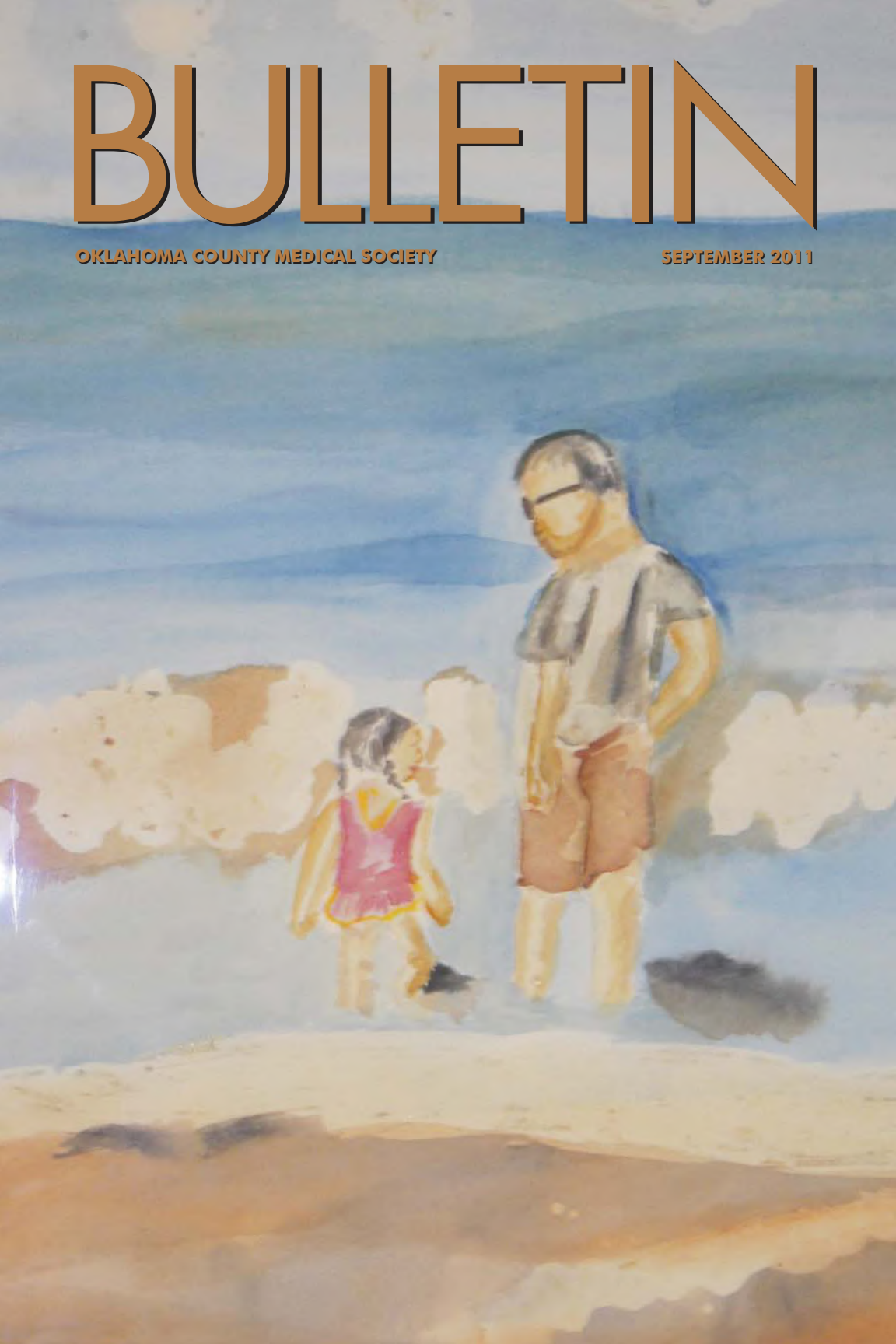
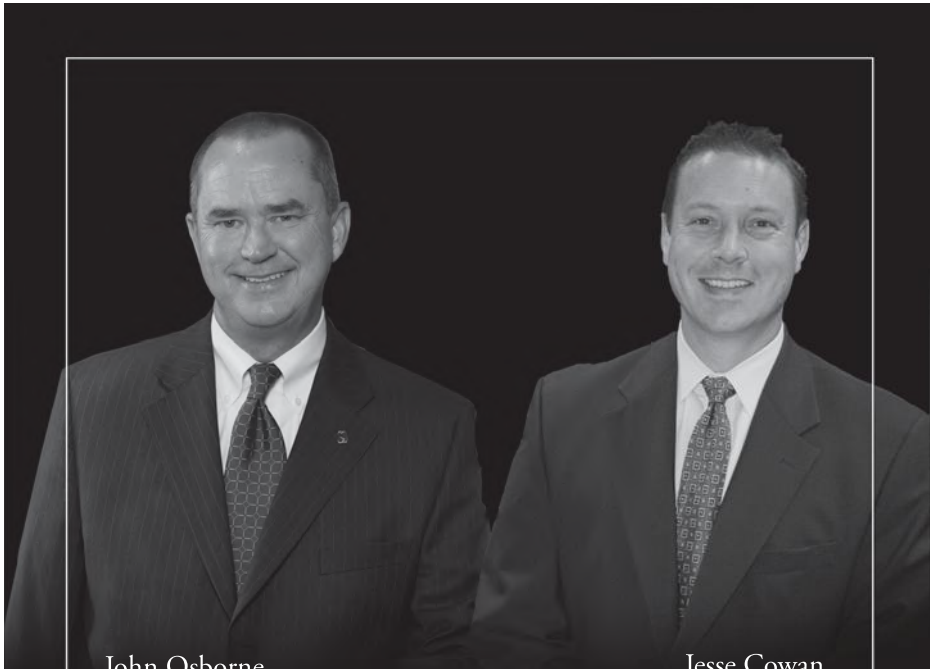
BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY

SEPTEMBER 2011





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The Oklahoma County Medical Society

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About the Cover

The watercolor on the cover of the Bulletin this month was painted by Dr. Anu Bajaj, of her father and niece at the beach. The title is "Generation Gap." Dr. Bajaj has been painting since high school and has taken art classes "to achieve balance" in her career. She is the author of a new feature called "Young Physicians," a column to be written by young physicians. ❑

In Memoriam

Thomas Haskell Fraley, Jr., MD
1935 - 2011

Tell Us What You Think

The Editorial Board regularly evaluates the Bulletin with an eye toward improving it and "giving the members what they want." To help us better understand how to accomplish that, they need to hear from you.

