# BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY

DECEMBER 2011

# THE BULLETIN
## The Oklahoma County Medical Society

December, 2011 – Vol. 84, No 6

**A Monthly Publication**
**Circulation 1500**

**Oklahoma City, OK 73105-1830**
**313 N.E. 50th Street, Suite 2**
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# Deaconess Hospital's Accredited Chest Pain Center


**Don't Delay!**

**Heart attack symptoms are often subtle.**

**Seek treatment immediately!**

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**Deaconess Hospital now has an accredited chest pain center. The Society of Chest Pain Centers reviews hospital standards in emergency assessment of patients with acute coronary syndromes, facility design, personnel competencies and training, process improvement, organizational structure and community outreach. Our team works together through a standardized set of diagnostic and treatment protocols, which results in less damage to the heart and better overall outcomes.**

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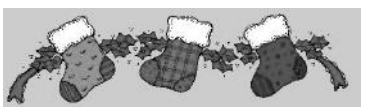
## About the Cover

The painting on the cover of the Bulletin this month was created by Clara Edmon, an Oklahoma City artist, and was originally published in "Blood and Thunder: Musing on the Art of Medicine." The painting reflects the sadness of children who are ill and suffering and want to be well and at home with their family at Christmas. It is titled "Wanting to Go Home." We are grateful to the artist for permitting us to use this painting. Mrs. Edmon, a member of the Citizen Potawatomi Nation, majored in art at Oklahoma City Community College in the 1970s and is a member of the Oklahoma Visual Arts Coalition. She works mostly in oil and her subjects vary from animals, landscapes, still life and Native American subjects. More of her work can be viewed at www.ovac-ok.org. ❑

Seasons Greetings
The Editor



## 2011 Scholarship Recipient

Susan Elizabeth White was selected to receive the Oklahoma County Medical Society Community Foundation's 2011 Medical Student scholarship. The award was announced and she was introduced to OCMS members at the Annual Meeting in early November. A native Oklahoman, Susan grew up in south Oklahoma City and plans to practice pediatrics in an underserved area; we sincerely hope it's in Oklahoma County. She has demonstrated tremendous dedication and determination to achieve her goals. Giving birth to her first child just before finals began during her freshman year, she managed to go to the College just long enough to take a test before returning to the baby. Her second child was born just after her third-year finals were finished. She maintained a 4.0 GPA in both freshman and sophomore years, and was "disappointed" that it dropped to 3.58 in the junior year. Her husband is equally determined Susan will achieve her dream — he became a full-time father with the birth of their second child, allowing Susan to devote the time and concentration she needs to focus on medical school. We look forward to having Susan join the House of Medicine. ❑

## New Members

Steven P. Brantley, MD
(ORS)
3301 NW 50th St.
University of Oklahoma
2005

Muneer A. Khan, MD
(IM)
5401 N. Portland, #310
Allama Iqbal Medical College,
Univ of Punjab, Pakistan 1999

Laura D. Stearman, MD
(U)
11000 Hefner Pointe Dr.
University of Oklahoma
2002

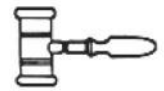
## Medical School Applications Increase

First-time applicants to medical school increased by 2.6 percent over last year, to 32,654, with total applicants increasing by 2.8 percent to 43,919. The increases also reflect more diversity among applicants. The number of Black/African American applicants increased by 4.8 percent while enrollees increased 1.9 percent. Hispanic/Latino applicants increased by 5.8 percent and enrollees increased 6.1 percent. The average GPA among applicants was 3.5 and the average MCAT score was 29. The majority of applicants reported slightly increased rates of premedical experiences in community service and medical research, with 82.5 percent reporting community service in medical and clinical settings, 68.4 percent in nonclinical community service, and 73 percent reporting experience in research. The Association of American Medical Colleges (AAMC) reported the enrollment data on October 24, 2011. ❑

## Couple Dies Holding Hands

An Iowa couple, married for 72 years, recently died holding hands in adjacent beds in a hospital ICU following a car accident. Gordon Yeager, 94, died at 3:38 pm., but his heart monitor continued to register a beat because, a nurse said, Norma's heart beat was going through them. Still holding Gordon's hand, Norma, age 90, died exactly one hour later, at 4:38 pm. Their son told the Des Moines' KCCI news station, "They just loved being together. He always said, 'I can't go until she does because I gotta stay here for her.' And she would say the same thing." ❑

# President's Page



Robert N. Cooke, MD

## Coming to the End of a Journey

Wow, has it been a year already? I must say that when I was privileged to become your 111th President, I wasn't sure what to expect. Here I am, many phone calls, emails, texts and meetings later and I must say, I've enjoyed the ride. Learning about and trying to understand the legislative processes on both the state and federal level was an experience I'll not forget. Speaking with the representatives and senators both at the State Capitol and in Washington, D.C. made me realize that many of our legislative agendas are complex and there are advocates on both sides of the issues who are quite involved. That's why it's important for our OCMS and the OSMA to be so involved and to carry the banner for physicians and their patients. No one will advocate for us unless we do. It's important for the well being of the public and for our healthcare system.

