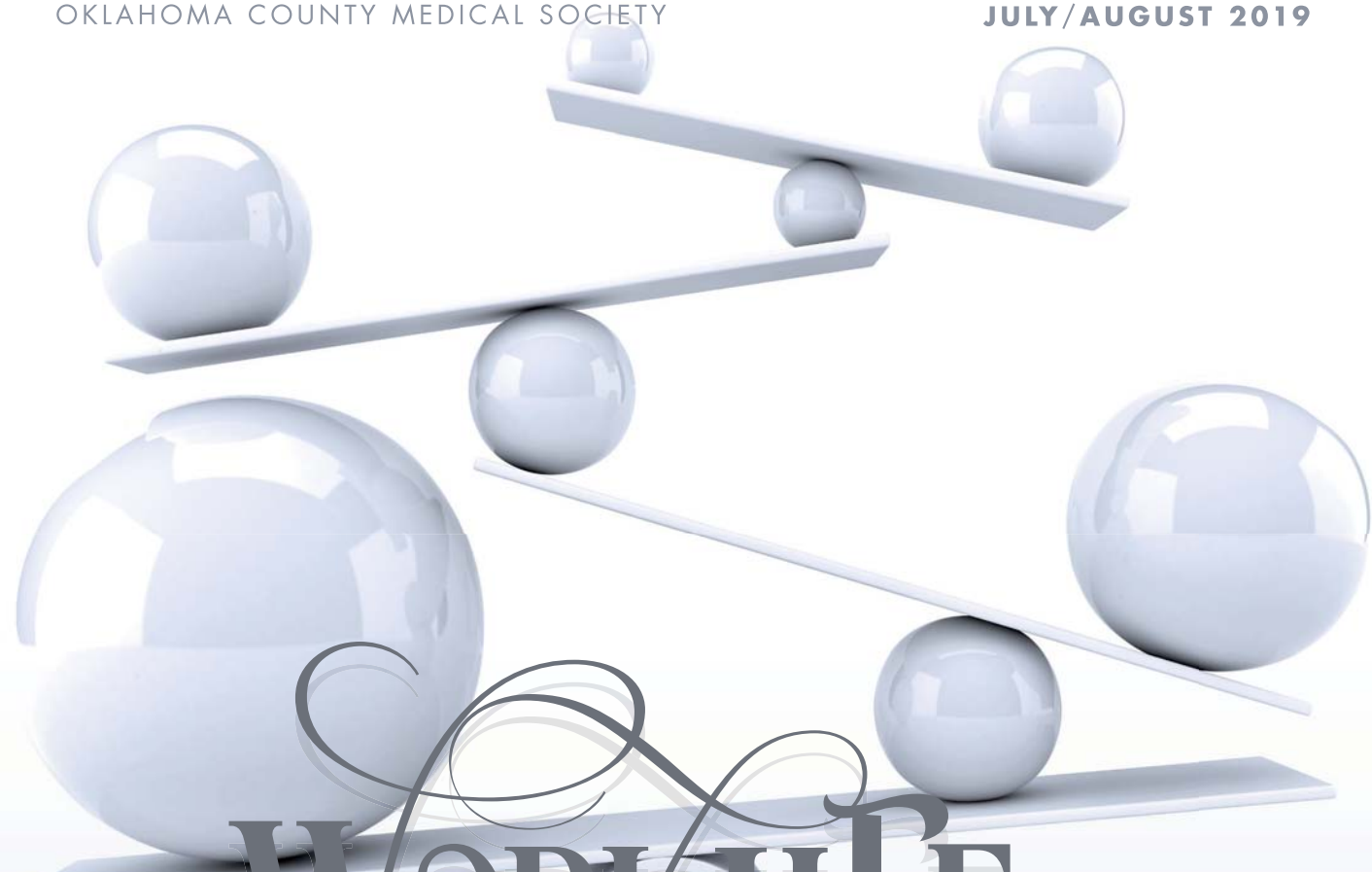
THE BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY

JULY/AUGUST 2019



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OKLAHOMA COUNTY MEDICAL SOCIETY

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THE BULLETIN

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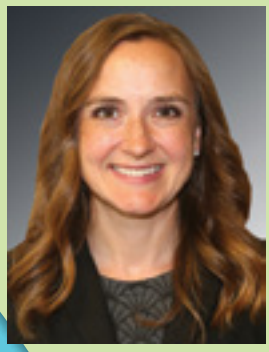
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ABOUT THE COVER

We launched our Physician Wellness Program more than a year ago. The goal of the PWP is provide counseling sessions to member physicians and residents. In the short time since the launch, the PWP has provided more than 65 visits to physicians in need in Oklahoma County. Sessions are 100% confidential, with no electronic records, no insurance billing, and off-site at a private location.

To continue to provide these sessions, we need your help. OCMS received a matching grant from the Oklahoma State Medical Association Foundation that is contingent upon member donations. First, the donations will be used to help pay for counseling sessions for participating members. Second, we hope to raise enough money to provide a local screening of "Do No Harm," a feature-length documentary that exposes the silent epidemic of physician suicide.

Life is not just about powering through. It's about having a safe harbor to empower and equip physicians with the tools to take care of themselves as they take care of their patients. The PWP is:

- Free – up to 8 sessions per year, provided by OCMS and our generous members
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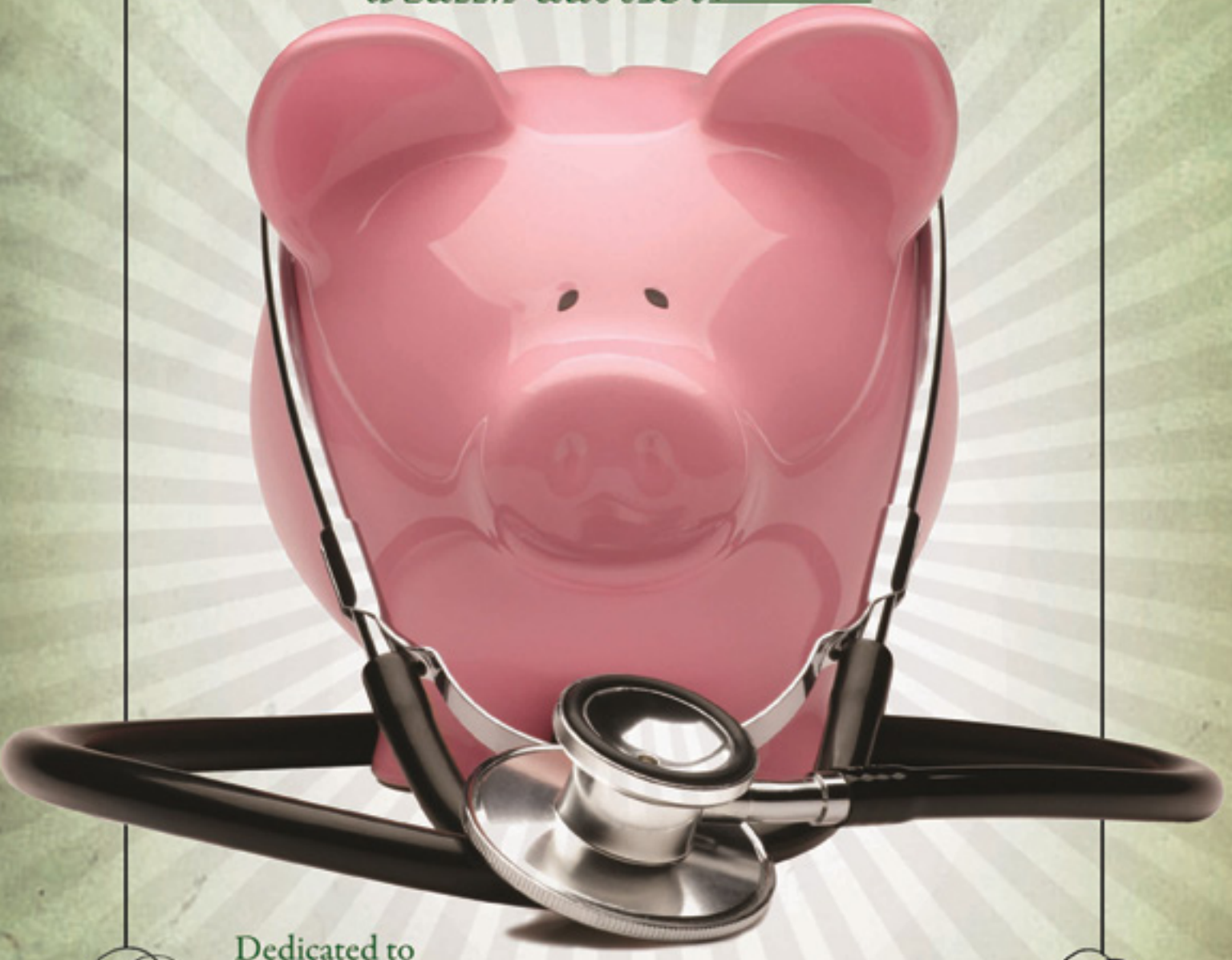

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PRESIDENT'S PAGE

R. KEVIN MOORE, MD

END THE EPIDEMIC

In the State of the Union Address on February 5, 2019, President Trump proposed to end the HIV epidemic in the United States. HIV has claimed the lives of more than 35 million people worldwide. In 2017, over 940,000 died globally. At the end of 2017, 36.9 million people were living with HIV and there were over 1.8 million new infections, almost half of these occurring in key population groups. 59% of adults, and 52% of children living with HIV received ART, antiretroviral therapy. Africa remains the most affected region, having 25.7 million people living with the virus. From 2000 to 2017 new infection rates fell 36% with HIV deaths falling 38%. Due to ART, over 11.4 million lives have been saved. A 2011 study showed that HIV+ patients adhering to an effective ART regimen, reduced rates of transmission by 96%. More than 10 studies have shown the effectiveness of pre-exposure prophylaxis and post exposure prophylaxis on reducing the chance of transmission.