Please take a minute to tell us – email llarason@o-c-m-s.org, fax 702-0501 or phone 702-0500 and ask for Linda. We'd like to know:

- What do you like about the Bulletin?
- What do you *not* like about the Bulletin?
- What would you like for us to include in the Bulletin?

And remember, we encourage members to submit articles or poems for consideration for publication as well as art work for the cover. If we don't have room to use it immediately, we will hold it for a later issue. ❑

OCMS Medical Student Scholarship Fund

The Oklahoma County Medical Society has a proud history of supporting not only its members but the larger community, as well. It was our members who led the development of the Oklahoma Blood Institute, Hospice of Oklahoma County, AMCARE which became EMSA, Schools for Health Lifestyles, Open Arms Clinic for uninsured patients, and most recently the Health Alliance for the Uninsured. Since the mid-1960s, your OCMS Community Foundation has financially supported select health-related community organizations.

Our members have touched far more lives in Oklahoma County than simply their patients. Now, it's time to nurture our profession, to support the next generation of physicians who will care for patients in our community.

Trustees of the OCMS Community Foundation have approved designating the first $10,000 of 2011 contributions to create a medical student scholarship fund. The scholarship will be awarded to a third- or fourth-year student with ties to Oklahoma County. With debt of nearly $140,000, on average, upon graduation, a scholarship from OCMS – a gift from the physicians of this Society – would be very much appreciated.

Please give generously, once again. Contributions should be addressed to the OCMS Community Foundation, Suite 2, 313 NE 50th Street, Oklahoma City, OK 73105. ❑

Robert N. Cooke, MD

A Meeting You Won't Want to Miss

The OCMS Annual Membership Meeting will feature long time member Jerry Vannatta, MD and will include the election of OCMS Officers who will serve you in 2012. Dr. Vannatta will present "The Art of Living and Dying."

The meeting will be at 313 NE 50th Street. The reception will begin at 6:00 p.m. with dinner following at 6:30 p.m. and the program at 7:00 p.m.

Please join us! ❑

President's Page

Robert N. Cooke, MD

Help Meet the Need

I hope everyone had a great summer and you are ready for college football! I was on vacation this summer and realized how nice it was to get away and "recharge my battery." I had lots of time to read books and information about the island we visited. My wife commented about the medical facilities that were available. The establishments were listed along with a statement that you could not be treated unless you have proof of health insurance. It made me wonder what one would do if they were in that situation and needed medical care. That snapped me back into reality. Of course no one can be denied medical care in the emergency rooms in the United States. Our health care system is insurance based but there are a number of people in this country that aren't covered. Although I understand our model is not perfect, at least patients can be seen in our ERs if needed.

What about those who need wellness and preventive care? I know that most of the physicians in Oklahoma County accept and care for those who cannot pay part or any of their medical bills. Even though the expenses of operating clinic offices have skyrocketed and physicians' reimbursement has dropped dramatically, most still offer their care to our more unfortunate citizens. Of course, no one office or individual can provide all of this free care. We all need to pitch in and help.

I checked with Pam Cross, the Executive Director of the Health Alliance for the Uninsured, and learned some interesting facts. Did you know that Oklahoma County is ranked at or close to the top of counties in the United States for the number of free clinics offered? That's spectacular! Multiple organizations *including the OCMS* have been proactive in this regard.

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So, how do we help the 140,000-150,000 people who are uninsured in our state? A lot of you already are, by accepting patients from the Open Arms Clinic. Many of you know about Variety Care which accepts and cares for these patients, also. The Health Alliance for the Uninsured is active and has had grants to help pay for diagnostic testing as well as provide prescription medications to patients.

I was shocked to hear that the Alliance only has 30 physicians signed up to help. I must admit I wasn't one of them. I'm not sure I remember a "drive" to sign up physicians. So … here goes. You'll find my name on the list as of July. I know that Oklahoma County physicians are caring and professional. I think we all realize you can't care for just the unfortunate and still run your offices and businesses. But can you do one a week or one a month? Just think – if all 1,000 plus physicians could do this, what a difference we could make in the lives of our fellow citizens. An added incentive is that you are provided with immunity from lawsuits (there are a few exceptions under grievous circumstances). This protection was provided by the Volunteer Professional Provider Service Immunity Act passed by the Oklahoma legislature.

Oklahoma County physicians are excellent, caring doctors. Your care for those in need has been impressive. ***Let's now take the next step and support the Health Alliance and free clinics in the county***. Those unfortunate citizens who are in need will be grateful and, who knows, sometimes they may pass on to others an act of kindness that you provided to them. What could be better for our society? The OCMS can help you sign up. Just call the office (702-0500) or check our website (www.o-c-m-s.org) for details. *THANKS*! ❑

Errata

Our apologies to Dr. William F. Parry, who wrote the memorial column about Dr. Donald Albers that was published in the June issue of the Bulletin. His name was inadvertently deleted from the article. His insights and long friendship with Dr. Albers were clearly evident in his tribute. ❑

Nursing Home

Hanna Saadah, MD

Yes, she was old
The crowded years around her eyes
Stood still and cold
And I do not forget her melancholy face
Forever gazing in that little space
Like an ancient moon
Like the aimless shadow or a wasted afternoon
So pale and frail, and waiting.

