BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY

MARCH 2012

THE BULLETIN
The Oklahoma County Medical Society

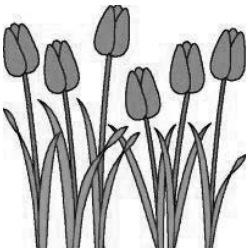
March, 2012 – Vol. 85, No 2

A Monthly Publication
Circulation 1500

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

Printed by Green's Graphix

TABLE OF CONTENTS



About the Cover

The photograph on the cover of the Bulletin this month was taken by Terri Underhill of Edmond, Oklahoma. She is an amateur wildlife photographer who uses a Canon T31 with a 100 to 400 lens. Her husband is Dr. Keith Underhill, a family physician at Canyon Park Family Physicians in Edmond. The bird in the picture is a male Indigo Bunting, taken at the Wichita Wildlife Refuge. The birds migrate to nest in April and leave in October. Except for the panhandle, they are found throughout the State of Oklahoma. We are grateful to Mrs. Underhill for the use of the photograph. ❑

The Editor

Seeking Doctors with Musical Talent

Do you or a member of your family play a musical instrument? Do you sing in a band or choir or alone? Would you share your talent with the OCMS family?

The OCMS Alliance and the OCMS Board of Directors are planning another fantastic family day event, date to be determined, and are hoping to introduce a new form of entertainment: "Docs that Rock." This will not be a talent show in the traditional sense of the word – there will be no judging of participants. It will simply be a fun afternoon for OCMS members and spouses, children and grandchildren.

Please call the OCMS office, 702-0500, or email us (llarason@o-c-m-s.org) to let us know how you want to participate … or to "rat out" colleagues who may be withholding valuable information from us. ❑

In Memoriam

Richard Allen Clay, MD
1918 – 2012

William Arthur Miller, MD
1925 - 2012

John Richard Smith, MD
1932 – 2012

Ronald E. Wright
1944 – 2011

Preventive Services Brochure

The AMA and AARP recently released a "Team Up to Stay Healthy" brochure to help seniors receive the preventive services that are now covered by Medicare. With the passage of the Affordable Care Act, physicians now have more opportunities to help their Medicare patients receive preventive services. The free brochure explains the types of physician visits covered by Medicare in clear, simple language and gives patients an overview of common preventive screenings. The brochure helps patients prepare for their physician visits by explaining what to expect, what to bring and what to ask their physician. It also offers patients access to additional information and helpful resources about their covered services.

The brochure is available in both English and Spanish. Patients can download and print individual copies and physicians can order bundled copies to give to patients.

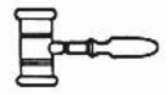
English: http://www.ama-assn.org/resources/doc/public-health/ama-aarp-brochure.pdf.

Spanish: http://www.ama-assn.org/resources/doc/public-health/ama-aarp-brochure-spanish.pdf.

Bundled copies: http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/preventive-care-patient-brochure-request.page.

Information about preventive service CPT codes: http://www.ama-assn.org/go/preventive-services. ❑

President's Page



Tomás P. Owens, MD

The Individual Mandate

This summer the U.S. Supreme Court will render an opinion on whether the Affordable Care Act (ACA) is constitutional. It is fair to say that the constitutionality of a law is better discussed by those experts in the legal arenas, just as physicians should be the ones rendering medical opinions. Nevertheless, it will affect us physicians, lawyers and lay people all the same. To be sure, the case is not quite "ripe" in legal-parlance, since nobody has been "harmed" or affected yet; but going to the high court it is.

Appeals courts struck it down in the 11th Circuit in August 2011 and upheld it in the D.C. Circuit in November 2011. Both were 2:1 votes.

My commentary deals with the individual mandate portion of the law.

In a limited view, as just a citizen, constitutionality is a high calling yet not a practical one. The founding fathers, brilliant and exquisite in their presentation as they were, could not foresee a great number of things in the future, such as privacy clause relevance on electronic and social media, satellite and drone use and its effect in yet unknown forms of espionage, or air and space travel. And though the constitution is specific and declarative about very specific areas, for example the decennial census, it is silent about Social Security, Medicare and Medicaid. All of which, of course, did not exist then and could today be deemed unconstitutional if closely (or even less than closely) evaluated.

All those who are insured are already paying for part of the uninsureds' healthcare, a type of unspoken mandate on those that have insurance.

Surveys have found that very few resist the concept of health insurance on principle. Almost all present and future (even under ACA) uninsured will be so because of cost.

Interestingly, the question of the individual mandate is driven by the "no preexisting condition." Almost every physician and non-physician I know supports the elimination of the preexisting condition exemption of coverage. It appeals to the deepest sentiment of our professional devotion and our human condition to protect those afflicted with a serious ailment (many times through no fault of their own) and needing care. While near-universal approval exists for the elimination of the preexisting-condition coverage restrictions, there is very casual discussion among most of us about how to pay for this. In traditional capitalist economies, asking a health insurer to accept an individual with a pre-existing condition is akin to asking a car insurer to insure someone only after he has crashed his car. Many health plans do, though – those that have a large number of constituents and are part of larger corporate packages.

Most health insurance is not properly insurance (a product that would compensate an unforeseeable catastrophic event) but rather a collective pre-pay system for healthcare delivery – about every man woman and child uses health benefits regularly.

Many argue that just as states mandate that drivers insure vehicles, they could well require people to insure their health. But people have the right *not* to own a car, and the government is not mandating they *buy* one. Consequently, we are not really "mandated" to get vehicular insurance.

If one totals one's car by crashing against a fence post while uninsured (for the sake of this example we won't hurt third parties), he is simply without a vehicle. On the other hand, if he is injured in that crash, every emergency Department in the nation *would be required to* take him and heal him, insured or not; most importantly, he himself would insist on the mercy of society to give him a lending hand at that time and every physician I know would exert every effort to save him without first inquiring if he is insured.

The only way to dissolve the high insurance risk is for everyone to be insured. The constitutional question is whether the nation can force them to be.

The argument on constitutionality hinges on the interstate commerce clause. It may turn out that, with a strict interpretation, the mandate is unconstitutional. Nevertheless, Judge Laurence Silberman put it well in his upholding opinion, "Congress, which would, in our minds, clearly have the power to impose insurance purchase conditions on persons who appeared at a hospital for medical services – as rather useless as that would be – is merely imposing the mandate in reasonable anticipation of virtually *inevitable future transactions* in interstate commerce."

