

## Science and Spirit



David W. Parke II, M.D.  
DMEI President and CEO

*“Science  
doesn’t just  
march on;  
it rushes  
forward!”*

The doubling time of biomedical knowledge – that time required for all that is known in the science of medicine to actually double – is said to be less than three years. And it is not slowing down. Over 10,000 clinical trials are conducted annually in the United States. Nearly \$40 billion is spent every year by the National Institutes of Health (NIH) and pharmaceutical firms combined in biomedical research. Science doesn’t just march on; it rushes forward! We at DMEI are proud to be a part of this. At the recent large international meeting for vision research, DMEI scientists contributed 30 presentations and papers, and we now rank sixth in the nation in research awards from NIH!

Much of this science is now making its way into patient care. For example, the basic science of the early 1990’s led to new drugs that were tested in the late 1990’s and are now available for clinical use. Clinical trials have demonstrated the power of specific diagnostic and therapeutic tools and procedures

applied in the right way and at the right time.

The questions then are: “*Are physicians keeping up with all of this avalanche of information*” and “*How can physicians consistently and effectively employ all the most current and best medical knowledge to the benefit of their patients?*”

Put another way, we have some good proven science – but do we have the spirit to change the way healthcare is delivered in order to ensure that “best practices” are employed in a standardized way? This isn’t an issue of physicians trying harder – physicians already work hard to deliver the best care for their patients. The issue is changing the system of care to help and to enable



Robert E. Anderson, M.D., Ph.D., DMEI Director of Research

physicians – ensuring that validated science and technology is consistently delivered to everyone that needs it.

Before you think otherwise – this doesn't require a wholesale redo of the American health care system. It involves the systematic use of evidence-based guidelines for medical practice to deliver care that is optimally safe, effective, patient-centered, timely, efficient, and equitable.

A recent study demonstrated that only 55% of patients in a random sample received recommended care. Another study estimated that 18,000 Americans die annually following a heart attack because they don't receive medications proven to be effective.

These medical errors are devastating—and not simply in their consequences to patient health and wellbeing. They cost this country billions of dollars every year. They damage the trust that must exist between patients and the professionals that deliver their health care. They damage the already fragile morale of care givers.

Other factors accentuate the problem – notably the American medical liability system that promotes defensive medicine which encourages statistically unnecessary services and which inhibits frank communi-

cation between patient and physician. Defensive medicine complicates an already massively complicated system, adds cost, and diminishes trust.

The National Academy of Sciences has commissioned studies of this problem, resulting in two landmark publications: *To Err is Human:*

*These medical errors are devastating—and not simply in their consequences to patient health and wellbeing.*

*Building a Safer Health System* and *Crossing the Quality Chasm: A New Health System for the 21st Century*. Both deal with this quandary of assuring quality in the complex application of highly technical and sometimes contradictory information.

The potential solutions to this problem are complex and multifaceted. Two deserve mention here: (1) the use of powerful information technologies, and (2) the incorporation of evidence-based medicine.

Consider that the U.S. healthcare system is a \$1 trillion segment of our economy. From a business perspective it involves the integration of payers (state and federal governments and thousands of insurance companies and networks), hospitals, other healthcare facilities, physicians and other providers, various intermediaries, and patients. Yet key transactions are still paper-based. Doctors handwrite hospital orders and prescriptions. Patient health information in the physician office and in most hospitals is written by hand (sometimes illegibly) and is warehoused as thick, paper-based charts. Charts are a compendium of handwritten notes, dictated reports, imaging study hard copy, and laboratory and

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DMEI DIRECTORY

instrument digitized results.

How wonderful could an ideal digital record system be for physician and patient alike! Your doctor appointments could be made over the phone or online. When you saw your physician, he or she could graphically reorganize data from past appointments to generate new clinical insights. At the end of the appointment, prescriptions would be instantaneously FAXed or transmitted over the web to pharmacies (after they'd been automatically screened to ensure accuracy, lack of adverse medication interactions, and checked against your insurance formulary). Useful information on your condition could be printed out or emailed to your home. Bills would be immediately and electronically conveyed to your insurance company. And two days later when you contacted the

*How wonderful could an ideal digital record system be for physician and patient alike!*

doctor on call with a question, he could go to his home computer, call up your record, answer your questions, and enter a note in the record documenting what you were told.