Good years
Good years forever gone
Good years consumed
What little time that lingers on
Is doomed
No depth, her pleasures mild and few
No dreams, no luster, nothing new
And every morning summons less of sunshine with it
Less who love and less who care and less who visit
Yet still, she's waiting.

Fatigue has come to dwell
Among the crowded years
Among the chilly loneliness and fears
And still she hears
The fading echoes of her soul
Resound against a hopeless void:
"I wait, I wait, I know not why?"
She waits to die
And still, she's waiting. ❑

Introducing New Feature

See page 9 for the new Young Physicians column – written *by* young OCMS members *for* young physicians. Authors, age 40 and under, will write about things they have learned since beginning their practices or things they wish someone had told them before they had to learn it the hard way. Authors have been selected for the next few issues, but we welcome volunteers and would love to hear from you! Authors select their topic; articles may range from 500 – 1,000 words and are due approximately five weeks prior to publication. ❑

Young Physicians

Anureet Bajaj, MD

Lately, I've been thinking about how my career has evolved – the lifecycle of a physician, if you will. Most of us began our careers as competitive individuals in college, progressed to medical school (where we were extremely competitive and vied to attain the best residencies), then proceeded to fellowship and, finally, our first jobs. Initially, we may have been involved in societies and volunteer activities, but as our careers matured, we may have had less time for outside activities.

A common theme across medical societies nationwide is how to recruit younger physicians and maintain their involvement in organized medicine – I spent a recent weekend at the quarterly board meeting of the American Society of Plastic Surgeons, and we hosted a Forum on the Future to discuss this specific topic. The Oklahoma County Medical Society is not immune to this concern. At our editorial meetings for the Bulletin, one discussion topic is how to engage the younger physicians and better meet their needs. This column is one step in that direction. We hope that by creating a column written for and by young physicians, we can learn from each other and address concerns that are unique to those of us in the early stages of our careers.

So back to the lifecycle … In medical school and residency, we are busy learning medicine and honing our medical skills; when we first start our practices, we are busy applying these skills to our own patients; then we try to learn how to manage our offices, employees, and finances – things that aren't taught in medical school. Finally, we try to refine and improve our skills – a process of lifelong learning. While in training, we have an abundance of opportunities to discuss these issues with one another – interesting patients, balancing work and family, taking boards. Once we start practicing, these opportunities become less frequent.

This column is for and written by young physicians. My hope is that over the next several months, each of you will volunteer to write. Writing can be intimidating, but the best articles are written when you have personal experience or a passion for a certain subject. The goal is to learn from one another and discuss issues that may not have been addressed in our training or to teach our colleagues from our own experiences – good and bad.

The topics can and should be varied. In our plastic surgery version, known as YPS Perspective (Young Plastic Surgeon Perspective), we have discussed how to start a practice, academic vs. private practice, social networking sites and your patients, red flag patients, how to speak with difficult patients, negotiating your first contract, hiring and firing employees, managing your office – the topics are endless. In the past, I have learned and applied numerous pointers from these articles – such as how to use Google alerts to monitor your web presence or how to incorporate new technology in your practice.

I hope something I've said today will resonate with you – I hope you will want to read this column and contribute. I believe this type of contribution is important – I don't do research; I don't teach residents or medical students; and I don't publish papers. Participating, at both the local and national level, has been my contribution for what others have done for me. By staying involved in our local, regional, and national societies, we can maintain this interaction with other physicians and get reinvigorated and excited about our jobs. ***And continue our process of learning from one another***. ❑

News from the AMA

The Affordable Care Act created a new program that provides a health coverage option for individuals who have been uninsured for at least six months, have a pre-existing condition, and have been denied coverage (or offered insurance without coverage of the pre-existing condition) by a private insurance company. This program will provide coverage until 2014 when such individuals will have access to affordable health insurance choices through an exchange, and can no longer be discriminated against based on a pre-existing condition.

The Department of Health and Human Services is trying to increase enrollment in this program by reducing premiums and easing application requirements. HHS announced on May 31 that an applicant for the Pre-existing Condition Insurance Plan will be able to qualify in part by submitting a letter from a physician, physician assistant or nurse practitioner stating that the patient has or has had a pre-existing medical condition, disability or illness. The department previously had required PCIP applicants to submit a letter of denial from a health plan before qualifying.

HHS also is lowering plan premiums by up to 40 percent in 18 states and notifying other states that they can enact similar premium reductions. The application and premium changes will take effect on July 1. Oklahoma is among those that can run its own programs.

Please share this information with your patients. ❑

Dean's Page

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

On June 30, 2011 the College of Medicine, the University of Oklahoma, and the State of Oklahoma held a wonderful dedication ceremony for the new and beautiful Peggy and Charles Stephenson Oklahoma Cancer Center located on the Health Sciences Center campus on the southeast corner of N.E. 10th and Philips Streets. The new Cancer Center has 210,000 sq ft of space on seven floors. The entrance has a beautiful "living room" atrium that is inviting and warm, and appointments, furnishings and the décor throughout contribute to a healing and compassionate environment. In addition to outstanding clinical space and advanced radiation therapy equipment, the new facility has physician offices, dedicated clinical research and clinical trials space, and room for expansion. The dedication was attended by University president David Boren and Mrs. Boren, University regents, College administration, cancer center officials, faculty physicians, students, residents, fellows, staff, patients, families, the press and media, and many distinguished guests including Peggy and Charles Stephenson. The speaker was Dr. Siddhartha Mukherjee, author of the Pulitzer Prize winning book *The Emperor of All Maladies: A Biography of Cancer* published in 2010. Dr. Mukherjee is a former Rhodes Scholar, and graduated from Stanford University, University of Oxford, and the Harvard Medical School. He is a faculty member in the Department of Medicine at Columbia University.

