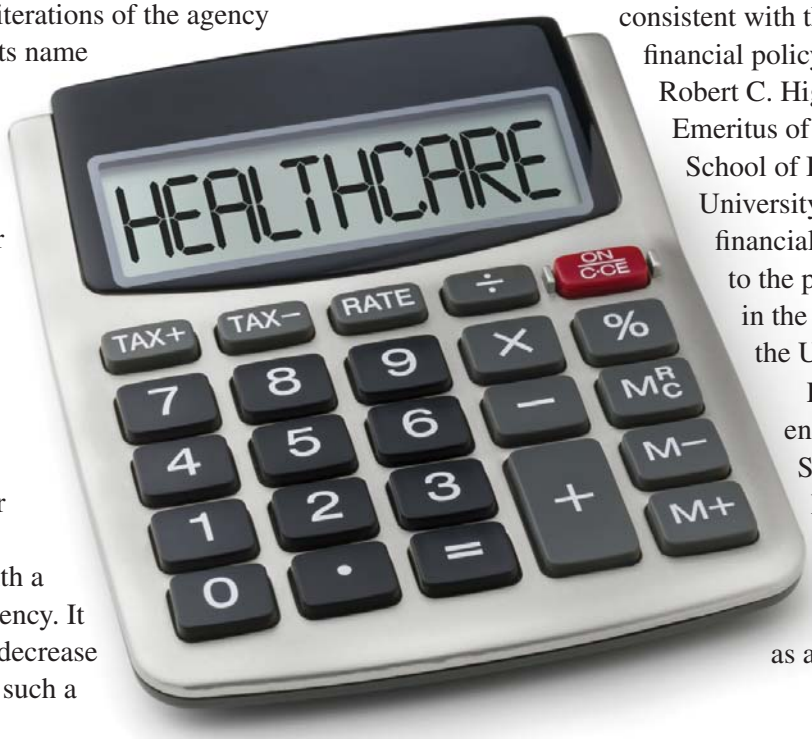
THE PEARL

R.I.P. SGR: GREAT!
Hello MACRA: We'll See

By Tomás P. Owens, MD
Chair, Family Medicine, Integris Baptist Medical Center
Associate Director - Great Plains Family Medicine Residency

Medicare was born in 1965. Before long, it became apparent that sensible regulation of expenses was necessary. The Health Care Financing Administration (HCFA) was created in 1977. Many of us grew up in the medical field minding the adjustments and iterations of the agency up until 2001 when its name changed to Center for Medicare & Medicaid Services and its acronym somehow lost a letter to be simply known as CMS.

Medicare is amongst the highest federal expenditures, extremely necessary for the welfare of our population, growing exponentially and with a fund at risk of insolvency. It made sense to try to decrease the rate of growth of such a big and expensive operation, in order to save it. That's wherefrom SGR came to be. A solution to rescue Medicare.



The Sustainable Growth Rate (SGR) is defined as the maximum growth rate a company can achieve consistent with the firm`s established financial policy[1]. Its creator was Robert C. Higgins, Professor Emeritus of Finance at the Foster School of Business at the University of Washington. This financial tool was extrapolated to the public healthcare arena in the late 1990s and taken to the US capitol.

Following, congress enacted the Medicare-SGR as part of the Balanced Budget Act of 1997. The measure would use growth in real GDP as a major determinant

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MACRA *Continued from page 17 …*

for the adjustment of payments to physicians: when spending per-beneficiary exceeds the real GDP growth, proportionate reductions in payments to physicians must occur.

The Medicare-SGR highly complex formula was first used in 2001. Every year since, the formula has determined cuts to physicians' payments were to occur. And every year, after much negotiating between medical associations/academies and legislators, the cuts were averted by a suspension or adjustment called the doc fix. Technically the temporary doc fix. In a few of those years, minimal increases in reimbursement to doctors actually occurred, at a rate much lower than inflation[2].

Starting in 2009, the postulated cuts escalated precipitously. Since the process is cumulative, each year the mandated cuts increased, eventually reaching a 24.5% estimated cut-per-visit for 2014.

After the release of the physician fee update every March 1st and the order to produce the cuts by July 1st, a ritual of pilgrimage to Washington, DC every spring became an impediment to progress in other areas of healthcare and source of severe frustration to doctors, medical providers and their staffers.

The SGR led to a sense of instability in the medical finance world, reduction of physicians serving Medicare beneficiaries and an earnest effort by many of our organizations to introduce an alternative to congress. The AMA, AAFP, ACP, AOA among many others promoted a substitute.

Re-evaluation of SGR or adjusting of the formula was felt to be unacceptable and full repeal became the mantra of all physicians serving Medicare patients across the land.

On April 16th, 2015 President Obama signed into law the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act of 2015 (MACRA) which ended the use of the SGR, in effect a permanent doc fix.[3]

It mandated that pre-April 1st payment rates remained to June 30th. Starting in June and through December 31st 2015, physician payments will increase by 0.5%

From January 2016 through December 2019, physician payments will rise by 0.5% per year, but, January 2020 to December 2025 no further payment updates (increases or decreases) will be scheduled. Rates will be frozen at 2019 levels with the opportunity to choose from two payment tracks with additional payment adjustments.[4]

How are these adjustments (judgments) going to be made?

