BULLETIN

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The Oklahoma County Medical Society

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About The Cover

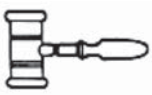
The photograph on the cover of The Bulletin this month is of a replica of the skyline of Manhattan before September 11, 2001, reproduced by Morgan Stanley Investments. The twin towers of The World Trade Center are shown, rising proud and majestic above the other buildings. The 110 floor towers, designed with a steel frame, opened in 1970. The Waskowitz family, Bill and Barbara, wanted our family to dine at the restaurant – "Windows on the World" – at the top of the World Trade Center. Diana, my daughter, and I still remember the longest elevator ride we ever took. It felt as if we were being catapulted into outer space. The best place to buy theater tickets was reported to be on the plaza between the two towers. I have a photograph of myself with replicas of George H.W. Bush and Gorbachev. I have my arms around both of them as if uniting them in world peace. The first hijacked plane crashed into the 93rd to 99th floors of the North Tower. The second jet slammed into the 77th to 85th floors of the South Tower. As Fink and Mathias wrote in their book *Never Forget: An Oral History of September 11, 2001*, a recording of the survivors, "the tragic events" were not only in New York but also at the Pentagon and in Pennsylvania. They wrote, "What happened that morning would be considered the single most devastating attack ever unleashed on the United States of America." Richard A. Clarke in his book *Against All Enemies: Inside America's War on Terror* wrote, "We owe thanks to the 9/11 Commission. We also owe thanks to the family members of the victims of 9/11…without the efforts of those families, so much of the events leading up to and on 9/11 would not have become public knowledge. In their grief, they have done the government and nation that failed them an enormous service. We shall forever owe them a debt of gratitude, for they more than anyone have pressured the government to take steps to ensure that the failures of 9/11 are not repeated." ❑

The Editor

To be feared is to fear: no one has been able
to strike terror into others and at the same time
enjoy peace of mind.

Seneca (5 BC – 65 AD)

President's Page



Larry A. Bookman, MD

As summer fades and fall approaches, thoughts of vacations and suntans turn to the return to school and education again fills the air. A new class of future doctors fills the halls, labs and lecture arenas, filled with dreams and aspirations, just as we were when it was our turn to enter those hallowed halls. Many of us dreamt of becoming a physician for much of our lives. Yet we awaken now to find we are not "doctors," we are "providers." Medicine has changed over the last 30 years, and more changes are in front of us. Some may not like the direction those changes are taking us, but our primary purpose, to care for the sick, has not changed. We may gripe or even become angry over the way physicians have been treated by our federal government but when confronted with wide eyed students, thirsting for knowledge, our course should be positive and educational. It is also important to be informed. That is an important benefit of belonging to the Oklahoma County Medical Society and the Oklahoma State Medical Association. Both organizations spend a lot of time and resources keeping up with the latest changes, both at the state and federal levels.

The most recent and important news comes from Washington, where pediatrician Donald Berwick, MD has been appointed the head of the Centers for Medicare and Medicaid Services (CMS). CMS has not had a permanent head since Mark McClellan, MD stepped down from the position in September, 2006. The decision to appoint Dr. Berwick was supported by the AMA leadership. But who is Dr. Berwick and what were his qualifications to head one of the most important and powerful positions in healthcare? Dr. Berwick is the CEO of the Institute for Healthcare Improvement, a partnership with physicians and hospitals to improve quality and patient safety. He is also Clinical Professor of Pediatrics and Health Care Policy at the Harvard Medical School, and Professor in the Department of Health Policy and Management at the Harvard School of Public Health. He is the first "Independent Member" of the Board of Trustees of the American Hospital Association and has

received many awards including the appointment of "Honorary Knight Commander of the British Empire" in honor of his work with the British National Health Service. He has been accused of supporting "health care rationing" and is a proponent of the British style of health care delivery. In 2007, in a speech to the British Health Service, he stated, "Here, in the NHS, you have historically put primary care where it belongs: at the forefront. You could have protected the wealthy and the well, instead of recognizing that sick people tend to be poorer and that poor people tend to be sicker, and that any health care funding plan that is 'just,' must redistribute wealth from the richer among us to the poorer and less fortunate. Excellent healthcare is by definition redistribution." He has stated that he is against making the individual patient financially responsible. "Internationally, when one looks at high performing systems around the world, and ours is nowhere near the highest performing one, it is almost a routine characteristic of the best systems that they have first dollar coverage, and there is no attempt to make patients pay more when they are sick, which is a stupid thing to do." When discussing the advancing wave of technology and new drugs and the associated costs, Dr. Berwick stated "…One of the drivers of low value in health care today is the continuous entrance of new technologies, devices, and drugs that add no value to care. If we had strong national policy, it would allow us to know the difference." On February 27, 2008, Dr. Berwick was quoted in the Boston Globe stating, "Managed healthcare was a great idea when it first emerged, before the term got hijacked by insurance companies that claimed to manage care but in many cases only managed money. The innovations that managed care and capitation made possible were good for almost everyone. Thousands of people avoided needless hospital visits; they got more appropriate, less expensive, better coordinated care in office settings."

So, it appears more changes are on the horizons. Only it feels like we have been here before, and it did not work well. And if Britain and Europe had such great health care delivery, why are so many foreign doctors coming to the United States to live and practice? Changes to the health care delivery system may be necessary; I'm just not sure these are the changes we meant. ❑

What we call "progress" is the
exchange of one nuisance for another nuisance.
Havelock Ellis (1859-1939)

Fall Membership Meeting

Summer has officially ended – at least so far as the OCMS meeting scheduled is concerned. So mark your calendar and get ready to convene.

The Fall Membership Meeting will be Monday, September 27, 2010, at the OSMA Headquarters, 313 N.E. 50th Street, Oklahoma City. The reception will begin at 6:00 p.m., dinner will be served at 6:30 p.m. and the program will begin at 7:00 p.m. Both candidates for Governor – Lieutenant Governor Jari Askins and Congresswoman Mary Fallin – have been invited to address our membership and answer your questions. ❑

In Memoriam

Raul E. Chanes, MD
1932 - 2010

Jim Glendon Duckett, MD
1927 – 2010

Dwight M. McGlohon, MD
1956 – 2010

Malcomb Robinson, MD
1942 – 20 10

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Dean's Page

M. DEWAYNE ANDREWS, MD
Executive Dean
University of Oklahoma College of Medicine

Two new department chair appointments at the College of Medicine became effective July 1, and I am pleased to tell you about them. Laurence Z. Rubenstein, MD, MPH, was appointed as the Donald W. Reynolds Professor and Chairman of the Department of Geriatric Medicine. Dr. Rubenstein received his MD from the Albert Einstein College of Medicine, took residency training in internal medicine at Albert Einstein Bronx Municipal Hospital Center in New York and UCLA Medical Center in Los Angeles. He also completed a Robert Wood Johnson Foundation Clinical Scholar program with training in health services research, public health, and health policy and administration. Before joining the OU College of Medicine this summer, Dr. Rubenstein was Professor of Medicine at UCLA and senior physician for the Geriatric Research Education and Clinical Center and Chief, Division of Geriatric Medicine at the Sepulveda VA Medical Center in California. He has authored over 200 peer-reviewed papers, 29 books and 100 book chapters and given presentations throughout the world. Rubenstein's 1984 landmark clinical trial on the effectiveness of comprehensive geriatric assessment remains frequently cited to this day. His current research interests include fall risk assessment in the elderly and the development of interventions to prevent falls. Dr. Rubenstein is highly regarded in the national geriatrics community, and we are very happy that he has joined our College to lead this important department.