I wish to touch on some changes that occurred during the summer publishing hiatus of the *Bulletin*. After 17 years of dedicated and productive service as chairman of the Department of Urology, Dr. Daniel Culkin stepped down from his position

at the end of June to support bringing new leadership to the department. Bradley Kropp, MD, vice-chairman of the department and chief of the pediatric urology division, was appointed as interim chairman July 1. A national search is being conducted for Dr. Culkin's successor as chairman. Jon Brightbill was appointed as associate dean for executive affairs, having served the past 18 months as assistant dean for administration. Steve Blevins, MD, internal medicine faculty, was appointed on a part-time basis as assistant dean for curriculum development; he is doing some innovative things with the capstone experience that closes the last three months of the second year curriculum. In September, Pascale Lane, MD, pediatric nephrologist, joins our faculty and will spend one-third of her time as associate dean for faculty development having established successful programs in that area while at the University of Nebraska Medical Center.

Finally, on July 1, I took on the additional duties and responsibilities of Senior Vice President and Provost of the University of Oklahoma Health Sciences Center while continuing as executive dean of the College of Medicine. It is my privilege and honor to accept this request and dual appointment from President Boren and the OU Board of Regents during a particularly exciting time in the history of the development of the Health Sciences Center. We have much about which to be grateful and proud. We continue to attract highly qualified students and trainees. Their energy, idealism and excitement rejuvenate us annually as they arrive and begin their studies and programs. Our dedicated faculty and staff continue to excel in many ways, and our influence is felt broadly throughout the state and region. The creativity and industry of our faculty in scientific discovery, clinical research, and patient care are impressive. Our campus has become a destination with its concentration of health care education, clinical care, biomedical research, new and expanded facilities, and biomedical enterprise development zone. I am convinced that a strong and upwardly moving academic medical center has many positive effects for the city, the state and the region. I look forward to a bright future and appreciate your support. ❑

Krishna Community Service Award

No one has ever doubted the compassion that Dr. R. Murali Krishna has for the underserved. Since serving as President of Oklahoma County Medical Society in 2005, Dr. Krishna has been an unwavering voice for those in need of health care in Oklahoma County. By leading the Health Alliance for the Uninsured as Board President, and by his service on the Oklahoma State Board of Health, Dr. Krishna demonstrated a commitment to health and community that is unmatched.

As his responsibilities grew when elected to a leadership position on the Oklahoma State Board of Health, Dr. Krishna wanted to ensure that the Health Alliance would continue to grow and develop into a vital community-based organization. Dr. Krishna moved to the position of Founding President for the Health Alliance and was succeeded by Stanley F. Hupfeld. The Board of Directors for the Health Alliance wanted to recognize all that Dr. Krishna has given and the important role model he provides to medical students.

The Board initiated the R. Murali Krishna, MD Award for Community Service in collaboration with the OU College of Medicine and presented the first award on February 26 during the Bridges to Access conference, an event coordinated by the OU Community Health Alliance. Students, faculty and free clinic personnel nominated fourth-year students who exemplify tremendous compassion, dedication and skills. Michael Porter received over twenty nominations and was presented the beautiful award. Now Dr. Porter, he writes from his residency, "The Dr. Krishna Award is one of the most meaningful accolades I received in medical school. Dr. Krishna's commitment to community service and his initiative in changing our community for the better serves as a great encouragement to the idealist in me that applied to medical school hoping to be a part of those same things. His passion for improving healthcare to the underserved is contagious. As an emergency physician I work with this population and am faced with the barriers they have to care every day. Rather than losing hope over this very difficult situation I have gained a sense of duty to be an advocate and a problem solver

for these patients because of people like Dr. Krishna. Earning anything associated with his name is a tremendous honor and one that further inspires me to continue improving our community for everyone." ❑

Michael Porter, MD

Call for Nominations

Rhinehart Medical Service Award

Nominations are open for the seventh 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; and the reason(s) why that involvement or service is considered worthy of recognition. Nominations, not exceeding 650 words, are due by October 3, 2011. The recipient will be selected at the November Board of Directors meeting and the award will be presented at the Inaugural Dinner in January.

Nominations may be mailed to 313 N.E. 50th Street, Suite 2, Oklahoma City, OK 73105, faxed to 702-0501, or emailed to llarason@o-c-m-s.org. ❑

Letter to the Editor

Dear Editor:

Re: 39 week OHCA proposal

Well, it is already happening. I recently saw a drop-in patient at the Baptist L&D unit. She was having abdominal pain and presented to the unit because it was closer than the hospital where her physician practiced and had delivery privileges.

She was a 35 yo G5, P4,L2 with a history of having an abruption and stillbirths with her last 2 deliveries at 31 and 34 weeks. Although her physician suspected a clotting disorder, no work-up had been performed. As we were talking about her planned repeat C-section, she informed me that her physician wasn't planning to deliver the baby until 39 weeks because of the new Medicaid rules.

She and her husband were frantic because they wanted an earlier delivery because of her history of the stillbirths with the last 2 pregnancies. She understood that abruptions can occur without warning and as with her last 2 pregnancies, so suddenly that often there is no time to intervene before fetal death. She didn't care about the Cesarean Section Quality Initiative. She said that she would much rather have her baby in the NICU for a few days than have to bury another child.

I have a unique perspective on this issue because I have been a web consultant for the site BabyCenter.com as well as chairman of the Quality Assurance program at Baptist Hospital for over 20 years.

As a web doc, I have corresponded with and answered questions for over 40,000 women from all over the world. In the last 18 months, I have seen a disturbing increase in complaints of patients reporting that their physicians were not delivering them before 39 weeks because of the fear of Medicaid censure and/or refusal to pay for the delivery services.

For example, the patient with preeclampsia at 37 weeks who is told that she was not "sick enough" to be induced under the new Medicaid guidelines. She presents 5 days later with eclamptic seizures, abruption, and fetal distress, which resulted in an emergency C-section and a prolonged maternal hospitalization and NICU admission.

