BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY

JUNE 2012

DOES YOUR MEDICAL PRACTICE HAVE TYPICAL PATIENTS?

A: OF COURSE NOT.

Your medical practice provides individualized solutions to meet the unique needs of each and every patient.

At the Private Bank we don't have typical clients either. Our dedicated team provides individualized solutions tailored to fit your practice.

Call the Private Bank today for your own uniQue solution.

www.QuailCreekBank.com
405.755.1000
12201 N. MAY AVE. • OKC
MEMBER FDIC

Quail Creek
PRIVATE BANK

Cash Management • Remote Deposit • Lockbox • Working Capital
Real Estate & Equipment Financing • Mortgage • Wealth Management

Paid Advertising

THE BULLETIN
The Oklahoma County Medical Society

June, 2012 – Vol. 85, No 3

A Monthly Publication
Circulation 1500

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

Nominees

Nominees to stand for election to serve on the 2014 OCMS Board of Directors include Archana P. Barve, MD and Joseph Broome, MD, Position 1-Deaconess/Baptist; Sudhir K. Khanna, MD and J. Samuel Little, MD, Position 2-Deaconess/Baptist; Don P. Murray, MD and Ronald J. Sutor, MD, Position 3-Deaconess/Baptist; and Louis Chambers, MD, Position 4-St. Anthony. Candidate information and photographs will be published in the September issue of the Bulletin. Ballots will be mailed to all members prior to September 15. They must be returned to the OCMS office – postmarked no later than September 30 – for your vote to count.

Nominating Committee members were Drs. Robert N. Cooke, Chair; Larry A. Bookman, Vice Chair; Jim Brinkworth, Thomas H. Flesher, III, C. Douglas Folger, and Robin L. Harms. ❑

NEW MEMBERS

Laura K. Chong, MD
(AI IM)
750 NE 13th St.
University of Illinois
2004

Daniel N. Fong, MD
(OBG)
11200 N. Portland Ave.
University of Oklahoma
2007

Angela K. Morgan, MD
(FM)
1501 S.E. 19th
University of Oklahoma
2005

David A. Neumann, II, MD
(IM) (GE)
4188 Gaillardia Pkwy, #200
University of Oklahoma
2006

About the Cover

The floral design pictured on the cover of the Bulletin this month was painted by Michelle L.E. Powers, MD. The painting was done in a class at Wine and Palette from an original by Shannon Roberts. Permission to reproduce her version was given by the artist and company. The photograph of the painting was taken by her husband, Stephen Powers. We thank them both. ❑

The Editor

In Memoriam

Daniel F. Keller, MD
1953 - 2012

H. Craig Pitts, MD
1937 - 2012

Gary G. Roberts, MD
1940 - 2012

Joseph B. Ruffin, MD
1928 – 2012

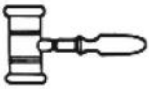
Impending e-Prescribing Deadline

June 30, 2012 is the deadline to report on at least 10 electronic scripts to avoid the 2013 Medicare e-prescribing program penalty. Physicians who are not able to meet the requirements of the program should apply for a hardship exemption applicable to their particular case before the June 30, 2012 deadline.

In November 2011 CMS released the final regulation on the 2013 Medicare e-prescribing penalty program. The penalty for not successfully participating in the program, or not filing for an exemption on time, is a 1.5 percent payment reduction for all Medicare claims based on the 2013 fee schedule amounts during the year. Visit https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234 to apply for an exemption.

Additional information about the e-prescribing penalty and the reporting requirements is available at http://www.ama-assn.org/resources/doc/hit/avoid-erx-penalty-tip.pdf. ❑

President's Page



Tomás P. Owens, MD

Spring Forward

For decades the OCMS has set the pace developing a number of not-for-profit medical institutions in the metro area. We have also strongly defended the rights of patients and practitioners in our state.

This year we continue to pursue new and relevant tasks for the benefit of our county.

In cooperation with several local organizations, the OCMS is spearheading a program to provide transportation for seniors in the metro area. The Independent Transportation Network, now on its second stage of fact-finding and planning, envisions a transportation system to take individuals wherever they request in the designated service area. Similar projects have found success in Maine, Washington, New Hampshire and New York City.

With the banner-carrying stimulus of the Alliance, we are pursuing "*Docs Who Rock*," a yearly show that "enables local physicians to show off their musical talents" either in a group or performing solo, while encouraging more interaction between the public and docs. This activity was born at the Summit County Medical Society of Akron, Ohio and has been a great success since its inception in 2004. In later years it has grown from a fun-filled medical/paramedical festival to a full-blown musical extravaganza and fund-raiser for community affairs. We have bought the naming rights and will have the Communications Director of United Way of Akron, Ohio in Oklahoma City this month, so we can have insight on how to reproduce their success within our midst.

Our second Leadership Academy class received completion

awards during this year's OSMA Annual Meeting Presidential Inauguration at the Oklahoma City Civic Center. We are continuing this effort for 2012-2013 as we must encourage new members.

An incipient young-physician section is in the making. To that effect, we are continuing a series of Young Physicians receptions sponsored by Quail Creek Bank. We hosted Mercy docs last fall and will have St. Anthony doctors and Integris Baptist/Deaconess residents on June 7. Gatherings for recently minted medicos of the remaining quadrants of the metro will be forthcoming.

A family get together is also being planned for this autumn; we will keep you posted.

The legislature has been very active this year. Last month, after several attempts to change the manner in which physicians access the Prescription Monitoring Program, and the way patients access decongestants, the legislature settled for Senate Bill 2941 which limits purchases of pseudoephedrine. The measure reduces purchases of the drug to 3.6 grams a day or 7.2 grams a month. The current ceiling is 9 grams a month. The bill lowers the annual purchase cap to 60 grams from 108 grams. The previous restriction applied only to dry tablet forms of the drug; now it will include liquid and gelcap forms, which the DEA says can also be used to make methamphetamine. In addition, Oklahoma will now be linked to a 21-state electronic drug-tracking system. This will allow the state to prevent pseudoephedrine buyers from avoiding sales limits by crossing state lines and will help reduce "smurfing" (persons who, for a fee, buy raw materials on behalf of meth cooks). A bill promoted by prosecutors, that would require a prescription for the drug, failed.

Legislation to allow cities to restrict tobacco use was defeated in committee and a personhood bill was unsuccessful.

In the national front, a Supreme Court decision is still pending on the constitutionality of all or part of the Affordable Care Act.

While many issues were *improved* by legislative actions so far this season, several actions were considered that would threaten the independence of clinicians. Without regard to our personal politics, we should continue to act in defense of the patient-doctor relationship and emphasize that licensed physicians and not legislators should practice medicine.

This is happening everywhere, to wit: the 2012 Annual Leadership Forum of the American Academy of Family Physicians felt it necessary to approve a resolution asking all legislatures to respect the patient-physician relationship by staying clear of imposing regulations on the clinical aspect of our practices. The action was modeled after that of several national specialty organizations.