Our fundamental proposition has been that increases in cost do not necessarily mean waste. If increases beyond the real GDP changes result in better outcomes, they should be welcome. Consistent with this argument, then disassociating payment from fee-for-service volume alone, would result in compensation based on results or 'merit'.

Thence, the Merit-Based Incentive Payment System (MIPS). MIPS will be an addition to the current Medicare fee-for-service model. It is the amalgamation of all current value-based models: Physician Quality Reporting System (PQRS), Value-Based Modifier (VBM) and Meaningful Use of Electronic Health Records (EHR MU). All of these will sunset in 2018 and MIPS will apply starting on January 1st, 2019.[4]

As explained in the AAFP website, physicians can choose to be 'evaluated' for their merit payments by MIPS or participate in the Alternative Payment Model (APM). APMs include Patient Centered Medical Homes (PCMH), any model under the Center for Medicare and Medicaid Innovation Center, Accountable Care Organizations (ACOs) and selected Medicare demonstration projects.

MIPS

A performance score will be based on Quality, Resource Use, Clinical Practice Improvement Activities (CPIA) and Meaningful Use of a Certified EHR. The measures of quality performance will be published annually. Resource use will be a variant of the VBM with physician and other groups' input. CPIAs will be specific to the specialty and type of practice. The EHR MU will proceed as it has been.

Composite performance score will range from zero to 100. Payment adjustments will happen over a threshold based on the mean or median for all physicians. Payment reductions for below threshold docs will be capped at 4% in 2019, 5% in 2020, 7% in 2021 and 9% in 2022.

The payment increases for those above the median are to be capped by an actual figure of $500 million per year until 2024. Payment increases and decreases will be linear (based on how close or far you are from the median).

Continues on page 20 …

MACRA *Continued from page 19 ...*

APM

After January 2026, the eligible MIPS doctors will receive 0.25% upgrade per year, those in an APM will receive a single conversion update of 0.75% per year.

MACRA also extends CHIP for two years, Community Health Centers and National Health Service Corps and Teaching Health Center primary care residency program grants through 2017.

In principle, the SGR idea of payment adjustments based on the gyrations of the national economy without much basis on healthcare was irrational and untenable. MACRA brings potential increases AND reductions in payment but in relation to measurable parameters that do relate to actual patient care. Having said that, is important to pay attention to the details. Some of the EHR MU criteria continue to be debated, the Quality measures must be of real significance to the well-being of patients, unequivocally measurable and under the influence of physicians' actions. Resource use, the most fundamental of the cost-containment measures, should be constantly monitored for medical appropriateness and the responsibility should be on both patient and clinician to restrain excess use. Additionally, effective malpractice reform should accompany all these initiatives. The greatest success of MACRA is that medical and beneficiaries groups are now incorporated to a degree at the decision-making level. We have much to thank our colleague-representatives at state, specialty society and national level for fighting their way to be at the table. It is our duty to remain supportive with our membership and be active providing real-life real-time feedback to our associations' leaders.

Change is always present and always challenging. As much as MACRA's different approach can be frightening to some, is important to remember the words of Warren Buffett: "In a chronically leaking boat, energy devoted to changing vessels is more productive than energy devoted to patching leaks."

[1] *https://en.wikipedia.org/wiki/Sustainable_growth_rate*
[2] *https://www.acponline.org/advocacy/state_health_policy/hottopics/sgr.pdf*
[3] *https://en.wikipedia.org/wiki/Medicare_Sustainable_Growth_Rate*
[4] *http://www.familydocs.org/payment-reform/macra*

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THE OKLAHOMA CITY BALLET

When most people think about Oklahoma City Ballet, visions of Sugar Plum Fairies and elegant dancers performing on stage usually come to mind. While a large part of Oklahoma City Ballet is focused on professional productions featuring its 36 company dancers, many in the audience are not aware of the strong education program at The Dance Center at Oklahoma City Ballet. The Dance Center at Oklahoma City Ballet teaches close to 300 students each year, with many students starting as young as age 3 and continuing through high school, and even beyond. Many ballet careers have been forged in the same studios used by Oklahoma City Ballet's company.