As the chair of Baptist Quality Assurance, I remember the days when I used to write physician letters about their higher than average C-section rates with the idea that we could reduce the C-section rate through peer pressure and education. Then, after 13 years, I was involved in my first malpractice lawsuit where I found that the medical legal system isn't about the truth or the facts of the case.

Are there questionable reasons for C-sections? Most definitely – yes. The reason is because, in 2011, the question physicians must now ask themselves is ***not***, are the mother and baby healthy enough to be safely delivered vaginally.

The question that obstetricians must now ask themselves is: can my management be defended in case of a poor fetal outcome?

When the Oklahoma Health Care Authority had the initial meetings, several of the obstetricians tried to explain what we felt was the main cause for the rising C-section rate. It was the ever-looming specter of being accused of medical malpractice for anything less than a perfect obstetrical outcome. I remember making the comment that if they could find a way to protect the physicians from malpractice lawsuits, they would see a decrease in the C-sections rates that they desired.

There was a long pause, with a generalized glazed look on the faces of the OHCA staff and then the response, "Let's stick to factors that we have control over. Well then, let's move on."

So, Phase 2 will be a panel of 6 physicians who will, retrospectively, judge the physician, after the fact, as to the medical necessity for the C-section. The end game, I predict, will be the implementation of a financial penalty as they have in Texas.

Texas Medicaid follows recommendations of the American Congress of Obstetricians and Gynecologists (ACOG) regarding elective inductions of labor. Effective for dates of service on or after May 2, 2011, Texas Medicaid will restrict any non-medically-indicated Cesarean section, labor induction, or any delivery following labor induction to the following additional criteria:

- Gestational age of the fetus should be determined to be at least 39 weeks or fetal lung maturity must be established before delivery.

- Maternal or fetal conditions, gestational age, cervical status, and other factors must indicate medical necessity when the delivery occurs prior to 39 weeks.
- Records will be subject to retrospective review. **Payments made for non-medically-indicated Cesarean section, labor induction, or any delivery following labor induction that fail to meet these criteria, will be subject to recoupment. Recoupment may apply to both physician services and hospital fees.**

So, where does that leave the practicing obstetrician?

On one side, if there is a bad fetal outcome, the malpractice lawyer will try to convince the jury that the baby would have been protected from harm "if only the doctor had performed a C-section." This will open up a completely new potential for medical malpractice lawsuits.

Plaintiffs Lawyer: "Doctor, were you under any financial incentive or financial penalty for not (performing a C-section, inducing before 39 weeks, etc)?"

On the other side, if a C-section is deemed non-medically-indicated, the OHCA has the potential to deny payment to the physician and hospital.

Physicians will be in the schizophrenic position of always being second-guessed by persons who were not at the patient's bedside when the decision for surgery was made.

If the patient I saw recently, once again, abrupts at 38 weeks and files a malpractice suit, will the OHCA and the panel of 6 physicians be named in the lawsuit? Of course not.

They will back pedal and claim that nothing they did interfered with the physician's decision making regarding the management of the mother who is now grieving the loss of her third child.

I predict that some clever lawyer will find some way to sue the OHCA using coercion laws. Coercion is defined as the act of trying to force an individual to act or think in a certain way by use of pressure, threats, or intimidation. I would contend that the Cesarean Section Quality Initiative, with its potential to deny payment for delivery services to a physician and hospital if a retrospect review deemed a C-section 'not-indicated,' is a form of coercion.

As I have said before, if the OHCA wants to decrease the C-section rate for its Medicaid population, all it has to do is find some way of protecting the delivering physician from the medical liability. Do that and the C-section rates will drop of its own accord. Otherwise, the Cesarean Section Quality Initiative is just another way of throwing physicians to the lions.

Dr. Larry Kincheloe

New AMA Resources

▪Annotated Model Physician-Hospital Employment Agreement developed by AMA's general counsel and Organized Medical Staff Section, no cost to members online, nonmembers purchase through AMA bookstore for $149.

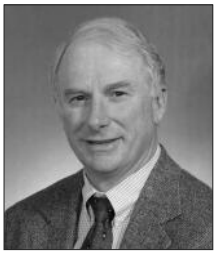
http://www.ama-assn.org/go/employmentagreement

▪AMA Coding Online, authoritative coding and compliance resources and updates to latest coding, billing and compliance changes.

https://commerce.ama-assn.org/store/

Pearl of the Month

Iri Brabec, MD, PhD



James R. Couch, MD, PhD

Spontaneous Intracranial Hypotension
A Headache to Keep in Mind

A 44 year old elementary school teacher with a prior history of only rare mild tension headache was sitting in a conference and had sudden onset of a severe holocranial headache with nausea, vomiting and mild photophobia and phonophobia. She remained at the conference for two more hours and then drove home and went to bed. By the next morning, the headache was only modestly improved and became severe when she got out of bed. She was seen at a local emergency room and received an unknown treatment. Over the next 6 weeks, she continued to have a headache that would reach 7-8/10 when up and about and would decline to 2-3/10 when lying down. She was seen by a neurologist and treated with various medications including combination analgesics, hydrocodone, oxycodone and caffeine. These produced essentially no change in the headache. Preventive antimigraine agents were tried without success. Work-up included an EEG and MRI scans of head and spine which were reported to be "normal." A radionuclide cisternogram was attempted but failed.

She was seen in our hospital two months after onset. Neurological examination was normal. An MRI scan of the head with contrast showed pachymeningeal uptake of contrast suggesting intracranial hypotension (IH). Cerebrospinal fluid examination revealed a protein of 129 mg/dL, glucose of 50 mg/dL, 3 WBC, and 8 RBC, but cultures showed no growth. The elevated CSF protein value was thought to be a result of mild chronic, sterile inflammation related to the CSF leak.

She received an epidural blood patch of 40 cc volume with good resolution of the headache within 24 hours. She has had no recurrence of the headache at 6 month follow-up.