Systems with much of that functionality exist now. Why doesn't everyone have one? First, no system out there is absolutely perfect, and all of the systems are expensive. Second, the learning curve is difficult and may lead to some loss of efficiency. Third, no one knows which of the systems will survive. What happens to the data when your software is declared obsolete? Do we have the spirit to step in and take the chance?

The Dean McGee Eye Institute has tested several of these systems over the past decade, and we have finally chosen an exciting new dig-

*The final system will permit us to ... analyze outcomes – to determine what changes we can make to ensure uniform, consistent, and optimal care.*

ital system. We will shortly begin a two year conversion to an electronic medical record – a multi-million dollar project designed not to save money (it won't), but to help us provide better care. The final system will enable us to integrate the digital output of most of our diagnostic equipment and will permit secure, remote access by physicians throughout our system. It will permit us to analyze outcomes – to determine what changes we can make to ensure uniform, consistent, and optimal care.

What about evidence-based medicine? Here we have some help. The American Academy of Ophthalmology has generated a number of Preferred Practice Patterns – scientifically constructed and validated algorithms for the management of common and serious eye diseases. These are continually updated as new data appear in the literature. Other such algorithms have been developed elsewhere. Our new information technology will permit us to monitor the application of these Preferred Practice Patterns throughout the Institute. At DMEI, we already preach these algorithms. With a more robust information system we can better monitor if they are actually being used the way they should be.

All of this is part of our commitment to you – our patients and our friends. We want to use our talents and our resources to cross the quality chasm and to employ the most up-to-date scientific data and deliver you the best quality medical care – every time.



## The Dean McGee Legacy:

### *PROFILE OF A DMEI DONOR – HAROLD KLEEN*

Harold Kleen, a retired geologist who graduated from the University of Nebraska in 1933 was a long time employee and friend of Dean A. McGee. Because of his relationship with Mr. McGee, he became a supporter of the Eye Foundation in 1976 and has been one of the most loyal donors to DMEI for over 28 years.

In 1934 Mr. Kleen married his lovely wife, Luella, and three years later the family moved to Tulsa, Oklahoma, where he went to work for Skelly Oil Company. They eventually moved to Oklahoma City where Mr. Kleen became the manager of Skelly's new office. In 1949 he joined the Kerr-McGee Oil Company and soon became their Chief Geologist.

His new boss at Kerr-McGee was Dean A. McGee. Mr. McGee was not only one of the most generous philanthropists and Oklahoma City civic leaders, he always encouraged his employees to support local char-



*Mr. and Mrs. Harold Kleen*

ities whenever they could. On occasion, Mr. Kleen went to Mr. McGee to seek his advice as to which charity he should support. On one of those occasions, Mr. McGee told him that he and several Oklahoma City physicians (including Richard Clay, M.D.) had recently become involved with the creation of a new Eye Foundation – they were raising money for a new clinical and research building and could use some help. That advice from Mr. McGee led Mr. Kleen to make his first gift to the Eye Foundation, and he has been a very generous annual supporter ever since.

Mr. Kleen's long time support has always been restricted for vision research. His wife of 68 years passed away last August at the age of 93. She had (and Mr. Kleen suffers from) macular degeneration – the most common cause of severe vision loss in Americans over age 60. It is also a disease that remains incompletely understood and for which there are inadequate treatments available. DMEI has a large and productive macular degeneration research group. Mr. Kleen thinks very highly of the scientists at DMEI and (as a scientist himself) appreciates the complexities of their research. It is important to him that scientists find improved ways to treat macular degeneration and possibly someday find a cure.

Mr. Kleen is 92 years old and is still very active in the community. He and Luella had two children – a son, Roger, who lives with his family in Vail, Colorado and a daughter, Karen Inman, who lives with her family in Oklahoma City.

