THE BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY

JULY/AUGUST 2016

OCMS
OKLAHOMA COUNTY MEDICAL SOCIETY

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THE BULLETIN

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RIVERSPORT

ABOUT THE COVER

RIVERSPORT Rapids, Oklahoma City's new $45.2 million whitewater rafting and kayaking center, opened May 7th with US Olympic Team Trials for Canoe/Kayak Slalom. The whitewater center was built in the city's Boathouse District as part of MAPS 3, a one-cent sales tax initiative to fund projects that enhance the quality of life for metro area residents.

The OKC Boathouse Foundation operates the new whitewater center and offers recreational rafting, kayaking and tubing along with adventure activities, rafting and kayaking lessons, leagues and camps. The adventures and whitewater activities are open to the public.

RIVERSPORT Rapids is one of only three man-made whitewater venues in the nation. Six pumps recirculate treated water through two channels to create class II-IV rapids. Flow can be adjusted to offer various levels of rafting and kayaking experiences.

Also part of the new facility is the Big Water Grill, a full service restaurant and bar open daily from 11a-8p and for special events. The menu boasts an array of salads, wraps, sandwiches, burgers and nachos, all for $10 or less. The bar offers a selection of beer and wine.

All Access Passes are available for a day or for the whole year, starting at $49. They include whitewater rafting, tubing, zip lining, the 80 SandRidge Sky Trail, flatwater kayaking and paddleboarding, adventures at Lake Overholser and more. For more information and to buy passes online, visit riversportokc.org.

Photo credit: Georgia Reed

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PRESIDENT'S PAGE

By Don L. Wilber, MD

Oklahoma has just faced the largest budget shortfall in history of $1.3 billion. This was caused primarily by the fall in revenue due to the oil bust. With some last minute work a budget was fashioned that came close to covering the gap. Had that not been accomplished it was projected that many nursing homes and rural hospitals would have been forced to close due to lack of funding from the Oklahoma Health Care Authority (OHCA). The proposed decrease in Medicaid reimbursement due to the budget shortfall would have initiated a provider exodus from the program leaving many Oklahomans without access to physicians. Patients would then be forced to seek care in emergency rooms further increasing costs as well as overburdening and decreasing the effectiveness of this venue of care.

In September 2015 the budget deficit was estimated at $900 million. By January it was estimated that the shortfall would be closer to $1.3 billion. The OHCA implemented a 3% decrease in provider reimbursement effective January 1, 2016 rather than waiting until July and implementing a 6% cut. As budget talks progressed the OHCA realized a 25% reduction in provider reimbursement would be necessary if legislative action was not taken to address the deficit. One of the proposed solutions to close the budget shortfall was an increased tax on tobacco. This failed because some Republicans did not want to increase taxes and some Democrats wanted to force the Governor and Republican legislature to accept the federal money for Medicaid expansion. Medicaid expansion is part of the Affordable Care Act that reimburses states for increasing the eligible number of recipients in that state's Medicaid program.

To mitigate cuts without the need for new taxes the legislature acquired $600 million of one time money such as the Rainy Day fund. An additional $200 million was taken from the Department of Transportation funding which will be replaced through the sale of bonds. This financial maneuvering has maintained common education funding at the same level as last year and provided a small increase in funding for the OHCA. However due to the means of sourcing the shortfall it will be even harder to make up a budget deficit next year because the one time money is gone and the legislature will wish to avoid selling more bonds which creates more debt. The budget passed closely on a 52-46 vote.

Once again we see how imperative it is that the physicians and their organizations actively participate in convincing our elected officials about the importance of issues that affect the health of Oklahomans. I thank each of you who made the effort to contact your legislators.

THE BULLETIN

WELCOME NEW MEMBERS!

Christopher B. Cunnyngham, MD, is a pediatrician with OUHSC – The Children's Hospital. He completed medical school at the OU College of Medicine, his internship and residency at OUHSC, and fellowship at UT Southwestern in Dallas.

Lance Craig Smith, MD, is an orthopedic physician with McBride Orthopedic Hospital. He completed medical school at the Univeristy of Kansas Medical School, internship and residency at OUHSC, and a fewllowship at the University of Southern California.

James M. Vollers, MD, is a board-certified pediatric anesthesiologist with OUHSC. He completed medical school at the University of Texas Medical School at Houston, internship at Duke University, residency at the Hospital of the University of Pennsylvania, and a fellowship at the Children's Hospital of Philadelphia.

DEAN'S PAGE

By M. Dewayne Andrews, MD, MACP
Executive Dean and Regents' Professor,
University of Oklahoma College of Medicine

The construction and interior finish work on the College's new academic office building is nearing completion, and we are looking forward to moving into the new building beginning in August. The building provides many facilities and conference spaces badly needed by the College as well as office space to accommodate the tremendous growth in faculty and programs that we have experienced over the past decade. This new building will be a prominent and beautiful signature building for the College of Medicine, located at the southeast corner of Stanton L. Young Boulevard and Phillips Avenue. It is connected to the teaching hospitals complex and to the Williams Pavilion by elevated walkways. We are deeply grateful to the University Hospitals Trust for making construction of this building possible. The departments moving to the new building include: Internal Medicine, Obstetrics & Gynecology, Orthopedic Surgery, Otolaryngology Head & Neck Surgery, and Surgery. In addition, Dean's Office functions (except Admissions and Student Affairs) and the Office of Continuing Professional Development move to the new building. This transition with the departments above vacating their existing space in the Williams Pavilion will allow us to renovate that building and provide sorely needed additional space for the clinical departments remaining there.

For more than a decade, across this country the average "life span" of serving as a medical school dean has consistently been about five years. Only a handful of the current U.S. medical school deans have served more than ten years. This July, I began my 15th year serving as executive dean of the College of Medicine – a rare privilege and honor. While too frequent turnover in leadership is not in the best interest of medical schools or universities, it's my firm belief that such institutions are best served by periodic planned changes in leadership. It provides needed opportunity for fresh energy, fresh ideas, and new approaches to how the institution can best move forward. That belief, coupled with my turning age 72 this year, led me to a decision that I will step down as dean and retire from this position in the spring of 2017. In late February, I informed the University's president and Board of Regents of my decision, and in early March I informed the department chairs and dean's staff, giving the university approximately one year advance notice of the change. The Board of Regents has approved the individuals appointed to a broad-based search committee to identify potential candidates to be my successor, and the search process is underway.

