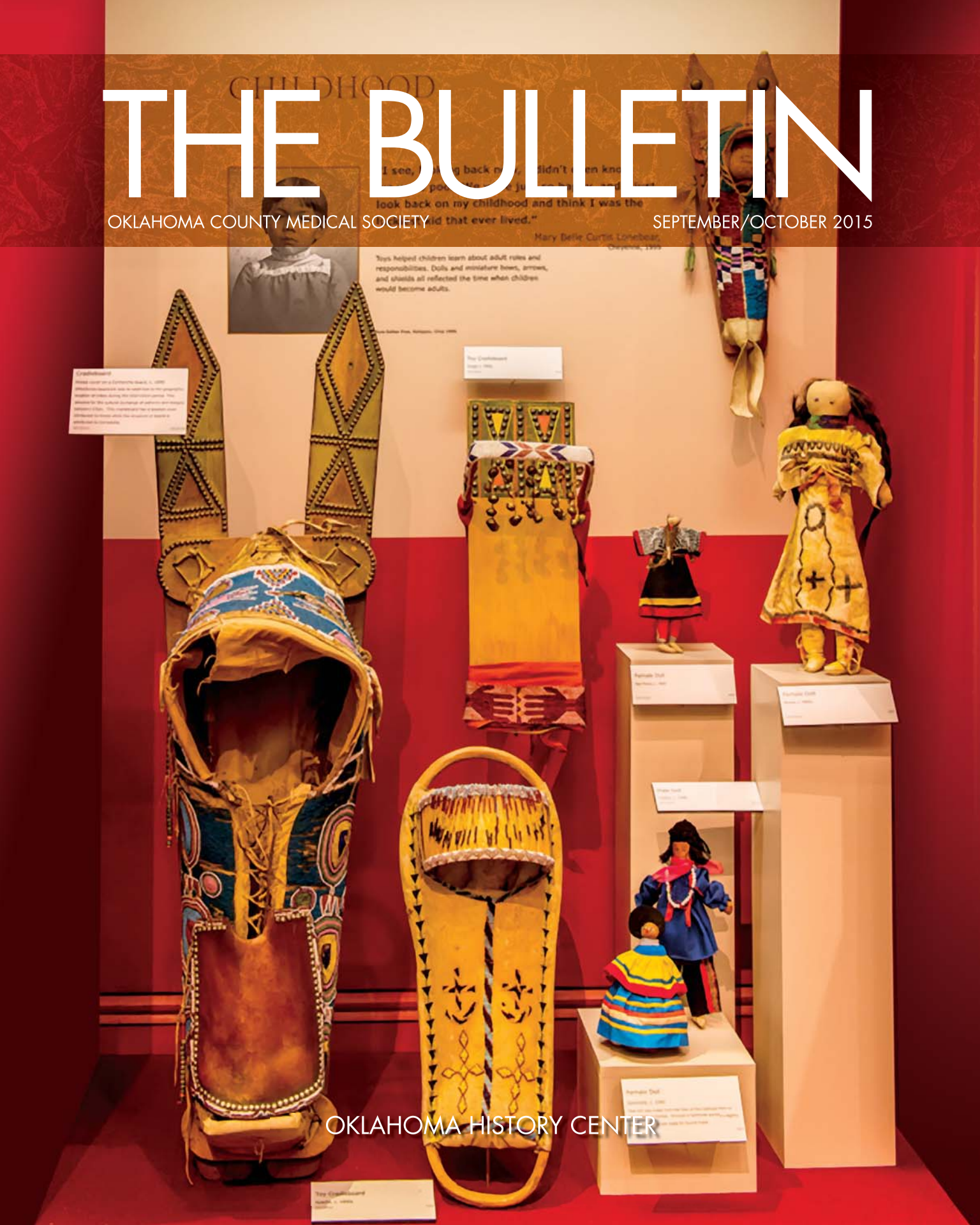
THE BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY SEPTEMBER/OCTOBER 2015



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Laura Nunnery
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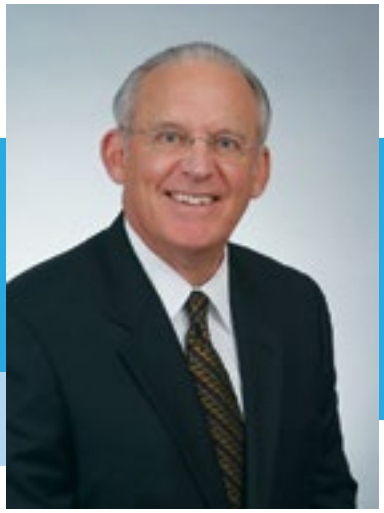
ABOUT THE COVER

Pictured on the cover is an exhibit case with cradleboards and dolls from the Oklahoma History Center's "We Are Who We Were" ONEOK American Indian Gallery. The Oklahoma History Center, located in Oklahoma City, is the only facility in the United States that is American Alliance of Museums accredited and affiliated with both the Smithsonian Institution and the National Archives. The Oklahoma History Center is a division of the Oklahoma Historical Society (OHS), and one of more than 30 OHS museums and sites across the state. The OHS mission to collect, preserve and share Oklahoma's history is made possible by its membership. The benefits of membership include free admission to all OHS sites and museums, subscriptions to The Chronicles of Oklahoma quarterly journal and Mistletoe Leaves monthly newsletter, and special programs, concerts and educational events. More information is available at www.okhistory.org and by calling 405-522-0317.

OCMS
OKLAHOMA COUNTY MEDICAL SOCIETY

PRESIDENT'S PAGE



By C. Douglas Folger, MD

As I would guess many of you were, I was quite surprised when I heard the news that PLICO is being sold to the MedPro Group, which is a division of well-known Berkshire Hathaway. I know that PLICO, which is owned by the OSMA, has been a very successful business operation for the past several years. I began wondering about the circumstances underlying the decision by the OSMA and PLICO boards to pursue the sale. Then in early July, an information-rich letter from OSMA President, Dr. Woody Jenkins, on the behalf of the OSMA, was sent to OSMA members nicely explaining the business case for selling PLICO at this particular time. The same information was shared by Dr. Jenkins in his July 2015 edition of the OSMA Journal President's Page. The decision to sell at this time seemed most prudent to the boards in view of present day increasing consolidation of physician practices and the ever changing hospital owned practice environment.

