BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY JANUARY/FEBRUARY 2014

THE BULLETIN
The Oklahoma County Medical Society

January/February, 2014–Vol. 87, No 1

Six Annual Publications
Circulation 1500

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OKLAHOMA COUNTY MEDICAL SOCIETY

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OCMS Delegate Caucus

April 12, 2014
OSMA Annual Meeting
& House of Delegates
Tulsa, OK

November 17, 2014
OCMS Membership Meeting
& Election of Officers

For more information on any of these events, please call 702-0500

About the Cover

Pictured on the cover is Julie Strebel Hager, MD, the 114th President of the Oklahoma County Medical Society. Standing in the photo left to right are: Dr. Hager; her father, Gary Strebel, MD; and her sister, Jennifer Strebel Mall, MD. The three are OB/GYNs and practice together at Drs. Funnell and Strebel in Oklahoma City. Her mother, Sherry Strebel, is the office manager.

Dr. Hager followed in the footsteps of her father by becoming an OB/GYN. She graduated with a medical degree from the OU School of Medicine in 1998 and completed a residency in obstetrics and gynecology from Exempla St. Joseph Hospital in Denver in 2002.

Dr. Hager is board-certified by the American Board of Obstetrics and Gynecology, and is a graduate of the first class of the OCMS Leadership Academy. She is a fellow of the American Congress of Obstetricians and Gynecologists.

She has held a number of committee positions at Mercy Health Center and other professional organizations, including serving as president of the Oklahoma City OB/GYN Society. This year, she is president of the University of Oklahoma College of Medicine Alumni Association.

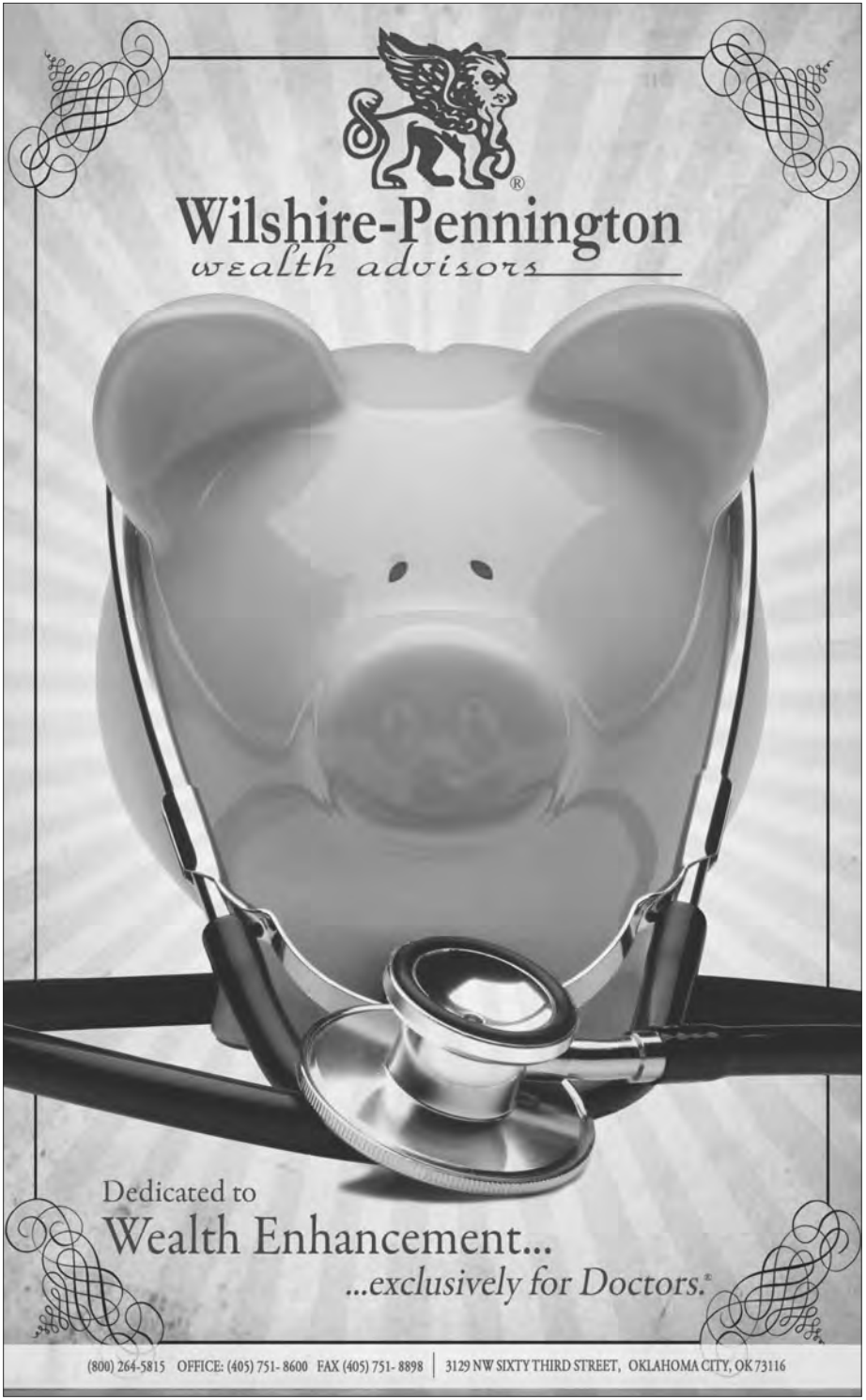
Dr. Hager serves as an AMA alternate delegate and is a delegate for OSMA. Her volunteer community work includes serving on the Advisory Board for the construction and funding of the Toby Keith Foundation's OK Kids Korral. She is an ordained elder at Covenant Presbyterian Church in Oklahoma City. ❑

