BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY

MARCH/APRIL 2020

DISTANT THUNDER

LYRIC THEATER OF OKLAHOMA

Save the Date for
Medicine Day
2020
Legislative Reception

Presented by the Oklahoma State Medical Association

Wednesday, March 25

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Legislator Reception: OSMA, 313 N.E. 50th Street, OKC, 5 to 6:30 p.m.

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THE BULLETIN

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ABOUT THE COVER

Lyric Theatre of Oklahoma will present the world premiere of the Native American Musical Distant Thunder this spring as part of the organization's New Works Initiative. The production will be staged at Lyric at the Plaza, 1725 NW 16 St., March 25 through April 11. Sponsorship opportunities, as well as single and season tickets, are now available.

DISTANT THUNDER

Distant Thunder centers on Darrell Waters, a successful young attorney, who returns to his childhood home in Montana to broker a deal that can benefit his tribe, the impoverished Blackfeet Nation. He soon faces his reclusive father about their painful past and grapples with the paradigm of what it means to be Native American in the United States. Cultures collide and unite through music, dance, stories and faith as we witness the dawning of a Distant Thunder.

The book is written by famed director/choreographer Lynne Taylor-Corbett and her actor/writer son, Shaun Taylor-Corbett. Distant Thunder features music and lyrics by Chris Wiseman and Shaun Taylor-Corbett, with additional music and lyrics from Robert Lindsey-Nassif and Michael Moricz. The production will be directed by Lynne Taylor-Corbett and feature scenic and lighting designs by Shawn Irish and costume design by E.B. Brooks. Music direction will be provided by Michael Morris with stage management by Laurena Sherrill.

"Bringing new works to Lyric Theatre's stage creates relevant and meaningful experiences and provides a rare opportunity to engage with the future of musical theatre," said Lyric Producing Artistic Director Michael Baron. "Each new work tells the story of our condition, the culture of our time and adds to the canon of musical theatre. I am proud to have Distant Thunder premiere at Lyric Theatre, where Native American tribes are an integral part of the state of Oklahoma. This new American musical educates audiences and promotes Native peoples and artists to the world through a powerful, heartfelt and inspiring story."

This marks the sixth production in Lyric's New Works Initiative, which began with the world premiere of Triangle (2014), Bernice Bobs Her Hair (2015) and Mann… And Wife (2016) and When We're Gone (2018) – all staged at the Plaza Theatre. Lyric unveiled a new production of Disney's When You Wish during the 2017 Summer at the Civic Center season.

Lyric received a Production Grant, part of the Frank Young Fund for New Musicals, from the National Alliance for Musical Theatre (NAMT) to assist with the production of Distant Thunder.

Single tickets start at just $25. For more information, visit LyricTheatreOKC.org or call Lyric's box office at (405) 524-9312.

Founded in 1963, Lyric Theatre of Oklahoma is the state's leading professional theatre company. Lyric produces classic and contemporary musicals, new works, and plays featuring artists from Oklahoma and around the nation. Shows are presented at two Oklahoma City venues — the intimate Plaza Theatre and in the summer at the grand Civic Center Music Hall. Lyric's Thelma Gaylord Academy is the premier professional theatre training ground, offering classes in all aspects of the performing arts. Lyric is a nonprofit member theatre of the National Alliance for Musical Theatre and Allied Arts. For more information, visit www.LyricTheatreOKC.org.

LYRIC THEATRE OF OKLAHOMA

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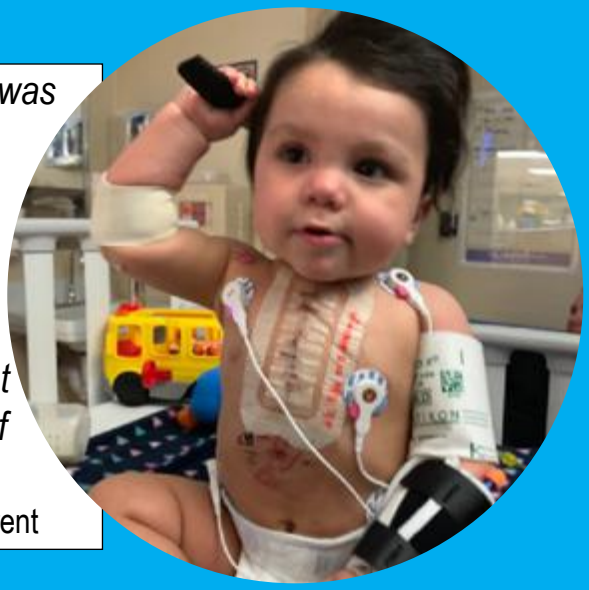

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OCMS
OKLAHOMA COUNTY MEDICAL SOCIETY

PRESIDENT'S PAGE

LISA J. WASEMILLER, MD

Physician burnout. Depression. Anxiety. No Longer a Silent Epidemic.

You may not be aware that September is designated as National Suicide Awareness month. September 10th is National Suicide prevention Day; ironically, that is also my son's birthday. I recently learned about this dealing with my son's personal encounter with anxiety and depression. In conjunction with the monthly recognition, September 17th is designated as National Physician Suicide Awareness Day.

It is never too early to create awareness and strength in the fight against suicide. Messages concerning work and life balance, mental health awareness, overall physical wellness flood our culture. As healers, physicians diagnose and manage these issues regularly in providing patient care. Despite extensive training, physicians often struggle to identify depression and other mental illnesses— in colleagues and themselves. Frequently, physicians themselves defer seeking treatment, finding it difficult to seek help for their own healing due to of fear of embarrassment and possible loss of respect from family, friends, and colleagues.

The culture of medicine also plays a role in this phenomenon. Stoic training environments normalize stress and distress as inherent or even necessary components of physician identity. Physicians often feel they are capable of handling their own treatment because they are so knowledgeable about medicine.

Physicians often learn to ignore signs and symptoms of burnout, depression and suicidality. Thus, the medical profession sustains a dangerous "culture of silence. This should no longer be the case.

For many doctors, the strains of medical school marked the beginning of mental health conditions. In 2016, an analysis found at 27.2% of medical students were depressed or had symptoms of depression but only 15% of the students who were depressed reached out for psychiatric care. Unfortunately, these numbers only increase during residency rising to a proximately 29% according to report in 2015. And additional reports indicate that this only continues to worsen with time.