Greg A. Krempl, MD, was appointed Professor and Chairman of the Department of Otorhinolaryngology. He also holds the Steve Moore Head and Neck Cancer Chair. Dr. Krempl received

his MD degree from the OU College of Medicine in 1992, followed by a general surgery internship at the Johns Hopkins Hospital, residency in otolaryngology at the University of Texas San Antonio Health Science Center, and then fellowship in head and neck oncologic surgery at OUHSC. He was appointed to the faculty of the College of Medicine in 1999 and has served with distinction in a variety of important roles in the department and College. His interests are in head and neck cancers focusing on medullary thyroid cancer, malignant melanoma, parathyroid disease, and minimally invasive techniques. He has contributed to more than 100 publications, book chapters and presentations. Following a national search, and a period of interim chairmanship, Dr. Krempl was appointed to this position.

An amazing amount of construction continues at the Oklahoma Health Sciences Center campus involving The Children's Hospital, the OU Cancer Institute, a new ambulatory surgery center (scheduled to open in October), expansion of the Dean McGee Eye Institute, and major expansion of the facilities of the Oklahoma Medical Research Foundation. I hope you have had an opportunity to observe the remarkable changes taking place around the medical school.

An eager new class of 165 first year students started their medical studies in mid-August in the new "Curriculum 2010" which is a significant reorganization of structure and content of the entire preclinical curriculum along systems based lines rather than discipline based lines. The new curriculum involves students in much more active education and small group problem solving sessions to inculcate good life-long learning habits. The students had their White Coat Ceremony on August 19, during which they are formally welcomed into the family of medicine; this is always an impressive and memorable event for students and families. Finally, I wish to express great appreciation to members of the OCMS who serve as community-based preceptors for students in their Principles of Clinical Medicine experiences and continue to take a strong interest in nurturing of the next generation of physicians. ❑

Pearl of the Month

Farhan Tariq, MD **James R. Couch, MD, PhD**

Brain Death

With the widespread use of resuscitation and life support, the need for a better definition of death has become obvious. Brain death is a legal indicator of death in the USA that refers to the irreversible end of all brain activity (including involuntary activity necessary to sustain life) due to total necrosis of the cerebral neurons following loss of blood flow and oxygenation. The Uniform Determination of Death Act (UDDA), adopted by most states, emphasizes three findings: coma, absence of brainstem reflexes, and apnea.

Brain-stem death and not whole brain death is taken to be the major indicator of brain death and should not be confused with a persistent vegetative state. Today, both the legal and medical communities in the USA use "brain death" as a legal definition of death, although in English-speaking countries they use brainstem death as an indicator of death of the human being. Use of the brain death criteria allows resolution of situations in which life support equipment allows the heart to keep working even when there is no hope for brain recovery.

Difficulties with ethics and decision to withdraw life support may arise if it is not made clear to the family that brain stem death is equivalent to death. One report found that roughly one-third to one-half of physicians and nurses surveyed do not adequately explain the concept to relatives so that they understand that the brain is dead and recovery is not possible.

Historical note

The concept of brain death originated with observations made by Mollaret and Goulon (1959) noting that severely brain damaged patients maintained on ventilators showed severe coma and apnea, a state they termed *coma dépassé* In a landmark paper in 1968, the first set of tests demonstrating the irreversible cessation of all brain functions was set forward (Ad Hoc Committee 1968; Belkin 2003). A survey of brain death practices worldwide disclosed the accepted practice of brain death determination in 80 countries surveyed with practice guidelines available in 70 of these countries; legal standards were in effect in 55 countries. Although there was widespread agreement on the concept of brain death, some differences exist in the clinical practices of determining brain death (Wijdicks 2002; Hornby et al 2006).

Brain Death Determination

Prerequisites:

Brain death examination can be performed by any physician with adequate knowledge of the nervous system. However, the determination is usually performed by neurologists or neurosurgeons or intensivists who are in direct care of patients with an acute brain injury. The primary prerequisite is irreversible coma of known origin. The following supporting evidence should be present:

1. Neuroimaging to help explain the coma
2. Absence of any CNS depressant drug
3. No evidence of neuroparalytic agents present
4. Absence of electrolyte, acid base, endocrine abnormality
5. Normothermia
6. Systolic blood pressure> 100
7. No spontaneous respiration

Examination

Only when all these above-mentioned confounders are excluded, should one proceed with a clinical examination to determine brain death. This concentrates on the brainstem and lack of appropriate response to painful stimulus:

1. Pupil, mid-position (5-9 mm), fixed, non-reactive to bright light.
2. Absent eye movements to oculocephalic maneuver (doll's eye), or caloric stimulation.
3. Absent corneal, gag, or cough reflex (stimulate trachea with catheter through endotracheal tube).
4. No facial movement to noxious stimuli at supraorbital nerve, temporomandibular joint.
5. Absence of motor response except for minimal withdrawal to noxious stimuli in all four limbs, which may represent a spinal reflex.

Apnea test

An apnea test of a minimum of 8 min shows no respiratory movements with a documented increase in $Paco_2$ of > 20 mm Hg from pretest baseline. (A full description of the procedure can be found in Neurology 2010 (23);74:1911-18, [June 23])

Common confirmatory tests in Brain Death

1. Cerebral angiography: No intracranial penetration of dye.
2. Cerebral scintigraphy (technetium Tc 99m hexametazime) showing no intracranial penetration of radionuclide.
3. Electroencephalography: Minimum of eight scalp electrodes. (With electrode distance 10 cm, sensitivity increased to at least 2 μV for 30 minutes) There should be no evidence of any possible electrocerebral activity of >2 microvolts amplitude.
4. Transcranial Doppler ultrasonography: The abnormalities should include a lack of diastolic or reverberating flow, small systolic peaks in early systole, and a lack of flow found in previously demonstrated normal velocities.

