THE BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY

SEPTEMBER/OCTOBER 2019

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EXHIBITION

21C MUSEUM | OKLAHOMA CITY | THROUGH DECEMBER 2019

OCMS
OKLAHOMA COUNTY MEDICAL SOCIETY

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THE BULLETIN

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Thank You

"Make a habit of two things: to help; or at least to do no harm." – Hippocrates

The Oklahoma County Medical Society would like to thank the following physicians for their generous donations to the Physician Wellness Program:

- ★ Steven A. Crawford, MD
- ★ Sam S. Dahr, MD
- ★ Shirley E. Dearborn, MD
- ★ William F. Kern III, MD
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- ★ Michael Steelman, MD
- ★ Don L. Wilber, MD
- ★ Peter A.S. Winn, MD
- ★ Lisa J. Wasemiller-Smith, MD

The Physician Wellness Program provides free, confidential counseling at no charge to physicians. To date, the program has provided more than 70 visits to Oklahoma County physicians in need. Anonymous feedback has been overwhelmingly positive.

You can make a difference in the life of a fellow physician with your donation. Your contribution is tax-deductible. Donate online at okcountymed.org/pay or mail a check to the OCMS Community Foundation, 313 NE 50th, Suite 2, Oklahoma City, OK 73105.

ABOUT THE COVER

"The relation between what we see and what we know is never settled. Each evening we see the sun set. We know that the earth is turning away from it. Yet the knowledge, the explanation, never quite fits the sight."

"We only see what we look at. To look is an act of choice."

– John Berger (1926-2017)
Ways of Seeing

This multi-media selection of works by over two dozen artists explores what and how we see today, revealing the visible and hidden forces shaping both what the contemporary world looks like, and how we consume and interpret that information—how visual and psychological perception are evolving in the 21st century. The global pervasiveness of conflict has engendered the normalization of shock and numb; wanting to look but not to see, we lose sight. As many of these artworks reveal, we are disturbed by violent, unjust, or tragic incidents, yet accustomed to their regularity, and may be blind to their causes and costs.

Contemporary art is the heart of the 21c experience. Look for the sixteen-foot-high perforated steel tree, Woozy Blossom, which produces a continuous fog along Main Street; then explore the current exhibition; dine in a sculpturally expressive space at Mary Eddy's; or discover the art of time with the site-specific installation River of Time.

***Seeing Now**, an exhibition from the 21c Museum in Oklahoma City Through December 2019*

OCMS
OKLAHOMA COUNTY MEDICAL SOCIETY

PRESIDENT'S PAGE

R. KEVIN MOORE, MD

BIG PHARMA, BIG PROFITS.

I hope that everyone had a great summer. It seems summer just started, and here we are ready for football! I decided to continue on from my last article for this month's Bulletin and discuss Big Pharma and their profits, and how the consumer is the one that suffers. Truvada is a fixed dose combination of two antiretroviral medications, tenofovir and emtricitabine. It is manufactured by Gilead Sciences, Inc., "a research-based biopharmaceutical company that discovers, develops, and commercializes innovative medicines in areas of unmet medical needs" and is headquartered in Foster City, CA. They produce and hold patents on approximately 10 HIV medications, several Hepatitis C medications, and new cancer treatment drugs. On June 11, 2019, the United States Preventive Services Task Force (USPSTF) recommended Truvada and PrEP for all individuals at risk of HIV. This "A" recommendation will help ensure that insured Americans at risk of HIV have access to PrEP meds with no out-of-pocket costs to them, as the ACA requires that insurers provide preventative services with an "A" and "B" recommendation at no cost. Gilead has pledged to donate 2.4 million bottles of PrEP annually to people without insurance up to the year 2030, covering about 200,000 lives.

Research on Truvada began in 1986 when a European scientist filed a patent for tenofovir. In 1997, Gilead and the UC San Francisco, showed that tenofovir treated HIV intravenously; in 2004, the FDA approved use of Truvada with other ART medicines for the treatment of HIV in patients 12 years of age and older. Then, Truvada was approved for PrEP therapy in 2012. It is currently the only drug in the United States approved for PrEP therapy for HIV negative people to prevent them from contracting HIV. It currently has 6 US patents protecting it and 237 international patents which are set to expire in 2021. Gilead's CEO, Daniel O'Day, testified before a congressional hearing in May 2019 defending his company's high cost of the medication to pay for continued research. It is

People are forced to search elsewhere for medication treatment options.

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estimated that Truvada costs about $1.1 billion dollars to research, develop, and do clinical trials. Gilead has spent over $6 billion dollars on HIV/Aids research since 2000. When Truvada was first released, it cost about $800 per month; now, the cost has ballooned to about $2000 per month. Truvada earns Gilead about three billion dollars per year and about 36 billion dollars overall since its approval. Gilead posted profits of $13.5 billion in 2016 with almost the entirety going to shareholders – not research and development.

A senate committee just unveiled drug pricing reforms that would cap how much drug makers can hike prices in Medicare and cap out-of-pocket expenses for Medicare beneficiaries.

Congress zeroed in on the tens of millions of dollars in government grants and research done by scientists at the CDC that showed how effective Truvada was in the prevention of HIV to challenge the patent. The high cost of the medication is felt to be the main reason why less than 20% of the individuals who should be taking PrEP are on it. The FDA reports that the average cost of developing a drug and bringing it to market is about $2.6 billion. Drug development is not cheap, but it is also not nearly what the industry claims it to be. When a drug company has a potential blockbuster on hand, they will charge whatever they can to maximize profits. Perhaps this is why the monthly cost of Truvada has jumped from $800 to over $2000 a month over the past 10 years.

The Democratic candidates for POTUS have been focusing on Big Pharma and their profits. Bernie Sanders has tweeted that there is no rational reason why insulin and other life-saving medications should cost ten times more in the US than they do in Canada. Trump has repeatedly pledged to lower pharmaceutical prices, but his plan was later dropped after it was estimated it would boost federal spending by $177 billion over the next 10 years. Scott Gottlieb, former chief of the FDA, resigned to take a post on Pfizer's board. A judge blocked the administration's attempt to force drug manufacturers to disclose their prices in TV ads. Joe Biden and Kamala Harris have both put forth drug pricing plans that would involve capping drug prices, and profits above this cap would be taxed at 100%. Prescription drug prices is one of the most important concerns to US voters, but somehow, it received very little mention during the recent debates. A senate committee just unveiled drug pricing reforms that would cap how much drug makers can hike prices in Medicare and cap out-of-pocket expenses for Medicare beneficiaries. This is expected to save the government $85 billion in spending over the next decade.