In Memoriam

Willard Aronson, MD
1928-2013

Merle D. Carter, MD
1933– 2013

Larry L. Long, MD
1937– 2013



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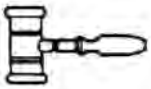
President's Page



Julie Strebel Hager, MD

As I sit here on a crisp autumn day writing this article, our government is at a partial standstill. The men and women who do our country's work are NOT working because those in Washington who make the rules can't seem to agree on the fiscal viability of the Affordable Care Act, referred to by most as "Obamacare." By the time you read this in January perhaps this will be clearer, but for now, January 2014 appears to be the new deadline for medicine, and this law seems to have brought this country to a stalemate.

"Medicine has changed." This is what I hear from colleagues all the time. And undoubtedly, I believe that while the "environment" in which we practice is changing, "medicine" itself is not.

When I entered private practice more than a decade ago, I joined my father's group, a group that spans nine decades of service to Oklahoma patients. And if you ask some of those patients who have shared two, three, or four decades in our office, they would tell you that within our office walls, the practice hasn't changed much at all.

Sure, computers have replaced appointment books and the faces of the staff have fewer wrinkles, but when they call because they are sick or need routine yearly check-ups, they receive "care" just like they always have. And just as we all took an oath to do, we diagnose, manage and sometimes cure their diseases, ease pain and suffering, and overall try to improve health for the people we are privileged to call our patients. Because that's what doctors do.

The roadmap we use to accomplish this in the changing environment of medicine may be somewhat different than in the past. Our titles include integrated hospitalist physicians, intensivists, MD-VIP practitioners, private practitioners, and allied health providers

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who extend medical services beyond the physical and time constraints of their supervising physicians.

But this roadmap can still provide coordinated and quality care .... if we as physicians remember our oath. We all have a choice. We can let the environmental climate of the practice, which today has yet to be agreed upon, change our attitude toward those we serve, or we can remember the reasons we chose "medicine" as a profession in the first place.

No matter what January 2014 and the Affordable Care Act will present, the blessed art of caring for patients will still be required. They will get sick, they will need pain eased, they will seek preventive care, and need chronic problems managed .... and they will call us to help. Yes, the environment in which we practice medicine is changing. But doctors "caring" for patients will always remain the same fundamental part of the job that brought us here in the beginning. ❑

Dean's Page

M. DEWAYNE ANDREWS, MD
Senior Vice President and Provost
Executive Dean, College of Medicine
University of Oklahoma Health Sciences Center

In November, I attended the annual meeting of the Association of American Medical Colleges, held this year in Philadelphia. This meeting brings together over 4,000 people representing medical school educators, biomedical researchers, active specialty clinicians, all of the medical professional societies, and most of the nation's major teaching hospitals.