Two important associated issues need to be reconciled: the question of how small businesses are going to afford this imposition and the fact that the current fine for declining coverage won't dissuade some from forgoing coverage.

Unconstitutional it could be, but for all practical purposes we might have to accept it as the only economically feasible option and work very hard on ways to pay for it. On the physician's side, it is our responsibility to be good stewards of our country's treasure and judicious in driving healthcare expenditures. ❑

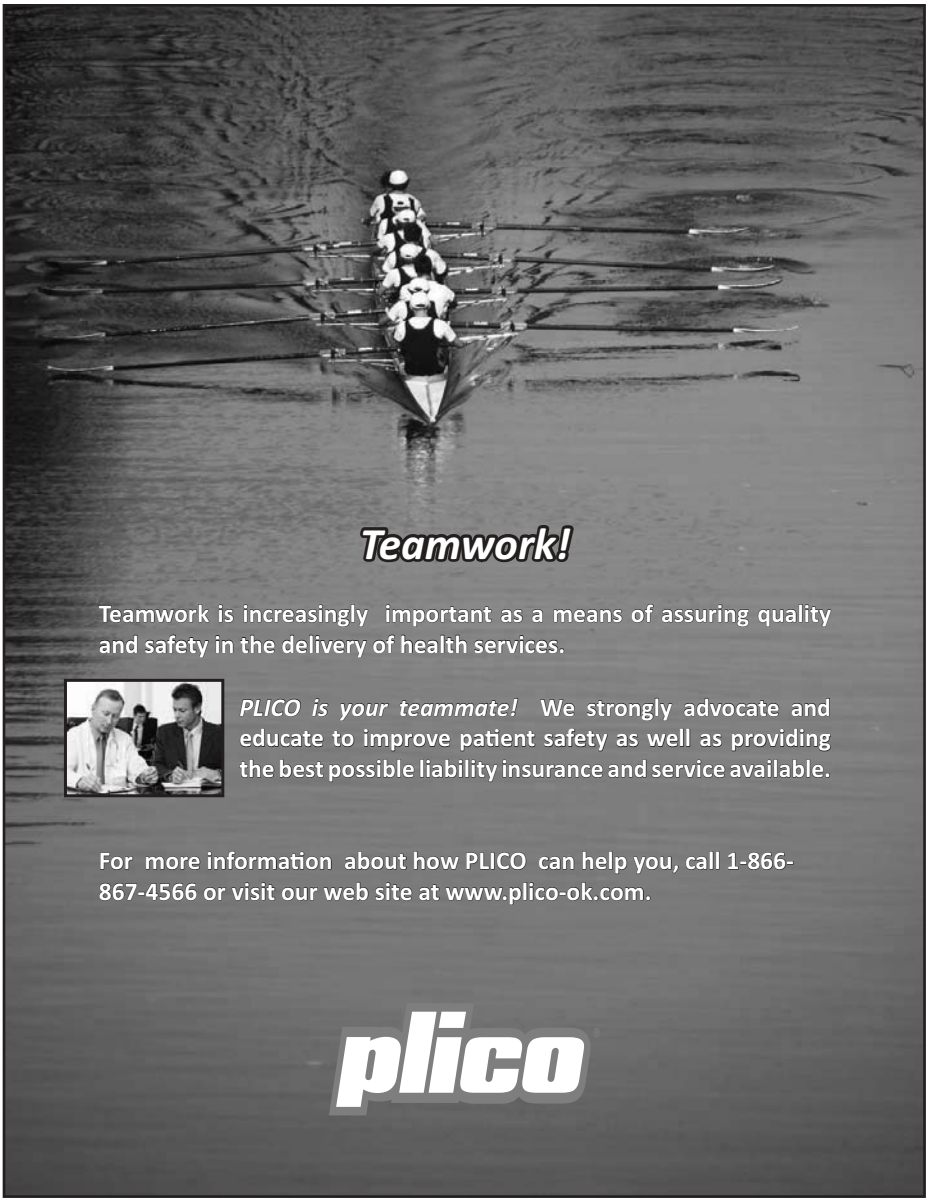
In Memoriam

Richard W. Welch, MD

The family of medicine lost a special member on December 10, 2011. Richard W. Welch MD was a consummate physician whom I had the good fortune to call my partner and my friend. Richard earned his MD and PhD as a James Scholar at the University of Illinois. He served in Vietnam and retired as a major. He then served 10 years in academic medicine at the University of Texas, San Antonio, receiving accolades for his ability and excitement to teach gastroenterology. He moved to Oklahoma City to enter private practice. I had the good fortune to meet Richard in 1993 and the idea of a single specialty GI group was born. In 1994, we founded Digestive Disease Specialists, Inc. and changed the way gastroenterology was practiced in Oklahoma. Richard was the cornerstone, working tirelessly seeing patients and supporting our new outpatient endoscopy unit. Richard knew no boundaries, seeing patients in the emergency room at Baptist Hospital whenever called and being available to his referring physicians on a moment's notice. His patients loved him as he was always there to listen to their problems and offer knowledgeable medical advice as well as fatherly advice when needed.

But Richard was far more than just a hard working doctor. He loved to "relax" with his family and friends, and did so with the same fervor and intensity that he practiced medicine. He worked out regularly, trying to stay in peak physical shape, and enjoyed his respite in Naples, Florida with his wife JoAnn and family and friends. While at home, he enjoyed nothing more than a relaxing afternoon with his family and his beloved Jack Russell terriers.

In 2000, Richard fell on the ice, hitting his head on the concrete. He sustained serious injuries and required months of rehabilitation



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and speech therapy. He worked as hard as we knew he would. He improved and I was honored when he attended my inauguration as OCMS president in 2010. Unfortunately, his weakened state eventually led to a battle he would not win. Richard is survived by his wife JoAnn, his children Ron Natale, Rick and Nancy Natale, Erika and Kent Wyatt, seven grandchildren and countless friends and patients who will never forget this amazing man and physician. ❑

Larry Bookman MD

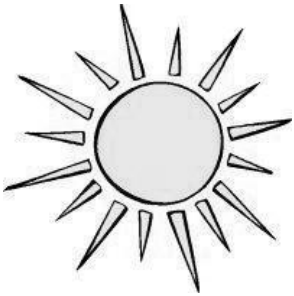
Doctor/Patient Disagreement

Eighty percent of doctors believe patients are not educated enough to understand their notes if posted online. Eighty percent of patients believe the information would help them take charge of their health. From a patient perspective:

- ✓ 94 percent believe the records should be available.
- ✓ 90 percent said the information would give them more control.
- ✓ 80 percent said they would take better care of themselves because of the information.
- ✓ More than half said the information would help them take their medication properly.