How is the average American supposed to afford these life saving medications at such astronomical prices? Some have little to no out of pocket cost to receive these medications. Others are still charged hundreds of dollars per month, despite insurance coverage. Some insurers refuse to pay for PrEP at all, even though covering PrEP would be cheaper than dealing with expensive HIV treatment for life. Others refuse to cover preventive therapy, despite the aforementioned "A" rating from the USPSTF. People are forced to search elsewhere for medication treatment options.

Cipla, the largest generic manufacturer in India, received the right to produce the generic version of Truvada (Tenvir-EM) a few years ago. India currently has the third-highest rate of HIV worldwide, and Tenvir-EM is available from Indian pharmacies at

about $35 per month. Though it takes several weeks to ship and the purchasing process is annoying, Americans are turning to this option and hoping they receive legitimate medication and not a placebo filler.

I'm not sure what the answer should be. Perhaps a cap on what a drug company can charge for a medication. Perhaps getting rid of the years that a medicine can be under patent without a generic option available. After the company has shown what it cost for research and development, and after a certain percentage of profit is made, then a generic option could be available. But something must be done about prescription prices in this country. Every day that someone who should be on PrEP but isn't, another 100 people get diagnosed with HIV. As physicians, we must examine the candidates for president closely and their positions and plans for medication reform to help make our decision for 2020.

THE BULLETIN

OCMS
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events

Save the date for these upcoming OCMS events!

Monday, October 28, 2019
LGBTQ+ Physician Collegiality Dinner
Pearl's Oyster Bar – Classen Curve - 6:30 p.m.
Registration required: okcountymed.org/lgbtq-dinner

Monday, November 11, 2019
OCMS Annual Membership Meeting & Election of Officers
OSMA Headquarters – 6:00 p.m.
Topic TBD – Registration required: okcountymed.org/rsvp

Friday, January 31, 2020
OCMS Inaugural Dinner
Oklahoma City Golf and Country Club – 6:30 p.m.
Honoring Incoming OCMS President Lisa J. Wasemiller-Smith, MD
Registration available soon

CALL FOR NOMINATIONS:
RHINEHART MEDICAL SERVICE AWARD

Nominations are open for the 15th 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 on January 25, 2019.
Email nomination to: afink@okcountymed.org
Deadline: October 11, 2019

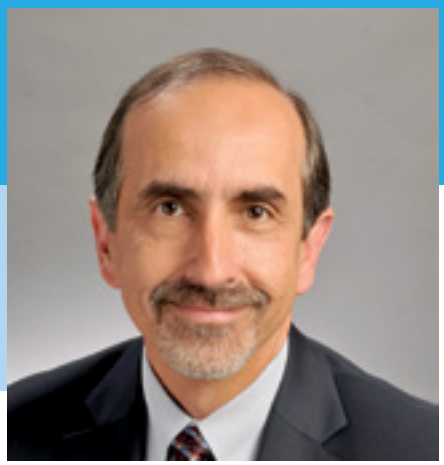
IN MEMORIAM

CHARLES WESLEY CATHEY, MD
1927-2019

THOMAS FINN, MD
1927-2019

DEAN'S PAGE

JOHN P. ZUBIALDE, MD
EXECUTIVE DEAN AND PROFESSOR,
FAMILY AND PREVENTIVE MEDICINE
UNIVERSITY OF OKLAHOMA COLLEGE OF MEDICINE



In the OU College of Medicine's mission of training the physicians of tomorrow, our curriculum could be considered a living document – a broad set of courses that are modified over time to meet the changing needs of our students and the profession of medicine.

One of the most valuable additions in recent years is the Clinical Transitions course, designed to help second-year medical students more smoothly shift from the lecture halls of their preclinical education to the hospital wards and clinics of their third and fourth years. Last year was the inaugural year for Clinical Transitions, a weeklong course designed by LaTasha Craig, M.D., one of our college's dedicated educators, and co-led by Mark Fergeson, M.D., our Associate Dean for Student Affairs. Clinical Transitions is also held on our Tulsa campus, led by Jeanne Hayes, M.D., and Michael Weisz, M.D., and faculty members organize the course according to the needs of the School of Community Medicine.

Clinical Transitions is held the week before students begin their clerkships and, by all accounts, serves as excellent preparation as they step into the clinical world for the first time. The course features information that is both practical and specific. In sessions led by their faculty, students learn about everything from working with diverse populations to writing concise notes to how to dress and where to park.

During the session on interprofessionalism, students come to understand that, in medicine, we work as a team of health professionals on behalf of patients, including nurses, dietitians, lactation consultants, social workers and pharmacists. Our medical students are introduced to the concepts of interprofessionalism during their preclinical years, but this is the first time they are putting it into practice, and we want them to understand the value of each person on the team.

Students also hear a lecture on death and dying. When they begin rounding on patients, students will inevitably face death, many of them for the first time. We not only want to teach them how to care for a patient who is dying, but also how to speak with families and how to cope with witnessing death. We don't want students to become immune to the strong feelings that come with death, but they also need tools for working through it.

Working with diverse patient populations is also a critical element of clinical care. This requires purposefully addressing implicit bias and how it may affect their care of patients as well as their work with families and caregivers. Students learn from faculty members about how to understand this bias and interact with patients from across many different populations. Whether it is in matters particular to ethnic, pediatric, geriatric or LGBTQ populations, understanding is critical to achieving the best care possible. Three different panel discussions – featuring fourth-year medical students, residents and clerkship directors – allow students to hear different perspectives and ask questions. Panel members provide helpful "do's and don'ts," situational awareness and what will be expected of students as they round on patients with a team.

