BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY
DECEMBER, 2009

THE BULLETIN
The Oklahoma County Medical Society

December, 2009 – Vol. 82, No 10

A Monthly Publication
Circulation 1600

Oklahoma City, OK 73105-1830
313 N.E. 50th Street, Suite 2
Phone (405) 702-0500

EXECUTIVE OFFICE

313 N.E. 50th Street, Suite 2
Phone 405-702-0500 FAX 405-702-0501
Oklahoma City, OK 73105-1830
E-mail: ocms@o-c-m-s.org.
Web Site: o-c-m-s.org
Jana Timberlake, Executive Director
Linda Larason, Associate Director
Managing Editor, The Bulletin
Ashley Merritt, Membership Coordinator
Administrative Assistant

Printed by Green's Graphix

TABLE OF CONTENTS

Bulletin Contributors

Each year, many OCMS members and friends contribute time and articles to produce the Bulletin. As we enter this holiday season, we extend our sincere appreciation for their contributions. Once again, we invite you to submit articles, poetry and artwork for consideration to be published. And, once again, we solicit your feedback – please take a moment to let us know what you like, or don't like, about the Bulletin and what you'd like to see included in it.

James W. Hampton, MD, Editor-in-Chief
William P. Truels, MD, Associate Editor
Johnny B. Roy, MD, Assistant Editor-Pearl
Chris Codding, MD, Assistant Editor-On Professionalism
S. Sandy Sanbar, MD, PhD, JD, FCLM, Assistant Editor-Law and Medicine
Jana Timberlake, Executive Director
Linda Larason, Associate Director/Managing Editor-The Bulletin
Ashley Merritt, Membership Coordinator/Administrative Assistant

Contributors

M. Dewayne Andrews, MD
Anureet Bajaj, MD
P. S. Bajaj, MD
Amy Richter Bankhead
Jordan Bookman
Larry A. Bookman, MD
Craig Bowron, MD
Donald C. Brown, MD
Chris Codding, MD
Daniel J. Culkin, MD
Joe Denney, RN
Vincent J. Devlin, MD
Jim Dunlap
Lu Garrison
Andrew C. Gin, MD
Jerome Groopman, MD
Pat Hall
Diana Hampton, MD
Kent King, MD
Lisa Korber
Aurora Macaraeg
Emmanuel Macaraeg, MD
Karen Mask
Michael Massad
Nina Massad
Sivash Nael, MD
Nancy H. Nielson, MD, PhD
Peyton Osborne, MD
Emily Owens
Tomás Owens, MD
Thomas Owens
Roy Macbeth Pitkin, MD
Suzanne Reynolds
Senator Andrew Rice
Mary Holloway Richard, JD, MPH
S. Sandy Sanbar, MD, PhD, JD, FCLM
Ashlie Schooler
Jeary Seikel
Teresa Shavney, MD
John R. Smith, MD
Representative Kris Steele
John P. Sullivan, DFP® CLU, ChFC
Jana Timberlake

About the Cover

The photograph on the cover of the Bulletin this month is of Saint Nicholas (aka Robert Dennis) with two children, Isabela and Carolina Pardo. We are grateful to all of them for permission to print this Christmas celebration. St. Nicholas lived in the 4th century and his reputation for generosity won him the support of the people who elected him, a layman, to be the bishop of Myra. They recognized that this unassuming person was meant by God to lead them. His love of children touched the hearts of those who learned from this holy man what a beautiful thing giving is. He was especially interested that families had enough to eat, a good place to live and that all people lived out their lives with dignity and respect. A book review by Jerome E. Groopman, MD is featured in this December issue. Dr. Groopman is a professor of Medicine at Harvard Medicine School. His first book, "The Measure of Our Days," was published in 1997 and explores the spiritual lives of patients with serious illnesses. His second book titled "Second Opinions: Stories of Intuition and Choice in the Changing World of Medicine" was published in 2000. The "Anatomy of Hope" is his third book and is currently being developed for HBO. His review of two books is very provocative. ❑

Seasons Greetings
The Editor

President's Page

Teresa M. Shavney, MD

When Is Enough Enough?

It has been hard to think of ten columns to write for this President's Page, mainly because I have wanted to stay positive. It's easy to find things to complain about. For me, a day without complaining is like a day without talking. But as my husband says, I've reached my "Popeye" point – I've had all "I can standze and I can't standze no more."

The Senate voted down the proposal to fix the SRGs. Rules have been published notifying providers (us) and Medicare recipients there will be a 21 percent cut in reimbursement in January 2010. There are very few of us who will be able to reduce overhead to accommodate a cut this deep. The only way I can work more is to sleep less.

Why does it seem that doctors are the target of all the cuts in reimbursement? We are the ones who gave up about ten years of our lives for medical school and residency. Most of us ran up a significant debt for that privilege. A recent patient with a ruptured appendix had a hospital bill of $40,000. My fee accounted for 1/100th of that. The government will certainly recoup an astounding amount from me after January 1.

Hospitals put out new protocols in response to Joint Commission guidelines. Foley catheters cannot stay in longer than 48 hours without justification. A hospital acquired UTI is a "never" event. Where is the common sense that a comatose, ventilator dependent ICU patient needs a foley? I am told that everyday after the 48 hours, I must document the reason the foley stays in. Will someone make a stamp that says "monitoring strict I+O" or "in my judgment patient needs a foley?"

No one wants to operate on the wrong side or body part. A hassle, but I have succumbed to the routine of writing "yes" on the appropriate side and body part. But does it make any sense that I must write "yes" on a breast that has had a wire placed by the radiologist to localize a lesion? It is sticking out for all to see, but it is protocol.

Then there is the "time out" in the OR. Everyone must have eye contact with the circulator. A recent surveyor didn't think the anesthesiologist could bag the patient and give adequate eye contact at the same time. Eye contact was considered more important.

Electronic medical records will be the end of the solo practitioner. The cost will be so prohibitive many will quit or be forced to become employed. Chaos will ensue when no one's system interfaces with others'. Will yours be an X-Box, a Playstation, or a Wii?

Together, we have banded together to improve our community. The physicians of OCMS have started the Oklahoma Blood Institute, Hospice of Oklahoma County, OCMS Community Foundation, Schools for Healthy Lifestyles, and Health Alliance for the Uninsured. In addition, countless hours have been donated to free clinics and worthy causes. Yet, if we chose to be a union instead of a service organization, we'd go to jail.

When will enough be enough? Each of us will have to make that decision alone. I still love what I do. As long as a patient entrusts his life to me and allows me to use my knowledge and experience and by the grace of God make them better, I will keep going.

I encourage each of you to continue to be a member of OCMS. There is strength in numbers. As we continue to be of service to our community, maybe our example will encourage our patients to fight for our rights. Dues statements are in the mail. Remind your colleagues to pay their dues.

Thank you for the privilege of serving you this year. Making an effort to stay positive has helped me stay positive. Even voicing my frustration in this column has reminded me that, at the end of most days, I have helped someone. When that doesn't happen anymore, enough will be enough. ❑

Dean's Page

M. DEWAYNE ANDREWS, MD
Executive Dean
University of Oklahoma College of Medicine

Planning for Curriculum 2010 (discussed in the Nov 2008 Bulletin) continues on target for introduction beginning with the class entering August 2010. This curriculum change converts the traditional, discipline-based first two years to an organ-system approach fully integrated over the first two years. More small group learning sessions, more student-centered active learning, and more problem-solving approaches are introduced along with numerous technological changes in how information is delivered and received.

In late August the 14-story OU Children's Physicians Building opened providing a much needed new home for all pediatric and other specialties providing children's health care. Patients, families, physicians and staff all marvel at this new facility compared to the mazes and difficult way finding of the old children's hospital clinics area. Meanwhile, work continues on the adjacent, dramatic new atrium entrance for the Children's Hospital and the Women's and Newborn Pavilion. This addition includes a new education and conference center for the OU Medical Center complex. We anticipate opening of the atrium entrance and education center by the summer of 2010.

Medical school applications have continued to increase over the past two years, and the Admissions Board is now busy with interviews. The number of exceptionally well qualified candidates seems to have increased.

Laine Friedman Ross, MD, PhD, author, pediatrician and authority on medical ethics involving children and a member of the faculty at the University of Chicago School of Medicine, received the College of Medicine's 2009 Patricia Price Browne Prize in Biomedical Ethics. At $10,000, it is the largest such award in the nation and is made possible through an endowed faculty position established by Mrs. Browne's family. Eligible to receive the biennial award in biomedical ethics are physicians, nurses, research scientists and others who demonstrate the

(Cont'd on page Thirty-one)

For Lease

Medical Facility

6824 S. Western Ave., Oklahoma City

Former Deaconess Wound Care Center

3,835 Square Feet

Lease rate: $5,333.00/mo. (NNN)

* Built in patient file cabinets * Ample on site parking
* 8 treatment rooms with hand sinks * 4 Restrooms
* Alarm System * Large waiting area * X-Ray Room
* Interior & exterior sprinkler system

2008 Demographics: Daily traffic count 24,800

	1 Mile	3 Mile	5 Mile
Population:	14,160	105,286	197,830
Households:	6,488	43,221	75,188
Average Income	42,284	47,531	52,940

KENNETH WILEY
405-630-9808
Owner Broker

JACK GILES BROKER
405-947-5013
Fax: 405-917-2321
Email: jackgls@aol.com

Paid Advertising

Pearl of the Month

Daniel J. Culkin, MD

Sexuality is an integral part of a marriage and/or relationship. The loss of this intimacy can affect a relationship negatively. In the case of the male, this dysfunction can be due to many causes that relate to level of desire and ability to function sexually. Its occurrence can be emotionally devastating to both partners. The topic of this pearl is impotence or erectile dysfunction.

The most current terminology, erectile dysfunction (ED), is defined as the inability to attain or sustain an erection for sexual intercourse. The diagnosis can be made on the basis of a history and physical exam. Two important historical findings are reduced libido and the presence of Peyronie's Disease. It is important to realize that hypogonadism can cause a reduced desire but also the inability to perform can result in a diminished enthusiasm as well. ED can be multifactional and most commonly includes endothelial dysfunction of the cavernosal arteries. In my practice, I have rarely seen hormone replacement therapy cure ED. In truth, I have seen the corollary of enhancing performance anxiety for an individual who has a new enkindled enthusiasm that is met with performance failure because of inadequate vasculature.