But physicians worry that access to their notes would confuse patients, that it would not benefit them because they would not change their behavior, and that it would lead to such an influx of phone calls and concerns that their practices would be overwhelmed. Eighty percent of the surveyed doctors reported they are frightened by the idea of allowing the records to be accessible.

The study, from Harvard Medical School, surveyed 38,000 patients from several medical centers around the country, and 173 doctors. Participating physicians were also asked to place their notes online for patients to access freely. About 70 doctors declined to do so. The study was reported by USA Today and published in the Annals of Internal Medicine, Ann Intern Med December 20, 2011 155:811-819. ❑



Morning Love

Hanna Saadah, MD

I watch the birth, far at the edge of earth
A gladdened shimmering without a cry
And then the flapping, golden clouds of mirth
Before the fireball redeems the sky.

At splendid morns like these, I find your eyes
In quiet clouds that lash upon the skies
In vast awakenings that reunite
The depth of darkness and the laughs of light.

The mighty kindness of the morning sun
The Maker's daily gift for everyone
A giving love, conditionless and free
Is for the frightened, ruthless world to see.

I love you so, much like the mornings do
And find the morning joys in loving you. ❑

We could learn a lot from crayons;
some are sharp, some are dull, while
others are bright, some have weird names,
but they all have learned to live together
in the same box.

Robert Fulghum

Dean's Page

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

On January 26, the College of Medicine's Alumni Association hosted its 28th annual *Evening of Excellence* at the National Cowboy and Western Heritage Museum here in Oklahoma City. This has become one of the anticipated, enjoyable highlights of the winter scene in Oklahoma City and brings together a wide variety of individuals in healthcare, medical education, civic and charitable organizations and the business community of our city and state. The event is dedicated to increasing the pool of biomedical research in Oklahoma by raising funds for and providing start-up seed grants for young faculty investigators. Many of the individuals who received small grant awards in the past have been able to launch their success in subsequently obtaining significant extramural funding, especially from the National Institutes of Health. Each year the College selects one of these individuals to tell the audience how the small grant award program has influenced his or her career. This year, Dr. Sarah Zhang, assistant professor in the Department of Medicine, was featured. She received an Alumni Association seed grant award in 2007 and has gone on to become one of our outstanding young investigators in diabetes and retinal degeneration disorders. She has been the recipient of several important grants from the NIH, allowing her to build a major research team here at the Health Sciences Center and the Harold Hamm Diabetes Center.

This year the Dean's Award for Distinguished Medical Service was presented to Terrence Stull, MD, Professor and Chairman of the Department of Pediatrics, in recognition of his tremendous contributions to developing a significantly enhanced and expanded pediatrics department and working with several of our key partners in developing an outstanding Children's

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Hospital and new OU Children's Physicians Clinic Building. Christy Gaylord Everest, one of the College's great benefactors and friends, served as the presenter for Terry's award.

The 2012 Dean's Award for Distinguished Community Service was shared this year by a wonderful couple – Joseph Ferretti, PhD, and his wife Martha Ferretti. H.E. "Gene" Rainbolt, Chairman of BancFirst and another great benefactor and friend of the College, served as the presenter for the Ferrettis' award. Joe Ferretti served for 16 years as Senior Vice President and Provost of the Health Sciences Center, retiring from that position last June. Joe is a renowned scientist whose work on the *Streptococcus* genome was pioneering. Marti is chair of the Department of Rehabilitation Sciences in the College of Allied Health. Together they have consistently contributed their time and energy to many community organizations in Oklahoma City and the state.

The selection committee was extremely proud of their choices for these awards this year, and it was a marvelous evening enjoyed by over 900 persons in attendance. On behalf of the entire faculty and staff of the College of Medicine, I am delighted to express our deep gratitude for the continuing support of the Alumni Association and for its vision in beginning this important *Evening of Excellence* event 28 years ago. ❑

NEW MEMBERS

Ryan D. Brown, MD
(PD)
940 N.E. 13th St., #2G2300
University of Oklahoma
2001

Joshua P. Carey, MD
(GS)
2801 Parklawn Dr., #303
University of Kansas
1999

David L. Graham, MD
(D)
609 S. Kelly Ave., #E-2
Stanford University
1977

Savannah D. Stumph, DO
(PD)
416 W. 15th St., Bldg. 200
OSU, College of
Osteopathic Medicine 2008

alliance

Introducing Alliance Leadership

(front) Suzanne Reynolds, Donna Parker, Stacie Evans
(back) Gov. Fallin, Kathy Bookman

The OCMS Alliance Leadership Ceremony was January 12 in the Blue Room of the Oklahoma State Capitol. Governor Mary Fallin praised the Alliance for its dedication to community health and wellness, physician advocacy, and strengthening the medical family.

Governor Fallin administered the Alliance presidential oath of office, outgoing President Donna Parker passed the pin and gavel, and a celebratory reception was held in the Rotunda.

2012 Executive Officers: Kathy Bookman, President; Suzanne Reynolds, President Elect; Donna Parker, Treasurer; Stacie Evans, Treasurer Elect; and Dianna Digoy, Secretary.

2012 Board of Directors: Amy Bankhead, Diane Brown, Michele Davey, Mary Delafield, Cara Falcon, Rhonda Gelczer, Berna Goetzinger, Jane Griggs, Karen Gunderson, Barbara Jett, Courtney Karam, Lori Hill, Nina Massad, Elissa Norwood, Anette Shukry, Linda Stewart, and Mucki Wright.

Committee Chairs: Mary Delafield, Stacie Evans, Barbara Jett, Joan Larson, Keith Oehlert, Jennifer Tortoricci, Donna Parker, and Penelope Srouji. ❑

From the end spring new beginning.
Pliny the Elder (23 AD - 79 AD)

Pearl of the Month

Tomás P. Owens, MD

Sick? Count on that Urinalysis!