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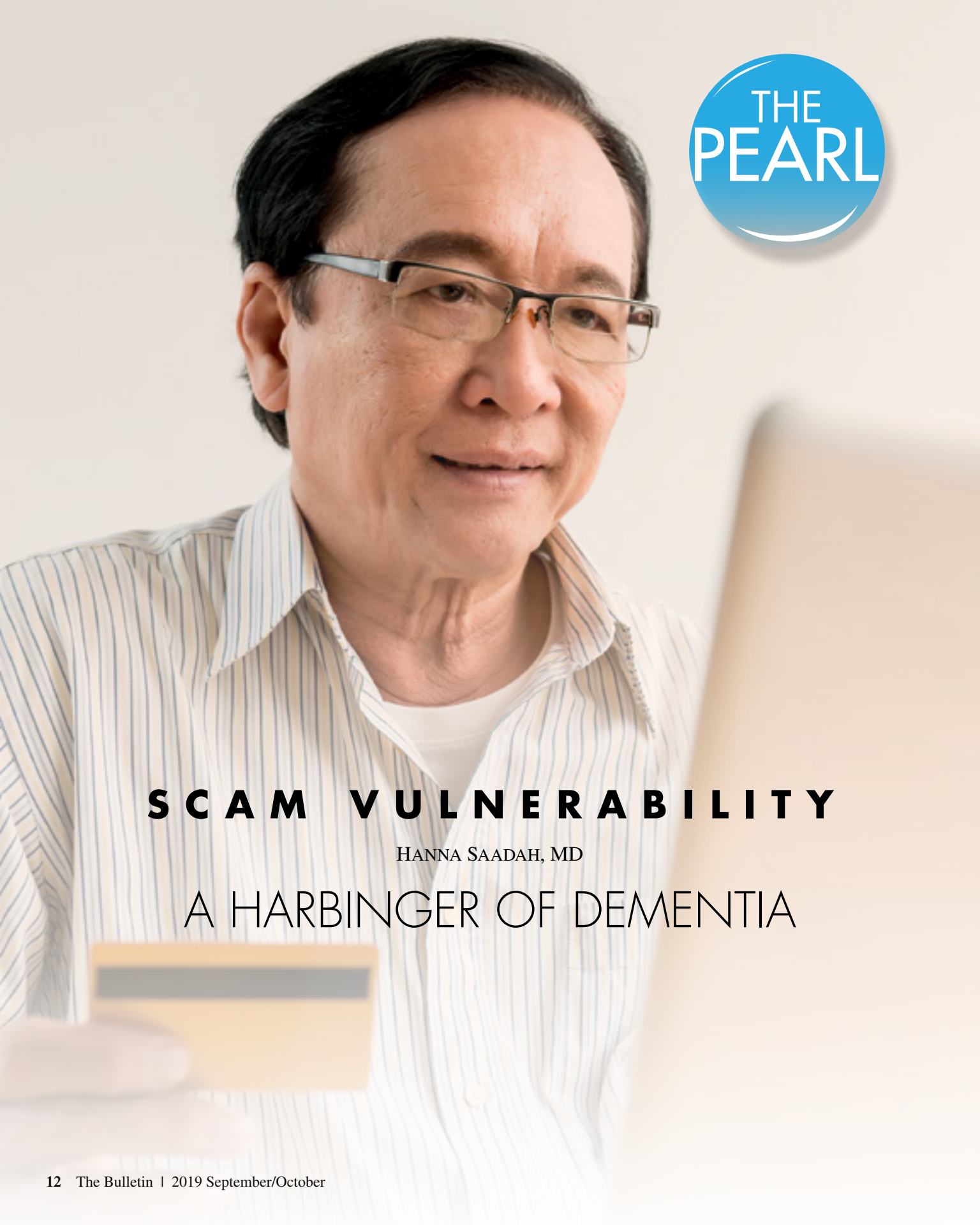
Of a more practical nature, students are taught how take a focused patient history, followed by writing a concise, efficient note about the patient's chief complaint. It's also important that students learn to think about a patient's differential diagnosis before they walk into a room. Our faculty members created a clever acronym to help students remember – CCDIF, or the Chief Complaint Differential. In the afternoons, students then go to the college's Clinical Skills Education and Testing Center, where they practice gowning and gloving, inserting IVs and other procedural skills they may perform. This hands-on training ensures they are ready to go on day one of rotations.

One of the most powerful aspects of the Clinical Transitions course is a story shared by an Oklahoma physician who speaks not about his work, but from his perspective as a parent. A few years ago, his son, who was about to become a high school senior, was diagnosed with an aggressive form of acute myeloid leukemia. The family sought care at hospitals in three states, but their son ultimately lost his battle last October. His father talks to students about the compassionate care his son received, but also about some of the poor care that added to the despair his family was feeling. But the biggest impact of the talk was that students witnessed his grief and gained a better understanding of how their professional lives will be interwoven with families' deepest loss and greatest joys.

After hearing this profound story, students recited a reaffirmation of the oath they took as first-year students, reminding themselves that they are about to begin experiencing the ultimate reason they began medical education: to care for patients.

I believe the Clinical Transitions course provides a crucial week of experiences for our new third-year medical students. It is a time when they take all the knowledge they have learned over the past two years and begin applying it to patient care. This move to the patient's bedside is what they have been working toward, and our mission is to give them both the skills and the empathy to make a difference.



THE PEARL

SCAM VULNERABILITY

HANNA SAADAH, MD

A HARBINGER OF DEMENTIA

Nature's way empowers the strong to prey on the weak and the con artists to prey on the trusting. When laws cannot protect our vulnerable elders, they fall prey to nature's way. Such is the state of scams today.

Lightening-speed technology has transformed humanity's finite possibilities into infinite opportunities for both the good and bad. One of the unforeseen consequences of lightening-speed technology is its adverse effect on our vulnerable elderly, who can be repeatedly scammed in great numbers at very little cost.

Age-Related Frailty, i.e. diminished homeostatic reserve, occurs because of intellectual and physical decline. Intellectual decline, when it manifests as Mild Cognitive Impairment, is a precursor of dementia. It is upon this vulnerable stage of Age-Related Frailty that scammers knowingly prey.

For the intellectually intact, spotting and dismissing scams takes but a quick decision-making click. For the intellectually frail, especially when lonely and isolated, spotting scams gets harder the older they get. Senior citizens possess a large amount of the nation's household wealth, wealth they have accrued over a lifetime of hard work, wealth that is the prime target of scammers. Estimates that financial fraud results in losses of 35 billion dollars annually fail to include the undeclared frauds, which many competent elders are too ashamed to report.

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Decision Making is a highly complex cognitive activity, which requires integrating multiple abilities while managing challenging social situations. Evidence suggests that impairments in Decision Making, which affect cognitively normal people, precede Mild Cognitive Impairment and dementia by several years.[1] Making sound decisions regarding scams and financial matters requires recognition of treachery, perception of the con artist's personality, and regulation of one's own behaviors. An awareness of the deceptive tactics used by scammers is essential for making correct decisions. It is unfortunate that many elders, who seem cognitively intact, have an age-related loss of Scam Awareness, which renders them Scam Vulnerable. Hence, Scam Vulnerability, which precedes Mild Cognitive Impairment and dementia, may be a valuable clinical marker of early cognitive decline.