Peyronie's Disease is a problem that merits attention as well. In its most dramatic presentation, it presents as severe painful curvature of the penis with erection. The pain is caused by inflammation and fibrosis of the corporocavernosum. The inflammatory pain is usually medically treatable with NSAIDs. The fibrosis, however, is more difficult to treat since there is no uniformly effective treatment.

Whereas the diagnosis of ED is made by history and physical exam, the treatment is based on goal directed therapy. The first line of therapy is with the phosphodiesterase type 5 inhibitor (i.e., sildenafil, vardenafil and tardenafil).

Each medicine is prescribed mainly in two doses. These are effective in 70% of men. Contraindications include active use of nitrate and/or

nitrite medications that can result in a synergistic lowering of blood pressure if used consecutively. Other medicines such as alpha blockers used for the treatment of benign prostatic hyperplasia (BPH) can cause the troublesome orthostatic hypotension as well. If this treatment option fails or is contraindicated, I recommend a Duplex Doppler Ultrasound of the penis without and with a vasoactive agent intracavernosal injection to differentiate arteriogenic from venogenic impotence.

It is important to realize that the endothelial dysfunction that is so prevalent in our society is progressive. There is yet to be a medication discovered or developed that halts or reverses the pathogenesis of arterial decrease. So patients with time will very likely require increased dosages and these medications can become ineffective. Then there is available second line and third line therapies.

Arteriogenic impotence can be treated with penile injections. Depending on the result, while in my office, instructions, precautions and prescriptions can be provided during that visit. If the patient does not opt for injection therapy or he has venogenic impotence, a vacuum erection device (VED) or penile prosthesis is offered. The VED has not gained very wide acceptance because of unsatisfactory results (i.e., inadequate erection) and its being a difficult process.

I have had great success with the penile prosthesis in this select population. This therapy has provided the greatest satisfaction, to patient and partner, of all other forms of therapy. The problems that can occur are mainly infection and mechanical failure which require removal and replacement. Of the last 500 inflatable penile prosthesis that I have done, there have been six (1.2%) that have been complicated by infection that required removal (N = 4, 0.8%) or removal and replacement (N = 2, 0.4%). With the production of antibiotic coated prosthetics, this infection rate has been reduced by half. The operation is done as an outpatient and takes approximately 45 minutes. Mechanical failure has occurred in 16 (3.2%) and has included fracture tubing, auto inflation, and tubing leaks. However, since most recent engineering improvements, in the last 150 implants only a single leak has been identified, auto inflation has been eradicated and there has been no fractured tubing.

In summary, a goal directed therapeutic approach to erectile dysfunction will provide the most efficient process of sexual rehabilitation. An understanding of the desire process necessitates a thoughtful follow up to assure introduction to the next available therapy, if and when the initial therapy fails. Prosthetic surgery is a safe, reliable and efficacious form of therapy for ED. ❑

Christmukkahs to Remember

Jordan Bookman

It's not just the chill in the air or that glow from the fireplace that signifies the winter holidays. For our family, the holidays were unique. They brought together two different religions in one household. We were fortunate to learn the history of both Judaism and Christianity and experience the joys of celebrating the holidays associated with each religion. Whether we were spending Saturdays at the synagogue, or Sundays at church, we realized there was an essential link that tied the two together.

One of my earliest memories from Saturdays at the synagogue was a sewing project. The majority of ten-year old children do not know how to sew and I was most certainly one of them. On the other hand, I was a strong-willed and determined child and had my mind set on sewing the lush, lime green fabric into a beautiful Torah cover. After about 20 minutes of intense dedication to my project, I stood up to leave the room and realized that my fabric followed me…it was, in fact, sewn to my hand! Not only did I learn the meaning of the Torah that day, but I also learned that I couldn't sew!

This is a story my family laughs about often, just as we fondly remember the evenings spent with three other families celebrating Hanukkah, with each family as unique as our own. Our families took turns hosting these get-togethers on the first night of the eight day celebration of Hanukkah. Like a movie reel, memories of Dr. Hirsch's stories are stored in my head. Following an evening of delicious holiday foods, complete with traditional, warm latkes, Dr. Hirsch with his gift for storytelling would gather the children together and make the story of *The Macabees* come to life. The story shared made sure we understood the purpose of the evening and why it is important to celebrate Hanukkah. Even now, images of families gathered around the menorah lighting the Hanukkah candles flash by and remind me how special those years spent with those families and friends were.

That tradition was important, just like our annual tradition of going to church on Christmas Eve and honoring the holy birth

that reminds us of why we have Christmas. Songs sung by the beautiful voices of the choir struck chords in our hearts as we prayed, read scripture and lit candles in reverence. On the secular side of the holiday, my mother made Christmas into a magical time of year, where sugar plums literally danced over our heads. The house was filled with smells of cinnamon and spice, candy canes sweetened the room, and the anticipation of Santa Claus and reindeer were evident year after year. Most importantly, the holidays were not complete without a Christmas tree. We created a *memory tree* that shone brightly with ornaments depicting the story of our family. Gymnasts, ballerinas and soccer girls hung at the top followed by hand-crafted ornaments that only an adoring kindergartener can make and finally, memories of family vacations were scattered about highlighting all of the wonderful places we had explored.

It is the memories of the holidays that my sister and I will cherish for the rest of our lives, but more importantly, it is the support our parents showed for one another that we will remember most. Although they came from two different religious backgrounds, they created one family with two daughters, and one household filled with love, excitement and tradition. Every Hanukkah, our mother stands beside our father lighting candles on the menorah and happy to read a passage from the prayer book each night. Every Christmas, our father sits beside our mother in church celebrating Christmas Eve with us as a family and just as proud as he can be of his daughters as they light the church candles. Our parents taught us that love and respect is what makes this arrangement work. They taught us about two different cultures and about a part of their past, but what we appreciate the most is that they blended their beliefs to make it *our present.*

The chill in the air, the glow from fire embers, and the taste of hot chocolate mean something different to everyone. Although some call that time of year Christmas, and others call it Hanukkah, we are proud to have a Chrismukkah that we will always remember. ❑

Jordan graduated from the University of Richmond in May and now resides in Dallas. Blair, Jordan's younger sister, is a sophomore at Texas Christian University in Ft. Worth. They are the daughters of Dr. Larry A. Bookman, OCMS President-Elect, and Kathy Bookman.

Filipino Christmas Traditions

(My Christmas Experiences)

Aurora C. Macaraeg and Emmanuel N. Macaraeg, MD

When I was growing up in the Philippines, Christmas time meant a lot of things to me. I know Christmas day is just around the corner when I hear Christmas songs fill the air as early as late October or early November. When I see commercial buildings, storefronts, streets, trees, hotel lobbies and almost every Filipino home decorated with the parols, the star-shaped lanterns of different sizes, with intricate designs and adornments, made of multicolored Japanese paper and glued over a bamboo frame, I know it's Christmas time. I also notice the belen, the Nativity scene with all the figures, displayed in every church and almost every home and every store window. Carolers, with monetary inducements, can be seen and heard in and around the neighborhood, singing Christmas songs in English and Tagalog.

As Christmas day draws near, I join family and friends in attending the Misa de Gallo (mass of the rooster – dawn mass) for nine consecutive mornings beginning December 16, the official start of the Filipino liturgical Christmas. After mass, we buy and eat native delicacies such as puto bungbung (purple glutinous wild rice), suman, puto and bibingka (rice cake) in stalls or tiendas located around or near the church.

On Christmas Eve, the family goes to church for the midnight mass. After this, we hurry home and enjoy the Noche Buena (night of goodness), a supper of thanksgiving where the table is set with lots of food, ranging from pure Filipino dishes and native delicacies, castanas (chestnuts) and fresh fruits to Filipino-Spanish and/or Filipino-Chinese dishes, including relleno (stuffed whole chicken), embutido (ground meat roll), leg of lamb, ensalmadas (cheese buns), queso de bola (cheese ball) and arroz caldo (hot rice porridge) with chicken.

After the midnight feast, we gather around the Christmas tree to open our aguinaldos (gifts) from Santa Claus. Yes, Santa Claus gets around even in the tropics. On Christmas day, we visit our baptismal godfathers (ninongs) and godmothers (ninangs) to solicit our aguinaldos and, showing our respect, we kiss the back of their hands.

(Cont'd on page Thirty-one)

Wishing You Christmas Gift

Emily Oehlert and Amanda Oehlert

Many families spend the holidays with first one side of the family and then the other side of the family. At the very least, immediate family members usually spend both Thanksgiving and Christmas together. However, when your father is a doctor, he will always have patients and will always be on call … even over the holidays. This meant that until our father retired from practicing medicine, our family had to choose between the four of us being all together or splitting up to see one side of the family or another.

Christmas was a day just for the four of us. None of our extended family lives in Oklahoma. We chose to stay in town because our dad always took call that holiday and had to make rounds and cover emergencies. We started the morning trying to be the first to wish each other "Christmas Gift." (This is a tradition passed down on my mother's side that dates to early America when slaves would wish their masters "Christmas Gift" since they could not afford gifts. This was spread during the Civil War when so many didn't have the ability to give each other gifts.) Like most families, we would start the day early with opening presents under the tree, but we made a point to open presents from out-of-town family first so we could call them to wish them a merry Christmas, and mention how much we liked their gifts. Each greeting started with "Christmas Gift!"

After opening our other presents, our father and I, the older sister, would go on rounds at the hospital while I, the younger sister, would usually be focused on my new gifts, and our mother finished making Christmas dinner. Our mom had to hurry though because there weren't usually many patients in the hospital (who wants to be in the hospital over the holidays?—and the people who are there are very sick yet very kind on a holiday) so we would return in decent time in the mid-afternoon. During dinner

with just the four of us, one of our father's partners would take call for him so we could eat uninterrupted, and when we were finished, he was back on call. Sometimes he was able to stay home the rest of the day and after cleaning up dinner, we would all open our stockings. But sometimes, he would be called back to the hospital. If it wasn't too serious or didn't take too much time, we would wait for him to return home before we would open our stockings, but every now and then it would be something really serious or very long, and we would open our stockings without him.

Since our father has retired, our holidays are much the same as they were when he was practicing. As for Christmas, we still stay here in Oklahoma, but now there are no more rounds and no more emergency phone calls at any hour. And now that we're all a bit older, Mom doesn't have to prepare the meal alone – I, the older sister, enjoy cooking the dishes ahead of time and then the three of us take care of the rest while our dad watches football, just like most families. One tradition we continue to enjoy is that of writing thank you notes. There is one present to be opened after all the letters of gratitude are finished. Gratitude is one of the blessings of the holiday season and the reward for expressing it is fun too.

