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OKLAHOMA COUNTY MEDICAL SOCIETY

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The Oklahoma County Medical Society

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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

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Inaugural Photos May Be Purchased

Gennesse Photo and Party Pix took candid photographs at the OCMS Inaugural. These included some taken during the program, others of guests at tables, and several group photos of medical school classes. They are available for purchase. Log onto www.geneseephoto.com/static/index.htm, click on "Event Images" on the top left of the screen, scroll down the list of Recent Events to OCMA-Inaugural Ball-1.15.11 and click on it. The proofs will open. At the bottom of each page of photos, click on "next" to go to the next page. When you see a photo you want to order, click on it. You will be able to choose the size you want to order, add it to your cart, and continue shopping or check out. Order as many or as few as you want. ❑

Doctor of the Day

Serving as Doctor of the Day at the Capitol during legislative sessions provides an opportunity for physicians to interact with those who make decisions that can have profound impact on the practice of medicine in this state – and April provides an opportunity for you to volunteer to be a Doctor of the Day. Hours are Monday through Thursday, usually 8:00 a.m. until around 5:00 p.m. or until the legislature adjourns, which is often earlier on Thursdays. Doctors of the Day are introduced in both the House and the Senate chambers as sessions open. Call the OCMS office, 702-0500, to choose your Day in April to "watch sausage being made," as the saying goes. ❑

About the Cover

The reproduction on the cover of the Bulletin this month is from a 2006 greeting card design by the artist Lucinda Cornish. She is an Oklahoma artist born in Tulsa who currently focuses on botanical watercolors. She writes that the handmade greeting cards are a "liberation" from the usual detailed botanical illustrations. Her art can be viewed at Pickard Art gallery and both locations of Pirate's Alley in Oklahoma City. We are grateful to her for permission to use her design. ❑

The Editor

OCMS Family Day
Down on the Farm
(in the City)

Mark your calendar … save the date … join your colleagues for BIG TRUCK tacos, music, dancing, children's activities, and old fashion fun. The only agenda will be to get to know your OCMS family better and have a good time.

Please join us Sunday, April 17, 2011, at the Harn Homestead, 1721 North Lincoln Boulevard. We will begin at 2:00 p.m. and end at 5:00 p.m. If it is raining, we will move into the barn – but we're holding out for a lovely spring day.

Watch your home mailbox for the invitation but please be sure to RSVP (702-0500 or llarason@o-c-m-s.org). ❑

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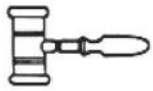
President's Page



Robert N. Cooke, MD

What Happens Now?

As I begin writing this, it's a cold day in January and I can't help but think that Spring is just beginning as this is published. I will have been to Washington to the National Advocacy Conference, which leads me to the topic for this month: Medicare and health care reform. Most of you know that Congress has passed and the President has signed into law legislation that averts the 25 percent cuts in Medicare reimbursements that was scheduled to occur on January 1. Your payments for Medicare services will remain the same as the 2010 levels for this year. This legislation translates into $220 million dollars for Oklahoma physicians that would have been cut —that's $30,000 per physician. This allows for our Medicare patients to have access to care and allow us to continue to operate our businesses as usual.

So, what happens now? There is broad bipartisan agreement that the SGR formula presently used is flawed and needs to be reformed. The real question is, how? With the bitterly partisan politics at the present and the large federal deficit, I doubt that a quick solution is in the offing. The National Commission on Fiscal Responsibility and Reform made an interesting proposal. The Commission recommended that Medicare payments remain unchanged through 2013. In 2014, the payments would be cut one percent, the SGR reimbursement formula revamped and a new payment system implemented in 2015. Should this not occur, the SGR model would be reinstituted based on the 2014 reimbursement. That, I fear, would lead to draconian cuts for physicians. All the while, we continue to face increases in expenses. As many of you may remember, the Commission's recommendations didn't

receive the required 14 votes (out of 18) that would have allowed Congress to consider and perhaps vote on the proposals, which included a "fix" for reducing the national debt. Perhaps this will at least stimulate discussion that will produce substantive debate.

The two political parties have widely differing views on health care legislation. The present move to repeal the health care legislation probably won't succeed, yet Democrats are already talking about "tweaking" the law. Representative James Lankford had an editorial in the paper recently that touted the Republican efforts to propose new health care legislation. Whatever will happen will surely be partisan despite the "new civility" in Congress. I believe it is our duty as physicians to be involved as much as we can. Contact your Representative or Senator with your views. I'd also encourage you to support whatever national organizations you choose to be members of. Most have legislative lobbyists or PACs that can represent your views. In my opinion, it is our duty to advocate for our patients' safety and access to medical care as well as trying to perpetuate the health care establishment that employs a multitude of Americans.

It's a critical time in the United States and we are part of the solution. Let's be a significant voice and advocate in the solutions. ❑

Proposal Seeks Local Control of Tobacco Regulations

If it becomes law, HB 2135, introduced by Speaker Kris Steele, will modify the Smoking in Public Places and Indoor Workplace Act to let local communities control where smoking is and is not allowed. Current law prohibits regulations that exceed those in state law – known as "preemption." Oklahoma is one of only two states that prevent municipalities from establishing their community's regulations.

If you support this change in the law, contact your legislators and encourage them to vote to approve HB 2135. To determine who your representative and senator are, and how to contact them, log on to http://www.capitolconnect.com/Oklahoma. ❑

In Memoriam

William L. Hughes, MD, FACP
1932 -2011

William (Bill) Lyon Hughes was born in Kearney, Nebraska. He moved to Oklahoma as a small child and lived in Clinton, Lawton, Oklahoma City, Enid, and Tulsa, in addition to Bolivar and Springfield, Missouri. He graduated from Will Rogers High School in Tulsa, completed undergraduate studies at Northwestern University in Evanston, Illinois, and attended the University of Oklahoma School of Medicine, graduating in 1957. He did his internship at the University of Virginia and returned to the University of Oklahoma hospitals, where he was a resident in internal medicine, a research fellow in hematology, and a chief resident in internal medicine. He completed his postgraduate training in 1962.