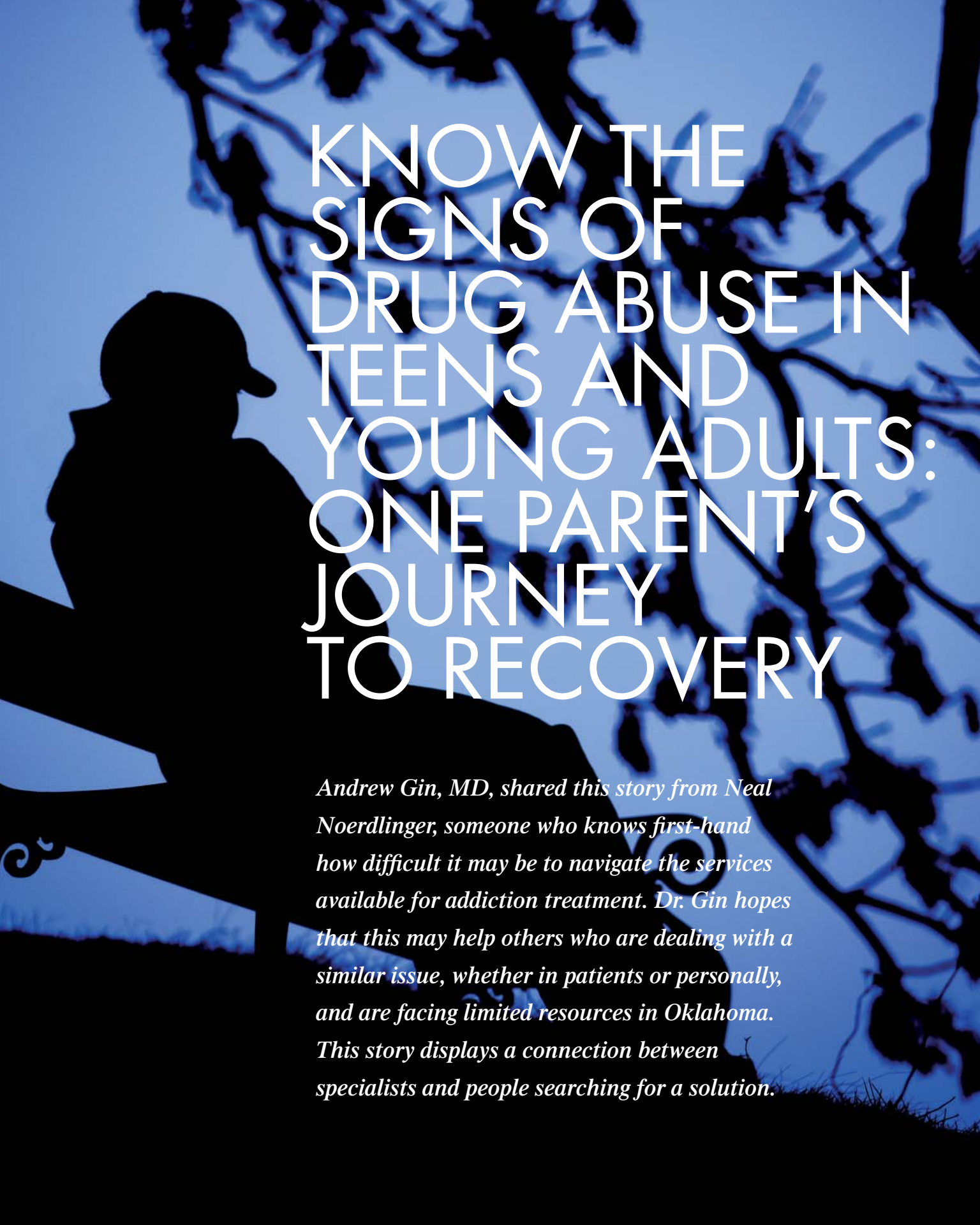
Roma Catania started her ballet career at The Dance Center at Oklahoma City Ballet when she was just a young girl. Like all young ballerinas, she lived to dance. In 2013, trainers from the prestigious American Ballet Theatre (ABT) were at The Dance Center of Oklahoma City Ballet to certify the school, an honor shared by no other ballet school in the state of Oklahoma. To do this, the staff asked a few of the ballet students to assist in the process. 15 year old Roma was one of these students. Roma had attended the Oklahoma City Ballet Dance Center school since she was very young, and had made an impression on her teachers. She had been cast as "Fritz" in The Nutcracker, and gone on to attend the Houston Ballet Academy for a year before returning to Oklahoma City. After watching her dance for a short time, the ABT teachers pulled her mother aside and offered Roma a full scholarship to American Ballet Theatre School in New York City, an honor and opportunity afforded to a few outstanding students across the United States. Her start at The Dance Center gave her the skills she needed to pursue her dream. She is currently attending the Jackie Kennedy Onassis School at American Ballet Theatre in New York City.

Students at The Dance Center of Oklahoma City Ballet share the same facility with Oklahoma City Ballet's professional company dancers, giving them daily opportunities to observe company classes and rehearsals. Dance Center of OKCB students will also have the opportunity to audition for the youth performing company Oklahoma City Youth Ballet, the all new production of The Nutcracker presented by Devon Energy, and other OKC Ballet full length productions. Classes offered by the Dance Center of OKCB include Pre-Ballet, Ballet, Pointe, Variations, Pre-Professional training, Ballet Boys, Jazz, Modern, Adult Beginner and Intermediate, as well as Mommy & Me for ages 2-3 and Ballet Discovery for ages 3-5.