The American Foundation of Suicide Prevention estimates that 300-400 physicians commit suicide each year in the US; approximately one per day. That's approximately the size of 2 medical school classes per year lost to the decision to "die by suicide". Through a process of education, we can make a difference in this trend. Stigma reduction is a core component in a successful wellness and suicide prevention program. It is important that programs and hospitals provide opportunities for those experiencing distress to follow up with mental health professionals without fear of punitive consequences.

Physicians may also fear of seeking treatment because of potential future impact on hospital

Continues on page 6 …

privileges, state licensure and insurance credentialing. Many physicians say they know they are in crisis but refuse to seek help for fear of potential negative impacts to their careers. Questions on medical licensure applications about past and current mental health conditions also discourage physicians from seeking help due to fears about licensing and discrimination in hospital credentialing, and therefore loss of the ability to practice their profession. This results in a loss of income as well as consequences pertaining to personal and liability insurance due to disclosure of mental health diagnoses.

Therefore, we, as physicians, need to address the manner in which some licensure boards ask about physician's current mental health, previous mental health conditions, and or any history of hospitalization or impairment from a mental health condition. This line of questioning on forms leads some physicians to self-medicate, self-prescribe, seek prescription assistance from a colleague just to be able answer NO to these questions. This is the time to realize the adage "Physician heal thyself" is NOT appropriate. There is currently no evidence to suggest that a physician's mental health diagnosis and treatment per se imply impairment or increased risk of harm to patients.

The Oklahoma County Medical Society recognized the need in this area and moved forward to implement a program to assist in maintaining appropriate mental health for our physician Members.

The program has now been in place for over a couple of years and has provided for more than 80+ visits by Physician members. The program is open to resident members and medical students in Oklahoma City.

The Oklahoma County Medical Society recognized that the other county medical societies could benefit from this program as well and have reached out to Tulsa County and Rural County medical societies to inform them of this program and potential expansion into those medical societies as well.

As a reminder, the PWP, is TOTALLY FREE for up to eight sessions per year provided by the generosity of the Oklahoma County Medical Society and by generous donations from its members. The entire process is 100% confidential with NO REPORTING to alleviate concerns about credentialing or licensure restrictions. Appointments are made through direct contact from the physician to the therapist, avoiding going through an answering service or through a secretary receptionist for scheduling privacy. Immediate same-day appointments are available. Counseling is done by competent vetted therapists in established practice. Sessions occur in a private offsite location with times scheduled to meet the needs of the physician.

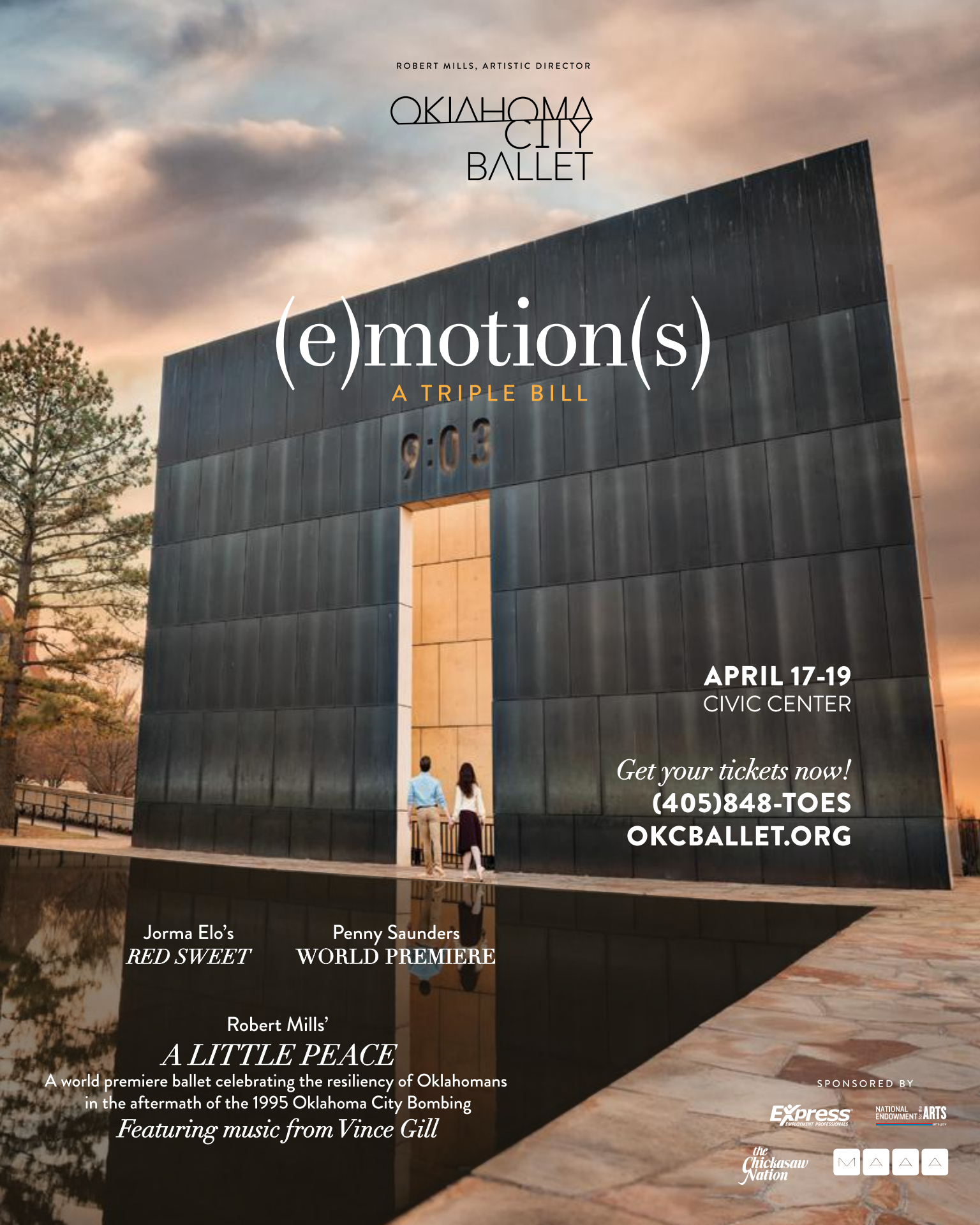
Please consider supporting your Oklahoma County Medical Society physician wellness counseling program with a tax-deductible donation. Support is also available through fundraising via the sale of physician suicide awareness prevention Rustic Cuff bracelets. Donate and see the bracelets available online at okcountymed.org/news.