Interval between two evaluations, according to patient's age

Term to 2 mo old, 48 hr
>2 mo to 1 yr old, 24 hr
>1 yr to <18 yr old, 12 hr
>18 yr old, interval optional

Use of confirmatory tests

Term to 2 mo old, 2 confirmatory tests
>2 mo to 1 yr old, 1 confirmatory test
>1 yr to <18 yr old, optional
>18 yr old, optional

Conclusion

Brain death is a clinical diagnosis made on the basis of assessment of the patient's clinical and neurological status. The tests noted above are adjuncts to the clinical examination and cannot be used as the sole determinant of brain death without an appropriate clinical examination. ❑

Drs. Tariq and Couch are with the Department of Neurology, University of Oklahoma Medical School, Oklahoma City, Oklahoma

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If the stars should appear but one night every thousand years
how man would marvel and adore.
Ralph Waldo Emerson

Medical Professionals Chinese Exchange Program

James R. Claflin, MD

The Oklahoma/Gansu Province (China) Medical Professionals Exchange Program sponsored by the Oklahoma State Department of Health is alive and well. The sixth "class" of medical professionals is currently with mentors in various offices throughout the Oklahoma City metroplex. To date, summer 2010, there have been six classes with 35 participants. The seventh class of six individuals will arrive in October, 2010, for a six month rotation.

The specialties involved have included pulmonology, urology (3), transplant surgery, general surgery (2), nephrology (2), reproductive medicine (2), pediatrics (2), orthopedic (hand and forearm) surgery (2), orthopedic nursing, head and neck surgery (3), thoracic surgery, ophthalmology (2), ob/gyn (3), gynecologic oncology, endocrinology, anesthesiology, adult cardiology, critical care medicine, radiology (2), medical administration, and pharmacy. This has required a minimum of 32 mentors volunteering their time and allowing the Chinese professionals the opportunity to "shadow" their practice. The Oklahoma State Department of Health (Dr. Cline and staff) is very appreciative of the willingness exhibited by the medical community to undertake this project. It is very simple: without the mentors, the project would not exist.

The current class notes that the Oklahoma program is the most sought after shadowing opportunity available for medical professionals in their province. Other countries involved with shadowing for Gansu Province have included Japan, Australia, Canada, Britain, France, and Scandinavia.

Many of the medical professionals completing six months of observation have returned to leadership positions within the Gansu Province medical community. They have been able to make needed changes in the delivery of medical care and education within their medical community. A physician in the first group, spring 2007, instituted the first smoke-free hospital in Gansu Province.

Physicians interested in being a mentor for the program or even visiting our Sister-State, Gansu Province, to observe our

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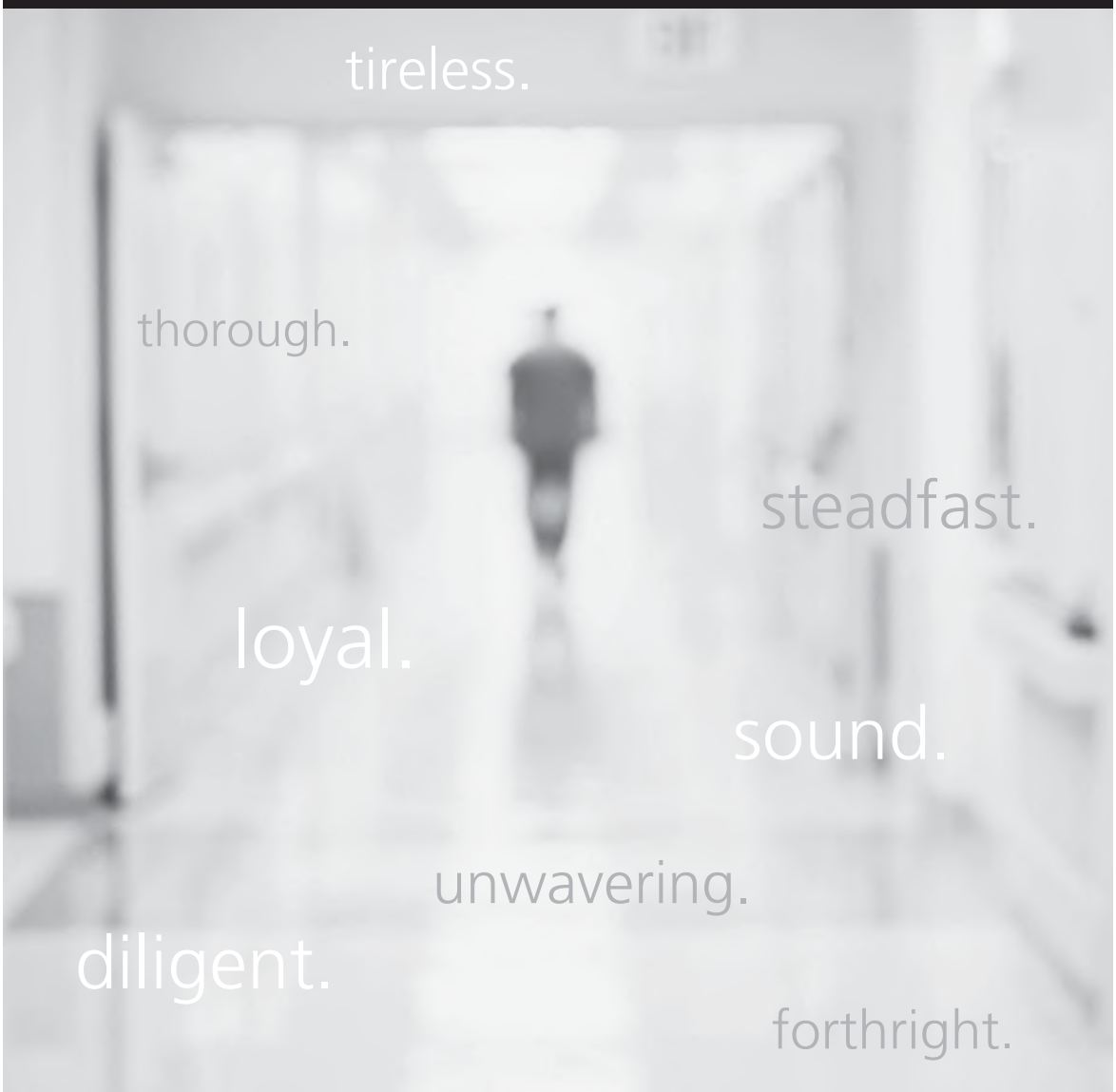

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colleagues as a visiting professor should contact the OCMS medical staff for information. Physicians who may offer insight regarding a visit to Gansu Province include Jay Cannon, Eli Reshef, Dennis Parker, Norman Imes, Paul Pressler, Andy Gin, Chris Codding, Sherri Baker, and Jack Beller.

