BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY **SEPTEMBER/OCTOBER 2013**

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THE BULLETIN
The Oklahoma County Medical Society

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Fall Membership Meeting To Feature Hospital CEO Panel

The OCMS Annual Fall Membership Meeting Nov. 11 will feature a moderated panel of local hospital system CEOs discussing 'The Evolution of Healthcare Systems in Oklahoma City.' The panel will be moderated by Bob Spinks, director of the master's program in Non-Profit Leadership at Oklahoma City University and former president & CEO of United Way of Central Oklahoma. The meeting agenda also includes the election of officers for 2014.

The meeting will be held Monday, Nov. 11, 2013, in the Multi-Purpose Room at the Oklahoma State Medical Association building, 313 N.E. 50th St., in Oklahoma City. The meeting will open at 6 pm with a wine and cheese reception, dinner will be served at 7 pm, and the program will start at 7:30 pm.

For more information, please call OCMS at 702-0500. ❑

Call for Nominations: Rhinehart Medical Service Award

Nominations are open for the 9th annual Don F. Rhinehart, MD, Medical Service Award.

This award recognizes OCMS members, active or retired, who have demonstrated significant involvement in projects to help improve health care, the community or the state.

Nominations must include:

- the name of the nominee,
- the project(s) in which the nominee has been involved at the local, state or national level,
- the reason(s) why their involvement or service is worthy of recognition.

Nominations should not exceed 650 words. The recipient will be selected at the November OCMS Board of Directors meeting; the award will be presented at the Inaugural Dinner in January 2014.

Nominations are due by Friday, Oct. 18, 2013. You may mail your nomination to Tracy Senat at OCMS, 313 N.E. 50th St., Suite 2, OKC, OK 73105; or fax it to (405) 702-0501; or email it to tsenat@o-c-m-s.org. ❑

About the Cover

by Tom Lynn, MD

The cover photograph is of Nazih and Annette Zuhdi, his wife of over 40 years.

Nazih Zuhdi grew up in both Syria and Lebanon. He completed his high school at the Mission Laique Francaise, and his collegiate and medical education at the American University in Beirut, Lebanon. These studies made him aware of the broad opportunities in the USA. He came to the USA in 1951 and was associated with the innovative leaders of American cardiac surgery, cardiac physiology and total body perfusion, including:

* Columbia Presbyterian Hospital (1951-1952) with Dr. Arthur Voorhees, who was developing synthetic vascular grafts;

* State University of New York, Downstate Medical Center in Brooklyn, NY (1952-1956) with Dr. Clarence Dennis;

* University of Minnesota (1956) with Dr. C. Walton Lillehei, both as a trainee-fellow and co-investigator, and participated in the early development of cardiopulmonary bypass technology and its bifurcation into mechanical support of a failing heart and open heart surgery.

Dr. Dennis called him a 'co-worker' and Dr. Lillehei described him as a 'master surgeon.' Dr. John Kirklin from the Mayo Clinic in Rochester, MN, and in 1966 with the University of Alabama School of Medicine, wrote, "Dr. Zuhdi has been working in the field of open heart surgery since its beginning."

Dr. Zuhdi came to Oklahoma City in 1957 in the Department of Surgery of the University of Oklahoma School of Medicine, which was chaired by Dr. John Schilling, and established a laboratory in the basement of the old medical school library. Allen Greer, John Carey and Nazih Zuhdi, Inc., was formed to promote the research and application of modern heart surgery. Dr. Zuhdi remained dedicated to his research in total body perfusion bypass physiology, establishing a new laboratory at Mercy Hospital on 13th Street in Oklahoma City (1958-1965). Through experimentation in continuum from 1957-1960, he attained the final solution, Total Intentional Hemodilution, which was adopted by the whole world.