Being in a doctor's family means that you share with patients. Rounds and being on call mean that you cannot think only of yourselves. This is a good thing, but it can wreak havoc in planning a special dinner. Having one of Dad's partners take call for two hours was a treasured gift that allowed us the pleasure of dinner with each other, and to be like most other American families for a little while.

Season's Greetings or, as in our family, Christmas Gift! ❑

Emily lives and works in Oklahoma City. Amanda is pursuing another degree and lives in Oklahoma City. They are the daughters of Dr. W. H. Oehlert, past President of OCMS and OSMA, and Mrs. Keith Oehlert, past President of OCMSA and OSMAA.

Christmas is not a time nor a season, but a state of mind. To cherish peace and goodwill, to be plenteous in mercy, is to have the real spirit of Christmas.

Calvin Coolidge

Holidays with the Jaqua Owens

Emily A. Owens and Thomas P. Owens, III

We celebrate our holidays alternating between the family homes of our parents in Sioux Falls, SD and Panamá. We stay in Edmond, OK when dad is on-call. We like to spend a lot of time with family. We look forward to the different weather (snow in SD and sunshine and warmth in Panamá). Both mom and dad are one of five siblings, so the gatherings can be very large!

In SD, typically, the larger extended family meets for Christmas Eve. We usually assemble at my Uncle Mike's. Food is simple consisting of sandwiches, maybe soup and relish trays and an assortment of sweets. We work with our cousins to make up skits and little 'choreographed' numbers with either singing or dancing that we 'present' from the top of the staircase. At Thanksgiving, the adults draw names for the Christmas gift exchange. No one is supposed to know who has whose name. On Christmas Eve the wait is over and gifts are opened. You usually get your 'assigned' gift and at least one or two gag gifts. It is a lot of fun to see people laughing out loud as they open each one! The kids get gifts from everyone (one of the perks of being young!). The festivity lasts way past midnight. We leave my Uncle's, go back to Grandma's and go to bed--excitedly awaiting Santa's gifts in the morning.

On Christmas day we open more gifts, go to church (Lutheran or Catholic) and then get the family together again. Everyone usually gathers at Grandma's for Christmas Day Dinner. Grandma fixes turkey and dressing, mashed potatoes, and broccoli rice casserole. Everyone brings other dishes to share. Grandma also has plenty of Norwegian sweets including lefse (a delicious treat of sweet butter, sugar and a potato-based thin pancake of sorts), krumkake (a cookie with yes, a very funny name) and rosettes (deep-fried crunchy pastry with powdered sugar). Another tradition is to load everyone into the car and drive among the neighborhoods and Falls Park to enjoy the Christmas light displays.

For New Year's Eve we stay at grandma's, play lots of board games and cards (mostly Spades) and watch the NYC Times Square Ball drop. New Year's day may take us out to run in the snow, snowmobile or ice fishing.

When in Panamá we go to Club Unión (a country club by the ocean) often and swim or play sports. Our favorite snack bar foods are 'empanadas' (meat-filled pastries) and 'carne en palito' (beef on a stick), and we have 'No me olvides', a delicious ice cream with pound cake, marshmallow cream and milk sweets. Because weather is warm and the dry season is starting, we get some nice (and much needed) breeze and less rain than usual. While we are there, we go to see 'nacimientos' (detailed miniature towns created by artisans that depict life in the Holy Land) and Belén street (more contemporary holiday trees and Christmas displays). Sometimes we also join in 'Posadas' (singing songs while walking around the neighborhood). We gather at one of our uncles' or aunt's home for the Eve and have baked ham, turkey and the local fare of tamales, rice with raisins, 'plátanos en tentación' (plantain baked with brown sugar) and 'arroz con pollo' (rice and chicken). Flan and 'bocado del rey' or 'tres leches' are our favorite desserts. We go to midnight Mass and then chat at one of my dad's sibling's home until late. It is tradition to open all the presents on Christmas day. We have leftovers that day and hang out with family or head to the beach.

New Year's Eve the families get together at our Tia Patsy's. Her previous apartment was in a place where we could see what we called the '360 fireworks' with literally *hundreds* of different fireworks all around! It was incredible! She has since moved to a house, but we get to see plenty from her new neighborhood. New Year's Day we go to the club's "Egg Nog" brunch and visit with other relatives.

We are very lucky to enjoy both families and, at either country, we have a wonderful Christmas. ❑

Thomas Owens, a Junior, and Emily Owens, a Sophomore, at Edmond Memorial High School are the children of Tammy Jaqua Owens, RN and Tomás Owens, MD, Secretary-Treasurer of OCMS and Editorial Board Member.

Christmas in our Lebanese Home

Michael Massad

Christmas is an enchanted time of year, but Christmas in our house is not plagued with consumerism and superficiality.

On Christmas Eve, the family attends the traditional Christian Orthodox Service. That night we then have a large feast in celebration of the birth of Jesus. Prior to this feast, at the start of the Advent Season, we grow wheat next to a display of the Nativity as a symbol of new life with the Birth of Jesus. On Christmas Eve, after the feast of many traditional dishes, we sing happy birthday to Jesus with a ceremonial candle lighting. To continue the festivities, the whole family joins in some caroling with dad or my sister at the piano. After several songs and a few good laughs, we go to bed waiting for Santa's gifts left by the chimney.

The next morning we have an incredible brunch together, then we open a few gifts. But to maintain the focus of the week, we then ready ourselves for yet another feast that night.

The week of Christmas is a beautiful time with close family and friends. The family engages heartily in table fellowship, prayer and overall camaraderie. Life would be much emptier without this time of family renewal and celebration of the birth of Jesus. ❑

Michael, a sophomore business student at the University of Oklahoma, is the son of Nina Massad, OCMSA President, and Dr. Paul Massad, member of the Bulletin Editorial Board.

Why Frontier?

We realize there is a lot of competition for your hospice referral. You, your patients and their families deserve the best care available. A service gap exists between competitors and we want you to know why Frontier is the choice of so many of Oklahoma's top medical professionals.

Key Metrics

- *24 hr a day 7 day a week referral/admit availability*
- *3 hr referral response time*
- *Exceptional patient and family satisfaction (98%)*
- *Over 93% of patients stay at home or in their residence*
- *Volunteer participation hours exceed Medicare requirements by over 200%*

Staff

- *Medical Directors with over 30 years end-of-life experience*
- *Hospice board certified Medical Director*
- *24/7 on-call PharmD*
- *Full time RN Case Managers*
- *Full time social workers*
- *Full time Bereavement Care*
- *Full time Spiritual Care*
- *Hospice certified Home Health Aides*

Corporate Support

- *American Hospice is one of the nation's oldest and largest hospice companies.*
- *Corporate resources enhance and enrich local programs*

Compliance

- *Full time quality compliance expert*

For Referrals Call
405 789-2913

The Promise of Comfort

Frontier Hospice
An American Hospice Company

3908 North Peniel
Suite 500
Bethany, OK 73008

www.americanhospice.com

Solidarity and Clinical Research: A Neglected Principle of Ethics in Medicine?

John J. Mulvihill, MD

> *As a doctor first, as a citizen second, and eventually as a patient third, I'm very glad to be in France. It's kind of a luxury: you are sick, you step into a hospital, you get the care you need. It doesn't depend on your premiums; it depends on what you need. The principle is solidarity: people who are better off pay for those who are worse off. You pay according to your means, and you receive according to your needs.*
>
> *Dr. Gillen in the movie* Sicko *by Michael Moore.*

Each Spring, the University of Oklahoma College of Medicine second-year students take a short course, Clinical Ethics and Professionalism. Its co-director is none other than our incredibly busy Dean, Dewayne Andrews, MD. Obviously, he places high priority on the course and his role gives an important signal to our future colleagues.

For several years, I had a little cameo. A few times, I organized a two hour session on ethical dilemmas encountered in my specialty, medical genetics. One year, the assignment changed to emphasize cross cultural differences in health care. My associates in pediatric endocrinology helped assemble eight young patients, all with diabetes mellitus, but all of different ethnic heritage (Euro-American, African-American, Native American, Vietnamese, and Mexican) and ages (early and middle childhood; teenaged and young adult). Each module of students interviewed one volunteer and reported back to the class, focusing less on the pathophysiology of the condition and more on the issues of cultural differences the patients encountered in interacting with their doctor and using complementary and alternative medicines. The point was the same "disease" was very different in specific patients and families, based in part on culture. (Sadly, that session had to be displaced one year to get sophomores informed on HIPAA, which, to my good luck, was handled by another faculty member.)

In Spring 2007, my topic was Clinical and Translational Sciences, a thrilling new initiative of the National Institutes of Health (NIH). This program, one of few growth centers of our nation's engine for improving health through research, addresses a paradox about NIH's impact on our health status. Namely, why, after a half trillion dollars spent in the last half century, is America not healthier than it is, ranking low on many common measures of well-being? The

answer that the new NIH program offers is that, as good as the Nobel-prize winning 20th century strategy of understanding the molecular mechanisms of disease predisposition and progression was, it did not get findings to appropriate clinical trials nor translate them beyond the academic health centers into rural America. So, the scant new money we give to NIH through Congress is marked for augmenting clinical and translational research. The University of Oklahoma and Oklahoma Medical Research Foundation want to help and our >600 page application was submitted in October 2009.

If awarded, one hope of the proposals is that many Oklahoma physicians, both metropolitan and rural, will join efforts to make all of us and our patients more aware of our shared vital role in contributing to clinical and translational research that has a real prospect for improving our county's and state's health. You see, I believe, we should all be in this quest together – solidarity in medicine.

The Clinical Ethics and Professionalism course rightly emphasizes the classical ethical principles of medical practice: justice, autonomy, and privacy. But, given the need for everyone's participation in clinical and translational science for health, not to mention the crisis in our American health care system, maybe we need to turn the spot light on "solidarity." In cynical moments, I think, "What a total oxymoron!" Our effort is not directed to health, it doesn't offer continuous care, and it's really not a good system. It's an "acute illness quick-fix non-system!" Access to health insurance as a solution seems to perpetuate the odd concept that medicine and a true health-maintaining, disease-preventing medical home must support the structure and bureaucracy of a financial system that passes money around for our services and expertise, while taking a sizeable administrative fee. The financial services crisis must surely hold a metaphor for the disease services industry.