Mr. Kleen believes in the accomplishments and future promise of research programs at the Dean McGee Eye Institute and plans to continue his financial support as long as he can. The physicians, faculty and staff at DMEI are truly grateful to him for his generosity. We know that it is friends and visionaries like Harold Kleen that help make our work possible. ▲

# 2003 DEVELOPMENT UPDATE

## ANNUAL APPEAL: IN SUPPORT OF INDIGENT CARE

The physicians and staff at the Dean A. McGee Eye Institute (DMEI) want to express their appreciation to all of you who supported the 2003 Annual Appeal. For the second year in a row, we saw the number of donors increase as more and more people gave so that their fellow citizens without financial resources might enjoy better sight. DMEI physicians give of their time and talent, and all who donated helped to make up the difference.

This past year's annual appeal raised more than \$93,000 (a 41% increase over last year) from 389 donors to help defray an indigent care budget that reaches \$1 million annually. Those who made a contribution to the 2003 Annual Appeal will help those patients at DMEI who cannot afford treatment and have few other places to go. Every single gift received in response to the annual appeal will help pay for the eye care for those patients. We are truly grateful to each and every one of you.



*Penny Mills Voss, CFRE  
Vice President for  
Development, DMEI*

## CALENDAR YEAR GIVING

This past year, we received a record number of gifts. More than 656 donors pledged or contributed \$345,189 to the Dean A. McGee Eye Institute Foundation during calendar year 2003 to help support various programs and projects. We also received numerous gifts honoring the memory of long time DMEI physician and teacher Hal D. Balyeat, M.D.

## HOW TO MAKE A GIFT

Gifts to the Dean A. McGee Eye Institute Foundation can be restricted to vision research, patient care or medical education. Alternatively, your gifts can be unrestricted, making funds available where the Eye Institute has its greatest need. The attached self-addressed return envelope has been included to provide you with an easy way to make a gift to the Foundation. After your gift has been processed, we will send you an acknowledgement and receipt for your records. ▲



*Dean A. McGee Eye Institute*

# CALENDAR YEAR 2003 GIVING BY LEVELS

## RECOGNITION

The Dean A. McGee Eye Institute would like to recognize and to honor the hundreds of individuals, corporations, foundations and organizations that have so generously supported the Institute this past year through their gifts and pledges. We hope that you will take a minute to look at the names of the people and organizations whose gifts have improved the quality of life for so many in this state and surrounding region and whose support of vision research has advanced eye care for all.

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## **DMEI Ranks #6**

Among all research project grants, those that are awarded by the National Institutes of Health are generally considered to be the most highly coveted. That is because applications for NIH support must survive a rigorous review by a team of scientific peers. The grant applications take months to prepare, must include copious quantities of preliminary data, and must be prepared by investigators with a track record of success. They are frequently many inches thick. Ultimately, only about one in every four applications is approved for funding.

It was only a decade ago that scientists at DMEI and the Department of Ophthalmology ranked near the bottom of all 126 academic eye institutes/departments of ophthalmology in NIH funding. In late April of this year, NIH released

its most recent rankings of NIH funding in ophthalmology. (Drum roll, please!) For the most recent fiscal year, DMEI/Department of Ophthalmology ranks 6th nationally in NIH funding. Of DMEI's \$8.7 million research budget for this year, \$5.8 million comes from NIH to support the research of 11 different scientists. The total value of all grants (some are multiyear) is nearly \$31 million! This represents the highest rate of growth over the last decade of any major vision research institute in the United States. Congratulations to our scientists. They've earned this support with a track record of innovation, productivity, integrity, and an unwavering focus on important, cutting-edge science.

# images from DMEI

## -DMEI CHINA MISSION



*Dr. Cannon demonstrates phacoemulsification*

From May 27 through June 5, 7 DMEI ophthalmologists and 2 scientists spent 9 days in Sichuan Province lecturing and teaching clinical and surgical techniques (DMEI's third trip to the region). Heart to Heart International, an organization with extensive experience in medical missions in southwest China, coordinated the trip. The mission was conducted with the active and enthusiastic support of the Sichuan Minister of Health and the Western University – the principal medical school in this region. Our objective was to further identify the level of ophthalmic expertise in Sichuan (population 90 million), as well as to help Chinese ophthalmologists better address both treatable and preventable blindness.