Atrial Fibrillation: The facts.

What's old? What's new? What's changed? What's worth using? What's overhyped?

ELIZABETH WICKERSHAM, MD

Just the facts: Atrial fibrillation (AF) in increasing in incidence and prevalence in the US and the death rate from AF as a primary or secondary cause has been rising. The most recent statistics available are that each patient with AF adds over $8,700 to their annual medical care expenses compared to the those without AF, which costs the US $6 billion annually, and there are 130,000 deaths annually.

WHAT TO DO:

Begin at the beginning: look at the EKG. Convince yourself it is NOT sinus rhythm rather than jump to the conclusion of AF. Improper diagnosis can lead to improper treatment with potentially life-threatening consequences (think WPW).

Look for treatable causes: We all love pnuemonics so here is one for this: **ATRIAL FIB. A**=alcohol, **T**= thyroid, **R**=rheumatic heart disease, **I**=ischemia, **A**=atrial myxoma, **L**=lung (PE, COPD), **F**=pheochromocytoma, **I**=infection, **B**=blood pressure. Clever right? Contains horses and zebras: perfect for medicine. Obviously treating reversible causes can preclude any further AF treatment as it (hopefully) will resolve the issue.

Assess for duration: This kind of bugs me since someone can have asymptomatic AF so by definition we would not know how long this has been an issue for the person. Nonetheless, know that management varies depending on duration of AF.

Think about rate and rhythm control. The current recommendation is to control the ventricular rate to a target rate of <80 bpm for symptomatic patients and <110 bpm for asymptomatic patients without heart failure. Rate control can be achieved via medication or AV nodal ablation plus permanent ventricular pacing for select patients. The medications for this are not really new but the addition of the option of catheter ablation is the newer consideration. While there are those advocating to reserve this for people who cannot tolerate or have failed antiarrhythmic medications, it is now being considered as a reasonable initial strategy in some patients. It is important to remember that catheter ablation does not obviate the need for anticoagulation.

Anticoagulation, is it for everyone? Who shouldn't be anticoagulated and why? Who should be and with what for how long? One of the best tools available I have found is at www.sparctool.com and I would encourage you to check it out and play with it. It was developed by Peter Loewen, ACPR PharmD FCSHP, and is a tool designed to weigh the risks and benefits of treating atrial fibrillation, given a particular patient's set of circumstances. As I'm sure you are aware, it is important to assess the patient's risk for stroke (via CHADS or CHA2DS2-VASc score) and bleeding (HAS-BLED score). You don't have to remember any of those tools if you remember the Sparctool because it is all incorporated in this. It also calculates the treatment information needed for each of the treatments available for AF, reminding you of very handy things like "use edoxaban cautiously in patients with renal disease" (but says it more specifically). It updates the patient's risk/benefit status real-time as you input the data and spits out very patient-friendly information like "chance of being harmed by treatment X per year versus no treatment X" and "chance of benefit per year". This allows you to compare the information between warfarin vs edoxaban vs "whatever" so you can make informed decisions with the patient. At the moment it appears apixaban may have a bit of an edge over the other NOACs as a general statement, but again, I refer you to the Sparctool, which I wish I was smart enough to have developed.

New thoughts for warfarin: Patients who have been stable with their INR goal >6mo can be checked every 12 weeks. The time in the therapeutic window was noninferior to checking every 4 weeks.

Continues on page 10 …

Next warfarin new thought: When do I adjust the warfarin dose when the INR is out of the 2.0-3.0 therapeutic window? If the INR is less than 1.5 or greater than 3.5 the dose should be changed per a standardized Coumadin protocol. However, I am going to need your help to find a dosing protocol that follows the "do nothing if within 0.5 of the target goal. I found several, but none that are in keeping with the 9th edition ACCP recommendations we are reviewing in this paper. Just remember, if the INR is between 1.6-3.4 the recommendation is to continue the current dose and recheck in 1-2 weeks.

Surprised? Well it is real. "The enemy of good enough is just a little bit better" and the data shows that patients spend LESS time in the therapeutic window if we change more than this.

There is modeling data on the costs of warfarin vs NOACs based on cost-effectiveness data but no solid studies of real-world data. Obviously this can be a very complex comparison so stay tuned…

Want all of this and more? Check out the 9th edition of the ACCP guidelines for antithrombotic therapy and prevention of thrombosis. Scintillating reading!

Happy learning!!

1. CDC 2015; http://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_atrial_fibrillation.htm accessed on 4/15/2016
2. Sparctool http://www.sparctool.com
3. Rose AJ, Ozonoff A, Berlowitz DR, Henault LE, Hylek EM. Warfarin dose management affects INR control. J Thromb Haemost. 2009;7(1):94-101.
4. Guyatt GH, Akl EA, Crowther M, Gutterman DD, Schuunemann HJ. Executive summary: Antithrombotic Therapy and Prevention of Thrombosis, 9th ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. Chest. 2012;141(2 Suppl):7s-47s
5. Buelt A, DO. Questioning Medicine. In: Andrew Buelt D, ed. Warfarin - Far From a War; 2015

THE POET'S SPOT

Whereas animals are individually primitive but collectively advanced, humans can be individually advanced but remain collectively primitive. To save our planet, we will need to achieve collective enlightenment. Given the fallibility of human nature, which has, so far, defied all governments and prophets, seeking such collective enlightenment should become our universal goal.

When The Heartache Comes

HANNA SAADAH, MD

It has been a long while, now
And still everything is well
Smiles glimmer, nonchalant, on our faces
Our bodies, surfeited, sigh in their sleep
Friendships hold us in their profound embraces
And hope, like roots, runs dark and deep
And full of promises it cannot keep.

In placid innocence, we've lived and loved
And slumbered, unaware of predators or fate
Unaware that—like change and age and death
The heartache always comes to those who wait.

Our teachers taught us many things
Especially things we did not need to know;
Our teachers (who were not real teachers)
They were newspapers and screens and magazines
And handed down ideas, which belied
But still became our uncontested guide.

Though no one ever taught us that
Like change and age and death
The heartache always comes to each of us
Though no one was allowed to teach us thus
Lest our minds should grovel and become unnerved
Yet nonetheless, the heartache always comes
When least expected and when least deserved.