We can make a difference.
We can all help prevent suicide.
Spread the word
Ask
Listen
Offer hope

"Place your hand over your heart. Can you feel it? That is called Purpose.

You are alive for a reason, so don't ever give up".
Anonymous

If you are experiencing thoughts of suicide, please call 1-800-273-8255. Help is available. To access the Physician Wellness Program, please visit okcountymed.org/pwp. Same-day appointments are available.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PHYSICIANS' NEWS


Crawford


Cookson


Landrum


Moxley


Saadah

The University of Oklahoma College of Medicine named family medicine physician **Steven Crawford, MD,** as senior associate dean and director of the newly formed Office of Healthcare Innovation and Policy. The Office of Healthcare Innovation and Policy was launched to harness resources within the college and across the academic healthcare enterprise to address the social determinants of health - the social factors that significantly impact health conditions among Oklahomans. Crawford has been serving as chair of the Department of Family and Preventive Medicine for 20 years and brings a background and dedication to helping people achieve better health in their own communities.

Michael Cookson, MD, current OCMS board member, was recently elected president of the Society of Urologic Oncology. He currently sees urologic cancer patients at Stephenson Cancer Center at OU Medicine. He was installed in his new role December 3rd in Washington and will sever a one-year term.

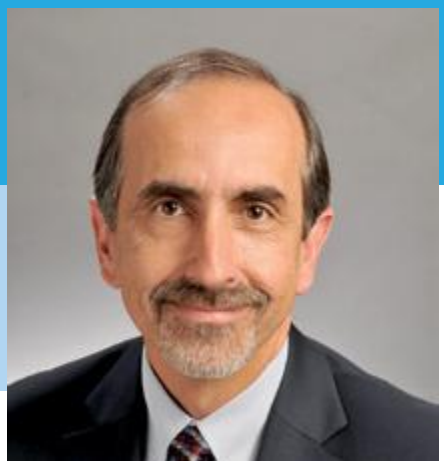
Gynecologic oncologist **Lisa Landrum, MD, PhD**, has been honored for her national advocacy work on behalf of her patients with gynecological cancers. Landrum was presented the Ambassador Wared for the Society of Gynecologic Oncology. As one of the two winners across the United States, Landrum was recognized for educating Oklahoma's congressional delegations about several issues of great importance to women who are fighting gynecologic cancers and the physicians to treat them.

Gynecologic oncologist **Katherine Moxley, MD**, is one of only 10 physician-scientists to receive a leadership award from the National Cancer Institute. The NCI Cancer Clinical Investigator Team Leadership Award recognizes Moxley's efforts to improve the lives of people with cancer through leading NCI-funded clinical trials. The award acknowledges her leadership efforts at Stephenson Cancer Center as well as with clinical trail collaborates throughout the United States. The award comes with a monetary prized that she will use to develop a comprehensive precision medicine program.

Hanna Saadah, MD, will be honored at the OU Alumni Reunion Day on May 1st with the Friend of Medicine Award.

DEAN'S PAGE

John P. Zubialde, MD
Executive Dean and Professor,
Family and Preventive Medicine
University of Oklahoma College of Medicine



As part of an academic healthcare system, the mission of the OU College of Medicine involves taking our work beyond the boundaries of our campus and across Oklahoma, where physicians and patients manage health conditions in their home and community settings.

To more fully work toward that mission, I was pleased last month to announce the creation of the Office of Healthcare Innovation and Policy and its director, Dr. Steven Crawford. Many of you know Dr. Crawford as the longtime chair of the Department of Family and Preventive Medicine and for his advocacy with numerous state organizations. We are delighted that he is joining the Executive Dean's Office, where he will also serve as Senior Associate Dean.

The Office of Healthcare Innovation and Policy will serve as an umbrella for resources within the College of Medicine and across the OU Health Sciences Center. Our faculty members are leading many exciting programs across the state, and the role of this office is to coalesce these efforts in a strategically aligned fashion. The medical care we deliver is important, but equally so are the resources for our patients in the communities where they live. Approximately 75% of the care we provide is for people with chronic illness. Once they leave the doctor's office or hospital, they must manage their conditions, and we want to work with communities and health systems to find innovative solutions to address the things that most impact their health and wellbeing.

For example, in Healthy Hearts for Oklahoma (H2O), our team led a project that assisted approximately 300 primary care clinics across the state in incorporating and standardizing guidelines known to decrease the risk of cardiovascular disease. By embedding a person known as a practice facilitator into each practice, we were able to work in-depth with both clinicians and office staff to leverage their electronic health records for the project. Rural practices are especially strapped for time and resources to conduct quality improvement initiatives, but with assistance in using their EHR to its full potential, they saw several positive outcomes. Overall, practices saw an increase in documentation of aspirin use when appropriate, an improvement of blood pressure control, and more consistent verification of a person's tobacco use and referral to treatment. The three-year project was funded by the Agency for Healthcare Research and Quality.

The success of that program led to a similar program called Do No Harm, a pain and opioid management effort in conjunction with the Oklahoma Department of Mental Health and

Continues on page 10 …

Substance Abuse Services. We recently increased to 100 primary care practices across the state where our practice facilitators work with physicians and staff to standardize their approach to consenting a patient for opioid treatment, discussing it with them and checking the Prescription Monitoring Program as required by law.

The Oklahoma Department of Mental Health and Substance Abuse Services also asked the OU College of Medicine to collaborate on another project called SBIRT – Screening, Behavioral Intervention and Referral for Treatment. By implementing a process to screen patients for depression, suicide risk and substance use disorder, physicians can intervene and either treat the patient or refer for treatment. The project also raises awareness about less-prescribed medications such as those that can help people decrease alcohol use.

There are many other initiatives in the planning or early stages, including a partnership with the Oklahoma State Department of Health to focus on diabetes prevention, particularly in high-risk areas of the state. Other projects involve helping primary care clinics standardize vaccine practices, as well as screening for dementia.

As important as these medical interventions are, at least 40% of our population's total health outcomes are shaped by upstream factors before people ever see a physician. Medicine must do better at understanding and recognizing the social determinants of health and adverse childhood experiences, and the effect they can have on people's physical and mental health throughout their lives. The work of the Office of Healthcare Innovation and Policy dovetails with that of the OU Hudson College of Public Health, whose work focuses on improving the health of an entire population rather than treating acute illnesses as they arise.