We must work as hard as possible for the success of our society, by inviting new members, supporting new ventures that will benefit all, and conscientiously safeguarding the purity and independence of our practice. One way to do this, I must add, is contributing to OMPAC.

Please email or text me with your thoughts or suggestions. Have a great summer! ❑

References:
United Way of Akron Ohio
Tulsa World
The Oklahoman

OCMS Leaders Recognized

Once again, members of the Oklahoma County Medical Society were well represented among leaders recognized by OSMA at its annual inaugural dinner in late April. Dr. Diana Hampton has begun her second year as president of the OSMA Alliance. Dr. Hampton, who practices comprehensive ophthalmology, is actively involved in both her professional organizations and in the Oklahoma City civic community.

Dr. James W. Hampton, long-time Editor-in-Chief of the Bulletin, received the Gordon H. Deckert, MD, Award for Community Service. This award recognizes physicians for reaching Oklahomans through actions and activities that improve the overall health and wellbeing of our citizens and have a demonstrated positive impact on both physicians and the patients they serve. Dr. Hampton was nominated by OCMS for leading the creation of the first nonprofit hospice in Oklahoma. Hospice of Oklahoma County continues today under the INTEGRIS umbrella.

The Ed L. Calhoon, MD, Leadership in Organized Medicine Award was presented to R. Murali Krishna, MD. He was also nominated by OCMS for his vision and leadership in developing the Health Alliance for the Uninsured (HAU), which began in 2005 during Dr. Krishna's term as our Society's president.

And finally, the OCMS Leadership Academy Class II members received their graduation plaques. These outstanding young leaders will represent the Family of Medicine well; we expect great things from them in the coming years. Graduates include Drs. Anureet Bajaj, Michelle Powers, Thomas Showalter, III, Thu Nguyen, and Rajesh Kumar (who was not able to attend the festivities). ❑

Explore

Shari Moore, Vice-President
PLICO Risk Management

For over 32 years, PLICO has stood as an advocate for medicine in Oklahoma, continually striving to advance the delivery of healthcare by supporting physicians and other providers with timely and relevant educational opportunities. In 2012, PLICO will advance the state of educational programming and dialogue by hosting EXPLORE: Oklahoma Healthcare Summit, a conference for physicians, practice managers, healthcare administrators and other providers. As the first of its kind in the state, this event will provide Oklahoma healthcare with a centrally located, comprehensive learning experience. Attendees will *explore* the rapidly evolving future of medicine and best delivery practices. Current and future technology will be showcased at a state-of-the-art exposition. Continuing education credit will be available for daily breakout sessions along with informative and entertaining keynote speakers, including the acclaimed subject of the book "Catch Me if You Can," Frank Abagnale, as well as Business Innovation Expert Chris Trimble, and Futurist Dr. Lowell Catlett. In addition, Governor Mary Fallin and Insurance Commissioner, John Doak, have been invited to discuss the State of Oklahoma Healthcare.

EXPLORE: Oklahoma Healthcare Summit will be held August 9–10, 2012 (8:00am-5:00pm) at the beautiful Renaissance Oklahoma City Convention Center Hotel in downtown Oklahoma City. In addition to the programming, attendees will also enjoy a Thursday evening social event as well as the opportunity to *explore* downtown Oklahoma City and its new riverfront attractions.

PLICO is sponsoring Explore: Oklahoma Healthcare Summit as part of our continuing mission to help medical professionals successfully navigate the ever-changing and technologically focused healthcare environment. This first annual statewide summit will provide an invaluable educational, insightful and cutting edge opportunity to get some practical answers to some of the toughest questions regarding the future of medicine.

We invite you to join us as we *explore* the future of healthcare in Oklahoma.

For more information or to register online, visit www.oklahomahealthcaresummit.com or call PLICO Risk Management at 405.815.4803. ❑

AUGUST 9-10, 2012

Renaissance Oklahoma City Convention Center Hotel,
Downtown Oklahoma City

Registration Fee: $200

PLICO Insureds may take advantage of a discounted rate of only $100!

Residents and Medical Students attend at no charge.

For more information or to register please call PLICO Risk Management at 405.815.4803
or visit www.oklahomahealthcaresummit.com.

Earn up to 8% in PLICO premium credits

Attend the first Oklahoma Healthcare Summit, a comprehensive conference that will give you the tools to succeed in the ever-changing healthcare industry. Receive continuing education in daily breakout sessions that will inform you on the future of medicine and timely keynote addresses by acclaimed subject of the book "Catch Me If You Can," Frank Abagnale, Business Innovation Expert, Chris Trimble, and Futurist, Dr. Lowell Catlett. In addition, Governor Mary Fallin and John Doak, Insurance Commissioner have been invited to discuss the State of Oklahoma Healthcare.

The host, PLICO (Physicians Liability Insurance Company), is an informed industry leader providing comprehensive insurance services and products to Oklahoma healthcare providers.

Paid Advertising

Dean's Page

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

In March, approximately 300 health professions students at the OU Health Sciences Center, spearheaded by students in the College of Medicine, assembled voluntarily on a Saturday to consider problems in health care in their *Bridges to Access Conference*. These annual, student-organized conferences are an outgrowth of the formation several years ago of a coalition of medical students concerned about access to health care for many of our less fortunate and underserved citizens. The conference began with a keynote speech by former Lieutenant Governor Jari Askins. The students asked me to give a "wrap-up" summary to the audience at the end of the conference tying together the various aspects of what transpired that day. Dr. Robert McCaffree (OSMA) and Dr. Tomás Owens (OCMS) who participated in this conference suggested that I include portions of my summary in a future *OCMS Bulletin* column. I'm happy to accommodate that request.

The conference was organized around breakout sessions focused on various topics including: a conversation with the uninsured (one of the most interesting sessions), nutrition and diabetes, the importance of multi-disciplinary approaches to health care, the burden of clinical trial participation, and the interactions between culture and health.

Several themes and important factors were covered. As reflected in the annual report of the State Health Department, *State of the State's Health*, Oklahoma has significant problems, many related to tobacco use, obesity, poor health choices, and poor health literacy. Health care professionals can and should play an important role in influencing legislators and decision-makers. There are 140,000 uninsured in Oklahoma County alone. Even people who have

done well most of their lives can fall into financial problems, lose a job, and develop significant and expensive health problems. We need sensitivity about such circumstances and individuals and need to remember there are "dignity issues" for those who become uninsured. One issue garnering attention was the "voluntarily uninsured," referencing that 43 percent of Americans in the 18-64 years age group who have incomes at or above 2.5 times the poverty level but can't afford health insurance. Students also were engaged in discussions about the socioeconomic and educational factors that influence health and access to health care, domestic violence, drug addiction, and exercise and health.