Patricia Boyle of Rush University, in a community-based study of aging, followed 935 cognitively normal octogenarians for 6 years[2]. During that period, 151 developed Alzheimer's dementia, and 264 died and their brains were autopsied. Low Scam Awareness, measured with a 5-point questionnaire, was associated with older age, lower cognition, lower financial and health literacy, lower psychological wellbeing, poorer decision making, increased risk of Alzheimer's dementia (HR 1.56), and increased risk of Mild Cognitive Impairment (HR 1.47). Each unit decrease on the score of Scam Awareness was associated with a 60% increase in dementia risk.

Rates of incident Alzheimer dementia almost quadrupled from 11 cases per 1000 person-years for High Scam Awareness to 42 cases per 1000 person-years for Low Scam Awareness. Similarly, those of Mild Cognitive Impairment more than doubled from 38 cases per 1000 person years for High Scam Awareness to 91 cases per 1000 person years for Low Scam Awareness. Low Scam Awareness was also associated with a more rapid decline in global cognition, indicating that Scam Awareness may be an early indicator of pathological cognitive aging.

Low Scam Awareness was also associated with the pathological hallmarks of Alzheimer's disease, namely brain beta-amyloid plaques and tau tangles. Pathologically, the lower the Scam Awareness, the

higher were the beta-amyloid and tau depositions in the autopsied brains. Thus, Low Scam Awareness seems to be not only an early harbinger of cognitive decline but also a manifestation of accumulating Alzheimer's pathology in the brain. This is in contrast to other predictors of Alzheimer's dementia and Mild Cognitive Impairment, which have not been strongly associated with direct Alzheimer's disease pathology.

Old brains accumulate a lot of pathology before Mild Cognitive Impairment becomes manifest. Low Scam Awareness, which entails difficulty in making decisions, can function as a red flag that alerts providers to the possibility of future cognitive decline and dementia. Low Scam Awareness and difficulty making decisions are complex, higher integrative functions that begin many years before age-related neurodegenerative disease is recognized.

Many cognitively intact elders answer the phone even when they do not know who is calling, listen to telemarketers because they are lonely, have trouble ending a telemarketer's call, and believe that what

is too good to be true is indeed true. Elder fraud is a major public health problem. Educating our cognitively intact elders on how to recognize and avoid fraud is a pressing ethical issue.

In the Geriatric Department at the VA Hospital, we teach students the 16 phenotypes of the Geriatric Syndrome by using the acronym: 4-F, 4-D, 4-I, and 4-P:[3]

- Falls, Failure to thrive, Frailty, Functional decline
- Delirium, Dementia, Depression, Driving problems
- Incontinence, Iatrogenesis, Impaction, Institutionalization
- Pain, Pressure ulcers, Polypharmacy, Post-discharge problems

As of this month, we have added Scam Vulnerability as the seventeenth Geriatric Syndrome phenotype. Asking patients if they had been scammed and letting them tell how it happened can be a sensitive indicator of early cognitive decline, a decline that is too mild for the usual neuropsychiatric tests to detect. It is unfortunate that the questionnaire used in the study by Boyle was not validated for individual use.

When such a validated questionnaire becomes clinically available, it will help us detect patients before they are scammed, which would give us a golden opportunity to teach them scam-avoidance skills and to delay the onset of Mild Cognitive Impairment and dementia by treating hypertension, diabetes, and hyperlipidemia, and by modifying life style, smoking, alcohol consumption, and physical activity.

[1]Low Awareness of Scammers' Tactics Linked to Dementia Risk in Cognitively Normal People. JAMA July 2, 2019 Volume 322, No 1.
[2]Scam Awareness Related to Incident Alzheimer Dementia and Mild Cognitive Impairment, A Prospective Cohort Study. Patricia A. Boyle, PhD; Lei Yu, PhD; Julie A. Schneider, MD, MS; Robert S. Wilson, PhD; and David A. Bennett, MD Ann Intern Med. 2019;170:702-709. doi:10.7326/M18-2711.
[3]Dr. Saleem Qureshi, VA Chief of Geriatrics and OUHSC Assistant Professor of Geriatric Medicine, developed this acronym in 2010, diagramed it in a bowtie pictogram, and has been teaching it to medical students ever since.

TREATMENT OF SUBSTANCE ABUSE DISORDER BY DRUG COURTS

COMPILED BY

S. SANDY SANBAR, MD, PHD, JD, FCLM*

The U.S. Constitution does not guarantee a right to healthcare. Patients addicted to drugs often end up in jail instead of receiving medical treatment. During the past two decades, the U.S. has been moving away from criminalization of substance abuse, and substituting a more compassionate model that is consistent with scientific findings that substance abuse is a disorder.

In 1925, in *Linder v. United States,* an Oklahoma physician gave Ida Casey one tablet of morphine and three tablets of cocaine for her addiction. She took the drugs alone in divided doses over a period of time, to satisfy her cravings. The Trial Court ruled that the treating physician violated The Harrison Narcotic Law. But the U.S. Supreme Court reversed the case, and held that direct control of medical practice in the states is obviously beyond the power of Congress.

In 1962, *Robinson v. California* was the first landmark decision of the U.S Supreme Court in which the Eighth Amendment of the Constitution was interpreted to prohibit criminalization of particular acts or conduct, as contrasted with prohibiting the use of a particular form of punishment for a crime. The California statute made narcotic addiction a punishable misdemeanor offense. The U.S. Supreme Court ruled that California could not imprison a person solely for being addicted to narcotics. In general, a law that punishes a status will unlikely be upheld.

In 1981, as a result of the cocaine epidemic, President Ronald Reagan signed laws that imposed harsh sentencing on crack-cocaine sales and use. Critics stated the laws were discriminatory in practice. They were not as humane as rehabilitation services, and did not succeed in quashing the drug epidemic. They overburdened the prison system, and they disproportionately impacted impoverished African Americans.

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*Executive Director, Diplomate and Past Chairman, American Board of Legal Medicine; Vice President and Director of CME, Western Institute of Legal Medicine, California; Fellow and Past President, American College of Legal Medicine; and Adjunct Professor, Medical Education, OUHSC.

In 2006, the U.S. Supreme Court ruled in *Gonzales v. Oregon* that the United States Attorney General cannot enforce the federal Controlled Substances Act against physicians who prescribed drugs, in compliance with Oregon State assisted suicide law, to terminally ill patients seeking to end their lives, often referred to as medical aid in dying.