Moving forward, OSMA/PLICO leadership will hold multiple town hall meetings around the state, over the next few months, to explain to OSMA members and PLICO insured the details of the decision to sell and the expected benefits from the sale. Details of the decision to sell and its ramifications will be the main topic of discussion at the November OCMS membership meeting. Importantly, PLICO insured will continue to be able to purchase high quality professional liability insurance. Also importantly, the sale will help ensure the long term financial stability of both OSMA and PLICO.

I applaud the OSMA and PLICO leadership for their careful and thorough due diligence. I am, frankly, excited about the decision to sell. I can envision the proceeds of the sale having revolutionary effects on organized medicine in Oklahoma. The OSMA is the amalgamation of the component county societies. Dues-paying members of the OCMS, TCMS and the Oklahoma rural county society all pay dues to the OSMA and, hopefully, will be able to benefit from the proceeds of this sale. Potential benefits that come to mind are joint initiatives to increase county society and OSMA physician membership, special programs to support and nurture the professional experience of our Oklahoma physicians, and altruistic projects directed at improving the health of Oklahomans and all people.

The OSMA/PLICO leadership will be asking for your ideas on how to wisely invest the proceeds of this significant sale. Please freely share your ideas.

New members are the key to our future success, as well as continuing the legacy of OCMS.

Get your county medical membership free* by recruiting new members.

Recruit 1 member:

1. Pay your regular OCMS dues.
2. Promote the society and recruit one new member.
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5. You will receive refund of **$127.50**** *(half of OCMS dues).*

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DEAN'S PAGE

By M. Dewayne Andrews, MD, MACP

A new class of medical students, the Class of 2019, began their studies in August with their orientation sessions culminating in the White Coat Ceremony. This year marks a new chapter in the history of the College of Medicine. The Tulsa branch campus of the College has been in operation since 1974, as a community-based program with third and fourth year educational experiences for students who elected an option to complete the last two years of medical school in Tulsa.

This year, for the first time, some of our new students will begin first-year studies at the Tulsa campus and have all four years in Tulsa. Renamed the School of Community Medicine in 2008, the Tulsa campus experience is categorized as a separate "educational track" in the College of Medicine by the Liaison Committee on Medical Education (LCME), the accrediting body for U.S. medical schools.

Tulsa campus leaders wanted to have a unique identity and emphasize how the medical school could more directly influence the health of the Tulsa community. More recently, they desired to develop a full four-year medical school experience in Tulsa. A major gift from the George Kaiser Family Foundation was instrumental in moving the plan forward. With approval of the University's Board of Regents, work began on a program and a partnership with the University of Tulsa involving the basic sciences.

The overall class enrollment for the College remains at 165 per year. During the admission application students now indicate whether they wish to apply to the Oklahoma City campus, the Tulsa campus, or be considered for either campus. Initially, twenty-five students per year can be accepted into the Tulsa educational track. After the track is fully established and running well, Tulsa campus leaders plan to expand it progressively up to 60 students per year if the application pool is sufficient and the LCME grants approval. There are, of course, operational challenges in delivering the pre-clinical curriculum to two campuses; a great deal of coordination between Oklahoma City and Tulsa faculty is required, distance education technology will be used extensively, and on-site instructors will also be present in Tulsa a significant portion of the time. The LCME will be monitoring the outcomes, and we are required to file progress reports at regular intervals. Our Tulsa bound students are very excited about this new opportunity.

We've had some changes in the administrative lineup in the College in the past few months. Mark Fergeson, MD, associate professor of pediatrics, was appointed as associate dean for student affairs beginning in June. Dr. Bob Roswell, who served with distinction as senior associate dean since 2004, retired in July. John Zubialde, MD, professor of family

Continues on page 8 …

medicine, who has served admirably as associate dean for graduate medical education since 2001, has been promoted to the position of senior associate dean. Replacing him in September as associate dean for graduate medical education is Elisa Crouse, MD, associate professor of obstetrics and gynecology; she has over a decade's experience serving as a residency program director and has been involved in many of the GME policy decisions in the College.

The College's new academic office building is progressing nicely; the extreme spring rains obviously delayed things and construction is behind schedule about two months. Nonetheless, it is exciting to see this important new building and future home of the College of Medicine taking shape. We anticipate opening the new building in the summer of 2016.

IN MEMORIAM

Nancy Ryan Craig, MD
1924-2015

Phillip Edward Green, MD
1931-2015

Kent Braden, MD
1931-2015

Paul C. Houk, MD
1933-2015

OCMS LEADERSHIP ACADEMY CLASS VI

Class VI of the OCMS Leadership Academy begins on September 26 with 15 participants. The Leadership Academy brings together a group of physicians and one Alliance member for leadership and community education for six Saturday mornings during the fall and spring. Class members are invited to attend and are recognized at the OCMS presidential inaugural dinner in January. Participants are:

Sumit Ahluwalia, MD – Gastroenterology
Serena S. Anderson, MD - Family Medicine
Ryan W. Dennis, MD - IM/Hospitalist
Shawn Ellis, DO – Anesthesiology
Cara Falcon - OCMS Alliance
Basel S. Hassoun, MD - Urology
Johnny D. Hickson, III, MD - Urology
Lauren Cooper King, MD - Pathology
Bradley K. Lamprich, MD - Radiology
Aimee Levy, MD – GS
Betsy M. Nolan, MD - Orthopedic Surgery
Lori L. Pickrell, MD - Internal Medicine
Justin Sparkes, DO - Family Medicine
Joel Thomas, MD - Diagnostic Radiology
Soni Zacharias, MD – Cardiology

Many thanks to the Leadership Academy Planning group! If you are interested in joining Class VII starting in September 2016, please contact Jana Timberlake at 702-0500 or jtimberlake@o-c-m-s.org.

LET THE CELEBRATION BEGIN

By Larry A. Bookman, MD
Chairman, OSMA Board of Trustees

As July 4 signifies the independence of the United States, July 2015 may signify the independence and stability for OSMA. As many already know, PLICO Health, which is solely owned by OSMA, will most likely be sold to MedPro, which is a subsidiary of Berkshire Hathaway this past month. Questions about the pending sale have been voiced and I hope I can answer many of them in this article.

First, let me assure everyone – there is no golden parachute for anyone concerning this sale. All proceeds will go to OSMA and the Board will determine how the money is to be used. The plan will be presented to the House of Delegates for ratification. The executive board, including myself, has spent many hours and multiple meetings asking the questions and getting the right answers before the sale was authorized and approved.