Case Reports

1) A 5 year-old child is brought to be evaluated for a 2 week history of abdominal pain. He had a lot of pain initially, then got somewhat better about 6 days prior to office visit, and now has worsened. He has a temperature of 100° F. The examination is challenging but it appears that there is tenderness a few centimeters above the symphysis and questionable guarding there. He has pain on deep palpation of the L lower quadrant. He has a white blood cell count (WBC) of 15K. His urine analysis (UA) showed 15 RBC and 5 WBC per high power field (hpf) + for leukocyte esterase (leuk) and negative for nitrites.

2) A 61 y.o. morbidly obese diabetic male is worked up for fever, lethargy and hypotension. He is in pre-shock. His lung, cardiac, abdominal exams are normal. UA had 4-5 RBCs and 12-15 WBC per hpf.

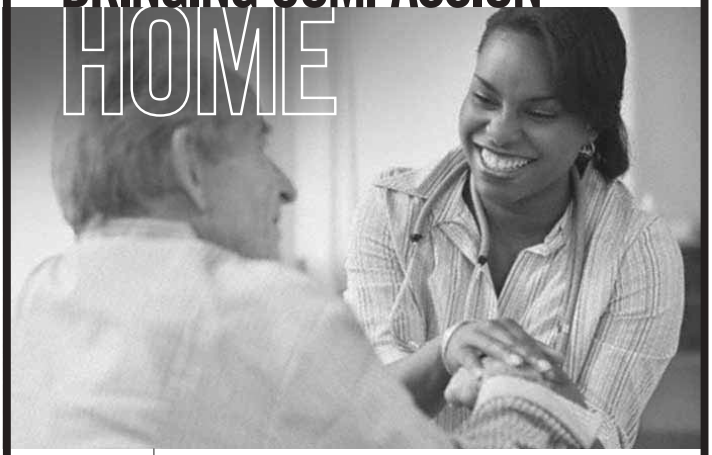
3) A 70 y.o. woman with dementia is seen for fever and presumed lower back pain (she is unable to give a good history). She has shown lassitude and decreased appetite and no longer participates in the activities at her nursing home. Her urine sediment has 4 RBCs and TNTC (too numerous to count) WBCs, + for leuk. and + nitrites.

4) A 93 y.o. nursing home resident with moderate dementia is found to be obtunded and refusing food. His lungs are clear, his abdomen is unremarkable. He was previously a very loquacious and mobile individual. His urine showed 4-5 RBCs and 12 WBCs per hpf, + for leuk. and + nitrites.

PHYSICIAN • PATIENT • TECHNOLOGY • PROCEDURE • COMMUNITY BENEFIT • **AWARENESS**

INTEGRIS Health

BRINGING COMPASSION HOME



INTEGRIS EXPERTISE EXPANDS AGAIN

INTEGRIS Health has acquired Odyssey HealthCare of Oklahoma City, which includes hospice home care and inpatient services. Hospice of Oklahoma County, Inc. (an affiliate of INTEGRIS Health) will provide the services previously offered by Odyssey HealthCare of Oklahoma City in an effort to strengthen services.

The inpatient facility opened in 2006 and is located in northwest Oklahoma City. Caring for approximately 800 patients, the twelve-bed facility will be known as INTEGRIS Hospice House. This is Oklahoma's first licensed inpatient hospice facility, and the newest addition to INTEGRIS Health.

We are excited about the new addition to our family of healthcare services – and look forward to caring for more Oklahoma families by bringing compassion home. Hospice of Oklahoma County is certified by Medicare, and is one of an elite group to be accredited by The Joint Commission.

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Each of these individuals was diagnosed with and treated for urinary tract infection (UTI), possible sepsis.

Their UTI was defined by UA findings. Technically they all had pyuria. Did they have a UTI? If so, was that the cause of their actual illness? This is the follow-up:

Patient 1: Could not give a very good history. The prolonged history was highly atypical for an intra-abdominal catastrophe. Nevertheless, while already on treatment for a "UTI," a savvy clinician ordered an abdominal CT to further evaluate his abdominal pain.

Patient 2: With hydration became very coherent and denied any symptoms urinary or otherwise. Remained febrile at day 3 of IV therapy for urinary pathogens and became more hypotensive, then developed full blown shock. Wisely, a clinician proceeded to do a rectal examination to assess for prostatitis.

Patient 3: Her exam remained "normal" yet difficult to assess due to her dementia. She did not defervesce on two days of IV fluids and antibiotics. She remained confused and belligerent. Her urine culture was sensitive to the antimicrobials used. A thorough re-examination was undertaken.

Patient 4: Worsened over the first 24 hours, in spite of aggressive crystalloid resuscitation and optimal Gram negative coverage with fluoroquinolone. Reexamination was not revealing. Lung, abdominal and rectal examinations were normal within the limitations of a non-cognitive patient that was obtunded. Chest xray was normal. Laboratories were reviewed and redrawn.

What was the outcome?

Patient 1: The little boy's CT showed a massive, walled-off peri-appendiceal abscess. He underwent an urgent laparotomy and did very well.

Patient 2: His challenging rectal examination (on account of his massive body mass index) was normal. While at it, the doctor noticed a surprisingly, non-tender induration of his R medial thigh. Further examination and ultrasound revealed a massive thigh abscess. This was urgently drained and further debrided. The patient healed completely over 3 months and is now back to work.

Patient 3: A detailed re-examination showed normal ears, throat, neck, lungs and skin. A subtle, reproducible wince was noted with left lower quadrant pressure. A CT scan revealed a

(Cont'd on page 29)

Health IT Tutorials

The American Medical Association (AMA) released three online educational tutorials in January to help physician practices better implement health information technology (health IT).

This series of short video tutorials feature downloadable tools and best practices about health IT for physician practices. The tutorials provide guidance on how to better use health IT.

The three tutorials cover ePrescribing, pre-visit planning and point-of-care documentation. The first tutorial explains the value of ePrescribing and the quality, safety, and efficiency of ePrescribing compared to handwritten prescriptions. The tutorial also allows physicians to identify opportunities for medication management improvement while enhancing physician and patient convenience.

The pre-visit planning tutorial will help physician practices to establish a pre-visit planning structure that provides full patient information to the physician before the patient arrives. This can create new efficiencies that will allow more time for patient-physician interaction and shorter patient wait times. The point-of-care documentation tutorial addresses decisions regarding the type of hardware used during an office visit. The tutorial also helps physician practices understand the type and format of information that should be entered during a visit.