The Dance Center at Oklahoma City Ballet also offers a variety of adult dance classes, for those looking for fun and fitness, taught by teachers and Oklahoma City Ballet Professional dancers. These classes are offered at both the Studio location on Classen and the Downtown administration location, The Loft on Film Row. New classes will include Ballet, Modern Dance, and Hip Hop, but all will be at an introductory level.

The success of The Dance Center is mirrored by the growth of the Oklahoma City Ballet in terms of ticket sales and numbers of performances. The 2015-2016 is the most ambitious season with five ballets in total, three with the Oklahoma City Philharmonic, thirty-six dancers, and more performances than ever before.

It's not too late to purchase season tickets for the remainder of the season. You will not want to miss The Nutcracker presented by Devon Energy, December 12-22, complete with gorgeous new sets and costumes debuted in 2014. February 26-28, enjoy a Triple Bill performance of Scheherazade: 1,001 Arabian Nights, and bring the whole family for Peter Pan, April 15-17. OCMS members receive 20% off tickets by calling the box office at (405) 843-9898. For more information visit okcballet.com.



KNOW THE SIGNS OF DRUG ABUSE IN TEENS AND YOUNG ADULTS: ONE PARENT'S JOURNEY TO RECOVERY

Andrew Gin, MD, shared this story from Neal Noerdlinger, someone who knows first-hand how difficult it may be to navigate the services available for addiction treatment. Dr. Gin hopes that this may help others who are dealing with a similar issue, whether in patients or personally, and are facing limited resources in Oklahoma. This story displays a connection between specialists and people searching for a solution.

By Neal Noerdlinger, as told to Johannah Homoky

It's been over five years ago, now, that I was on a business trip in Washington, D.C. when I received a jarring phone call from my wife at home in Los Angeles. The second I heard the phone ring, I knew she wasn't calling to say hello. After all, it was 4:25 a.m., Pacific Time.

As it turned out, just minutes earlier, our twenty-one year-old son had confessed to his mother that he was an addict – another victim of prescription painkillers. Hanging up the phone, I felt numb. All I could think was that our younger son is a good kid. He's smart, lively, sociable, and loving. A sophomore in college, majoring in English, he has a bright future ahead of him – a future that I never imagined might include the agony of addiction.

How could I have been so completely unaware of this double life he'd been leading? I felt guilt at being oblivious to the situation, anger at him for not telling me about this problem, and overwhelming fear that his life – our family's life – had inescapably changed. I asked myself repeatedly: How could it be that I had no indication?

Many parents have heard about the warning signs of excessive drug or alcohol use in teens and young adults. A list provided by The National Institute on Drug Abuse (NIDA) includes these standards:

- a change in peer group
- carelessness with grooming
- a decline in academic performance
- loss of interest in favorite activities
- changes in eating or sleeping habits
- deteriorating relationships with family members

Most parents would say these are easy behaviors to spot, and common sense tells us that sudden changes in our kids' behavior could be the harbinger of a negative development. But the problem, as my experience confirmed, is how such obvious signs are interpreted. It's the interpretation that's not always as clear-cut as one might think.

First of all, with my son off at college, living one-hundred miles away from his home, there was an immediate geographic disconnect. I'd phoned at 3:00 in afternoon and caught him still asleep, but I chalked that up to the "college life style."

Even when he sounded distant and distracted, I assumed he was simply focused on the new relationships he was forging with classmates or roommates. After all, the familiar connection with his family was bound to change as his horizons expanded.

As far as academic performance was concerned, I knew he was smart, based on the grades he'd made in high school and the interest he took in learning. When I heard he'd dropped a class, again, I merely attributed it to the college factor—more difficult curriculum, busy social life, freedom from constant parental oversight.

And when his mother complained about his spending habits and the neglect of several expensive items we'd purchased for him, the typical, "well, after all, he's a boy" refrain came into play.

Was I a completely clueless dad, insensitive to my son's plight, wrapped up in my adult world? Yes, I was. And I think a large part of my self-imposed ignorance was a function of denial. How could it be possible that my child, whom I loved fiercely and unconditionally; had raised, coddled, and encouraged for twenty-one years, had done something to endanger himself and disappoint his parents? So, in spite of his displaying known signs, I chose to disregard them, simply because I had no desire to admit they might be revealing something I didn't want to know.

If I had the luxury of reliving this experience, I'd make sure my son had the opportunity to talk to a professional who could accurately assess the situation. Issues with self-esteem could be a precursor that might eventually cause kids to exhibit one or more of those NIDA warning signs – and, ultimately, to experiment with drugs. In my case, psychological evaluation and counseling could possibly have prevented that outcome, and I realize now that affordable options are readily available in almost all communities.

But do know that if you miss the mark – like I did – there's still hope. Through the plethora of recovery programs, there are ones that fit each family's financial situation. But no matter the program, it takes the addict's intense and fervent desire for sobriety that will save his and your family's lives.

Yes, this story has a happy ending. My son is gainfully employed, excited about life and his future, gaining

Continues on page 26 …

maturity and self-respect every day. The agony of addiction undeniably exists; however, with love, perseverance, the fortitude of his mother – Janet, and faith in the 12-step program, our problems can be overcome – one day at a time.