The OU College of Medicine also has launched an innovative program called the PARTNER Council, a clinician and patient advocate advisory board to the Oklahoma Primary Healthcare Improvement Cooperative (OPHIC). Created in 2015, OPHIC is a statewide collaborative effort aimed at strengthening the state's primary care delivery system, using an approach similar to cooperative extension methods. During our second PARTNER think tank last fall, we welcomed 85 participants from around the state to talk about how we can better integrate social care into health care.

As physicians, we may successfully treat a patient who has been in the hospital, but if we send them home with a prescription that they never fill – perhaps because they couldn't afford it or they didn't have transportation to the pharmacy – then they are likely to be readmitted to the hospital, increasing the cost for all of us. The PARTNER Council provides insight and engagement about how to "move healthcare upstream" to address the social determinants of health.

In order to improve the health of Oklahomans, we must rethink the way we deliver healthcare and find innovative solutions to support our patients both inside and outside of their healthcare appointments. This is a challenging yet exciting time for academic medicine, and we are eager to partner with you to improve health and quality of life for people throughout our state.

THE BULLETIN

IN MEMORIAM

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1929-2019

JOHN M. BROWN, MD
1922-2020

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Dr. Laura Chong

Dr. Richard Hatch

Dr. Bret Haymore

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THE SKINNY ON GENETIC OBESITY

Ryan T. Morgan, DO, FACOI, Dipl ABOM, Dipl ABCL

When it comes to the medical community, few topics are as divisive as obesity. That might seem counterintuitive because we know that excess weight is associated with a myriad of medical conditions; but, consider this: IAEDP, or the International Association for Eating Disorders Professionals, encourages physicians and health care providers to practice Health at Every Size (HAES). HAES rejects pathologizing specific weights and teaches people to eat to pleasure. Those that support HAES claim that weight stigmatization and weight cycling cause obesity and disordered eating, unlike the unrestricted mindful eating that HAES promotes. On the flip side, the government's Let's Move campaign focuses on increasing healthy foods and physical activity, believing that poor compliance in these areas are the root of the obesity epidemic. A third perspective absent from HAES and Let's Move, is treating obesity as a disease, a core stance of the American Medical Association and the Obesity Medicine Association.

The reality lies somewhere in the intersecting middle ground of a Venn diagram of all these approaches. We know that a complex cocktail of mental health, media, social pressures, socioeconomic status, exercise, food accessibility, energy density, sleep quality, sleep duration, and leisure time all play a role in the rising obesity epidemic. In addition, less known factors such as endocrine disrupters, epigenetics, and antibiotic exposure may also play a role.

Genetics is one area that is overattributed by patients, but also underappreciated by physicians as a significant cause of weight gain. In medical school most of us learned rare genetic disorders that have obesity as a prominent feature, like Alström syndrome, Albright Hereditary Osteodystrophy, and Bardet-Biedl Disease. Another, Prader-Willi, is the largest syndromic cause of obesity. There are several others that are less well-known such as leptin deficiency, leptin receptor deficiency, POMC (Pom C) deficiency, PCSK1 and 3 deficiencies, BDNF deficiency, TrkB deficiency, and SIM1 deficiency. MC4R.org.uk suspects 1% of the adult UK population with severe obesity has the melanocortin 4 Receptor (MC4R) mutation. If applicable, the 7.7% of the US population with extreme (severe) obesity would equate to more than 250,000 Americans. This number may be even higher with some researchers estimating 2.5% of those having severe obesity also have MC4R deficiency, making it the largest monogenic cause of obesity.

As of now, there are over 100 known genetic markers discovered to be associated with obesity. While we are certainly learning more about these markers and their association/correlation, consider the following. Similar to the way diet and lifestyle can affect the phenotypic expression of lipids in genetically susceptible patients with familial combined hyperlipidemia, obesity too may be increased in patients who have a confluence of weight-promoting genes plus weight-promoting lifestyles.

Within the past 30 years, scientific research into genetic causes of obesity has shed more light onto the pathophysiology of weight regulation. We know that there are over ten peripherally circulating hormones that cross the blood-brain barrier and act on the hypothalamus. These hormones act on 1st order nuclei, namely NPY/AgRP and POMC/CART, which then go on to act on each other and downstream on to 2nd and 3rd order nuclei. This process is tightly regulated with feedback loops to keep the body in homeostasis. It's the understanding of genetic obesity, with mutations or deficiencies somewhere along the pathway, that have helped scientists to understand that obesity is also a disease. Yes, poor diet and lifestyle absolutely contribute to weight gain, but how the body responds to hypothalamic dysfunction caused by obesity is why obesity is a disease.

Most of us are familiar with insulin resistance, wherein our body does not have a problem producing insulin, but rather sensitizing to insulin. Similarly, leptin which is produced from adipocytes acts on the hypothalamus to turn on pathways that promote weight loss. When individuals have excess adiposity, especially central adiposity, the excess leptin is unable to have the same affect on the brain, tipping the scale in favor of the orexigenic and weight-promoting NPY/ Agouti-related protein pathway.

Continues on page 14 …

THE PEARL

While there are some medications in the development pipeline, it is true no medication currently exists solely to treat genetic causes of obesity. Anecdotally, many of those who treat patients with obesity report that by simply finding a diagnosis, patients are more likely to lose weight. This makes sense when considering the parent of a child with Prader Willi and the feelings of guilt that can ensue when the child is begging for food. A parent knowing that he or she is showing love, rather than cruelty, by locking cabinets and refrigerators without giving in to the child can make a world of difference.

Currently, there are 10 FDA approved medications for weight loss and an additional 8 medications that can be used off-label for weight loss. Despite no FDA-indicated medication for genetic obesity, we can use current medications available to help augment the abnormal pathologic pathway for obesity in the brain. For example, we can use bupropion to stimulate POMC and naltrexone to block the MOP receptor, which would normally decrease the efficacy of POMC activation. Together, these increase the anorexic pathway and decrease the orexigenic pathway in the brain, promoting increased energy expenditure and decreased energy intake.

We know behavioral changes such as mindfulness can improve calorie consumption, we know increased activity and decreased energy density can also improve weight. One unfairly chastised component of treatment is medication. Our goal in treatment is not for patients to rely solely on medication, but medication can be a useful adjunct to the treatment of obesity. Anti-obesity medication is no different than medication for hypertension or diabetes, which can also be improved with diet and lifestyle. To ignore this fact is to allow societal views that patients with obesity are weak and lazy to cloud our medical judgment and knowledge of the facts. By considering genetic causes of obesity, we can shed some of the stigma we might hold on patients, and by doing so, improve a relationship that can foster change.