These activities have been certified for AMA PRA Category 1 Credit™. To view the tutorials, visit www.ama-cmeonline.com/health_it_workflow. ❑

Trying to "Kick the Habit"

One more challenge that poor and uneducated people face: it's harder to stop smoking, according to a study by a tobacco dependence researcher at The City College of New York (CCNY). The study tracked smokers from different socioeconomic backgrounds after they had completed a statewide smoking cessation program in Arkansas. Whether rich or poor, participants managed to quit at about the same rate upon completing a program of cognitive behavioral therapy, either with or without nicotine patches. But as time went on, a disparity between the groups appeared and widened. Smokers on the lowest rungs of the socioeconomic ladder were 55 percent more likely than those at the upper end to start smoking again three months after treatment. By six months post-quitting, the probability of their going back to cigarettes jumped to two-and-a-half times that of the more affluent smokers. Americans with household incomes of $15,000 or less smoke at nearly three times the rate of those with incomes of $50,000 or greater. The study was reported January 23 on PsychCentral.com and is scheduled to be published this month in the American Journal of Public Health. ❑

Young Physicians

Michelle Powers, MD

Bridging the Generation Gap

Recently, I was told that I have a "surprising work ethic for my generation." I'm a pathologist, and I love my job, but this made me think for a moment about what this comment meant for me and what it said about "my generation" – the generation Y or Millennial generation.

Currently in the healthcare workforce, there are four generations of working physicians. Understanding the differences between these generations can help relieve some professional tensions and discomfort that is a natural consequence of communication between professionals who have been shaped by a different set of cultural values and have a different set of goals and ideals.

The oldest generation in the healthcare sector at this time is the Traditional generation. This group is also known as "the greatest generation" or the "silent generation." The Great Depression and World War II had strong influences on the development of this generation. Respect, "top down" management styles, and a feeling that everyone needs to pay their dues prior to progressing in their careers are all important to those in the Traditional generation. Although the majority of this generation has reached retirement age, there are some practicing physicians currently in this age group.

The Baby Boom generation is defined by the US Census Bureau as individuals born between 1946 and 1964. This group has had the largest impact on American society to date due to its large size (approximately 78 million). This generation was shaped by the Vietnam War, Kennedy and King assassinations, Watergate and the sexual revolution. This generation equates work with self-worth and this generation started the "workaholic" phenomenon.

This group is at the mid to late point of their careers and is likely to play a larger leadership role in most physician practices. However, within the next two decades, the majority of this generation will be reaching retirement age of 65.

Generation X is defined by the US Census Bureau as the segment of individuals born between 1968 and 1979. This generation grew up in a time with increased financial and societal instability. This is the first generation predicted to earn less than their parents did. In most families, both parents worked, and there was a higher rate of divorced and single-parent households than for the preceding generations. This group, the first to be heavily influenced by video games and computers, also was affected by MTV and the AIDS epidemic. This group is less likely than the Boomer or Traditional generation to be loyal to their employers and is more likely to switch jobs several times in their career. Instead, the X'ers have strong loyalties to their family and friends and highly value autonomy and independence more so than their predecessors.

The youngest generation in the physician workforce to date is the Generation Y or Millennial generation. This group is stated to have been born between 1980 and 1999 but the ranges are still not finalized. This group is heavily shaped by "parental excesses" and is more likely to rely heavily on their parents for financial support well into their mid to late twenties. This generation is comfortable with technology, and places value on diversity, teamwork, and flexibility. This group was influenced by the end of the Cold War, the internet, and September 11. This generation, along with the X'ers, has a strong desire for a "work-life balance" and is good at multitasking. This generation is less intimidated by authority figures, making them more likely to approach authority figures with questions rather than communicating through some type of leadership hierarchy.

Although these categories make broad generalizing statements for each of the generations, there is some truth to each of the categories and understanding where the other generations are coming from could help release tensions that arise due to these generational differences. I not infrequently hear that newer or younger physicians are not as driven or willing to work as hard as the older generation. However, if you consider that with

the generational-colored glasses, the reality is that the younger generation places different emphasis on work and achieving that "work-life balance." In my practice, this means when offered 20 days of vacation, I'm likely to use all of those days – but I'm also working on mobile devices, communicating with doctors via cell phones and email and multitasking throughout my work day (and sometimes when on vacation!). This may differ from my Boomer colleagues who may use only one-third to one-half of their vacation but are not using newer technologies as much in their daily practice. One way is not better or worse than the other – they are just different because our value systems are different.

Understanding generational differences can help diffuse tensions in the workplace with so many different generations working in the healthcare workforce at one time. We are all products of what has been happening around us during our career development. Working together is easier when we consider some of these issues prior to making assumptions about each other. ❑

2012 Inaugural Gala

What a Fun Night!

The weather was cooperative – no howling winds or icy parking lots; the flowers were stunning; the dinner, delicious; the program, short and entertaining; the music, lively; and the crowd, enthusiastic. On Saturday, January 14, Tomás P. Owens, MD became the 112th president of the Oklahoma County Medical Society. Dr. Owens' brother, nephew and niece came from Panama and Tammy Owens' mother escaped frigid South Dakota to join the celebration. It was close to perfect! The time in Oklahoma was "the best three days of my life," proclaimed young Patricia Owens. ❑

Dr. Owens addresses the membership.

Dr. Robert Cooke passes the gavel to Dr. Owens.

Owens; Arlene Jaqua; Tammy Owens; Emily Owens, Tomás P. Owens, MD; Thomas Owens; Carlos Owens, MD.

Carlos Owens, Jr., MD; Patricia Dr. James Hampton, Editor-in-Chief of the Bulletin, receives a bound set of 2011 issues of the Magazine.

2012 OCMS Board of Directors

(front l-r) Drs. Don Wilbur, William Miller, Tim Hill, Julie Strebel Hager, Tomás Owens, David Holden and Gary Riggs (back l-r) D. Randal Allen, Ralph Shadid, Robert Cooke, C. Douglas Folger, and Paul Kanaly

Dr. Robert Cooke receives the 2011 President's plaque from emcee Dr. Larry Bookman.

Dr. Larry Bookman presents a gift to Diane Cooke.

The Owens family enjoys the dance floor – young Patricia danced every song.