We tend to forget what our society has done for the public in Oklahoma County. It's perhaps the most important role of the OCMS. From the creation of the Oklahoma Blood Institute, Hospice of Oklahoma County, EMSA (formerly AMCARE), and Open Arms Clinic, to the Health Alliance for the Uninsured, much has been done for the wellness of the public. No society could be any more involved in trying to improve the health of its citizens regardless of one's ability to pay. It doesn't happen without the excellent and caring physicians of the OCMS. I both congratulate and thank you for your tireless and devoted participation. No profession gives of itself more than physicians. This is what life's all about: *giving back some of what has been afforded to us*.

Finally, I'd like to recognize all those physicians who served on committees and on the board this year. It was truly my privilege to work with you. Our staff at the OCMS could not be any better. They run our everyday affairs and make our Society function in a seamless manner. Jana Timberlake, Linda Larason, and Ashley Merritt are indeed the backbone of the OCMS. We all owe them our deep gratitude and thanks.

So, that's about it. No more articles to write. I'd like to leave you with one thought. As you look at the societies you want to be a part of and consider what they do for you, the OCMS should be at the top of the list. It's a great organization that advocates for you and gives generously to those in our county who are in need. I hope everyone has a Merry Christmas and Happy Holidays. ❑

# Young Physicians

Ana Kumar, MD

## Balancing Work and Family

As women, we have decided to achieve an education and career independent of the traditional roles of women. We pursue a life in medicine. We spend additional time after medical school in residency ranging from three to seven years, putting us close to thirty-something when we complete our education. The irony is that once we have completed our formal education the juggling act begins. For many of us there is an innate desire to have children and enjoy our lives raising a family.

According to health statistics from the Kaiser foundation in 2010, there were 8,100 female graduates to 8,700 male medical school graduates. The numbers are real: women comprise roughly 50 percent of today's physicians. In addition to being physicians, we are also expected to be mothers and wives. The question is, how do we handle the daily commitment to our families and the requirements of our medical career?

***Time management planner***

The first step is to adhere to a schedule. There is comfort in predictability. For each family member, devise a calendar which marks each person's activities, meetings and special events. This will allow you to recognize any conflicts in events and prepare an alternate plan. Being active in your children's school and activities will empower you. It will decrease anxiety about what you feel you are missing.

***Household assistance***

Know your limitations, know when to ask for help. You will most likely need a household extender, or as we affectionately say: a "nanny." These people are indispensible. They are the backbone to your household operations, providing assistance in taking or picking up the children from school and activities. They should be advised they will need to be flexible as your pager can go off at

any minute. Ask them to keep a journal of what you have missed in your absence. Divide and conquer!

***Quality time with the family***

During the busy week, we look forward to the weekends to spend quality family time. During the week you can steal some time in the evenings or at dinner to discuss one another's day. Weekends (off call) should be special, participation for the whole family. These precious moments are yours to enjoy your children and spouse.

***Relax and reclaim yourself***

Find time for you – yourself – to relieve stress through exercise, yoga or meditation. Schedule time off every week to pamper yourself. Thinking of everyone else is exhausting. Don't forget about staying healthy to continue to take care of your family and patients.

We have chosen a wonderful profession. Medicine is rewarding and gratifying. We are also capable of being wonderful mothers, and wives. It is all a matter of planning. Best of luck! ❑

## Adding to the Arsenal

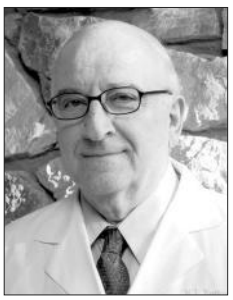
### *Combatting Childhood Obesity*

Joining the First Lady's "Let's Get Moving" Campaign, local governments' efforts to improve parks and walking trails, school districts' restructuring of lunches, public gardens, and other efforts to overcome the epidemic of childhood obesity is new approach: giving high school students information and helping them sort through it to make responsible decisions.

Using a curriculum that blends media literacy, politics, nutrition, and cooking, 15 Manhattan high schools have added Science of Food classes, the New York Times reported in late October. The curriculum, developed by two former high school teachers for the nonprofit group FoodFight, teaches students to "evaluate food labels, to prepare nutritious and affordable meals, and to identify the political and economic forces that shape their diet." Students are learning that "they are part of a lucrative demographic, and they are learning how companies target them" – and they don't like being targeted; they want to make independent decisions.

Although the curriculum has been taught for only a year, teachers are seeing results: some students have given up sugary drinks and are drinking water, some are tuned closely to portion control and eating regular meals rather than binging, some have continued keeping food journals although they've finished the class … and some are losing weight as a result. ❑

# Pearl of the Month



**H. T. Kurkjian, MD**

## On Ordering Tests and Managing Results

If you've ordered a test today, you might have started a cascade of events that could last a long time and result in significant professional and liability issues.

***Who orders the tests*?** Physicians and their assistants, PAs, nurses and nurse practitioners, residents, fellows and students. Health care reform proponents may be working frantically to empower and justify others. A test could be ordered under your name as an old standing order that you may not be even know still exists.