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Heather R. Burks, MD is a board-certified fertility and reproductive endocrinologist with OU Physicians. She completed medical school at the Vanderbilt University School of Medicine, residency at the University of Oklahoma College of Medicine, and fellowship in reproductive endocrinology and infertility at the University of Southern California Los Angeles.

Tommy Ibrahim, MD is Executive Vice President, Chief Physician Executive of INTEGRIS. He serves as the physician executive in charge of leading the strategic direction for clinical services throughout the health system, including all clinical excellence, quality and patient safety objectives. Dr. Ibrahim received his Bachelor of Medical Science degree and his Doctor of Medicine degree from St. Christopher's College of Medicine in Cambridge, England, and holds a Master of Science degree in Health Administration from Seton Hall University in South Orange, New Jersey. He is a practicing hospitalist and boarded in internal medicine and hospital medicine.

Summer Jatala, MD is a board-certified family medicine phyisican with Variety Care in Oklahoma City. She received her medical degree from St. Matthew's University and completed her residency at the University of Oklahoma.

Michael Edward Johnson, MD is a Board-Certified pediatrician who pursued his medical training at The University of Oklahoma College of Medicine and his pediatric residency training at Cincinnati Children's Hospital Medical Center. He began working at The Children's Center Rehabilitation Hospital as a hospitalist in 2013 and then joined the team full time in 2015 as medical director of inpatient services. Dr. Johnson was named vice president of medical services/medical director in 2016 and chief medical officer in 2020.

Jennifer Morris, MD completed medical school at the University of Oklahoma, and then undertook internship and residency in psychiatry at Griffin Memorial Hospital. Dr. Morris completed her board certification in 2004. After working in private practice for 6 years, Dr. Morris launched the Transcranial Institute of Oklahoma in 2009, and shortly afterwards founded Edmond Psychiatric Associates, LLC. Dr. Morris practices general psychiatry, with special focuses on treatment resistant depression, depression associated with comorbid medical illnesses (including polycystic ovarian syndrome), attention deficit disorder, suboxone management (opiate detox), and transcranial magnetic stimulation (TMS) treatment and management.

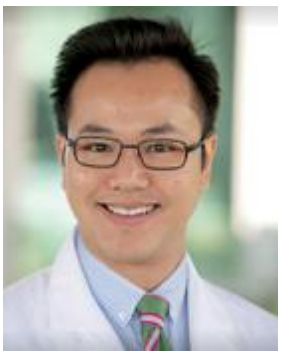
WELCOME NEW MEMBERS

Jeffrey L. Sabine, MD is a board-certified family medicine physician with Mercy Clinic Primary Care in Bethany. He completed medical school at the University of Texas and residency at Shasta General Hospital in Family Medicine.

Laura Shamblin, MD received her medical education at the University of Oklahoma College of Medicine, graduating in 2005. She did her residency training at Children's Hospital of Oklahoma, finishing in 2008. After residency, Dr. Shamblin worked full time from 2008-2012 for The Children's Center in Bethany, OK, a long-term care hospital for children with special needs.

Chittur A. Sivaram, MD is a board-certified cardiologist with OU Physicians Cardiovascular Institute. He's sub-specialty certified in cardiovascular disease and echocardiography. He completed medical school at Kerala University; fellowship and residency at the University of Alberta.

Quy Tien Tran, MD is a board-certified family medicine physician with Mercy Midwest City. He completed medical school at the University of Oklahoma and residency at the University of South Alabama College of Medicine.



Gretchen Wienecke, MD is an associate professor of anesthesiology specializing in pain medicine at the University of Oklahoma Health Sciences Center and has been a faculty member since 2001. She is the medical director of the OU Physicians Pain Medicine clinic and also program director of the pain medicine fellowship. Dr. Wienecke received her medical degree at the University of Oklahoma Health Sciences Center. Her internal medicine internship was completed at St. Mary's Hospital in San Francisco, followed by anesthesiology residency at Tufts Medical Center in Boston. She completed her fellowship in pain management at the OU Health Sciences Center. She is board certified in anesthesiology and pain medicine.

PART 1 | OLDER DRIVER SAFETY

MEDICAL & ETHICAL ASPECTS

S. Sandy Sanbar, MD, PhD, JD, FCLM*

There are both ethical and legal issues that relate to identifying impaired older drivers, balancing the patient's desire to continue to drive with public safety, reporting by clinician of impaired older drivers to state agencies, and ensuring that the patient has indeed stopped driving. Part 1 of this article presents the medical and ethical issues. Part 2 will cover the legal aspects of older driver safety.

More than 40 million older drivers are licensed to drive in America. Between 2007 and 2016, the number of older drivers increased 34 percent. On average, driver involvement in fatal crashes increases significantly after age 75 for women and after age 80 for men. The total number of traffic fatalities among the older population, who were 65 and above, increased by 13 percent – 20 percent in males and 4 percent in females. There is a significantly greater involvement in fatal crashes among male drivers in any age group from 65 to over 85, compared to female drivers. Most automobile crashes involving older adults occur during the daytime and on weekdays and involve other vehicles.

In 2002, a study compared the average life expectancy and maximum driving age for people older than 70 years old. The results showed that the majority of older drivers in the United States will outlive their ability to drive by about 7 to 10 years.[1] Driving safely requires the ability to move, think, and see, all at the same time. A good number of older people have challenges with one or more of the three requirements for safe driving.

Clinical risk factors for impaired driving[2] include:

1. ***Physical problems,*** such as history of falls, impaired ambulation, hearing, vision or function – for example, slow response to visual or auditory cues, impaired, inability to use the gas or brake pedals, or decreased range of motion in head and neck making it difficult to turn the head to fully visualize an area.

Cognitive impairment such as decreased short-term memory, easily distracted, decreased way-finding, and difficulty learning new information quickly or recognizing unsafe conditions or situations.

*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.

Physicians should use their best judgment when determining when to report impairments that could limit a patient's ability to drive safely.