Ironically, my son's recovery has impacted my own recovery from this ordeal by completely changing my life. Today, I'm a life coach (thanks to Maria Shriver) committed to working with families in crisis by guiding them through the treatment options that will work best for them and their financial situation. My mission to help other families in crisis never would have happened had it not been for my son's recovery.

Despite our nation's polarized political climate, however, there seems to be growing bipartisan support for changing our drug laws and draconian mandatory sentencing for non-violent, drug-related offenses. I like to think the reason for that is because addiction is a nonpartisan abuser. It hits Republicans, Democrats and Independents alike, and hopefully our laws will reflect what is already known by a growing number in our society, that drug addiction is a health issue, not a matter of law enforcement.

About Neal Nordlinger

Neal recently launched inCrisis Consultants (http://incrisisconsultants.com) based upon his experience with his twenty-something son's journey through addiction and recovery. Due to a plethora of appeals from other families hit by addiction, Neal provides them attorney and treatment options available per their financial resources and insurance status. Neal originally came to Oklahoma City from Los Angeles in 2009 to raise funding and run an Internet start-up he founded.

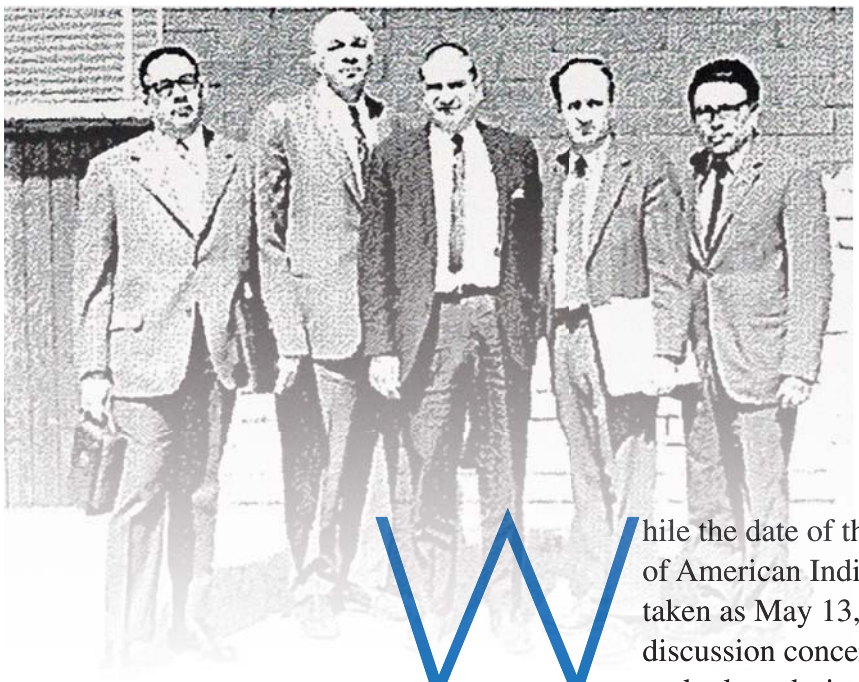
About Johannah Homoky

Based in Oklahoma City, Johannah is a freelance writer and editor, specializing in energy industry topics, as well as in marketing and copywriting for local businesses.

ESTABLISHMENT OF THE ASSOCIATION OF AMERICAN INDIAN PHYSICIANS: THE FIRST 10 YEARS

EVERETT R. RHOADES, MD

This is a largely personal account of Dr. Rhoades, based upon his own experience and recollections, of the establishment of the Association.



While the date of the establishment of the Association of American Indian Physicians (AAIP) might well be taken as May 13, 1971, the earliest outcome-oriented discussion concerning Indian physicians as a group took place during a planning session for Indian Health Service (IHS) held in Denver in February 1969. Everett Rhoades, MD, a member of the Kiowa Tribe and a young Assistant Professor of Medicine at the University Of Oklahoma College Of Medicine, had been invited to attend. At this meeting, Dr. Rhoades discussed with Dr. Emery Johnson, the IHS Director, the possibility of identifying physicians of Indian descent, with a view to establishing a system of communication between them or even an organization and Dr. Johnson was interested in recruiting Indian physicians for the IHS. Soon after, Dr. Johnson appointed Dr. Robert Kirk, an education specialist with IHS, to conduct a search and identify known Indian physicians.

In June, Dr. Kirk visited Dr. Rhoades and they discussed what use might be made of the physician list, specifically whether or not it might be feasible to form an organization. Such an organization could have several functions, not the least of which would be support for

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other Indian physicians, but it also might well serve as a means of fostering the recruitment of American Indians into health careers. The practicality of a functioning national organization comprising a few individuals, all of whom were already heavily committed, was an open question.