Look, what a Homo sapiens herd
Unthinking, unaware, surreal, absurd
While the rivers cough and choke
And the cities blur in smoke
Battles, bombs, and bullies reign
Aggression dispensed in vain
No one wins by causing pain.

AUTHORIZATION

H. K. Kurkjian, MD

Those of us who continue to be independent physicians face more and more hurdles. These have been partly removed for physicians signing up with hospitals and other organizations.

Authorization has been invented by the businessmen of healthcare. These are mostly health insurance people. Authorization may be required for a procedure, a medication or simply to allow the specialists to see a patient. Authorization is most commonly granted by an inexperienced worker. At times it just a matter of giving the authorizing person minimum information needed. At other times the situation can degenerate into an argument that may take a lot of time and multiple phone calls. Another form of authorization is getting a patient referral from a family physician's office so one can see a patient. Authorizations are required for imaging, like CT scans and pet scans.

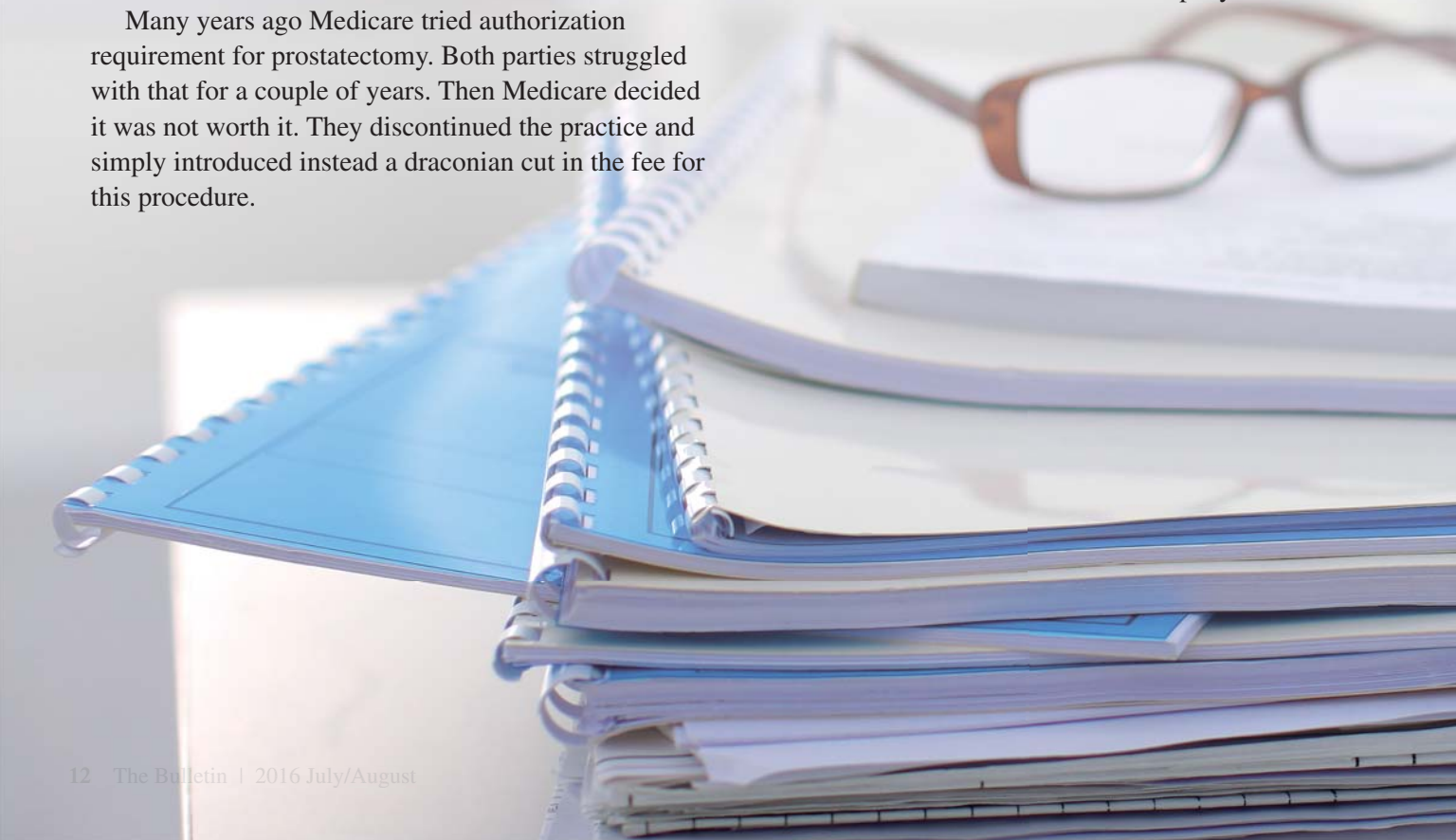
Many years ago Medicare tried authorization requirement for prostatectomy. Both parties struggled with that for a couple of years. Then Medicare decided it was not worth it. They discontinued the practice and simply introduced instead a draconian cut in the fee for this procedure.

In my opinion, the whole idea of authorizations and health-care is distrust of the physician or simply a delay tactic. A $12.00 per hour employee of the insurance company can discourage or deny just one CT at $1,200.00. This could pay the salary of that employee for more than 2 weeks. How about one chemotherapy for $95,000? This would pay the employee's salary for more than 5 years.

Family physicians referring patients to specialists also encounter a lot of difficulties. Just filling the form by the employee takes too much time. I'm also concerned that some physicians don't have time to review the referral form and may sign it anyway.

Delayed treatment and diagnosis could be detrimental to the patient's health.

Sometimes insurance companies can be vindictive. At times I have had to operate on a patient on the weekend and the health insurance company would not



authorize retrospectively. The work was done but I couldn't get paid. At times even during the week if we made a mistake of not getting authorization prop the claim would be denied. No appeal would succeed.

Patients don't think much of authorization and have very little understanding how that works. They are persistent in calling us back at times blaming us as to why the authorization is taking so much time. Most patients insist to have their insurance company pay for Viagra. Insurance companies are very reluctant to this, especially now that one Viagra tablet costs more than 70 dollars.

On Friday afternoon after the clinic closed I decided to try to get an authorization for Viagra for a patient. I initiated the call and I told the person on the other side that I was recording the conversation. We talked back and forth as she was asking for unending information. Once in a while she would put me on hold and check with her "manager" on something. This at times would take 5 minutes but I would wait. At times you would think she's doing this so I will hang up. However, I wouldn't. I was just trying to see what it takes to get an authorization. Finally, she came back and said it would not be approved. I looked at my watch it was a full 18 minutes since we had started.