***Who follows up and acts on the tests results*?** Some physicians may delegate this to their assistants but, ultimately, the physician may be held responsible for the outcome.

The most common way of following test results is by paper records or electronic medical records (I guess some of us can still rely on memory). I now use a combination of both after having used EMR alone for a while. This is how I do it:

1. We enter the information for the request in the EMR.
2. Two paper copies are printed. We give one to the patient to take to the lab, most of the time with accompanying instructions.
3. The other is filed in a file cabinet with one slot for weekly results and 12 others for the months of the year.

If a test is ordered with results expected in less than a week, the request is filed in the weekly slot. When the results are

back and managed, the request is removed and filed away. At the beginning of the following week, one can check and see the remaining requests to find out what requests are still pending. On a PSA that is ordered for six months in, say, April of next year, the request is filed under May of next year. By early June one will check the remaining requests in the May slot and know if the ordered tests were done.

In our EMR, as the request is generated it asks for the test date and date of recall. This is how it can run a report of unresolved tests later. For clinicians who do not use an EMR, there are standalone software products that can do this without having to invest or convert to an EMR.

Double entries are placed in the appointment scheduling software, one for the return appointment and another to check on the test a week after it is scheduled.

All faxes and mail received from the labs are placed in my incoming box on my desk. I check each and initial it, then place it in the filing bin after the patient is contacted and the outcome is charted. If a report is found on a desk and is not check marked or initialed, then the employee has to return it to my incoming box.

7. For results due within 24 hours, we leave a message to ourselves in the message notebook for the next day (use of sticky notes is discouraged in the clinic.)

On my desk also is a large calendar where I make notes and reminders for biopsies and other crucial lab.

The patient care portals of hospital computers are checked daily for a list of patients and the tests they have had done.

At the end of the clinic, we sit down with the nurse and the receptionist. Results and messages are checked, the patient is called and the action is entered in the chart. The test is marked "resolved" in the tracking software so it will not reappear in the reports run for incomplete tests. We also remove the duplicate lab request copy from the file cabinet and scan it in the patient's chart.

***Some observations***:

An organizer or calendar can be a good option.

Double entries in the appointment scheduling notebook can be of great help.

Simply keeping a log may not be helpful if a test is scheduled for a few months later.

Ordering a test does not mean it gets done. A surprising number of patients do not comply.

Some tests get canceled by the lab.

Some physicians tell their patients not to worry if they don't hear from the physician. The patient thinks, "I have not heard from my doctor. He is a good doctor, he surely would have called me if there was something wrong." On the contrary, we insist that all patients call us for their results. Patients sign a form in my office that they are responsible to call us for results. In spite of repeated instructions, a large percentage of patients never call back.

Some hospitals empower their patients to check on their own results on the hospital website. In my opinion, this may lead to miscommunications.

EMR alone could be very efficient. However, it may be prone to problems. One click on the "reviewed" button or, even worse, on "all reviewed" could be catastrophic.

Modern times require a more sophisticated employee. Employees that we hire need to be trained more extensively and taught the importance of precision, ethics and reliability. It is the human factor that restrains the ultimate capabilities of the computer. Too much automation by software programmers can lead to unforeseen and dire consequences.

As you can see I have six redundancies in place. At times the system still proves itself imperfect, usually a reflection of human imperfection. With patients and society demanding perfect outcomes in health care, we can't be too obsessive in our efforts.

I am sure most of us have good systems in place. For our young physicians and providers starting out, these may be some helpful suggestions. ❑

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## 2012 Dates to Remember

It will soon be time to begin scheduling important dates on your 2012 calendar. Please be sure to enter the following dates now and plan to join us:

January 14, 2012 – Inaugural Dinner
February 6, 2012 – Membership Meeting
November 5, 2012 – Membership Annual Meeting

We're also planning to have another family event and will announce the date when it is set. ❑

# In Memoriam

**Warren M. Crosby, MD**
**1931 - 2011**

It was with great sadness that we learned of the unexpected death of Dr. Warren M. Crosby. A valued mentor and friend, he had an impact on thousands of students, residents, fellows, nurses, patients and colleagues.

Born and raised in Topeka, KS, he finished high school at Cranbrook, in Detroit, MI. His first three years of undergraduate work were at Stanford University; he finished his final year at Washburn University in Topeka. Following graduation from medical School at Kansas University and an internship at St. Luke's Hospital, he completed his OB/GYN residency in San Francisco, CA.

Dr. Crosby came to Oklahoma City in 1962 as Vice Chairman of the Department of Obstetrics and Gynecology at OUHSC, joining James A Merrill, MD. Together they built a nationally recognized and respected program which has expanded and continues today.

He was known for his research, especially as related to seat belts and pregnant women. Due to his sophisticated baboon research, pregnant women around the world now wear seat belts with a significant decrease in morbidity and mortality from automobile accidents.

In the mid-1970s, he began a fellowship program in maternal-fetal medicine in the Department of Obstetrics. Dr. Crosby was a board examiner not only for general OB/GYN but an initial examiner for the MFM subspecialty boards.