In the United States 1.1 million people are living with HIV. More than 700,000 people have died since 1981. Although the rate of new infections has dropped, it has stalled and remained stable at about 40,000 new cases a year. 50% of new cases occur in the South, and 40% in African American men. In 1988 the CDC recommended delaying treatment with ART until the CD4 count had dropped less than 500. In 2012, they recommended treating all, but still relied on the CD4 count. As of 2016, the recommendation is treatment for all as soon as possible to reduce transmission. To achieve the goals to end the epidemic, the DHHS hopes to reduce the rate of new infections by 75% in 5 years and by 90% by 2030. This strategic initiative hopes to achieve these goals by diagnosing all individuals with HIV as early as possible after infection, treat HIV rapidly and effectively with ART to suppress the viral count, prevent at risk individuals from contracting HIV by using pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PeP), and rapidly detecting and responding to new clusters of HIV as they develop to reduce transmission.

In the United States there are over 3,000 counties nationwide. More than 50% of new HIV cases, however, occur in just 48 counties, Washington DC, and Puerto Rico. Seven states also have disproportionately high rates in rural counties. Oklahoma is one of these seven states and Dallas is one of the hot spots of new activity. In the 1980's before ART was available, a diagnosis of HIV was a death sentence. The stigma of HIV among homosexual men and IV drug abusers was profound. We have come a long way in our understanding of HIV and its treatment and prevention, but we still have a long way to go. Large studies have shown that undetectable

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means untransmissible. This means that an HIV+ person, who is on ART and maintains an undetectable viral load will not transmit HIV. By using PrEP, we could theoretically eliminate HIV in the United States. Realistically, this will take a coordinated level from the Federal, State, and local levels to insure that the poor and indigent receive care.

In order to reach the goals of 2030, there are 4 key strategies: Diagnose, Treat, Protect, and Respond. With more than 50% of new cases occurring in just 48 counties, most of these occurred from people transmitting the virus who didn't know that they were infected, or who knew of the diagnosis, but had not yet been started on treatment. Strategies must first rely on increasing the diagnosis among high risk groups. Get tested early and often. Then as soon as a diagnosis is made, beginning treatment asap with ART. Protection involves getting as many people in high risk groups on PrEP therapy so that fewer cases will occur. From recent data, only 10% of high risk groups that could benefit from PrEP therapy receive it. By increasing this number to 90%, more than 50,000 new cases can be prevented. Finally, by improved laboratory methods and epidemiological techniques, the CDC and its partners can respond quickly to new outbreaks and prevent further transmission.

There remain many barriers to the above strategies. The stigma of being diagnosed with HIV prevents many people at high risk from getting tested. The cost of ART therapy is substantial. Many insurance plans do not cover PrEP therapy or HIV treatment. If medications are not taken daily, the chance of transmission goes up. By our local health department increasing awareness, making testing more open and available, and the costs of medications made affordable and available to all, the goals of ending the epidemic by 2030 may actually be attainable.

EARLY MEMBERSHIP RENEWAL OPPORTUNITY

Why am I receiving a bill?

Some members expressed concern about many professional memberships being billed late in the calendar year, resulting in financial hardships. Other members found it difficult to renew or join in the middle of an academic year.

What is the dues cycle?

The dues cycle remains the same - January 1-December 31.

Can I still pay with Easy Pay?

Yes. Easy pay can be split into three monthly payments.

When is the due date?

Members will be dropped from membership if payment for 2020 dues are not received by March 1, 2020. The change in billing is a convenient option for those who prefer to renew earlier.

Is the price changing?

No.

Questions? Contact Rebecca Carr
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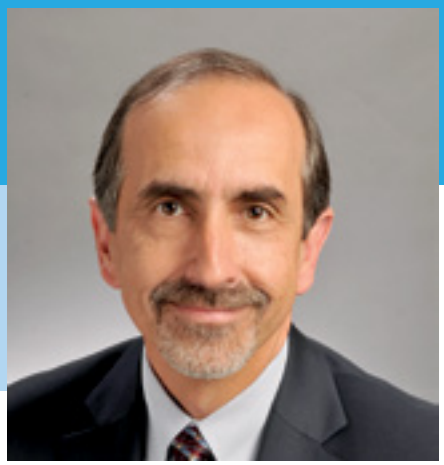
DEAN'S PAGE

JOHN P. ZUBIALDE, MD
EXECUTIVE DEAN AND PROFESSOR,
FAMILY AND PREVENTIVE MEDICINE
UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE



This year's College of Medicine Alumni Day was held on campus on Friday, May 3 and included the annual awards ceremony and reception at the Embassy Suites near the medical center, in the evening. Recipients of the Alumni Association Awards this year included: Bill McCurdy, M.D. (1964), Physician of the Year-Private Practice Award; Charles Pasque, M.D. (1989), Physician of the Year – Academic Medicine Award; and the Friend of Medicine Award, to Chaplin Danny Cavett, Director of the Pastoral Care Team for OU Medicine. Special recognition was given to the 50-year reunion class, the Class of 1969.

Plans are underway for welcoming the College of Medicine Class of 2023 on August 13. The 165 new students to the Oklahoma City campus will begin their 3-day orientation to their new medical education program and will be concluded by the White Coat Ceremony, now a well-established tradition in its twenty-second year.

I would like to take this opportunity, now, to address a growing health concern in our state. Oklahoma, like many other states, remains in the grip of the opioid epidemic. According to the Centers for Disease Control and Prevention, on average, 130 Americans die every day from an opioid overdose. In 2017, the number of overdose deaths involving opioids was six times higher than it was in 1999.

At the OU College of Medicine, we believe we have a responsibility to address the opioid epidemic in all areas of our mission: patient care, education and research. Along with our partners at all seven colleges here at the OU Health Sciences Center, as well as our teaching hospitals, our mission is to reduce the number of deaths due to opioid overdoses. For our future physicians, we have created a framework that will guide them in addressing chronic pain in ways that are far less likely to lead to addiction and overdose.

In 2012, the Department of Family and Preventive Medicine in the OU College of Medicine began discussing and planning a new pain medicine curriculum for residents built on the foundation of several basic questions: What is chronic pain? What causes it? What does the medical literature say we should do to treat it?

Unfortunately, primary care physicians traditionally have not received good training about chronic pain. Over the course of a year, a committee, led by Dr. Rachel Franklin, gathered evidence that would guide them in the management of chronic pain that is not related to cancer or a terminal illness. Studies on the topic are limited, but the committee worked diligently to create the new curriculum, gathering guidance and refining through faculty consensus and peer review. The result is a framework that guides residents through identifying the mechanisms of chronic pain and tailoring management of that pain to the mechanism. The focus first is on non-pharmacologic treatments – yoga, massage therapy, counseling, biofeedback – followed by non-opiate pharmacologic management, such as antidepressant therapies and anti-inflammatories.

In short, the department now teaches residents about the patho-physiology of different types of pain and what the literature says will or will not work. One of the best examples of chronic pain treatment is with fibromyalgia, which appears to be caused by the brain's abnormal processing of painful stimuli in the body.

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Physicians know that self-care measures such as yoga and biofeedback help people with fibromyalgia, as do antidepressants and, sometimes, anti-seizure drugs. However, opiates do not address the brain's abnormal processing of signals.

Creating a new educational process was an achievement, but the curriculum couldn't be introduced until the clinical environment had been prepared for it. All OU Physicians clinics made changes to their structures well before Oklahoma's new opioid prescribing law went into effect on November 1, 2018. Clinic staff were educated about the coming changes, including provider-patient agreements and the development of treatment plans that focus on the cause of the patient's pain. A registry was created of patients who were on opiate medications, and letters were sent to those patients, explaining the safety concerns about opioids and asking for their partnership in looking at their chronic pain in a new light.

In the Family Medicine Clinics, workflow was modified in a way that gives the physician more time to visit with patients. Before each patient visit, the nursing staff checks the prescription monitoring program report and asks the patient how their function is affected by pain. Providers no longer ask for a pain score; rather, they assess 10 areas of function, which helps them to better understand what the patient's experience of suffering means to them. Areas of function range from how much they can lift to duration of standing to quality of their sleep.

When the resident or physician goes to see the patient, all that information is available to them on a dashboard. That allows them to spend time making eye contact, developing a relationship with the patient, and developing a clearer understanding of the patient's perception of their pain.

Although the pain medicine curriculum is targeted for family medicine residents, the committee has been working with the College of Medicine to address resident educational needs in other specialties, as well as identifying best practices for educating medical students in their undergraduate years. The opioid epidemic touches almost every specialty.

For people who are struggling with an opioid addiction, the college's Department of Psychiatry and Behavioral Sciences in the OU College of Medicine offers a robust addiction medicine treatment program. The treatment team, which includes both physicians and mental health providers, takes an integrated approach to treating addiction because people who struggle with substance abuse sometimes also have a co-occurring psychiatric illness as well as trauma issues. When healthcare professionals reduce patients' psychiatric symptoms and help them feel less tormented by their trauma, patients are often better able to practice their addiction recovery because their brain is now engaged in the process.

The department also offers a Suboxone clinic to treat patients who are addicted to opiates, where patients also are required to engage in the psycho-social treatment approach.

Through its research mission, the OU College of Medicine is dedicated to discovering new ways to treat pain and avoid overdose. Researchers have been conducting various studies for several years, but the effort has recently become more focused. Through the Oklahoma Clinical and Translational Science Institute, headquartered at the OU Health Sciences Center, pilot grants are being awarded for opioid-related research. The projects aim to address the opioid epidemic in rural and underserved communities in Oklahoma in one or more of the following areas: treatment for opioid use disorder, prevention, recovery/rehabilitation, and pain management. The program especially encourages collaborative and multidisciplinary projects between institutions and tribal groups.