This year, the "imperative for change" was on everyone's mind as we wrestled with the implications of the changing healthcare marketplace and the realities of the fiscal situation in which the United States currently exists.

Medical exchanges, massive consolidation into large regional health systems, "accountable systems," doctors "running to hospitals," reference pricing, tiered networks (narrow networks, skinny networks), coordination of care transitions, redefinition of employment benefits, "learning to live on Medicare," clinical integration, and stagnant research funding – these were the key concepts and themes that resonated throughout the meeting and consumed much of the energy.

The Affordable Care Act came in for some support but mainly bashing, of course. Most people are convinced that Congress will have to make adjustments for several years running if the new law is going to become workable – not unlike the situation in the 1960s with Medicare when it was first implemented. There was, however, no escaping the conclusion that the costs of healthcare must be reduced, at least when looked at on a per capita basis.

As I reflected on these themes, I couldn't help but think about how little we physicians actually know about specific healthcare costs, especially for hospitalized patients. Contrast this with any other business endeavor (and medicine is a business, too) in the U.S. A recent

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survey revealed that 63 percent of residents in training programs in the U.S. report that they have no idea about the costs of the tests and procedures they order. Some thoughtful observers think that a more accurate assessment is 90 percent of residents have little or no knowledge about such costs. Medical schools and residency training programs alone can't solve this problem, but we can do our part to address this lack of knowledge.

I personally teach our medical students about the macroeconomics of U.S. healthcare, but that's not enough. We physicians have an obligation to do our part in reducing the costs of healthcare. That means we have to learn about them as we are learning about diseases and how to take care of patients with those diseases.

I have asked our Medical Education Committee to begin looking for ways that the costs of various aspects of healthcare can be integrated into the curriculum – not as another course added to an already overcrowded medical education program, but becoming an essential part of understanding that diagnostic tests and treatment procedures have real costs.

Likewise, I have challenged our department chairs and program directors to emphasize the real costs of tests, procedures, and treatments to residents in training. Residents need to have a grasp of the costs of what they are ordering – is another CT scan really necessary? This transition means faculty physicians have to know more about costs. That means all practicing physicians ultimately will need to know more about costs. And that means that hospitals will have to share such information with us, especially as they continue to employ more and more physicians.

The "imperative for change" affects all of us. ❑

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WELCOME NEW MEMBERS!

Michael Shawn Cookson, MD, MMHC, is a board-certified urologist. He completed medical school at the University of Oklahoma College of Medicine, an internship and residency in urology at the University of Texas at San Antonio, and a fellowship in urologic oncology at Memorial Sloan-Kettering Cancer Center in New York.

Steven David Cromwell, MD, is a board-eligible anesthesiologist. He completed medical school at the University of Oklahoma College of Medicine, and completed an internship and residency in anesthesiology at Scott & White Healthcare in Temple, TX.

Chris Espinoza, MD, is a board-eligible orthopedic surgeon. He completed medical school at the University of Colorado, an internship and residency at the University of Texas Southwestern Medical Center in Dallas and a fellowship at Steadman Philippon Research Institute in Vail.

Kertrisa McWhite, MD, is a board-certified general surgeon. She completed medical school at the MCP-Hahnemann School of Medicine in Philadelphia, an internship and residency at Monmouth Medical Center in Long Branch, NJ, in general surgery, and a fellowship at UT Southwestern in Dallas in surgical breast oncology.

WELCOME NEW MEMBERS!

Sheleatha M. Taylor-Bristow, MD, MPH, is a board-certified family medicine physician. She completed medical school at the University of Oklahoma College of Medicine, and an internship and residency at the Great Plains Family Medicine Residency Program.

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Thanks to all of you who contributed to the 2013 Bulletin!

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LAW AND MEDICINE

Electronic Health Records Liability

Compiled by S. Sandy Sanbar, MD, PhD, JD

Spoliation (alteration) of hard-copy medical records is illegal and fatal to a malpractice lawsuit. The advent of electronic health records (EHRs) has created new liability issues principally involving the *discovery* of protected health information. The liability issues comprise potentially all electronic aspects, from software and hardware selection, set-up, implementation, use, staff education and storage of patient information.