The preamble to the U.S. Constitution speaks of solidarity: "In order to … promote the general welfare." What's good for one, is good for all. The haves must help the have-nots. The Polish labor movement we call "Solidarity," founded by Nobel Prize winner Lech Walesa, contributed to the demise of the Soviet Union, the fall of the Berlin Wall, and the growth of new Eastern European democracies entering the European Union.

Volunteerism seems to be at a record high among medical students at OU, with an estimated 60 to 70 percent volunteering for community efforts. Solidarity embraces our profession's considerable activities in Oklahoma County, not just donation of money, as valuable as that is, but also contributions of our time to voluntary clinics, to tedious committee work to improve health care, and . . . maybe eventually

to clinical and translational research in our own settings. That's solidarity! ❑

Dr. Mulvihill attended Dartmouth Medical College and the University of Washington and served his internship at University Hospital, Seattle, and his pediatric residency at the Johns Hopkins Hospital. After two decades with the National Cancer Institute and the InterInstitute Medical Genetics Program of NIH, he founded the Department of Human Genetics at the University of Pittsburgh. In 1998, he became Children's Medical Research Institute-Kimberly V. Talley chair in Genetics in the Department of Pediatrics at the University of Oklahoma College of Medicine, Oklahoma City. His wife Charlotte is Professor of Biotechnology at Oklahoma City Community College. Their three children have their kids in Philadelphia, San Francisco, and Johnston City, IL.

Director's

DIALOGUE

Gratitude

Feeling gratitude and not expressing it is
like wrapping a present and not giving it.

William Arthur Ward, author

"I can complain that the rose bush has a thorn or rejoice that the thorn bush has a rose," is one of the final things I read as I rush out the door for work each day. It serves to remind me that each day is a gift, and I need to strive for an attitude of gratitude.

As 2009 draws to a close, there are many things for which I am grateful. It has been a pleasure working with Dr. Teresa Shavney and the Board of Directors this year. These *volunteer* leaders carved time from their busy practices and personal lives to serve their peers. Their leadership and dedication to this organization have been outstanding, and I ask you to thank them for their service.

To all of the loyal Oklahoma County physicians who retained their membership during 2009, thank you! While experiencing decreased reimbursements, increased overhead and financial uncertainties through most of the year, you paid your membership dues. Without physicians' financial support, the Oklahoma County Medical Society would cease to exist.

On behalf of the uninsured patients served by the Open Arms Clinic, thanks go to the Oklahoma County physicians who volunteered at the Open Arms Clinic as primary care physicians or accepted specialty referrals. Established in September 1993, the clinic continues to serve the needy in Oklahoma County. I am grateful to Dr. Mukesh Parekh for serving as the clinic's medical director for many years and look forward to working with Dr. Blake Stanfield, the new medical director. In addition to our membership's support, the clinic continues to receive generous funding from the Butterfield Foundation and Deaconess Hospital, resident staffing from the Great Plains Family Practice Residency Program and medical student volunteers from the OU College of Medicine.

Much gratitude goes to the Society's staff. During this year, Linda Larason and Ashley Merritt both approached their work with enthusiasm and professionalism...with a little humor sprinkled in for good measure. Believe me, we needed a few laughs as we undertook moving into the new Oklahoma State Medical Association headquarters in early summer. The months went by in a blur as we settled into our new surroundings, and to say there were a few challenges would be an understatement. But we are grateful to the membership for providing a lovely work environment for us. If you haven't visited our new location at 313 N.E. 50th Street, I hope you will plan to attend an OCMS membership meeting soon or to stop by for a tour of the facility.

In addition, the Health Alliance for the Uninsured staff, Pam Cross, Executive Director, and Joe Denney, systems analyst, made the move with us to the new building. The HAU's accomplishments are growing as the organization continues its efforts to coordinate healthcare delivery to the uninsured in this community.

As the holiday season looms before you, take a moment from your hectic schedule and remember all those things for which you are grateful...most importantly gratitude for the gift of another day. If you find yourself caught up in "doing" and not "enjoying" the season, just remember to. . .

Do all the good you can,
By all the means you can,
In all the ways you can,
In all the places you can,
At all the times you can!
John Wesley

...and do it with a joyful heart. Happy Holidays!
Jana Timberlake, CAE, Executive Director

Pre-Planning for EMR Implementation

Joe Denney, MD

Although no one knows for sure what the final "meaningful use" and "certified EMR" rules are going to look like, it's important to begin the planning process soon for your EMR implementation. My experience is that the entire process from the decision to implement an EMR until the time you are live and fully implemented takes between 12 and 18 months. Given the deadlines built in to the HITECH portions of ARRA, physicians who want to take full advantage of the incentive payments need to start their planning processes soon.

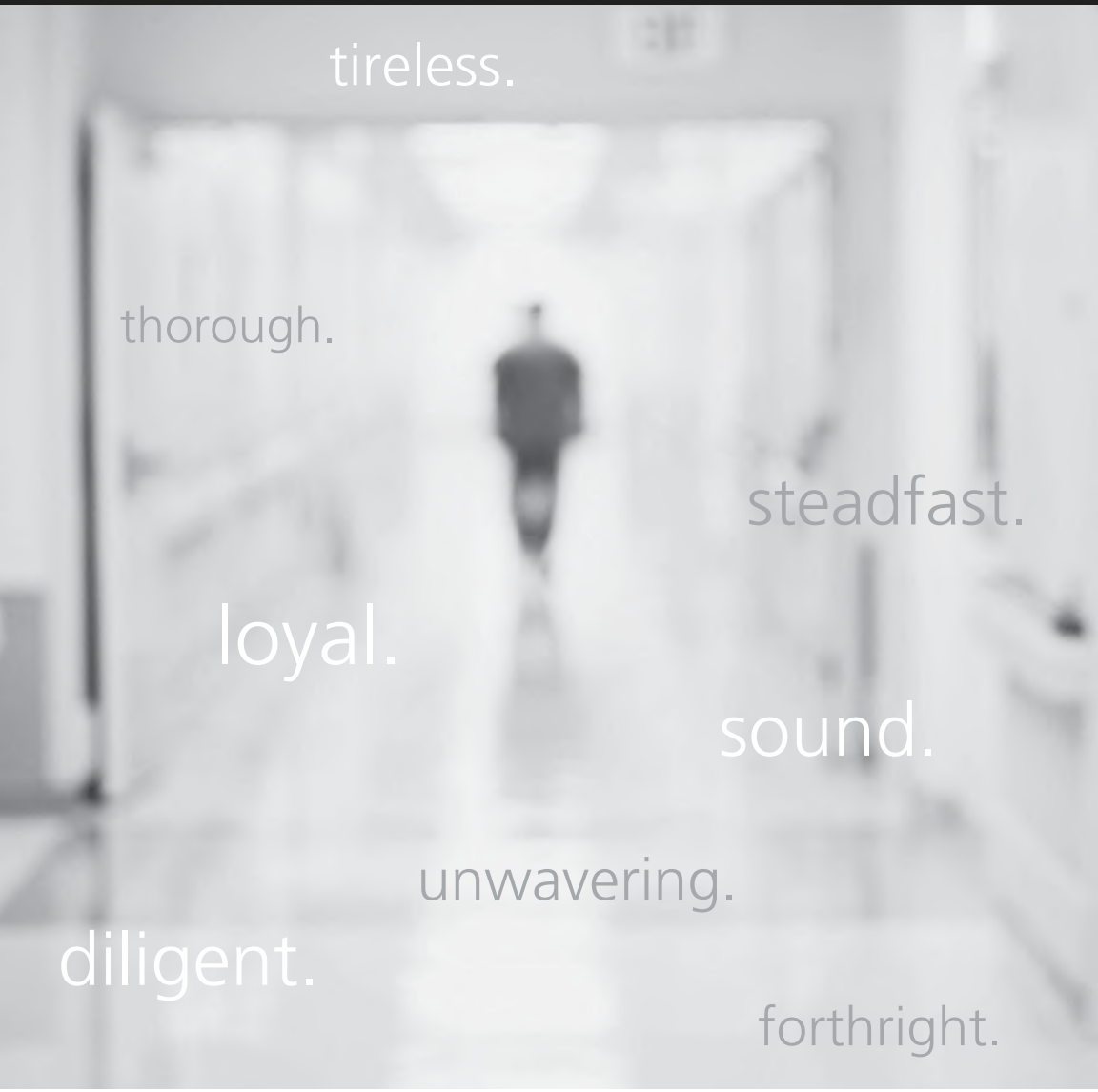
Investing the time and money to plan your implementation process is one of the best things you can do to be sure your implementation stays close to your budget and timeline. This month I will focus on the pre-planning phase, which will help you identify the assets and constraints to consider as you research potential vendors and begin to gather cost and implementation timeline ideas.

The goal of the pre-planning process is to have an accurate picture of your existing environment so you can plan for all the things you need to have a successful implementation. I'm going to focus on three areas of assessment to complete in this phase of your implementation process. These are the *physical and infrastructure assessment*, the *operating environment*, and the *human asset assessment*.

The physical and infrastructure assessment includes things such as: how many computers do you have now, what operating system are they running, how much RAM do they have, how much hard drive space is left, what size is the monitor. What are your current options for printing, faxing and scanning? How old are these machines, and what computers, if any, are they connected to? Do you have an existing network? If so, is it wired, wireless, or a hybrid? What type of connection to the internet do you have, and how fast is it? Who is your internet service provider? Do you have adequate battery backups on the network and workstations? Do you have a server? If not, and your EMR selection requires a server, do you have a secure physical location with adequate ventilation/temperature control, proper power and battery backups, space for backup media, a backup plan that is HIPAA compliant and the technical know-how, either on staff or via consultant, to do this?

The operating environment will certainly give you some constraints, based on the different systems you will have to interact with. The first environmental variable is your practice

Choose your health coverage from people who share your idea of what it means to truly, passionately want to make a difference.



OSMA Health is a health benefits program built and governed **by physicians, for physicians —** and available exclusively to members of the Oklahoma State Medical Association, their employees and their families.

OSMA HEALTH

people you know, coverage you can trust.℠

Contact us today for more details. Oklahoma City **405.290.5646** Toll-Free **866.304.5628**

Paid Advertising

management software. You will want to have your EMR and your PM software talking to each other, so talk with your PM vendor about what EMRs they integrate with. If not, what is the process for getting an interface developed? Does your PM use industry standards for data exchange? If you practice in a hospital or would like to share data with a hospital, ask what EHR systems they use and what EMR systems they have interfaces with. Some hospitals may not work with anything other than their vendor, and some may work with EMRs using standard data transfer protocols. What other systems do you need to exchange data with? Does your lab provider have the capacity to send results directly to an EMR? If so, what EMRs do they have interfaces with? Basically, any resource you send patient (information) to and receive patient (information) from should be considered as possible constraints on what EMR you select. If an EMR won't talk to your lab and to your imaging provider, that EMR probably isn't a good fit. Gathering information now about who can interface with you without a problem, who you will have to pay to develop an interface to, and who simply won't interface can save you much time and heartache as you go through the selection process.