Starting the perinatal continuing education program (PCEP) in Oklahoma, he was responsible for the education of thousands of nurses and health care professionals resulting in decreased perinatal morbidity and mortality in Oklahoma. This program continues today. There is no labor and delivery nurse in Oklahoma

that does not know and respect Dr. Crosby, as they should.

In January 2011, Dr. Crosby was honored with the Dean's award for distinguished medical service. This was only one of many honors he received during his career.

His personal life was just as incredible. Married to his lovely wife Joanne for 57 years, they had one daughter, Sarah, who shared her birthday with her father. He adored his daughter and I remember only rarely having a conversation with him that we did not discuss Sarah and her current activities. Joanne and Sarah were part of our "residency" family. I remember playing poker and having Journal Club at their home, always a pleasant distraction from our residency duties.

Dr. Crosby loved sports, especially Oklahoma football. A member of the swim team at Stanford during his college days, he continued this activity throughout his years. Fly fishing and golfing were other sports he enjoyed immensely. Another of his great passions was snow skiing. I can report first hand that he skied circles around all of us who had the opportunity to ski with him.

Knowledgeable about almost all topics and always with a joke or story, he was always a delight to be with. For all of us whose life he touched in so many ways, he will forever be appreciated, respected, and missed. Thanks, "Cros." May you Rest in Peace. ❑

David A. Kallenberger, MD

# 2011 Contributors

Each year, as I prepare the December issue of the Bulletin, I am amazed by the number of people who have submitted articles and allowed us to use their beautiful artwork and photographs on the cover. The only compensation they receive is my "thank you" and a copy of the Bulletin that includes their work. I occasionally get to thank them in person, usually in chance encounters (such as the nail salon). If you happen to see any of these contributors in the coming year, please be sure to let them know how much we appreciate their work, whether articles, letters to the editor, poems, or cover art.

Linda Larason, Managing Editor



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Theodore Violett, MD
S. Sandy Sanbar, MD, PhD, JD, FCLM

We appreciate receiving submissions for consideration, and we welcome suggestions to improve the Bulletin. ❑

# Management of Atrial Fibrillation

## *Questions and Answers*

Mel Clark, MD and Emily Geurin, BS

**Q**: I want to leave my patient in atrial fibrillation but slow the ventricular rate (rate control); what drugs are reasonable to use in this regard?
**A**: Depending on the individual patient, Digitalis, verapamil, diltiazem.

**Q**: How do I tell when I have slowed my patient's rate adequately?
**A**: This is somewhat controversial, but some experts believe that rate control does not need to be horribly strict. Keeping the heart rate below 80 at rest and at or below 110 beats per minute after a 6 minute walk test appears reasonable.

**Q**: I want to keep my patient in sinus rhythm (rhythm control); what drugs should I use?
**A**: For patients with no heart disease and no hypertension, the guidelines suggest either sotalol, flecainide, propafenone, or dronedarone.

For patients with hypertension and left ventricular hypertrophy: amiodarone.

For patients with coronary artery disease: sotalol, dofetilide, dronedarone.

For patients with congestive heart failure: amiodarone or dofetilide.

**Q**: How do I decide which anticoagulation medicines to use to reduce my patient's risk of embolic stroke?
**A**: Use the CHADS-2 score. Patients receive 1 point for a history of congestive heart failure, hypertension, age 75 or above, or diabetes; patients with a prior history of stroke or TIA receive 2 points. In general, patients with a 0 CHADS score need no anticoagulation or at most aspirin, patients with a CHADS score of 1 can receive either aspirin or warfarin, patients with a CHADS score of 2 or above should receive warfarin.

**Q**: Isn't aspirin as good as Coumadin for reducing the risk of stroke?
**A**: No, aspirin is not nearly as good and only slightly reduces the risk of stroke in patients with atrial fibrillation.

**Q**: My patient with a CHADS score of 2 is worried about bleeding on Coumadin. Should I switch the patient to aspirin and clopidogrel?
**A**: No, this will result in more embolic strokes and has not been shown to reduce the risk of bleeding.

**Q**: My patient cannot take Coumadin but can take aspirin. Should I advise adding clopidogrel to this?
**A**: This is probably reasonable as it will reduce somewhat the risk of stroke, but the trade off is that there is some increased risk of bleeding.

**Q**: My patient has a CHADS score of 3 but has fallen twice. Should I not use Coumadin because of the patient's falls?
**A**: Not necessarily. Many experts feel that elderly patients with falls are under-treated in terms of warfarin. Any fall can be serious, but one would have to fall many times (perhaps hundreds) to negate the strong beneficial effect of stroke reduction with warfarin in appropriate patients.

**Q**: When do I refer a patient for ablation?
**A**: In general, patients who have symptomatic atrial fibrillation, usually somewhat younger patients, have failed one or more medications for atrial fibrillation and do not have dilated atria or severe lung disease and do have reasonably good left ventricular systolic function.