EHRs are discoverable in malpractice lawsuits primarily to delineate the cause of the alleged malpractice incident and to uncover spoliation in an effort to undermine the records that are being presented in defense of the malpractice claim. By examining the metadata (historical electronically stored information), a computer investigator can determine what time each event or note happened, whether it was before or after another event, which could become critical points in a malpractice trial.

Of note, Colorado physicians using office-based EHRs did not have significantly different rates of liability claims than non-EHR users, nor were rates different for EHR users before and after EHR implementation.[1]

EHRs may be altered by authorized software upgrades wherein metadata may be lost or may unintentionally and unknowingly be reformatted, presented and reported differently. Thus, always back up and securely store the electronic records ***before*** every software upgrade in the event the EHRs get called into question in the light of discovery of errors in the record during a malpractice suit.

EHR liability includes:

- EHR systems have customization tools that doctor might use.
- The design of the screens or capture and populating of information could also lead to problems, such as phone messages.
- EHRs may have inherent errors, such as not documenting information correctly.
- The EHR form may not specifically account for or match up with every notation in the paper medical chart. The discovery process

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Young Physicians

Omar E. Beidas, MD

The 2011 ACGME Duty Hour Changes: Analysis of a University-Based Surgical Program One Year Later

With the introduction of the new Accreditation Council for Graduate Medical Education (ACGME) duty hour rules two years behind us, it seems a good time to reflect on these latest set of rules enacted on July 1, 2011. While most readers will already be familiar with the work hour changes that recently took effect in teaching hospitals across the United States, a quick summary of the major changes is provided.[1]

Maximum hours of work per week (VI.G.1)

The 80-hour work week, averaged over four weeks, is still in effect, but now includes internal and external moonlighting hours.

Mandatory time free of duty (VI.G.3)

No changes were made to the requirement of one day off in seven, averaged over four weeks. The Institute of Medicine (IOM) 2008 recommendations[2] include a 48-hour consecutive time period off per month, but this recommendation did not make its way into the ACGME changes.

Maximum duty period length (VI.G.4)

PGY-1 residents may not be scheduled longer than 12 hours; PGY-2s and above may be scheduled a maximum of 24 hours. Four additional hours are allowed to all residents to wrap up patient care duties, but may not be used for new clinical responsibilities. An ambiguous clause in this section adds that, under reasonable justification, "residents, on their own

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A Most Unusual Case

By David W. Foerster, MD

Sometime around the spring of 1962, a third-year surgical resident had OD duty at the Oklahoma City VA hospital. A patient with acute abdominal distress was admitted to his service. After careful work-up, X-rays, and lab, it became apparent that this patient had a perforated peptic ulcer.

This was not an uncommon emergency in those days, as the etiology was thought to be psychosomatic rather than bacterial and effective preventive treatment was a future discovery.

As was his responsibility, the third-year resident called the fourth-year senior resident, who had the right to either delegate or personally perform the needed surgical intervention.

After a brief discussion, the chief asked the third-year if he felt confident in proceeding without him. The answer was 'yes' so the chief gave permission for him to proceed, but said that if the resident ran into any problems, he would be available to help.

The patient was then prepped for surgery and given a general anesthetic. Just before the resident made an upper midline incision, he happened to glance at the OR clock. The time was almost exactly 7:30 pm.

After opening the abdomen, the duodenal perforation was readily apparent. The resident closed this with a double purse string repair and then explored the abdomen looking for any gastric fluid loculation or possible abscess. Finding nothing, he irrigated the repair site and suctioned the fluid. He elected not to use drains as the abdomen was quite clean. A layered repair was done and, as the last skin suture was tied, he again glanced at the clock, which now read 7:47 pm. He complimented his OR crew and said that, because of their excellent help, they together had done the surgery skin-to-skin in 17 minutes.

The following day, the ORs were abuzz about the 17-minute surgery, especially among the OR techs and nurses. This apparently continued for some time, even after the resident had left the service. The patient did quite well and was able to be discharged in due time.