Your human assets are probably the most overlooked and arguably the most important part of the assessment process. First, look in the mirror. Are you committed to the process of having an EMR? You are the most important person in this process, because you will be both the primary user and the leader of the implementation team. You must demonstrate leadership to your staff, because they will be looking to you for cues on how important this is. Taking the attitude that EMR implementation is going to be tough, but doable will go a long way. How comfortable is your staff in using computers? Does anyone need extra training on the basics? Do you have a "guru" who everyone goes to with problems now? What assets do you have or will you need to get to network your office, provide support and help you document and plan your implementation?

This process is not easy, but will pay big dividends for you in the future as you are able to make good, informed decisions about what you need, based on what you have. If you haven't already, consider finding a good project management/IT professional to help you plan your process. While these people may not be cheap, they can save you considerable money down the line as you avoid some expensive landmines during your implementation and operational phases. ❑

A Holiday Message

Nina Massad
President

The Holiday Season is fast approaching and so is the end of the year 2009. We look forward to magic times with family and close friends and the exchanging of gifts. With all the happiness ahead, let us not forget to look back and count our blessings throughout the past year. During these difficult economic times, we can look around at some of the problems that close friends and family members are enduring. We can think of it as a time and season when we can be sensitive to the needs of others by sharing our strength, wisdom and bounties with those less fortunate.

The OCMSA's big project of the year focuses on helping organizations in Oklahoma. The Kitchen Tour, completed in October, was attended by hundreds of people in one day. The weather was fabulous for a few hours and kind visitors from everywhere told us how much they looked forward to this event every year. Funds raised this year will benefit Schools for Healthy Lifestyles and Health Alliance for the Uninsured.

The Cruise year has been a blast so far, with the first port of call in Hawaii followed by the Mediterranean voyage and the International food Fest. Master Kim, who holds a black belt in Tae Kwon Do, taught us some self-defense techniques and the importance of our fingers, elbows, knees and high heels. Senator Susan Paddack spoke in November at the general meeting about health reforms.

When I pause and contemplate the many blessings of this past year, I feel a deep appreciation to all the members who helped, whether by cooking, calling, publishing, running, assisting in the kitchens, paying for tickets, baking, meeting, posting signs or writing letters to the donors – and the list goes on....

What a privilege to be able to help one another – forging a bonding friendship and also helping individuals in need.

Please don't let the Alliance cruise ship sail without you. More fun is awaiting in 2010.

May the blessings from above dwell in your hearts and your homes during this Holy Season. ❑

The Thing Speaks for Itself
(Res Ipsa Loquitur)

S. Sandy Sanbar, MD, PhD, JD
Chairman, American Board of Legal Medicine
Adjunct Professor Medical Jurisprudence, TUN

The doctrine of res ipsa loquitur assists the Plaintiff to prove negligence.

CASE 1: In 2001, a patient underwent laparoscopic abdominal surgery and discharged home the same day. Later that day, she returned to the Hospital complaining of pain in her right shoulder. The diagnosis was Type II posterior labrial tear injury to her shoulder. She sued the Hospital for malpractice claiming that she had sustained the shoulder injury during the surgery, while she was unconscious, and as a result of Hospital's negligence.[1]

At trial, in 2006 and 2007, the patient, Plaintiff, testified that she had sustained no pre-operative injury, had no pre-operative pain in the shoulder, and doctors had examined her shoulder four days before the surgery and found no injury, swelling, or tenderness. However, she presented no direct evidence that any Hospital employee dropped her arm during the surgery or otherwise caused her injury and that her injury was caused to a reasonable degree of medical certainty by Hospital negligence.

The Hospital denied negligence and claimed that it used due care to prevent such an injury. The Hospital expert witness testified that the evidence relating to the patient's shoulder injury was inconsistent with an arm dropping injury during surgery, and that her shoulder pain was a classic referred pain from the surgery itself.

At the conclusion of the trial, the Judge found in favor of Hospital and stated that, "As of this time, the plaintiff has come nowhere close to persuading the trier of fact (Jury) that an accident occurred while Ms. Norman was under the defendant's control."

On Appeal, the Oklahoma Court of Civil Appeals stated that "the doctrine of res ipsa loquitur was designed to aid plaintiffs in making a prima facie case of negligence where direct proof was beyond their power and control, but within the power of the defendant. This is precisely the type of case for which the rule was designed: Plaintiffs presented proof that Rhonda was unconscious when she sustained her injury, and direct proof of the event was solely within the power and control of Hospital. Common knowledge infers negligence from these facts. The Court reversed

and remanded the case for a new trial.

CASE 2: In 1999, Plaintiff Parris was discovered to have a positive prostate specific antigen (PSA). Needle biopsy of his prostate revealed adenocarcinoma and high-grade prostatic intraepithelial neoplasia, and he underwent a radical prostatectomy. Five-year follow-up with frequent PSA tests were negative.

On September 2, 2004, the patient obtained his medical records and found a report dated October 26, 1999, from the surgical pathologist advising the urologist that he had examined patient's removed prostate three days after the prostatectomy and found no sign of cancerous cells in the prostate. The report indicated that the pathologist had discussed his findings with the urologist on the day of his original examination and, again, on the day he issued his written report. According to patient, the urologist never advised him of the pathology findings.

The patient sued the doctors and the hospital for malpractice.[2] He alleged that the Defendants were negligent in conducting the biopsy and examination which resulted in the diagnosis of cancer, that the pathology slides of the biopsy were in the exclusive custody of the defendants, that these slides were "negligently mismarked, misidentified or misread which ordinarily does not occur in the absence of negligence," and that the urologist had intentionally concealed the information that Plaintiff's prostate was cancer-free, thereby preventing Plaintiff from discovering Defendants' negligence until September 2004.

During the course of the litigation, the Plaintiff filed a motion requesting to proceed without a medical expert, citing the doctrine of res ipsa loquitur as authority. The trial court denied the motion and ordered the Plaintiff to name an expert within 30 days. The Plaintiff responded that an expert witness was not necessary to make a prima facie showing of Defendants' negligence, but, if it was, then the pathologist would be his expert. The Defendants obtained an affidavit from the pathologist stating that he had not agreed to be the Plaintiff's expert, and that "[i]t is known and reported in the pathology literature that a needle biopsy will demonstrate cancer but a later surgical prostate specimen could show little or no signs of the malignancy." The trial court granted the motions to dismiss.

On appeal, the case was reversed and remanded for further proceedings, because an expert witness was not necessary for Plaintiff to prove malpractice, and in this particular situation the surgical pathologist may be compelled to testify as an expert on behalf of Plaintiff.

---

[1] *Norman v. Mercy Memorial Health Center, Inc.*, 2009 OK CIV APP 55 (Okla. Civ. App., 2009)

[2] *Parris v. Limes*, 2009 OK CIV APP 19 (Okla. Civ. App., 2009)

(Cont'd from page seven)

highest professional standards in the medical or professional ethics fields.

College of Medicine scientists Shrikant Anant, PhD, and Courtney Houchen, MD, both associate professors of medicine, have discovered the first evidence of a stem cell protein responsible for regulating a natural tumor suppressor. This groundbreaking research appeared in the journal Gastroenterology.

John Iandolo, PhD, professor and chairman, Department of Microbiology and Immunology, is leaving this position after 12 years and will become Vice President for Research at OUHSC in January. We are starting the process to fill the vacancy created by this recently announced change.

In November, The Scientist magazine published its survey of scientists and ranked the University of Oklahoma Health Sciences Center as fourth in the nation on its list of the best U.S. places to work in academia. The three institutions ranked ahead of OUHSC are Princeton University, University of California San Francisco, and the Albert Einstein College of Medicine. Emory University was number 5. In 2007, OUHSC was listed as number 30. We are obviously proud of the results for the 2009 survey.

Finally, it's again that special time when we take time to reflect on the past year and think about family and friends and many things for which we are thankful. In this special season, may I take this opportunity on behalf of the entire College of Medicine to express appreciation to our many friends in the Oklahoma County Medical Society for your friendship and support and to wish each of you wonderful holidays and the happiest of New Years! ❑

(Cont'd from page thirteen)

And lastly, on New Year's eve, while waiting for the midnight mass and another noche Buena, we go out into the streets, creating as much noise as possible by lighting firecrackers (paputuk) firing bamboo cannons with carburo (calcium carbide) mixed with water, tooting horns, ringing bells, clanging pots and pans and dragging them behind the car until the wee hours of the morning.

This is how I remember and celebrated Christmas in the Philippines – with God, family, relatives and friends. ❑

Aurora is a Past President of the OCMS Alliance. Her husband, Dr. Emmanuel N. Macaraeg, is a retired anestheologist and longtime OCMS member. Both are natives of the Philippines.

Paid Advertising

Book Review

Diagnosis: What Doctors Are Missing

Jerome E. Groopman

Carrying the Heart: Exploring the Worlds Within Us
by F. González-Crussi
Kaplan, 291 pp., $26.95

The Deadly Dinner Party and Other Medical Detective Stories
by Jonathan A. Edlow, M.D.
Yale University Press, 245 pp., $27.50

Several months ago, I led a clinical conference for interns and residents at the Massachusetts General Hospital. It was thirty-three years since I had trained there, and beyond discussing the topic of the gathering, I was keen to learn from these young doctors how they viewed recent changes in the culture of medicine.