Don F. Rhinehart, MD
Medical Service Award

Terrence L. Stull, MD is the 2012 recipient of the Don F. Rhinehart, MD Medical Service Award. Established in 2005, this annual award is named for the OCMS President whose vision and leadership launched the development of the Oklahoma Blood Institute, a nationally recognized blood bank. The award honors OCMS members who have contributed exemplary service at the local, state, or national level.

Dr. Stull earned his undergraduate degree in philosophy at Vanderbilt University and his medical degree at the University of Alabama-Birmingham School of Medicine, with three months at Baragwanath Hospital, South Africa, and Manzini, Swaziland. His internship and residency were with the Department of Pediatrics at Stanford University Medical Center; he was Chief Resident at Children's Hospital-University of Alabama; and his Fellowship was in the Division of Pediatric Infectious Diseases, Children's Hospital and Medical Center, Seattle.

Oklahoma's children were blessed when Dr. Stull decided in 1994 to make Children's Hospital his professional home, where he is now Professor and Chairman of the Department of Pediatrics and holds the CMRI Patricia Price Browne Distinguished Chair. Under his leadership the number of full time faculty has nearly tripled, from 54 to the current 156; department extramural research funding has grown from $2.3 million to $14.2 million annually; the Department of Pediatrics' operating budget has increased from $15 million to more than $82 million annually; the department now boasts 17 endowed chairs to provide world-class depth and expertise; the training program has expanded to 45 pediatric residents and 12 medicine pediatrics residents per year and includes fellowships in seven

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sub-specialties, and the department is ranked 52nd out of 135 departments of pediatrics in National Institutes of Health research funding; Oklahoma's ranking was 87th when he arrived on the scene.

With this growth in the department, and the spectacular new hospital, over 142,000 children – including 44,000 in off-campus/satellite locations Dr. Stull has created – receive top quality care each year.

Not long ago, physicians and parents in the metro area and throughout the state often complained that Children's Hospital had inadequate programs, outdated facilities, and insufficient staffing to accommodate the transfer of their very sick children from community hospitals. But with Terry Stull's leadership and partnership with the hospital and community, Children's Hospital at OU Medical Center has become a well-known destination for children throughout Oklahoma and the region to receive world-class care in a multitude of areas. The change at Children's has been rapid and complete: so much so that that it was a metro-area emergency department physician who nominated Terry for the award. ❑

(Cont'd from page 19)

diverticular abscess of the sigmoid colon. She got proper anaerobic coverage added and resolved fully without surgical intervention. She is back to her usual state of health at the nursing home.

Patient 4: A detailed look at his laboratories showed a bilirubin of 1.9 mg/dL and ALT of 80 U/L which was originally ascribed to shock-liver of sepsis. A RUQ ultrasound showed severe cholecystitis with dilated bile ducts. He got metronidazole added to his ceftriaxone regimen and underwent an ERCP with sphincterotomy two days later. He is back at his nursing home harassing everyone in sight.

Though an important tool, sometimes a urinalysis can lead us astray. These four cases illustrate the perils of committing to a UTI diagnosis solely on the basis of UA results and the wisdom of re-evaluating, on new light, a patient that does not rapidly improve after adequate therapy ❑.

Medical Professionalism and Legal Knowledge

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

The medical profession has for centuries recognized the need to teach medical students and physicians the legal aspects of medical practice. Increasingly, American medical schools are including law in the core curriculum. During the past two hundred years, the law of medicine has been referred to as medical jurisprudence, forensic medicine, legal medicine, medical law and health law.

Thomas Percival (1740-1804)[1]published in 1803, "Medical ethics; or, a code of institutes and precepts, adapted to the professional conduct of physicians and surgeons," which comprised guidelines for conduct in hospital practice, private or general practice, in dealing with apothecaries, and concerning legal matters.[2] Percival's text specifically addressed "professional duties…which require a knowledge of law."[3] Described as "the most influential treatise on medical ethics in the past two centuries,"[4] the code has been adopted by both the British and American medical professions. In 1847, the AMA adopted Percival's Code at their first meeting, and despite several revisions much of Percival's wording and concepts still remain.

In 1860, physician/lawyer John J. Elwell, published, "A Medico-Legal Treatise on Malpractice and Medical Evidence: Comprising the Elements of Medical Jurisprudence."[5] The book depicts much about medical jurisprudence in the 19th century, and the relationship between physicians and lawyers.

In 1845, Walter Channing (1786-1876), the first editor-in-chief of the New England Journal of Medicine and Surgery, now the New England Journal of Medicine, found the relationship between medicine and law intellectually stimulating and of practical interest.[6] In 1860, Channing[7] wrote:

"Physicians should know enough law to be useful and credible witnesses in court," and made this belief a core of his medical school lectures on the subject.

"The physician may be in court as a witness, as plaintiff, and as defendant. Under whatever circumstances, it is one of the most disagreeable calls he may ever be required to make."

Medicine and law, "two of the most diverse callings, may act in perfect harmony, and for the equal benefit of both."

"A doctor who knows nothing of law, and a lawyer who knows nothing of medicine are deficient in essential requisites of their respective professions," quoting David Paul Brown.

Courts set the "standard of care" just right for physicians, and that legal rule applies to lawyers with the same force. "Every person who enters into a learned profession undertakes to bring to the exercise of it a reasonable, fair and competent degree of skill."

The same can be said in the 21st Century. Physicians should be well versed in both the ethical and legal aspects of medical practice. For a detailed accounting of the history of legal medicine in the United States, refer to a contemporary medico-legal text[8] or the E-Book on Legal Medicine and Medical Ethics.[9] ❑

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[1] http://www.uab.edu/reynolds/histfigs/percival

[2] Pellegrino, "Thomas Percival's Ethics…" Introd. to *Medical ethics*, Classics of Med. Lib. Spec. Ed., pp. 7-8, 11-14.

[3] Percival T. Medical ethics. Manchester: S. Russell, 1803, 7

[4] Beauchamp TL & Childress JF. Principles of biomedical ethics, 5th ed. New York: Oxford U. Press, 2001, 31

[5] A medicolegal treatise on malpractice and medical evidence *comprising the elements of medical jurisprudence* 3rd ed., rev. and enl. by John J. Elwell. Published 1871 by Baker, Voorhis in New York.