He practiced hematology-oncology from 1962 until his retirement December 31, 1997, originally joining the Oklahoma City Clinic and later joining Ted Clemens in a joint practice for many years before becoming a solo practitioner. He was joined in practice by Craig Reitz in 1985 until his retirement. He remained closely associated with Ted Clemens, Jerry Vannatta, Doug Folger, Mark Johnson, Houston Jameson, and Jay Benear midway through his practice career. He eventually became an active staff member of Mercy Hospital and a member of Cancer Care Associates.

He was a member of Alpha Omega Alpha and a Fellow in the American College of Physicians. He was also a member of the American Society of Internal Medicine; both the American Society of Hematology and the American Society of Clinical Oncology from their earliest days; Southwest Oncology Group; the New York Academy of Science; and the Oklahoma County, State and

American Medical Associations, chairing the OSMA Council on Legislative Affairs during the 1980s. He was governor of the Oklahoma Chapter of the American College of Physicians from 1983 to 1987.

He was Clinical Professor of Medicine at the OU College of Medicine and was Chairman of the Volunteer Faculty Advisory Committee from its inception until his retirement. He was the first official chairman of the OU Medical School College of Admissions and served on the Board of Admissions for many years. He was an energetic supporter for the College of Medicine, and very much enjoyed the teaching of housestaff and medical students. He had close relationships with Stewart Wolf, Bob Bird, James Hammarsten, Solomon Papper, and Pat McKee.

He was on active staff of Wesley Hospital before it became Presbyterian Hospital. He was influential in the construction of the current Presbyterian Hospital, and served on or chaired numerous committees for over 25 years. Later in his career, he moved to Mercy Hospital, where he served as Chief of Staff from 1995 to 1997. He received the Laureate Award in Internal Medicine from the American College of Physicians, and was honored by the OU College of Medicine Alumni award as Physician of the Year in 2000.

Dr. Hughes' community interests were numerous, but he is best known for establishing the art program at Presbyterian Hospital, including introducing many local artists to the public on the "yellow wall" and the annual "Evening of Art" show. He was an avid collector of western and American Indian art, and shared many of these with patients in his office and exam rooms.

Bill Hughes was an avid bird hunter and fisherman, which he continued until near the time of his death.

In terms of being a friend and advocate of the OU college of Medicine, there are few physicians in private practice in Oklahoma who rivaled his support. He was instrumental in the original bone marrow transplant program at both the University of Oklahoma and Presbyterian Hospital, and some of this cooperative work was published in the Journal of Clinical Oncology and other publications in the 1980s. Many of the first 15 years of hematology-oncology fellows from the University of Oklahoma rotated through the program with Bill Hughes and/or

Ted Clemens at Presbyterian Hospital.

On a personal note, Dr. Hughes very much cared for his patients, and he was very much loved by his patients for the extraordinary time he spent with them. His close friends will always remember his Christmas in July parties. He was an extremely hard worker, usually finishing rounds late in the evening. He was never pretentious, a fact to which many of his closest friends and hunting/fishing buddies could attest. He had a very laid back style in dealing with patients and people, but in the practice of medicine he personally demanded excellence–a trait an occasional medical student learned the hard way. He was the ultimate advocate for the medical school and hematology-oncology program. I marveled at how he kept up to date in medicine for his age, and it was not unusual to find evidence on a Saturday or Sunday afternoon when we were practicing together where he had been reading the latest JCO, NEJM, and reviewing the MSKSAP well into his late 60s. Medicine was his life. Even after retirement, he continued to work on a part-time basis with and for his former partners, covering oncology patients in the clinic in what is affectionately called "incident to" service, which he and the personnel he touched enjoyed greatly. He felt a physician should go home each day only when all of the patients had received that physician's best effort. He worried about the potential adverse effect of shift work in medicine. He worried about physicians who would attempt to auscultate his or anyone's heart through several layers of clothing. Despite all of those concerns, he remained the eternal optimist about the practice of medicine, regarding it as the noblest of professions. Bill was a lifelong and tireless advocate of academic medicine and the training process for physicians. One should also note that, like the iconic William Osler who had an alter ego in Egerton Yorick Davis, Bill had a mischievous sense of humor, and many will smile remembering his tricks, jokes, not-so-secret societies, quick repartee and sharp sense of humor. ❑

Have courage for the great sorrows of life
and patience for the small ones;
and when you have laboriously accomplished your daily task,
go to sleep in peace.

Victor Hugo

Jay P. Cannon, MD
Rhinehart Award Recipient

Dr. Jay P. Cannon received the Don F. Rhinehart, MD Community Service Award in recognition of his many contributions to the family of medicine.