Continues on page 20 …

Ethical approaches to managing older drivers

Driving cessation can lead to depression, reduced quality of life, and social isolation. Elderly non-drivers are more likely than those who drive to be institutionalized in long-term care facilities. Caregivers are also negatively affected if a patient stops driving. They are expected to arrange or provide alternative transportation. There are three approaches to managing older drivers:

1. The ***principle*** approach focuses on autonomy, beneficence, nonmaleficence and justice. Clinicians working with older drivers must balance the four ethical principles.
   - The older driver who chooses to continue driving is exercising autonomy.
   - Beneficence may allow the clinician to recommend driving cessation in order to reduce the risks for car crashes and associated injuries.
   - Driving cessation may harm the patient and violate the principle of nonmaleficence (first, do no harm).
2. The ***utilitarian*** approach optimizes outcomes of ethically driven decisions to produce the best results or the greatest amount of good.
   - An ***act utilitarian*** considers only the consequences of a single act. For example, it is alright for an elderly patient with dementia to continue driving despite the increased risk of accidents because that is the best for that person.
   - A "rule utilitarian" considers all the consequences resulting from following a rule of conduct. For example, permitting older people to drive for as long as possible produces the greatest good (1) for the older person, (2) for the people who will have to drive that person around, and (3) for society which will not have to bear the costs of transportation alternatives like para-transport services.
3. The ***professional*** approach includes the special fiduciary and confidential obligations clinicians have to their patients. Professionals should do what is best for the patient and put the best interests of the patient ahead of the professionals. Healthcare professionals are also obligated to honor the principle of confidentiality and to not disclose patient information to family without the patient's permission.

Ethically, whether the clinician applies a principle, utilitarian, or professional approach, older people should stop driving when the risks of continued driving outweigh the benefits to the patient, family, and society. This is in keeping with The American Medical Association Code of Ethics which states:

"Physicians should use their best judgment when determining when to report impairments that could limit a patient's ability to drive safely. In situations where clear evidence of substantial driving impairment implies a strong threat to patient and public safety, and where the physician's advice to discontinue driving privileges is ignored, it is desirable and ethical to notify the department of motor vehicles."

Evaluation of driving ability and documentation

First, the clinician should assess the patient's perception of his/her driving ability and inquire about any social pressures that affect driving behavior. Determine if the patient has family members or caregivers who can support the mobility transition, and whether they disagree among themselves about the patient's driving ability or need for support. If indicated, consult or refer the patient to a neurologist, an occupational therapist, a social worker, or a geriatric care manager.

Next, ask the patient to give permission to have family/caregiver present when explaining the assessment results. Describe in detail the patient's level of dysfunction and why this is important when considering safe driving. State the potential risks of driving, for example injury, public safety, and financial liability. Conclude with either a recommendation to stop driving or for the specific driving restriction such as driving short distances in daytime only.

It is essential to document the discussion in writing and give a copy to the patient and/or to a family member or caregiver if the patient lacks decision-making capacity.

Communicating with the elderly patient

Ask the patient open-ended questions such as, "Kindly tell me about your concerns regarding the assessment results and recommendations." The patient may be anxious, upset or angry. That should be acknowledged without engaging in long discussions or disagreement. The clinician should not vacillate and make sure the patient understands that the safe driving recommendation is made for his/her safety. Encourage the patient to devise a transportation plan to include alternative transportation methods, support system, and potential barriers.

Finally, the patient should return for follow up after 1 month, and as needed subsequently, to evaluate for signs of depression, social isolation, and worsening mental or physical health. Inquire about transportation resources and how the patient is managing without driving. Educate the family/caregivers on signs of depression and self-neglect, and inquire about their concerns. Some patients may find comfort talking to their trusted friends, clergy or personal attorney.

[1]Foley DJ, Heimovitz HK, Guralnik JM, et al. Driving life expectancy of persons aged 70 years and older in the United States. *Am J Public Health*. 2002; 92:1284-1289.

[2]American Geriatrics Society and National Highway Traffic Safety Administration. *Clinician's Guide to Assessing and Counseling Older Drivers*. 3rd ed. https://geriatricscareonline.org/ProductAbstract/clinician's-guide-to-assessing-and-counseling-older-drivers/B022. Published 2015. Accessed December 1, 2017.

Note – 4th edition of the Clinicians Guide, is in progress and expected to be released in 2019

LEPRECHAUNS

PHILIP MAGUIRE, MD

Leprechauns are very small Sprites related to Elves and are peculiar to Ireland. They take the form of old men, very short and stout in stature, rather tiny. They are known to be solitary and not at all friendly by nature. They live alone in remote places like wine cellars. Sometimes in old farmhouses and such, spending their time in solitude.

They may aid humans, perform small tasks for them. Sometimes they ask for supplies for which they trade objects that bring luck and good fortune.

They spend most of their time making shoes. Some say only shoes for elves. They will always be seen working on only one shoe. Thus, the name Leprechaun is thought to be derived from the Irish: Leith - half and Brog - shoe or Brogan. They are quite visible to us and dressed brightly in green with red Caps and small leather aprons. But it is the noise of their hammering that will betray them to their seekers. When found working on the shoe they usually have a purse, but it never contains more than a shilling.

When they finish their work, they have wild feasts called Cluricauns and become slightly drunk. Then they can be seen riding wildly across the moonlight on the backs of dogs.

Each Leprechaun was thought to have hidden at the foot of a Rainbow a pot of pure gold. If captured and threatened with bodily harm the hiding place would be revealed but only if the captor did not glance away. If the Leprechaun could trick the captor into glancing away the leprechaun would vanish.

Monday, March 23, 2020
OCMS Membership Meeting and
50-Year Physician Recognition
Speaker: John Armitage, MD, CEO –
Oklahoma Blood Institute
Free for members, guests/non-members $25:
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Saturday, April 18, 2020
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events AND UPDATES

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LOVE ALSO DIES

Hanna A. Saadah, MD

When Tennyson penned *In Memoriam*,[1] it was a requiem for his beloved Cambridge friend, Arthur Hallam, who had died suddenly at 22 of a cerebral hemorrhage. However, his gratitudinal[2] stanza, lamenting love lost to death, has been expanded by Time to include love lost to life.

I hold it true whatever befall
I feel it when I sorrow most
'Tis better to have loved and lost
Than never to have loved at all.

Even though love always dies when we die, it also lives because it mentors by example from womb, to birth, to motherhood, to life, leaving its heritable impressions upon successive generations. Indeed, having experienced love transforms and enriches souls long after relationships or loved ones die. We cling to love as long as it survives and then we live thereafter in its Elysian Fields, a concept so brilliantly expressed by Elizabeth Browning's famous sonnet, *How Do I Love Thee.*

…I love thee with the breath,
Smiles, tears, of all my life!—and, if God choose,
I shall but love thee better after death.