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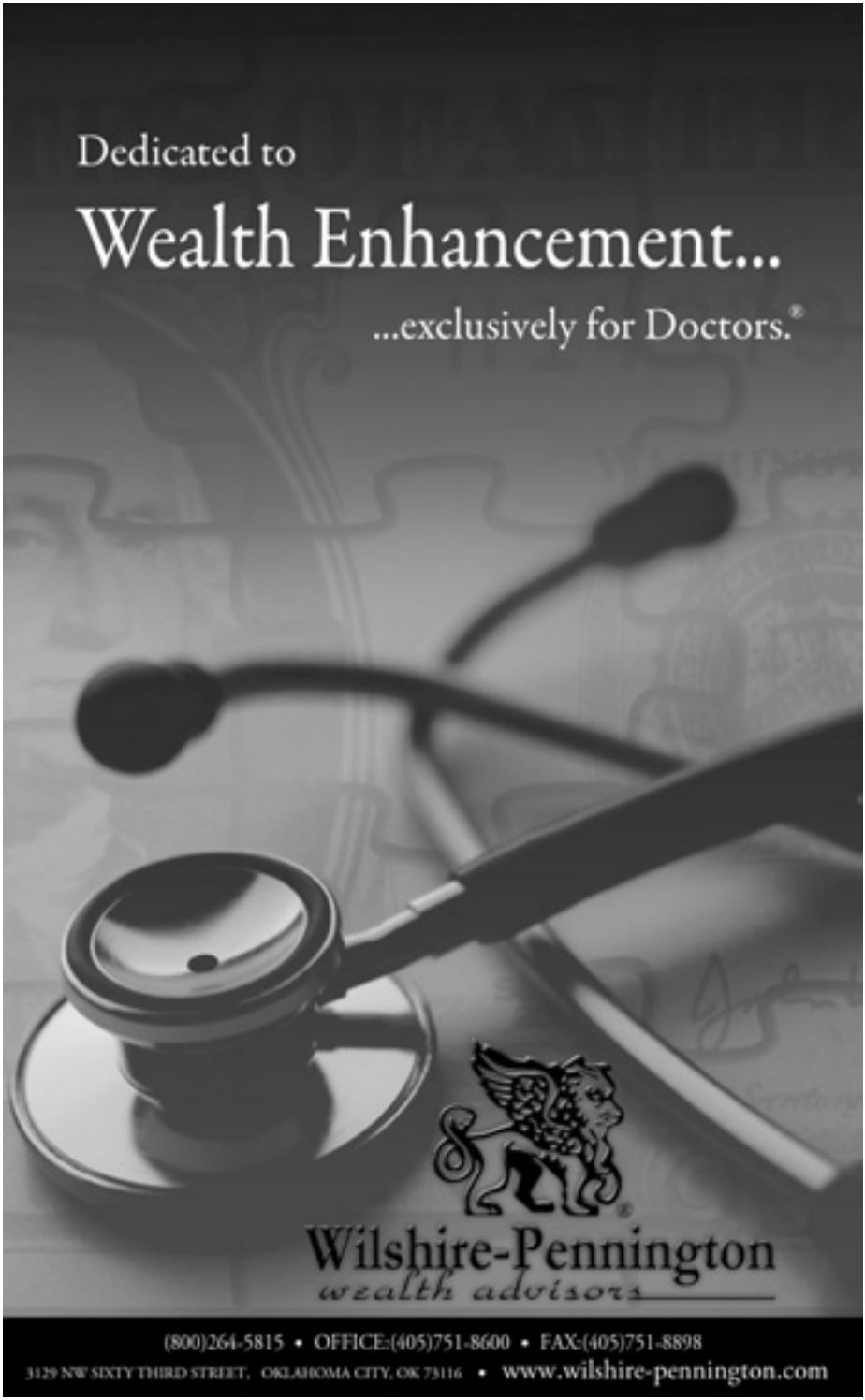

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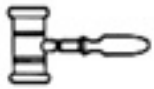
President's Page



Thomas H. Flesher III, MD

New Beginnings

The Oklahoma County Medical Society is in the midst of summer activity. This summer we have undertaken a revision of the OCMS logo and a redesign of our website. OCMS leadership felt it was important to bring our organization into the 21st century and enter the electronic world with both feet.

Our new logo brings a modern interpretation to the ancient symbol of the Staff of Asclepius. I am not really a symbolic person (I'm an orthopedic surgeon), but I've been told it brings together the past and also looks toward the future.

By the time you read this, our new website should be live at www.o-c-m-s.org. If you haven't visited our website lately, I encourage you to do so. The new site is colorful and very simple to navigate. Even I can navigate it easily.

The new website features a number of new membership benefits, including physician job postings, legislative updates, a searchable online Bulletin, free medical legal advice, a mentoring program and more. The website also has a mobile site that will be just a click away with your iPad or phone. I think you will like it.

There is excitement on the membership numbers front. We have 32 new members to date from our mid-year DocBookMD promotion, our first-ever joint membership promotion with OSMA. For this promotion, we and OSMA offered half dues for the rest of the year, which allowed new members to immediately access DocBookMD, a HIPAA-compliant tool for physicians.

Now we turn to tort reform. We will keep you informed. ❑

Dean's Page

M. DEWAYNE ANDREWS, MD
Senior Vice President and Provost
Executive Dean, College of Medicine
University of Oklahoma Health Sciences Center

It is a pleasure to inform you that we have appointed Michael Cookson, M.D., M.M.H.C., as Professor and Chairman of the Department of Urology; he will also hold the Donald Albers Endowed Chair in Urology.

Dr. Cookson was formerly professor and vice chairman of the Department of Urologic Surgery at the Vanderbilt University School of Medicine where he established a distinguished career. He has authored over 170 peer-reviewed journal publications and 25 chapters of various textbooks in surgery and urology. A member of numerous national professional societies, he has been recognized nationally for his outstanding contributions to urologic oncology.