The opioid epidemic did not develop overnight, nor will it be solved quickly, but as part of Oklahoma's comprehensive academic health center, we believe we should take a leading role in resolving the crisis. I am grateful for all that the OU College of Medicine has achieved and will continue to do to reverse one of the most serious and heartbreaking epidemics of our time.

In closing now, I wish you an enjoyable and productive summer – best wishes!

Author's Note: I would like to credit April Wilkerson, Staff Writer, OU Medicine, for her substantive help on this Dean's Page. Thank you, April!

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- **The Honorable Noma D. Gurich, Program Co-Chair,** Chief Justice, Oklahoma Supreme Court
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- **Commissioner Terri L. White, MSW,** OK Department of Mental Health and Substance Abuse Services
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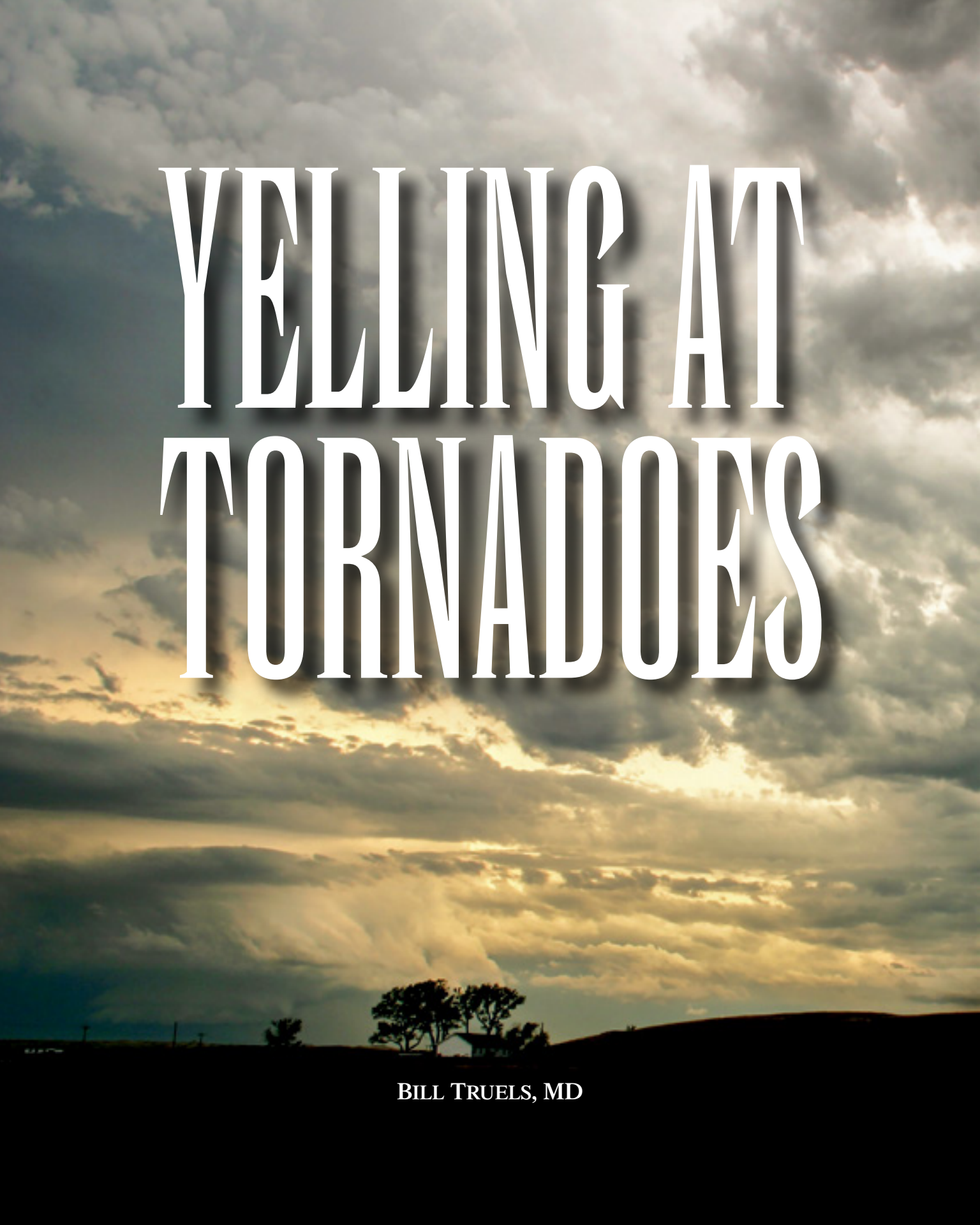

YELLING AT TORNADOES

BILL TRUELS, MD

I was sitting in the doctor's lounge waiting for my case to start when Herb Krakow, the plastic surgeon walked in.

"You know, Dr. Truewater, there's just too much emphasis on bad weather in Oklahoma," Herb said, as he took off his galoshes following a recent rain storm. "It's bad for business!"

"How's that, Herb?" I asked.

"Well, companies do research on where to expand. They look at Oklahoma – a sunshine state with lots of labor, and then they look at all these negative weather reports about Oklahoma."

"They talk about hail storms and high winds and wind shear. Then it's tornado this and tornado that. Why, in forty years in Oklahoma I've only seen two tornados, and only one came close!" Herb continued.

"You only need one tornado to come close, Herb, before you get lifted up into heaven."

"That's Wizard of Oz fairy tale kind of stuff," Herb answered. "We're not in Kansas anymore!"

"Why, it shook the doors on the storm cellar, but that's as far as it got!" Herb added. "We were all a little scared as we huddled in the underground shelter in the front yard, but that's Mother Nature for you!"

"I agree with you, Herb," I replied. "Why, you can get struck by lightning playing golf, and that could happen anywhere."

"In fact, the only tornado I ever saw was where I grew up in Illinois. I was in third grade and the tornado took off part of the school roof! We were all hiding under our desks, like it was a nuclear attack or something – the teacher just wanted us to be safe! Those big old-fashioned school windows shook, but they didn't break!"

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"Those were crazy times!" I added. "It turned out that the weather was a bigger threat than the Russians during the Red Scare in the sixties!"

"Speaking of crazy times, that reminded me of that crazy dermatologist, George Spears. Do you remember him, Dr. Truewater?" Herb asked.

"Wasn't he that elderly dermatologist who thought everything was a skin cancer? I mean, he missed one melanoma, along with the pathologist, and from then on, he got paranoid that everything was a skin cancer!"

"Right, well George was our next door neighbor, and one day I was in the shelter with my wife and kids eating our rations, and I could hear George's wife next door, yelling at him to get in the shelter."

"'Get in the shelter, George!' she yelled."

"I had to open our shelter door and peek out, which you're not supposed to do, because by then the wind was blowing pretty hard, and the doors were rattling!"

"Well, it was pitch black in the middle of the afternoon on Easter Sunday, but you could still see this big tornado, kind of spindly, with a deafening roar, like some angry God, sucking up everything in it's path – lawn chairs, cars – you name it – and crazy George was throwing his hands up in the air, yelling at the tornado. It was the craziest thing I've ever seen!"

"You see, George was a buttoned-down kind of guy, and he couldn't handle disorder. The tornado was messing things up."

"I yelled at George to get in the shelter. George was a good golfer, and we needed him for the upcoming Member-Guest Spring-Fling tournament, if we had any chance of winning."

"Lord, take me!" George yelled. "I challenge you to take me!" as the hailstones whipped against his body.

"It was a classic case of Man vs Nature – our desire to assert ourselves against all the forces that seek to destroy us. For a moment, I thought George was admiring the sheer power of the damned thing!"

"Was it suicidal? I don't know. But George was challenging the Destructive Force – he was immersing himself in the destructive element – Joseph Conrad would have been proud!"

"It reminds me of Dylan Thomas," I added. "Do not go gentle into that good night – Rage, rage against the dying of the light."

"I still can't figure out why George would yell at that tornado," Herb interjected. "Perhaps, like ancient times, he was offering himself as a human sacrifice. Take me and spare my family!"

"Well, it was foolhardy, nevertheless, and stupid," I said. "It's not good to get angry at God. Sometimes we are our own worst enemy! Be careful what you wish for!"

"Some people interpret tornadoes and natural disasters as a sign that God is punishing them for past sins," Herb replied.

"Others, like Sister Mary, who was next door to a house that was flattened, took it as a sign that God was telling her to get on with her dream of building a retirement center. That gave rise to Epperson Village, complete with walking paths and a beautiful garden."

"But why couldn't God get Sister Mary's attention by just leaving her a note to build her retirement center?" I asked.

"Wouldn't be as dramatic," Herb answered. "Flattening that house next door got her attention. And she took it as a miracle that her house was untouched."

"At any rate, George got a second chance. He pulled the wood splinters out of his skin, took some time off to heal his wounds, and then resurrected his practice."

"Perhaps it was a catharsis – I don't know. He seemed happier after that – like he had stood up and challenged the tornado and won!"

"Or perhaps he had seen the face of God!" I added.