In December 1969, Dr. Rhoades wrote a letter to each of the individuals identified by Dr. Kirk and received an overwhelmingly positive response to his query about interest in possibly forming an organization of Indian physicians. Particularly, Dr. Rhoades was impressed with the response from Dr. Thomas St. Germaine Whitecloud Jr., a member of the Fond du Lac Chippewa Tribe of Wisconsin, who was already well known in Indian country. The level of enthusiasm encouraged Dr. Rhoades to seek financial support from Dr. Johnson to convene a small planning group to meet and discuss the feasibility of forming an organization. Dr. Johnson continued to be supportive and Dr. Rhoades invited Drs. Whitecloud (Lac du Flambeau Chippewa), Lionel DeMontigny (Turtle Mountain Chippewa), Taylor MacKenzie (Navajo), and Beryl Blue Spruce (San Juan Pueblo) to a planning meeting in Albuquerque in March 1970.

Dr. Rhoades had been acquainted with Drs. MacKenzie and Whitecloud by reputation and had met Dr. DeMontigny at the February 1969, IHS planning meeting in Denver but had not previously met Dr. Blue Spruce. The meeting of this group took place in the Native American Legal Defense and Education Fund offices in Albuquerque. Considerable time was spent in simply getting acquainted, but discussions moved to the nature of such an organization, anticipated goals and objectives, requirements for membership. Dr. Whitecloud preferred an informal communications group rather than a formal organization and the age old consideration of the degree of Indian blood that might be a requirement for membership was also discussed at length. Dr. Kirk attended this meeting in order to continue IHS support and to provide any assistance that might be sought. The consensus was that efforts should be made to establish a formal organization. Subsequently, Dr. Rhoades again turned to Dr. Johnson with a request for funds with which to pursue an organizing meeting of as many Indian physicians as could attend. With a grant of $10,000 from IHS, administered through the Oklahoma City IHS Area Office, along with a grant of $1,000 from the Association on American Indian Affairs, an organizational meeting was held in Oklahoma City May 13-14, 1971.

Almost as soon as the meeting convened a very interesting process arose spontaneously. Before any business could be conducted, it was necessary for each attendee to describe their personal experiences, sometimes at considerable length. This occupied almost the entire first day, to such a degree that Dr. Rhoades was concerned that the required business of establishing an organization might not be completed before adjournment. However, it was a necessary process truly seemed to serve as a kind of catharsis. Without it, it is possible that the organization would have failed at the time of its conception. Dr. Rhoades proposed three working groups: 1) Constitution and by-laws; 2) membership, meetings, and dues; and 3) aims, goals, and future programs.

By the end of the next day, the group had passed a formal resolution establishing an organization and elected a slate of officers. The latter were to function as an executive committee to further the aims of the new organization. Dr. Rhoades was elected President; Dr. Blue Spruce, President Elect; Dr. Demontigny, Secretary, and Dr. Linwood Custalow; Treasurer. Provision was made for the immediate past president and secretary to remain on the Board for an additional year in order to provide a degree of continuity. The keynote speaker at the banquet was Mrs. LaDonna Harris, the president of Americans for Indian Opportunity, who urged the organization to focus on efforts to increase Indian health manpower. After the meeting adjourned, several attendees traveled to Anadarko to attend the annual celebration of the Kiowa Blackleggings Society, thus establishing an effort to hold annual meetings as near local Indian celebrations as possible.

Dr. Rhoades set out to obtain support with which to establish an office. He met with Dr. Robert M. Bird, the Dean of the College of Medicine, who was supportive and suggested that he contact Dr. Thomas Lynn, Chairman of the Department of Community Medicine regarding possible support for an office. Dr. Lynn not only provided office space, but generously made available graduate student Melody Marshall, a nurse who was pursuing a doctorate in human ecology who could serve as an executive secretary to the organization so long as it did not interfere with the pursuit of her doctorate.

Within a matter of weeks, through the generous support of the University of Oklahoma College Of Medicine, AAIP found itself not only with a modestly furnished office, but a valuable graduate level Executive Secretary. The first office was an upstairs room in a building owned by the Department and soon, as a result of Ms. Marshall's efforts, it was possible to employ a young Indian woman as clerk/typist. The fortunate availability of a graduate level Executive Secretary was a tremendous gift and greatly facilitated the huge amount of work necessary to establish a new national organization.

Other individuals also generously donated time, expertise and support. One of the most important of these was Mr. Vincent Knight, a member of the Ponca Tribe and a recent law graduate who was very active in several Indian organizations, especially in Oklahoma City. He donated the necessary legal work for the organization such as drafting a constitution and by-laws, articles of incorporation, establishing a 501c3 non-profit corporation and many other vital contributions. Additional legal advice was donated by another young Indian attorney, Kirke KickingBird (Kiowa).

The executive committee began the work of establishing a formal organization. The first meeting of the Executive Committee

took place July 9-10, 1971 in Dr. Blue Spruce's home in Ann Arbor, Michigan. Initial work involved further discussion of the nature of the organization and drafting the legal documents necessary for the organization. One result was completion of Articles of Incorporation as a 501c3 organization August 19, 1971. The incorporators were Drs. Rhoades, Blue Spruce, Demontigny and Custalow. A second meeting was held in November in Reno, Nevada in conjunction with an annual meeting of the National Congress of American Indians. By this time the new Executive Secretary was on board and began planning for an annual meeting. Essential support for Executive Committee meetings was provided by the Association of American Indian Affairs.