Dr. Cookson is a 1988 graduate of the OU College of Medicine and took his residency training in urology at the University of Texas San Antonio Health Sciences Center, followed by his fellowship in urologic oncology at Memorial Sloan-Kettering Cancer Center in New York. He has been at Vanderbilt since 1998. We are delighted that Dr. Cookson and his family have moved to Oklahoma City and joined the OU College of Medicine family.

When most of us graduated from medical school, the notion of not matching to a residency program somewhere was just something we didn't consider a possibility. It was, however, the sad reality for hundreds of well-qualified medical school graduates across the U.S. this year. By the end of Match Week 2013, an unprecedented 528 U.S. M.D. seniors did not secure a residency training position – that's more than twice the number in 2012. *(continued on page 8)*

(Dean's Page continued from page 7)

The Association of American Medical Colleges has been investigating this question with student affairs deans at medical schools. The most common reasons for students not matching, according to the AAMC, revolve around the increased competition that exists now for residency positions.

Medical schools nationwide have been increasing overall medical school enrollment for the last 10 years in response to demands for more physician production to mitigate the coming physician shortage. Since 1997, however, the government has capped the number of federally supported residency training positions, effectively putting a freeze on residency training. Student affairs deans across the country also noted that some students did not rank a sufficient number of residency training programs or limited their rank order lists only to highly competitive programs.

The 2013 Match makes clear the urgent need to increase federal support for residency training. Medical schools are doing their part to reach by 2017 a 30 percent enrollment increase over 2002 levels. But these efforts will not result in a single additional practicing physician until Congress lifts the 1997 cap on the number of residency training positions it supports. In Oklahoma we also have the state Physician Manpower Training Commission, which assists in funding family medicine residencies. However, the PMTC can't begin to address the overall problem. In addition, students must be convinced to heed being advised about the realities of a more competitive environment for residency training positions. While it is disappointing to some students to learn they are simply not competitive for certain residency fields and programs, it is in fact the reality they face and growing worse.

Medical schools, including ours, are trying to develop better strategies to deal with these significant problems. Ultimately, though, this is a national problem that seeks a national solution. Unless Congress acts to expand residency training support, the problem will only get worse. ❑

OCMS Board Nominees Announced

These OCMS members are board nominees for 2014. Ballots will be mailed no later than Sept. 16. Return ballots must be postmarked no later than Sept. 30. To be sure your vote counts, please mark your ballot and return it immediately.

Position I

Sam Dahr, MD

Specialty: Ophthalmology/Vitreoretinal Disease and Surgery

Date of Oklahoma license: 2005

Medical School: OU College of Medicine	**Residency:** University of Cincinnati College of Medicine, Ophthalmology
Internship: OU College of Medicine Department of Internal Medicine	**Fellowship:** National Eye Institute National Institutes of Health

Position I

Sudhir Khanna, MD

Specialty: Nephrology/Internal Medicine

Date of Oklahoma license: 1992

Medical School: S.N. Medical College, Hospital, Agra, India	**Residency:** Mount Sinai Hospital, Toronto, Canada; Sunderland and Middlesborough Hospitals, U.K.
Internship: S.N. Medical College, Hospital, Agra, India	**Fellowship:** The Toronto Hospital, Canada; St. James' Hospital, Leeds, U.K.

Position III

David Chansolme, MD

Specialty: Internal Medicine

Date of Oklahoma license: 2004

Medical School: OU College of Medicine	**Residency:** Tulane University, New Orleans, Internal Medicine
Internship: Tulane University, New Orleans	**Fellowship:** University of Alabama-Birmingham, Infectious Disease

Position III

Baolien Tu, MD

Specialty: General Surgery

Date of Oklahoma license: 1996

Medical School: University of Nebraska Medical Center	**Residency:** University Hospital, University of Nebraska Medical Center
Internship: University Hospital, University of Nebraska Medical Center	**Fellowship:** Mayo Clinic, Rochester, Minnesota, and Scottsdale, Arizona

Position IV

Zahid Cheema, MD, FAAN

Specialty: Neurology

Date of Oklahoma license: 1996

Medical School: Allama Iqbal Medical College, Pakistan	**Residency:** University of Oklahoma, Neurology
Internship: University of Oklahoma, Tulsa,OK	**Fellowship:** University of Texas Southwestern Medical Center, Neurophysiology

Position IV

Duc M. Tu, MD

Specialty: Family Medicine

Date of Oklahoma license: 1990

Medical School: OU College of Medicine	**Residency:** OU College of Medicine, Tulsa, Family Practice
Internship: OU College of Medicine, Tulsa	