Spontaneous intracranial hypotension (SIH) is a recognized clinical entity, with orthostatic headache being the most prominent clinical symptom. Although originally described in 1938 by Georg Schaltenbrand, its diagnosis was markedly improved by MRI imaging.

The cause of SIH is leak of cerebrospinal fluid through a defect in arachnoid membrane. This may occur spontaneously or may relate to minor trauma such as coughing, straining, or neck extension. Up to one-third of the patients may have an underlying connective tissue disorder such as Marfan syndrome, Ehlers-Danlos syndrome, etc., or bone disease predisposing to such defects.

The leak of CSF impairs intracranial hydrodynamics through lack of the CSF volume and thus decreased intracranial pressure. This leads to decreased buoyancy of the brain which then "sags" towards the foramen magnum. Various clinical symptoms may arise due to compensations for a missing CSF volume by engorgement of intracranial vasculature, and also by mechanical traction upon arachnoid trabeculae and bridging veins and even subdural hematoma. As it sags downwards to posterior fossa and foramen mangnum when the patient is erect, this descent of the brain may cause compression of the brainstem and descent of cerebellar tonsils below foramen magnum with compression of the medulla.

The most typical feature of intracranial hypotension is a headache that is usually diffuse in location, dull or pressure-like. The headache is markedly relieved by lying down for >5-15 minutes and is usually exacerbated within 15 minutes of sitting or standing from a recumbent position. The headache is thought to be caused by downward displacement of the brain and resulting traction on the richly inervated dura. According to International Classification of Headaches, the headache must be accompanied with at least one of the following: 1. neck stiffness, 2. tinnitus, 3. hypoacusis, 4. photophobia, 5. nausea. The headache can differ from person to person, and sometimes requires several days to develop the "postural headache" pattern noted above. There are also documented cases of SIH without accompanying headache. The correct diagnosis, as well as use of appropriate treatment, can thus be delayed. Less common symptoms include vertigo, balance disturbance, blurred vision or visual field deficits, diplopia, facial pain or numbness, facial weakness or spasm, and dysgeusia, also attributed to cranial nerve distortion or compression of pons or medulla caused by downward displacement of the brain. In the

most severe cases, brainstem compression and tonsillar herniation can present as stupor, coma and be cause of death.

MRI of the brain with gadolinium contrast should be obtained unless contraindicated in all patients with suspected SIH. The hallmark of the intracranial hypotension is intracranial pachymeningeal thickening and post contrast enhancement. Other variable findings, depending on severity, are subdural fluid collections (subdural hygroma or hematoma), pituitary hyperemia, narrowing of prepontine space or flattening of the pons or tonsillar descent at the forament magnum or tentorial herniation.

If the MRI is contraindicated, other diagnostic tools are focused on visualization of CSF leak (conventional myelogram, CT or MR myelogram) or impaired circulation of the CSF (radionuclide cisternography).

Treatment options can be divided into three main categories: 1. conservative management, 2. epidural blood patch, and 3. surgery.

As some cases can resolve spontaneously, the conservative management, consisting of bed rest and hydration to treat symptoms, might be suitable for mild and uncomplicated cases. Caffeine in high doses may help here. The epidural blood patch is performed by administration of autologous blood into the epidural space, usually at a lumbar level. There exist a multiple variation in technique, but usually 5-30 mL of blood and fibrin glue is used. The expected mechanism of action is that epidural blood patch produces dural tamponade.

The epidural blood patch may need to be repeated one to several times in order to achieve sealing of the defect.

Large or persistent defects may need surgical treatment. This choice is largely dependent on skill of the surgeon and the type of the defect.

As in every condition, the early recognition of the disease is important in prevention of late complications and usually results in better therapeutic outcomes. As noted in the case above, the condition may not present with typical set of symptoms – i.e. the headache does not resolve completely with recumbency. Confusion with migraine or chronic headache is thus very easy. Nevertheless, with correct diagnosis, the use of epidural blood patch use can be very effective with only small amount of recurrence (<10%). ❑

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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. Larry Bookman, Chair; Teresa Shavney, Vice Chair; Stephen Archer; Douglas Folger; and Elizabeth A. Wickersham.

POSITION I

Todd M. Kliewer, MD

Medical Degree:	University of Oklahoma College of Medicine, Oklahoma City, OK, 1994
Internship:	University of Oklahoma Health Sciences Center, Oklahoma City, OK, 1994-1995
Residency:	University of Oklahoma Health Sciences Center, Oklahoma City, OK, 1995-1997
Fellowship:	Oklahoma University Health Sciences Center, 1997-1999
Specialty:	Internal Medicine/Medical Oncology
Date of Oklahoma License:	1979

Donald L. Wilber, MD

Medical Degree:	University of Oklahoma College of Medicine, Oklahoma City, OK 1978
Internship:	Oklahoma Children's Memorial Hospital, Oklahoma City, OK, 1978-1979
Residency:	Oklahoma Children's Memorial Hospital, Oklahoma City, 1979-1981
Specialty:	Pediatrics
Date of Oklahoma License:	1979

POSITION II

James A. Totoro, MD

Medical Degree:	University of Oklahoma College of Medicine, Oklahoma City, OK, 1975
Internship:	University of Oklahoma Health Sciences Center, Oklahoma City, OK, 1975-1976
Residency:	University of Oklahoma Health Sciences Center, Oklahoma City, OK, 1976-1980
Specialty:	Surgery
Date of Oklahoma License:	1976

Paul J. Kanaly, MD

Medical Degree:	University of Oklahoma College of Medicine, 1974
Internship:	University of Oklahoma Health Sciences Center, Oklahoma City, OK, 1974-1975
Residency:	University of Oklahoma Health Sciences Center, Oklahoma City, OK, 1975-1981
Specialty:	Thoracic Surgery
Date of Oklahoma License:	1974