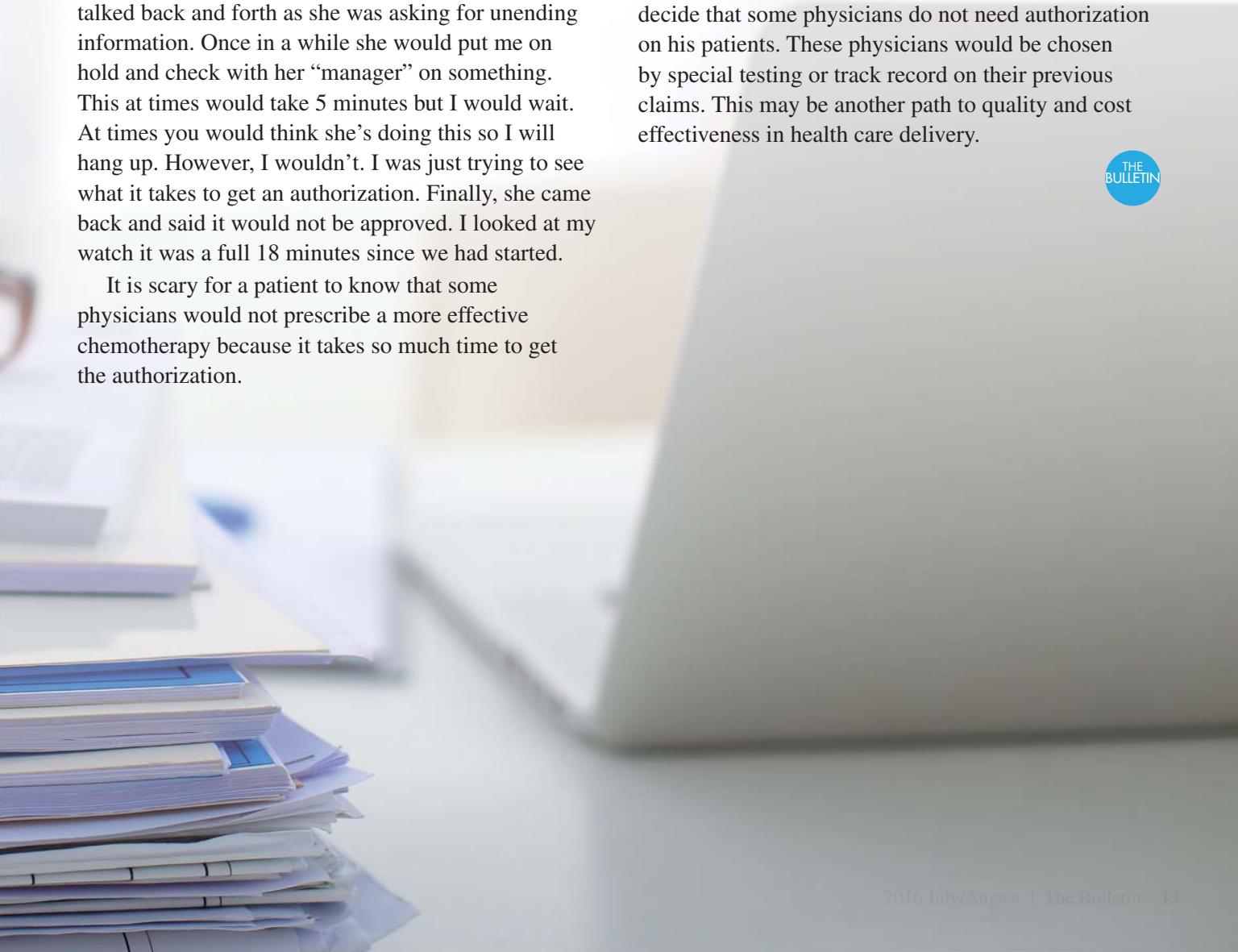
It is scary for a patient to know that some physicians would not prescribe a more effective chemotherapy because it takes so much time to get the authorization.

So what can we do?

In requesting CT scans I have found that the independent radiology clinics are more than happy to do the authorization. This has saved us several hours. Some people will recommend that we asked to speak to the manager of the person on the other side of the line. On more expensive requests, we may even ask to be connected to the medical director could give better results and quicker action.

This phenomenon may disappear for physicians in Accountable Care Organizations. These are groups usually made up of a hospital and employed physicians. They get the one global fee from the insurance company to take care of the patient. This would eliminate the need for authorizations.

For other physicians, the insurance company may decide that some physicians do not need authorization on his patients. These physicians would be chosen by special testing or track record on their previous claims. This may be another path to quality and cost effectiveness in health care delivery.



IN MEMORIAM

LAWRENCE WILLIAM DAVIS, MD
1949-2016

RVU Calculator Available

The Harris County Medical Society has developed a Work RVU Calculator to help physicians determine their total work RVUs. The calculator includes 40 different specialties based upon the top 50 codes for their particular specialty. Plus, if a particular code is not listed within the top 50 codes additional codes can be added to help determine work productivity based upon the work RVU. To access the calculator, visit **www.hcms.org/work-rvu-calculator**.

Barbara Jett, A True Icon.

Barbara Jett, second from left, pictured with husband Mason Jett, MD, daughters Elizabeth Jett, MD and Sharon Jett, and grandsons Coulter and Landon Gaske.

I first met Barbara Jett at an Allied Arts party in 2003. Roy and I had just moved back to Oklahoma City. The party was held in a beautiful home and it was packed with patrons. Barbara was so friendly and immediately introduced herself to us, as we did not know anyone at the party. She was very interested in us as people and we quickly became friends. During that initial conversation she told us all about her two wonderful daughters. She spoke so lovingly about them and all of their accomplishments. I never forgot that night and often think what a kind and good person Barbara Jett is and continues to be to her friends, her family and her Medical Alliance.

Continues on page 20 …

Barbara Elizabeth Waters Jett, an only child was born in Salem, Illinois. She graduated from Salem Community High School. She then graduated from Eastern Illinois University with a BS degree in Education as well as a MS in Education. Her major was Business with a minor in Home Economics. She also took many courses in early Childhood Education. She was employed as a teacher working at Kimball Junior High School, Larkin High School, Deep Creek Junior High School, Heritage Hall Upper School and Covenant Presbyterian Preschool.