The sale will benefit OSMA with financial stability, which should mean a benefit to the individual members as well as the component societies. It will allow OSMA to be more involved politically as well as improve programs which will benefit our members and the citizens of Oklahoma. There have been financial constraints that have prevented significant participation in these areas in recent years. This sale will also help PLICO and their insured. It will now have the financial clout to be able to cover larger entities such as hospitals and hospital-employed medical groups. It will also have the financial strength to weather the declining written premium numbers that has occurred the past few years and the future now looks bright.

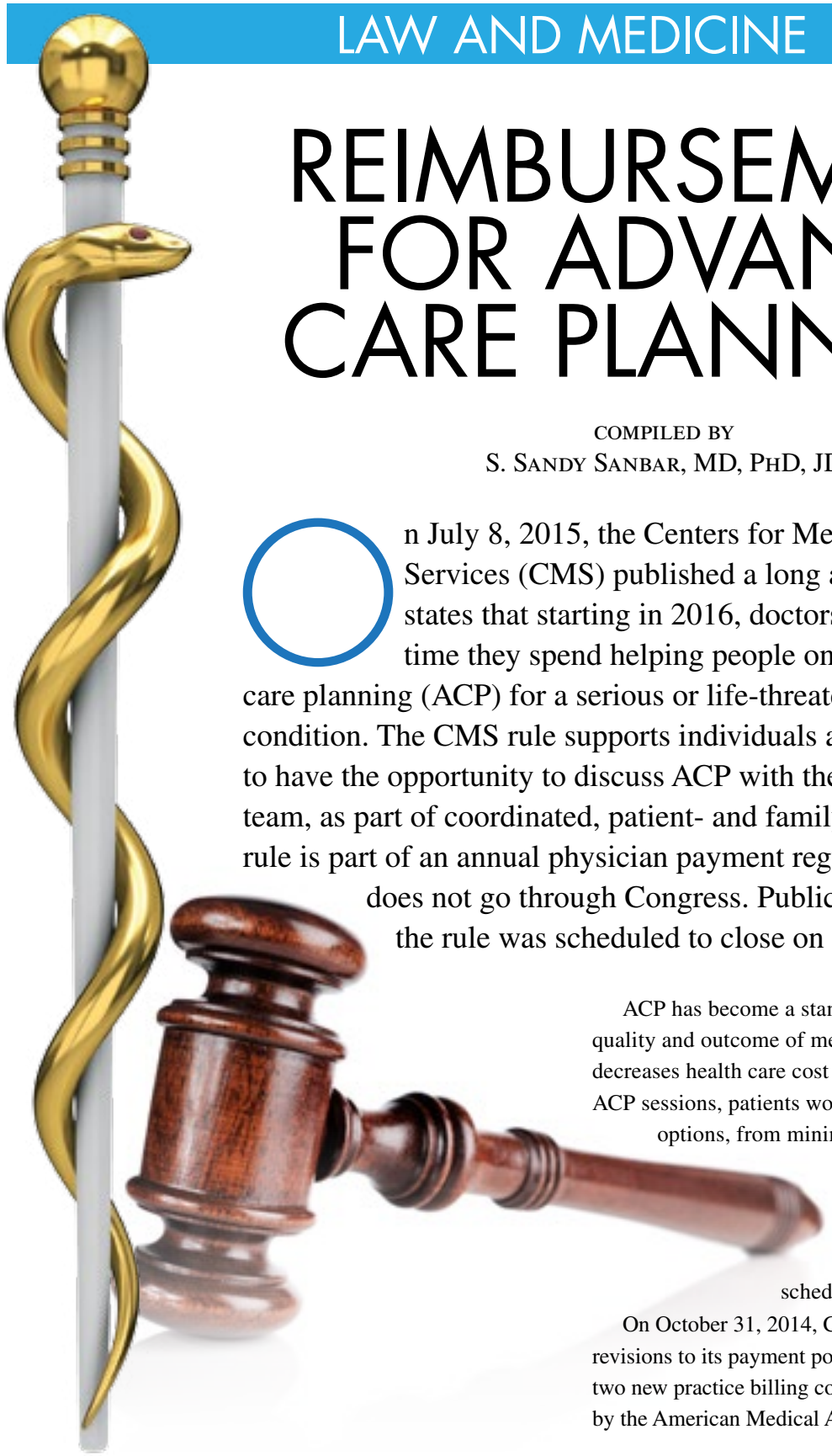
Let me be clear – this was not a forced sale. PLICO was, and is, in very good financial shape. This was an opportunity whose time had come. The individual policy holders will see no change in their policy rates this year and they should remain stable for several years. There will still be tail coverage in place and there will be local control with Dr. Carl Hook, and virtually all of the PLICO support staff, still on board. There should be a seamless transition as policies come up for renewal.

In conclusion, when the sale is finalized in late August or early September, fireworks should be heard for the independence of OSMA. This is truly a WIN-WIN for all.

REIMBURSEMENT FOR ADVANCE CARE PLANNING

COMPILED BY
S. SANDY SANBAR, MD, PHD, JD

On July 8, 2015, the Centers for Medicare and Medicaid Services (CMS) published a long awaited new rule which states that starting in 2016, doctors will be paid for the time they spend helping people on Medicare do advanced care planning (ACP) for a serious or life-threatening disease or condition. The CMS rule supports individuals and families who wish to have the opportunity to discuss ACP with their physician and care team, as part of coordinated, patient- and family-centered care. The rule is part of an annual physician payment regulation proposal that does not go through Congress. Public comment period for the rule was scheduled to close on September 8, 2015.



ACP has become a standard of care. It improves the quality and outcome of medical care and substantially decreases health care cost at the end-of-life. During the ACP sessions, patients would get advice on a range of options, from minimal medical interventions to demanding that every treatment possible be offered near the end of life. Patients can choose whether or not to schedule end-of-life counseling.

On October 31, 2014, CMS issued a final rule regarding revisions to its payment policies. This document contains two new practice billing codes, 99487 and 99497, submitted by the American Medical Association, which will officially

recognize the efforts of physicians or other qualified, trained and licensed health care professionals to engage in ACP with patients, including the explanation, discussion, and completion of standard advance directive forms.

Bipartisan bills in both the House and the Senate have called for physician reimbursement for what can be a time-consuming sensitive conversation. Numerous physician groups have endorsed it.