Dr. Cannon graduated from the OU College of Medicine in 1970 and completed his residency in surgery there in 1975. He joined the faculty, serving for nine years before moving to the Oklahoma City Clinic-Presbyterian where he practiced for 13 years. In both locations, residents in both surgery and family medicine rotated through his clinics. He moved his practice to Baptist and Deaconess hospitals in 1998 and continues in that location. At Baptist, he has served as Chair of the Department of Surgery and is currently Chief of Staff. He was Chairman of the Board of University Hospital in the 1970s, prior to its transfer to the Department of Human Services. He has served as both President and Treasurer of the OU Medical School Alumni Association. He was the first President of the John A. Schilling Surgical Society and has been active in the American College of Surgery. He has also been active in the Oklahoma State Medical Association and the Oklahoma County Medical Society, which he served as president in 2007

In late 2003, the OU Level I Trauma Center became overwhelmed and was at risk of closing. Jay agreed to lead an ad hoc committee that developed a community wide emergency call rotation system to offload Level II and III injuries to community hospitals. That system enabled the state's only Level I Trauma Center to remain open. Six years later, the Regional Trauma Advisory Board has authority over the system, but Jay and members of the original committee continue to meet as a subcommittee of the Region 8 RTAB and the OCMS office has assumed responsibility for circulating the call schedule among the hospitals. The process sounds simple, but it wasn't. With the committee composed of community hospital administration representatives and specialty physicians from throughout the City, emotions ran high, meetings were tense, and the road was often bumpy. But today, the system is recognized as a model for other states. Dr. Cannon provided the steady leadership necessary to make it happen. ❑

Dean's Page

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

Because of the constantly increasing demands and societal expectations placed on them, America's medical schools and academic medical centers have become huge enterprises whose sources of operational funds are far different than was the case before the 1990s. This month, I want to provide you an overview of our budget and the sources of operational funds for the University of Oklahoma College of Medicine.

For fiscal year 2010 (ended June 30, 2010), the College of Medicine had a total operating budget of $585 million. The operating budget for the Oklahoma City campus was $482 million and for the Tulsa campus it was $103 million. Below is a breakdown of the categories of the sources of the funds by percent for the College's FY 2010 operational budget:

- Clinical Practice Revenue – 50.0 percent
- Afiliated Hospitals professional services contracts, mission support – 16.1 percent
- Grants & Contracts, including research – 13.5 percent
- State Appropriations – 8.0 percent
- Residency Programs transfers (through hospitals) – 5.8 percent
- Tuition – 3.2 percent
- Gift Income – 1.9 percent
- Endowment Funds – 1.5 percent

While we are called a state-supported medical school, it is more accurate to speak of us as a "state-assisted" medical school. State appropriations as a percent of the budget have been declining for years, even though the actual state dollars have been cut only modestly, and in FY 2010 accounted for only 8.0 percent of the

total (FY 2008, 10.3 percent and FY 2009, 10.4 percent).

The largest source of funds in our operating budget comes from direct faculty effort. This includes faculty clinical practice, professional service contracts, and research grants and contracts which together account for 63.5 percent of the college's funds in FY 2010. Clinical funds generated through faculty practice and professional services cover physician faculty compensation costs, clinical operations personnel salaries, all the usual overhead costs of running a clinical practice, assessments for the "Dean's tax," a central University overhead charge, and department practice funds that are used to underwrite some of the costs of residency education. Because the vast majority of the College's extramurally funded research occurs on the Oklahoma City campus, if one considers only the main campus in Oklahoma City the percentage of funds derived from research grants and contracts is higher than what is reflected above with corresponding adjustments in the other percentages. Tuition and fees for students generated only 3.2 percent of the operating funds. Reflecting the national economy of the past two to three years, the endowment funds have dropped in value over the past few years, accounting for 3.1 percent of the operating budget in FY 2005 compared to 1.5 percent for FY 2010.

How does this breakdown compare to other public medical schools? In general, we have a lower percent provided by state appropriations. This number is also substantially lower in total dollars (by about 50 percent on average) than schools in all of our surrounding states and our institution has a higher percentage dependence on clinical revenue. It's also true that all medical schools, public and private, have increased their dependence on clinical revenue significantly over the past two decades. I hope this brief overview gives you a better idea about the financial resources with which we operate the medical school and all its various functions and components. ❑

Fear less, hope more; eat less, chew more; whine less, breathe more;
talk less, say more; hate less, love more; and all good things are yours.
Swedish Proverb

2011 Inaugural Smashing Success

The more than 200 OCMS members and guests gathered at Dr. Cooke's Inaugural Dinner and Dance had such a good time they're already looking forward to 2012! The ballroom was beautiful, the food was delicious, the band was lively, and the guests were exuberant. If you missed it, you won't want to make that mistake again!

(left, l-r) Jeff, Bob, Diane, Everette, and Tommy Cooke at the Inauguration of Robert N. Cooke, MD, 111th President of the OCMS.

(right) Dr. Cooke delivers his Inaugural address.

(left) Dr. Larry Bookman, 2010 OCMS President presents the Don F. Rhinehart, MD Community Service Award to Dr. Jay P. Cannon

(l-r) Drs. Tom Flesher, William Miller, Ralph Shadid, Jerry Brindley, Robert Cooke, Larry Bookman, Tomás Owens, Julie Strebel Hager, Randy Allen, Sherri Baker, Dan Donnell, Doug Folger, Tim Hill, and Wynter Kipgen, the 2011 OCMS Board of Directors. Not pictured are Drs. Donald Brown and David Holden.

2011 Officers, (l-r) Drs. Tom Flesher, Larry Bookman,Julie Strebel Hager, Bob Cooke, and Tomás Owens.

(on left) 2009 OCMS President Dr. Teresa Shavney, who served as emcee for the evening, presents the President's plaque to 2010 President Dr. Larry Bookman

(on right) Kathy Bookman receives the 2010 "First Lady"gift from Dr. Shavney. Kathy will serve as the 2011 OCMS Alliance President.

(on left) Linda Larason, Managing Editor of the Bulletin, receives the 2010 volume of Bulletins from Dr. Larry Bookman. Editor-in-Chief Dr. James Hampton was not able to attend the party.