In 1970 she married the love of her life, Mason P. Jett, MD a successful General Surgeon and Burn Surgeon. She so passionately refers to him as "Smokey." Smokey and Barbara had their first date on his 16th birthday and they just celebrated their 46th wedding anniversary. They each went to different schools but were married after his first year in Medical School at Johns Hopkins. Barbara belonged to the Hopkins Medical School wives' auxiliary and the Hopkins resident wife's group. Therefore, she has been an auxiliary/alliance member since 1971. She says that she married someone with the same goals and values as herself. She also says that communication is very important. Barbara says that someone once told her that no one guarantees you a retirement, so live a little along the way. So together Smokey and Barbara took trips, gave their children unique experiences and placed a high value on education.

Together they raised two successful daughters. Sharon Carol Jett is an attorney and CPA practicing in Dallas, Texas. Elizabeth Ann Jett, MD (Betsy) is a radiologist practicing in Oklahoma City, Oklahoma.

Smokey and Barbara have two grandchildren: Coulter Gaske, 11and Landon Gaske, 8. Both boys attend Heritage Hall School.

Barbara has served on many Boards and has volunteered with many Community organizations such as Westminster Presbyterian Church, Covenant Presbyterian Church, Heritage Hall School, Lyric

Theatre, Allied Arts, Schools for Healthy Lifestyles, Redlands Council of Girl Scouts, Saint Anthony Hospital, Baptist Hospital, and the American Heart Association Heart Ball. However, we in the Alliance really appreciate her leadership in all Alliance positions. For example, Barbara has been elected and completed the following leadership positions:

AMA Foundation Chair 2006-07
Bylaws Chair 2007-2012, 2015-6
Board Development chair 2012-2014
Oklahoma State Medical Association Alliance – 1980-present
Board Member- 1988-present
Treasurer
Historian
Health Promotion Chair
Secretary
Treasurer Elect
Finance Chair
Past President
Vice President RPS
President 1996-97
Health Education Foundation Treasurer 1998-present
Chair of the Presidential Committee – President 2007-2008
Bylaws chair, 2014
American Medical Association Alliance – 1980 present
Health Promotions Committee member-1997-98
AMA Foundation Committee member-1998-1999
Elected to national nominating committee-1998
AMA Foundation Chair and Board of Directors – 1999-2000
Field Director 2000-2001, 2002-2004
AMA Alliance Bylaws committee member – 2000-2001
Chair of Bylaws Reference committee – annual meeting 2001
Elections committee 2005, 2006
Integrated Marketing Committee 2005-2006
Task force for Senior Members 2015-16
Oklahoma State Medical Association Council on Legislation and Regulation 1996-2005
Southern Medical Association Auxiliary Member – 1997-present

Today one can find Barbara on the sidelines watching her grandsons play all kinds of sports. Her legacy of hard work, kindness and honestly lives on in her grandchildren. Last month Kathy Bookman, OSMA Alliance President, presented a "Presidential Citation" award to Barbara. Barbara was chosen for her outstanding leadership and commitment to the OSMA Alliance. On behalf of your Alliance family we say, "Congratulations and great job Barbara."

Amy Richter Bankhead
President
Oklahoma County Medical Society Alliance

PART 4: PEER REVIEW – CONFIDENTIALITY, DISCOVERABILITY, ADMISSIBILITY AND PRIVILEGE

COMPILED BY
S. SANDY SANBAR, MD, PHD, JD, FCLM, DABLM, DABFM

Since 1995, Oklahoma has recognized the doctrine of independent corporate negligence or responsibility (or negligent credentialing),[1] which is separate and apart from hospital malpractice or liability and has no cap damages. Corporate negligence imposes a duty upon hospitals, through its peer review process, to "ensure that: (1) only competent physicians are granted staff privileges; and (2) once staff privileges have been granted to a competent physician, the hospital must take reasonable steps to ensure patient safety when it knows or should know that a staff physician has engaged in a pattern of incompetent behavior." The peer review credentialing and re-credentialing process evaluates (a) the credentials, (b) competence, (c) professional conduct, and (d) health care services of a health care professional.

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In Oklahoma, peer review information shall be private, confidential and privileged.[2] The information comprises "all records, documents and other information generated during the course of a peer review process." This includes any reports, statements, memoranda, correspondence, record of proceedings, materials, opinions, findings, conclusions and recommendations, credentialing data and re-credentialing data.

To prove a case of corporate negligence or negligent credentialing, it is essential that the plaintiff patient obtain relevant peer review information. How is that accomplished?

First, certain peer review information/documents are specifically excluded by statute and are discoverable, including:

1. *Medical records* of a patient whose health care in a health care facility entity is being reviewed;
2. *Incident reports* and other like documents;
3. Identity and factual statements of any individual who has personal knowledge regarding the facts and circumstances surrounding the patient's health care in the health care facility entity; and
4. Identity and copies of all documents and raw data *previously created elsewhere and considered* during the peer review process, whether available elsewhere or not.

Second, the peer review statute has two exceptions which allow discovery of peer review information:

1. With notice to the professional under investigation, relevant peer review information may be provided to a *State agency or Board which licenses the health care professional* who provides the services being reviewed in a peer review process or who is subject to a credentialing or re-credentialing process.

2. In a negligent credentialing/hiring claim against a health care facility, "*the credentialing and re-credentialing data,* and the *recommendations made and the actions taken* as a result of any peer review process is discoverable, *prior to the date of the alleged negligence*. However, the peer review information is admissible as evidence in a trial after a judge or jury has first found the professional negligent in the care of the patient in the health care facility.

Of import, merely labeling a committee or process as a peer review committee or process is not sufficient to convince the court. The Judge decides whether the activities are part of the "ordinary course of business" or in connection with formal peer review committee activities. When determining if a committee is conducting peer review, Judges use the following factors:

1. Whether the sole purpose of the committee is to conduct peer review and not have multiple functions;
2. Whether quality assurance is the primary purpose of the committee;
3. Whether the investigation of the health care professional is conducted by one person or by a committee of several professionals;
4. Whether the investigation is an internal one that is not carried out by a regularly constituted committee; and
5. Whether non-physicians participated in the review process.