In 2007, 1he National Institute on Drug Abuse (NIDA) Survey revealed that:

- 49% of federal inmates and 40 % of state inmates participated in a drug program, typically based on a self-help platform, such as peer counseling.
- 15% of state inmates and 17 % of federal inmates were in a drug treatment program in which a professional addiction specialist provided recovery services.
- Of the nearly eight million adults and 700,000 juveniles involved in the justice system, access to treatment services is minimal with less than 10 percent of offenders receiving the treatment that they need.

In 2010, the *Fair Sentencing Act* (FSA) was enacted by Congress and signed into federal law by U.S. President Barack Obama. It reduced the disparity between the amount of crack cocaine and powder cocaine needed to trigger certain federal criminal penalties from a 100:1 weight ratio to an 18:1 weight ratio and eliminated the five-year mandatory minimum sentence for simple possession of crack cocaine, among other provisions.

In 2011, in *Tapia v. United States*, a woman engaged in illegal immigration practices. When it came time for her sentencing, the trial court recognized that she was experiencing substance abuse. To help her recover while incarcerated, the trial court imposed a sentence of 51 months, to qualify her for the Bureau of Prisons' Residential Drug Abuse Program (RDAP). The U.S. Supreme Court held that:

- Neither state nor federal courts can impose a prison sentence on a defendant, nor lengthen a prison sentence, just so the defendant can receive drug recovery services or complete a program for inmates.
- And a person dealing with substance abuse cannot be sent to prison to get help, but can still get help once in prison.

In 2012, the U.S. Supreme Court held in *Dorsey v. United States* that the lower minimum sentences under the *Fair Sentencing Act* apply to offenders sentenced after the FSA's passage, even for crimes committed before its passage. (pre-Act offenders)

In the 2012 landmark case of National Federation of Independent business et al. v. Sebelius et al, the U.S. Supreme Court upheld the constitutionality of Affordable Care Act. It contained benefits related to substance abuse, including treatment and healthcare insurance coverage.

State Drug Courts has been exemplary in properly treating substance drug abusers.

- They complement the U.S. Supreme Court's decisions.
- They can provide individuals experiencing substance abuse with meaningful help.
- And drug courts are one of the most effective ways that the legal system can help individuals recover from substance abuse.

Although statistics may vary, the effectiveness of the drug court program is evident from the following:

- The success rate is 75% in 2 years;
- Crime can be reduced by as much as 45 % compared to other approaches;
- An individual is six times more likely to remain in treatment long enough to make a meaningful recovery; and
- Parents who participate in family drug courts are twice as likely to enter a rehabilitation and complete treatment.

Drug court programs offer many people an opportunity to recover from substance abuse and have a future free of drugs and free of a criminal record.

May drug use during pregnancy constitute child abuse?

Drug Abuse by pregnant women can result in preterm labor, stillbirth and withdrawal symptoms for new babies.

In the Interest of L.J.B. involved a girl who following her January 2017 birth suffered withdrawal symptoms at birth (neonatal abstinence syndrome). She was hospitalized for 19 days. Her mother, A.A.R. used opioids and marijuana during pregnancy. The issue at trial was whether the mother was a perpetrator of child abuse. The trial court held that the Child Protective Services Law (CPSL) did not provide for a finding of child abuse due to actions taken upon a fetus.

On appeal, the Pennsylvania Superior Court, an intermediate appellate court, held that a mother's illegal drug use while pregnant may constitute child abuse, as defined by the CPSL, if it caused bodily injury to her child.

But the Supreme Court of Pennsylvania stated that the CPSL defines a "child" as an individual who is under 18 years of age, but includes no definition of or provisions regarding a fetus. And it defines the "perpetrator" as a person who commits child abuse, such as a parent.

On Dec. 28, 2018, the Court opined *In the Interest of L.J.B.* that the CPSL requires the existence of a child at the time of the allegedly abusive act in order for the actor to be a perpetrator and for the act to constitute child abuse. Since the CPSL's definition of child does not include a fetus or an unborn child, one cannot be a perpetrator of child abuse,

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under the CPSL, upon a fetus. Therefore, a mother cannot be found to be a perpetrator of child abuse against her newly born child for drug use while pregnant.

Is incarceration appropriate following failure to appear for a drug test?

In 2018, in *Commonwealth v. Eldred,* Julie had suffered from substance use disorder since age 15. She was originally convicted of larceny for stealing jewelry to support her addiction. Her probation required her to (1) enroll in outpatient treatment, (2) submit to random drug screenings, and (3) remain drug-free.

Originally, she complied with her probation. She enrolling in an outpatient treatment program and was started on a course of Suboxone. But she relapsed shortly thereafter and tested positive for the powerful opioid fentanyl. Then, she failed to appear for a court-ordered drug test.

Because no inpatient drug treatment facilities had open spots, the judge overseeing Eldred's detention hearing ordered her held in custody until one became available 10 days later.

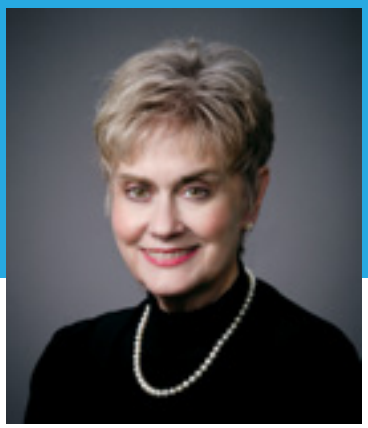
Eldred argued at the full hearing on her probation violation that the 10-day detention was unlawful because her substance use disorder "rendered her incapable of remaining drug free." And, the Massachusetts Medical Society also argued that relapse was a symptom of a disease that must be treated, and not punished.

The judge disagreed and found that Eldred had violated her probation, but granted Eldred's motion to report the question regarding the lawfulness of the drug-free condition to the Massachusetts Supreme Judicial Court. The SJC unanimously ruled that judges can require individuals with substance use disorders to remain drug-free as a condition of probation.

Serious harm may arise from sudden discontinuation of opioid pain medicines

In 2019, the U.S. Food and Drug Administration (FDA) announce that serious harm may result to patients who are physically dependent on opioid pain medicines from suddenly having these medicines discontinued or the dose rapidly decreased. These include serious withdrawal symptoms, uncontrolled pain, psychological distress, and suicide. The FDA is requiring changes to the prescribing information for these medicines that are intended for use in the outpatient setting. The FDA will provide expanded guidance to health care professionals on how to safely decrease the dose in patients who are physically dependent on opioid pain medicines when the dose is to be decreased or the medicine is to be discontinued.