In May, 2015, sixty-six organizations representing medical providers and senior citizens, including the AMA and the AARP, wrote to Health and Human Services Secretary Sylvia Mathews Burwell urging the federal government to establish a way to pay for advance care planning.[1] The letter noted that,

"Published, peer-reviewed research shows that ACP [advance care planning] leads to better care, higher patient and family satisfaction, fewer unwanted hospitalizations, and lower rates of caregiver distress, depression and lost productivity."

"ACP is particularly important for Medicare beneficiaries because many have multiple chronic illnesses, receive care at home from family and other caregivers, and their children and other family members are often involved in making medical decisions."

In 2014, the Institute of Medicine (IOM) report entitled, "Dying in America: Improving Quality and Honoring

Continues on page 12 …

Individual Preferences Near the End of Life,"[2] cited payment for Advance Care Planning (ACP) as one of its five key recommendations. It noted that the hallmark of good ACP is open, clear, respectful communication between the person doing the planning and his or her clinicians, loved ones, and health care agents. And, reimbursement for ACP should be based on models that focus on this type of communication, such as Respecting Choices.

In early 1990s, La Crosse implemented the Wisconsin-based Respecting Choices (RC) ACP initiative. [3] RC was a community-wide collaboration between the four major health organizations in La Crosse – namely, Gundersen Clinic, Lutheran Hospital, Skemp Clinic, and Franciscan Health System. ACP conversations between clinicians and patients were not reimbursed by any traditional payers. The RC model relied on trained ACP facilitators who volunteered their time and assisted persons with the advance care planning process. ACP facilitators worked with patients and their medical providers to improve the patients' understanding about their disorders, help bridge gaps of medical knowledge, engage patients about their values, beliefs, preferences, and goals, and communicate with their health care proxies or agents and other loved ones about those values and goals of care. The facilitators also assisted patients in documenting their health care proxies or agents and goals of care in living wills, powers of attorney for health care, POLST and Do-Not-Resuscitate physician orders, and they made certain that the documented plans are easily retrievable by those who may need access to them including health care proxies or agents, loved ones, and medical providers.

The La Crosse ACP facilitators were trained and certified by RC to conduct ACP in three distinct stages: (1) when adults were relatively healthy; (2) when patients were beginning to suffer the effects of a chronic or life-limiting illness, and (3) when they were near the end-of-life.

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The ACP facilitators included physicians, nurses, social workers, and community volunteers without medical training. They were assigned to work with populations that fit their level of training, and they engaged only with people who said they wanted to create an advance care plan.

In 1995 and 1996, two years after the community-wide implementation of the RC model, the La Crosse Advance Directive Study (LADS I) was conducted as a retrospective study of 540 decedents in La Crosse. The study found that 85 percent of the decedents had an advance directive and that 95 percent of these directives were documented in their medical records.[4] Only eight patients were found to receive medical treatment inconsistent with their documented preferences in LADS I.

In 2007 and 2008, a second study was conducted (LADS II). The results showed that the numbers of decedents with advance directives that were also documented in their medical records rose, respectively, to 90 percent and 99 percent.[5] LADS II found no cases of patients that received treatment inconsistent with their documented treatment preferences.

The RC model had an economic impact on utilization and health care expenditures in the last two years of life, which was attributable to reducing wasteful spending related to providing unwanted care to patients at the end of life.

According to the Dartmouth Atlas for Health Care, the Gundersen's 2010 utilization score of RC was 0.40, which is lower than institutions in the National average (1.0), and even in institutions in the 10th percentile (0.62). [The Gundersen score is a ratio of the number of days patients spent in the hospital and the number of physician encounters they experienced as inpatients during the last two years of a person's life compared to a baseline score of 1.]

The RC Gundersen's average Medicare expenditures per person over the last two years of life in 2010 were $48,771, which was well below institutions in the 90th percentile ($102,939), the National average ($79,337), and even the 10th percentile ($58,866).

Respecting Choices has been implemented in many health systems and organizations throughout the United States and in Canada, Australia, Singapore, and Germany. Successful statewide ACP programs such as Honoring Choices Wisconsin, Honoring Choices Minnesota, Honoring Choices Virginia, and Honoring Choices Florida are based on the RC model.

1 http://www.aafp.org/dam/AAFP/documents/advocacy/coverage/end-of-life/LT-HHS-AdvanceCare-051215.pdf

2 http://www.khi.org/assets/uploads/news/13726/dying_in_america.pdf

3 http://iom.nationalacademies.org/~/media/Files/Report%20Files/2014/EOL/Report%20Brief.pdf , Death and End-of-Life Planning in One Midwestern Community, Arch Intern Med. 1998;158(4):383-390.

4 http://archinte.jamanetwork.com/article.aspx?articleid=191392

5 http://www.polst.org/wp-content/uploads/2013/01/AComparativeRetrospective.pdf , Bernard J. Hammes, PhD,_ Brenda L. Rooney, PhD, MPH,w and Jacob D. Gundrum, MS_J Am Geriatr Soc 58:1249–1255, 2010.

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OKLAHOMA COUNTY MEDICAL SOCIETY **ALLIANCE UPDATE**

alliance

The Oklahoma County Medical Society Alliance is a 501(c)3 nonprofit organization of physicians' spouses who work together to enrich the community and assist nonprofit organizations that meet a health-related need in Oklahoma County.

Our big fundraiser is the Oklahoma County Medical Society Alliance Kitchen Tour held in the city of Nichols Hills. This year the Kitchen Tour will be held on Sunday, October 2015. It will be the 24th year of our successful event. Our wonderful co-chairs, Berna Goetzinger and Natasha Neumann have been planning our event for months.

The beautiful homes that will be featured include:

- Leigh Ann and Paul Albers home at 6609 N.W. Grand Blvd.
- Libby and Todd Naifeh's home at 1505 Bedford Drive
- Jessica and Ryan Johnston's home at 1606 Norwood Place
- Tonya and Michael Stone's home at 6619 Avondale Drive
- Seda and Koray Bakir's home at 1204 Marlboro Lane

Local retail store Culinary Kitchen will have cooking demonstrations and wine tasting for all interested guests. The cost of the tickets are $15.00 in advance and $20.00 the day of the tour. Tickets may be purchased in advance at the following retail stores:

New Leaf Florist
On A Whim
Culinary Kitchen
42nd Street Candy Company
The Lime Leopard
Lush Blow Dry Bar

This year, following our Mission statement, all proceeds will go to three beneficiaries. The first is an organization near and dear to our hearts, the Health Alliance for the Uninsured. The second organization is The Mental Health Association of Oklahoma, and third organization is Oklahoma Mother's Milk Bank.