The Nominating Committee members are: Tomás P. Owens, MD; Robert Cooke, MD; Christopher Hayes, MD; Wynter Kipgen, MD; K.A. Mehta, MD; and Ralph Shadid, MD. ❑

LAW AND MEDICINE

Telemedicine: Medical-Legal Aspects

Adam W. Christensen, JD, MBA, Blake D. Christensen, DO, Nazette Zuhdi, JD, LLM, Jonathon M. Miles, JD, Adrian Maurer, MD, S. Sandy Sanbar, MD, PhD, JD

Telemedicine has come of age both nationally and internationally. In 1997, the ***Oklahoma Telemedicine Act*** (OTA) was passed. The OTA states that all health care service plans, disability insurer programs, workers' compensation programs, or state Medicaid managed care program contracts are to include coverage for telemedicine services, where appropriate, as determined by a health care provider[i].

Telemedicine is broadly defined under the OTA as the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, or exchange of medical education by means of audio, video, or data communications[ii]. It encompasses such issues as emails, physician-patient communications and transfer of patient medical information from clinic to clinic and facility to facility. Telemedicine has demonstrated its potential to offer widespread access to medical care while at the same time reducing health care costs. Doctors can conduct video consultations with others in the same state, in other states and abroad. Telemedicine, however, does not include consultations provided by telephone or fax machine.

There is no universal law of telemedicine. States take significantly different approaches to regulating it. Indeed there are many regulatory and legal issues to consider when developing a mobile app that involves exchange of healthcare information, an online health and wellness platform involving healthcare data, or another telemedicine or telehealth project. Regulatory and legal issues include:

- Privacy and Confidentiality
- Informed Consent
- Malpractice Due To Equipment Failure and General Liability Principles
- Jurisdiction and Registration, Jurisdiction and Liability
- Malpractice Liability, Negligence, Duty of Care, Standard of Care, and Negligence for Not Using Telemedicine

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It Started Around Age 40

Philip Maguire, MD

Sometime around age 40 I began to grunt when I bent over. And it happened when getting back up, too. It happened when getting in or out of a car. I also noticed about this time that I didn't bend as well as I used to. I had a little more trouble straightening back up, too.

It wasn't because of arthritis or some other known malady. I didn't feel any joint pain or creaking in the joints, just a little crepitation. I'm not exactly sure why I began to grunt. I didn't think of it as being progressive. It's not any worse now, though still present.

My wife blamed it on my age, that I was getting older. A concept I categorically refused to accept. Anyway, 40 isn't old. Old people wobble and shuffle, which I did not do. I don't do that now.

Still unsure of the etiology, I just learned to accept it. I have to say it can be embarrassing when people look over at you as you audibly grunt in public.

Another thing: I seem to drop things more than I used to. ❑

(Law and Medicine continued from page 13)

- Regulation of Telemedicine and Telehealth by State, Licensing, and Professional Disciplines
- Ethical Constraints in a Given Profession (such as medicine, psychology, psychiatry, or counseling)
- Insurance Issues Including Insurance Fraud, Billing and Coding, Medicare and Medicaid Fraud/Abuse, Fee-Splitting, Kickback Law and Stark, and Healthcare Fraud.

Giving information on the Internet regarding generic health care conditions is legally permissible. However, giving information tailored to a specific patient, considered as ***diagnosis*** and ***treatment*** of a medical condition, is controlled by the medical licensing statutes. Telemedicine providers who don't recognize the differences may run afoul of current law and regulation.

In Oklahoma, the health care practitioner who is in physical contact with the patient has the ultimate authority over the care of the patient and needs to obtain informed consent from the patient. If the patient wishes to utilize telemedicine, a detailed explanation of the risks and benefits and potential privacy concerns must be discussed. Telemedicine in Oklahoma is not centralized, but primarily offered through collaborative telemedicine networks and individual providers. Oklahoma supports telemedicine through the state's high speed intrastate network, OneNet.

One thing is for certain: telemedicine is evolving and will enhance the physician's ability to deliver medical care. Rural hospitals, not-for-profit hospitals, public health departments, correctional and military facilities and people involved in emergency response situations like the May 20, 2013, tornado, all have need for the utilization of telemedicine.

A fully developed and sophisticated communications infrastructure is needed to transport telemedicine information. However, this infrastructure is absent in many of the area's most in need. Perhaps in the future, there will be ways to fund the telecommunications infrastructure and site equipment. The good news is the technology is here. Perhaps political forces will team up to find ways to fund the use of telemedicine and eliminate the barriers that are stunting its growth. ❑

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[i] §36-6803. Added by Laws 1997, c. 209, §1, eff. July 1, 1997

[ii] §36-6802. Added by Laws 1997, c. 209, §1, eff. July 1, 1997

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Letter to the Editor:

As a third-year medical student in 1969, I suffered from a false feeling of shortness of breath, which was made better by jogging or exercise. I had no cough, wheezing, or chest pain, but I did have a persistent urge to take in deep sighs, which did not appease my sense of dyspnea except for a few seconds at a time. This pseudo-dyspnea feeling persisted for several months, did not improve or worsen with time, sometimes got briefly better with food or drink, and was not influenced by position. I presented my case to several of my professors, but none could give me a satisfactory explanation.