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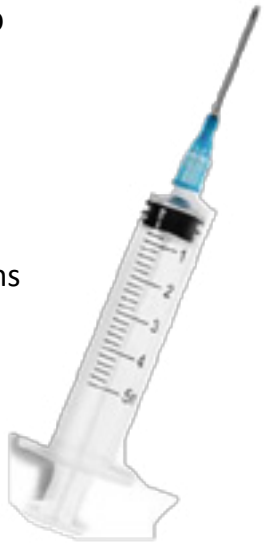

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OKLAHOMA STD RATES REPORT

IVONNA MIMS, RN, BSN, STP NURSE CONSULTANT

The number of reported sexually transmitted diseases has reached record breaking highs in the United States over the last 5 years. According to The Centers for Disease Control and Prevention, more than twenty million new STDs are reported annually placing a financial burden on the health care system of more than $16 billion. The alarming rates of increase among the three most common reportable STDs (Chlamydia, Gonorrhea and Syphilis) sparked national and local concern. In 2017, Oklahoma experienced a 29% increase in Chlamydia, a 104% increase in Gonorrhea, and a 349% increase in the number of primary and secondary syphilis cases since 2012. Since 2016, Oklahoma has seen a 2.4% increase in the number of new HIV cases. Oklahoma has been identified as one of seven states with the highest rates of HIV transmission in rural counties and currently ranks 2nd in the nation for the highest prevalence of hepatitis C and 6th in the nation for highest rates of Gonorrhea.

Despite the robust efforts of Oklahoma health departments, the number of reported cases of STDs continues to rise. The use of nucleic acid amplification test (NAAT) provides high sensitivity and specificity for detection of C. trachomatis and N. gonorrhoeae which has greatly improved detection and tracking. Behavioral, social, and economical obstacles among vulnerable populations also contribute to the spread of STDs in our state. Barriers to STD care include lack of knowledge of STDs and available services, cost, shame associated with seeking services, discrimination, and the perceived provider and societal stigma regarding STDs in general. Adolescents and young adults experience additional barriers to STD information and care that include, confidential access to screening and prevention resources, limited knowledge of symptoms, fear of family discovering, misconceptions about the safety of anal and oral sex, and overall more casual attitudes regarding sexual practices. In 2018, budget constraints triggered an overwhelming reduction of over 100 nurses and nurse practitioners throughout Oklahoma rural health departments. As a result, many rural county health departments were forced to cancel walk-in appointments for STD screening, while others were limited to offering services to only one or two days per week upon availability of a nurse. These barriers have contributed to increased ER visits for STD screening, and delayed detection of the infections.

Since many STDs are asymptomatic, the risk for delayed diagnoses and inappropriate treatment greatly increases the risk for transmission and adverse outcomes. In Oklahoma, more than half of reported Chlamydia and Gonorrhea are among young adults ages 15-24. Additionally, reported cases among Oklahoma females are nearly twice the number of reported cases in males. While both Chlamydia and Gonorrhea can be effectively treated with antibiotics, delayed detection, inappropriate treatment, and reinfection due to untreated partners are contributing to sequelae of adverse outcomes including Pelvic Inflammatory Disease, miscarriage, and ectopic pregnancy. While trends tend to emphasize the severity of adverse outcomes for females, these infections can lead to infertility in both males and females. Barriers to extragenital STD screening and assessment for high risk sexual practices increases the threat of missed opportunities for diagnoses and treatment of rectal and pharyngeal gonococcal and chlamydial infections in Oklahoma males and females. Additionally, these infections when left untreated increase the risk for acquiring and transmitting HIV. Past literature on HIV identify blood and genital fluids as the primary sources of HIV transmission. New research has found that the viral load of HIV RNA in rectal fluids is 25 times higher than the viral loads of genital fluids and blood which emphasizes the importance of screening clients for sexual behaviors and upscaling STD screening of the appropriate exposure sites.

Primary care providers are often the first to encounter patients with STD symptoms and play an important role in preventing, diagnosing, and treating STDs by screening for those at-risk and providing counseling to educate on the high-risk behaviors that may lead to STDs and their sequelae. Many patients feel uncomfortable disclosing their history of sexual practices, partners, and risk factors. Taking a complete sexual history using open ended communication allows providers to identify those at risk for bacterial STDs, HIV, and hepatitis, identify appropriate screening sites, and assess the client's knowledge of prevention methods. Effective interviewing skills characterized by respect for clients sexual preferences, gender identity, compassion and nonjudgmental attitude, are crucial to establishing a strong rapport and obtaining a thorough sexual history assessment. Provider support and counseling of tailored STD prevention techniques through the use of condoms, vaccinations, Pre-Exposure Prophylaxis (PrEP) and Expedited Partner Therapy (EPT) are crucial to raising public awareness, reducing transmission, and reducing adverse outcomes of untreated or inappropriately treated STDs.

Oklahoma primary care physicians play a crucial role in addressing the STD epidemic in our state. The Centers for Disease Control and Prevention and United States Preventive Services Task Force urge primary care providers to implement open ended sexual history taking as routine assessment at the initial visit, routine preventative exams, or when signs and symptoms are suspected or observed during examination on all sexually active clients of all ages, married and unmarried pregnant females, and MSM. The Oklahoma State Department of Health urges primary care physicians to partner with us by upscaling STD detection, screening and treatment with the following strategies:

- Utilize the 2015 CDC STD Treatment guidelines as reference for most current screening and treatment recommendations.
- Normalize positive sexual health conversation and perform a thorough sexual history assessment as a part of routine examination for all sexually active patients.
- Consider presumptive treatment with dual antibiotic therapy for symptoms of Gonorrhea and Chlamydia.
- Normalize and upscale HIV/Syphilis screening and routine 3 site (genital, rectal, and oropharyngeal) STD screening for Gonorrhea and Chlamydia with CDC approved NAAT screening.
- Educate and provide prevention vaccinations, condoms, PrEP, and Expedited Partner Therapy for gonorrhea and chlamydia.

Primary prevention of STD transmission begins with identifying risk and initiating change in the behaviors placing Oklahomans at risk. For more information on how you can help with the Oklahoma STD epidemic contact the Oklahoma State Department of Health HIV/STD Service at 405-271-4636.

SCREENING RECOMMENDATIONS AND CONSIDERATIONS REFERENCED

	WOMEN	PREGNANT WOMEN
CHLAMYDIA	Sexually active women under 25 years of age USPSTF[1] Sexually active women aged 25 years and older if at increased risk[2] USPSTF[1] Retest approximately 3 months after treatment CDC	All pregnant women under 25 years of age USPSTF[1] Pregnant women, aged 25 years and older if at increased risk[2] USPSTF[1] Retest during the 3rd trimester for women under 25 years of age or at risk[4] CDC[3] Pregnant women with chlamydial infection should have a test-of-cure 3-4 weeks after treatment and be retested within 3 months USPSTF[1]
GONORRHEA	Sexually active women under 25 years of age USPSTF[1] Sexually active women age 25 years and older if at increased risk[9] USPSTF[1] Retest 3 months after treatment CDC[10]	All pregnant women under 25 years of age and older women if at increased risk[11] USPSTF[1] Retest 3 months after treatment CDC[10]
SYPHILIS		All pregnant women at the first prenatal visit USPSTF[11] Retest early in the third trimester and at delivery if at high risk AAP/ACOG[12]
HERPES	*Type-specific HSV serologic testing should be considered for women presenting for an STD evaluation (especially for women with multiple sex partners) CDC[17]	*Evidence does not support routine HSV-2 serologic screening among asymptomatic pregnant women. However, type-specific serologic tests might be useful for identifying pregnant women at risk for HSV infection and guiding counseling regarding the risk for acquiring genital herpes during pregnancy CDC[17]
HIV	Women 21-29 years of age every 3 years with cytology Women 30-65 years of age every 3 years with cytology, or every 5 years with a combination of cytology and HPV testing USPSTF[23],ACOG[24],ACS[25]	Pregnant women should be screened at same intervals as non-pregnant women USPSTF[23],ACOG[24],ACS[2]
HEPATITIS B SCREENING	Women at Increased Risk CDC[27]	Test for HBsAg at first prenatal visit of each pregnancy regardless of prior testing; retest at delivery if at high risk CDC[27] USPSTF[28]
HEPATITIS C SCREENING	Women born between 1945-1965 CDC,[29] USPSTF[30] Other women if risk factors are present[30] USPSTF[30]	Pregnant women born between 1945-1965 CDC,[29] USPSTF[30] Other pregnant women if risk factors are present30 USPSTF[30]

* Please note that portions of this table marked with an asterisk are considerations and should not be interpreted as formal recommendations.
** USPSTF recommends screening in adults and adolescents ages 15-65

IN THE 2015 STD TREATMENT GUIDELINES AND ORIGINAL SOURCES

MEN	MEN WHO HAVE SEX WITH MEN (MSM)	PERSONS WITH HIV
*Consider young men in high prevalence clinical settings[5] or in populations with high burden of infection CDC[6]	At least annually for sexually active MSM at sites of contact (urethra, rectum) regardless of condom use CDC[6] Every 3 to 6 months if at increased risk[7] CDC[7]	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter CDC[8] More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology CDC[8]
	At least annually for sexually active MSM at sites of contact (urethra, rectum, pharynx) regardless of condom use CDC[10] Every 3 to 6 months if at increased risk[7] CDC[7]	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter CDC[10] More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology CDC[10]
	At least annually for sexually active MSMCDC[13] Every 3 to 6 months if at increased risk[7] CDC[7]	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter CDC, HRSA, IDSA, NIH [14,15,16] More frequent screening might be appropriate depending on individual risk behaviors and the localepidemiology CDC[13]
*Type-specific HSV serologic testing should be considered for men presenting for an STD evaluation (especially for men with multiple sex partners) CDC[17]	*Type-specific serologic tests can be considered if infection status is unknown in MSM with previously undiagnosed genital tract infection CDC[17]	*Type-specific HSV serologic testing should be considered for persons presenting for an STD evaluation (especially for those persons with multiple sex partners), persons with HIV infection, and MSM at increased risk for HIV acquisition CDC[17]
		Women should be screened within 1 year of sexual activity or initial HIV diagnosis using conventional or liquid-based cytology; testing should be repeated 6 months later CDC, NIH, IDSA[26]
Men at increased risk CDC[27]	All MSM should be tested for HBsAg CDC[2]	Test for HBsAg and anti-HBc and/or anti-HBs. CDC[27]
Men born between 1945-1965 CDC,[29] USPSTF[30] Other men if risk factors are present[30] USPSTF[30]	MSM born between 1945-1965 CDC[29] Other MSM if risk factors are present[30] USPSTF[30]	Serologic testing at initial evaluation CDC, NIH, IDSA32,33 Annual HCV testing in MSM with HIV infection CDC31

Please visit **okcountymed.org/stdrates** for a copy of this graphic and all sources.