Please contact Chairman Berna Goetzinger at (bgoetzinger@cox.net) or Co-Chairman Natasha Neumann (Natasha.neumann@yahoo.com) for any questions or sponsorship opportunities.

All the Best,
Amy Bankhead
President, Oklahoma County Medical Society Alliance

PAY FOR PERFORMANCE: A Community Health Perspective

By Steve Ramirez MD

Pay for performance (P4P), a term now firmly ensconced in the vocabulary of many payment systems and private insurers alike is used to describe initiatives that are aimed at improving the quality, efficiency, and overall value of health care which are then tied back to financial incentives. My objective is not to specifically highlight the advantages or disadvantages in proposed pay for performance models but will provide historical information for context and ultimately share with you what a Community Health Center is and how Variety Care - Oklahoma's largest Community Health Center accomplishes this.

In the early 2000s serious deficiencies in the quality of health care in the United States were highlighted in two major reports by the Institute of Medicine under the title "Crossing the Quality Chasm". Its conclusion was that the U.S. health care delivery system did not provide consistent, high-quality medical care to all people. Along with it, it explored potential ways in which change could be implemented to positively affect this dynamic. Of the many recommendations made, a particular focus recommended aligning payment policies with quality improvement efforts giving credence to a concept known as pay for performance.

For decades concerns had been raised about the predominant incentive structure built into the US Healthcare system. The model, known as the fee-for-service, was designed around paying individual providers according to whatever specific services they provided based on the volume and complexity of the services rendered with little to no consideration in the quality or efficiency of that care. This was felt to lead to increased costs by containing built-in incentives to promote unnecessary care and many have come to agree that this system is in part responsible for the country's skyrocketing health care costs. It is in this context, pay for performance emerged as a way for payers to focus on quality, with the expectation that doing so would also reduce cost. This methodology differed significantly because it does not reward the rendering provider merely based on volume and complexity of the care they provide, but for the quality of the care they deliver. Many P4P initiatives have been set up in Medicare, Medicaid and private insurance plans, and have been incorporated into new financial arrangements for coordinating patient care. Many of which have been propelled by the Affordable Care Act (ACA) itself. The best known probably being

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Accountable Care Organizations or "ACO" model, where a group of providers that agree to coordinate care agree to share responsibility for specific patient populations and are given financial incentives by health plans related to quality of care, health outcomes and costs. Thus being held accountable for the quality and costs of the services they provide.

Community Health Centers (CHCs) are private, non-profit entities that deliver comprehensive primary and preventative care in medically underserved areas where populations typically have limited access to health care. CHCs operate under comprehensive federal standards and are designated as Federally Qualified Health Centers (FQHCs), which grants them special payment rates through programs such as Centers for Medicare and Medicaid Services in addition to support through federal and state grants. A unique feature of a CHC is that they are governed by a community board of which a majority of members are patients themselves of the CHC. In turn CHCs are expected to have ongoing quality assessment and improvement programs that include clinical services and quality management that place emphasis on health outcomes and demonstrate the value of the care delivered by those health centers. The performance measures are chosen by the Health Resources and Services Administration to provide a comprehensive representation of the health center services provided. The measures are typically aligned with those of national standard setting organizations and are commonly used to assess quality performance. Following are some examples of those measures.

Percentage of patients aged 2 until 17 who had evidence of BMI percentile documentation AND who had documentation of counseling for nutrition AND who had documentation of counseling for physical activity during the measurement year

Percentage of patients aged 18 and older who had documentation of a calculated BMI during the most recent visit or within the six months prior to that visit and if the most recent BMI is outside parameters, a follow-up plan is documented

Percentage of children with their 3rd birthday during the measurement year who are fully immunized before their 3rd birthday

Percentage of patients age 18 years and older who were screened for tobacco use at least once during the measurement year or prior year AND who received cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user

Percentage of patients aged 5 through 40 with a diagnosis of mild, moderate, or severe persistent asthma who received or were prescribed accepted pharmacologic therapy

CHC's report these performance measures through a program known as the Uniform Data System (UDS). They are then included in the Clinical and Financial Performance Measures for Service Area Competition (SAC) and Budget Period Progress Report (BPR) grant opportunities. The process provides opportunity to establish quality and performance goals and assess their progress toward these goals thus highlighting the core concept of P4P.

Pay for performance should include thoughtful monitoring and evaluation to identify design elements that will positively affect outcomes and must be viewed as but one element in a set of strategies undertaken to improve the value of health care spending.

REFERENCES

Julia James, Health Policy Brief: "Pay-for-Performance" Health Affairs, October 11, 2012, http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_78.pdf, accessed July 20, 2015

Adam Sonfield, "Pay-for Performance: Making it Work for Safety-Net Family Planning Centers and the Clients They Serve, GPR, Spring 2014, Volume 17, Number 2, < http://www.guttmacher.org/pubs/gpr/17/2/gpr170208.html>, accessed July 20, 2015

SAVE THE DATE

FALL MEMBERSHIP MEETING
NOVEMBER 9, 2015

Plan to attend the fall Membership Meeting on the evening of Monday, November 9, 2015 at 5:30 p.m. in the Board Room of the Oklahoma State Medical Association.

WHY ATTEND?

OCMS is the only organization for physicians in Oklahoma County. Your input on the following items will help shape the future of activities that benefit you, including legislation to support your practice and OCMS services that are catered to you.

WHAT WILL BE DISCUSSED?

- Election of 2016 OCMS Officers
- Board election winners announced
- The sale of PLICO and the effect on OCMS and physicians
- Bylaws revision for OCMS
- Budget approval

Please look for an invitation in the mail to this event, or visit www.o-c-m-s.org. Contact us at 702-0500 if you have additional questions or would like more information.

"SEARCH BEHIND THE DISEASE"

By Hanna Saadah, MD

"No matter how bright the physician, the illness is always smarter.
Like an onion, under every layer lurks yet another and another …
We peel and peel but seldom get to know the heart."

These were Dr. Muchhammer's humbling remarks to us, his internal medicine team at the VA Hospital. On that day in 1972, upon hearing this declaration, we all froze with awe before our attending physician as if he were the oracle of Delphi, pontificating from the southern slopes of Mount Parnassus.