We have the world's most sophisticated health care in the U.S., and yet 50 million of our citizens have no health insurance and experience difficulty with access to health care (yes we understand emergency rooms, but that's not the answer for primary care). We have sophisticated health care though we don't have a real "system" of health care that makes economic or even medical sense. To solve America's health care dilemma will not be easy. Costs continue to rise amidst increasing pressure to reduce costs. Health care workforce shortages loom in the future, a factor that will likely require us to rethink and redefine who does what in health care, and place greater emphasis on prevention/wellness, and greater emphasis on volunteerism and community engagement. Many problems were discussed, some approaches suggested, and no solutions emerged nor were necessarily expected. However, it is important for students in health professions to understand these issues and begin thinking about their roles in solving them. It's also important for them to gain experience in the community, which many of them are doing in free clinics and other venues. It was a good conference and a good day. I understand much remains to be done and there will be no simple solutions. Going home I felt better about our students and our future. ❑

We all create the person we become by our choices as we go through life.
In a real sense, by the time we are adults,
we are the sum total of the choices we have made.
Eleanor Roosevelt

OSMA Makes Hill Visits

Kathy Musson

The 2012 AMA National Advocacy Conference (NAC) was held February 12-15, 2012 in Washington, DC. The AMA NAC provides leaders of the medical community from around the country the opportunity to gather and receive the latest information on various political and advocacy issues of interest to physicians and their patients.

Representing the Oklahoma State Medical Association was President-elect John Robinson, MD, OSMA Vice President Robert McCaffree, MD, and Governmental Activities Chair Dean Drooby, MD. Also in attendance from Oklahoma were Mary Anne McCaffree, MD, AMA Board of Trustees member; Tom Flesher, III, MD, President-elect of the Oklahoma County Medical Society; Diana Hampton, MD, OSMA Alliance President; OSMA Executive Director Ken King; and I.

As in previous years, Oklahoma attendees, along with OSMA Federal Lobbyist John Montgomery, made "house calls" to the Oklahoma Congressional Delegation and had an opportunity to personally visit with all of Oklahoma's U.S. Senators and Representatives.

The primary message to Congress was to reiterate OSMA's opposition to further short-term patches that have made Medicare physician payment cuts more severe and reform even more costly, and to ask Congress to permanently replace the flawed Sustainable Growth Rate (SGR) formula with a new updated formula based on medical practice cost increases. On Wednesday, February 1, it was reported from Capitol Hill that conferees had reached agreement on extending the payroll tax holiday, unemployment insurance benefits, and current Medicare physician payment rates for the next 10 months, through the end of 2012. In lieu of the 27.4 percent physician payment cut scheduled to take effect on March 1, a payment freeze will be effective through the end of the year. OSMA will continue to lobby for a permanent repeal of the SGR.

In addition, the OSMA delegation asked for support for H.R. 1700 introduced by Rep. Tom Price, MD (Georgia), and S. 1042 by Senator Lisa Murkowski (R-AK), "the Medicare Patient Empowerment Act" which would allow Medicare patients and their physicians to enter into private contracts without penalty to either party.

The physician contingency also asked the Oklahoma delegation to support the "Healthcare Truth and Transparency Act" introduced last year by Oklahoma Representative John Sullivan. This legislation will ensure that patients have accurate information regarding the education, training, and qualifications of individuals providing their health care services.

OSMA physicians discussed the members' concerns about various provisions in the "Affordable Care Act," which was enacted last year, as well as the need for national medical liability reform. While Oklahoma had significant success in reforming Oklahoma's lawsuit abuses over the past two years, we also remain committed to reforming our medical liability system at the national level to make it more fair and just for patients, physicians, and other health care providers. OSMA urged our delegation to support the "Help Efficient, Accessible, Low-cost, Timely Healthcare Act" (HEALTH) legislation as introduced by Representatives Phil Gingrey and Lamar Smith.

OSMA's Federal Legislative Agenda, along with a contact list for the Oklahoma Congressional Delegation, is posted on the OSMA Website at www.okmed.org and will be printed in the OSMA Journal. Additional information on OSMA's federal legislative agenda is available by contacting Kathy Musson, OSMA Associate Executive Director, at (800) 522-9452 or by e-mail to Musson@okmed.org. ❑

Ken King, Drs. Diana Hampton, John Robinson, Bob McCaffree, Tom Flesher, III, and Dean Drooby, John Montgomery (OSMA D.C. lobbyist)

Angel Flight

Free Air Transportation for Your Patient

Errol A. Mitchell

Angel Flight Oklahoma serves patients in need of air transportation to or from medical treatment. Angel Flight, a non-profit charitable organization of pilots, volunteers, and friends, will arrange free air transportation for any legitimate, charitable, medically-related need. There is never a fee of any kind, either to the patient or to the healthcare provider, for an Angel Flight.

Angel Flight was created by a group of pilots who believe in the benefit of volunteering and is primarily financially supported by them through the use of their airplanes, time and operating expenses, as well as by contributions from service clubs, individuals, social and religious groups and corporations. Angel Flight receives no financial aid from any government entity.

Angel Flight primarily serves patients needing transportation to or from the heartland region. As a member of the Air Care Alliance, Angel Flight can coordinate with other organizations to arrange transportation for patients on longer flights to other parts of the country.

Patients in need of an Angel Flight must meet several requirements. For instance, patients must be ambulatory and able to travel in a small, non-pressurized aircraft, without access to lavatory facilities, for the duration of the flight. Healthcare professionals seeking to arrange transportation for a patient should contact the Angel Flight office to obtain required documents necessary for qualification.

To arrange free air transportation for your patient or to learn more, please contact Angel Flight at 918.749.8992, Angel@AngelFlight.com, or www.AngelFlight.com. ❑

Errol Mitchell is the Vice President/CFO for the Oklahoma City metro INTEGRIS Health hospitals and serves on the Angel Flight board of directors. If you have any questions about Angel Flight services, he can be reached at 405.951.2253.

Too often we...enjoy the comfort of opinion
without the discomfort of thought.
John F. Kennedy

Inflation on Investments

R. Todd Owens, CFA

Inflation is a rise in the general level of prices of goods and services in an economy over time. That sounds like a textbook, but we can see this each day at the grocery store or the gas station. This past year, inflation has been occurring in the price of food commodity prices. Lately, we have experienced rising gas prices. Typically, inflation is caused by an increase in the money supply, which leads to price increases. I think we are all aware that the Fed has been printing a lot more money than usual. At some point in time, there will be a consequence.

What can be the consequence to your portfolio? Both bonds and stocks are significantly impacted by inflation and their value can decrease as a result of rising inflation rates. It doesn't matter whether the money is invested in stocks or bonds, or sitting under a mattress. Inflation slowly erodes away the value of that money. For example, a bond with a fixed income payment of 3 percent, during a time when the inflation rate is 2 percent, will result in a real return (after inflation) of only 1 percent. Typically, fixed income investors are hit the hardest by high inflation rates. During the biggest 10-year inflation period in the most recent history, 1973–1982, the cumulative real return (after inflation) for long-term U.S. Treasury bonds was an abysmal 23.73 percent.

Unlike bonds, inflation typically does not pose as great a risk on stocks. The value of a company's stock is more affected by how investors view the underlying business of the company. Over the long term, a company's revenue can increase directly with the general direction of interest rates. One of the most significant impacts of inflation on stock prices is that inflation can lead to a false sense of revenue growth. This could result in a false sense of growth in company earnings that might not reflect the true value of the company.