**Summary**: The above summarizes some important points in the management of atrial fibrillation. The reader is referred to recently published guidelines by the American College of Cardiology and American Heart Association on management of atrial fibrillation for a more detailed summary. ❑

***NOTE**: The $CHADS_2$ score is used to establish the risk of stroke in patients with atrial fibrillation. The stroke risk is computed by assigning one point each for recent heart failure, history of hypertension, age over 75 years, and diabetes and two points for previous stroke or TIA. The $CHADS_2$ score identifies a patient's risk of stroke so that the appropriate antithrombotic therapy can be prescribed. It is recommended that a patient with atrial fibrillation who has zero risk factors for stroke take aspirin. A patient with one risk factor should take aspirin or an anticoagulant such as warfarin. These moderate risk patients should aim for an INR of 2 to 3, the range where the maximum protection against stroke is achieved. Patients with atrial fibrillation that have two or more risk factors for stroke should take warfarin. The INR target range for these patients is also 2 to 3 and patients with a prosthetic heart valve should aim for an INR of greater than 2.5. It is important to find a balance between prevention of stroke and prevention of hemorrhage complications when determining the appropriate therapy for atrial fibrillation patients.*

Fuster V, Ryden L, Cannom D, et al. 2011 ACCF/AHA/HRS Focused Updates Incorporated Into the ACC/AHA/ESC 2006 Guidelines for the Management of Patients with Atrial Fibrillation. J Am Coll Cardiol 2011; 57: 101-198.
Menke J, Luthje L, Kastrup A, et al. Thromboembolism in Atrial Fibrillation. Am J Cardiol 2010; 105: 502-510

# Diagnostic Malpractice Claims

The rapid growth of diagnostic testing appears to be placing physicians at greater risk for medical malpractice claims for test communication failures, according to an article in the November 2011 issue of the Journal of the American College of Radiology. The article was written by Brian D. Gale, MD, MBS, assistant professor of radiology at SUNY Downstate Medical Center in Brooklyn, and colleagues.

Between 1996 and 2003, malpractice payments related to diagnosis increased by approximately 40 percent. Contributing factors in cases associated with communication failures include, for example, failure of physicians and patients to receive results; delays in report findings; and lengthy turnaround time. Using data from the National Practitioner Data Bank (NPDB), the authors found that the total indemnity payout across all medical specialties for U.S. claims related to the three types of communication failures they studied increased from $21.7 million in 1991 to $91 million in 2010. Linear regression analysis of data from 1991 to 2009 indicated that communications related claims payments increased at the national level by an average of $4.67 million annually. Over the same period, NPDB data showed that communication failure awards accounted for an increasing proportion of total U.S. malpractice awards for all providers. The proportion increased by a factor of 1.7, from 0.93 percent in 1991 to 2.31 percent in 2009. The authors suggest that semi-automated critical test result management systems may improve notification reliability, improve work flow and patient safety, and, when necessary, provide legal documentation.

Dr. Gale says when reportable test results arise, healthcare organizations need clear policies that define the responsibility of reporting and referring providers to ensure patient follow-up. ❑

## Disaster Strikes Twice

As the EF5 tornado hit Joplin last spring, Mark Linquist rushed into the storm to put mattresses over the three men he cared for who could not be moved. The 200 mph winds tore him from the building, threw him a city block, and left him in an "unrecognizable, comatose state," the Times' NewsFeed.com reported. Doctors can't explain how he survived: all his ribs were shattered, his shoulder was chipped off, most of his teeth were knocked out, and he remained in a coma for two months. Without medical insurance, he filed a worker's compensation claim for the $2.5 million in medical bills that had accumulated to date. Accident Fund Insurance Company of America denied the claim, telling him he faced "no greater risk than the general public…" Elected officials – even his employer – petitioned the insurer on his behalf. After the story broke in the news, the insurance company reconsidered, saying "Upon further review of the case, and receiving additional information on the facts involved in this situation, Accident Fund believes the appropriate decision is to honor Mr. Mark Linquist's claim for worker's compensation benefits." His claims will no doubt continue to mount, with the additional surgeries he faces and his 11 daily prescriptions. Unfortunately, the three patients he tried to protect were among the 162 tornado casualties. ❑

## When a Daughter Dies

Hanna Saadah

When a flower dies
And spring (with one flower less)
Wears a bald spot on her sunny dress
Summer wonders why with gaping eyes?

When a harvest dies
And summer's birds, still hungry, fly away
With open beaks nor dance nor sing nor play
Fall sheds its yellowed tears and sighs?

When the final wink of snow melts down
Revealing underneath the winter's brown
Sun-hungry seeds awaken from their sorrow
To sprout the smiles that color spring's tomorrow.

When spring returns to color earth and bless
And it no longer has one flower less
Nor wears a bald spot on her sunny dress
It sings that life each spring does conquer death.

Whosoever returns to mother Earth
Comes back a smiling flower at rebirth. ❑

# *Why Frontier?*

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**Director's**

# DIALOGUE

## The Passage of Time

*How did it get so late so soon?*
*It's night before it's afternoon.*
*December is here before it's June.*
*My goodness how the time has flewn.*
*How did it get so late so soon?*
*Dr. Seuss*

It seems as if December was yesterday. Many of us do wonder how it got so late so soon ... we begin the year with resolutions and good intentions. By mid-year, we figure there is sufficient time to catch up on the pledges for self-improvement that have been put aside. Distractions are easily justified. Fall arrives, and football and Thanksgiving enjoy our focus. Then it's Christmas – that magical season of family and friends – when attention to silly resolutions made in January cannot possibly take precedent over preparing for the holidays.