Once again, many thanks to the mentors who have supplied time and talent for making the Oklahoma/ Gansu Province Medical Professionals Exchange Program a success! ❑

Practice Management Software

To assist physicians in selecting the most appropriate software to run their practices, the American Medical Association (AMA) and the Medical Group Management Association (MGMA) have developed the "Selecting a Practice Management System" toolkit.

"Selecting the right software to manage a practice has become increasingly challenging due to the rapidly-changing health care environment," said AMA President Cecil B. Wilson, MD. "Physicians who submit claims and do other business functions electronically and those who plan to participate in the government's EHR incentive program will need to upgrade or replace their current practice management software."

The toolkit provides a roadmap to make it easier for physicians to select and purchase the most appropriate practice management system (PMS) software. Physician practices can use this information to establish their organizational needs and take advantage of recent improvements in automation. The toolkit includes a five-step guide to PMS software selection, a comprehensive checklist of PMS software features and functionalities that physician practices can use to determine what their practice needs, and a sample "request for proposal" that physician practices can employ in their communications with PMS software vendors.

In a later phase of the project, an online directory of PMS software vendors that includes self-reported PMS software features and functionalities will be added to the toolkit in the winter of 2010.

For more information, or to request a copy of the toolkit, contact Lisa Lecas, AMA Media Relations, (312) 464-5980, or lisa.lecas@ama-assn.org. ❑

OCMS Election

The OCMS members listed below have been nominated for the four open positions on the OCMS Board of Directors. Ballots will be mailed no later than September 15. Return ballots must be postmarked no later than September 30. Please mark your ballot and return it immediately to be sure your vote counts.

Nominating Committee members include Drs. Teresa M. Shavney, Chair, D. Robert McCaffree, Vice Chair, D. Randel Allen, Robert N. Cooke, and Julie Strebel Hager.

POSITION I

Timothy J. Hill, MD

Medical Degree:	University of Oklahoma College of Medicine, 1979
Internship:	University of Oklahoma Health Sciences Center, Oklahoma City, OK, 1979-1980
Specialty:	Emergency Medicine
Date of Oklahoma License:	1980

Steven V. Richards, MD

Medical Degree:	University of Oklahoma College of Medicine, 1998
Residency:	Vanderbilt University, Nashville, TN, 1998-2003
Specialty:	Otorhinolaringology
Date of Oklahoma License:	2003

POSITION II

Glenn A. Koester, MD

Medical Degree:	University of Texas Health Sciences Center, San Antonio, 1989
Internship:	Vanderbilt University Hospital, Nashville, TN, 1989-1990
Residency:	Vanderbilt University Hospital, Nashville, TN, Internal Medicine, 1990-1991
Fellowship:	University of New Mexico, Albuquerque, NM, Dermatology, 1991-1994
Specialty:	Dermatology
Date of Oklahoma License:	1994

Wynter W. Kipgen, MD

Medical Degree:	University of Oklahoma College of Medicine, 1992
Internship:	University of Oklahoma Health Sciences Center, Oklahoma City, OK, 1992-1993
Residency:	University of Oklahoma Health Sciences Center, Oklahoma City, OK, 1993-1995
	University of Oklahoma Health Sciences Center, Oklahoma City, OK, Endocrinology, 1995-1997
Specialty:	Endocrinology
Date of Oklahoma License:	1995

POSITION III

David L. Holden, MD

Medical Degree:	University of Texas, Houston, 1978
Internship:	Hermann Hospital, Houston, TX, 1978-1979
Residency:	University of Texas Affiliated Hospitals, Houston, TX, 1979-1983
Fellowship:	Long Beach Memorial Hospital, Long Beach, CA, Sports and Knee Surgery, 1983
	Sacred Heart Hospital, Eugene, OR, Knee and Shoulder Surgery, 1984
Specialty:	Orthopedic Surgery
Date of Oklahoma License:	1994

Ervin S. Yen, MD

Medical Degree:	University of Oklahoma College of Medicine, 1981
Internship:	Oklahoma Memorial Hospital, Oklahoma City, OK, 1981-1982
Residency:	Oklahoma Memorial Hospital, Oklahoma City, OK, 1982-1984
Specialty:	Anesthesiology
Date of Oklahoma License:	1982

POSITION IV

Tim G. Bohn, MD

Medical Degree:	University of Oklahoma College of Medicine, 1977
Internship:	University of Oklahoma Health Sciences Center, Oklahoma City, OK, Internal Medicine, 1977-1978
Residency:	University of Oklahoma Health Sciences Center, Oklahoma City, OK, Radiology, 1978-1979 University of Oklahoma Health Sciences Center, Oklahoma City, OK, Family Practice, 1979-1981
Specialty:	Family Medicine
Date of Oklahoma License:	1978

Ralph Shadid, MD

Medical Degree:	University of Oklahoma College of Medicine, 1980
Internship:	University of Oklahoma Health Sciences Center, Oklahoma City, OK, 1980-1981
Residency:	University of Oklahoma Health Sciences Center, Oklahoma City, OK, 1981-1983
Specialty:	Internal Medicine
Date of Oklahoma License:	1981

New Members

Ethan D. Lindsey, MD
(CHP P)
6501 NE 50th St., #A
Univ. of Okla. 1987

Guruprasad Manjunath, MD
(NEP IM)
3366 NW Expressway, #550
Jawaharlal Institute of Medicine
Pondicherry, India 1994

Don L. Wilber, MD
(PD)
600 National Ave.
Univ. of Okla. 1978

Version 5010 HIPAA Standard

Physicians, other health care providers, payers and clearinghouses will be required to use Version 5010 of the HIPAA transactions beginning on January 1, 2012. It corrects technical issues, accommodates new business needs, and provides overall improvements from the current 4010 version. The AMA has prepared various resources to help you implement the new standard to prevent future cash flow interruptions and disruptions in transaction processing.

Several resources are available at no cost on the Web at www.ama-assn.org/go/5010. In addition, several publications and training opportunities are available for purchase.

In addition to the 5010 HIPAA transactions, practices will also be required to implement the ICD-10 code set no later than October 1, 2013, to meet the compliance deadline. Log on to www.ama-assn.org/go/ICD-10 to access various resources. ❑

What we see depends mainly on what we look for.
John Lubbock

Advancing SCIP in Oklahoma

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Oklahoma Foundation for Medical Quality
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On Professionalism

Passion, Principle, Policy

Gordon H. Deckert, MD

4th Century B.C. Oath of Hippocrates

Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption and will further from seduction of females or males, of free men and slaves.