Many fear falling in love because of the thorns that loving sprouts along its long, rosy stems. Nevertheless, even the most resistant ultimately succumb to Love's overpowering, siren calls and surrender their sails to the wild winds of Eros. In Midsummer Night's Dream, Shakespeare had Lysander say to Hermia:[3]

"The course of true love never did run smooth;"

Whenever we fall in love, we become delusional and sincerely believe that our love will last forever. In this vigorous freshness of love, we strut unaware that love is ephemeral and inevitably dies. Stanzas like this one, powered by painful truths, dishearten us, hurling us into a melancholy abyss.

Yes, I am well aware
That nothing lasts
Beyond the moment's edge,
That love at first will crawl
Then springs like roses marvelous and tall
Then browns and all the petals fall
And scatter through the air
Only the thorns remain
On branches, pleading, bare
With every thorn a pain
Yes, I am well aware.[4]

But then, in the same breath, the next two stanzas of the poem remind us that love continues to power the world, not only because wherever there is life there is love, but also because, as Gandhi said, *wherever there is love there is life.*[5]

But love is never lost
It softens life, unburdens, beautifies
Restores the broken souls
Redeems the spring within the hollowed eyes
Awakens seeds from dust.
Love is not lost
It flows from rose to flower like a bee
And every heart it liberates is free
To reach the height of smiles, the depth of tears
The mighty calm of peace, untouched by fears
The kindness of the cross that nails our souls together
And changes us forever.

Beyond love's empowerment by life, love can also be empowered and immortalized by literature. When lovers die, their love lives on in the memories of a generation or two before fading into oblivion. However, when love stories are turned into literature, love is resurrected with each reading and rekindled by our collective emotions with every remembrance. Romeo and Juliet forever live in our global consciousness because their love was turned into great literature,[6] and because that great literature continues to inspire other art forms such as music, sculptor, paintings, and ballet.

Continues on page 26 …

Loves powered by literature, immortalize the lovers. In this Shakespearean *sonnet*,[7] the last couplet tells the beloved that as long as that sonnet lives, it will continue to do him living homage.

Nor shall death brag thou wand'rest in his shade,
When in eternal lines to time thou grow'st,
So long as men can breathe or eyes can see,
So long lives this, and this gives life to thee.

Written love does not die, nor does it grow weary. It does not deceive, nor does it become unfaithful. It does not change with time, nor does it turn into vengeful hate. When Shakespeare penned sonnet 116,[8] stating that love is not time's fool, he idealized love, elevating it to unearthly heights, which every lover knows are not sustainable.

Love is not love
Which alters when it alteration finds,
Or bends with the remover to remove:
O no! it is an ever-fixed mark
That looks on tempests and is never shaken;

However, old Time, which does change everything alive and dead, cannot change what has been written. As Khayyam observed,[9]

The Moving Finger writes; and, having writ,
Moves on: nor all your Piety nor Wit
Shall lure it back to cancel half a Line,
Nor all your Tears wash out a Word of it.

Written love is life's Fifth Season, the season that is ever-present, and the bond that holds humanity together. Written love does not separate people into groups, tribes, and nations, as the rest of our written languages do. Rather, literary love is the only language that transcends groups, tribes, nations, and holds us together as a bouquet of beautiful individuals.

Lovers, when you love, do not just repeat the words, *I love you*. Repetition does not vouchsafe endurance to love. Take time to write your love because, on paper, words become things, things that survive their authors and their times, as Byron so aptly put it.[10]

But words are things, and a small drop of ink,
Falling like dew, upon a thought, produces
That which makes thousands, perhaps
millions, think;
'Tis strange, the shortest letter which man uses
Instead of speech, may form a lasting link
Of ages; to what straits old Time reduces
Frail man, when paper - even a rag like this -,
Survives himself, his tomb, and all that's his.

I wrote the following love sonnet, *My Fifty Season*, to ensure that my love for my wife will endure despite the ravages of old Time, which holds in its trigger-happy fingers Pandora's jar of disease, dementia, and death.

The sonnet is a manifesto against relentless aging, written in a literary form that defies old Time, transcends group ethos, and asserts Protagoras's claim that, *Man is the measure of all things*.[11]

Building on Protagoras's sagacious adage—which created a major controversy when interpreted by Plato to mean that there is no absolute truth but that which individuals deem to be the truth—I proclaim my own truth that, *The individual is the only measure of true love*.

My Fifth Season
Sonnet 112

I am seasonal, as I have always been
Like life and weather, and all that's in between
I spring up high, then summer fly, then falter
And fall like ice into a livid winter.
I voyage between death and resurrection
Re-living all the verdicts of my seasons
From boldest action to coldest inaction
Nature conducts my life and gives no reasons.
But you and I fly in a lofty atmosphere
Beyond our planet's surly bonds and twirling sphere
Where love's a season that endures forever
And changes not with times or climes or weather.
You are my fifth, unending, love-lit season
My joy, my gratitude, my sun-lit reason.

ENDNOTES

[1]*In Memoriam* is a 252-page poem by the British poet Alfred, Lord Tennyson, completed in 1849. It is a requiem for the poet's beloved Cambridge friend Arthur Henry Hallam, who died suddenly of a cerebral hemorrhage in Vienna in 1833.

[2]Gratitudinal is my made-up adjective form of the noun gratitude.

[3]The main characters in William Shakespeare's play " A Midsummer Night's Dream" which takes place in Athens, Greece are Lysander and Hermia, two lovers whose love is forbidden by Hermia's father, Egeus.

[4]From the poem, *Love Is Not Lost*, from the poetry book, *Vast Awakenings*, by Hanna Saadah.

[5]Mahatma Gandhi: The truth is that where there is love, there is life. Love is the power of the universe, and everything is alive through an inexplicable power that could be called, ultimately, love.

[6]*Romeo and Juliet*, a play by William Shakespeare, continues to speak to all of humanity.

[7]Sonnet 18 begins by comparing Shakespeare's beloved gentleman to a summer's day: *Shall I compare thee to a summer's day – Thou art more lovely and more temperate*.

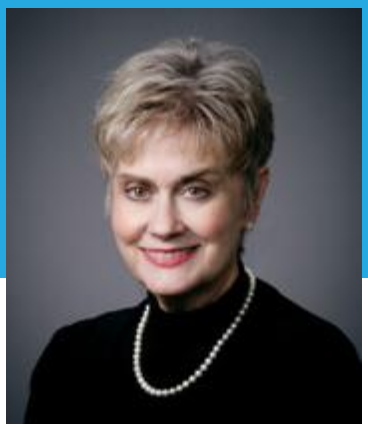
[8]Shakespeare's Sonnet 116 begins with, *Let me not to the marriage of true minds - Admit impediments*.