New Members

Dale W. Bratzler, DO
(IM)
14000 Quail Springs Pkwy
Kansas City University School of Medicine and Biosciences 1981

Melissa K. Clements, MD
(D)
6301 Watrerford Blvd., #100
University of Utah, College of Medicine 1981

Raymond L. Cornelison, Jr.,MD
(D DMP)
3727 NW 63rd St.
University of Oklahoma
1968

Courtney V. Gray, MD
(EM)
1102 W. MacArthur
University of Oklahoma
2001

Christopher D. Hayes, MD
(FM)
1700 Renaissance Blvd.
University of Oklahoma
2005

Daniel Molina, MD
(FM)
4913 W. Reno Ave.
Uniformed Services University, Bethesda, MD 2004

Prithi S. Reddy, MD
(PD)
600 National Ave.
Medical University of Silesia, Katowice, Poland 2004

Roger E. Smith, Jr., MD
(IM END)
5401 N. Portland, #310
Wake Forrest, Winston Salem NC
1999

Walk the Doc

Walk the Doc is a fun one- or three-mile walk and family event for physicians, medical and resident students, friends of medicine and all their families. It will be from 9 AM to 1 PM Saturday, May 7, 2011, (Walk starts at 10 AM) at Lake Hefner Stars and Stripes Park. The purpose is to demonstrate the commitment of our physicians and their spouses to health and wellness for themselves, their families, and the community. The beneficiary will be Schools for Healthy Lifestyles.

Walk the Doc will encourage physicians and families to be physically active and to lead by example. It will also be a fun and active way to connect with each other. The press will be invited to help us spread the word that the medical community is promoting regular exercise as a way to stay healthy and fight obesity. We look forward to connecting with new and younger members for both OCMS and the Alliance while we have fun and walk "with a purpose."

The event is free! There will be many activities for children, such as clowns, balloon animals, temporary tattoos, kite flying and face painting. There is a basketball net for contests among older children and adults. We welcome dogs on a leash; the kids can enter them in contests. There will be music and entertainment, and special guests and dignitaries will be invited to join us.

OCMS members are recruiting sponsors and soliciting donations such as food and drink, T-shirts or special scrubs, pedometers, water bottles, dog bandanas, etc. If you can help in any of these areas, please let us know. There will also be raffle items, the best of which is an I-Pad! That alone is worth attending!

Please join us and bring your families and office staff. We need to know how many to plan for so please return the registration form on page 35 or register online at www.ocmsalliance.org.

For more information, contact Lori Hill at loriwhill@cox.net, or Diana Hampton, M.D. at d-hampton@sbcglobal.net. See you May 7 at Stars and Stripes Park! ❑

Walk the Doc, Saturday May 7, 2011 9 AM – 1 PM

Pearl of the Month

Johnny B. Roy, MD

Hypogonadism and Cardiovascular Risks

Male hypogonadism is defined as a decline/failure of the testes to produce adequate amount of sex steroid-testosterone. This decline could occur as a normal aging process or could be induced chemically as when treating cancer of the prostate with androgen deprivation therapy (ADT).

Testosterone deficiency is associated with diverse effects in the well being of healthy men. The symptoms may be vague behaviorally and physically. These can include diminished motivation, fatigue, depression, decrease in libido and erectile dysfunction, obesity with/without diabetes mellitus, osteoporosis, and mild anemia. Increasing evidence links low testosterone to the risk of metabolic syndrome. Its role in increasing cardiovascular risk is unquestioned. (Shabsigh, R et al. Cardiovascular issues in hypogonadism. Am. J Cardiol 2005; 96(12B):67M-72M.)

Low testosterone is shown to be associated with severe aortic atherosclerosis (Hak AE, et al. Low levels of endogenous androgens increase the risk of atherosclerosis.V.Clin Endo Metab.2002;87:3632 .)

After adjusting for clinical covariates, low serum testosterone in male veterans was found by Shores et al to be a risk factor for increased mortality (Shores MM et al. Low serum testosterone and mortality in male veterans. Arch Intern Med, 2006,166:1660.)

Several studies have shown that testosterone modulates the immune response to inflammatory cytokines and its deficiency

contributes to increased risk of heart disease. (Malkin et al. The effect of testosterone replacement on endogenous inflammatory cytokines and lipid profiles in hypogonadal men. J. Clin. Endo Metab.2004;89:3313.)

Currently we are faced with a large cohort of men with prostate cancer receiving androgen deprivation therapy (ADT). Contrary to previous views, prostate cancer survivors with no evidence of recurrence can receive testosterone supplementation with practically no risk. (Sarosdy MF. Testosterone replacement for hypogonadism after treatment of early prostate cancer with brachyotherapy. Cancer, 2007; 109:536.)

D'Amico et al described increasing odds of coronary artery disease and myocardial infarction after ADT. (D'Amico et al. Influence of androgen suppression therapy for prostate cancer on frequency and timing of total myocardial infarction. J Clin Oncol. 2007,25:2420.)

In conclusion a significant negative correlation between hypogonadism and coronary artery disease does exist. However management demands clinical acumen when weighing benefits versus risks as is customary in any clinical setting. Thanks for reading. ❑

Heart Disease Costs to Soar

The cost to treat heart disease in the United States will triple by 2030, according to a policy statement published in *Circulation: Journal of the American Heart Association*. The panel estimated future medical costs based on the current rates of disease and used Census data to adjust for anticipated population shifts in age and race. The methods they used did not double count costs for patients with multiple heart conditions, and the estimates do not assume that new discoveries will be made to reduce heart disease. Currently, 36.9 percent of Americans have some form of heart disease; by 2030, approximately 116 million (40.5) will have some form of cardiovascular disease. The largest increases are anticipated in stroke (up 24.9 percent) and heart failure (up 25 percent). Between 2010-30, the cost of care for heart disease (in 2008 dollar values) will rise from $273 billion to $818 billion. Costs associated with lost productivity will also increase: from an estimated $172 billion in 2010 to $276 billion in 2030. ❑

Practice "Standard" Quality Medical Care

And Never Underestimate Medical Personnel Whistleblowers

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

A "whistleblower" is one who reveals misconduct, such as breaking the law, committing fraud or corruption, by the employer or by another business or entity. Fraud can be a violation of the False Claims Act or similar state and local laws. Protected by law, the whistleblower, known as "relator," who exposes fraud on the government can bring a qui tam lawsuit on behalf of the government, and can receive a share of the recovery as a reward.