OCMS **2019** BOARD NOMINATIONS

Notice: *The election process is changing. The OCMS Board of Directors ballots will be emailed on or before September 15. In the unlikely event you are a voting member and do not have an email on file, a paper ballot will be sent. Please check your email for the ballot.*

Below are the official nominations for the 2019 Board of Directors.

Position 1

Michael S. Cookson, MD

Michael S. Cookson, MD, MMHC, FACS is Professor and Chairman of the Department of Urology at the University of Oklahoma's College of Medicine (COM) and holds the Donald D. Albers Endowed Chair. He is a 1984 graduate of OU with a BA in Journalism and graduated with high honors from OU's COM in 1988. He completed his Urology residency at UT San Antonio in 1994, and his fellowship in Urologic Oncology at Memorial Sloan-Kettering Cancer Center in New York City in 1996. Before returning to Oklahoma in 2013, he was the Vice Chairman of Urology at Vanderbilt University Department of Urologic Surgery in Nashville. He also earned a master's degree in health care management at the Owen Business School. Dr. Cookson's clinical practice is devoted to the surgical and clinical management of patients with Urologic Cancer, and he currently practices at the Stephenson Cancer Center at OU Medicine. He holds numerous national positions including President-elect of the Society of Urologic Surgeons and is a member of the American Association of GU Surgeons. In 2018, he received the American Urological Association (AUA) Presidential Citation for Outstanding Service and was also named the OU COM's Alumni of the Year in 2018.

Bret R. Haymore, MD

Dr. Bret Haymore completed his medical school training at Penn State Hershey College of Medicine where he was elected to the AOA honor society. He subsequently completed a residency in internal medicine and was chief medical resident. He has received numerous teaching and research awards and has published numerous articles in the medical literature. He served on the Board of Regents of the American College of Allergy, Asthma and Immunology from 2007-2008. He served on active duty in the Army for nine years during which time he completed his residency in Internal Medicine and then an Allergy-Immunology fellowship at Walter Reed Army Medical Center (WRAMC) in Washington D.C. Dr. Haymore completed his active duty service in 2011 as a Major and Chief of Clinical Services for the Allergy and Immunology Department at WRAMC. He also deployed in support of Operation Iraqi Freedom during his tenure in the military. He has been in private practice in Oklahoma since his departure from the military. Dr. Haymore and his wife have 5 children and enjoy many activities together including sports, music and outdoor activities. They are active in their Church and the community.

Position 2

Bradley J. Margo, MD

Dr. Margo grew up in Oklahoma City and attended medical school at the University of Oklahoma. He trained in orthopedic surgery at Oklahoma and then completed a one year fellowship at Insall, Scott, Kelly Institute in New York City. He is currently a partner at McBride Orthopedic Hospital.

Dr. Margo is on the Oklahoma County Medical Society Finance Committee and currently serves as chairman. He was also a member of the inaugural class of the OCMS Leadership Academy. He has been married for 19 years and is raising three boys.

Irim S. Yasin, MD

Irim S. Yasin MD, grew up in Oklahoma. She attended the University of Oklahoma for her undergraduate studies receiving a degree in biochemistry with a minor in economics. She earned her medical degree from the University of Oklahoma College of Medicine. She then went to the University of Illinois at Chicago for residency, where after two years she decided to apply for and was accepted to a fellowship in Hematology/Oncology. She completed her training and moved back to Oklahoma City to practice Oncology with INTEGRIS Cancer Institute. After returning to Oklahoma, Dr. Yasin helped establish a free clinic (Shifa Clinic) which is currently seeing uninsured patients for basic medical care.

Dr. Yasin was recently nominated for Leukemia and Lymphoma Society Woman of the Year, in which she worked diligently to raise funds for and bring awareness of LLS. She is always looking for new ways to get involved in the community. In her free time she enjoys flying planes, traveling with her family, hiking and nature.

Position 3

Ryan T. Morgan, DO

Ryan Morgan, DO attended Oral Roberts University and received a degree in Biology and Spanish. He went on to earn his medical degree at Oklahoma State University Center for Health Sciences and to complete his residency in Internal Medicine at Oklahoma State University Medical Center. Last year he was honored as a Fellow of the American College of Osteopathic Internists. Dr. Morgan currently works as a hospitalist at INTEGRIS Southwest Medical Center, and until early 2019, also worked as a rural hospitalist in Elk City.

Dr. Morgan is a Diplomate of the American Board of Obesity Medicine and the American Board of Clinical Lipidology; the only physician in the state to hold these two distinctions. He is currently in the process of starting a medical weight management clinic, Vitalis Metabolic Health, slated to open in the fall of 2019. The goal of the clinic is to improve overall health through evidence-based and individually tailored treatment. He is regularly seeking opportunities to become more involved in his community, and in his free time enjoys seeking out new cultures by traveling the world, escaping in the serenity of sailing, and discovering the heart of cultural connection by learning languages.

Nathan I. Valentine, MD

Nathan Valentine, MD, is the Chief Medical Officer for Variety Care, a 13-site FQHC serving the Oklahoma City metro area and 2 western Oklahoma towns. He is responsible for all clinical services offered with over 100 clinicians reporting to him - over half of whom are Pediatrics, Family Medicine and Women's Health. Dr. Valentine graduated from medical school at the University of Oklahoma and completed Family Medicine residency in Wichita at Via Christi. He is board certified in Family Medicine with a CAQ in Hospice & Palliative Care. Dr. Valentine completed his Certified Physician Executive through the American Association of Physician Leaders (AAPL, formerly ACPE). Following residency, Dr. Valentine and his wife traveled (couch-surfed) for about nine months. Upon return, he started his solo House Call practice for patients who have difficulty getting out of the house to see their doctor, and his wife joined INTEGRIS Baptist. Six years later, Dr. Valentine closed his solo practice to join Variety Care, getting his first taste of leadership as Director of Family Medicine. He has been the CMO for about two years and thoroughly enjoys the ability to positively impact the quality of life and longevity of 65,000 medical patients, many

Continues on page 22 …

of whom utilize the need-based sliding fee scale. He also serves as Clinical Advisor for Oklahoma Primary Care Association and the PCNOK (an accountable care organization consisting of FQHCs). Dr. Valentine enjoys reading, spending time with family and kitesurfing on the occasion that work lets him cat the wind.

Position 4

Melissa G. Boersma, MD
Dr. Melissa Boersma is a board-certified radiation oncologist in Oklahoma City. She received her medical degree from the University of Texas Medical School.

Michelle L.E. Powers, MD

Dr. Michelle Powers has been practicing in Oklahoma City with The Pathology Group, PC for 9 years. She is board certified in anatomic and clinical pathology as well as hematopathology. She also serves as the lab medical director at two hospitals in Oklahoma as well as president of her group. She feels that active participation with the county and state medical society helps keep our profession alive. She also enjoys traveling with her 6 year old, energetic son.

OCMS
OKLAHOMA COUNTY MEDICAL SOCIETY
news

On Monday, April 22, OCMS hosted its first physician collegiality dinner, focused on **Women in Medicine**. The dinner gave practicing physicians the opportunity to connect with fellow women practicing medicine, discuss top challenges in their specialty/workplace and talked about ways how organizations like OCMS can help them in their day-to-day life. Attendees were able to commiserate, collaborate, connect and celebrate. The event was beyond networking – it was an opportunity for OKC women physicians to truly connect.

Sponsored by LifeSquire, Inc., more than 30 OCMS members and non-member guests attended the dinner at Hefner Grill in Oklahoma City. OCMS plans to continue this event for women multiple times per year, along with other dinners for more practicing physicians.

If you have an idea for an event group, please email Alison Fink, Associate Director (**afink@okcountymed.org**).

WOMEN IN MEDICINE

STRENGTH IN DIVERSITY

BETSY NOLAN, MD

Last month was a special month. As a woman orthopaedic surgeon, I am a proud member of the 6% club. It's not that I don't normally notice being outnumbered by men. I do. It's pretty obvious. It's not that I don't enjoy my mostly male colleagues. I do. Most of them are great. But opportunities to specifically network with other women physicians and surgeons, and to recognize and support their substantial accomplishments, are just special.

On April 20, 2019, the Orthopaedic Society of Oklahoma had the distinct privilege of welcoming Kristy L. Weber, MD, the first female President of the American Academy of Orthopaedic Surgeons. While it's a bit disappointing that it took 86 years to get to this point, it's a tremendous step forward nonetheless, and Dr. Weber is certainly an extremely well qualified leader. As the Immediate Past-President (and only woman President so far) of our state society, it was my pleasure to help with arranging and hosting her visit. It was well attended despite being a holiday weekend, demonstrating the appeal, I think, of the program. Her speech included presenting the Academy's Strategic Plan, which includes an ambitious but necessary change in the current culture.

A specialty society within the AAOS, the Ruth Jackson Orthopaedic Society, exists to provide networking, career development, grants and scholarship opportunities to women in our specialty as well as to those women in training or considering a career in orthopaedics. Through its annual Perry Outreach Program and Medical Student Outreach Program, we are helping to build the pipeline for the

future of women in orthopaedics. Under the leadership of Dr. Sheila Algan, high school women interested in learning more about careers in orthopaedic surgery and engineering are able to meet women at different stages of those career paths and ask them directly about their experiences as well as participate in a hands-on skills lab with sawbones and power tools. As in recent years, we were fortunate to have some outstanding male surgeons participate as mentors as well, including Dr. Chris Jordan and Dr. Wayne Johnson. It is especially important in the current climate that we appreciate our male colleagues who take the time and care enough to mentor us. All mentors are important. Supporting all of our colleagues is important.