"To become good doctors you have but to know two things. First, you have to know the patient, who will always remain a half-solved mystery, no matter how much he reveals to you because no patient ever tells everything. Second, you must know the disease otherwise you would not be able to ask the key, unlocking questions. And disease will also remain a half-solved mystery, because it continues to change with theory and with discovery."

With these precepts, Dr. Muchhammer led us on rounds, stroked patients' brows, asked infrared questions, peeled layer after layer, and then helped us deepen our shallow analyses. We yearned to learn how did he know to ask the one question, which we never thought to ask, and how did he manage to unveil – for us the purblind to see – the inscrutable diagnoses with hardly a test or an x-ray in hand.

One dark winter morning abuzz with admissions, we presented our cases with sleep-deprived eyes and yawning aspects, for we had admitted ten patients during our night shift. Presenting our last elderly patient, I happened to mention that he was a perennial seeker of emergency care.

"Perennial?" He asked with raised eyebrows.

"Yes, Sir. He is admitted through our emergency department about once a month, always with the same complaint, shortness of breath. His blood gases from admission till discharge stay about the same, with no measurable improvement, but he always feels better when he leaves. His emphysema has been rather stable even though he continues to smoke and drink."

"Why, then, does he seek monthly admissions?"

"I don't know, Sir," I sheepishly replied. "I've reviewed his entire chart of five volumes, but could find no clues. He seems ever the same, admission after admission, and his blood gases have never been alarming."

Dr. Muchhammer stood up, placed his palm onto the patient's piled, five-volume-chart, scrutinized our listless aspects with his glittering eyes and asked, "Did you search behind the disease?"

"Behind the disease, sir? I'm not sure I understand what you mean."

"Search behind the disease," he muttered, and walked away.

At the dragging tail of that laborious day, my team and I went over the patient's details, re-examined and re-questioned him, but unearthed nothing of value. My intern suggested that we visit his home to look for dust, mold, sick house syndrome, and whatever else might be hiding behind his disease. The patient granted us permission. We called his wife from his room and set our visit for the next day, Saturday.

Mrs. Poumon was delightfully hospitable. She gave us a tour of her very clean house and of Mr. Poumon's equally clean woodcarving shop. "That's where he spends all of his time," she announced, pointing to his seat, table, and tidy tools. "Ever since he returned from the war, that's all he wants to do. He was much more sociable before."

Sipping coffee and munching on doughnuts, we asked Mrs. Poumon sundry questions, but uncovered no clues. On our way out, my intern asked her that one last question, which none of us thought to ask.

"Mrs. Poumon, does the wood dust bother you and do you cough or wheeze or suffer from any lung problems?"

"No, I feel mighty fine and Harry hardly makes any dust. I just wish he would spend more time with me and less time in his shop," she smiled,

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holding the doorknob in her hand. "We hardly go anywhere anymore."

Crestfallen, we thanked her and dispersed, the impending Monday morning rounds with our attending, nagging at our brains.

When Dr. Muchhammer walked in that Monday morning, he must have seen capitulation in our eyes because he asked no questions. He half smiled and said, "Let's start with Mr. Poumon."

Sitting on Mr. Poumon's bed, Dr. Muchhammer greeted, said few words of encouragement, and then abruptly asked, "What war were you in?"

"Pearl Harbor, Sir. We didn't know we were at war when the Japs hailed bombs on us."

"What was your position?"

"We were antiaircraft gunners on the USS Nevada, Sir."

"We?"

"Me and my buddy. James Lovelorn was his name."

"Was?"

"Under the orders of Ensign Joe Taussig Jr. we were returning fire against bombers that were targeting us when we sustained a direct hit from a torpedo. Parts of the ship started to burn, smoke was everywhere, and ..."

At this point, Mr. Poumon choked, gulped, and his lips began to quiver. We stood in silence and watched Dr. Muchhammer grasp Mr. Poumon's hand, bow his head as if in prayer, and whisper, "And what happened to James?"

Mr. Poumon collected himself, cleared his throat, adjusted his sniffling nasal prongs, and whispered back, "A shrapnel beheaded him while he sat right next to me. There he was, sitting without a head, his body twitching, with blood spewing from his neck like a geyser..."

Another moment of silence…

Dr. Muchhammer handed a tissue to Mr. Poumon and waited.

"I began to choke on the bellowing smoke, but continued to return fire until I was blown into the harbor and began to drown. I held on to a floating body, which happened to have its life vest on. 'Under water I would drown. Over water I would choke and burn with the burning oil.' That's all I could think about while I clung to that dead man's life vest."

Another moment of silence…

"And who rescued you?"

"I have no idea, Sir. I woke up on a hospital ship with burns all over my body and a horrible heat in my lungs."

"Burns?"

Mr. Poumon pulled up his sleeves and uncovered his legs for us to see.

"The burns were superficial, Sir, but what got me was the smoke. I coughed for years and I'm still coughing, but not nearly as bad as before. About once a month, though, when I get into a bad coughing spell, it sends me back to Pearl Harbor and I truly believe that I am choking to death. That's what scares me so bad and makes me rush to the emergency room."

Sweat began to accumulate on our sallow faces, not the sweat of awe or embarrassment, but rather that of epiphany. Dr. Muchhammer was revealing to us, layer by layer, the scorched landscape behind Mr. Poumon's disease.

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"So, do you think that re-living your fear is what sends you to the emergency room each month?"

"Yes, Sir. You just hit the nail on the head. I flat out panic and think that I'm choking and dying."

"If we were to take care of your fear, you wouldn't panic, would you?"

"I didn't know there were treatments for fear, Sir, which is why I've never told a soul…"

In the early seventies, even though the Vietnam War was still raging, the posttraumatic stress disorder syndrome, though partially remediable, was not yet a fashionable diagnoses. Nevertheless, under good psychiatric care, Mr. Poumon's panic admissions ceased and, in time, he was able to stop drinking and smoking. However, his incessant woodcarving, which was his self-discovered occupational therapy, continued unabated. For a while, I kept in touch with him by phone, calling him occasionally for a friendly chat. At the end of that year, Dr. Muchhammer received a wood-carved USS Nevada from Mr. Poumon. On the hull, the following words were inscribed: "To Dr. Muchhammer, with gratitude." Harry Poumon.