Medical personnel or physician co-workers may also submit allegations to the Medical Licensing Boards alleging poor quality or "substandard" care by a physician. The physician who retaliates against the whistleblower may confront administrative, civil and criminal liabilities.

In 2007, the Texas Medical Board (TMB) determined that Dr. A, a 58-year-old medical doctor, had failed to adequately supervise a physician assistant in his work at a weight loss clinic and failed to "make an independent judgment" about protocols for treating obesity that were in place there. The TMB restricted his medical license for three years, fined him $1,000, and ordered him to complete continuing medical education in ethics, medical records, and the treatment of obesity.

In April 2009, two registered nurses, G and M, who had worked with Dr. A at Winkler County Memorial Hospital in Kermit, Texas, forwarded to the TMB an anonymous letter along with patient records alleging that Dr. A was practicing substandard medicine. Dr. A contacted the Winkler County sheriff (friend and patient), urging him to trace the letter back to the nurses. The county prosecutor criminally charged both nurses with misuse of official information. Additionally, they were fired by the hospital. The county prosecutor dropped the criminal charge against nurse G. The case against nurse M went to trial in February 2010, because her letter to the TMB

allegedly stemmed from a personal vendetta against Dr. A. The jury found nurse M not guilty.

Both nurses filed a civil suit in federal district court against Dr. A, the Sheriff and other government officials, and the hospital, accusing them of malicious prosecution, violation of state whistleblower law and violation of their free speech rights. In August 2010, the parties settled the case, with the defendants agreeing to give the nurses $750,000.

In June 2010, the TMB acted on the nurses' original complaint and charged Dr. A with multiple offenses, including poor medical judgment, non-therapeutic prescribing, failure to maintain adequate records, overbilling, and witness intimidation. As of December 2010, the TMB case against Dr. A was before a state administrative judge.

Meanwhile, the Texas attorney general's office filed a court complaint stating that:

Dr. A illegally disclosed patient information to the Sheriff to help him track down the authors of the anonymous letter to the TMB, and

That Dr. A disclosed this information so that the complaints against him, which he characterized as harassment, would cease.

On December 21, 2010, Dr. A was arrested by officers of the Texas Attorney General and charged with two 3rd-degree felonies: (1) misuse of official information and (2) retaliation against two nurses who turned him in for substandard care. Each charge is punishable by up to 10 years in prison and up to a $10,000 fine. Dr. A surrendered without resistance, appeared before a district court judge in Winkler County, and was released on a personal recognizance bond, pending trial.

Lesson: Physicians should practice quality, evidence-based, "standard" medical care, and they should never underestimate whistleblowers, especially physician-co-workers. ❑

God grant me the serenity to accept the people I cannot change,
the courage to change the one I can,
and the wisdom to know it's me.

Author unknown,
variation of an excerpt from
The Serenity Prayer" by Reinhold Neibuhr

Insurers Profit on Medicare Float

Private health insurers are making millions covering Medicare patients by investing funds the government sends in advance, but aren't needed immediately, according to a report obtained and reported by the Associated Press. Unlike the federal employee health program, Medicare lets its plans keep the cash. Medicare pays the plans on the first of the month and changing that schedule would require approval from Congress.

The inspector general's audit estimated that Medicare Advantage plans received $376 Million from investment income from advance payments in 2007. The auditor estimated Medicare could have earned $450 million by delaying payment for a few weeks because the Treasury's long-term securities typically pay higher interest than the short-term investments in which the insurance companies invest the funds. Medicare officials maintain those cost savings would not materialize "because the plans would increase their bids to recoup the lost revenue" or "start demanding interest on any funds Medicare owes them." The IG's report states that Medicare could recover the money without Congress passing a new law simply by issuing a "regulation that requires insurance companies reduce their annual bids by the amount they expect to receive from investment earnings." The article notes the Obama administration has "moved to regulate private Medicare plans more closely" than its predecessor, but has not touched the investment