POSITION III

David C. Teague, MD

Medical Degree:	University of Texas-Southwestern, Dallas, TX, 1988
Residency:	University of Oklahoma Health Sciences Center, Oklahoma City, OK, 1989-1993
Fellowship:	University of Washington, Harborview, Seattle, WA, 1993-1994
Specialty:	Orthopedic Surgery/Trauma
Date of Oklahoma License:	1988

Mikio A. Nihira, MD

Medical Degree:	UCLA School of Medicine, Los Angeles, CA, 1992-1994
Internship:	UCLA Department of Obstetrics-Gynecology, Los Angeles, CA, 1994-1995
Residency:	UCLA Department of Obstetrics-Gynecology, Los Angeles, CA, 1995-1998
Fellowship:	Greater Baltimore Medical Center, Baltimore, MD, 1998-2001
Specialty:	Obstetrics-Gynecology/Female Pelvic Medicine/Reconstructive Surgery
Date of Oklahoma License:	2006

POSITION IV

Anureet K. Bajaj, MD

Medical Degree:	University of Pittsburgh School of Medicine, Pittsburgh, PA, 1996
Residency:	Loma Linda University, Loma Linda, CA, 1997-2003
Fellowship:	University of Texas M.D. Anderson Cancer Center, Houston, TX, 2003-2004
Specialty:	Plastic Surgery
Date of Oklahoma License:	2003

Gary D. Riggs, MD

Medical Degree:	University of Oklahoma College of Medicine, Oklahoma City, OK, 1997
Internship:	University of Oklahoma Health Sciences Center, Oklahoma City, OK, 1997-1998
Residency:	University of Oklahoma Health Sciences Center, Oklahoma City, OK, 1998-2000
Specialty:	Internal Medicine
Date of Oklahoma License:	2005

Questioning of Physician by Government Agent

S. Sandy Sanbar, MD, PhD, JD

Physicians should consult with legal counsel before making statements to an investigator that involve the substance of the physicians' prescribing of controlled medications.

Most federal and state agents or investigators operate professionally, ethically and legally within the boundaries of their agency's authority. A few agents, however, exhibit behaviors that require an attorney's involvement and ultimately a referral to internal affairs or office of professional responsibility.

When agents drop by a medical office without notice, it is usually because they are investigating a patient, the physician, or both. Agents should:

- Identify themselves;
- Display their credentials;
- Provide a succinct summary of their intentions;
- Explain the purpose of the requested meeting;
- Properly give the physician the opportunity to fit a meeting with them into his/her schedule and minimize the potential of embarrassment; and
- Minimize interference with the medical practice.

It is important to cooperate with government agents when they are seeking information that relates to a patient or other person the physician reported. If the agent is from the licensing board, the physician is required to cooperate and provide copies of requested records and other paperwork relating to the medical or healthcare license.

Physicians must be alert to the pairing of agents who have different levels of authority – such as an administrative agent with a law enforcement agent. The potential for unethical and unprofessional conduct in the pairing of agents is quite significant, and the physician should consult a lawyer. When licensing board agents pair up with law enforcement agents, they often do so because of health care fraud task force or drug task force operations within a region.

The physician can request a lawyer at any time for any reason. When an agent requests an interview, plays coy and gives a global response such as "we just want to talk with you about your prescribing practices," this should be a warning to the physician to seek legal help. Some agents intentionally mischaracterize their intentions and attempt to get a practitioner to talk with them. They use phrases like "this is just an informal interview of the doctor and his/her prescribing practices." Nothing is informal when agents from agencies with both administrative and law enforcement authority are sitting across from a physician wanting to talk with him/her about the details of the controlled substance prescribing practices and operation of the medical practice overall.

There are avenues to report agent misconduct. When agents act unethically and unprofessionally, the physician should consult an attorney and preserve his/her legal standing and legal rights. The attorney can find out whether the physician is a target of a formal investigation, and can try to find out whether a grand jury is actively hearing the case. The attorney can protect the physician's rights, and can serve as a scribe who takes down your statements during the meeting and memorialize them in a letter back to the agents. Working with an attorney does not make the physician look "guilty." Agents are used to dealing with attorneys, and can actually result in progress and ultimately, through appropriate channels, reassurance from the lawyers who direct the agents' investigations.

The physician who forgoes expert legal counsel may end up waiving important legal rights and may incriminate himself or herself. The outcome often relates to the reason the agent approached the physician. An attorney can ask questions and insist on boundaries much more effectively than the physician can. Attorneys do these things objectively, and the agents cannot use what the attorney says against the physician. ❑

I am still determined to be cheerful and happy, in whatever situation I may be; for I have also learned from experience that the greater part of our happiness or misery depends upon our dispositions, and not upon our circumstances.

Martha Washington (1732 - 1802)

Director's

DIALOGUE

And when it rains on your parade, look up rather than down.
Without the rain, there would be no rainbow.

Gilbert K. Chesterton, English author

Believe it or not, I saw a rainbow one late-July morning. Since my area had just a brief shower, I blinked twice to be sure I was not seeing things. Rainbows have been a symbol of hope for me since I was a young child. With this long, hot summer nearing an end, I look forward to beautiful warm autumn days when nights turn crisp enough for a sweater and forecasts of 107 are but a memory!

The American Association of Medical Society Executives annual conference was in Boston in July. I always look forward to this meeting as an energizing force. Attendees hear about best practices, participate in panel discussions about current events shaping our profession, discuss legislative issues and share concerns about the future of organized medicine. This year, many sessions focused on reimbursements, technology and membership numbers. Fortunately, AAMSE included some professional development presentations about "how to recharge your battery." Believe me, at the conclusion of this conference, a lot of batteries needed to be recharged...mine included.

There is always a hot topic. This year's was attracting young physicians to membership in organized medicine. No one had the magic bullet to communicate the value of medical association membership to young physicians. With a generation of cultural differences, this group is either concerned that involvement will interfere with family life or do not grasp the value of joining with other physicians to create a powerful voice for themselves. How do we engage the next generation of leadership with young physicians' increasing belief that large decision-making bodies are irrelevant? Some suggestions included increasing the use of social media, young physician get-togethers, communicating via new technology and the formation of a young physician section.