As a fourth-year medical student, I happened to treat an isolated episode of heartburn with liquid antacid and noticed that the antacid temporarily relieved my pseudo-dyspnea. When I took the antacid four times a day for a few weeks, my pseudo-dyspnea disappeared and did not return.

As a practicing internist, I began seeing this condition in my patients and learned to ask three questions to differentiate it from true dyspnea: 1) Does your dyspnea get worse or better with activity or exercise? 2) Do you feel the need to take in frequent, deep sighs? 3) Do you cough, wheeze, have chest pain, edema, or fatigue? Treating these patients, whose only two symptoms were frequent sighing and pervasive pseudo-dyspnea, as if they had acid reflux disease provided slow but complete relief. They tended to improve by the end of the first week of therapy and were usually well within six weeks. I also noticed that patients who suffered from comorbid anxiety disorders became much more alarmed at their pseudo-dyspnea and made themselves even sicker by hyperventilating.

In December of 2012, I published my observations to the non-medical public on my website, *www.saadah.net*, under the title "False Shortness Of Breath (Pseudo-Dyspnea)."

When a review of gastro-esophageal reflux disease appeared in the June 1, 2013, issue of *The Lancet* without mentioning pseudo-dyspnea, I did a Google search. The only result was my web article, as referenced above. At that point, I realized that this relatively common clinical presentation was not widely recognized and felt an obligation to bring it to the attention of our readers, hoping to find out if other physicians had made similar observations.

Respectfully,
Hanna Saadah, MD, FACP

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Young Physicians

Ryan Wicks,MD

Changing Times?

New physicians face immense challenges as they begin to venture out on their own into the practice of medicine, and today's doctors encounter unique obstacles and demands that are altering their decisions in dramatic ways.

Intense regulations in the era of the 80-hour work week have accustomed new physicians to a more structured role as part of a healthcare team that is more used to zealous oversight.

The cost of graduate and post-graduate education has imposed serious financial burdens on doctors who flock to the security of guaranteed contracts and away from the freedom and danger of private practice. Finally a cultural shift in the desires for what provides happiness has made many young physicians eager to seek a balance that sees them spending more time away from the hospital.

Residents over the recent past have had a serious alteration in their training that has caused a significant change in the type of practice they flock to once ready to embark on their own.

Intense oversight and legal pressures have altered what it is to be a resident. Gone are the days that are reminisced about by current attendings of middle-of-the-night surgery without a thought of calling for supervision. Every-other-night call is a thing of the past. Current residents spend more time typing thorough notes than with their patients to ensure they are legally protected and all billing may be adequately justified.

It is no surprise that being "brought up" in this kind of environment will make one more prone to be comfortable with it. That is not to say that some of these changes do not have merit, but it does help explain why young physicians seek out similar type positions in their ultimate career path.

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Angel Flight: Free Patient Air Transportation

Angel Flight Oklahoma serves patients in need of transportation to or from medical treatment. Angel Flight arranges free air transportation for any legitimate, charitable, medically related need. For more information, please contact Angel Flight at (918) 749-8992, email Angel@AngelFlight.com or visit www.AngelFlight.com. ❑

(Changing Times continued from page 19)

Additionally, new physicians have encountered a soaring cost of higher education. According to AAMC, in 2011-2012 the average annual tuition of public medical schools was $24,257 for residents and $45,647 for non-residents and $42,407 for private medical schools. This does not include additional fees, books, insurance, or living expenses. Efforts have been made to mitigate these expenses with favorable student loans, but it is not surprising that many of today's interns start with $200,000+ in loans to pay back before earning a single paycheck.

New physicians are flocking to guaranteed contracts with large health organizations that ensure the ability to pay back loans and live comfortably. Many are worried about starting their own practice, dealing with insurance companies or running a business, and would rather have less upside reward while eliminating downside risk.

Finally, there has been a cultural shift that has affected what positions new physicians often covet. Previous doctors' very existence was tied to the hospital and the role they played in people's lives. They spent countless hours caring for their communities' ills without a second thought. They were able to accommodate this with other aspects of their lives.

New physicians have increasingly put an emphasis on their non-medical life. They focus more on life outside of the hospital and their interactions with family, friends, or recreation. This is not to say that medicine is not a priority for them, but there has been a change in desires that has tended more toward balance. This has changed what type of practice each new physician is willing to pursue once out of residency.

The decision of what type of practice to pursue once out of a grueling residency is unique to each individual, but it is clear that new physicians are faced with a different set of pressures than in the past.