[6] Channing W. *Of the medical profession, and of its preparation* (1845), http://www25.uua.org/uuhs/duub/articles/walterchanning.html

[7] Channing W. A medico-legal treatise on malpractice and medical evidence—a review. Boston Medical and Surgical J. 1860; 62: 233-241; 259-265; 300-307

[8] Sanbar SS et al., eds., LEGAL MEDICINE, American College of Legal Medicine, Legal medicine 7th ed. Philadelphia: Elsevier, 2007

[9] Sanbar SS, ed., LEGAL MEDICINE &MEDICAL ETHICS, ACLM, ABLM, & ACLM Foundation, 8th ed., Law of Medicine Publication, 2010

Director's

DIALOGUE

There are things that we don't want to happen but have to accept,
things we don't want to know but have to learn, and
people we can't live without but have to let go.

Author Unknown

Grief is the normal process resulting from a loss. All of us experience it – whether from the loss of a family member, a friend or a beloved pet. My first memory of grieving was over Lady, a magnificent Irish setter with a silky red coat and an enthusiasm that knew no bounds. Lady is my first memory of a family pet. The unfortunate error of a gate left open one summer evening resulted in her escape from the yard, and she was hit by an automobile at dusk on the nearby highway. As a child, the loss was monumental but the grieving process did not last long as my attention soon was diverted. Even though my age was young, this loss was imprinted on my heart forever.

Denial, anger, bargaining, depression and acceptance comprise the five stages of grief. The order and manner in which we grieve is different, and the entire process is not always completed. Helping survivors cope with grief is an important component of hospice care. Hospice of Oklahoma County, a not-for-profit hospice established by Oklahoma County Medical Society physicians and now a part of INTEGRIS Health, provides bereavement counseling and emotional support following the death of a loved one.

Bob Willis was the Bereavement Coordinator at Hospice of Oklahoma County until recently – this is a retirement from his second career. His first career as a Southern Baptist minister spanned 18 years before he became a bereavement coordinator. It was during these 16 years that Bob adopted sculpture as a hobby. Last year, he began offering to create keepsakes cast in stone to Hospice of Oklahoma County families. Bob was interviewed by the Journal Record in May 2011 about this service, and below are excerpts of what I believe to be Bob's most touching story:

"My most challenging was a casting of a 21-day-old baby girl who died in our hospice service. It was also the first time I'd done that. The family wanted something to hold after she was gone. So I was able to sit with the parents as they held her and I took the casting. It was grief and bereavement work. And then you look at the end result, when I

gave the final product to the mom and dad. When the mom held those tiny hands up to her face, I realized this was a valuable gift that I could share with others."

What was once a hobby has become Bob's third career. These "Moments...Cast in Stone" can commemorate births by casting a baby's hands and feet; weddings with the hands of the bride and groom cast together; or sports achievements by casting a hand holding a baseball, golf ball, etc. As his flyer states, "Unlimited possibilities...use your imagination." If you are interested in a stone casting, Bob can be contacted at the Rocking W Gallery located at 1104 NW 30th Street, Oklahoma City.

Bob's life has been spent in service to others – from his first career to his third. It was a privilege to be associated with him through Hospice of Oklahoma County during my tenure on the board, and my family has benefitted from his knowledge and wisdom. Bob's grace, sweet spirit and calm demeanor have been a balm to many people on their journey through the grief process. He is a gift to everyone he encounters and now, through his talents, he is sculpting moments in time to be treasured for a lifetime. Good luck, Bob! You deserve everything good that life has to offer... ❑

Jana Timberlake, CAE, Executive Director

Extreme Cost Cutting

Healthcare costs are soaring and patients are complaining, but at least one Massachusetts dentist has, perhaps, been too focused on saving money, according to an early February "Huff Post Weird News" report. Dr. Michael Clair was sentenced in early February to a year in jail for using paper clips instead of stainless steel posts in root canals. Prosecutors had sought a sentence of five to seven years. Charges against him included assault and battery, defrauding Medicaid of $130,000, illegally prescribing medications and witness intimidation. Although using paper clips, he billed Medicaid for the costs of stainless steel posts, and submitted false claims using other dentists' provider numbers. His license to practice was suspended in Massachusetts in 2006; he was suspended by Medicaid in 2002 but continued to file claims from August 2003 to June 2005 by using the names of other dentists in his practice. The Massachusetts Attorney General says he is no longer licensed to practice in any state. ❑

A Broken Carburetor

My Patient's Most Pressing Health Need

Douglas Jutte, MD, MPH

During medical school and pediatric residency I spent over a year living in the Dominican Republic and Guatemala, so when I finished my training I wanted to continue my work with Spanish-speaking families. My first job was in the neighborhood clinic of East Palo Alto, California, a low-income community inhabited primarily by first- and second-generation Mexican immigrants.

One of my earliest patients in East Palo Alto was a little boy with Down syndrome and a serious congenital heart defect, a common feature of that condition. When I met him, he had recently undergone open-heart surgery and had a gastric tube placed so that he could be fed without requiring him to eat. His mother was enormously attentive but had very limited resources and spoke only Spanish. Together we monitored his health as he stabilized, grew and began to eat on his own. With a full medical recovery, his continued healthy development now relied primarily on obtaining the proper setting for his schooling.

With no caseworker or nurse in my clinic to help me out, I made calls and wrote letters to enroll him in a fantastic school near the Stanford campus. Months later, before a pending well-child visit, I called the school to get an update on his development. I was shocked to learn that it had been weeks since he had last attended. When he and his mother came in for their appointment, I learned her car had broken down. She was saving money for a fix, but had no one to rely on for her son's transportation and hadn't known where to turn for help. Desperate, I called the school and discovered that not only did they have a shuttle service but also it was free for needy children.

This was a crystallizing moment for me. The long-term health and well-being of a developmentally delayed child whom I had helped coax through recovery from prolonged hospitalizations and multiple complicated surgeries hinged not on the quality of my medical care but on a taxi voucher and a broken carburetor.

This month the Robert Wood Johnson Foundation, in partnership with Harris Interactive, released a poll indicating that the majority of physicians are not only conscious of the relationship between the social risk factors of their patients and poor health outcomes, but they perceive these factors to be as important as their patients' medical conditions. In regard to that latter point—the recognition that social needs are as important as medical conditions—I was, admittedly, a bit surprised. And when I told a colleague of mine, her response was, "Are you kidding me?"