There was a time when I was very impressed with the Hippocratic Oath. In some ways, I still am. In the early fifties, as a medical student, I *walked* into homes in Chicago to deliver babies. Later, as a Fellow in Medicine at the Mayo Clinic, I *walked* into my office to see and work with patients, more than a few from around the world. But then, as the Chief of Medicine and Chief of Staff at Tinker Air Force Base Hospital, my functioning as a professional went beyond merely walking into the hospital and then my office, per se.

In the fall of 1957, I was summoned to the base commander's office. There, I learned that I was to be the "czar" of all the health care systems of Oklahoma, in the event of a nuclear war. I was overwhelmed. I was to prepare for the possibility, but keep it a secret. Later, while still in the reserve, I was contacted during the Cuban Missile Crisis to "get ready, a nuclear war was likely." Now, what did it mean for me to be a professional in that circumstance? I wasn't simply a physician seeing a patient in the 4th century B.C. or even in the 20th A.D. The Hippocratic Oath was not sufficient! I would have to *walk* into and work throughout Oklahoma, not merely into my office or my hospital. The impact of that experience on me was even greater than I realized at the time.

Yes, my *passion* to improve and maintain the health of my patients continued. But, for me, a focus on the whole community became a requirement. Overtime, my definition of community expanded considerably, as did my passion. Was I to ignore the poor health status of Oklahoma compared to the United States? Or, for that matter, the health status of the United States compared to other established market economies? Is professionalism that limited?

Professionalism is defined by Webster's Dictionary as "the conduct, aims, or qualities that characterize or mark a profession or a professional person." Yes, the *principles* of conduct as outlined by Hippocrates still apply in my practice. But what are my *principles* of conduct that go beyond my patients? To support effective interventions for the larger community is much more difficult to determine, much less to apply.

The Constitution of the United States of America speaks repeatedly for promoting "the general welfare." In this era, does that include health status and health care? For me, it definitely does! And that means, in the best sense of the word, that we must *critically* examine our health care systems. I am certainly not alone in concluding that they are economically unsustainable and even operationally dysfunctional.

So that brings me, that brings us, to *policy*. What course or method of action do I select, or do we as professionals select, to guide and determine our present and future actions? That indeed is very difficult! Religious convictions, political views, economic orientation, personal experiences, and priorities often get in the way.

So, I guess, I can avoid these larger professional issues by simply focusing on my patients and my practice and keep repeating The Hippocratic Oath as my guide, as if today that is still sufficient.

No, in this century, in this world that is not sufficient! It's just a beginning. ❑

Dr. Deckert is a David Ross Boyd Professor Emeritus in the University of Oklahoma. As an ex-internist and a psychiatrist he has had multiple teaching awards and multiple honors. His speaking engagements have included all fifty states. His major contributions to The National Board of Medical Examiners are still recognized. When President of the Board of Health, he created what is now the annual State of the State's Health Report.

OCMS Fall Membership Meeting
September 27, 2010

Director's

DIALOGUE

Chance encounters are what keep us going

Haruki Murakami, Japanese author

Stop and think how many chance encounters you have had in the last week. The answer would probably be several – whether it was with a new patient, at a restaurant or sporting event or even the grocery store. I attended two conferences during the summer months, and my chance encounters were quite interesting.

In association work, everyone is focused on how organizations can retain and even grow membership. At the Oklahoma Society of Association Executives' annual meeting we heard an interesting speaker, Jim Mathis, a man with an explosive personality who calls himself a "reinvention strategist." Realizing that he was one of hundreds of individuals who called themselves "consultants," he began to ask his clients what they wanted from him. They asked the same question over and over again: How do I reinvent myself? Jim has successfully *reinvented* himself to better serve his clients by answering this question.

One of the books Jim suggested reading was *How Full is Your Bucket* by Tom Rath and Donald Clifton. It is a very small book that illustrates how interactions affect your relationships, productivity, health and longevity. They used the metaphor of a bucket and a dipper and asked the reader to think about the people around them – are they continually filling your bucket or dipping out of it? We all need people to fill our buckets to increase the positive moments in our lives and avoid negative behavior of those bucket dippers.

Later in July, I attended the American Association of Medical Society Executives annual meeting in Seattle. While the gorgeous scenery and cool temperatures tempted all of us to slip out of the Friday afternoon session, we stayed and heard Glenn Tecker speak about "Leading in the Transformation." Mr. Tecker reminded us

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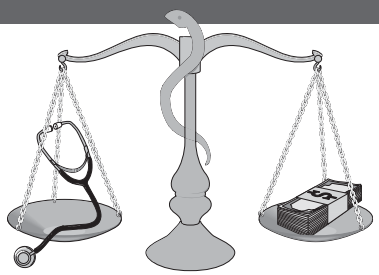

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that different members define value differently and organizations should redesign the services provided to them without losing the personal touch. He also stated that organizations need to shift from vision-based to value-based planning and stressed the importance of not abandoning the basic characteristics of an organization's mission-driven voluntary leadership and membership participation.

Organizations worry about their operating budgets, and many boards focus on downsizing services to address budgetary constraints. Mr. Tecker said, "Reshaping is not the same as right-sizing, which too often just means reducing cost. Instead, consider reshaping values by re-evaluating member benefits to eliminate those programs less important and beef up those of higher value."

Mr. Tecker went on to say, "Earning a reputation for having capacity to remain relevant over time as things change is the primary source of prospective member loyalty." I immediately recalled the OCMS Membership Development Committee's assertion that for the Oklahoma County Medical Society to continue to exist it must remain relevant to its members. Mr. Tecker's message certainly resonated with me.

While waiting for my flight home, an attractive older woman sat next to me in the airport waiting area and we began a casual conversation: Were you in Seattle on business or pleasure, etc. If business, what is your occupation? I told her about the conference and how membership organizations throughout the U.S. are all wrestling with one major issue – how to remain relevant in order to retain/grow membership. But in this difficult time I was not prone to panicking but saw it as an opportunity to perhaps find a better way to sustain membership loyalty.

Then the conversation shifted to her – Dr. Muriel O'Tuel, a motivational speaker and author. Dr. O'Tuel was an English teacher who had obtained her master's degree in counseling before receiving her PhD in counselor education and psychology. She worked for many years with the South Carolina schools, is an author and now devotes most of her time to her professional speaking career. Just as the conversation got interesting, the gate agent made the boarding call, we said our nice pleasantries, and I gathered up my belongings. Before boarding the plane, Dr. O'Tuel handed me a brochure that featured her book, "Footprints on the Heart." I thanked her and placed the piece of paper in my

bag.