DIRECTOR'S DIALOGUE



BY JANA TIMBERLAKE, EXECUTIVE DIRECTOR

"The only limit to our realization of tomorrow will be our doubts of today." ~ Franklin D. Roosevelt

One year ago, I stated in this article that the Oklahoma County Medical Society needs more members. This reality has not changed. The question that begs to be answered remains, "Does the Society continue to be relevant?" From a staff member's point of view, the answer is "yes." But I do not need to be convinced – the hundreds of Oklahoma County physicians who are not members do need to realize this organization exists to benefit them.

The Society leadership has scheduled a Board Retreat on Saturday, September 21, 2019, that will focus on one issue – membership. Those of us who work in organized medicine understand the demographics of the Oklahoma County Medical Society's membership today, with a majority of the physician members at or near retirement age.

To tackle this issue, OCMS board members will be reminded of one of their responsibilities – to inform others about the organization, while advocating for it. This sounds simple, but it is not as easy as one might think. As the Board is led through its deliberations, ideas and recommendations will be formulated and a plan will be adopted.

Since the Society is unified with the Oklahoma State Medical Association, various members of OSMA's leadership and staff are being invited to participate in the retreat. This will ensure that any policy developed will not conflict with OSMA's bylaws and/or policies regarding membership.

As an OCMS member, you are encouraged to submit your membership ideas for consideration. You will be kept apprised of the Board's decisions and possibly be asked to participate in recruitment efforts.

Remember – if we "doubt" the Society's relevance today, the realization of tomorrow's dreams will be limited. Let's not limit ourselves! Happy fall...

Jana Timberlake, Executive Director

OCMS **2019** BOARD NOMINATIONS

The OCMS Board of Directors elections will be electronic. Please check your email and vote electronically for the 2020 election. If you have any questions, please contact Alison Fink at 405-702-0500.

Cookson

Haymore

Margo

Yasin

POSITION 1

Michael S. Cookson, MD

Michael S. Cookson, MD, MMHC, FACS is Professor and Chairman of the Department of Urology at the University of Oklahoma's College of Medicine (COM) and holds the Donald D. Albers Endowed Chair. He is a 1984 graduate of OU with a BA in Journalism and graduated with high honors from OU's COM in 1988. He completed his Urology residency at UT San Antonio in 1994, and his fellowship in Urologic Oncology at Memorial Sloan-Kettering Cancer Center in New York City in 1996. Before returning to Oklahoma in 2013, he was the Vice Chairman of Urology at Vanderbilt University Department of Urologic Surgery in Nashville. He also earned a master's degree in health care management at the Owen Business School. Dr. Cookson's clinical practice is devoted to the surgical and clinical management of patients with Urologic Cancer, and he currently practices at the Stephenson Cancer Center at OU Medicine. He holds numerous national positions including President-elect of the Society of Urologic Surgeons and is a member of the American Association of GU Surgeons. In 2018, he received the American Urological Association (AUA) Presidential Citation for Outstanding Service and was also named the OU COM's Alumni of the Year in 2018.

Bret R. Haymore, MD

Dr. Haymore completed his medical school training at Penn State Hershey College of Medicine where he was elected to the AOA honor society. He subsequently completed a residency in internal medicine and was chief medical resident. He has received numerous teaching and research awards and has published numerous articles in the medical literature. He served on the Board of Regents of the American College of Allergy, Asthma and Immunology from 2007-2008. He served on active duty in the Army for nine years during which time he completed his residency in Internal Medicine and then an Allergy-Immunology fellowship at Walter Reed Army Medical Center (WRAMC) in Washington D.C. Dr. Haymore completed his active duty service in 2011 as a Major and Chief of Clinical Services for the Allergy and Immunology Department at WRAMC. He also deployed in support of Operation Iraqi Freedom during his tenure in the military. He has been in private practice in Oklahoma since his departure from the military. Dr. Haymore and his wife have 5 children and enjoy many activities together including sports, music and outdoor activities. They are active in their Church and the community.

POSITION 2

Bradley J. Margo, MD

Dr. Margo grew up in Oklahoma City and attended medical school at the University of Oklahoma. He trained in orthopedic surgery at Oklahoma and then completed a one year fellowship at Insall, Scott, Kelly Institute in New York City. He is currently a partner at McBride Orthopedic Hospital. Dr. Margo is on the Oklahoma County Medical Society finance committee and currently serves as chairman. He was also a member of the inaugural class of the OCMS Leadership Academy. He has been married for 19 years and is raising three boys.

Irim Yasin, MD

Irim S. Yasin MD, grew up in Oklahoma. She attended the University of Oklahoma for her undergraduate studies receiving a degree in biochemistry with a minor in economics. She earned her medical degree from the University of Oklahoma College of Medicine. She then went to the University of Illinois at Chicago for residency, where after 2 years she decided to apply for and was accepted to fellowship in Hematology/Oncology. She completed her training and moved back to Oklahoma City to practice Oncology with Integris Cancer Institute. After moving to Oklahoma, Dr. Yasin helped establish a free clinic (Shifa Clinic) which is currently seeing uninsured patients for basic medical care. Dr. Yasin was recently nominated for leukemia and lymphoma society women of the year,

Morgan

Valentine

Boersma

Powers

in which she worked diligently to raise funds for and bring awareness of LLS. She is always looking for new ways to get involved in the community. In her free time she enjoys flying planes, traveling with her family, hiking and nature.

POSITION 3

Ryan T. Morgan, DO

Ryan Morgan, DO attended Oral Roberts University and received a degree in Biology and Spanish. He went on to earn his medical degree at Oklahoma State University Center for Health Sciences and to complete his residency in Internal Medicine at Oklahoma State University Medical Center. Last year he was honored as a Fellow of the American College of Osteopathic Internists. Dr. Morgan currently works as a hospitalist at INTEGRIS Southwest Medical Center, and until early 2019, also worked as a rural hospitalist in Elk City. Dr. Morgan is a Diplomate of the American Board of Obesity Medicine and the American Board of Clinical Lipidology; the only physician in the state to hold these two distinctions. He is currently in the process of starting a medical weight management clinic, Vitalis Metabolic Health, slated to open in the fall of 2019. The goal of the clinic is to improve overall health through evidence-based and individually tailored treatment. He is regularly seeking opportunities to become more involved in his community, and in his free time enjoys seeking out new cultures by traveling the world, escaping in the serenity of sailing, and discovering the heart of cultural connection by learning languages.