The subject of the conference centered on how physicians arrive at a diagnosis and recommend a treatment—questions that are central in the two books under review. We began by discussing not clinical successes but failures. Some 10 to 15 percent of all patients either suffer from a delay in making the correct diagnosis or die before the correct diagnosis is made. Misdiagnosis, it turns out, is rarely related to the doctor being misled by technical errors, like a laboratory worker mixing up a blood sample and reporting a result on the wrong patient; rather, the failure to diagnose reflects the unsuspected errors made while trying to understand a patient's condition.[1]

These cognitive pitfalls are part of human thinking, biases that cloud logic when we make judgments under conditions of uncertainty and time pressure. Indeed, the cognitive errors common in clinical medicine were initially elucidated by the psychologists Amos Tversky and Daniel Kahneman in their seminal work in the early 1970s.[2] At the conference, I reviewed with the residents three principal biases these researchers studied: "anchoring," where a person overvalues the first data he encounters and so is skewed in his thinking; "availability," where recent or dramatic cases quickly come to mind and color judgment about the situation at hand; and "attribution," where stereotypes can prejudice thinking so conclusions arise not from data but from such preconceptions.[1]

A physician works with imperfect information. Patients typically describe their problem in a fragmented and tangential fashion—they tell the doctor when they began to feel different, what parts of the body

bother them, what factors in the environment like food or a pet may have exacerbated their symptoms, and what they did to try to relieve their condition. There are usually gaps in the patient's story: parts of his narrative are only hazily recalled and facts are distorted by his memory, making the data he offers incomplete and uncertain. The physician's physical examination, where he should use all of his senses to try to ascertain changes in bodily functions—assessing the tension of the skin, the breadth of the liver, the pace of the heart—yields soundings that are, at best, approximations. More information may come from blood tests, X-rays, and scans. But no test result, from even the most sophisticated technology, is consistently reliable in revealing the hidden pathology.

So a doctor learns to question the quality and significance of the data he extracts from the medical history of the patient, physical examination, and diagnostic testing. Rigorous questioning requires considerable effort to stop and look back with a discerning eye and try to rearrange the pieces of the puzzle to form a different picture that provides the diagnosis. The most instructive moments are when you are proven wrong, and realize that you believed you knew more than you did, wrongly dismissing a key bit of information that contradicted your presumed diagnosis as an "outlier," or failing to consider in your parsimonious logic that the patient had more than one malady causing his symptoms.

At the clinical conference, I recounted this reality to the interns and residents, and emphasized that like every doctor I knew, I had made serious errors in diagnosis, errors that were detrimental to patients. And I worried aloud about how changes in the delivery of health care, particularly the increasing time pressure to see more and more patients in fewer and fewer minutes in the name of "efficiency," could worsen the pitfalls physicians face in their thinking, because clear thinking cannot be done in haste.

When the discussion moved to formulating ways of improving diagnosis, I raised the issue of the growing reliance on "clinical guidelines," the algorithms crafted by expert committees that are intended to implement uniform "best practices." Like all doctors educated over the past decade, the residents had been immersed in what is called "evidence-based medicine." This is a movement to put medical care on a sound scientific footing using data from clinical trials of treatment rather than on anecdotal results. To be sure, this shift to science is welcome, but the "evidence" from clinical trials is often limited in its application to a particular patient's case. Subjects in clinical trials are typically "cherry-picked," meaning that they are included only if they have a single disease and excluded if

they have multiple conditions, or are receiving other medications or treatments that might mar the purity of the population under study. People are also excluded who are too young or too old to fit into the rigid criteria set by the researchers.

Yet these excluded patients are the very people who heavily populate doctors' clinics and seek their care. It is these many patients that a physician must think about deeply, taking on the difficult task of devising an empirical approach, melding statistics from clinical trials with personal experience and even anecdotal results. Yes, prudent physicians consult scientific data, the so-called "best evidence," but they recognize that such evidence is an approximation of reality. And importantly, clinical guidelines do not incorporate the sick person's preferences and values into the doctor's choice of treatment; guidelines are generic, not customized to the individual's sensibilities.[3]

At the conference, an animated discussion followed, and I heard how changes in the culture of medicine were altering the ways that the young doctors interacted with their patients. One woman said that she spent less and less time conversing with her patients. Instead, she felt glued to a computer screen, checking off boxes on an electronic medical record to document a voluminous set of required "quality of care" measures, many of them not clearly relevant to her patient's problems. Another resident talked about how so-called "work rounds" were frequently conducted in a closed conference room with a computer rather than at the patient's bedside.

During my training three decades ago, the team of interns and residents would move from bedside to bedside, engaging the sick person in discussion, looking for new symptoms; the medical chart was available to review the progress to date and new tests were often ordered in search of the diagnosis. By contrast, each patient now had his or her relevant data on the screen, and the team sat around clicking the computer keyboard. It took concerted effort for the group to leave the conference room and visit the actual people in need.

Still another trainee talked about the work schedule. Because chronic sleep deprivation can lead to medical mistakes, strict regulations have been implemented across the country to limit the amount of time any one resident can attend to patient care. While well intentioned and clearly addressing an important problem with patient safety, the unintended consequence was that care became more fragmented; patients now were "handed off" in shifts, and with such handoffs the trainee often failed to learn how an illness evolved over time, and important information was sometimes lost in the transition.

After the clinical conference, I chatted with my hosts, the two chief residents. I saw what had not changed over the years: the eagerness and excitement about human biology; the mix of tension and pride in taking responsibility for another person's life; the desire, while acknowledging its impossibility, for perfection in practice and performance; and a growing awareness that deciding with the patient on the "best treatment" is a complex process that cannot simply be reduced to formulas using probabilities of risks and benefits.

The two chief residents showed a level of insight about the limits of medical science that I had not had at their age. In the 1970s, clinical medicine was encountering molecular biology for the first time, and I was dazzled by the cascade of findings about genes and proteins. Recombinant DNA technology with gene cloning promised to revolutionize the profession, and indeed it has. Now, diseases are unraveled based on mutations in the genome, and drugs are more rationally designed to target such underlying molecular aberrations.

As an intern and resident, my focus was firmly fixed on this marvelous and awesome science.[4] Although I prided myself on probing deeply into the patient's history in search of clues that would point to a diagnosis, I too often missed the deeper narrative—the tale of the meaning of the illness to the person. My fellow trainees and I spent scant time pondering how the sufferer experienced his plight, or what values and preferences were relevant to the clinical choices he faced. The two chief residents seemed deeply engaged by their patients' lives and struggles, yet deeply frustrated, because that dimension of medicine, what is termed "medical humanism," was, despite much lip service, given short shrift as a consequence of the enormous change in how medical care is being restructured.

What I heard from the residents at the Massachusetts General Hospital was not confined to that noon meeting or to young physicians. A close friend in New York City told me how his wife with metastatic ovarian cancer had spent six days in the hospital without a single doctor engaging her in a genuine conversation. Yes, she had undergone blood tests and been sent for CT scans. But no one attending to her had sat down in a chair at her bedside and conversed at eye level, asking questions and probing her thoughts and feelings about what was being done to combat her cancer and how much more treatment she was willing to undergo. The doctors had hardly touched her, only briefly placing their hands on her swollen abdomen to gauge its tension. The interactions with the clinical staff were remote, impersonal, and essentially mediated through machines.

Nor were these perceptions of the change in the nature of care

restricted to reports from patients and their families. They were also made by senior physicians. My wife and frequent co-writer, Dr. Pamela Hartzband, an endocrinologist, reported conversations among the clinical faculty about how a price tag was being fixed to every hour of the doctor's day. There were monetary metrics to be met, so-called "relative value units," which assessed your productivity as a physician strictly by measuring how much money you, as a salaried staff member, generated for the larger department. There is a compassionate, altruistic core of medical practice—sitting with a grieving family after a loved one is lost; lending your experience to a younger colleague struggling to manage a complex case; telephoning a patient and listening to how she is faring after surgery and chemotherapy for her breast cancer; extending yourself beyond the usual working day to help others because that is much of what it means to be a doctor. But not one minute of such time may be accountable for reimbursement on a bean counter's balance sheet.[5]

Still, I wondered whether my diagnosis of the ills of modern medicine was accurate. Perhaps I was weighed down by nostalgia, my perspective a product of selective hindsight. Certainly, coldly mercenary physicians were familiar in classical narratives of illness. Tolstoy satirized "celebrity doctors" who were well paid for offering Ivan Ilych ridiculous remedies for his undiagnosed malady while ignoring his suffering. Turgenev in "The Country Doctor" depicted an unctuous provincial physician whose degree of engagement with the sick was tied to the size of their pocketbook. Molière repeatedly lampooned the folly of pompous and greedy physicians.

Such doctors have been members of the profession since its founding. And it would be naive to believe that money is not one part of the exchange between physician and patient. But only recently has medical care been recast in our society as if it took place in a factory, with doctors and nurses as shift workers, laboring on an assembly line of the ill. The new people in charge, many with degrees in management economics, believe that care should be configured as a commodity, its contents reduced to equations, all of its dimensions measured and priced, all patient choices formulated as retail purchases. The experience of illness is being stripped of its symbolism and meaning, emptied of feeling and conflict. The new era rightly embraces science but wrongly relinquishes the soul.

In his book Carrying the Heart, Dr. Frank González-Crussi, a professor of pathology at Northwestern University, has made a sharp departure from medicine as a cold world of clinical facts and figures. Rather, he asks us to return to a view of the body not as a machine but as a wondrous work of creation, where both the corporeal and

Complimentary One-on-One Financial Consultation

Additional Strategies for:

- Asset Allocation
- Business Planning
- Estate Planning*
- Life Insurance for Personal & Business Needs
- Retirement Planning
- Education Planning*
- Tax Planning**
- Investment Planning
- Long-Term Care Insurance
- Disability Income Insurance
- Survivorship Planning

John Sullivan, CFP®, ChFC, CLU
Financial Consultant

john.sullivan@axa-advisors.com

AXA Advisors, LLC
609 S. Kelly Avenue, Suite E3
Edmond, OK 73003

Tel. (405) 285-4500
Fax (405) 285-4897

AXA ADVISORS
redefining / standards

www.AXAonline.com

*Funded through the use of life insurance and other financial products.
**AXA Advisors, LLC does not provide tax or legal advice. Please consult your tax and/or legal advisors regarding your particular circumstances.

There is no cost or obligation for the initial financial consultation. Product purchases are subject to additional fees and commissions. Securities and investment advisory services offered through AXA Advisors, LLC (NY, NY 212-314-4600), member FINRA, SIPC. Annuity and insurance products offered through an affiliate, AXA Network, LLC and its subsidiaries. GE-46643(a) (10/08)

Paid Advertising

the spiritual coexist. His aim, he writes, is to increase the public's awareness of the body's insides. By this, I do not mean the objective facts of anatomy, for most educated people today have a general, if limited, understanding of the body's parts and functions. I mean the history, the symbolism, the reflections, the many ideas, serious or fanciful, and even the romance and lore with which the inner organs have been surrounded historically.