Along those lines, the OCMS has recognized the need for women physicians to connect with and support one another. Women represent only 22% of the OCMS membership despite medical schools being close to 50% women now. The first fellowship dinner was held on April 22, 2019 at the Hefner Grill. Even in the age of hugely popular online groups such as the Physician Mommy Group or I Look Like a Surgeon, there is no substitute for actual (IRL if you speak that language) friends. The demand was so great the event was full within a very short time of its announcement, and there was even a wait list for next year. The series will continue with additional fellowship dinners providing opportunities for other subgroups of physicians. It was a pleasure to attend and meet so many inspiring women, most of whom I simply don't cross paths with in my usual work life on a day to day basis.

Perhaps one day the demographic of our physician cohort will more closely resemble that of the patients for whom we care. We've come a long way, but there is still a lot of work to be done. The good news is there are champions and leaders among us. Soon-to-be OCMS President, Dr. Wasemiller-Smith, as well as Drs. Weber, Algan, Jordan, Johnson, and the late Drs. Perry and Jackson, to name just a few. It is perhaps more important than ever, as the house of medicine faces so many threats, that we support each other. That's what this organization is about. We are stronger together.

DR. ZUBIALDE NAMED NEW EXECUTIVE DEAN

John P. Zubialde, M.D., has been named Executive Dean of the University of Oklahoma College of Medicine. The OU Board of Regents recently approved Dr. Zubialde for the position.

Dr. Zubialde has been serving as interim Executive Dean since July 2018, providing leadership during a period of transformation for the college and campus. He is truly a leader among leaders as shown through his proven leadership of the OU College of Medicine and the respect he has garnered among colleagues across the OU Health Sciences Center and OU Medicine.

A family medicine physician and longtime academic medicine leader, Dr. Zubialde joined the

OU College of Medicine in 1991, and is a professor in the Department of Family and Preventive Medicine. He served as program director of the Family Medicine Residency Program from 1994 to 2000, guiding new physicians through the next stage of their training.

Dr. Zubialde was next promoted to associate dean for Graduate Medical Education, during which time he oversaw all residency programs for the OU College of Medicine. In 2015, he was promoted to senior associate dean and, for nearly a year, has been serving as interim executive dean.

Dr. Zubialde completed both his medical degree and residency in family medicine at the University of New Mexico School of Medicine. After residency, he served in the United States Air Force, attaining the rank of major and serving as chief of Family Medicine Services at the U.S. Air Force Clinic and Hospital at Tinker Air Force Base. He received the Air Force Commendation Medal for Meritorious Service.

Dean Zubialde's role includes leading the OU College of Medicine across all of its missions of education, research, and patient care—with opportunities such as: increasing GME residency positions, growing research funding across College of Medicine departments and in collaboration with other Health Sciences Center colleges and centers, and improving and expanding health care delivery within the OU Physicians group practice and across the OU Medicine academic health system. Dean Zubialde will continue to work with leadership and faculty across the College of Medicine, both on the Oklahoma City campus and the regional School of Community Medicine campus in Tulsa. He also will serve on the board of directors for the OU Medicine Inc. health system.

THERAPEUTIC JURISPRUDENCE AND DRUG COURTS, WHERE JUDGES, LAWYERS AND DOCTORS WORK TOGETHER AS "HEALERS"

S. SANDY SANBAR, MD, PHD, JD, FCLM*

Law has been proven as an agent of societal order. Individuals who transgress the normative rules deserve punishment through the courts, and justice must appear to be served. The traditional approach to U.S. justice has been the ***'adversarial'*** process that focuses on blame and punishment. It is based on legal rights, entitlements and remedies.

'Retributive' justice focuses on the defendant and solutions are found through punishment, be it monetary, loss of liberty, community service or a combination thereof. It seeks to isolate an offender as a form of deterrence. It pays little or no attention to the offender's rehabilitation. And, minimal attention is given to the victim's needs.

'Restorative' justice is a different model. It requires a changed mind-set in the perceptions of crime and punishment. In ***restorative justice***, a crime is seen as a disruption to interpersonal relationships and community harmony or wellbeing. ***'Restorative'*** processes turn harm to healing for individuals and community. The restorative approach is inclusive with input from victims, offenders and the community. It focuses on repairing the harm to victims and preventing its reoccurrence by healing the hurt, and restoring the relationships that have been damaged. The fields of forensic psychology and forensic psychiatry operate at the juncture of law and the mind.

'Therapeutic jurisprudence' is the most recent approach to justice. In 1990, law professor David Wexler[1] coined the term in a paper, delivered to the National Institute of Mental Health in 1987, to acknowledge the socio-psychological consequences of any legal action. ***"Therapeutic jurisprudence"*** is the study of the effects of law and the legal system on the behavior, emotions, and mental health of people. It is a multidisciplinary examination of how law and mental health interact. According to therapeutic jurisprudence,

*Executive Director, Diplomate and Past Chairman, American Board of Legal Medicine; Vice President and Director of CME, Western Institute of Legal Medicine, California; Fellow and Past President, American College of Legal Medicine; and Adjunct Professor, Medical Education, OUHSC.

the processes used by courts, judicial officers, lawyers and other justice system personnel can impede, promote or be neutral in relation to outcomes connected with participant wellbeing such as respect for the justice system and the law, offender rehabilitation and addressing issues underlying legal disputes."[2]

Law is capable of operating as a therapeutic agent. Law is a social force which inevitably gives rise to unintended consequences, that may be either harmful (anti-therapeutic) or beneficial (therapeutic). ***Therapeutic Jurisprudence*** aims at reforming the law in order to positively impact the psychological well-being of the accused person.[3]

The medical/therapeutic jurisprudence approach in criminal justice is multidisciplinary. It focuses on an offender's actions as problems. It requires rehabilitation and transformative outcomes by specialist courts, such as Drug Courts, Mental Health Courts, and Alcohol Courts.

Therapeutic Jurisprudence integrates medical treatment services with judicial case processing, ongoing judicial intervention, close monitoring, immediate response to behavior, and collaboration with community based, and government organizations. It is a holistic solution that addresses the behavioral, emotional, psychological, or situational issues of the accused person. It is neither paternalistic nor coercive. Judges, lawyers and health care providers involved in specialist courts proceedings combine their efforts to create a strategy that will assist the offender to take responsibility for making positive changes in their own lives.[4]

In 1989, a team of justice professionals established the ***nation's first drug court in Miami-Dade County*** after expressing dissatisfaction with ***high recidivism rates***. Chief Judge Gerald Wetherington, Judge Herbert Klein, State Attorney Janet Reno, and public defender Bennett Brummer designed the drug court for nonviolent offenders to receive treatment for drug problems.

Drug Courts incorporate treatment, individual therapy, 12-step meetings, random urinalyses and court appearances. Many courts require participants to find a job or complete volunteer work while in treatment, which generally last between 6-12 months. As of May 2017, over 3,100 drug courts operated in the United States.

People with substance abuse problems or those accused of drug-related crimes are allowed to participate in drug courts. They must be aged 18 or older, plead guilty to the charge, admit to having a substance abuse problem, not have been dismissed from a drug intervention program, have no history of a violent felony, residential burglary, or drug trafficking or distribution, reside in the county that the drug court serves, have no pending charges from another county, and volunteer to enter drug court.

Drug Courts are most effective in assisting individuals with substance use disorders, people likely to be unsuccessful in standard treatment, and those with extensive criminal backgrounds. In 2017, President Donald J. Trump endorsed the recommendations of his President's Commission on Combating Drug Addiction and the Opioid Crisis[5], in particular the establishment of drug courts in every federal district court. In Oklahoma[6], there are Adult Drug Court, Mental Health Court, Veteran Support, Juvenile Drug Court, Family Drug Court, and Crisis Intervention Team (CIT).

In 1999, ***therapeutic jurisprudence*** was applied for the first time to drug treatment courts (DTC). In 2019, it has been embraced by most drug courts in the U.S., Canada, Australia, New Zealand, England, Israel, Pakistan, India, and Japan. Presently, there is an International Society for Therapeutic Jurisprudence, a society with a comprehensive and authoritative website and an *International Journal of Therapeutic Jurisprudence*.

Nationwide, Drug Courts significantly reduce crime as much as 45 percent more than other sentencing options, and 75 percent of Drug Court graduates remain arrest-free at least two years after leaving the program.

[1]*Therapeutic Jurisprudence: The Law as a Therapeutic Agent* by David Wexler (Wexler 1990); and Wexler and Winick in their 1991 book, *Essays in Therapeutic Jurisprudence.*
[2]https://definitions.uslegal.com/t/therapeutic-jurisprudence/
[3]Institute of Medicine Meeting https://www.youtube.com/watch?v=XBlO_SzS92o - NASEM Health and Medicine Division, Published on Mar 3, 2014. David Wexler, International Network of Therapeutic Jurisprudence.
[4]Therapeutic Jurisprudence - The Lawyer as Healer? January 12, 2016; Michael Crystal, Hosted by Dr. Gordon Atherley; https://www.voiceamerica.com/episode/89806/therapeutic-jurisprudence-the-lawyer-as-healer
[5]https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf
[6]https://www.ok.gov/odmhsas/Substance_Abuse/Criminal_Justice_Services_/index.html

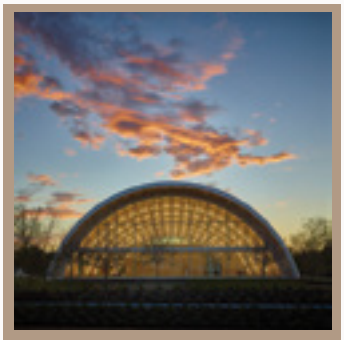
2019-2020 SEASON

SUBSCRIBE TODAY AND SAVE!