Nathan I. Valentine, MD

Nathan Valentine, MD, CPE, FAAFP graduated from medical school at the University of Oklahoma-where he met his wife, also a Family Physician-and completed Family Medicine Residency in Wichita at Via Christi. He is board certified in Family Medicine with a CAQ in Hospice & Palliative Care. Following residency, Dr. Valentine and his wife traveled (couch-surfed) for about nine months. Upon return, he started his solo House Call practice for patients with mobility concerns, and his wife joined INTEGRIS Baptist. Six years later, Dr. Valentine closed his solo practice to join Variety Care, getting his first taste of leadership as Director of Family Medicine shortly after joining. He was the CMO for a little over two years and thoroughly enjoyed the ability to positively impact the quality of life and longevity of those in need. He also served as Clinical Advisor for the Oklahoma Primary Care Association, chairing the Clinical Quality Committee. For PCNOK (an Accountable Care Organization consisting of community health centers), Dr. Valentine serves as Medical Director, and has helped deliver performance at 100% on the 2018 quality metric score plus $2.8 million of savings for Medicare (on track for shared savings in 2019). While at Variety Care, Dr. Valentine grew to enjoy physician leadership; he is a graduate of the OCMS Leadership Class IX. Earlier this year, he also completed his CPE credential, Certified Physician Executive, through the American Association of Physician Leaders (AAPL, formerly ACPE) which requires 150 hours of leadership training spanning from the individual to the organization level. Dr. Valentine enjoys several nonmedical interests including reading, spending time with family and kitesurfing on the occasion that work lets him catch the wind.

POSITION 4

Melissa G. Boersma, MD

A naturally pragmatic advocate, Dr. Melissa Boersma pursued medicine in order to connect with patients and their families during critical health situations. She thinks innovatively and compassionately, enabling her to provide excellent care as a radiation oncologist. Dr. Boersma completed medical school and residency at the University of Texas Health Sciences Center at San Antonio. She is board-certified in radiation oncology, with a sub-specialty certification in hospice and palliative care medicine. Dr. Boersma finds it incredibly rewarding to mentally, physically, and spiritually prepare patients for their diagnosis and treatments by providing emotional support and encouragement while they are navigating this difficult period of their lives. She enjoys time away from the office with her family by swimming, knitting, Tae Kwon Do, and tennis.

Michelle L.E. Powers, MD

Dr. Michelle Powers has been practicing in Oklahoma City with The Pathology Group, PC for 9 years. She is board certified in anatomic and clinical pathology as well as hematopathology. She also serves as the lab medical director at two hospitals in Oklahoma as well as president of her group. She feels that active participation with the county and state medical society helps keep our profession alive. She also enjoys traveling with her 6 year old, energetic son.

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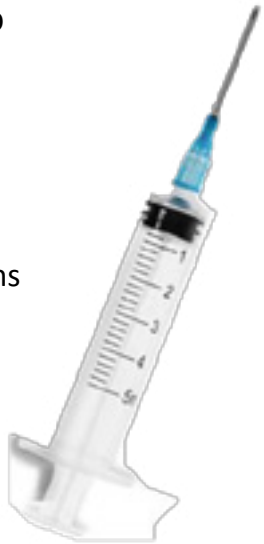

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THE POET'S SPOT

A Posthumous Sonnet

Hanna Saadah, MD

This sonnet was commissioned by a patient of mine who knew that she was actively dying and wanted me to read it at her funeral. She gave me no guidance as to what to say and I could not finish it in time for her to read.

The sonnet says what I thought everyone of us would have liked to say had we been in her place.

To friends who came to my funeral
I saw my birth with all my children born
Then saw my death when friends and loved ones died
And in between life's evening and her morn
At times I laughed, at times, indeed, I cried.
I've journeyed all the way from shore to sea
And now I journey back from sea to shore
Rich soil awaits to reunite with me
And mother earth to hold me in her core.
My gratitude to all who set me free
My love to all who hurt on my behalf
My thanks to all who came to escort me
My joy to those who humored me to laugh.
Go home, my friends, love more, and humor fate
Long as you live, love never is too late.

MEN DO NOT CRY

MEN DO NOT CRY

HANNA SAADAH, MD

My ringtones should sound the same, I thought as I dozed. What makes this one sound different? Startled, I sit up. Oh, that's what made it different. It was not a ring. It was a purr, a yawn, a sigh, a one-eyed blink that merely rattled the bedroom air. I rub my eyes and gaze at the lit cellphone screen. The message is a one-line blur. I yawn, I sigh, I blink, and rub my eyes again. Who on earth is messaging me at 3 am?

"Ghazi died one hour ago," read the message. My mind, half submerged in sleep, travels faster than light, flies back 56 years, lands in 1963 on the lawn of the American Evangelical Boys School in Tripoli, Lebanon, and drops me on the stage during our high school graduation ceremony. We were 16 Ghazi and I, sitting next to each other on the platform, facing our audience of families and friends, hearing them cheer all twenty-one of us as, one by one, we pranced across the stage to receive our diplomas. Twenty-one graduates in 1963, who had spent 12 fraternal years huddled together, said goodbye to one another, and went their sundry ways to meet their lives.

Of course, we smiled from behind our goodbye tears as we hugged one another, because, after graduation, we had instantly become men, strong men, men who do not cry. And of course, we promised to meet every year or two, but we didn't because life tore us apart. Nevertheless, we promised to stay in touch and, indeed, we did.

❁❁❁

Now, in 2019, 56 years after graduation, the alive twenty are frantically texting one another:

"Have you heard? Ghazi just died."

"How horrible. Sick for two years. Four weeks in coma."

"His wife took such good care of him, though."

"He has a great family."

"He never complained."

"He lived and died with a brave smile on his face."

❁❁❁

Ghazi and I never saw one another after graduation, but we talked on the telephone once every few years. Two years ago, I called to wish him a happy birthday. He had just returned from Dubai to his home in San Diego, returned to find that his kidneys had failed, that he needed dialysis, and that he also needed coronary artery bypass grafts. I, on the other end of the line, felt well. The contrast between us hissed like a hot coal dropped in water. I was sad for Ghazi but happy for me, sad for Ghazi's health but grateful for mine.

How could I be happy and sad at the same time, I wondered? Is it possible to be in a sad-happy state, in a dark-light dawn, in a light-dark dusk, in a sleep-awake trance, in the throes of a hot-cold contradiction? Two moods in one is mere confusion, an irrational state that is impossible to sustain. It brought to mind what Robert Frost (1874-1963) had said in his poem, *Home Burial:*

No, from the time when one is sick, to death,
One is alone, and dies more alone.
Friends make pretense of following to the grave,
But before one is in it, their minds are turned
And making the best of their way back to life
And living people, and things they understand.