Drs. Cynthia Bradford and Sterling Cannon (DMEI Chief Resident) spent much of their time teaching and performing cataract surgery both in the Provincial Hospital in Chengdu, as well as on the Mobile Eye Unit (18 wheel tractor-trailer unit equipped for eye surgery) in the mountains of Baoxing near Tibet. With the help of Alcon China, this was the first attempt in China (and a very successful one) to perform modern cataract surgery in a mobile unit.

Drs. Reagan Bradford, Bradley Farris, Ron

Kingsley, Adam Reynolds, and Lucas Trigler, joined the others in Baoxing after spending additional time in Chengdu both lecturing and teaching Retinal Surgery, Neuro-Ophthalmology, Medical Retina, Glaucoma, Pediatric Ophthalmology and Strabismus. Most patients seen in the crowded clinics daily were suffering from blinding cataracts, glaucoma, dry eyes, congenital abnormalities, and neglected eye disease due to the unavailability of a sufficient number of trained specialists in southwest China.

DMEI research scientists Drs. Gene Anderson and Wei Cao devoted most of their time

to exploring the possibility of collaborative research opportunities and possible exchange programs for future scientist training.

All 9 DMEI physicians agreed that the experience was greatly reward-

ing, the needs are great in China, and DMEI has an opportunity to making a significant difference.

DMEI anticipates returning next year and developing a sustained relationship with the ophthalmologists, public health officials, and people of Sichuan. ▲



*Drs. Bradford and Farris board the Mobile Eye Unit*



*Dr. Trigler teaches pediatric ophthalmology to Chinese residents*



*Traditional acupuncture is still in use to treat some eye diseases*

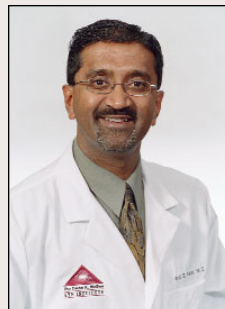
## ANIL D. PATEL, M.D. JOINS DMEI FACULTY

Neuro-ophthalmologists deal with problems that involve neurologic aspects of eye disease. This includes lesions of the optic nerve that connects the eye's light-sensing retina with the occipital cortex of the brain (the center for vision). It also involves problems involving the control of eye movement (nerves emanating from the brainstem and from the brain's cerebral cortex), of the nerves controlling the pupil, and of many other areas as well. Neuro-ophthalmologists diagnose and assist in the management of a spectrum of diseases from multiple sclerosis to tumors to myasthenia gravis to inflammations of the brain and nerves.

In all of Oklahoma, only one ophthalmologist, DMEI's Bradley K. Farris, M.D., is fellowship-trained in neuro-ophthalmology and limits his practice to that field. (DMEI's R. Michael Siatkowski, M.D. is fellowship-trained in both pediatric ophthalmology and neuro-ophthalmology and sees some patients with neuro-ophthalmology problems.)

For several years, DMEI has searched for an additional neuro-ophthalmologist. They are a rare commodity with less than forty completing fellowship training every year in the United States.

The Dean A. McGee Eye Institute therefore announces with great pleasure the appointment of Anil D. Patel, M.D. to its faculty. "Not only did we succeed in recruiting a neuro-ophthalmologist of impeccable cre-



Anil D. Patel, M.D.

*"I am both honored and excited to join the wonderful faculty and staff at this prestigious Institution. DMEI's commitment to patient care, medical education, and research is an attractive setting for me to flourish. My family and I look forward to meeting all of you some day."*

– Dr. Patel

dentials," noted Dr. Parke, "but Anil is also a physician with experience as a teacher and as an academic leader."

Dr. Patel's professional activities will involve both patient care and clinical investigation. A native of Canada, Dr. Patel completed his residency at the University of Saskatchewan and his two-year neuro-ophthalmology fellowship at the University of Iowa. After serving as a member of the faculty at the University of Iowa, he returned to the University of Saskatchewan, ultimately as Department Chairman. Dr. Patel is board certified by the American Board of Ophthalmology and is a Fellow of the Royal College of Physicians and Surgeons of Canada. He has received several awards for medical scholarship and is the author of numerous publications. ▲



DMEI Residents, Clinical Fellows, and Faculty Ophthalmologists

# DMEI TELEPHONE DIRECTORY

## IN THE OKLAHOMA HEALTH CENTER

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Rhea L. Siatkowski, M.D.

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