When Dr. Muchhammer's rotation ended, we grieved, but his indelible impact never left our medical minds. We spent the rest of our medical careers investigating the triad of patient, disease, and that undiscovered landscape, which always lurks behind the disease.

"Learn all we lacked before; hear, know, and say
And feel, who have laid our groping hands away;
What this tumultuous body now denies;
And see, no longer blinded by our eyes." *

*From The South Seas Sonnet by Rupert Brooke (1887-1915)

TRANSSEXUAL SURGERY

The Early Years

David W. Foerster, MD

Of all the surgical procedures done today, the most controversial has been and still is sexual reassignment, i.e. the changing of external genitalia from one sex to another, be it male to female or female to male. There are numerous reasons for this controversy including religious opposition the difficulty of overall somatic conversion, i.e. some male to female patients who retain male facial shape, muscle mass and voice, as well as a generalized feeling among the public that this is frivolous surgery.

Ironically, transsexual conversion surgery had its origin in the United States by highly ethical and respected surgical teams. Beginning in the 1960s, three such teams, one at Stanford, one at Johns Hopkins and one at Oklahoma (each working independently) began to lay the groundwork for these complex procedures. By the early 1970s, these groups and affiliated non-surgical specialties and individuals came together and established the Harry Benjamin Gender Dysphoria Society in order to set standards and terminology. Dr. Donald Laub (chairman of plastic surgery at Stanford Medical Center) was elected president. Other attendees included Dr. Milton Edgerton (chairman of the plastic surgery department at Johns Hopkins), Dr. Charles Reynolds and myself from the Oklahoma Health Science Center, as well as Dr. Stanley Bieber from Trinidad Colorado (no affiliated with any medical center but a gifted surgeon with a great interest in such surgery). A committee was appointed to establish ethical guidelines for patient eligibility. From this committee and with the approval of the Society, criteria were established that included the necessity for patients to undergo a thorough psychological evaluation by a psychiatrist or clinical psychologist in order to ascertain that the individual was truly transsexual and that surgical conversion was a proper recommendation. Furthermore, the surgical candidate must be unmarried and live, work dress and establish a lifestyle of the desired sex for a minimum of one year period prior to conversion. This was done to eliminate ambivalent or psychotic patients from surgery.

Transsexualism or gender dysphoria is a potentially high mortality disorder as approximately 50% of such individuals died of self-inflicted injury prior to the availability of surgical transformation. True transsexualism is a fairly rare disorder of unknown etiology occurring only in 1 of 20,000 births. Most

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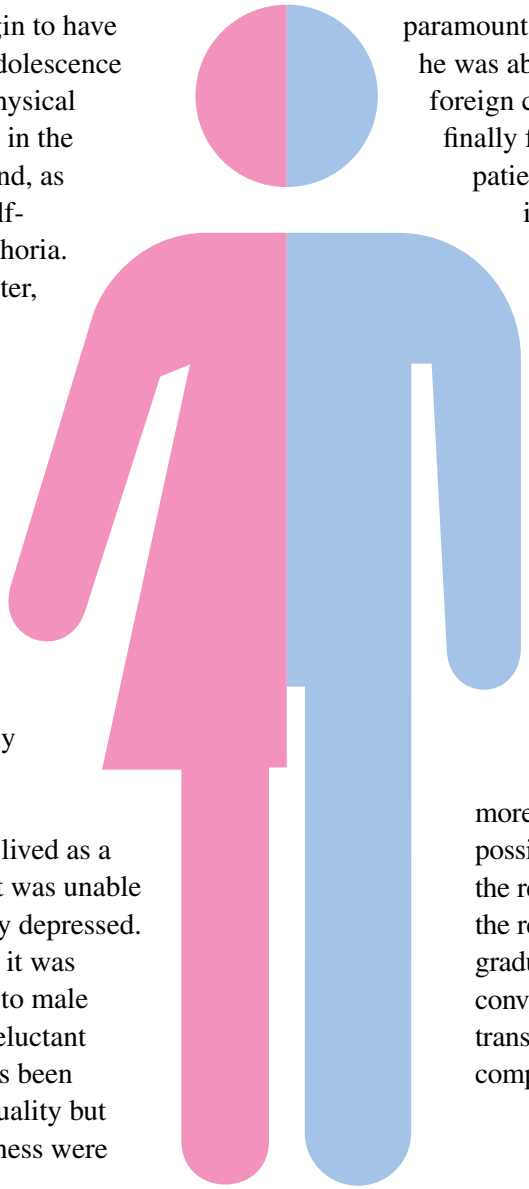
individuals with this disorder begin to have symptoms in childhood and by adolescence or deeply disturbed about their physical sexuality. The intensity of "being in the wrong body" increase with age and, as previously noted, can result in self-inflicted death to relieve the dysphoria. In order to minimize such a disaster, surgical conversion has been a life-saver. There is a less ever condition now known as "transgenderism" in which the patient is satisfied to simply dress and live as the opposite sex but not undergo the surgical conversion.

These criteria for surgery have worked well throughout the years and in my experience only two patients (one not initially operated on by our team) have been unhappy with the change. Our patient was a physician who lived as a converted female for 10 years but was unable to find a mate and became terribly depressed. After lengthy psychiatric therapy it was decided that the conversion back to male would be the best option. I was reluctant at first to do this as the patient has been very pleased with her female sexuality but the rejection by males and loneliness were paramount. After conversion back to male, he was able to find a "bride for hire" from a foreign country whom he married and was finally free of his loneliness. The other patient was a psychologist operated on in California (I'm unsure if proper guidelines were followed). There seemed to be a great deal of ambivalence in the change to female genitalia and the general consensus was to return her to male genitalia. After completion he seemed to be much happier but was later lost to follow-up.

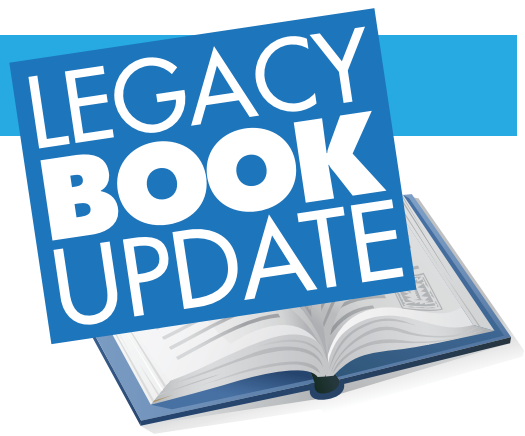


At the present time, surgical conversion has become more refined including facial modification procedures for male to female patients as well as reduction of the male "Adams apple." I'm sure that in the future more and more improvements will be possible and greater satisfaction with the results will be possible. Hopefully the religious and frivolous stigma will gradually disappear so that surgical conversion of properly diagnosed transsexualism will find its place as a compassionate and life-saving procedure.