The resident surgeon went on to specialize in a different surgical specialty and eventually went into practice in the Oklahoma City area.

Several years later, while working with residents in his own specialty, he asked if any of them had recently been on service at the

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initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient."

Minimum time off between scheduled duty periods (VI.G.5)

A minimum of 10 hours between duty periods is recommended, with a minimum of eight hours off required. Fourteen hours off-duty must be allotted after 24 hours of in-house call.

At-home call (VI.G.8)

PGY-1s are no longer allowed to take home call.

While these rules all made my first year in training less stressful than my predecessors, it did—as the saying goes—push the work uphill. At our program at the University of Oklahoma, residents rotate at three main hospitals: the university hospital (UH), the children's hospital (CH), and at the local veteran's health administration (VA) hospital. UH consists of seven services: three general surgery (GS) services, trauma floor (TF), trauma intensive care unit (TICU), cardiothoracic surgery (CTS), and a night float (NF) team to cover all these services at night. The CH and VA are each their own services.

Prior to the duty hour changes, the intern on CTS would take home call as very few of the issues require a body at the bedside, but the new rules have taken that luxury away. Instead, the PGY-2 on night float is now responsible for the nighttime pages. In direct opposition to the ACGME's requirement to reduce transitions in patient care, the day intern on CTS must check-out to the PGY-2 on NF, who knows nothing more about these patients than what is told to them in a brief five-minute handover. Similarly, on the plastic and reconstructive surgery (PRS), interns were able to answer pages from home, again because most issues—except for the occasional face call night—do not require a resident in-house. Now, however, one of the interns on NF covers the PRS service while the intern on-service goes home. Not only does this once again leave a resident responsible for patients s/he knows nothing about, it violates the ACGME's doctrine of reducing handovers. These changes essentially allow the PRS and CTS interns to rest comfortably at home

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while another resident answers the respective pages for the service. Interns on these services are thus no longer able to admit a patient and follow their illness from admission to discharge, taking away a major learning opportunity from these surgeons-in-training.

Night call at our VA is relatively benign, with very few pages after 10 pm. With four lower-level residents on the service, call was approximately every fourth night with each resident covering one weekend per month. However, VA home call now falls on PGY-2s, of which there are two on the service, whereas previously this could be split between them and two PGY-1s. The new changes have effectively doubled the number of night calls for PGY-2s. At our CH, a similar change has taken place, where a PGY-3 must take on extra responsibilities because interns on-service are not permitted to take home call. One intern must miss daily rounds, and thus the plan on each patient, in order to satisfy duty hour restrictions. That intern then returns at night to be handed patients s/he knows little about nor was involved in the medical decision-making process.

On several, if not all services, operative opportunity has been taken away from interns due to the new duty hour restrictions. During the day, interns are busy doing orders, doing admissions, and discharges, as well as seeing consults and pre-operative patients. It is generally not until the afternoon that an intern's floor duties are completed, which happens to coincide with the time most procedures are completed. And, by the time the patient with acute appendicitis—that the intern on-service saw in the afternoon—goes to the operating room, the ACGME rules dictate that the PGY-1 must go home rather than stay and operate. More so, the new rules force interns on the same service to split day and night call to cover a 24-hour period. This leaves one intern during the day to do all floor work and one at home sleeping. In practical terms, both interns are thus denied entry into the operating room.

Interestingly, student duty hours are not monitored by any governing body and, as such, vary from program to program. In my fourth year of medical school, I frequently took call, just like many other students across the country, for 24 or more hours.

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The Sailing Ship

Hanna Saadah, MD

The sailing ship travels the winds each year
Finds new, uncharted trails along the way
Docks at new harbors, learns and trades and hears
The tales of travelers from far away.
Then off again she blows, new winds astriving
New sunshines and new storms and netherlands
Await her journeying before arriving
At seashores, lush, with fresh, untrodden sands.
Then when at life's flea markets, after gales
She trades with younger ships her fairy tales
Watches them marvel at her journeying
With trepidation, awe, and envying
She oft regales them with a toast of wine:
"May all your journeys harbor home like mine."