During the flight, I read what Dr. O'Tuel gave me. The brochure describes Dr. O'Tuel's roots in North Carolina and provides an outline of the book. One chapter encompasses the belief that there's no such thing as a "self-made" individual, and the positive footprints others leave on your heart help lead you to success. I continue to acknowledge the positive footprints others have left on my heart that have given me guidance and support throughout my life – I wouldn't be here if not for them! Dr. O'Tuel's book concludes with illustrating how the reader can leave his/her own footprints on the hearts of others.

So, my many "chance encounters" this summer energized me and provided some tools for my professional life. I leave you with this quote from Albert Schweitzer, which says it all. ❑

In everyone's life, at sometime, our inner fire goes out.
It is then burst into flame by an encounter
with another human being.
We should all be thankful for those people
who rekindle the inner spirit.

JanaTimberlake, Executive Director

Save the Date!

A Day with the Judges

Medical Malpractice, SSA Disability,
Workers' Compensation, Pain Management &
End of Life Legal & Ethical Issues

Friday, October 15, 2010
7:45 a.m. – 4:10 p.m.
James L. Henry Auditorium
INTEGRIS Baptist Health Medical Center
3300 N.W. Expressway, Oklahoma City
$125 OCMS Members * $175 nonmembers * $225 attorneys
CME and PLICO Credits
Contact: Sandy Deeba, deeba@okmed.org or 601-9571

Compassionate Physician: Conversation about End-of-Life

S. Sandy Sanbar, MD, PhD, JD,
and Chris Codding, MD

Palliative care is extremely important, albeit time consuming. Some physicians help directly their terminally-ill patients and take time discussing important aspects of advanced planning at offices or during recurrent hospitalizations, which are typical of chronic, life-limiting illness. Other physicians opt to work with a palliative care team and relinquish or share responsibility with a subspecialist, palliative care consultant, pain specialist, hospice medical director, hospitalist, or advanced practice nurse. Palliative care consultant services are available at many hospitals and hospice organizations. When conversing about impending death, the compassionate physician (and the palliative care team) might consider the following suggestions:

1. The physician should repeatedly reassure the patient that he or she will continue to be cared for and will receive the best care possible. That means a lot to the patient. The patient needs to comprehend that the physician is providing not only treatments but also attending to the patient's symptoms and sense of wellbeing.
2. The physician should encourage the patient to plan for the important end-of-life period, and to consider important things left undone including people to visit, places to see and projects to complete.
3. The physician should urge the patient to document (or review and alter if necessary) his/her choices in a written advance directive and a health-care proxy or limited power of attorney. The patient should be requested to discuss his/her goals and concerns with the health-care proxy.
4. The physician should help the patient recognize the progression of disease by reviewing how patient was doing at the onset of the illness, response to treatment, current symptoms and

what might be expected to happen in the next several weeks or months.

5. The physician should ask the patient's permission to talk about the terminal illness and indicate that the discussion may occur now or it can wait and resume when the illness is more advanced.
6. The physician should not wait for the patient to bring up the subject of terminal illness. Instead, the physician should inform the patient that the illness is progressing, and at some point in time, people with this illness do die. The patient deserves to know if he/she is coming to the end-of-life, based on the symptoms, signs, findings in the medical records and description by the family members of how things have been going.
7. The physician should discuss a palliative care program that is modeled after hospice programs and that offers pain management and other comfort care in the patient's home. Such a program provides more satisfaction for patients and family.
8. The physician should allow time for the patient to permit them to ask if he or she is dying. Should that question arise, the physician should not change the subject. Instead, the physician should take advantage of the question, "Doctor, how long do I have or when will I die?" The patient should be asked why he or she is asking that question now, to open a frank dialogue. If the patient gives permission, include loved ones in the conversation.
9. The physician should provide the patient with the information needed to make his or her choices, using plain language. For example, the patient is interested in general statistics on the success of CPR in patients with similar conditions. The physician should explain the meaning of success versus futility in these situations, expectations about leaving the hospital, stabilizing the disease process, going to an extended care facility, ability to attend to one's self or live independently.
10. The physician should deal openly and frankly with the ability or inability to make the patient better. If the treatment will not be expected to make the patient better and death is

imminent, the physician should ask the patient where he or she would want to die, in the hospital, in the intensive care unit or at home. Discuss whether the patient would want life-prolonging intervention, such as a pacemaker for very slow heart rate, a breathing machine for lung failure, or cardiopulmonary resuscitation (CPR) performed if the heart suddenly arrests.

11. Finally, the physician should inquire about a Do Not Resuscitate (DNR) order, and who is the designated and trusted health-care proxy that the physician could talk to if

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Health Literacy Action Plan

The US Department of Health and Human Services (HHS) has released the National Action Plan to Improve Health Literacy intended to make health information and services easier to understand and use. It contains seven goals, each with specific strategies for different sectors of the health system, such as payers, the media, government agencies, and health care professionals, to improve health literacy. These goals emphasize the importance of creating health and safety information that is accurate, accessible, and actionable.

The Action Plan is available on the Department's website: http://www.health.gov/communication/HLActionPlan. ❑

Alliance


Donna Parker

If you see one of the 42 women who served on the May 2009–May 2010 Alliance Board of Directors, please give them a heartfelt pat on the back, handshake or high-five! What they did for the Alliance this past Spring was a perfect blend of savvy and intestinal fortitude! What they did was nothing short of amazing!

Last year's board approved funding to bring in a management consultant who specializes in helping nonprofits grow. Frank Merrick, Foundation Management–Oklahoma City, has been working with our Board of Directors since May. We have updated our mission statement, restructured our organizational chart, and built new committees designed directly from the mission statement. Last but not least, we have reduced our Board of Directors size by one-half!

While most leadership systems seek to self-perpetuate power and control, our courageous leaders put the Alliance above self or ego and chose to take action for the good of the organization. Our elected leaders in Washington, DC could take a lesson here!

"Times have permanently changed, folks. Now more than ever, the critical element of an organization is to have courageous leadership that is willing to commit to positions, whether popular or not, that uphold the best interests of the organization." (Lucky for us, we've never been short on courageous leadership!) "You will need to do 'less' so that you can accomplish 'more', based on your mission and purpose. And what you do, make sure you do it very, very well." These were Frank's directives – and our board was ready for the challenge!

As a result of the work done that day, all operational work will now be done under the guidance of Committee Chairs, with all decision-making placed squarely in the hands of the collective committee members. And no longer using its time on operational details, our trim new Board of Directors will spend a good part of its meeting time giving attention to the future, doing strategic planning.

There is real beauty in this simplicity. Committees are steering and navigating the ship, and the Board of Directors gets to choose

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the destination port! As an organization of volunteers, members are empowered under this system. The result will be invigorating and rewarding.