Continues on page 27 …

MEN DO NOT CRY

Continued from page 25 …

❁❁❁

In 2019, the alive twenty from the class of 1963, are still frantically texting one another:

"Let's have a class reunion."

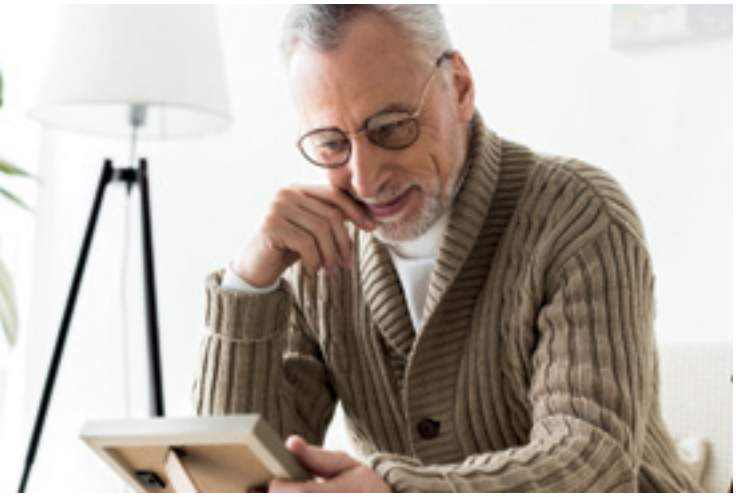
"Let's all meet somewhere, before it's too late."

"We need to see each other soon, very soon."

"Let's not trust fate and wait."

"Fate grows bolder as we grow older."

"We must act now. 'There is a tide in the affairs of men…' "



I recognize the quote. It's from Shakespeare's *Julius Caesar*:

There is a tide in the affairs of men,
Which, taken at the flood, leads on to fortune;
Omitted, all the voyage of their life
Is bound in shallows and in miseries.
On such a full sea are we now afloat,
And we must take the current when it serves,
Or lose our ventures.

❁❁❁

For days I live with a morose mood.

My wife repeatedly asks, "What's wrong?"

"Nothing is wrong."

"You're in a bad mood. Something happened at work?"

"No. Work is fine."

"You're getting too many phone calls from people I don't know."

Continues on page 28 …

Continued from page 27 …

"They're my classmates."

"Classmates that you have not seen for 56 years?"

"You just don't understand, Dear. It's cultural. We were sibling-close."

"But, people drift apart after half a century of no contact."

"My classmates and I have never lost contact, Dear. We've called, texted, emailed, and stayed in touch. Like I said, it's cultural."

❁❁❁

I collected all the emails I received in a special folder, which I named Ghazi. They contained memories, stories, anecdotes, photographs, and echoed with the same existential theme, the death-of-peers leitmotif:

"We are all in our seventies."

"Ghazi was the first to leave."

"Who will be next, and when?"

"Is that how we're all going to die, one after the other?"

Pity the one who will die last; he will have no classmate to lament him."

Blaise Pascal (1623-1662), the French mathematician who invented a calculating machine, died at 39, died too young to know about the death-of-peers zone. But, being a mathematician, he could calculate and knew enough to say:

Life is like living in a prison from which every day fellow prisoners are taken away to be executed.

They taught us about the death-of-peers zone when we were in college. We laughed and never believed it could happen to us. Death-of-peers zone was too far away to see, too far away to sense, and too far away to believe it even existed. We all were still at a picnic, frolicking under the cover of lusty clouds, as described by the poet, W. H. Auden (1907-1973)

"Death is the sound of distant thunder at a picnic."

❁❁❁

I wrote the following email to my classmates but never sent it because I wanted to keep it for myself:

After a death, if we allow sadness to invade our souls and stay, death wins. But, if we muster the courage to drive sadness away, life wins. We owe it to our beloved dead to live on, on their behalf.

Then, attempting to emerge from confusion, I penned down a poem, which I didn't want anyone else to read:

Be happy when someone dear to you dies
Because it wasn't you who died
And because having preceded you in death
Your dear one will have taught you
To value life more deeply.
Be happy because you will grow
Wiser with grief
Nobler with loss
Humbler with gratitude
More generous with your love
And less wasteful with your time.
Be happy because
When it's your turn to die
You will relinquish your space
Bequeath your assets
Let go of your memories
Return everything you had earned and learned
And leave life as debt-free as when you entered it.
Be happy because
By re-joining Mother earth
You will make others happy
Because it wasn't they who died
And because by preceding them in death
You will have taught them to value life more deeply.

❁❁❁

After I finished the poem, unruly tears gushed out of my face in a grand catharsis. My wife must have heard my sobbing because she rushed to me with worried eyes.

"What's wrong, Dear?"

"Nothing is wrong."

"Don't you give me that answer again. You're crying. You never cry. What's wrong?"

"Nothing is wrong, Darling. In fact, everything is just the way it should be."

"Why are you crying, then? Men do not cry."

"I'm crying because Ghazi absconded with my youth."

"Oh, Honey. Don't talk like that. You're still young."

"I'm as young as my mind, as old as my body. I'm in a sad-happy state, in a dark-light dawn, in a light-dark dusk, in a sleep-awake trance, in the throes of a hot-cold contradiction. I'm in the sound of distant thunder at a picnic. I am in the prison from which every day fellow prisoners are taken away to be executed."

"You are grief stricken, Dear. You're confused."

"No, Darling. I've just emerged from confusion and I am exactly where I need to be."

"You're grieving a friend that you have not seen for 56 years more intensely than you grieved your own father when he died, and you don't think you're confused?"

"Losing a friend is much worse, Darling. When I lost my father, his fathership lived on through me. When I lost Ghazi, his friendship died with him. It is the death of an idea that I lament, the idea of my other self."

"Your other self? What's that?"

" *'A friend is another self,'* said Aristotle."

"These weird feelings must come from your emotional east, because I, as a westerner, don't understand them. But, regardless of our cultural differences, you've always been strong. Whatever happened to your inner strength?"

"We are as strong as our willingness to recognize our weaknesses and as weak as our denial of our frailties."

❁❁❁

And let there be no purpose in friendship save the deepening of the spirit.

Gibran Khalil Gibran (1883-1931) from *On Friendship*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