The party that claims the peer review privilege, usually the hospital, has the burden of proving that the peer review information is protected. In some cases where a party asserts the peer review privilege, the judge upon request/motion by the opposing party may obtain the requested documents sealed in an envelope. Then the judge may privately review the documents, so-called in camera review, to determine whether or not the peer review privilege applies.

The statute also provides that *peer review committee members* may not be permitted or required to testify regarding the peer review process in any civil proceeding or by written discovery requests. However, they may be sued for failing to follow the hospital bylaws, rules and regulations of the peer review process. If the peer review committee members prove that they did carefully follow procedure, then they are immune from liability. Other health care professionals who sit on non-peer review committees at a health care facility or who are not peer review committee members are not protected and may testify.

To date there are no appellate decisions pertaining to the Oklahoma peer review statute. Courts may look to case law in other states to determine how a particular peer review issue has been decided. A 2016 Illinois Supreme Court decision, *Klaine v. Southern Illinois Hospital Services*,[3] is a landmark decision that will have a significant impact on what peer review documents about the health care professional are discoverable, including copies of reports from the National Practitioner Data Bank. *Confidential does not necessarily equal privileged*. When the legislature creates "a privilege," it does so explicitly. The *Klaine* court found *the standard application for privileges was discoverabl*e as "[t]here is no general privilege under Illinois law that provides that information otherwise discoverable is privileged because it is confidential."

In claims alleging negligent credentialing, the plaintiff will have to prove that (1) the hospital chose not exercise reasonable care in granting a physician privileges, (2) the physician was negligent in the care of the patient, and (c) that the negligent grant of privileges was the proximate cause of the plaintiff's injuries.[4] In sum, health care facilities must not underestimate the importance of a thorough, complete and comprehensive credentialing and re-credentialing of their health care providers.

[1] *Strubhart v. Perry Memorial Hospital Trust Authority*, 1995 OK 10, 903 P.2d 263

[2] 63 O.S. Section 1-1709.1 (B)(1)

[3] 2016 IL 118217(Ill. S.Ct.)

[4] *Frigo v. Silver Cross Hospital & Medical Center*, 377 Ill.App.3d 43, 72 (2007)

2016 **BOARD NOMINEES** ANNOUNCED


NIHIRA


SALINAS


HASSOUN

NOMINEE FOR POSITION 2: EDMOND/MERCY

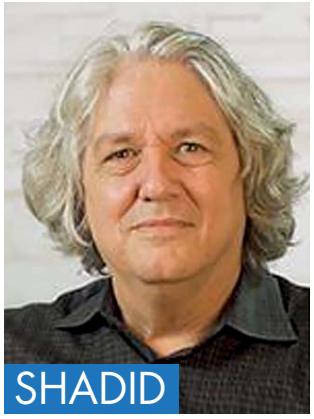
Basel S. Hassoun, MD
Dr. Hassoun is a board-certified urologist with Urology Surgeons of Oklahoma. He completed medical school at Kuwait University, residency with the University of Hawaii and OUHSC.

NOMINEES FOR POSITION 1: BAPTIST/DEACONESS

Mikio A. Nihira, MD
Dr. Nihira is a board-certified OB/GYN with OU Medical Center. He completed medical school, residency and internship with UCLA, and a fellowship at the Greater Baltimore Medical Center.

Robert C. Salinas, MD
Dr. Robert Salinas is an Associate Professor at the OU College of Medicine, Department of Family and Preventive Medicine. He is board certified in family medicine, geriatrics, and hospice and palliative medicine. He is also a graduate of the Harvard Medical School Scholars Program in Palliative Care Education and Practice and is founding Medical Director of the OU Medical Center Palliative Care program.


ROBERTS


SHADID

NOMINEES FOR POSITION 3: OU MEDICAL CENTER

D. Neil Roberts, MD
Dr. Roberts is a board-certified gastroenterologist. He completed undergraduate studies at Oklahoma Christian University, graduated from the OU College of Medicine in 2003, completed residency at the University of Alabama at Birmingham, and returned for fellowship at the OUHSC. He remained on faculty with the Section of Digestive Diseases from July 2009 through August of 2012. Thereafter, he started private practice with HPI as a member of The Physicians Group. He is a fellow of the ASGE. He serves at the Lighthouse Medical Clinic in south Oklahoma City, and has enjoyed recent mission efforts in Guatemala with Health Talents International.

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POSITION 3 NOMINEES, cont.

Ralph O. Shadid, MD
Dr. Shadid is a board-certified internal medicine physician. He completed medical school, an internship and residency at OUHSC, where he was Chief Resident. Dr. Shadid has been the Medical Director of INTEGRIS Southwest Medical Center since 2004.

NOMINEES FOR POSITION 4: ST. ANTHONY

Tabitha D. Danley, DO
Dr. Danley is a board-certified family medicine with OB physician with St. Anthony's. She completed medical school at the West Virginia School of Medicine, fellowship with the Spokane Family Medicine/Obstetrics, and residency and internship with St. Anthony's.