The graph below shows the relationship between inflation rates and annual returns on stocks and 10 year U.S. Treasury bonds. You can see the effect on bonds during a period of high inflation rates. For example, during the period from 1977 to 1981, the return in 10-year Treasury bonds averaged a return of 1.28 percent. During the same period, inflation was 9.84 percent,

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

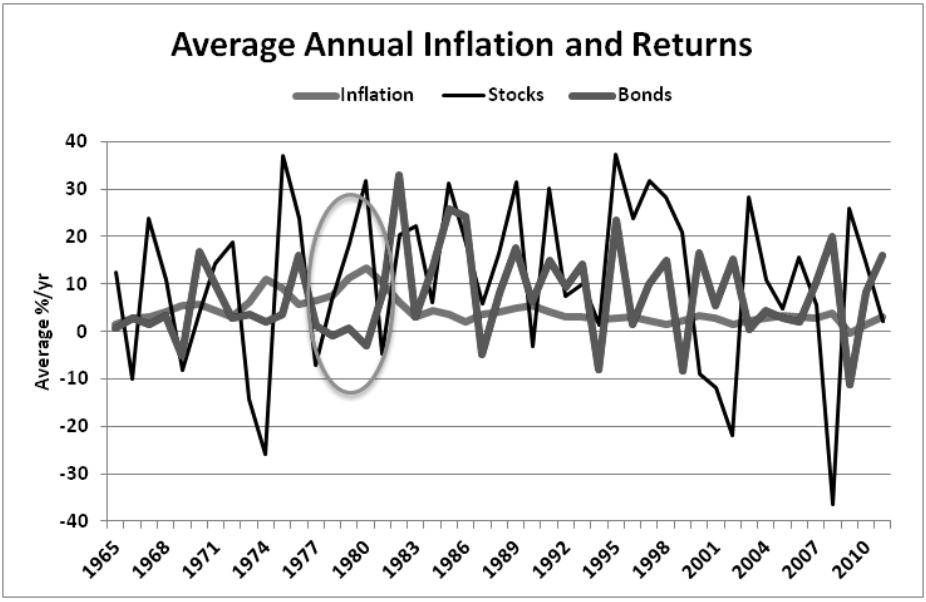
Frontier Hospice
An American Hospice Company

3908 North Peniel
Suite 500
Bethany, OK 73008

www.americanhospice.com

Paid Advertising

resulting in a real return of -8.56 percent for the 10-year Treasury bond. As this shows, inflation can pose the biggest risk to investors that depend on a fixed income (bond) return.



I believe it is not a question of *if* but *when* we will experience more widespread inflation. I believe there will be consequences to the amount of money that has been put into the financial system and it is important for investors to consider the risk that inflation can have on their portfolio. ❑

R. Todd Owens, CFA is President of Baker Asset Management LLC. Much (most), of this article was written with the help of Taylor Galvin (intern from OSU). For more information call Todd at (405) 415-7270 or todd@bakerassetman.com.

Source Links:
http://pages.stern.nyu.edu/~adamodar/New_Home_Page/datafile/histret.html (Graph)
http://www.usinflationcalculator.com/inflation/historical-inflation-rates/ (Graph)

He that is good for making excuses is seldom good for anything else.
*B*enjamin Franklin

alliance

Capitol Watch

Legislative Advocacy continues to be an important part of both the Oklahoma State Medical Association Alliance and the Oklahoma County Medical Society Alliance. Alliance members participated in a Legislative Training Session on Medicine Day, February 22, 2012.

To build on the legislative training, the OSMA Alliance organized "Capitol Watch" on March 27, with additional training and an update on legislative issues. Following this session, Alliance members made personal contact with legislators. The plan is to meet monthly while the Legislature is in session.

A big focus of legislative advocacy is to recruit physicians and spouses to serve as key contacts for their state senators and representatives.

The OSMA Alliance and the OCMS Alliance encourage and welcome all members to participate in legislative efforts. Keith Oehlert is the legislative liaison for the OCMS Alliance. Email her (kboehlert@gmail.com) or give her a call (590-6216) and explore how you can become a part of these important activities. ❑

Kathy Bookman, OCMS Alliance President

Young Physicians

Renee H. Grau, MD

Achieving the Cosmic Balance

It is a bit sobering to realize that 2012 marks my 10th year out of medical school. I look back on the last decade and reflect on lessons learned and the course of my career. It certainly looks different than what I anticipated when I walked across the stage to get my long awaited medical degree. However, I am deeply satisfied with where this adventure has led but consistently reevaluate the multiple facets involved in being a medical professional. As one enters into practice, he or she must learn another culture, much like learning to adapt to the culture during different stages of our training (the classroom years vs. the clinic years of medical school and intern year vs. residency). Unlike the training programs in which the curriculum and schedules are mostly set, beginning one's career in practice is less "standardized" and the possibilities and potential to creatively meet your patients' and your needs are multiple. To accomplish this requires a clear focus on your defined personal and professional goals, creative planning and time management, paired with a great team of staff, advisers, and family support to ensure the "*cosmic balance*" is achieved.

The "cosmic balance" is a term I use to refer to a constellation of competing demands of patient care, federal and state or insurance restrictions on how we practice, the dynamics of managing staff, the pursuit and transition to electronic medical records, continuing medical education, civic duties, as well as personal life and the pursuit of happiness. This constellation includes the following systems in orbit:

1. Managing Staff – This is my first "planet" in the constellation as it is quite eye opening the effects your staff can have on your patient care and day-to-day quality of life. It would be so much easier to have a Magic 8 ball one could use during hiring to predict which staff would have a respectable work ethic, rapport with staff and patients alike, and longevity with the practice. One's office manager plays an important role in the selection process; however, in my practice because I work so

closely with my medical assistants and they function as an extension of me, it is imperative I assist in the hiring of our employees.

2. Personal life balance – Being a mother of two and having a spouse with a rich and full career as well, I find that creative scheduling and problem solving are of the utmost importance. This requires thinking "outside the box" for ways to manage the time seeing patients and fulfilling mounting professional responsibilities as well as the evolving needs of one's family. However, it is achievable! It is one of the best gifts of being a physician: having some degree of flexibility in scheduling your work day and week in addition to ample resources to recruit and create your team. Over the last few years I have hired college students who help me with shopping and errands as well as tasks that do not specifically require my involvement. It is remarkable to me and my spouse just how helpful this is to the continuity and flow of the work week and improved quality of life.