DRACULA
October 25-27, 2019

THE NUTCRACKER
PRESENTED BY DEVON ENERGY
December 14-22, 2019

ROMEO & JULIET
February 14-16, 2020



FUTURE VOICES
ADD-ON PERFORMANCE
March 13-15, 2020

(E)MOTION(S)
A TRIPLE BILL
April 17-19, 2020

ROBERT MILLS, ARTISTIC DIRECTOR

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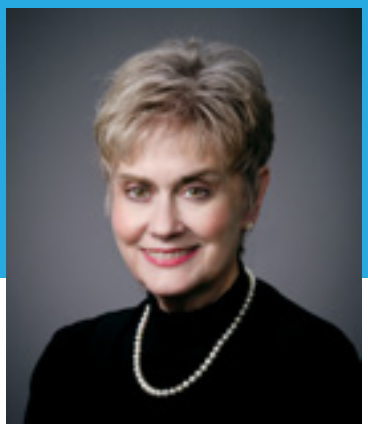
DIRECTOR'S DIALOGUE



BY JANA TIMBERLAKE,
EXECUTIVE DIRECTOR

Ch-ch-changes
Oh, look out you rock 'n' rollers
Ch-ch-ch-ch-changes
Turn and face the strange
Ch-ch-changes
Pretty soon now you're gonna get older
Time may change me
But I can't trace time
I said that time may change me
But I can't trace time ***– David Bowie***

The song, "Changes," was written by David Bowie and originally released on the Hunky Dory album in December 1971. I was an OSU freshman, and the world was in the midst of the Hippie Revolution. Each person seems to have his/her own meaning for these song lyrics, and perhaps that was the songwriter's intent. To this day, I remain a rock 'n roller – born towards the end of the Baby Boomer generation – and I must confess to not understanding the younger generation's penchant for what I think is non-music. That being said, I remember my parents making similar comments about rock 'n roll and how this musical genre would be the downfall of civilization!

Change is inevitable. Rebecca Carr, the new OCMS Membership Coordinator, is a great manager, communicator, organizer, mother of two teenagers and wife. She is also the leader of her church's Wednesday Night Food Ministry, along with being the president of the Tuttle Band Boosters Club. Rebecca graduated from Friends University in Wichita, KS with a Bachelor of Science in Business Administration. Please help me welcome her to the Oklahoma County Medical Society!

By the time you read this article, Alison Fink, Associate Director, will be a new mommy! Landon Emory Fink said "hello" to the world in June. This little boy is going to have so many "other" grandmothers that he will be unable to keep track of them. Perhaps some of these grannies will volunteer to babysit. We are so thrilled about Alison's and Jeff's new addition.

Drum roll please... This past May, I completed 30 years of full-time employment with the Society. Where did the time go? For more than half of my work life, I have enjoyed the wonderful opportunity to work with and on behalf of physicians. Memories of joy, laughter and sadness flood my mind. Thankfully, the "family" of OCMS staff members continues to support each other through all kinds of life events.

Looking back to May 1989, Dr. Boyd Shook was OCMS President; Dr. Ed Brandt was beginning his tenure as Executive Dean at the University of Oklahoma College of Medicine; the article, Caring Freely, provided Bulletin readers with a look inside the volunteer medical clinic run by Dr. William Hale and his wife, Sandy, who later received the Thousand Points of Light Award from President George H. W. Bush; and the 911 emergency telephone access system became operational.

The recent May-June 2019 Bulletin featured Oklahoma City's 33rd Red Earth Festival on its cover; the beginning of OCMS Collegiality Dinners; a history of Women in Medicine; Dr. Hanna Saadah, a tireless volunteer at the Open Arms Clinic, was the commencement speaker for the University of Oklahoma College of Medicine graduation; and the McCaffrees were wished Godspeed and happiness in their much-deserved retirement.

While the characters might be different, the projects and services provided to physicians, patients and this community continue to be among the best. The quote attributed to Alphonse Karr, "The more things change, the more they remain the same," still rings true. Happy Summer!

– Jana Timberlake, Executive Director

Oklahoma City VA Hospital, 1974

Veterans are challenged by life as much as by their military service. To many, military life was relatively easy compared to civilian life, and death was often preferable to loss of love and family.

"You should have let me die," mumbled Mr. Kaz as he awakened from his coma and saw me standing by his bed. Then after a sighing pause he added, "Death solves all our problems and life keeps piling them on."

1974 was a harsh year for Mr. Kaz, not because he had just returned from Vietnam, but because he found out that his wife no longer loved him.

"How do you know that she no longer loves you?" I asked. "Did she tell you so or you're just assuming?"

"No, Doc. She actually told me that she still loved me, but her eyes were the ones that said that she didn't."

"Are you sure?" Mr. Kaz. "Wives suffer when their husbands are in combat. They live with the daily fear of loss as long as their husbands are away and it takes them time to adjust when their husbands return."

"I wish I had returned in a body bag, Doc," said Mr. Kaz as he turned his head away and closed his eyes.

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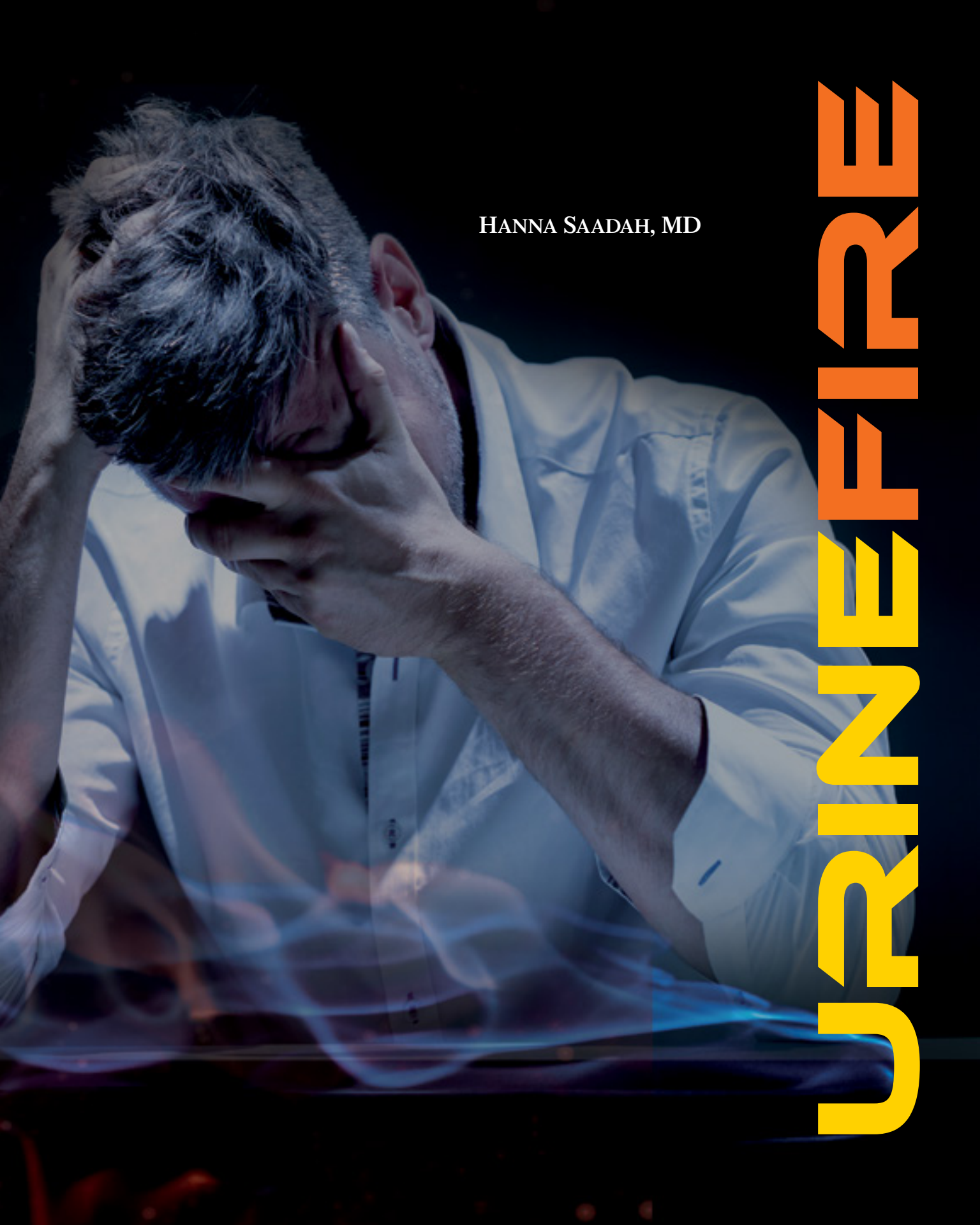

URINE FIRE

Hanna Saadah, MD

I left him alone for the rest of that day and busied myself with his medical issues. He was admitted last night, comatose with seizures. Eighteen hours later, his seizures stopped and he awakened, disappointed that we did not let him die. Our studies did not reveal the cause of his seizures or coma. His exam showed an inflamed mouth and throat, but was normal otherwise with good vital signs and no fever.

He refused to eat because his mouth and throat were too sore. When he tried to drink water, horrible pain traveled from his throat, down his chest, and all the way to his stomach. After a few, small swallows, he also refused to drink.

We suspected a suicide attempt but he would not admit it, nor would he tell us what he swallowed that set his mouth, throat, esophagus, and stomach on fire. "You should have let me die," was his one response to all our questions. He kept his eyes closed as if not seeing the world protected him from what the world had in store for him.