This précis captures the beauty and charm of his book. I learned from González-Crussi that for centuries the stomach was considered the most noble of organs, directing all important physiological functions. The ancients, González-Crussi tells us, called the stomach "the king of viscera," "the senate or the patrician class; the bodily parts were the rebellious plebeians." Shakespeare repeats this fable in Coriolanus, where the stomach lectures the rest of the body's organs about the importance of its function.

Our gastric elements were seen as having a leading part in joy and adversity, and were the seat of the soul—predating the belief that the spirit was housed in the heart or the brain. This regal position was ultimately relinquished through the observations of Dr. William Beaumont in 1822. Beaumont studied a young French-Canadian named Alexis St. Martin, who suffered an accidental musket shot to the belly. He was left with a perforation some two and a half inches in circumference, through which the doctor could look into the living stomach and perform experiments on its workings. Via this "stomach window," the physiology of the organ was gradually deciphered, and its fabled status faded.

No part of our anatomy, González-Crussi recounts, has failed to fascinate poets, priests, and philosophers—including the working of the colon. In the chapter on feces, we learn that the Chinese had a divinity of the toilet. "This was Zi-gu, 'the violet lady.' She was not entirely fictional," González-Crussi writes, but took her origin from a flesh-and-blood woman who lived about AD 689. To her misfortune, she was made the concubine of a high government official, Li-Jing. The man's legitimate wife, overcome by jealousy, killed Zi-gu in cold blood while she was visiting the toilet. Since then, her ghost has haunted the latrines, "a most inconvenient circumstance for anyone in a hurry."

The colon and its product also were part of the theology of the Aztecs. They believed that excrement was capable of bringing ills and misfortune, and associated with sin, but also powerful and beneficent, able to ward off disease, to subdue the enemy, and to transform sexual transgressions into something useful and healthy.

Gold was termed "the sun's excrement" and the sun god Tonatiuh

deposited his own feces in the form of this precious element in the earth while he passed through to the underworld.

González-Crussi also reminds us that there was an inordinate fixation on one's bowels during the Victorian age, which honored values of order, temperance, respect for tradition, and sexual repression. Personal self-control, the mark of British culture, was at odds with that urgent process of expelling air and waste: Perhaps no greater ambivalence has ever existed toward the bowel than in Victorian England, where this organ was viewed with simultaneous skittish embarrassment and fascination, shame and fixed interest, shy modesty and hypnotic engrossment.

A shocking consequence of this cultural tension is that one of the most proficient surgeons of the era, William Arbuthnot Lane, who devised procedures to successfully set compound fractures, concluded that without a colon, man would free himself from inner toxins and extend his health and longevity. A natural physiological function became a pseudodisease. Initially, Lane devised operations to bypass the large bowel, and he then moved on to perform total colectomies. Patients flocked to him from all over Great Britain and abroad, certain that their lives would be more salubrious and fulfilling without their large intestine.

González-Crussi treats with similar scholarship and playful insight the uterus, the penis, the lungs, and the heart. He melds history with literature, religion with science, high humor with serious concerns. The sum of his narrative shows that medicine does not exist as some absolute ideal, but is very much a product of the prevailing culture, affected by the prejudices and passions of the time. This truth is far from the sterile conception of care as a commodity and the body as a jumble of molecules, disconnected from the experience of illness shared between patient and physician. But our culture, with its worship of technology and its deference to the technocrat, risks imposing an approach to medical care that ignores the deeply felt symbolism of our body parts and our desperate search for meaning when we suffer from illness. Patients—their problems, perceptions, and preferences—cannot be reduced to lifeless numbers. Ironically, the emerging quantitative view of medicine is as misleading as are the past conceptions González-Crussi presents.

Jonathan Edlow is concerned with the doctor not as poet or philosopher or priest but as detective. An emergency room physician at the Beth Israel Deaconess Medical Center, a Harvard teaching hospital in Boston where I also work, Edlow recounts how as a teenager with no interest in a medical career, he received a copy of Berton Roueché's The Medical Detectives. This anthology

of articles from The New Yorker proved for him to be a companion to the Complete Stories of Sherlock Holmes. Arthur Conan Doyle, of course, was trained as a physician, and the skills of Holmes are precisely those a thinking physician needs. Both detective and doctor not only assemble evidence but must judiciously weigh what they have found, seeking the underlying value of each clue. The successful doctor-detective must be alert to biases that can lead him astray. This was the message of the clinical conference those months ago; and in Edlow's tales of difficult diagnoses, we can observe detours that are due to "anchoring," "availability," and "attribution."

Notably, the collection of cases in Edlow's book The Deadly Dinner Party takes us out of the clinic and into the field, as epidemiologists and infectious disease experts from the Centers for Disease Control and academic medical centers comb for clues in cooking pots that served a communal dinner and in the caverns of office buildings where workers fell ill. In his chapter "An Airtight Case," Edlow implicitly shows why so many of the standard formulas that policymakers promulgate fall short when answers are not obvious. He describes how an office worker (whom he calls Philip Bradford) thought he had developed "the flu—the usual cough, fevers, chest pain, just feeling lousy...." What appeared to be the symptoms of a typical viral illness did not spontaneously disappear. A chest X-ray showed pneumonia, but treatment with antibiotics proved ineffective. The presumptive diagnosis changed from infection to cancer, and Bradford was told by his doctor that he needed his chest opened to resect a piece of lung and identify the tumor.

Fortunately, the patient sought a second opinion, from a senior thoracic surgeon, and the diagnosis was again thrown into doubt—the specialist believed that the problem was neither infection nor an abnormal growth. Over the ensuing months, the mysterious pneumonia spontaneously cleared up, but after a year Bradford again started coughing and running a fever. "His chest X-ray blossomed with ominous nodules," Edlow writes, "then, as with the previous episode, after a few weeks his symptoms mysteriously vanished."

It was the good fortune of this ill office worker with the mysterious lung problem to see Dr. Robert H. Rubin, an infectious disease specialist at the Massachusetts General Hospital, at the time the director of the hospital's clinical investigation program. As Rubin recounts his deciphering of the ultimate diagnosis, what is striking is his "low-tech" thinking: "I was immediately impressed by three aspects of the case," Rubin recalled.

First was that Bradford appeared healthy and athletic, not the

picture of someone with a chronic disease. Second, between episodes, he continued to jog over five miles with no apparent problem. And third, his physical examination was normal.

With such comments, we are a universe away from sophisticated blood tests and CT scans, and deeply rooted in the world of the physician's five senses. The most seasoned clinicians teach that the patient tells you his diagnosis if only you know how to listen. The clinical history, beyond all other aspects of information gathering, holds the most clues. And it is this part of medicine—the patient's narrative, the onset and tempo of the illness, the factors that exacerbated the symptoms and those that ameliorated them, the foods the patient ate, the clothing he wore, the people he worked with, the trips he took, the myriad of other events that occurred before, during, and after the malady—that are as vital as any DNA analysis or MRI investigation.

Rubin concentrated that kind of questioning and listening on Bradford. He did not quickly dispatch him for more tests, but instead sharply shifted his focus to investigate clues in Bradford's environment that could reveal what was causing inflammation in his lungs. Edlow goes on to write in clear and fluid prose about how Rubin systematically pursued what could be the agent provocateur in the case. The lengths to which Rubin went are extraordinary, his skill in eliciting and interpreting the patient's narrative exemplary, and certainly not part of the rushed practice of today's clinic. I won't spoil the end of the story; what is important is that the solution came about only by dogged thinking that required the kind of time and inquiry that is absent in much of modern medical care.

The other detective stories in Edlow's compilation transmit the same message: we most need a discerning doctor when a diagnosis is not obvious, when the clues are confusing, when initial tests are inconclusive. No simple technology can serve as a surrogate for the probing human mind. Edlow's book is a welcome complement to González-Crussi's. Both show us that medicine is truly an art and a science that requires doctors both to decipher the mystery and illuminate the meaning of the body in health and disease. ❑

[1]*There has been a national focus on medical mistakes since the release of a report from the Institute of Medicine of the National Academy of Sciences, "To Err Is Human: Building a Safer Health System" (National Academies Press, 1999). Important measures have been implemented to improve patient safety in hospitals and clinics. But this report did not address the issue of misdiagnosis. See also Jerome Groopman, How Doctors Think. Houghton Mifflin, 2007); Pat Croskerry, "The Cognitive Imperative: Thinking About How We Think," Academic Emergency Medicine, Vol. 7, No. 11 (2000); Donald A. Redelmeier et al., "Problems for Clinical Judgement: Introducing Cognitive Psychology as One More Basic Science," Canadian Medical Association Journal, Vol. 164, No. 3 (2001).*

[2]*Amos Tversky and Daniel Kahneman, "Judgment Under Uncertainty: Heuristics and*

Biases: Bias in Judgments Reveals Some Heuristics of Thinking Under Uncertainty," Science, Vol. 185, No. 4157 (1974).

[3]*In addition, there is serious concern about the influence of the pharmaceutical and device industry in the formulation of clinical guidelines. There is no one process to craft such guidelines, nor is there agreement about limits on conflict of interest and types of funding to support the expert committees reviewing clinical trials and selecting what constitutes "best evidence." The Institute of Medicine recently released a report on this issue that recommends strict measures to avoid financial conflicts in crafting clinical guidelines: "Conflicts of Interest in Medical Research, Education, and Practice" (National Academies Press, 2009). See also David Aron and Leonard Pogach, "Transparency Standards for Diabetes Performance Measures," JAMA, Vol. 301, No. 2 (2009); and Barry Meier, "Diabetes Case Shows Pitfalls of Treatment Rules," The New York Times, August 17, 2009.*

[4]*Dr. Stanley Joel Reiser, in his recent book Technological Medicine: The Changing World of Doctors and Patients. Cambridge University Press, 2009), documents how the introduction of each new technology in the clinic, beginning with the stethoscope and extending to our era with MRI scans and electronic medical records, is initially enthusiastically greeted by both physicians and the public, but can impair the doctor in his relationship with the patient by forming a barrier to direct communication.*

[5]*Pamela Hartzband and Jerome Groopman, "Money and the Changing Culture of Medicine," The New England Journal of Medicine, Vol. 360, No. 2 (2009).*

Oklahoma City-County Health Department
Epidemiology Program
Communicable Disease Surveillance