3. Patient relationships – This has truly been one of the most rewarding parts of my career. One is able to see and appreciate the fabric of humanity at its finest (and, rarely, at its worst). However, just like any relationship, this requires investment of time and energy to establish a professional, healing, trusting bond with the people we serve. It is a crucial exercise to remind myself and our staff that *PATIENTS* are the entire reason we exist!! It is easy to lose focus on this sentinel point when faced with so many aspects of practice which, counter-intuitively, are not patient-centered. From the receptionist and medical assistants to the phone systems, I have observed that these facets are all a reflection and extension of this patient-physician relationship. To my surprise, this has been one of the most intricate processes because it encompasses so many areas: the ease at which a patient can negotiate the "phone system," receiving test results in a timely and predictable manner, spending time and energy to communicate at the bed side diagnoses, the risks and benefits of treatment options, and assisting in navigation of the health community to ensure that he or she gets the proper, timely care – just to name a few. As a result, you must be involved in and informed of how each of these is managed, not only to provide quality service to patients, but for medico legal purposes as well.

4. Difficult or out-of-the ordinary patient cases – This seems to occur with a surprising degree of frequency. It is an exciting, yet challenging part of our careers as it moves us from the comfortable, predictable "set" of management and treatment options to exploring new or different ways to diagnose and treat patients. These challenging

cases are the number one defense against complacency as they require carving out time to tap in and keep up with the ever evolving data and metamorphosis of diagnostic and therapeutic options.

5. Refusing to "atrophy"- This dovetails with #4 above. The nature of our profession and the multiple demands on one's time require a deliberate and conscious effort to continue our medical education and training. It is challenging because it is not the most pressing issue facing us daily but on-going education certainly cannot and should not be ignored.

6. Always looking for ways to improve – Unlike the years of medical school and residency in which you get the "score" and then move on, there is no cap or limit on how one can create professional and personal excellence. This requires regular scrutiny and desire to seek and accept constructive criticism from staff and patients.

7. Accepting and embracing change – This part of the "cosmic balance" causes me the most stumbling and juggling. Many of us, perhaps as a defense mechanism, assume that once the medical training is complete and practice starts, the finish line has been crossed and we can finally rest. This is not true. The medical and scientific communities change constantly with an explosion of data acquisition and delivery. I personally prefer and rely upon a standard pattern of doing things and "systems" that have been successful. If they are working well, then I wince at change and find it particularly painful. However, my paradigm has shifted, and now I realize change is unavoidable and I must accept and embrace it. In order to survive and adapt without becoming extinct (to honor a Darwinian concept), change becomes the "norm" and a regular part of young physicians' practices.

As young physicians, we are called to be much more adaptive than our predecessors. We will need to equip ourselves with the ability to maintain this cosmic balance and accomplish professional and personal success and fulfillment. 3-2-1… Lift off and best wishes to you all! ❑

Paid Advertising

Oklahoma Workers Compensation Act 2011

D. Wade Christensen, JD[1], J. Clay Christensen, JD[2],
L. Nazette Zuhdi, JD, LLM[3], Adam W. Christensen[4], JD, MBA,
and S. Sandy Sanbar, MD, PhD, JD[5]

On May 24, 2011, Governor Mary Fallin Christensen signed the new and extensively modified Workers' Compensation Act (WCA), which took effect on November 1, 2011, and directed the Administrator of the workers compensation court to reduce the fee schedule by 5 percent.[a] The following summarizes most of the new provisions of the WCA:

1. The Court will consist of 10 judges, no more than seven will be assigned to Oklahoma City and no fewer than three will be assigned to Tulsa. The WCA will not apply to certain employees including volunteers; sole proprietors, persons providing services in a medical care or social services program; persons who employ relatives; persons employed by employers who are liable under certain Acts of Congress; persons employed in agriculture who have certain gross annual payrolls; real estate brokers; persons employed by youth sports league; owner-operators, and drive-away owner-operator.
2. Injuries that do not occur during the employment relationship or in the course of employment are excluded, as are some injuries which occur from certain willful acts, willful failure to act, drug use, and horseplay.
3. The time period a worker can file a claim is shortened from two years to 90 days;
4. Public state entities are required to provide workers' compensation benefits, paid out of their respective funds, to employees and certain elected officials and to insure against liability for workers' compensation with CompSource Oklahoma.
5. Voluntary mediation is available to any party to a claim, and the Court may also order mediation in any case.

---

[1] First Gentleman of Oklahoma; Owner, Christensen and Associates;
[2] Owner and Managing Director, Christensen Law Group
[3] Chair, Health Law Section, Christensen Law Group
[4] Attorney, Health Law Section, Christensen Law Group
[5] Of Counsel, Health Law Section, Christensen Law Group
Address for all: 210 Park Avenue Suite 700, Oklahoma City, OK 73102.

6. The employer is required to provide an injured employee with medical care within seven days of actual knowledge of an injury, without admission of compensability. The physician selected by the employer will become the treating physician. If the employer fails to do so, or in the case of an emergency, the injured employee may select a physician at the expense of the employer. If there has been a previous contract with a certified workplace medical plan, the employer will select a treating physician from within the network of such plan and the claimant may apply for a change of physician as set out in the plan. Where the employee is not covered by the plan, the employee may be granted one change of treating physician for any affected body part. A maximum of two changes of physician are allowed in a claim.
7. A new Workers' Compensation Medical Fee Schedule will be established in January 2012 with maximum rates that medical providers are permitted to be reimbursed for.
8. The Court will create and maintain a list of licensed physicians to serve as independent medical examiners and, at any time, may appoint an independent medical examiner to assist in determining any issue before the Court. After receiving a medical examiners report, the Court is required to submit reasons if it does not follow the opinion of the medical examiner.
9. The WCA established the use of nationally recognized treatment guidelines for injured workers. The Court will determine permanent impairment or disability and must be supported by medical testimony. The physician's opinion of the nature and extent of permanent partial impairment must be based on the "American Medical Association's Guides to Evaluation of Permanent Impairment."
10. The WCA encouraged early return to work by utilizing rehabilitation. Injured employees will be entitled to physical rehabilitation services and vocational rehabilitation services. The Administrator will hire a Vocational Rehabilitation Director to help injured workers return to work. No person will be adjudicated to be permanently and totally disabled, unless first having obtained an evaluation through vocational rehabilitation services, which are limited to 52 weeks and may be extended in certain circumstances.
11. And, a formula will be established that limits claims for legal services based on the type of case and disability. ❑

---

[a] http://www.oklegislature.gov/BillInfo.aspx?Bill=sb878

Additional Resources: http://www.workerscompensationok.com/ and http://www.owcc.state.ok.us/

Everything's On Loan

Hanna Saadah, MD

I borrowed all my atoms from the earth
And nature mixed and matched my human form
Amidst the constant death and vibrant birth
The heavens loaned me soul and made me warm.

My knowledge comes from years of human strife
My energy from mother earth and sun
My intellect, my nature, and my life
Are shaped and touched and changed by everyone.

My dwellings come from woods and stones and mines
All borrowed like myself and not my own
Nor do my children nor these very lines
Belong to me, no everything's on loan.