[9] Omar Khayyam (1044-1131) was a Persian poet whose Quatrains were translated into English by Edward Fitzgerald in 1859.

[10] Lord George Gordon Byron (1788-1842) was a British romantic poet. The quote is taken from his poem, *Don Juan*.

[11]Protagoras (490-420 BC) was a Greek philosopher trained by Democritus.

DIRECTOR'S DIALOGUE



SHOWING UP!

By Jana Timberlake,
Executive Director

The months of March and April are among my favorite times of the year. The ground is reawakening from its winter's sleep, the redbud trees are showing off with their spectacular color, and perennials are pushing through the ground towards the sun's warmth. It's life!

As I am writing this Director's Dialogue, my thoughts are filled with East Texas and the new great niece who made her appearance on Valentine's Day! She is joining two other siblings – 5 years old and 22 months old. And their parents accepted my offer of help! The children's mother is my namesake. She was born exactly two weeks after my birthday, and my heart swells every time I think about this incredible young woman. This special time together will be one of my greatest gifts.

Now, down to business... There are some important March and April dates that are listed below:

1. **March 5, 2020 - OCMS Delegate Caucus** - 5:30 p.m. - OSMA Board Room - If you are an elected OCMS delegate, please plan to attend.

2. **March 23, 2020 - OCMS Membership Meeting** - 6:00 p.m. - OSMA Multi-Purpose Room - 50 year physicians will be honored, and Dr. John Armitage, OBI, will be the keynote speaker. Make your reservations soon!

3. **March 25, 2020 - OSMA Medicine Day Legislative Reception** - 5:00 - 6:30 p.m. - OSMA Multi-Purpose Room - This reception provides OCMS/OSMA members with the opportunity to visit with legislators regarding issues important to the practice of medicine. Remember to wear your white coat! There will be a session at the Capitol earlier in the afternoon. If you plan to go, meet at the OSMA building at 2:00 p.m. This is important!

4. **April 18, 2020 - OSMA House of Delegates Annual Meeting** - Southern Hills Marriott - Tulsa, OK - All elected OCMS Delegates need to attend. Please look for email reminders from Alison and RSVP.

Showing up and working towards the greater good is an important goal for each of us. You never know what action you take will make **THE** difference!

"Start by doing what's necessary;
then do what's possible;
and suddenly you are doing the impossible."
~ St. Francis of Assisi

Jana Timberlake, CAE
Executive Director

THE GREAT MASQUERADER

Bill Truels, MD

As a pre-med student in college at Northwestern, I was working as a busboy on campus at a local sorority on Sheridan Road in Evanston, Illinois to make ends meet. Needless to say, as a full-blown Nerd, I was wet behind the ears.

My job during the first part of the lunch hour was to fill all the water glasses with ice water, as each girl arrived and sat down for her lunch.

Suddenly, I heard one of the girls scream from behind a partition near the lunchroom. The girls at the lunch table simply ignored her and continued with their meal. I poured some more ice water, and then this poor girl screamed again.

"Don't worry about it," one of the girls told me, as I spilled some ice water during one of the screams. "She'll be fine."

But the screaming continued, and finally, my curiosity got the best of me. I calmly put down my pitcher of ice water and quietly walked over to this partition when another scream bellowed out. This poor girl was doubled over in pain, with tears rolling off her cheeks.

I took off my white busboy coat and wrapped it over her shoulders. I noticed that both hands were pressing her right lower abdomen, and that every time she coughed, the pain would get worse.

I decided it was time to take action. I hurried back to the lunch table, put on my white busboy coat, and announced to the girls, "My name is Bill Truewater. I'm a first year pre-med student and just finished dissecting a frog in anatomy lab, so I know what I'm talking about. I've done a lot of reading, but I worked as an orderly last summer at Lutheran General Hospital. I have a lot of real world experience," I boasted.

"This young lady is tender right over Mcburney's point in the right lower quadrant," I continued. "She has rebound tenderness and voluntary guarding!"

"The most likely diagnosis is appendicitis, possibly ruptured, causing peritonitis and exquisite pain. Her face is red, and she's breathing fast- she's febrile with tachycardia and tachypnea- I'm afraid she's septic!" I declared.

"Appendicitis is known as The Great Masquerader, but I got this figured out!" I proclaimed. "This is a classic presentation, a slam dunk!"

"She needs emergency surgery and IV antibiotics. We need to get her to the Searle Hall Infirmary right away and get a differential white blood cell count!" I exclaimed.

None of the girls even looked up – one of them even giggled. Most of them just kept on eating their lunch. I was infuriated.

Finally, one of the girls looked up sympathetically and said, "That's Mary Anne – she does this every month. She's having her period."

Words cannot express how stupid I felt. If there was a hole to crawl into, I would have done so. But I learned an important lesson. Don't just look at the symptoms. Had I simply asked Mary Anne what was wrong, she would have told me!

I poured some more ice water and resolved to keep my mouth shut for the rest of the lunch hour. Part of making a differential diagnosis is talking to the patient and getting a good history!

But there was a bigger lesson here. Among the girls, I detected a quiet support for Mary Anne. They were allowing her to share her pain. But at the same time, the message was to go on with our lives. We must learn to live with our pain, be it Mittelschmerz or Weltschmerz!

In one sense, we are all Masqueraders – putting on a smile despite the frowns!

OKLAHOMA COUNTY MEDICAL SOCIETY

120TH Inaugural

2020 President and honoree Lisa J. Wasemiller-Smith, MD (center), with President-Elect Basel S. Hassoun, MD (left) and Immediate Past-President R. Kevin Moore, MD (right).

Jay P. Cannon, MD (right), presents the Rhinehart Award to M. Dewayne Andrews, MD (left).

The OCMS Executive Committee, from left to right: Sumit K. Nanda, MD – Secretary-Treasurer; Jeffrey Cruzan, MD – Member-At-Large; Lisa J. Wasemiller-Smith, MD – President; Savannah D. Stumph, DO – Vice-President; Basel S. Hassoun, MD – President-Elect; R. Kevin Moore, MD – Immediate Past-President.

Class X of the Physicians Academy, from left to right: T. Craig Kupiec, MD; Katherine B. Mansalis, MD, MBA; Jessica M. Yocum, MD; Elizabeth McCabe, MD; Latisha D. Heinlen, MD; Pramoda Kuduru, MD; Alan Hawxby, MD; Robert Glade, MD.

120TH OCMS INAUGURAL

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