New physicians desire a balanced life that will provide for not only their career but personal goals. The health care of our country will depend on the hard work and dedication of these young doctors and understanding their thought process will help all parties to succeed going forward. ❑

(About the Cover continued from page 3)

Later, in 1963-1965, he constructed an artificial bypass heart, with Navy Commander Clark Ritchie, which sustained the circulation of a dog, Merci, for four days. The heart-lung machine of Total Intentional Hemodilution and the artificial bypass hearts that were in the dog are in an exhibit at the Oklahoma History Center, 800 Nazih Zuhdi Drive, Oklahoma City, OK 73105-7917.

In 1960 a 7-year-old boy, Terry Gene Nix, had his pulmonary valve successfully managed using this innovation. The effect of this demonstration was that prairie hospitals would become advanced institutions competing with university hospitals. For this accomplishment, Dr. Zuhdi received national and international acclaim, and his Mercy laboratory was visited by interested surgeons from many countries, seeking information to allow them to use this system in their home facilities. Attention and commendations poured in. Particularly notable was praise from his old mentors and from Drs. Denton Cooley and Michael DeBakey in Houston.

In 1963, Dr. Zuhdi relocated to Baptist Medical Center in Oklahoma City. He performed the first heart transplant in Oklahoma in 1985, which heralded the beginning of the Oklahoma Transplant Institute at Baptist Medical Center and which later became the Nazih Zuhdi Transplant Institute. That institute became a multi-organ transplant facility dealing with adult hearts, adult single and double lungs, adult and infant livers, kidneys, pancreas, and small bowel, and the survival statistics were among the best in the nation.

In addition to his activities in medicine, Dr. Zuhdi has enriched the community by bringing notable performers here, including Luciano Pavarotti, Bill Cosby and Frank Sinatra. He also has been a recognized supporter of ecumenical efforts to create understanding between Islam, Christianity and Judaism. He, along with Leo Oppenheim & Co., Inc., and Rev. and Mrs. William F. Carpenter, and others, were instrumental in the design of the interfaith chapel at Baptist Medical Center, a house of prayer for all people.

Dr. Zuhdi's presence in Oklahoma City has drawn national and international attention, and certainly has made life here more interesting. ❑

Director's

DIALOGUE

"Adventure isn't hanging on a rope off the side of a mountain. Adventure is an attitude that we must apply to the day-to-day obstacles of life – facing new challenges, seizing new opportunities, testing our resources against the unknown and in the process, discovering our own unique potential."

~John Amatt, Author and Everest Expedition Leader

Now that I've had a few days to process the information I received at the recent American Association of Medical Society Executives' annual conference, I choose to think of the challenges ahead for the Oklahoma County Medical Society as an "adventure." We can develop an attitude to tackle future obstacles by embracing the inevitable changes and searching for new opportunities.

Prior to each AAMSE annual conference, I look forward to gaining new insight from associations' best practice models and interacting with my colleagues. Since the medical association membership model of the past is not working, our organization needs to continue the OCMS Board's efforts to enhance the value proposition to encourage new membership. So I was excited at the prospects of learning new approaches.

This year's AAMSE meeting began with such promise as I was inspired by the presentation, "Business Model Thinking for Healthcare Association Leaders." Jeff De Cagna, presenter, believes that the current strategic planning model is obsolete. He challenged us to question our assumptions about strategy and innovation by encouraging our associations to identify their stakeholders and ask them what they want from their association membership. Following this presentation, two medical association communication directors illustrated how they got their members' attention through the creative use of technology.

Fast forward to the second day...which was a real eye opener for me. I derived no inspiration from the morning's sessions,

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(Director's Dialogue continued from page 25)

but the general session after lunch certainly kept me awake! The physicians on the panel consisted of a managing partner of a large group integrated into a hospital system and two of his employees – one who joined the group directly from residency training and one who joined the group after closing a private practice. The two younger physicians liked the freedom of practicing medicine without the headaches of managing the business side of a medical practice. And, guess what? Not one physician on the panel was a member of the local medical society and only one had been a member of the state medical association! They spoke of the importance of their specialty societies but had never been interested in being involved in organized medicine at a local/state level. However, they agreed that it would be a good idea for medical societies to focus efforts on developing a dialogue with physicians during their residency training to begin demonstrating the value of membership.

The next session with presenters from the AMA and two state medical associations focused on how to create a forum for employed physicians. One medical association split its membership section into two focus areas – physicians integrated in health systems and physicians in solo/small group/large group practices – because their membership needs were so different. By the end of this session, my brain was really on membership overload!