Director's

DIALOGUE

"He who has a why to live can bear almost any how."
– Friedrich Nietzsche, German Philosopher

January – in the middle of winter and after the frenzy of the holidays – is a good time to reflect. It is a month of beginnings – a new year, with new opportunities and challenges. I frequently ask myself, "What was I put on this Earth to do?" The vast majority of us are not just settling for life but want it to be purposeful, to make a difference.

A good friend of mine lost her battle with liver cancer a few months ago, after beating ovarian cancer more than 20 years ago. She had a "why" to live – her friends, family, work and beloved cats and was a member of so many book clubs that I do not know how she kept them straight! Stephanie went through the cancer treatments with such grace, never uttering a negative thought. The diagnosis never got the best of her – she said it was merely a "bump" that she was encountering while traveling along life's long, winding road.

Perhaps some of her courage stemmed from being born with spina bifida. Growing up on a farm in Iowa, Stephanie was unable to run and play due to her physical limitations so she began a love affair with books that lasted throughout her life. Hearing about the Oklahoma oil boom in the 1970s, Stephanie and a friend built up their courage and made the decision to move to Oklahoma City. This is where she stayed, becoming a paralegal who had a wide array of interests...and along the way she gave us examples on to "bear the how" of life.

Many of us gathered at her bedside during her final hospitalization, trying to give her comfort, supporting her family, and being amazed by the collection of people who stopped in to say their final goodbyes. What Stephanie gave us was courage to face the challenges that life places in our paths and the example of acceptance

Stephanie's life was filled with purpose, and this quiet, unassuming Iowa farm girl left a huge, wonderful, positive mark on this world. Wouldn't it be great if this could be said of all of us? Happy reflections... ❑

Jana Timberlake, CAE, Executive Director

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(Young Physicians continued from page 19)

This varied between every sixth night on a general surgery service to every third night while in the surgical ICU. Regardless of the service, however, very seldom was sleep long-lasting. While we slept when possible, reading "Trauma: 45/M stab wound to the back" on our pager was enough to wake us and keep us up through the patient's acute illness.

While the ACGME attempts to ease the burden of residency on recent medical school graduates, all these new rules do is delay their entrance into regular residency training by an additional year without enhancing the educational experience during the intern year. Not only that, but as a fully-pledged practicing surgeon, will I not be called on at my 24th hour of wakefulness to take care of an acutely sick patient? Am I to tell such a patient that I have exceeded the maximum number of hours I am permitted to work at one time, and that I need eight hours off before I return to work and tend to their care? In medicine, this may be possible since many general practitioners are available to cover, even in a small-town setting. However, some areas are served only by a single surgeon, and patient handover is not an option. Patient abandonment, in order to go home and rest, is certainly physician neglect at the very least. ❑