But then I loved you and began to see
My thoughts, my feelings, do belong to me. ❑

I Wish Someone Had Told Me

Lisa Krieger, a science and medicine writer for the San Jose Mercury News, published an article describing the death of her 88 year-old-father – a death that was prolonged, at a cost of $323,000, despite his "do not resuscitate" and "desire for a natural death" directives. Ms. Krieger found herself "in the midst of a medical nightmare"… "the doctors offered hope, saying there is 'a decent chance we could turn it around'." Each attempt failed; he died four days after the heroic measures ceased. After reading her article, Daniel Callahan, bioethicist and cofounder of the Hastings Center, whom Ms. Krieger had interviewed, invited her to share "what she wished she had known." Following are excerpts from that interview, which was published February 12, 2012, online in Bioethics Forum. (Editor's note: Her comments have been edited for brevity. The Trial of "Death by Medicine": An Interview with Lisa Krieger is at http://www.thehastingscenter.org/bioethicsforum/.)

Where are we headed with all this?" … Let's assume all this crazy treatment works – what does his future look like? Skilled nursing? What is long-term wound care like? How much pain and suffering will it entail? Will he be able to walk? What might his mental state be?

I wish someone had told me the range of choices…We can do everything. Or we can do some things, but not others. Or we can do nothing, but keep him comfortable. Stopping isn't doing nothing. Stopping can be a gift.

In word choice, there's a way to shift the blame, and enable people to let go. Maybe saying, "Modern medicine is great, but it just isn't good enough right now to fix this, no matter how hard we try. We've run out of good options. It's just too tough a problem." Then describe what palliative care can provide – that it actually is doing something. That the loved one will not feel distress. That pain can be controlled. Support the heck out of them. My readers said that doctors suddenly "abandoned ship" when they stop the rescue. They said they felt abandoned. And guilty. If we're going to change the culture, we need to honor saying goodbye. ❑

Give sorrow words; the grief that does not speak whispers the o'er-fraught heart and bids it break.

William Shakespeare

Our Unrealistic Attitudes about Death, through a Doctor's Eyes

Craig Bowron

I know where this phone call is going. I'm on the hospital wards, and a physician in the emergency room downstairs is talking to me about an elderly patient who needs to be admitted to the hospital. The patient is new to me, but the story is familiar: He has several chronic conditions — heart failure, weak kidneys, anemia, Parkinson's and mild dementia — all tentatively held in check by a fistful of medications. He has been falling more frequently, and his appetite has fallen off, too. Now a stroke threatens to topple this house of cards.

The ER physician and I talk briefly about what can be done. The stroke has driven the patient's blood pressure through the roof, aggravating his heart failure, which in turn is threatening his fragile kidneys. The stroke is bad enough that, given his disabilities related to his Parkinson's, he will probably never walk again. In elderly patients with a web of medical conditions, the potential complications of any therapy are often large and the benefits small. It's a medical checkmate; all moves end in abdication.

I head to the ER. If I'm lucky, the family will accept the news that, in a time when we can separate conjoined twins and reattach severed limbs, people still wear out and die of old age. If I'm lucky, the family will recognize that their loved one's life is nearing its end.

But I'm not always lucky. The family may ask me to use my physician superpowers to push the patient's tired body further down the road, with little thought as to whether the additional suffering to get there will be worth it. For many Americans, modern medical advances have made death seem more like an option than an obligation. We want our loved ones to live as long as possible, but our culture has come to view death as a medical failure rather than life's natural conclusion.

These unrealistic expectations often begin with an over estimation of modern medicine's power to prolong life, a misconception fueled by the dramatic increase in the American life span over the past century. To hear that the average U.S. life expectancy was 47 years in 1900 and 78 years as of 2007, you might conclude that there weren't a lot of old people in the old days — and that

modern medicine invented old age. But average life expectancy is heavily skewed by childhood deaths, and infant mortality rates were high back then. In 1900, the U.S. infant mortality rate was approximately 100 infant deaths per 1,000 live births. In 2000, the rate was 6.89 infant deaths per 1,000 live births.

The bulk of that decline came in the first half of the century, from simple public health measures such as improved sanitation and nutrition, not open heart surgery, MRIs or sophisticated medicines. Similarly, better obstetrical education and safer deliveries in that same period also led to steep declines in maternal mortality, so that by 1950, average life expectancy had catapulted to 68 years.

For all its technological sophistication and hefty price tag, modern medicine may be doing more to complicate the end of life than to prolong or improve it. If a person living in 1900 managed to survive childhood and childbearing, she had a good chance of growing old. According to the Centers for Disease Control and Prevention, a person who made it to 65 in 1900 could expect to live an average of 12 more years; if she made it to 85, she could expect to go another four years. In 2007, a 65-year-old American could expect to live, on average, another 19 years; if he made it to 85, he could expect to go another six years.

Another factor in our denial of death has more to do with changing demographics than advances in medical science. Our nation's mass exodus away from the land and an agricultural existence and toward a more urban lifestyle means that we've antiseptically left death and the natural world behind us. At the beginning of the Civil War, 80 percent of Americans lived in rural areas and 20 percent lived in urban ones. By 1920, with the Industrial Revolution in full swing, the ratio was around 50-50; as of 2010, 80 percent of Americans live in urban areas.

For most of us living with sidewalks and street lamps, death has become a rarely witnessed, foreign event. The most up-close death my urban-raised children have experienced is the occasional walleye being reeled toward doom on a family fishing trip or a neighborhood squirrel sentenced to death-by-Firestone. The chicken most people eat comes in plastic wrap, not at the end of a swinging cleaver. The farmers I take care of aren't in any more of a hurry to die than my city-dwelling patients, but when death comes, they are familiar with it. They've seen it, smelled

it, had it under their fingernails. A dying cow is not the same as a person nearing death, but living off the land strengthens one's understanding that all living things eventually die.

Mass urbanization hasn't been the only thing to alienate us from the circle of life. Rising affluence has allowed us to isolate senescence. Before nursing homes, assisted-living centers and in-home nurses, grandparents, their children and their grandchildren were often living under the same roof, where everyone's struggles were plain to see. In 1850, 70 percent of white elderly adults lived with their children. By 1950, 21 percent of the overall population lived in multigenerational homes, and today that figure is only 16 percent. Sequestering our elderly keeps most of us from knowing what it's like to grow old.

This physical and emotional distance becomes obvious as we make decisions that accompany life's end. Suffering is like a fire: Those who sit closest feel the most heat; a picture of a fire gives off no warmth. That's why it's typically the son or daughter who has been physically closest to an elderly parent's pain who is the most willing to let go. Sometimes an estranged family member is "flying in next week to get all this straightened out." This is usually the person who knows the least about her struggling parent's health; she'll have problems bringing her white horse as carry-on luggage. This person may think she is being driven by compassion, but a good deal of what got her on the plane was the guilt and regret of living far away and having not done any of the heavy lifting in caring for her parent.

With unrealistic expectations of our ability to prolong life, with death as an unfamiliar and unnatural event, and without a realistic, tactile sense of how much a worn-out elderly patient is suffering, it's easy for patients and families to keep insisting on more tests, more medications, more procedures.

Doing something often feels better than doing nothing. Inaction feeds the sense of guilt-ridden ineptness family members already feel as they ask themselves, "Why can't I do more for this person I love so much?"