2011 passed quickly at the Oklahoma County Medical Society with new events, more collaboration with the OCMS Alliance, and a focus on recruiting younger physicians to organized medicine. The Leadership Academy's inaugural year was extremely successful, culminating in graduation at the Oklahoma State Medical Association annual meeting. The Academy was formed to train and orient OCMS members for future leadership positions at county, state and potentially national levels.

In the spring, the Society hosted a family event at the Harn Homestead, complete with activities for the children and excellent music for the adults. And the food – from Big Truck Taco – was the best! We also participated in the Alliance's event, Walk the Doc, at Lake Hefner. Physicians, spouses and children gathered to demonstrate the importance of exercise in the recipe for living a healthy lifestyle. There was even a visit from Rumble, the OKC Thunder's popular mascot.

A series of receptions began in the fall for young physicians to socialize and become more integrated into their medical community in Oklahoma County. With many physicians no longer having privileges at multiple hospitals, there is a tendency to know only "who you work with." Perhaps more of these types of functions in the future will return the local medical community to the cohesiveness it enjoyed many years ago with physicians, no matter the hospital, taking the opportunity to become engaged with one another.

Thank you to Dr. Bob Cooke for his leadership this year. He had the vision to establish a medical student scholarship in an effort to reduce the burdensome debt that is accumulated over a student's four years at the OU College of Medicine. The OCMS Community Foundation Board of Directors approved donations to be earmarked for this scholarship. Through the leadership of the OCMS Board of Directors, a plan has been developed to sustain the scholarship for future medical students.

To the staff ... It is an absolute joy to work with you. Linda and Ashley each brings special talents to this organization. No matter if the phone call is from a lonely, elderly person who needs to hear a kind, reassuring voice or a problem that needs to be solved, they always attend to the details with a sense of urgency. Thank you!

And finally ... there is one last bit of news to share with you. After 20 years, John Douglas and I were married on Halloween! I want to thank him for the many years of "behind the scenes" support and look forward to our lives together. His sense of humor keeps me from taking myself too seriously, and a life filled with laughter is priceless. I was asked by a friend, "Why after 20 years?" My answer, "Because the time was right." Happy Holidays! ❑

Jana Timberlake, Executive Director

## 2012 OCMS Officers

The 2012 OCMS officers were elected at the annual meeting on November 7. Dr. Thomas H. Flesher, III, will serve as President-elect, Dr. Julie Strebel Hager will be the Vice President, and Dr. C. Douglas Folger will become the Secretary-Treasurer. They will join Dr. Tomás Owens, who will be installed as President in January. Members elected to serve on the 2012 board of directors, announced in the November Bulletin, include Drs. Don L. Wilber, Paul J. Kanaly, David C. Teague, and Gary D. Riggs. ❑

# alliance

On Saturday, October 15, members of both the Oklahoma County Medical Society and the OCMS Alliance put on their walking shoes and t-shirts and donned bright red visors, ready to participate in the Susan G. Komen "Race for the Cure," the annual fundraising event for Breast Cancer.

Having consumed the early morning cup of coffee and breakfast, there was something very special about being in the Ball Park in Bricktown at 7:30 am. Although it was probably the most beautifully perfect weather day we could have asked for in Oklahoma City, it was the camaraderie that made it so special. Both of our organizations' memberships worked jointly to make a generous contribution to support another organization that strives to help others fight their battles with this devastating disease, and the fact that our presence was known among the community.

If you have not been a part of this amazing walk, you certainly need to consider joining the efforts of Komen next October. You will find men, women and children of all ages participating. Some are too young to understand how important this event is and, unfortunately, others know it all too well. Survivors are given bright pink t-shirts and as they come across the finish line, their names are announced. Many of these survivors were many years out and others obviously in the middle of their treatment or had just completed it. Being among the 20,000 participants is an incredible experience.

We are pleased to announce that "Team Alliance" raised $4,645.00 and had the honor of being the 4th highest ranking team!!

William Arthur Ward stated that, "Feeling gratitude and not expressing it is like wrapping a present and not giving it." Therefore, we want to express our appreciation to our Team Leaders, Suzanne Reynolds and Amy Bankhead, for their great leadership; to Dr. Bob Cooke, OCMS President, and to his Board for support and donation of our visors; Jessica Hawkins, for her creative design on the visors, and to each individual who supported the Team by either walking or donating. And…to those of you who supported the walk through the "Sleep in For the Cure" option and sent your check….we felt your presence! Thank you. ❑

Kathy Bookman and Donna Parker, Co-Presidents

# Switch Drip to Pill

Switching hospitalized patients able to take medication by mouth from intravenous to pill forms of the same drugs could safely save millions of dollars a year. With CMS reporting that roughly 12 percent of U.S. health care expenditures – $293.2 billion – are for medications and nondurable medical products, the savings potential is enormous.