In an effort to increase membership, many medical societies are expanding their membership bases to include other health professionals such as physicians' assistants and medical group managers. While it can be argued that these two professions are intertwined with physicians, a recent announcement by the American Hospital Association took us all by surprise. It has created a membership category for physicians...for those doctors whose practices are owned by hospitals. Think for a moment about the possibility of this further fracturing the ***one*** voice physicians so desperately need in the current environment.

In the midst of these challenges, I smiled inwardly when remembering that the Oklahoma County Medical Society is doing many of the things suggested as ways to encourage young physicians: creating the Leadership Academy, adding residents and medical students to the board, hosting events for young physicians at attractive venues, and steering away from large quarterly membership meetings in exchange for smaller focus groups. We can't go about business as usual anymore but need to devise new strategies for the future. My hope is to begin conducting listening sessions with small groups of physicians to determine what they really want from "their" organization. Dr. Bookman said something recently that I will not soon forget: "Young physicians want stability." The Oklahoma County Medical Society should begin to ***ask*** younger physicians what they want from us that they cannot get elsewhere...and do it often. By hearing what they need and acting on it, we will remain relevant and valuable.

I ask all Oklahoma County Medical Society members to thank the OCMS board for their commitment and leadership during a time when the future of medicine is unsettled. Following our board retreat last November, the facilitator told me he had never seen a more cohesive group of leaders who were focused on what was best for the organization and not their personal agendas.

As unsettling as things are right now, thinking of future opportunities is exciting. Remember, when it begins to rain again, always look up...you never know when there will be a rainbow! ❑

JanaTimberlake, CAE, Executive Director

What is the OCMS Alliance? We are an organization consisting of a diverse group of physician spouses and physicians dedicated to enriching our community through awareness and education about health and wellness, assisting other non-profit organizations that meet a health-related need within Oklahoma County, partnering with physicians to advocate positive legislative changes on behalf of the medical profession, and building a dynamic network for communication and support among our local community of physician families.

If you value the mission of the Alliance, there is a place for you to be involved. Membership in the Alliance, from medical school and residency through the busiest career years and into retirement, provides members a lifetime of networking with those who have shared similar experiences.

Best of all, our members share purpose-driven fun together as we "give back" to the community in which we have all chosen to live, raise our families and meet the challenges of our careers.

Discover more about the Alliance. Go to our website, ocmsalliance.org and look at our calendar of upcoming events. Browse through the latest photographs of our members at the recent Walk the Doc event at Lake Hefner and the Spring Member Luncheon at the Symphony Show House.

Befriend us on Facebook at OCMS Alliance, and please let us hear from you! Email us at ocmsalliance@gmail.com, and tell us what is most meaningful to you about our mission, and allow us the privilege of connecting you to like-minded members and activities that you will enjoy. ❑

Donna Parker and Kathy Bookman, Co-Presidents

Sow good services; sweet remembrances will grow them.
Madame de Stael (1766 - 1817)

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 System, Inc. (COINS)
Contact: Deborah Ferguson
Telephone: (405) 524-8100 ext. 103

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

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
Website: www.okafp.org

OUHSC-Irwin H. Brown Office of Continuing Professional Development
Contact: Susie Dealy or
Myrna Rae Page
Telephone: 271-2350
Check the homepage for the latest CME offerings:
http://cme.ouhsc.edu

St. Anthony Hospital
Contact: Lisa Hutts
CME Coordinator
Telephone: 272-6358

Orthopaedic & Reconstruction Research Foundation
Contact: Kristi Kenney
CME Program Director
or Tiffany Sullivan
Executive Director
Telephone: 631-2601

Oklahoma City-County Health Department
Epidemiology Program
Communicable Disease Surveillance

COMMONLY REPORTED DISEASES	*Monthly*			*YTD Totals^*	
	July'11	June'10	June'11	July'11	June'10
Campylobacter infection	7	14	6	38	41
Chlamydial infection	N/A	N/A	N/A	N/A	N/A
Cryptosporidiosis	3	5	6	14	12
E. coli 0157:H7	4	2	2	7	5
Ehrlichiosis	0	0	0	0	1
Giardiasis	0	1	0	1	12
Gonorrhea	N/A	N/A	N/A	N/A	N/A
Haemophilus influenzae Type B	0	0	0	0	0
Haemophilus influenzae Invasive	0	1	1	8	20
Hepatitis A	0	0	0	1	2
Hepatitis B*	17	15	26	88	101
Hepatitis C *	21	21	21	108	117
HIV Infection	N/A	N/A	N/A	N/A	N/A
Lyme disease	2	0	0	2	5
Malaria	0	0	0	0	1
Measles	0	0	0	0	0
Mumps	0	0	0	1	0
Neisseria Meningitis	0	0	0	1	2
Pertussis	1	9	5	17	19
Pneumococcal infection Invasive	0	0	0	3	8
Rocky Mtn. Spotted Fever (RMSF)	20	1	16	56	9
Salmonellosis	14	14	14	56	61
Syphilis (primary/secondary	N/A	N/A	N/A	N/A	N/A
Shigellosis	1	2	0	18	49
Tuberculosis ATS Class II (+PPD only)	56	57	38	304	367
Tuberculosis ATS Class III (new active cases)	3	0	5	18	14
Tularemia	1	0	0	1	2
Typhoid fever	0	1	0	1	1
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	1	0	237	13
Influenza, Novel Virus	0	0	0	0	0
Strep A Invasive	0	2	0	2	18
Legionella	1	1	2	3	2
Rubella	0	0	0	1	2
Listeriosis	0	0	0	0	1
Yersinia (not plague)	0	0	0	0	0
Dengue fever	0	1	0	0	1

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

^ *YTD - Year To Date Totals*

STDs/HIV - *Not available from the OSDH, HIV/STD Division*

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