Notice of the new organization appeared in the American Medical Association Newsletter, Vol. 3, No. 41, November 1, 1971:

> **THE ASSN OF AMERICAN INDIAN PHYSICIANS is seeking to identify every Indian now in medical or premedical training. Its goal is to establish a program that would enable these students to work under the direction of one of the estimated 38 Indian physicians in the U.S. The AAIP was organized last spring. Its president is Everett Rhoades, MD, a Kiowa on the staff of the VA Hospital in Oklahoma City and a member of the faculty of the U. of Oklahoma Medical Center. Beryl Blue Spruce, a Pueblo from Detroit, is the 1972-73 president-elect.**

The third meeting of the Executive Committee took place in Sarasota, Florida, Feb. 2, 1972, where an IHS office was located. Close cooperation with the IHS was vital to the early survival of the organization. The minutes of this meeting disclose a tremendous amount of work, not only having to do with organizational matters, but anticipating the upcoming annual meeting of the membership. In the spring of 1972, the Association incurred its first great personal loss with the untimely death of Dr. Thomas WhiteCloud Jr. His experience and wisdom were invaluable in getting the organization under way and he provided an essential moderating influence throughout several vigorous discussions. He did not live to attend the first annual meeting.

The fourth meeting of the Executive Committee was at the home of Dr. Custalow in Newport News, Virginia, on May 13, 1972. Considerations included finalizing a proposed constitution and by-laws and planning the first annual meeting. The focus of the planned annual meeting was on Indian medical students and their support.

Early meetings of the Executive Committee naturally turned to possible sources of ongoing support for the organization (perhaps the predominant concern of the organization to this day). It was clear that it would be many years before the size of the organization would support sustained operation through collection of membership dues.

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This remains undoubtedly the greatest challenge to the longevity of the organization. The most promising source of support, outside the IHS, was the Bureau of Health Manpower Education (BHME) located within the Department of Health, Education and Welfare (now the Department of Health and Human Services). Another fortuitous circumstance favored the organization, the appointment of George Blue Spruce, DDS as Director of the Office of Health Manpower Opportunity in the BHME. Dr. George, the brother of Beryl and the first American Indian dentist, not only encouraged the new organization to apply for funding but worked within his own organization and elsewhere to assure as much funding as possible. Support was now available for one of the three goals of the AAIP: the recruitment of Indian students into health careers. The proposal submitted by the AAIP was for $70,845.

Responses from other organizations and individuals even before the 1972 Santa Fe meeting provided immediate testimony to the value of an organization of Indian Physicians. Requests for participation by AAIP members occurred immediately. Dr. DeMontigny represented the organization at a meeting of traditional healers in Toronto (the earliest AAIP involvement with traditional medicine). A constitution and by-laws was submitted to the membership for mail vote on May 31, 1972 and a brochure describing the AAIP was developed.

A memorandum to the Executive Committee dated June 28, 1972 forwarding minutes of the May 13 meeting in Newport News states, "We would like to have a meeting in Santa Fe the afternoon of July 11, primarily for the purpose of discussing our contract with the Bureau of Health Manpower Opportunity. This contract is for $63,460". This milestone made it possible to move beyond the donated support provided by the IHS, the AAIA and the OU Health Sciences Center. It marked the arrival of a truly professional organization.

On October 30, 1972, Don Jennings was appointed Project Director for Recruitment, beginning a more formal program for recruitment of potential medical students as well as establishing programs for support of Indian medical students. At this time, AAIP moved to a larger office and the daily workload quickly grew; earlier preoccupations with establishment of an organization gave way to support for individuals and groups.

The purposes of the organization were succinctly laid out in the document prepared for the IRS application for 501c3 tax exempt status: The Association of American Indian Physicians, a private non-profit, educational organization, has as its purpose that of: 1)Recruitment of American Indians into

health careers, with an emphasis on medicine; 2)Providing a forum for the exchange of information between American Indian Physicians, student, and other appropriate groups concerning health and educational concerns of the American Indian; and 3)Serving in a consultant and/or advisory capacity to federal and other agencies/organizations regarding concerns and programs which affect the health status of the American Indian. The document also describes how the purposes will be carried out: 1) Identifying Indian pre-medical and medical students and assigning practicing Indian physicians to them on a "buddy system" for purposes of visiting and otherwise providing moral support; 2) Attending meetings of Indian youth (college level and below) and other groups for the purpose of recruitment; 3) Holding seminars, conferences, and other types of education meetings for the exchange of information and problem solving between Indian physicians and, where appropriate, Indian students; and 4) Assigning members and students to serve in an advisory capacity to appropriate groups, organizations, and agencies in the area of the health of the American Indian. This document appears to have been prepared after the 1972 Santa Fe meeting. The statements remain quite relevant years later and are perhaps worthy of review from time to time.