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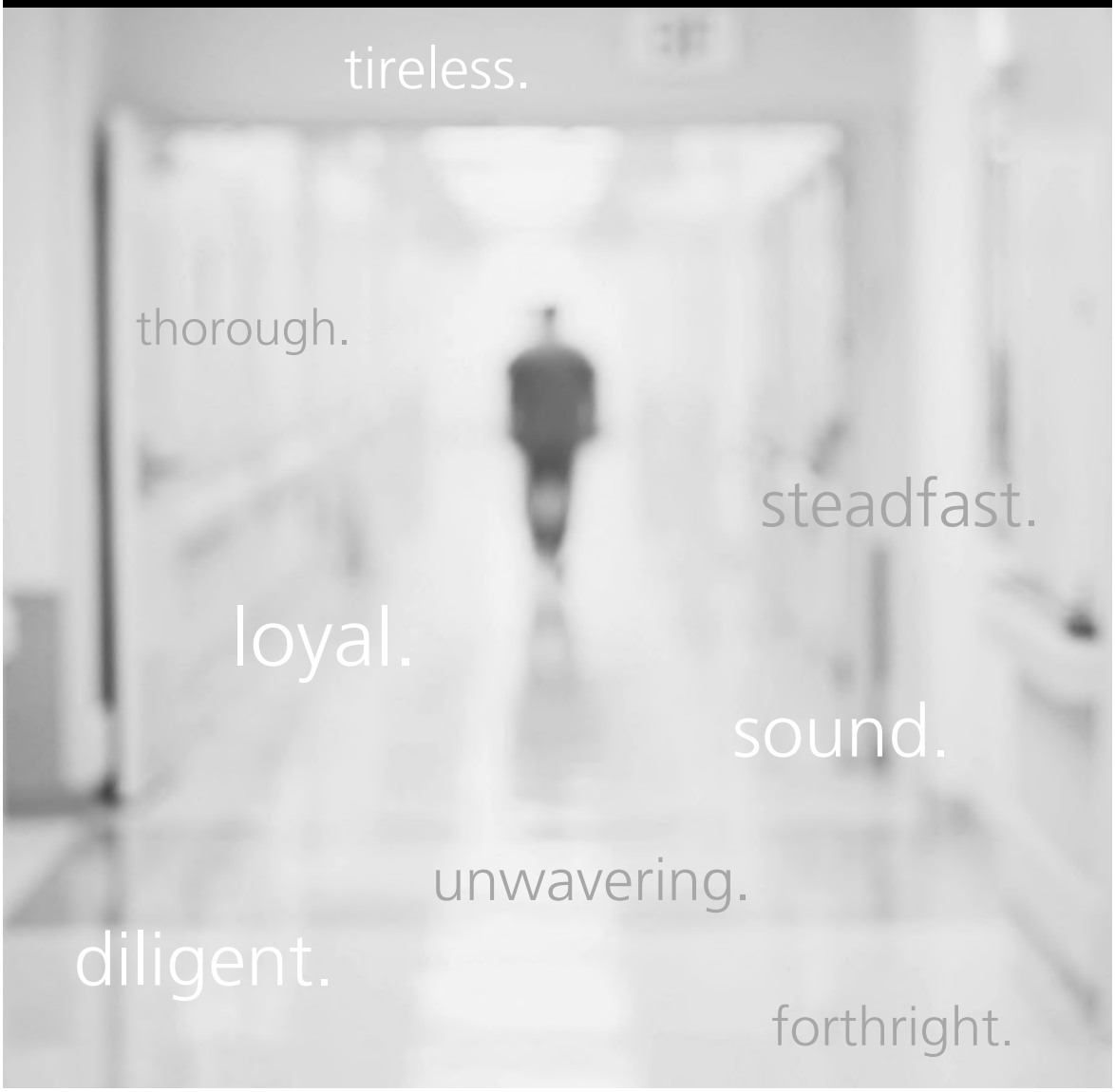
Medicaid Hospital Admissions Increase

Hospital admissions of patients covered by Medicaid jumped 30 percent between 1997 (5.6 million) and 2008 (7.4 million) compared to a five percent growth in patients with private health insurance (13.4 million to 14.1 million), according to the Agency for Healthcare Research and Quality (AHRQ). Admissions of uninsured patients rose by 27 percent (1.7 million to 2.1 million). A hospital's average cost for a Medicaid patient stay rose 11 percent (to $6,900), 34 percent for privately insured stays ($8,400) and 26 percent for uninsured patients (also $6,900). Costs are adjusted for inflation. Maternity-related and newborn infant care accounted for half of all Medicaid-hospital stays compared with one-third of privately insured patient stays and one-fifth of uninsured stays. About six percent of Medicaid stays were for mental health and substance abuse conditions, compared with four percent among privately insured, 10 percent among the uninsured. ❑

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



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Director's

DIALOGUE

OCMS in the Spring Time

Nothing great was ever achieved without enthusiasm.
Ralph Waldo Emerson

We are very enthusiastic about several Oklahoma County Medical Society and OCMS Alliance spring and near-spring events that were planned to capture your attention. Place these important dates on your calendar and plan to attend those still to come!

Honoring 17 physicians who have reached the 50-year milestone in medicine was the theme at the February general membership meeting on February 21. Since this was also Presidents Day, members had an opportunity to hear Robert Henry, OCU President, give a humorous talk about some of this nation's past presidents. We were honored that Mr. Henry accepted the OKC Clinical Society's invitation to speak. The wine and cheese reception was sponsored by John Sullivan, CFP.

Spring will arrive before you know it and so will the Society's Family Event at the Harn Homestead Museum. Make plans to bring your family to this special event on Sunday, April 17, from 2:00-5:00 p.m. Big Truck Taco will be catering so we know you won't want to pass up this treat! For those who want to dance, there will be music, and there will also be activities for children. So, bring your families and enjoy the wonderful spring afternoon.

Following close behind the OCMS Family Event is your opportunity to show the community that physicians "walk the walk" and don't just "talk the talk." You encourage your patients each day to become physically fit and now you can demonstrate how important exercise is in your daily life. The OCMS Alliance "Walk the Doc" event is scheduled on Saturday, May 7 at Stars and Stripes Park on Lake Hefner. From 9:00 a.m. until 2:00 p.m. you and your families will enjoy the park and walking trails at Lake Hefner. There will also be drawings for prizes and activities

for children.

The primary goal of this walk is to demonstrate against obesity and sedentary lifestyles. Targeted participants are physicians and their families (including grandparents), their nurses and staff members, and employees of organizations sponsoring the event. So, if you aren't a regular walker, dust off those walking shoes, get into exercise clothes and come join us for this inaugural event.