THE BULLETIN

Coming soon!

Frontiers of Healing: A History of Medicine in Oklahoma County is set to be released soon. The fully-illustrated, beautifully designed book, sponsored by the Oklahoma County Medical Society is authored by Gayleen Rabakukk and published by Legacy Publishing. OCMS looks forward to sharing more information about the release soon!



CALL FOR NOMINATIONS: Rhinehart Medical Service Award

Nominations are open for the 11th annual Don F. Rhinehart, MD, Medical Service Award. This award recognizes OCMS members, active or retired, who have demonstrated significant involvement in projects to help improve health care, the community or the state.

Nominations must include:

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

Nominations should not exceed 650 words. The recipient will be selected at the November OCMS Board of Directors meeting; the award will be presented at the Inaugural Dinner in January 2016. You may mail your nomination to OCMS, 313 N.E. 50th St., Suite 2, OKC, OK 73105; or fax it to (405) 702-0501; or email it to awilliams@o-c-m-s.org by Friday, October 16, 2015.

THE POET'S SPOT
THE BULLETIN

Relationships must reinvent themselves to thrive.
Monotony decays the souls.

Anew

Now that we've made a bridge of our souls
That I may flow to you and you to me
Above the River Life, which roars and blows
And floods its banks with flotsam and debris

Do one more thing for me, while by my side
One thing beyond love's blushing, lunar glow
One thing that anchors us against the tide
Arousing us to ever cling and grow

Stay new, no matter day or month or year
Wake up each morning with a novel face
And I will do the same for you, my dear
So every hug will be a new embrace.

What ever, and what ever, and what ever
Let us be always new to one another.

DIRECTOR'S DIALOGUE

By Jana Timberlake, Executive Director

FRONTIERS OF HEALING: A HISTORY OF MEDICINE IN OKLAHOMA COUNTY

As the publication date of the book depicting the history of medicine in Oklahoma County draws nearer, it is difficult to contain my excitement! The History Book Oversight Committee and I have had the opportunity to read each chapter as it has been completed, which has only made us more anxious to receive the next one.

Recently, the OCMS staff met with the book's author, Gayleen Rabakukk, to discuss the book's Forward and the pages within the publication that specifically pertain to the Oklahoma County Medical Society's history. This is when she shared her thoughts about a possible title for the book – Frontiers of Healing: A History of Medicine in Oklahoma County – which not only describes Oklahoma County's history as being a part of the frontier but that Oklahoma County medicine is also on the cutting edge of the new frontiers of medicine. Great title! Her suggestion resonated with everyone from OCMS leadership to members of the History Book Oversight Committee.

David Thelen, author of Memory and American History in the Journal of American History, wrote that "the challenge of history is to recover the past and introduce it to the present." Many hours have been spent by the author interviewing people and reviewing volumes of past Bulletins and historical documents. The OCMS staff recently uncovered history dating back to 1890 when the Oklahoma County Territorial Society was formed, which continued until 1908 when Oklahoma Territory became a state; and the present Oklahoma County Medical Society is a continuation of the group organized in 1890. In addition, this has given Alison Williams, new OCMS Associate Director, the opportunity to immerse herself in the Society's history within the first few months of joining the Society's staff – something it has taken me years to accomplish.

The target date for the book's publication is later this year, and the planning process has begun for the Society to host a book signing and reception. The quote below, by Charles Angoff, publisher and author, is a beautiful ending for this article:

"History is a symphony of echoes heard and unheard.
It is a poem with events as verses."

We will keep you informed about the event, knowing that many of you will want to be a part of this historical evening where the Society's "past will be introduced to its present."

JanaTimberlake, Executive Director

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COMMONLY REPORTED DISEASES

	Monthly										
	Jan'15	Feb'15	Mar'15	Apr'15	May'15	June'15	July'15	Aug'15	Sept'15	Oct'15	Nov'15	Dec'15
E. coli 0157:H7				0	0	1	1	0	0	0		
Ehrlichiosis				0	0	0	0	0	0	0		
Haemophilus influenzae Type B				0	0	0	0	0	0	0		
Haemophilus influenzae Invasive				6	2	0	1	1	4	2		
Hepatitis A				3	2	4	3	1	0	0		
Hepatitis B				3	0	1	3	4	1	1		
Hepatitis C				19	6	5	11	4	7	4		
Lyme disease				0	0	0	0	0	0	0		
Malaria				0	0	0	0	0	0	0		
Measles				2	1	0	0	0	0	0		
Mumps				0	0	0	0	0	0	0		
Neisseria meningitidis				0	0	0	0	0	0	0		
Pertussis				1	2	3	0	2	1	1		
Strep pneumo invasive, children <5yr				1	0	0	0	0	0	0		
Rocky Mtn. Spotted Fever				0	0	0	0	0	0	0		
Salmonellosis				8	1	4	9	8	11	4		
Shigellosis				17	13	11	14	16	15	10		
Tuberculosis ATS Class II (+PPD only				0	0	0	0	0	0	0		
Tuberculosis ATS Class III (new active cases)				0	0	0	0	0	0	0		
Tularemia				0	0	0	0	0	0	0		
Typhoid Fever				0	0	0	0	0	0	0		
RARELY REPORTED DISEASES/Conditions												
West Nile Virus Fever				0	0	0	0	0	0	0		
Pediatric influenza Death				1	0	1	0	0	0	0		
Influenza, Hospitalized or Death				172	51	18	1	1	1	2		
Influenza, Novel virus				0	0	0	0	0	0	0		
Strep A Invasive				0	0	0	0	0	0	0		
Legionella				2	1	2	0	4	1	1		
Rubella				0	1	0	0	0	0	0		
Listeriosis				0	0	0	0	0	0	0		
Yersinia (not plague)				0	0	0	0	0	0	0		
Dengue fever				0	0	0	0	0	0	0		

* Over reported (includes acute and chronic)

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

***Beginning in June 2012 medical health record was transitioned to the electronic format PHIDDO. Data for newly identified infections is not available at this time. OSDH is being consulted on obtaining data.

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