The first newsletter appeared in November 1972 and focused on medical students, the annual meeting, and announced the Thomas S. Whitecloud, Jr. scholarship. New members included Joseph Ball; Joseph Guyon; Thomas Matheson, and Constance Pinkerman. After two years, the organization was essentially complete and in business. The February 1973 newsletter noted new members Lyle Griffith, Robert Mitchell, Ed Pointer, Max Swancut, James Thompson, and Charles B. Wilson.

By July 1973 the organization had grown to 25 members; had fostered the establishment of the Association of Native American Medical Students; built a strong relationship with IHS and other national health and Indian organizations, and conducted a series of symposia directed toward teachers and counselors of American Indian students.

From the Editor:

As AAIP members today, more than 412 American Indian/Alaskan Native residents, licensed or retired physicians, express their commitment to pursuing excellence in Native American health care by promoting education in the medical disciplines, honoring traditional healing principles and restoring the balance of mind, body, and spirit.

THE BULLETIN

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DIRECTOR'S DIALOGUE

By Jana Timberlake, Executive Director

"Not what we say about our blessings but how we use them, is the true measure of our thanksgiving." *~W. T. Purkiser*

The holiday season is upon us and that means time will whizz by at warp speed! Over the next two months, days will be filled with family, cooking, eating, decorating, shopping for the perfect present and wrapping the gifts with all the trimmings. To give yourself some peace of mind before ramping up for "the holidays," take time to sit back, take a deep breath and consider your blessings.

When I begin thinking about the many blessings in my life, the song by Irving Berlin, "Count your Blessings," from White Christmas comes to mind. Wouldn't it be great to fall asleep each night by counting your blessings instead of worrying? The number of challenges in my life pale in comparison to all of the blessings – I just need to stop long enough to reflect on them.

One of my blessings is the opportunity to work with physicians and for physicians. It has been a pleasure to work with this year's officers and directors while attempting to address the tough issues that will ensure that the Society remains relevant to early career physicians. These individuals "volunteered" for their leadership roles in the organization, and I thank them for the many hours they have devoted at the end of some very long work days. Dr. Doug Folger has given wise counsel this year and taken every opportunity to express his appreciation to the staff. Thank you, Dr. Folger!

Another of my blessings is the Society's staff – Alison Williams and Eldona Wright. They are incredible, talented individuals who are funny, bright and dedicated to this organization. I thank them for their energy and ideas, and always know the office is in "safe hands" when I am away. If you haven't met them, stop by the OCMS office, have a soft drink or bottle of water and get to know them!

Finally, my greatest blessings in life are my husband, John, my fur babies – Ted and Fergie – my family and my friends. No matter what, they are always at my side to lend a hand, hear a story or give encouragement – and love me unconditionally. I suspect most of you who are reading this article have many of the same blessings. During this wonderful season of thanksgiving, promise to hold close those you love and be grateful for all life's blessings. Life is short and we have today – yesterday is gone and tomorrow isn't a reality.

As a final reflection, below is a quote from George A. Buttrick:

> *"We need deliberately to call to mind the joys of our journey. Perhaps we should try to write down the blessings of one day. We might begin; we could never end; there are not pens or paper enough in all the world."*

Wishing everyone a beautiful holiday season that is filled with more blessings than you can count!

Jana Timberlake, Executive Director

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CME Coordinator
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Contact: **Marilyn Fick**
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Contact: **May Harshburger**
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Phone: 610-8011

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Phone: 842-0484

Email: elliott@okafp.org

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Contact: **Kristi Kenney**
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Phone: 631-2601

To love a year is to live a year.
Vacant years add up to a lifetime of nothing.

LOVED A YEAR

Hanna Saadah, MD

THE POET'S SPOT

So much of life has spilled and still
Robust remains our coffer
So many pains we've paid for joy
And tears, for greener measure
Gently we pruned our souls
For meeker harmony
So sing to me my dear
For we have loved a year.

Our branches grow entwined and cling
Endure the wrestling weather
Our winglets dance about the sun
And fly above cloud cover
Our roots burrow for truths
Riddled in history
Fill up the cup and cheer
For we have loved a year.

Remark how dark begets the light
And light, the dark, forever
Thus you and I around the days
Have spun our lives together
The sky with our season flowers
And space is quietude for lovers
This time of year, the clouds are clear
Red ribbons wrap the atmosphere
For we have loved a year.

THE BULLETIN

Frontiers of Healing: A History of Medicine in Oklahoma County has experienced a delay and set to be released in early Spring 2016. The fully-illustrated, beautifully designed book, sponsored by the Oklahoma County Medical Society is authored by Gayleen Rabakukk and published by Legacy Publishing.

Many physicians helped sponsor the book by purchasing legacy pages, cementing their story in the only published historical account of the people, organizations and events that have shaped the medical profession in Oklahoma County.

Please share the word with your fellow physicians about this interesting and informative book. OCMS looks forward to sharing more information about the release soon!

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