In a review of computerized records for the year 2010, conducted at The Johns Hopkins Hospital in Baltimore, researchers estimated savings of more than $1.1 million in the Department of Medicine alone — not including surgical patients — by swapping out four commonly prescribed IV medications with their oral equivalents. A report on the study is published in the journal Clinical Therapeutics.

The four medications reviewed were chlorothiazide (a medication used to treat high blood pressure and address fluid retention), voriconazole (an anti-fungal), levetiracetam (to stop seizures) and pantoprazole (for acid reflux). By combing Hopkins' computerized provider order entry (COPE) system, they examined whether patients receiving these drugs intravenously were also prescribed other medications orally or if they were being fed solid meals, another indication that they would likely be able to swallow pills. In 2010, a total of 10,905 doses of the four medications were given by IV to patients admitted through the Department of Medicine. Brandon D. Lau, a medical informatics specialist at the John Hopkins University of School of Medicine and the study's leader, says the drugs are given even more frequently in surgery patients.

The team compared those results with the cost of the various medications. For example, the wholesale cost of a 5-milligram tablet of chlorothiazide is $1.48. An equivalent dose of the drug given intravenously is $357.24, more than 200 times as much as the oral version. Pantoprazole, the most commonly administered medication in the study, is $4.09 per 40-milligram tablet, while a 40-milligram vial is $144. That medication is often given to patients several times a day. The potential cost savings per patient for the acid reflux medication would be $680.98, the researchers found.

The study recommends hospitals with computerized medication systems add alerts that would appear when a patient on an IV medication meets eligibility criteria for oral medication. Teaching doctors that oral medication is a cheaper alternative to IV may also encourage them to make the switch without subjecting them to regular, potentially irritating reminders. ❑

# Forcible Involuntary Medication: The Four Sell Factors

**S. Sandy Sanbar, MD, PhD, JD, FCLM**
**Of Counsel, Health Law Section,**
**Christensen Law Group, PLLC, Oklahoma City, OK**

Physicians should be aware of the law governing forcible and involuntary medication of patients. In 2006, Vicente Ruiz-Gaxiola was charged with illegal reentry into the United States after having been deported. Shortly after arrest, Vicente was diagnosed with Delusional Disorder, grandiose type, and found incompetent to stand trial. He was not a danger to himself or others in the institutional context and he did not suffer from a grave disability justifying involuntary medication.

The government sought a court order authorizing it to medicate Vicente involuntarily for the sole purpose of rendering him competent for trial.[1] To involuntarily medicate, the government had to prove by clear and convincing evidence four specific criteria, known as the Sell factors, as enunciated by the U.S. Supreme Court[2]:

1. "that important governmental interests are at stake" in prosecuting the defendant for the charged offense;

2. "that involuntary medication will significantly further those concomitant state interests," i.e., it is substantially likely to restore the defendant to competency and substantially unlikely to cause side effects that would impair significantly his ability to assist in his defense at trial;

3. "that involuntary medication is necessary to further those interests," i.e., there are no less intrusive treatments that are likely to achieve substantially the same results; and

4. "that administration of the drugs is medically appropriate, i.e., in the patient's best medical interest in light of his medical condition."

The District Court adopted the magistrate judge's findings that the Sell factors were met and authorized the government to forcibly medicate Vicente. On appeal, the Ninth Circuit held that the District Court clearly erred when it found that the government had proved by clear and convincing evidence that the 2nd and 3rd

Sell factors for forcible medication were met. It granted Vicente's emergency motion to stay the order by the District Court.

As to the 2nd Sell factor, the Appellate Court noted that simply because the medication was designed to improve Vicente's mental state did not mean that it would be substantially likely to do so and substantially unlikely to have harmful side effects. The Appellate Court stressed that the government could not satisfy its burden of showing, by clear and convincing evidence, what the medication substantially likely would do, by showing what the involuntary medication regimen was designed to do. The Appellate Court found the government's expert testimony plainly insufficient to establish that the proposed regime of involuntary medication was substantially likely to restore Vicente to competency.

As to the 3rd Sell factor, the Appellate Court concluded that if a proposed treatment would not further the government's interest in prosecution, as required under the 2nd Sell factor, it could not possibly provide a necessary means of doing so under the 3rd Sell factor. The expert reports and testimony were in substantial agreement with regard to the extent of Vicente's mental condition and, although the defense expert believed it would be less intrusive and more beneficial to Vicente to receive therapy with a private psychiatrist unaffiliated with the prison system, it subsequently conceded that such an alternative treatment would not be practicable within the constraints of the justice system, structured as it currently is.