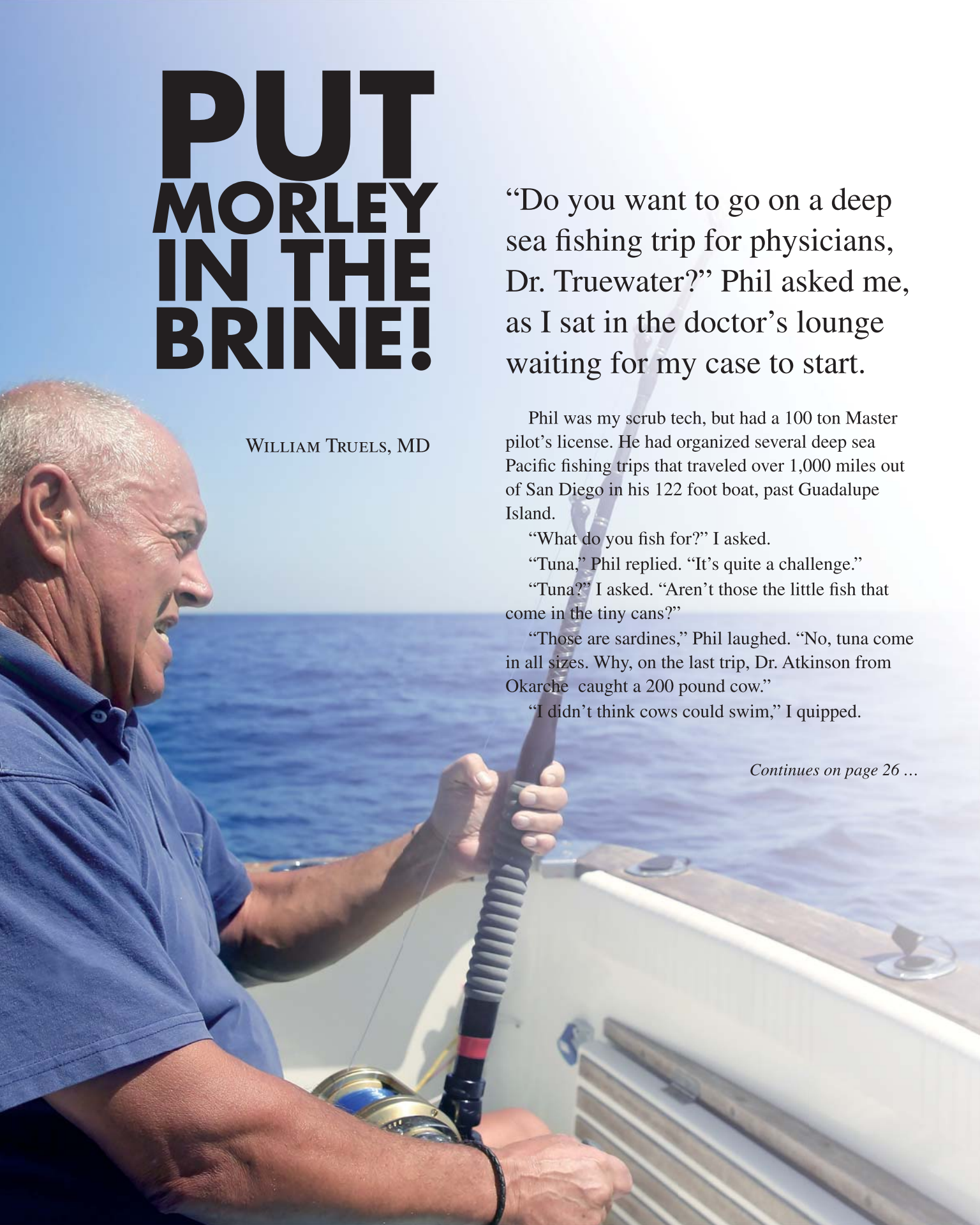
David W. Lam, MD
Dr. Lam is a board-certified hematology/oncology physician with St. Anthony's. He completed medical school at OU College of Medicine, and residency and fellowship at OUHSC.

The official ballot will be mailed to each OCMS voting member on or before September 15. Completed ballots must be received by OCMS postmarked no later than September 30.

Thank you to the OCMS Nominating Committee for their work this year: C. Douglas Folger, Chair; Julie Strebel Hager, MD, Vice-Chair; Jason S. Lees, MD; and Kersey Winfree, MD.

PUT MORLEY IN THE BRINE!

William Truels, MD



"Do you want to go on a deep sea fishing trip for physicians, Dr. Truewater?" Phil asked me, as I sat in the doctor's lounge waiting for my case to start.

Phil was my scrub tech, but had a 100 ton Master pilot's license. He had organized several deep sea Pacific fishing trips that traveled over 1,000 miles out of San Diego in his 122 foot boat, past Guadalupe Island.

"What do you fish for?" I asked.

"Tuna," Phil replied. "It's quite a challenge."

"Tuna?" I asked. "Aren't those the little fish that come in the tiny cans?"

"Those are sardines," Phil laughed. "No, tuna come in all sizes. Why, on the last trip, Dr. Atkinson from Okarche caught a 200 pound cow."

"I didn't think cows could swim," I quipped.

Continues on page 26 …

MORLEY *Continued from page 25 …*

"No, a cow is a large female tuna," Phil laughed again. "I can see you're in dire need of some deep sea fishing experience."

"The trip sounds interesting" I answered. "How'd your last trip go?"

"It was very successful," Phil replied. "Each doctor caught at least one tuna as well as dorado and wahoo. We had fifteen doctors on a sixteen day excursion."

"We left out of San Diego, and each doctor said it was the trip of a lifetime."

"Sounds fantastic," I replied.

"Well, except for one doctor," Phil added.

"One doctor?" I asked.

"Dr. Morley Oaks," Phil replied. "He didn't have such a good time."

"Well, let me qualify that," Phil added.

"For the first eight days, Dr. Oaks – he told us to just call him Morley – had a great time – the time of his life, he kept telling me."

"Then what happened?" I asked.

"Well, Morley was about 60 years old. He worked for 30 years as a cardiologist in Kingfisher. Never got to spend his money. But that's what kids are for."

"Anyway, Morley had been out in the sun and the salt breeze for sixteen hours a day for the previous eight days, and he got all excited – he managed to hook a big tuna cow. I guess you could call it a heart stopping experience."

"You see, tuna herd their prey, forcing smaller fish such as anchovy and herring to the surface in an ever smaller circle. We were in the middle of this circle, and all the docs were getting some action."

"Sounds exciting," I replied.

"That's when I noticed Morley– he'd hooked into a yellowfin cow tuna and was getting spooled. Then he sort of slumped against the side rail and dropped his fishing reel."

"What'd the other docs do?" I asked.

"Well, one of the other docs quick grabbed his reel as it went skittering across the deck—they knew Morley had hooked a big one."

"No, I mean what did they do for Morley?"

"Well, there was really nothing they could do. I mean, his buddies tried to resuscitate him – they pounded on his chest and all that, but it was no use. Besides, we were four days – 850 miles – from the nearest civilized land, and we didn't have a satellite phone."

"So then what happened?" I asked.

"Well, we left Morley on the deck so we could reel in his cow. Then, after the tuna left, we all gathered in a circle. One of the doctors – his name was Grule – had spent two years in seminary school before going to medical school, and he said a small prayer for Morley."

"That was very considerate," I said. "It must have been a solemn occasion."

"Dr. Grule said that Morley had been a good doctor, and that the same God that watched over the tuna watched over Morley."

"He said that just as Morley had reeled in the tuna, God had chosen to reel in Morley. It was very touching. There wasn't a dry eye on the boat."

"I imagine you must have cut the trip short, and headed back," I said. "It must have been a somber return home."