The OCMS Board of Directors, committees and staff are enthusiastic about this organization's 111th year in existence. Take advantage of the many opportunities to reconnect with your colleagues this spring and participate in some, if not all, of these events.

And one more thing before closing....you can now follow us on Facebook by visiting the Society's website: http://o-c-m-s.org/. It seems as if it was only yesterday that communicating by email was the hot trend, but now it is social media. I'm determined that if kids can figure this out, I can too! Happy Spring... ❑

Jana Timberlake, Executive Director

On Professionalism

Physicians Treating Relatives and Intimate Others

S. Sandy Sanbar, MD, PhD, JD, and Chis Codding, MD

The clinical encounter of a physician with a family member is not a typical physician-patient relationship. The latter is based on a fiduciary responsibility. The physician-"family patient" relationship is based principally on family affection (love). The treatment of relatives and intimate others is prone to omissions, abbreviations and informalities, and may result in compromised care, medical error and harm to the patients. When treating family members, physicians should carefully follow standard guidelines, including informed consent, telling patient relatives the truth about their diagnoses, respecting confidentiality and individual autonomy, and making the medical information accessible and shared with other caregivers. Examples:

1. A 76-year-old Jewish physician-attorney would not allow any other neurosurgeon than his son to operate on his severely painful and disabling, herniated lumbar disc. The son successfully performed the procedure with excellent results; the grateful father was extremely proud of his son.
2. A 66-year-old Mexican-American woman had cholecystitis with cholelithiasis, hypertension, prior deep vein thrombosis, gout and degenerative arthritis. She informed her "pride and joy" daughter, a general surgeon, that she will only allow her to operate, and that she would rather die than be operated by another surgeon. The daughter operated on her mother without complications.
3. A surgeon performed breast augmentation and abdominal liposuction on his first wife; she died during surgery. He was reprimanded by the State Medical Licensing Board and was required to take a course in ethics. Subsequently, he performed the same type of surgery on his second wife resulting in a similar outcome; he was criminally charged and found guilty; he lost his license to practice medicine.

Motivated by good reasons, physicians provide occasional medical care to their family members, friends, and employees, and even self-prescribe, often without apparent difficulties or complications. But physicians may confront significant problems, especially if substandard care is provided to the patient-relative. Treating relatives may be informal in nature, resulting in compromised history taking, physical

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examination, diagnosis, treatment and follow-up. Medical histories in these circumstances are often incomplete or assumed. Physicians may find it difficult to ask family members sensitive questions about drug use, sexual practices or other highly personal issues. Alternatively, patients may be uncomfortable disclosing this information to a relative. Emotional involvement may interfere with a physician's ability to be objective. Diagnostic reasoning may also be faulty.

The provision of health care to family members is a personal issue. Physicians can assist relatives in providing access to the health care system and advocacy without directly treating the patient. They should be cognizant of the following:

- Medical associations and societies generally discourage, but do not prohibit, physicians from treating family members. They limit such situations to those of necessity and caution that the patient be transferred to the care of another physician as soon as practical.
- Physicians should not write prescriptions for controlled substances for themselves or immediate family members except in dire emergencies.
- When a physician's relative develops an immediate problem that does not require new medical evaluation, the physician can quickly act within his/her area of expertise.
- It is acceptable for the physician-relative to simply "fill in" until the patient's primary doctor is available.
- Where the family member develops a new medical problem, the care provided by the physician relative is best restricted to minor services, unless no one else is available to deliver the care.
- It is generally unacceptable for physicians to act as the primary medical provider for their relatives or intimate others, to perform major surgery or to serve as psychotherapists. ❑

Placebos Work, Study Finds

Placebos work – even when patients know they're getting fake medicine – according to a study published online in the journal PloS One and reported in the Los Angeles Times. Lead author, Ted Kaptchuk, an associate professor of medicine at Harvard Medical School, said it was more difficult to persuade fellow researchers to explore an "honest" placebo than it was to enlist patients. The researchers were relying on conventional wisdom that patients need to think they're taking a real drug. Patients, on the other hand, said "that's weird" followed by "we think it might work." The three-week study included 80 people suffering irritable bowel syndrome who were told it was a novel "mind-body" therapy. Half the patients received a bottle labeled "placebo" and were told they didn't have to believe in the placebo effect but had to take the pills twice daily. The other half received no treatment. Result: 59 percent of the placebo-taking patients reported their symptoms had been "adequately relieved." Only 35 percent of those in the non-treatment group reported relief. ❑

CMS Policy Challenged

The Center for Medicare Advocacy has filed suit in Vermont challenging Medicare's policy controlling reimbursement for therapies and medical services for chronically ill patients. The suit alleges that care is illegally denied to thousands of patients by requiring them to achieve "demonstrable improvements in functioning" before Medicare will pay for physical, speech or occupational therapy, and skilled nursing care. The complaint claims Medicare is required by law to cover "reasonable and necessary" care and therapies "for the diagnosis of illness or injury." The lawsuit was filed on behalf of four individuals from Vermont, Connecticut, Rhode Island and Maine, together with the National Multiple Sclerosis Society, Parkinson's Action Network, Paralyzed Veterans of America, National Committee to Preserve Social Security and Medicare, and American Academy of Physical Medicine and Rehabilitation. The story was reported by the Chicago Tribune. ❑

Health Care in the Future

Results of the Thompson Reuters-HCPlexus National Physicians Survey link two fears doctors have about healthcare reform: their pay will go down, and the quality of care will deteriorate:

- 65 percent think quality will decrease but only 18 percent think it will improve,
- 55 percent believe nurse practitioners or physician assistants will be providing care,
- 58 percent believe the impact of the health insurance reform act will be negative, 27 percent think it will be positive, and 15 percent say it will be neutral,
- 74 percent think physician reimbursement will be less fair.