As to the 4th Sell factor, the Appellate Court stated that, even if forcible medication is found to be the only means of bringing an incompetent defendant to trial for a serious crime, and that it is substantially likely to restore him to competency without causing side effects that would render the trial unfair, the treatment is impermissible unless it is also in the defendant's best interest. ❑

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[1]*United States v. Ruiz-Gaxiola*, 623 F. 3d 684 (9th Cir. 2010)

[2]*Sell v. United States*, 539 U.S. 166, 180-81, (2003)

## Oklahoma City-County Health Department
## Epidemiology Program
## Communicable Disease Surveillance

| COMMONLY REPORTED DISEASES | *Monthly* | | | *YTD Totals ^* | |
|---|---|---|---|---|---|
| | **Oct'11** | **Oct'10** | **Sept'11** | **Oct'11** | **Oct'10** |
| Campylobacter infection | 4 | 9 | 7 | 57 | 65 |
| Chlamydial infection | N/A | N/A | N/A | N/A | N/A |
| Cryptosporidiosis | 1 | 2 | 3 | 21 | 20 |
| E. coli (STEC, EHEC) | 0 | 5 | 0 | 8 | 15 |
| Ehrlichiosis | 0 | 0 | 0 | 2 | 1 |
| Giardiasis | 0 | 2 | 0 | 1 | 14 |
| Gonorrhea | N/A | N/A | N/A | N/A | N/A |
| Haemophilus influenzae Type B | 0 | 0 | 0 | 0 | 0 |
| Haemophilus influenzae Invasive | 1 | 0 | 0 | 10 | 21 |
| Hepatitis A | 0 | 0 | 0 | 2 | 3 |
| Hepatitis B* | 24 | 13 | 10 | 137 | 155 |
| Hepatitis C * | 24 | 14 | 20 | 166 | 179 |
| HIV Infection | N/A | N/A | N/A | N/A | N/A |
| Lyme disease | 1 | 0 | 0 | 5 | 10 |
| Malaria | 0 | 0 | 0 | 0 | 1 |
| Measles | 0 | 0 | 0 | 0 | 0 |
| Mumps | 0 | 0 | 0 | 1 | 0 |
| Neisseria Meningitis | 1 | 0 | 0 | 2 | 2 |
| Pertussis | 3 | 4 | 6 | 29 | 36 |
| Pneumococcal infection Invasive | 0 | 1 | 0 | 5 | 11 |
| Rocky Mtn. Spotted Fever (RMSF) | 9 | 8 | 18 | 97 | 33 |
| Salmonellosis | 19 | 15 | 9 | 122 | 119 |
| Syphilis (primary/secondary | N/A | N/A | N/A | N/A | N/A |
| Shigellosis | 44 | 4 | 25 | 90 | 62 |
| Tuberculosis ATS Class II (+PPD only) | 52 | 41 | 39 | 471 | 526 |
| Tuberculosis ATS Class III (new active cases) | 1 | 2 | 4 | 26 | 22 |
| Tularemia | 0 | 0 | 0 | 1 | 2 |
| Typhoid fever | 0 | 0 | 0 | 1 | 1 |
| **RARELY REPORTED DISEASES/Conditions:** | | | | | |
| West Nile Virus Disease | 0 | 0 | 0 | 0 | 0 |
| Pediatric Influenza Death | 0 | 0 | 0 | 0 | 0 |
| Influenza, Hospitalization or Death | 0 | 0 | 0 | 237 | 13 |
| Influenza, Novel Virus | 0 | 0 | 0 | 0 | 0 |
| Strep A Invasive | 0 | 1 | 0 | 2 | 21 |
| Legionella | 0 | 1 | 0 | 3 | 5 |
| Rubella | 0 | 1 | 0 | 1 | 3 |
| Listeriosis | 0 | 0 | 3 | 3 | 1 |
| Yersinia (not plague) | 0 | 0 | 0 | 0 | 1 |
| Dengue fever | 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***

# CME Information

For information concerning CME offerings, please refer to the following list of organizations:

**Community-based Primary Health Care CME Program**
Sponsored by Central Oklahoma CARELINK (COINS)
Contact: Deborah Ferguson
Telephone: (405) 524-8100 ext. 103

**Deaconess Hospital**
Contact: Emily McEwen
CME Coordinator
Medical Library
Telephone: 604-4523

**Integris Baptist Medical Center**
Contact: Marilyn Fick
Medical Education
Office
Telephone: 949-3284

**Integris Southwest Medical Center**
Contact: Marilyn Fick
CME Coordinator
Telephone: 949-3284

**Mercy Health Center**
Contact: Debbie Stanila
CME Coordinator
Telephone: 752-3806

**Midwest Regional Medical Center**
Contact: Carolyn Hill
Medical Staff Services
Coordinator
Telephone: 610-8011

**Oklahoma Academy of Family Physicians Choice CME Program**
Contact: Sue Hinrichs
Director of
Communications
Telephone: 842-0484
E-Mail: hinrichs@okafp.org
Website: www.okafp.org

**OUHSC-Irwin H. Brown Office of Continuing Professional Development**
Contact: Susie Dealy or
Myrna Rae Page
Telephone: 271-2350
Check the homepage for the latest CME offerings:
http://cme.ouhsc.edu

**St. Anthony Hospital**
Contact: Lisa Hutts
CME Coordinator
Telephone: 272-6358

**Orthopaedic & Reconstruction Research Foundation**
Contact: Kristi Kenney
CME Program Director
or Tiffany Sullivan
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