Opting to try all forms of medical treatment and procedures to assuage this guilt is also emotional life insurance: When their loved one does die, family members can tell themselves, "We did everything we could for Mom." In my experience, this is a stronger inclination than the equally valid (and perhaps more honest) admission that "we sure put Dad through the wringer those last few months."

At a certain stage of life, aggressive medical treatment can become sanctioned torture. When a case such as this comes along, nurses, physicians and therapists sometimes feel conflicted and immoral. We've committed ourselves to relieving suffering, not causing it. A retired nurse once wrote to me: "I am so glad I don't have to hurt old people any more."

When families talk about letting their loved ones die "naturally," they often mean "in their sleep" — not from a treatable illness such as a stroke, cancer or an infection. Choosing to let a loved one pass away by not treating an illness feels too complicit; conversely, choosing treatment that will push a patient into further suffering somehow feels like taking care of him. While it's easy to empathize with these family members' wishes, what they don't appreciate is that very few elderly patients are lucky enough to die in their sleep. Almost everyone dies of something.

Close friends of ours brought their father, who was battling dementia, home to live with them for his final, beautiful and arduous years. There they loved him completely, even as Alzheimer's took its dark toll. They weren't staring at a postcard of a fire; they had their eyebrows singed by the heat. When pneumonia finally came to get him, they were willing to let him go. ❑

Craig Bowron, MD is a hospital-based internist in Minneapolis. This article was published in the Washington Post on February 17. It is reprinted with permission.

Patients Choosing Hospice Care

Almost 42 percent of all deaths in the United States occurred under hospice care in 2010, according to the National Hospice and Palliative Care Organization (NHPCO). An estimated 1.58 million patients received hospice services in 2010. The median time people spent in hospice care before dying was about 20 days. Sixty-six percent of hospice patients died in their homes, 42 percent in a private residence other than their own homes, 21 percent in a "hospice house" and 18 percent in nursing homes. Hospice patients died mostly of cancer (35.6 percent), followed by heart disease (14.3 percent). The Medicare hospice benefit, enacted in 1982, is the major source of funding for hospice care. The report, Hospice Care in America, 2011 Edition, is available at http://www.nhpco.org/files/public/statistics_research/2. ❑

Director's

DIALOGUE

"The Truth about Dogs..."

A person can learn a lot from a dog, even a loopy one like ours. Marley taught me about living each day with unbridled exuberance and joy, about seizing the moment and following your heart. He taught me to appreciate the simple things – a walk in the woods, a fresh snowfall, a nap in a shaft of winter sunlight. And as he grew old and achy, he taught me about optimism in the face of adversity. Mostly, he taught me about friendship and selflessness and, above all else, unwavering loyalty.

John Grogan, *Marley and Me, 2005*

Each time I notice Marley and Me, the 2008 movie, will be on television, I have some reticence about reliving Marley's life story with his human family. While the dog's antics elicit both horror and laughter, I also remember I need a tissue by the story's end. Being the "mom" of two dogs, I find many situations when I can relate to the discombobulation experienced by Marley's owners.

John and I share our home with two dogs, Fergie and Ted. It is an understatement to describe Fergie, a Cairn terrier, as independent. She is affectionate, but only when it is *her* idea. She responds to commands, but only when it is convenient for *her*. Catch my drift? Fergie is a "big" dog in a small dog's body and has a bark that announces guests at the door – wanted or unwanted. Trusting her without a leash would be inadvisable. I chose the name Lady Ferguson because Ferguson is my maiden name, but I assure you there is nothing ladylike about her! Ten years ago, she came into our lives one week before Christmas, following the death of my first Cairn. Loving the tenaciousness of the breed, only another "Toto" dog would help to heal the hole left in my heart. Even as she has aged, Fergie still believes she is in charge of the house ... and of Ted, the Bichon Frise.

We rescued Teddy Bear almost seven years ago, and he immediately adopted John as his "human." His first owner was an

elderly woman who could not manage a boisterous male puppy. His first attempted adoption was to a man who must have abused him. Sensing something was not right, she asked that Teddy Bear be returned to her. His once-gorgeous white fluffy coat was filled with burrs. Following a second attempt to keep him, she asked the dog trainer to find a good home for her beloved pet. That dog trainer is a friend who knew I was considering a companion for Fergie. It only took one look at the scared, anxious dog and my heart melted. The rest is history...

Several months later, I called his original owner to reassure her that her "Teddy Bear" had found a safe, loving home. She told me that when she asked him for a "kissy kiss" he would oblige her with a wet kiss on the cheek. Following our conversation, I decided to use those words to see if it would elicit a happy memory from him. It must have worked because his head spun around as if he was searching for the first person he ever loved! I wish I could greet each morning with Ted's level of cheerfulness. While he is affectionate with someone he knows, he will shy away from strangers and sometimes nip at their heels. This behavior has lessened with time as he has learned to trust once again.

Studies have confirmed pet owners enjoy several health benefits, such as better mental health, a boost to one's immunity and lowering of blood pressure. Several years ago, my Mother's Day present from the dogs was a stack of note cards with their picture on it. Each time I look at Ted nuzzling Fergie's neck, it brings a smile to my face as I recall some of their antics or how they "almost" caught the squirrel before it scampered up the tree. No matter how long or challenging my day might have been, I arrive home to exuberant barking announcing my arrival and two wagging tails waiting at the door.

We can learn a lot about life from our pets, and I cannot envision life without one sharing my home. Roger Caras, the former host of the Westminster Kennel Club Dog Show, once said, "Dogs are not our whole life, but they make our lives whole." That sums it up for me! Have a great summer... ❑

JanaTimberlake, CAE, Executive Director

A GOOD DEATH

William Truels, MD

I was sitting in the doctor's lounge waiting for my case to start when Herb walked in with a big smile on his face.

"Why so happy, Herb?" I asked.

"Well, Dr. Truewater, I just finished planning my grave marker," Herb grinned. "I don't want my family forced to do any last minute planning when I pass. Martha and I have a double gravestone, with our birthdates already engraved in marble."

"Isn't that a little premature, Herb?" I asked. "I mean, you're still alive and practicing plastic surgery."

"True enough, but you never know what can happen, especially at our ages – Martha and I are in our sixties now. And a double gravestone saves money – when you kick the bucket, all they have to do is chisel in a few numbers and dump you in the ground! "With a double gravestone, you and your wife are permanently united in death, just as you were united in life," Herb added.

"I don't know if I want to be permanently united in death," I quipped. "I might want to run around a little after I die. I'm not ready for a land of milk and honey – I'm a diabetic with lactose intolerance!"

"Besides, Herb, 60 is the new 40. Why, what would happen if you and Martha got divorced – it's kind of hard to cut a marble gravestone in half and move it to another plot!"

"We're not getting divorced, Dr. Truewater," Herb answered. "I'm way past my mid-life crisis. Nowadays, I'm just looking for a good death."