COMMONLY REPORTED DISEASES	*Monthly*			*YTD Totals^*	
	Oct'09	Oct'08	Sept'09	Oct'09	Oct'08
Campylobacter infection	5	13	12	80	132
Cryptosporidiosis	1	3	0	12	35
E. coli 0157:H7	1	0	0	8	7
Ehrlichiosis	0	1	2	7	6
Giardiasis	4	2	0	39	35
Haemophilus influenzae Type B	0	0	0	0	1
Haemophilus influenzae Invasive	0	2	2	13	16
Hepatitis A	0	1	0	4	8
Hepatitis B*	11	24	14	148	244
Hepatitis C *	11	23	20	220	297
Legionellosis	1	0	0	3	2
Lyme disease	0	0	0	5	11
Malaria	0	0	0	0	1
Measles	0	0	0	0	0
Mumps	0	0	1	2	0
Neisseria Meningitis	1	1	1	3	5
Pertussis	0	2	3	18	11
Pneumococcal infection	1	0	0	13	15
Rabies (Animal)	0	0	0	0	0
Rocky Mtn. Spotted Fever (RMSF)	0	4	1	28	30
Rubella	0	0	0	0	1
Salmonellosis	4	17	16	98	145
Shigellosis	10	5	21	139	50
Tuberculosis ATS Class II (+PPD only)	57	95	71	711	945
Tuberculosis ATS Class III (new active cases)	1	1	3	13	22
Tularemia	1	0		0	2
Typhoid fever	0	0	0	2	1
RARELY REPORTED DISEASES/Conditions:					
West Nile Virus Disease	0	0	1	4	6
Pediatric Influenza Death	2	0	0	3	2
Influenza, Hospitalization or Death	163	0	50	214	0^{+}
Influenza, Novel Virus	15	0	1	65	0^{+}
Strep A Invasive	2	0	1	33	42
Listeriosis	0	0	0	2	2
Yersinia (not plague)	0	0	0	0	1

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

^ ***YTD - Year To Date Totals*** **STDs/HIV -** ***Not available from the OSDH, HIV/STD Division***

PROFESSIONAL REGISTRY

Physicians interested in advertising in the Professional Registry should contact the Executive Office at 843-5619

ALLERGY

OKLAHOMA ALLERGY

& ASTHMA CLINIC, INC.

John R. Bozalis, M.D.*

Warren V. Filley, M.D.*

James R. Claflin, M.D.*

Patricia I. Overhulser, M.D.*

Dean A. Atkinson, M.D.*

Richard T. Hatch, M.D.*

**Diplomate, American Board of Allergy and Immunology™*

750 N.E. 13th

Oklahoma City, OK 73104

235-0040

OKLAHOMA INSTITUTE OF

ALLERGY & ASTHMA

EVIDENCE-BASED

ALLERGY & ASTHMA CARE

Amy L. Darter, M.D.

Diplomate American Board of Allergy & Immunology™

609 S. Kelly Ave., Suite J-1

Edmond, OK 73003

(405) 285-8315

BREAST MRI

BREAST MRI OF OKLAHOMA, LLC

AT MERCY WOMEN'S CENTER

Rebecca G. Stough, M.D.

Clinical Director

Alan B. Hollingsworth, M.D.

Medical Director

4300 McAuley Blvd.

Oklahoma City, OK 73120

(405) 749-7077

ENDOCRINOLOGY-METABOLISM-DIABETES

MODHI GUDE, MD, MRCP (UK), FACP, FACE

Diplomate, American Boards of

Internal Medicine and Endocrinology,

Diabetes & Metabolism

South Office: 1552 S. W. 44th

Oklahoma City, OK 73119

Phone: (405) 681-1100

North Office: 6001 N.W. 120th Ct., #6

Oklahoma City, OK 73162

Phone: (405) 728-7329

Practice limited to Endocrinology, Diabetes and Thyroid only

Special procedures:

Bone densitometry for osteoporosis detection and management. Diagnostic thyroid fine needle aspiration biopsy. Diagnostic endocrine and metabolic protocols. Radioimmunoassay of hormones.

ENDOCRINOLOGY-METABOLISM-DIABETES

THE ENDOCRINE GROUP
Comprehensive Endocrinology
Nuclear Thyroidology
Cheryl S. Black, M.D.
James L. Males, M.D.
Ronald R. Painton, M.D.
Diplomates of the American College of Internal Medicine
Endocrinology and Metabolism
Deaconess Professional Building South
5401 N. Portland, Suite 310
Oklahoma City, OK 73112
(405) 951-4160
Fax (405) 951-4162

GYNECOLOGIC ONCOLOGY & PELVIC SURGERY

Jeffrey J. Smith, M.D., F.A.O.G., F.A.C.S.
Senior Gynecologic
Oncologist in OKC
Board Certified in
Gynecologic Oncology
Female Cancer Surgery
General & Gynecologic Surgery
Advanced Laparoscopy & Hysteroscopy
Laproscopic Radical Hysterectomy & Trachelectomy
Laser Surgery
Surgery for Urinary Incontinence
Reparative & Reconstructive Surgery
Outpatient/Same Day Surgery
Office Surgery & Chemotherapy
Genetic Counseling

13128 N. MacArthur Blvd.
Oklahoma City, OK 73142

Phone: (405) 470-6767
Fax: (405) 470-6768
e-mail address: jjjsmd@aol.com
website: www.drjjsmith.com
Serving Oklahoma City & Edmond

MEDICAL ONCOLOGY

JAMES W. HAMPTON, M.D.
FACP
Medical Oncology
Hematology
CANCER CARE ASSOCIATES
Lake Hefner Cancer Center
11100 Hefner Pointe Drive 73120
(405) 749-0415

NEUROSURGERY

Neurosurgery

The University of Oklahoma
Health Science Center
DEPARTMENT OF NEUROSURGERY
Timothy B. Mapstone, M.D.
Mary Kay Gumerlock, M.D.
Eric H. Sincoff, M.D.
Craig H. Rabb, M.D.
Naina L. Gross, M.D
Michael D. Martin, M.D.
Gamma Knife Radiosurgery
Cerebrovascular Surgery
Pediatric Neurosurgery
Spine Surgery
Skull Base Surgery
Neurosurgical Chemotherapy
Carotid Artery Surgery
Tethered Spinal Cord-Repair
Chiari Malformation-Surgery

To schedule an appointment
call (405) 271-4912
Harold Hamm Oklahoma Diabetes Center
Suite 400
1000 N. Lincoln Blvd.
Oklahoma City, OK 73104

ORTHOPEDICS

HOUSHANG SERADGE, M.D.
Diplomate American Board
of Orthopaedic Surgery
Hand and Reconstructive Microsurgery
1044 S.W. 44th, 6th Floor
Oklahoma City, OK 73109
631-4263

PAIN MANAGEMENT

AVANI P. SHETH, M.D.
Diplomate of American Board
of Anesthesiology
Diplomate of American Academy
of Pain Management
4200 W. Memorial Road, Suite 305
Oklahoma City, OK 73120
(405) 841-7899
All plans accepted.

PEDIATRIC SURGERY

***DAVID W. TUGGLE, M.D.**
***P. CAMERON MANTOR, M.D.**
***NIKOLA PUFFINBARGER, M.D.**
***ROBERT W. LETTON, JR., M.D.**
The Children's Hospital at
OU MEDICAL CENTER
1200 Everett Drive, 2NP Suite 2320,
Oklahoma City, OK 73104
271-4356
*American Board of Surgery
*American Board of Pediatric Surgery

PSYCHIATRY

OKLAHOMA INSTITUTE OF PSYCHIATRIC MEDICINE
AMAR N. BHANDARY, M.D.
Board Certified: Psychiatry/Neurology
Fellowship: Consultation-Liaison Psychiatry
Treatment/Medico-Legal Consultation
for Professional Patients
Addiction/Dual Diagnosis
Adult ADHD/ADD • Anxiety Disorders
Brain Trauma Survivors
Chronic Pain Management
Competence Assessment • Geriatric Patients
Medically Ill Patients • Mood Disorders
Neruopsychiatry • Obsessive Compulsive Disorder
Psychopharmacology
Schizophrenia Violent Behaviors
COOPER CENTER #106
7100 North Classen Boulevard
Oklahoma City, OK 73116
Ph. 405-841-3337 • Fax 405-841-3338

RADIOLOGY

JOANN D. HABERMAN, M.D.
Breast Cancer Screening Center of Oklahoma
Mammography – Screen/Film
Breast and Total Body Thermology
Ultrasound
6307 Waterford Blvd.,Suite 100
Oklahoma City, OK 73118
607-6359
Fax 235-8639

THORACIC SURGERY

OU College of Medicine
Marvin D. Peyton, M.D.
Timothy H. Trotter, M.D.
Marco Paliotta, M.D.
Diplomates American Board of Thoracic Surgery
Adult and Pediatric Thoracic and Cardiovascular Surgery -- Cardiac, Aortic, Pulmonary, Esophageal and Congenital defects
920 Stanton L. Young Boulevard
Williams Pavilion Room 2230
Oklahoma City, Oklahoma 73104
405-271-5789

VASCULAR

Vascular Center

405-271-VEIN (8346)
Fax 405-271-7034

Vascular Internists

THOMAS L. WHITSETT, M.D.
Professor of Medicine

SUMAN RATHBUN, M.D.
Associate Professor of Medicine

ANGELIA KIRKPATRICK, M.D.
Assistant Professor of Medicine

Cardiovascular Interventionalists

JORGE SAUCEDO, M.D.
Associate Professor of Medicine

THOMAS A. HENNEBRY, M.D.
Assistant Professor of Medicine

EMILIO EXAIRE, M.D.
Assistant Professor of Medicine

MAZEN ABU-FADEL, M.D.
Assistant Professor of Medicine

Cardiothoracic & Vascular Surgeon

MARVIN PEYTON, M.D.
Professor of Surgery

Please Support your

Oklahoma County Medical Society

COMMUNITY FOUNDATION

with your gifts and memorial contributions

—please mail check to—

313 N.E. 50TH ST., SUITE 2

OKLAHOMA CITY, OK 73105-1830

• • • •

Contributions Tax Deductible

Oklahoma Tobacco Helpline

1-800 QUIT-NOW • 1-800 784-8669

- ***free information on quitting tobacco***
- ***one-to-one proactive telephone counseling***
- ***referrals to local cessation programs and services (dependent on availability)***

OKLAHOMA COUNTY MEDICAL SOCIETY
313 N.E. 50TH ST., SUITE 2
OKLAHOMA CITY, OK 73105-1830

ADDRESS SERVICE REQUESTED

PRESORTED STANDARD
U.S. POSTAGE
PAID
OKLAHOMA CITY, OK
PERMIT NO. 381