References

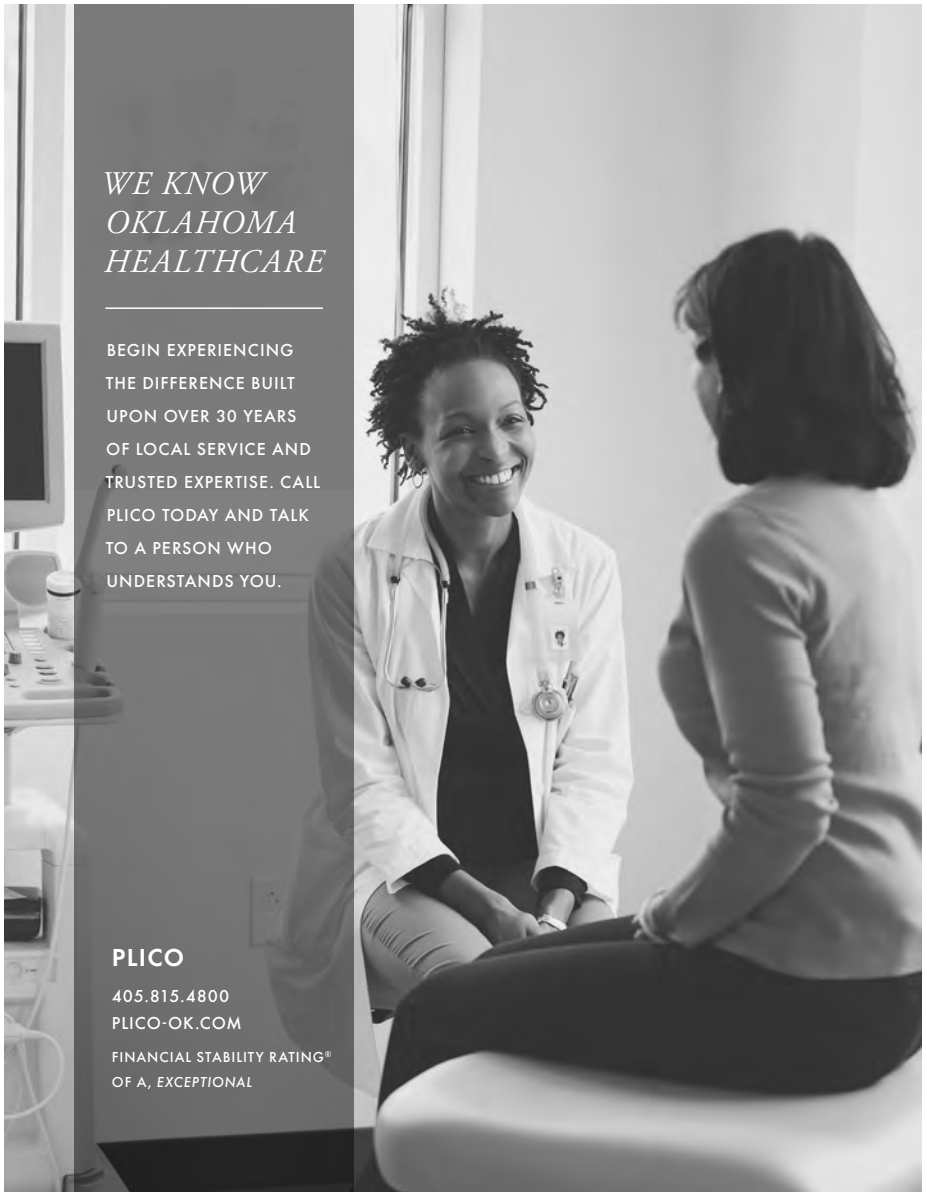
1. Accreditation Council for Graduate Medical Education. ACGME Duty Hours. Available at http://www.acgme.org/acWebsite/dutyHours/dh_index.asp. Accessed May 31, 2012.

2. Institute of Medicine. Resident Duty Hours: Enhancing Sleep, Supervision, and Safety. Washington, DC: National Academies Press; 2009.

(A Most Unusual Case continued from page 17)

VA. Two of them said they had and were still there. Out of curiosity, he asked the two if they had ever heard mention of a case done by a resident several years ago that had caused quite a stir at the time. To his surprise, they both replied that they had heard stories about a 17-minute abdominal case done by a resident years ago. No one remembered his name but the case was legendary.

Fifty-one years have now passed and I am sure that this case has been long forgotten. Nevertheless, I remember it well, almost as if it had taken place yesterday. ❑



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may include comparing the patient's old paper record with the history in the EHR.

- Some doctors do not sign their notes, causing not only a problem with billing, but also questioning whether the doctor actually provided those services to the patient.
- Some systems allow the physician to check off a box on the basis of what should have happened during the visit. Does the EHR support what the doctor said he did at the visit?
- When using templates and charting by exception, the physician is viewing "one" screen. But when checking off items in the box, that sends those data to five or six other screens. Deleting the information on "one" screen will not delete the information in the other populated areas.
- The vendor may store the data one way, but the doctor may store information another way, which changes the location in which information is stored. The historical record is actually changed.
- Where there is a product defect or design flaw, the doctor can be held liable because most vendors' contracts state that vendors do not practice medicine.