"Well, not quite," Phil replied. "The fourteen remaining doctors took a vote – we had two more days of fishing left, so we decided to continue the excursion."

"You kept on fishing after Morley died?" I asked.

"What was the vote?"

"Thirteen to one," Phil replied. "One of the doctors – I think he was a plastic surgeon – got seasick."

"Well, life must go on," I answered. "But, what'd you do with Morley?"

"We wrapped him in his fishing gear and threw him in the brine, next to his cow tuna."

"You threw Morley in the brine?" I asked.

"Sure, I mean, what else could we do? He was dead, after all. We put him on top, and face up, to show respect. We even left on his fishing cap. He floated there for eight days before we got back."

"Well, what did Morley's wife say when you got back to shore?" I asked.

"I called her on the phone and gave her the bad news. She cried for a few minutes, then she said that's what Morley would have wanted."

"Why would Morley have wanted that?" I asked.

"Well, you know, to die while you're doing what you love most – no ventilators, no electric shock, just go in peace."

"Let's face it," Phil added. "Life – sometimes just staying alive – is a battle – one that we will all eventually lose. The idea is to make the most of it while you can – that's what Morley was doing."

"True enough," I said, as I slipped on my mask and headed back to surgery.

"I guess you could say Morley got to sleep with the fishes!"

SAFE-DROP KIOSKS

Walgreens announced that it has implemented two programs in Oklahoma to combat drug abuse, part of a comprehensive national plan to address key contributors to the crisis.

Individuals now have a safe and convenient way to dispose of their unwanted, unused or expired prescriptions, including controlled substances, and over-the-counter medications, at no cost. Walgreens has installed safe medication disposal kiosks in locations across the state, including three in the Oklahoma City metro area. The safe medication disposal kiosks make the disposal of medications easier while helping to reduce the misuse of medications and the rise in overdose deaths.

Walgreens has also made naloxone available without requiring a prescription from an individual's physician in all of its Oklahoma pharmacies in accordance with state pharmacy regulations.

To kick off the launch of the safe medication disposal program in Oklahoma, Walgreens hosted at one of its Oklahoma City stores Governor Mary Fallin, State Senator John Sparks, Oklahoma City Mayor Mick Cornett, Oklahoma Commissioner of Health Terry Cline and Oklahoma Department of Mental Health and Substance Abuse Commissioner Terri White.

The installation of safe medication disposal kiosks in Oklahoma is part of a nationwide effort and is expected to be completed at more than 500 Walgreens locations later this year. The kiosks at will be available during regular pharmacy hours (24 hours a day at most of these locations) and will offer one of the best ways to ensure medications are not accidentally used or intentionally misused by someone else.

Select Oklahoma City metro-area Walgreens with safe medication disposal kiosks:

Edmond -- 1400 E. 2nd St.

Midwest City -- 101 N. Midwest Blvd.

Oklahoma City -- 5120 N. May Ave.

DIRECTOR'S DIALOGUE

By Jana Timberlake, Executive Director

"The reason I exercise is for the quality of life I enjoy."

~ Kenneth H. Cooper

Healthy Living & Fitness, Inc. is the organization selected by Oklahoma City to run the first Maps 3 Adult Wellness Center, located at 11401 N. Rockwell Avenue, Oklahoma City. Construction is underway, with a projected opening date in December 2016. I know all of this because I serve on the Healthy Living & Fitness, Inc. Board of Directors.

The Wellness Center will be a comfortable, safe environment to meet old friends and make new ones! Adults who are 50 years of age or older are eligible to become a member of this facility that will feature a swimming pool, exercise/fitness room, gymnasium, aerobics/exercise room, along with health screenings and seminars. Also offered will be arts and crafts classes, a billiards room, a demonstration kitchen and computer classes. Following a workout, friends may gather at the Center's café for a healthy lunch and an opportunity to "socialize."

At the present time, there is an opportunity for seniors to become a Founding Member by signing up for one of the options listed below:

- $1,000 Single Founding Membership - 3-year membership
- $2,000 Family Founding Membership - 3-year membership for 2 family members
- $1,500 Family Founding Membership - 2-year membership for 2 family members

This equates to a monthly fee of $27-$30 for each person. Founding Members will not only have access to a brand new facility, there will be a special grand opening event for Founding Members, name recognition in the Wellness Center and special Founding Member Only events during the year.

Think about it! The Wellness Center will be a great place to improve your physical fitness, learn new skills, expand your knowledge and stay active. It's very important that senior citizens (and yes, I am one of them) make the extra effort to keep their bodies and minds healthy! If you are interested in becoming a Founding Member, send an email to:

membership@healthylivingokc.com

or contact me at 405-702-0500 for additional information.

President John F. Kennedy said, "Physical fitness is not only one of the most important keys to a healthy body, it is the basis of dynamic and creative intellectual activity." Let's get moving!

JanaTimberlake, Executive Director

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Contact: **Marilyn Fick**, Medical Education
Phone: 949-3284

INTEGRIS SOUTHWEST MEDICAL CENTER

Contact: **Marilyn Fick**, CME Coordinator
Phone: 949-3284

MERCY HOPITAL OKC

Contact: **May Harshburger**, CME Coordinator
Phone: 752-3390

MIDWEST REGIONAL MEDICAL CENTER

Contact: **Carolyn Hill**
Medical Staff Services Coordinator
Phone: 610-8011

OKLAHOMA ACADEMY OF FAMILY PHYSICIANS CHOICE CME PROGRAM

Contact: **Samantha Elliott**, Director of Membership
Phone: 842-0484
Email: elliott@okafp.org
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Phone: 272-6748

ORTHOPAEDIC & RECONSTRUCTION RESEARCH FOUNDATION

Contact: **Kristi Kenney**, CME Program Director
or **Tiffany Sullivan**, Executive Director
Phone: 631-2601

RVU Calculator Available

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MEDICAL TRENDS

The Harris County Medical Society has developed a Work RVU Calculator to help physicians determine their total work RVUs. The calculator includes 40 different specialties based upon the top 50 codes for their particular specialty. Plus, if a particular code is not listed within the top 50 codes additional codes can be added to help determine work productivity based upon the work RVU. To access the calculator, visit **www.hcms.org/work-rvu-calculator**.

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It's a monthly email newsletter that we send to all of our members with news and information. It's short and easy to read, just right for our busy members. It is distributed in the middle of the month, so if you don't remember seeing it, please check in your spam email folder!

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