Additionally, service on the Board of Directors will be in three-year terms, but staggered so that one-third of the board rolls off each year as a new class rolls on. Our newly created Board Development Committee will work nine out of 12 months each year, discerning member skills and capacity for leadership, then finally selecting the new board class to rotate on for each upcoming year.

It takes a very selfless group of leaders to look ahead and be open to change. That's why these 42 original board members should be commended and congratulated for their "leap of faith" on behalf of the Alliance. They are smart ladies who recognize the benefit of change and simplicity in our governance and the need for diversity to build sound strategy for the future. Our leaders made a commitment to believe in the talent of our volunteers, be open to new innovation and technology, and most of all, to Making Things Happen. They had the vision to see that our future success rests on accelerating the pace of change within our organization to exceed the pace of change in our operating environment.

True leadership respects the past, adapts to the present *and* creates the future. The Alliance is beginning a new decade with a big task; it is an extremely worthwhile effort to make. I am confident we will ultimately credit our organization's turn for growth in this decade and beyond to the wisdom and courage of those 42 leaders in the Spring of 2010. ❑

Donna Parker

Remember to Vote for OCMS Board Members
Ballots Must Be Postmarked
No Later Than September 30

Use of Controlled Substances for the Treatment of Pain

Compiled by S. Sandy Sanbar, MD, PhD, JD, FCLM
Chairman, American Board of Legal Medicine

The Oklahoma State Board of Medical Licensing and Supervision (Board)[1] states that all physicians should become knowledgeable about (1) assessing patients' pain and effective methods of pain treatment, and (2) the statutory requirements for prescribing controlled substances.[2] Pain management is a part of quality medical practice for all patients with acute or chronic pain, especially those with a terminal illness.

Pain Management Standard

The prescribing, ordering, dispensing or administering controlled substances for pain should be for a legitimate medical purpose and based on sound clinical judgment. Prescribing pain medications must be based on clear documentation of unrelieved pain. *The validity of the physician's treatment of the patient is based on available documentation, rather than solely on the quantity and duration of medication administration.*

Pain management is considered to be within the usual course of professional practice if: (1) a physician-patient relationship exists; (2) the prescribing is based on a diagnosis and documentation of unrelieved pain; and (3) it complies with applicable state and/or federal law.

The goal of pain management is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors. Pain should be assessed and treated promptly and the quantity and frequency of doses should be adjusted according to the intensity, duration of the pain and treatment outcomes. *Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not the same as addiction.*

The Federation of State Medical Boards created its *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain* which distills safe opioid prescribing into seven concise principles: (1) Evaluation of the Patient; (2) Treatment Plan; (3)

Informed Consent and Agreement for Treatment; (4) Periodic Review; (5) Consultation; (6) Medical Records; and (7) Compliance with Controlled Substances Laws and Regulations.[3]

Substandard (Inappropriate) management of pain

Substandard or inappropriate management of pain may result from the Physicians' lack of knowledge about pain management, and the fears of investigation or sanction by federal, state and local agencies. It includes: (1) Non-treatment; (2) Under-treatment; (3) Over-treatment; and (4) Continued use of ineffective treatments.

Substandard or inappropriate management of pain is considered a *departure from standards of practice* and the Board will investigate such allegations:

1. Recognizing that some types of pain cannot be completely relieved;
2. Taking into account whether the treatment is appropriate for the diagnosis;
3. Referring to current clinical practice guidelines;
4. Using Expert review in approaching cases involving management of pain;
5. Considering current clinical knowledge and scientific research; and
6. Considering use of pharmacologic and non-pharmacologic modalities according to the judgment of the physician.

Drug Diversion and Abuse

The use of opioid analgesics for other than legitimate medical purposes poses a threat to the individual and society. The inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. To protect the public health and safety, physicians should incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

Disciplinary Action

Physicians should not fear disciplinary action from the Board for ordering, prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the course of professional practice.

- Allegations of substandard or inappropriate pain management are evaluated on an individual basis.

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- No disciplinary action is taken against a physician for deviating from Board policy when contemporaneous medical records document reasonable cause for deviation.
- The physician's conduct is evaluated to a great extent by the ***outcome of pain treatment***, recognizing that some types of pain cannot be completely relieved, and by taking into account whether the drug used is appropriate for the diagnosis, as well as improvement in patient functioning and/or quality of life. ❑

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[1] **Website:**
http://www.okmedicalboard.org/miscFunction.php?filename=Policy+on+Pain+Mgt..htm
[2] **Oklahoma State Bureau of Narcotics and Dangerous Drugs Control Administrative Rules** are **Title 475** "Oklahoma State Bureau of Narcotics and Dangerous Drugs Control" of the Oklahoma Administrative Code, http://www.ok.gov/obndd/Rules_and_Regulations/index.html; **Title 63 of the Oklahoma State Statutes, Title 21 - Food and Drugs, Chapter 13 - Drug Abuse Prevention and Control,** http://www.justice.gov/dea/pubs/csa.html
[3] **Responsible Opioid Prescribing: A Physician's Guide,** Scott M. Fishman, M.D., Federation of STATE MEDICAL BOARDS, http://www.fsmb.org/Pain/default.html

ECONOMIC IMPACT OF CHILDHOOD LEAD POISONING

Childhood lead poisoning is a major, preventable environmental health problem, which may cause developmental problems, lower IQ, behavioral problems, attention deficit disorder, learning problems, language delay, anemia, damage to the nervous system and, rarely, death, particularly in children less than 6 years of age.[1,2] Furthermore, this public health problem also results in billions of dollars in health care costs to taxpayers and the government. It has been estimated that the economic impact of childhood lead poisoning accounts for $43.4 billion annually.[3] Gould has estimated that loss of IQ points from elevated blood lead levels (EBLLs) falls between 9.3 and 13.1 million points, which results in a total lifetime earnings loss of $165- $233 billion, far exceeding the $10.8-$53.1 million in direct health care costs.[4]

Health Care Costs

In Oklahoma during 2009, there were 137 newly diagnosed (incident) EBLL cases. The additional cost of follow-up testing, case management, and medical management of these children was $35,291. This cost was calculated based on Kemper et al.'s cost estimates[5], which were inflated to 2009 USD using the Consumer Price Index (CPI) Inflation Calculator.[6]

IQ and Total Lifetime Earnings Loss

Several scientific studies have suggested a strong association between EBLLs and reduction in IQ. On the basis of Schwartz et al.'s estimates, one of the most commonly used estimates, each microgram per deciliter of blood lead level is associated with a loss of 0.257 IQ points.[7] Based on the average blood lead level of 16.2 µg/dL for 137 EBLL children in Oklahoma during 2009, the estimated IQ loss was 4.2 points per EBLL child. Gould estimated that each IQ point loss is associated with a loss of $17,815 (in 2006 USD).[4] Inflating this amount to 2009 USD ($18,958) and using the previously calculated IQ loss of 4.2 points per EBLL child, it can be estimated that Oklahoma will lose approximately $11 million from lifetime earnings being reduced of 137 children with an EBLL in 2009.