Golden rules:

1. Even if you follow the vendor's best practices, do not view EHR as a black box that works correctly.
2. Analyze sufficiently the EHR product and the design of the office workflow and processes.
3. The EHR requires more time and maintenance in areas that do not exist in the paper chart world.
4. Things could go wrong with the EHR or just work wrong. Monitor the performance of the EHR and your use of it.
5. Document your selection process for your EHR. This will show that you did due diligence to pick the appropriate product. In a malpractice trial, if you have chosen an EHR system that does not provide the information you need, this will count against you as far as back as why you ultimately selected that system.
6. Analyze, design, and plan to make sure you adequately vet the EHR itself and the set-up you establish, and document your training to show that you know how to use the system. ❑

[1] http://www.ncbi.nlm.nih.gov/pubmed/23192449

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4205 McCauley Blvd., Suite 375
Oklahoma City, OK 73120
405 751-4343

NEUROSURGERY

Neurosurgery

The University of Oklahoma Health Science Center

DEPARTMENT OF NEUROSURGERY

Timothy B. Mapstone, M.D.
Mary Kay Gumerlock, M.D.
Craig H. Rabb, M.D.
Naina L. Gross, M.D.
Michael D. Martin, M.D.
William B. Schueler, M.D.
Michael Sughrue, 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

PAIN MANAGEMENT

AVANI P. SHETH, M.D.
Diplomate of American Board
of Anesthesiology
Diplomate of American Academy
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Physicians
PLASTIC SURGERY

Kamal T. Sawan, M.D
Christian El Amm, M.D.
Suhair Maqusi, M.D.

Adult Clinic Location
OU Physicians Building
Suite 1700
825 NE 10th Street
Oklahoma City, OK 73104

Adult Services:
Facelifts
Endoscopic Brow Lifts
Nose Reshaping
Eyelid Surgery
Liposuction
Breast Augmentation
Breast Reconstruction
Breast Reduction
Tummy Tuck
Skin Rejuvenation
Laser Hair Removal
Botox & Fillers
Body Contouring after Weight-Loss
Birth Defects
Hand Surgery- Dr. Maqusi
Microsurgery
Burn Reconstruction
Skin Cancer Excision
MOHs Reconstruction

To schedule an appointment for Adult Services call 405-271-4864

Pediatric Clinic Location
OU Children's Physicians Building
2nd Floor, Suite 2700
1200 North Phillips Avenue
Oklahoma City, OK 73104

Pediatric Services:
Secondary Burn Reconstruction
Cleft Lip and Cleft Palate
Congenital Nevi
Craniosynostosis
Craniofacial Syndromes
Hemangiomas
Traumatic Defects
Vascular Lesions

To Schedule an appointment for Pediatric Services call 405-271-4357

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 & CARDIOVASCULAR SURGERY

The University of Oklahoma Health Sciences Center
Dept. of Surgery – Section of Thoracic & Cardiovascular Surgery

Marvin D. Peyton, M.D.
Donald Stowell, M.D.

Diplomate American Board of Thoracic Surgery
Adult Thoracic and Cardiovascular Surgery-
Cardiac, Aortic, Pulmonary, Esophageal,
Surgical Ablation for atrial fibrillation,
Thoracic and AAA endostents

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 MEDICINE

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

SUMAN RATHBUN, M.D.
Professor of Medicine

ANA CASANEGRA, M.D.
Assistant Professor of Medicine

ALFONSO TAFUR, M.D.
Assistant Professor of Medicine

CME Information

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

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 Hospital OKC
Contact: May Harshbarger
CME Coordinator
Telephone: 752-3390

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

Oklahoma Academy of Family Physicians Choice CME Program
Contact: Samantha Elliott
Director of
Membership
Telephone: 842-0484
E-Mail: elliott@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: Susan Moore
CME Coordinator
Telephone: 272-6748

Orthopaedic & Reconstruction Research Foundation
Contact: Kristi Kenney
CME Program Director
or Tiffany Sullivan
Executive Director
Telephone: 631-2601

Wanted: Bulletin Authors

Every issue of the Bulletin runs articles and columns from a diverse group of our physician members because it's important that our members discuss new ideas and issues with each other.

If you would like to be a Bulletin author, for one article or more, please let us know! You can share information on new clinical findings, business practices, or other topics you feel are important.

If you are interested, please contact Tracy Senat, Bulletin Managing Editor, at tsenat@o-c-m-s.org or call 702-0500. We look forward to hearing from you! ❑

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