The future may be playing out now in Mississippi, where a bill has been introduced in the legislature that would repeal a regulation requiring nurse practitioners to enter into a collaborative agreement with a physician within 15 miles. Nurses insist they sometimes can't locate a collaborating physician, while the president of the State Medical Association says the requirement provides needed clinical oversight.

Meanwhile, in Pennsylvania health insurer Highmark Inc. announced it will recognize nurse practitioners as primary care providers. The state requires they work under a collaborative agreement with a physician, not to provide supervision but to be available for consultation. ❑

Unique Needs of Aging Patients

The AMA has released a new eBook, *Geriatric Care by Design, A clinician's handbook to meet the needs of older adults through environmental and practice redesign,* to help physicians design their practices to address the unique needs of older patients. Topics include practice evaluation, structural design, health literacy and patient self-management. It includes case studies and lessons learned from primary and specialty care that provide information and clear insight on how to design an environment that meets the needs of physicians and patients.

The convenient eBook format features easy-to-implement ideas and resources to help physicians make changes in their practices. It is designed with bullet points, easy-to-use checklists, tables and links to resources for additional information. Visit http://www.ama-assn.org/go/geriatric-care-by-design or contact Leah Dudowicz, (312) 464-4813, for more information or to place an order. ❑

Walk the Doc

PHYSICIANS AND THEIR FAMILIES WALKING WITH A PURPOSE

REGISTRATION FORM

First Name _____ Last Name _____ Age _____

Address _____

City _____ State _____ Zip _____ Phone _____

Email address (rain date notification) _____

I am a Physician ☐ Family of Physician ☐ Friend of Medicine ☐

Those attending (check all that apply) ☐ My spouse (Name) _____

☐ Children under 18 Number _____ Ages _____ ☐ Parent(s)
☐ Grandchildren Number _____ Ages _____ ☐ Dog

By signing below I agree my dog will be current on all shots, on a SHORT leash (maximum five foot non-retractable leash), and I will bring bags AND pick up after my dog.

How did you hear about Walk the Doc? _____

_____

Waiver Release: I hereby certify the following: (1) My family and I are physically fit and have received medical clearance to participate in Walk the Doc. (2) In consideration for my application for me and my family to participate in Walk the Doc being accepted, I on behalf of myself, my heirs and assigns, and my estate, hereby waive and forever discharge the sponsors, organizers, affiliates, as well as their agents, and employees from any and all claims for any liability, injury, loss, or damage in any way connected that may accrue as the result of my participation, as well as my family's or my dog's participation. (3) I hereby grant the organizers of Walk the Doc specific permission to reproduce, publish, circulate, copyright or otherwise use any and all photographs and/or videotape of me and/or my family taken at Walk the Doc.

Participants' Signatures_____

Please mail form to "Walk the Doc," 7400 N. Country Club Drive, Oklahoma City, OK 73116 or
Fax to 843-5898 **OR REGISTER ONLINE AT WWW.OCMSALLIANCE.ORG**

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 Integrated Network System, Inc. (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 Medical Education
Contact: Letricia Harris or
Kathleen Shumate
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

Oklahoma City-County Health Department
Epidemiology Program
Communicable Disease Surveillance

COMMONLY REPORTED DISEASES	*Monthly*			*YTD Totals^*	
	Jan'11	**Jan'10**	**Dec'10**	**Jan'11**	**Jan'10**
Campylobacter infection	5	2	2	5	2
Chlamydial infection	N/A	N/A	N/A	N/A	N/A
Cryptosporidiosis	1	0	2	1	0
E. coli 0157:H7	0	0	0	0	0
Ehrlichiosis	0	0	0	0	0
Giardiasis	0	4	0	0	4
Gonorrhea	N/A	N/A	N/A	N/A	N/A
Haemophilus influenzae Type B	0	0	0	0	0
Haemophilus influenzae Invasive	2	3	1	2	3
Hepatitis A	0	1	0	0	1
Hepatitis B*	10	11	12	10	11
Hepatitis C *	20	17	10	20	17
HIV Infection	N/A	N/A	N/A	N/A	N/A
Lyme disease	0	0	0	0	0
Malaria	0	1	0	0	1
Measles	0	0	0	0	0
Mumps	1	0	0	1	0
Neisseria Meningitis	0	1	0	0	1
Pertussis	3	0	2	3	0
Pneumococcal infection Invasive	0	0	2	0	0
Rocky Mtn. Spotted Fever (RMSF)	0	0	0	0	0
Salmonellosis	9	6	8	9	6
Syphilis (primary/secondary	N/A	N/A	N/A	N/A	N/A
Shigellosis	9	3	2	9	3
Tuberculosis ATS Class II (+PPD only)	50	45	34	50	45
Tuberculosis ATS Class III (new active cases)	1	3	2	1	3
Tularemia	0	0	0	0	0
Typhoid fever	0	0	0	0	0
RARELY REPORTED DISEASES/Conditions:					
West Nile Virus Disease	0	0	0	0	0
Pediatric Influenza Death	0	0	0	0	0
Influenza, Hospitalization or Death	135	1	21	135	1
Influenza, Novel Virus	0	0	0	0	0
Strep A Invasive	0	5	0	0	5
Legionella	0	0	0	0	0
Rubella	1	0	0	1	0
Listeriosis	0	0	0	0	0
Yersinia (not plague)	0	0	0	0	0
Dengue fever	0	0	0	0	0

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

^ *YTD - Year To Date Totals*

STDs/HIV - *Not available from the OSDH, HIV/STD Division*

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