To conclude my second day, I had selected "The Evolution of Membership" but had second thoughts about attending one more membership session. So, I decided to join Kathy Musson, OSMA associate executive director, for something more light- hearted, "The Psychology of Happiness: What You Need to Know for Life Balance." Having already heard many of this presenter's suggestions, it was still a positive exercise to remember how to maintain a work-life balance and a wonderful, upbeat way to end my day!

The AAMSE conference's final day began with a panel discussing the topic "Health Care Delivery 2020 and Beyond." One of my take-aways from this session was that change is inevitable, but progress is a choice. No one has a crystal ball that looks into the future or a silver bullet to ensure a

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thriving membership for medical societies. My conclusion was that membership organizations should choose to embrace the changes and explore new concepts to create a different membership model focusing on the needs of our members.

To wrap up the conference, we had a choice of sessions ranging from the "virtual office concept" to "top apps and tech tools" utilized to bring the "wow" factor to an association's marketing plan.

Once again, I appreciate the opportunity I was given to attend the AAMSE conference this year as I learned new ideas and benefitted from interacting with my colleagues who encouraged the concept of CASE – copy and steal everything! There is no reason to try to reinvent the wheel – if someone else had success with an idea, take it and run.

I believe the best years lie ahead for the Oklahoma County Medical Society whether we develop new programs or choose to "steal" from an organization that has enjoyed success. And, we need to "discover our unique potential" to move forward. ❑

Jana Timberlake, Executive Director

Oklahoma City-County Health Department
Epidemiology Program
Communicable Disease Surveillance

COMMONLY REPORTED DISEASES	*Monthly*			*YTD Totals*	
	Jun '13	**Jun '12**	**May '13**	**Jun '13**	**Jun '12**
E. coli (STEC, EHEC)	0	0	0	0	9
Ehrlichiosis	0	0	0	0	1
Haemophilus influenzae Type B	0	0	0	0	0
Haemophilus influenzae Invasive	2	2	4	17	10
Hepatitis A	1	0	1	2	2
Hepatitis B*	8	12	8	62	81
Hepatitis C *	7	32	3	58	121
Lyme disease	0	0	0	0	0
Malaria	0	0	1	2	3
Measles	0	0	0	0	0
Mumps	0	0	0	0	0
Neisseria Meningitis	0	0	0	1	0
Pertussis	0	2	0	1	5
Strep pneumo invasive, children <5yr	0	0	0	3	5
Rocky Mtn. Spotted Fever (RMSF)	0	0	0	0	4
Salmonellosis	8	13	2	37	42
Shigellosis	10	3	10	49	72
Tuberculosis ATS Class II (+PPD only)	***	***	***	***	162
Tuberculosis ATS Class III (new active cases)	4	3	2	12	15
Tularemia	0	0	0	0	0
Typhoid fever	0	0	0	0	0
RARELY REPORTED DISEASES/Conditions:					
West Nile Virus Disease	0	0	0	0	0
Pediatric Influenza Death	0	0	0	0	0
Influenza, Hospitalization or Death	0	0	0	136	80
Influenza, Novel Virus	0	0	0	0	0
Strep A Invasive	0	0	0	0	0
Legionella	0	0	0	1	1
Rubella	0	0	0	0	0
Listeriosis	0	0	0	0	1
Yersinia (not plague)	0	0	0	0	0
Dengue fever	0	0	0	0	0

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

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

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

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

Pearl of the Month

To Image or Not to Image…or What to Image? (i.e. Trust Your Reflexes!)

Anthony J. Vaughn, MD, Assistant Professor of Neurology, University of Oklahoma Medical School
James R. Couch, MD, Professor of Neurology, University of Oklahoma Medical School

A patient comes to you and states, "My legs are weak and they feel funny." You've seen this complaint before and you know that there is a wide differential as to possible causes. Nonetheless you charge into the room having quickly resurrected all those neurological exam techniques from the recesses of your mind. Perhaps you are used to testing motor strength, sensation or even reflexes daily or maybe you are not. In my experience, it's usually the latter.

You finish your exam, suspect a spinal cord lesion and order an urgent or even a stat MRI. When you pull up all the possible MRIs you choose the lower lumbar spine with and without contrast because we're dealing with the legs only and send the patient on their way. They return to you eager for results but with a normal MRI report. Now you call your favorite neurologist and the first thing they will likely be asking you is, "What are the reflexes?" The second thing they ask for is another MRI, only this time of the cervical and/or thoracic spine, which not only frustrates you and the technician but also your patient.

Does this sound familiar? Did you catch a few pitfalls in the above scenario? There are two important concepts to take away from this case.

The first concept is that reflex testing is a very valuable bedside tool. It takes only a few seconds to perform and is an exceedingly objective test. First make sure you have a heavy hammer. A heavy hammer amplifies your ability to get a reflex. Second, swing from the wrist and let the hammer bounce on the tendon. Third, don't hesitate to hit the same area a few times until you either get a reflex or are convinced there isn't one at all.