Before I left that night, I tried to have a conversation with him, but again, he closed his eyes and turned his head away. His attitude was a hot pot of disillusionment and anger.

"You should have let me die," he growled. "No one has the right to keep a man alive if the man wants to die."

Standing by his bed, preparing to counter his right-to-die ethos, I noticed a shiny, blue-gray film floating over his urine in the Foley bag. It reminded me of fuel spills that, as a child in Lebanon, I used to see on rainy days at old gas stations. To drain the floating film, the nurse and I had to drain the urine bag from the bottom spout until a trace of urine remained with the film over it. That part, we drained into a kidney basin and took it away.

"Can you smell it?" I asked Nurse Spinosa.

"It smells like fuel," she replied with suspicious eyes.

"Let's put a match to it and see if it burns," I suggested.

"It's a fire hazard," she warned.

"Can we take it to the lab and ask them to light it?" I asked.

"It still would be a fire hazard. You're not allowed to light fires in the VA Hospital."

"I could take it home and see if it burns."

"You can't take lab samples home; it's against the rules."

"Knowing what this blue-gray film is could unlock Mr. Kaz's silence."

"If you're going to light it, light it in the kitchen, and don't let me see it burn."

"Why don't you want to see it burn?"

"Because if do, I would have to report you."

In the kitchen, with Nurse Spinosa peering at me from the corner of her eye, I dipped a cotton ball into the floating film, placed it in a clean kidney basin, and gave it a light. It burned with a bright, red-blue flame, which I immediately put out for fear that it might trigger the fire alarm. Then, abiding by the rules, I sent the urine sample to the lab and went home.

The next morning, I greeted Mr. Kaz and, holding his hand, I asked. "Did you try to kill yourself by drinking kerosene?"

This time, he opened his eyes, glared at me, and barked, "How did you find out?"

"I saw a blue-gray film, floating over your urine. It smelled like kerosene and when I gave it a light, it burned."

"How did you know it was kerosene and not some other fuel?"

"Because, in Lebanon, we cooked on Kerosene burners when I was growing up."

"Do you still do that over there?" he asked, looking bemused.

"Not anymore. We now use gas burners."

Having uncovered Mr. Kaz's kerosene ploy, he began to trust me, and his trust grew into fondness when, after some discussion, he realized that I knew a lot more about kerosene than he did.

When I shared with him that the lab had tested his urine and reported it as normal, he giggled. "If you hadn't set my urine on fire, no one would have known. You sure blew my secret, Doc," he said with a wry smile.

Mr. Kaz spent three days in the I.C.U. He and I, having become kerosene friends, had long discussions

before he was transferred to the psych ward. I wanted him to tell me what was it that drove him to attempt suicide but he wouldn't. However, during his last I.C.U. afternoon, he opened up because he knew that we might not see each other again.

"I came back from Nam, Doc, to find my wife pregnant. She wants a divorce. We have two young boys, six and eight. My life is a mess. That's what I came back to after risking my life for two years as a combat soldier."

"Where will the boys go?"

"She don't [sic] want them and they want to stay with me. She paid more attention to her boyfriend than to the boys while I was gone," he croaked.

"What made you choose kerosene? It is most unusual for a soldier not to use a deadlier method."

"You mean a firearm?"

"Yes. kerosene is not usually deadly unless you develop an inhalation pneumonia, which you did not because you did not vomit and aspirate."

"I had read enough about kerosene, enough to know that it isn't very deadly, but I did drink a large amount though. I drank as much as I could stomach, excuse the pun, thinking that it would be enough."

"It put you into coma, gave your seizures, and caused your mouth, throat, esophagus, and stomach to slough, but you survived it much like a good soldier survives a deadly battle."

Mr. Kaz sneered at me for the longest time, asked if I were a psychiatrist, and then asked, as if to test my abilities, if I really knew why he chose kerosene.

"We're all baffled about your choice, Sir. Did you choose it because it was not very deadly?"

"Nope. Try again, Doc," he whispered with a smug smile.

"I've read all there is to read about kerosene and I'm still flabbergasted about your choice. Did you do it for retribution?"

"Nope. You're wrong again," he frowned. Then after a deep, stuttering sigh, he added, "If you really want to know the truth, I did it for the boys."

"The boys?"

"I had read that kerosene is hard to detect by lab studies so I figured that my boys would never know that I had intentionally abandoned them. It would have

Continues on page 36 …

been bad enough for them to go live with their mother, her boyfriend, and their soon-to-be-born half sibling. But, on top of that, to go because I had killed myself would have devastated them for the rest of their lives."

I paused, giving Mr. Kaz more time to explain, but he didn't. He just wiped a tear and fell silent.

"Mr. Kaz," I asked. "If you have your boys to live for, then you cannot have a good reason to commit suicide. Perhaps that is why you chose the not-so-deadly kerosene."

Mr. Kaz did not answer, but his face grayed with remorse. Then, after a long, reflective pause, he nodded a tearful yes and said, "Perhaps unconsciously, I chose the not-so-deadly kerosene because I love my boys."

Silence, like a cold, stone wall stood between us, hindering further interaction. I could see the pain on Mr. Kaz's face, the pain that tasted of death, the pain of Lazarus, the pain of resurrection. I bowed my head to the solemnity of the moment and then, after a silent space, I resumed.

"Mr. Kaz. Have you heard of Albert Camus?"[1]

"I majored in Philosophy before I got my petroleum engineering degree."

"So you must remember The Myth of Sisyphus, that famous philosophical essay, which Albert Camus wrote."

"It has been a long time since I've read any philosophy."

"Well, allow me then to refresh your memory. Camus says in that essay that the greatest philosophical question that we should ask ourselves is, 'Shall I commit suicide?' If the answer is no, then it is because we have a reason to live. Did you ask yourself this question, Mr. Kaz?"

"I was blinded by anger and depression when I drank the kerosene, Doc. Depression makes us do things that are not reasonable. I know better now but I didn't then."

"What will you tell your boys when you return home?"

"I'll tell them that it took a little Lebanese doctor who was raised with kerosene to make the diagnosis of kerosene ingestion. I'll tell them that I am the only veteran in the history of the VA Hospital whose urine was set on fire in the I.C.U. I'll tell them that I will be their forever father. I'll tell them that I was so mad and angry that I couldn't think. I'll tell them that I love them. Then, I will gather them into my arms and beg their forgiveness."

After that declaration, as if Mr. Kaz's mind had been rekindled by our philosophical interlude, he smiled and teased, "What else did Albert Camus say?"

"I don't know," I confessed. "What else did he say?"

"He said that 'An intellectual is someone whose mind watches itself.' When I was angry and depressed, my mind was off watch, Doc."

"That's a wise and sobering thought, Sir."

"He also said something else that now comes to mind."

"You know a lot about Camus, it seems."

"I've read most of his books."

"What else did he say that now comes to your mind?"

"He said, 'I shall tell you a great secret, my friend. Do not wait for the last judgment; it takes place every day.' "

Mr. Kaz spent one week on the psych ward before he went back home to his boys. On his way out, he stopped to say good-bye. He couldn't remember my name, so he asked Nurse Spinosa if the little Lebanese doctor was there.

"He's in a meeting with his attending," she replied. "Would you like to leave him a message?"

"Yes, I would."

When, after the residents' conference, I returned to the ICU, Nurse Spinosa handed me a folded sheet of paper and said, "The man who ingested the kerosene came looking for you and left you this message."

I felt an urge to read his note alone, away from watchful eyes. Putting the note in my pocket, I walked toward the door.

"Aren't you going to read it to us?" Asked Nurse Spinosa with a curious expression.

"It might be personal. Let me read it alone first and then decide if I may share it," I replied, and headed to the cafeteria for my midmorning cup of coffee. There, in a quiet corner, I sat down and read his note.

Dear Doc,

Among the novels in the psych-ward library, I found a copy of The Plague[2], which I read during my week there. Do you know what else Albert Camus said in The Plague?

He said: "The evil that is in the world always comes of ignorance, and good intentions may do as much harm as malevolence, if they lack understanding. The most incorrigible vice is that of an ignorance that fancies it knows everything and therefore claims for itself the right to kill."

It is a most frightening realization that every one of us, no matter how educated and enlightened, could become temporarily ignorant when emotions overcome reason.

This is my last contribution to our kerosene philosophy.

Thank you for befriending me when I needed a friend.

Babboor Kaz

[1]Albert Camus (2013-2060), French philosopher, author, and reporter.
[2]A novel by Albert Camus (1913-1960) philosophizing about absurdism.

THE BULLETIN

Gazing at lake Hefner on a windy day,
I saw in the incessant searching of the waves,
the dilemmas of humanity.

Captain Adam, the metaphor for humankind,
recapitulates our recurrent misfortunes of
losses that could never be recovered.

CAPTAIN ADAM

HANNA SAADAH, MD

Look and see
Captain Adam in the tree
Searching through his telescope
For the ship he lost at sea.
Windy day
Look at Captain Adam sway
Raving, waving, as the wind
Blows his sailing ship away.
How in vain
Captain Adam went insane
Searching for his ship at sea
That he'll never find again.
Life is sad
Everyone is good and bad
Never finding what they lose
Always losing what they've had.

THE POET'S SPOT

NEW MEMBERS

WELCOME

Justin C. North, MD is a board-certified radiologist with OU Medicine. He is also Chief of Staff at OU Medical Center in Edmond. He completed medical school at the University of Oklahoma College of Medicine, and residency with OUHSC.

Priya P. Samant, MD is a board-certified internal medicine physician with Healing Hands Healthcare for the Homeless, a part of Community Health Centers, Inc. She completed medical school at the L. Tilak Municipal Medical College in Mumbai, India.

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