"A good death?" I replied. "That sounds like an oxymoron. I mean, death can't be a good thing. As doctors, we make a business out of preventing death and prolonging life. Why, I remember one Filipino resident during my training at Cook County who never wanted to let anyone die on his shift. You hated to follow him on duty!"

"We don't prevent death, Dr. Truewater," Herb answered. "As physicians, we can only delay death. When you're young,

you're like those novice pilots who think they're invincible. After you've been in battle for a few years, you begin to realize your own mortality!"

"True enough," I answered. "But then, what's a good death?"

"According to the hospice care team, a good death is when you make the terminally ill patient as comfortable as you can, with as little pain as possible, with your final plans in order."

"You mean, like funeral arrangements and legal documents in order?" I added.

"Yes," Herb replied. "But it also means being at peace with yourself in those final days – resolve family conflicts as best you can. Resolve personal conflicts. If possible, you want to have a chance to say good-by to those you love. And leave a legacy. Each person leaves some sort of legacy behind – something he or she wants to be remembered for."

"So, what's your legacy going to be, Herb?" I asked.

"I'd like to be remembered as a good plastic surgeon … someone who helped children overcome birth defects, like a cleft palate," Herb replied. "But, more importantly, I'd just like to be remembered as a good person – a little argumentative and confrontational, I admit, but basically a good person."

"That's very good, Herb," I answered, "but how do you know when your time has come?"

"Easy," Herb replied. "There're ten signs that death is near."

"Ten signs of death?" I asked. "What are they?"

"The first one is loss of appetite," Herb began.

"I haven't been that hungry lately myself," I commented. "What else?"

"Secondly, excessive fatigue and sleep," Herb said.

"I've been kind of tired lately myself," I added, getting a little worried. "I slept fourteen hours last night."

"Thirdly, increased physical weakness can be a sign of impending death," Herb added.

"I've been having trouble doing more than five push-ups," I stated, getting a little nervous and quickly checking my pulse for tachycardia or any extra beats. "Besides, my cardiologist says my aortic stenosis shouldn't be a problem for another ten years. And I've never had any symptoms—never had chest pain, dizziness, or sudden death, that I know of."

"Mental confusion or disorientation is another terminal sign," Herb added.

"I couldn't find my car in the parking lot yesterday after shopping four hours with my wife," I commented. "I had to use my key fob to sound the horn. But I'm sharp as a tack."

"Fifthly, labored breathing can be a terminal event," Herb said.

I sighed deeply and checked my nail beds. I was showing all the signs of a dying person.

"I notice I'm getting a little short of breath climbing the stairs at Holy Christian Hospital these days," I replied. "I'm using the elevator more. But my pulmonologist says my asthma and chronic bronchitis are under control."

"Social withdrawal is the sixth sign of a dying person," Herb replied.

"I'm getting to where I don't like parties anymore," I added. "Sometimes I just want to sit in front of the TV and watch a good movie instead of going out to a bunch of noise and commotion. My psychiatrist says that's not a problem."

"Changes in urination are the seventh sign of a terminally ill person, sometimes with urinary dribbling," Herb added.

"That's getting a little too personal, Herb," I replied angrily. "My urologist says I'm doing just fine. He says it's like you take your finger off the tip of a straw—there's always a little dribbling. What are some other signs of impending death?" I asked nervously.

"Swelling of the feet and ankles is the eighth sign of terminal illness," Herb added.

"I wear support hose to solve that problem," I answered. "My cardiologist says I have a good ejaculation fraction."

"Coolness in the tips of the fingers and toes is the ninth terminal sign," Herb replied.

"Well, it was a little cold this morning walking through the parking tunnel under the giant rotating cross at Holy Christian, and my fingers were a little numb but they're fine now," I said confidently.

"Mottled veins with bluish mottling is the tenth and final sign of impending death," Herb added.

"Well, I've had varicose veins with mottling for years," I replied defensively. "I'm just fine."

"I find it hard to believe that I could be in the final days or hours of my life," I told Herb, even though I'm positive for all ten signs. "But I have outlived both my Father and Mother. Maybe

I'm in my final days and I just don't realize it. I know the medical students look at me like I'm some sort of historic figure when I talk about practicing medicine in the good old days, before laparoscopic surgery, lasers, electronic medical records and socialized medicine. They think I'm a relic."

"It's later than you think, Dr. Truewater," Herb added. "I can remember when plastic surgeons didn't use any plastic!"

"Besides, you just told me you've got a cardiologist, a pulmonologist, a urologist, and a psychiatrist, in addition to your family doctor. Too many doctors are not a good sign. Dr. Truewater, you need to think seriously about retiring from surgery and planning for a good death."

"You may be right, Herb," I quipped, as I put on my mask and headed back to surgery. "But I'd like to work as long as I can. A good death for me is when they have to pry the scalpel from my cold, dead fingers!" ❑

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
Executive Director
Telephone: 631-2601

Help Improve the Bulletin

Do you have an interesting hobby? Do you write poetry? Are you an amateur photographer? Are you an artist? Do you volunteer on medical mission trips? Are you a mountain climber? Share your works and stories with your colleagues! The editorial staff welcomes – invites – your articles, poetry, letters and artwork for inclusion in the Bulletin. You may email them to llarason@o-c-m-s.org or mail them to Linda Larason, OCMS, Suite 2, 313 NE 50th Street, Oklahoma City, OK 73105. We look forward to hearing from you! ❑

PROFESSIONAL REGISTRY

Physicians interested in advertising in the Professional Registry should contact the Executive Office at 702-0500.

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.*

Shahan A. Stutes, M.D.*

Gregory M. Metz, M.D.*

Laura K. Chong, M.D.*

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

750 N.E. 13th St.

Oklahoma City, OK 73104

235-0040

OKLAHOMA INSTITUTE OF

ALLERGY & ASTHMA

EVIDENCE-BASED

ALLERGY & ASTHMA CARE

Amy L. Darter, M.D.*

Bret Haymore, M.D.*

**Diplomate American Board of Allergy & Immunology™*

1810 E. Memorial Rd.

Oklahoma City, OK 73131

(405) 607-4333

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.

ENDOCRINOLOGY-METABOLISM-DIABETES

THE ENDOCRINE GROUP
Comprehensive Endocrinology
Nuclear Thyroidology
Cheryl S. Black, M.D.
James L. Males, M.D.
Roger E. Smith, M.D.
Muneer A. Khan, 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 Smith, M.D., F.A.C.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
Vaginal 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
MERCY ONCOLOGY
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

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 & 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

PREMIER FINANCIAL SOLUTIONS

... from a Healthcare Specialist serving in Oklahoma & across the Nation.

- *Healthcare Specialist for over 35 years*
- *Serving practices in 36 states*
- *Partnering with local banks*

SNB

OKC: 6301 Waterford Blvd., Suite 101
8101 S. Walker Ave., Suite B
EDMOND: 1440 S. Bryant Ave.

Since 1894 • 405.427.4000 • www.banksnb.com
A Division of Stillwater National Bank • Member FDIC

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