Special Education

EBLL children with learning and behavioral problems are often in need of special education. Schwartz et al estimated that 20 percent of children with an EBLL above 25 µg/dL need special education, such as assistance from a reading teacher, psychologist or other specialist, for an average of three years.[7] During 2009, there were 15 children in Oklahoma with EBLL above 25 µg/dL. Korfmacher estimated that the average annual cost of special

education was $12,833 (in 1998 USD).[8] Inflating this amount to 2009 USD ($16,891), it can be estimated that average cost of special education for three years will be $50,673 per child or $152,019 for three children (20 percent of 15 EBLL children) with an EBLL in 2009.

Juvenile Offences

Studies have suggested that lead poisoning may result in delinquent behavior and future violent crimes.[9] [10] Korfmacher estimated that 10 percent of juvenile delinquency may be attributed to lead poisoning.[8] The U.S. Office of Juvenile Justice and Delinquency Prevention (OJJDP) estimates that the annual cost of incarcerating a youth is $34,000.[11] According to the Oklahoma Office of Juvenile Affairs, there were 641 violent juvenile offenders placed in custody or on probation during fiscal year 2008. Using the OJJDP estimates, the assumption can be made that the cost of violent juvenile offences attributable to lead poisoning in Oklahoma could be approximately $2,176,000 in 2009.

Summary

Based on the above conservative estimates, childhood lead poisoning in Oklahoma during 2009 alone could have cost the state and taxpayers approximately $13.3 million in direct health care, special education, and juvenile delinquency costs as well as total lifetime earnings loss.

It is important to note that the state data are collected on convenience samples and not representative samples and, therefore, are likely to underestimate the true incidence of childhood lead poisoning and the direct healthcare costs associated with it. Long-term healthcare costs associated with possible adverse effects on nervous, cardiovascular, and renal systems attributable to EBLLs have not been calculated here. Additionally, recent research shows adverse health effects of childhood lead poisoning at much lower levels. As a result, children with levels below 25 µg/dl may also need special education, therefore increasing the cost of special education attributable to lead poisoning. Last, cost of non-violent juvenile offences presumably due to lead poisoning has not been calculated here.

Given the high cost of childhood lead poisoning, measures such as investing in making high risk homes lead safe by reducing lead hazards and periodic monitoring of blood lead levels of children living in these homes appear to be significantly cost beneficial. ❑

Fahad F. Khan
Oklahoma State Department of Health

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The Whittington Lounge

On May 11, as part of the celebration of National Hospital Week, Deaconess Hospital named the physicians' lounge the Ken Whittington, MD Physicians' Lounge in recognition of his dedication to the hospital and medical staff. His family, friends and many physicians gathered early in the morning to surprise him as he was brought into the lounge completely unaware of what was taking place. His first comment, "Did I die?," was a "Whittington" comment and brought a roar of laughter. A breakfast reception followed with many physicians and friends coming by to give their congratulations. ❑

Oklahoma City-County Health Department
Epidemiology Program
Communicable Disease Surveillance

COMMONLY REPORTED DISEASES	*Monthly*			*YTD Totals^*	
	July'10	July'09	June'10	July'10	July'09
Campylobacter infection	14	11	27	41	50
Chlamydial infection	N/A	N/A	N/A	N/A	N/A
Cryptosporidiosis	5	0	7	12	9
E. coli 0157:H7	2	3	3	5	5
Ehrlichiosis	0	0	1	1	4
Giardiasis	1	7	11	12	26
Gonorrhea	N/A	N/A	N/A	N/A	N/A
Haemophilus influenzae Type B	0	0	0	0	0
Haemophilus influenzae Invasive	1	1	19	20	10
Hepatitis A	0	0	2	2	4
Hepatitis B*	15	18	86	101	108
Hepatitis C *	21	21	96	117	170
HIV Infection	N/A	N/A	N/A	N/A	N/A
Lyme disease	0	0	5	5	4
Malaria	0	0	1	1	0
Measles	0	0	0	0	0
Mumps	0	0	0	0	1
Neisseria Meningitis	0	0	2	2	1
Pertussis	9	1	10	19	13
Pneumococcal infection Invasive	0	1	8	8	12
Rocky Mtn. Spotted Fever (RMSF)	1	6	8	9	23
Salmonellosis	14	13	47	61	64
Syphilis (primary/secondary	N/A	N/A	N/A	N/A	N/A
Shigellosis	2	23	47	49	87
Tuberculosis ATS Class II (+PPD only)	57	64	310	367	519
Tuberculosis ATS Class III (new	0	0	14	14	8
Tularemia	0	0	2	2	0
Typhoid fever	1	0	0	1	1
RARELY REPORTED DISEASES/Conditions:					
West Nile Virus Disease	0	1	0	0	2
Pediatric Influenza Death	0	0	0	0	1
Influenza, Hospitalization or Death	1	0	12	13	0
Influenza, Novel Virus	0	1	0	0	47
Strep A Invasive	2	2	16	18	26
Legionella	1	1	1	2	1
Rubella	0	0	2	2	0
Listeriosis	0	0	1	1	0
Dengue fever	1	0	0	1	0

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

^ *YTD - Year To Date Totals* **STDs/HIV - *Not available from the OSDH, HIV/STD Division***

CME Information

For information concerning CME offerings, please refer to the following list of organizations:

Community-based Primary Health Care CME Program
Sponsored by Central Oklahoma Integrated Network Systems, Inc. (COINS)
Contact: Deborah Ferguson
Telephone: (405) 524-8100 ext 103

Deaconess Hospital
Contact: Yvonne Curtright
CME Coordinator
Telephone: 604-4979

Deaconess Hospital
Tuesday CME Program
Contact: Denise Menefee
Medical Library
Telephone: 604-4524

Integris Baptist Medical Center
Contact: Marilyn Fick
Medical Education
Office
Telephone: 949-3284

Integris Southwest Medical Center
Contact: Marilyn Fick
CME Coordinator
Telephone: 949-3284

Mercy Health Center
Contact: Debbie Stanila
CME Coordinator
Telephone: 752-3806

Midwest Regional Medical Center
Contact: Carolyn Hill
Medical Staff Services
Coordinator
Telephone: 610-8011

Oklahoma Academy of Family Physicians Choice CME Program
Contact: Sue Hinrichs
Director of
Communications
Telephone: 842-0484
E-Mail: hinrichs@okafp.org
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