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Once you have mastered the technique, then consider the distribution of the reflex results. Are the reflex changes symmetrical (i.e. bilateral legs, bilateral arms or all four limbs)?

Are the reflex changes in one limb (monolimbic) or on one side (hemibody)? The following should serve as a rough guide to reflex patterns.

- Diffuse hyperreflexia = lesion above C5
- Upper limb hyporeflexia with lower limb hyperreflexia = acute cervical lesion
- Upper limb normal with lower limb hyperreflexia (or hyporeflexic) = thoracic lesion (acute if hyporeflexic)
- Diffuse hyporeflexia (with weakness) = peripheral neuropathy or myopathy
- Diffuse areflexia or areflexia in lower limbs (with weakness) = Guillain-Barre Syndrome (Acute Idiopathic Demyelinating Polyneuropathy) likely in acute or subacute situation or related to chronic metabolic or toxic polyneuropathy if course is long term
- Hemibody reflex changes suggest an ipsilateral hemi-spinal cord syndrome OR a high contralateral brainstem or brain lesion

A final note to mention is that the most important reflex test to perform in the above scenario involves the Babinski or plantar reflex. Use of this test is essential to any reflex testing. A strong stimulus to the sole starting from the heel along the lateral plantar surface and over the base of the metatarsals with a key or other blunt instrument is a very telling sign. An up-going toe will quickly point to a central lesion involving the corticospinal tract in the spinal cord (thoracic or cervical cord), brainstem or brain.

So now you're an expert on performing the reflex test and getting results. The usual grading system is 0-4+ (0+=none, 1+= minimal reflex, 2+=normal, 3+=moderate hyperreflexia and 4+= clonus). The most important question is, "Are the reflexes there and if so are they normal, reduced or exaggerated?" And what is the distribution of the normal and abnormal reflexes? Are the reflexes what you expect? At times normal, 2+ ankle jerks in an older subject where diminished reflexes are expected could represent hyperreflexia, especially if the ankle jerks are more active than patellar reflexes.

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The second concept to consider is, "What is the right MRI sequence to consider and ultimately order?" Typical MRI sequences range from Brain, Cervical Spine, Thoracic Spine and Lumbar Spine. Important points are as follows:

- Contrast is always reasonable as long as the kidneys are working and the GFR is > 60.
- The spinal cord ends at L1-L2 so an MRI lumbar spine is only assessing the cauda equina and nerve roots (not the spinal cord).

The best way to approach ordering MRI sequences is to think top down as opposed to bottom up. Lesions in the brain or high cervical cord can cause symmetrical lower leg involvement and spare the arms in the beginning. However, if time and disease run their course, the arms will eventually catch up to the legs. So don't be tricked if the patient only complains of weak legs but you find reflex changes in the upper arms. Cervical myelopathy has an insidious and often prolonged course early, but when the legs become weak, the disease moves rapidly.

Now back to our patient scenario. If a patient comes in complaining of weakness, difficulty walking and sensory changes, the first step is a good motor exam with a focus on reflexes.

- Hemibody? Think brain, brainstem or high cervical spine.
- Bilateral legs with bilateral hand/arm involvement? Likely the cervical spine.
- Bilateral legs with Babinski and/or exaggerated reflexes? Think cervical and/or thoracic spine but don't forget to focus on the arms as well.

A last word of advice is when in doubt, short on time and monetarily restricted, feel free to give your local neurologist a quick call and ask where s/he may start looking first. More often than not, the MRI lumbar spine is not a useful test in scenarios similar to the one above. And having a good knowledge of reflex testing is essential to directing your workup and optimizing patient care and healthcare dollars. ❑

Unarticulated beauty reclines, unnoticed and unarticulated memories repose, dormant. Without words, one cannot express love nor explore the emotional depths of human experience.

Watching The Rise

Hanna Saadah, MD

That crimson morning when we spied the sky give birth
The rattling leaves took flight, tattling with earth
The trees, half nude, stood veiled in bashful hue
Such quietude, the morning hymns, and you
Watching the rise
With April dancing in your eyes.

And when the morning nooned
And shadowed sunny streaks
Upon your arms and cheeks
It weaved a thin embrace
That lingered on for weeks
Upon your face.

And still, I call you morning
Even when the sun had washed her hair and set
For it was morning when we met
And every sunset hails another rise
Beyond the oceans of your eyes.

Tomorrow, when the blooms begin to spatter
Do not ask me why I tear, nor what's the matter
Something about the morning makes the eyes fill up with dew
Remember when we watched the flames consume
The clouds, the stars, the edge of sky
Was it not you who tranced into the rise
With April rippling in your eyes?

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

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OUHSC-Irwin H. Brown Office of Continuing Professional Development
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Telephone: 271-2350
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St. Anthony Hospital
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