Our experience has been that, in many ways, the medical field rejects or downplays the notion that social factors are as important to consider as biological factors. It's not the way we, as doctors, are trained. Two years ago, I completed an article comparing the importance of social and biological risk factors in predicting poor health and educational outcomes for children, but was forced to publish in an epidemiology journal. Several medical journals rejected it, their reason: not "clinically relevant."

Perhaps the tide is turning. But what can be done to compel more health care providers to recognize this relationship? And what must be done to ensure they have the support to address these important social needs effectively?

We need stronger evidence. We need more science that makes the link between social factors and health, at the patient-doctor level, and what can best be done about it. Common sense may say there is a tie between the social needs of our patients and their health, but the medical field will not address the issue unless it is more than just a hunch, and until we have evidence for how to "treat" it. We also need cost-benefit data. Advocates for preschool have succeeded in increasing access across this country because they had data demonstrating that the benefits to society outweigh the costs. We need to ensure we can do the same.

We need to reevaluate the fee-for-service model. Doctors should be reimbursed for all interventions they make to better the health of their patients—not just the procedural ones. If the critical health issue requires a call to the school, or a letter to the landlord, or efforts to find a social service agency and arrange a referral, the doctor should be reimbursed for those efforts just as they are for a skin biopsy or blood pressure re-check. Currently the only way to get this work done is to spend our own—uncompensated—time, working longer days. As primary care physicians, we are already among the lowest paid doctors in this country. Is there any question as to why most medical students are not choosing to pursue primary care?

Doctors need to spend more time in the community. I have a vision that primary care doctors would have a compensated half-day per week—or perhaps every other week—to spend in the community, testifying at city council meetings, visiting neighborhood associations and consulting with schools and other community organizations. To free up more time for physicians, we should consider restructuring primary care clinics to increase the role of other health care providers like nurse practitioners and physician assistants. Doing so would allow doctors to focus both on the most complicated patients and on building an enhanced role in the community.

We need to evolve the medical training of young doctors. Unfortunately, most doctors, if given a half a day to spend in the community, would not know where to begin. Medical student training is focused on pathophysiology and in-patient care. During residency, we are educated primarily in a hospital setting—not in clinics—and we don't receive explicit training on a physician's role in dealing with the social needs of our patients. Some progress has been made in this area, for example pediatric residency programs now require an advocacy rotation of all their trainees involving work with community groups or expert testimony before state legislatures, but more efforts like this are needed.

We, as health care providers, need to make a commitment. Ultimately, nothing is going to change until doctors demand changes to the system of which they are a part. I am confident that most doctors became doctors for the right reason: to keep our patients healthy and to help those who are not healthy to get well. As shown by the RWJF/Harris interactive poll, we physicians increasingly recognize that having a warm place to live, food to eat and an income to support their families are integral to achieving those goals. However, that is only a first step. Next we must advocate for the services, policies, education and reimbursement structures that will better allow us to treat these critical, social determinants of health. ❑

Douglas Jutte, MD, MPH is an assistant professor at UC Berkeley's School of Public Health where he teaches in the UC Berkeley-UCSF Joint Medical Program and is Acting Director of the Health and Medical Sciences Master's degree program. His research interests focus on health resilience and vulnerability in children. He is interested in the biological links through which social-contextual factors contribute to children's long-term medical, psychosocial and cognitive outcomes, and he has a long-standing collaboration with the Manitoba Centre for Health Policy in Canada using their unique longitudinal population health database for pediatric research. Jutte received his MD from Harvard Medical School, a Master's degree in Public Health from UC Berkeley and a BA from Cornell University. His post-doctoral research training in population health was through the Robert Wood Johnson Foundation Health & Society Scholars program. He continues his clinical work as a neonatal hospitalist attending high-risk deliveries and caring for healthy and ill newborns at a local community hospital.

This article, published December 7, 2012 on NewPublicHealth.org, a public health news and information forum from the Robert Wood Johnson Foundation, is republished with permission. Visit NewPublicHealth.org to join the conversation on how social factors shape people's health and other public health topics.

What Fed the Obesity Epidemic?

There is general agreement that many factors contribute to obesity: lack of exercise, increased TV and computer time, supersized portions, over consumption. Two Los Angeles Times articles in late 2011 focused attention on some additional factors.

"Globesization"

Roberto De Vogli, lead author of a study published in Critical Public Health in December 2011, believes public debate overlooks the global forces in society that are shaping behaviors worldwide. The study compared the number of fast-food restaurants per capita in 26 countries with advanced economies. Subway, the sandwich shop, was used as a proxy measure because it reportedly had the most restaurants worldwide. Not surprisingly, the U.S. and Canada had the highest density of restaurants per capita: 7.52 and 7.43 per 100,000 people, respectively. The prevalence of obesity for men and women in the U.S. is about 32 percent; in Canada, it's about 23 percent. Japan, with 0.13 such restaurants per 100,000 people has an obesity rate of 2.9 percent for men and 3.3 percent for women. Norway has 0.19 restaurants per 100,000 people and an obesity rate of 6.4 percent for men and 5.9 percent for women. "If you look at trends over time for obesity, it's shocking," said De Vogli.

Mom

Melinda Sothern, a nutrition expert at Louisiana State University, believes the obesity epidemic can be traced to mothers in the 1950s. She thinks the rates exploded in the 1980s because "Ozzie and Harriet" moms "smoked, spurned breast feeding and restricted their weight during numerous, closely spaced pregnancies" – the obesity trinity. She cites her own family as the example: Her mother's obstetrician told her to gain less than 20 pounds during her three pregnancies and that smoking a pack of cigarettes a day was a good way to keep the weight down. The three siblings, born within four years, were bottle fed since breast-feeding was not in vogue. She has struggled to control her weight by carefully monitoring her diet and exercising religiously. Her brother is diabetic and her sister, obese.

Sothern says inadequate nutrition during pregnancy can program babies to catch up on growth during infancy. Studies

suggest such growth spurts increase the risk of later obesity. Smoking during pregnancy is thought to contribute to obesity risk in children because nicotine disrupts the body's ability to control appetite, metabolic rate and fat storage. Studies have shown that formula-fed babies are at higher risk for obesity than breast-fed babies. And since breast feeding can prevent ovulation, non-nursing mothers were more likely to experience multiple pregnancies in a shorter period of time. Successive generations have gotten bigger, with heavy women having large babies. Large babies also have a high risk of obesity because they are less sensitive to hunger cues and to insulin, says Sebastien Bouret, an assistant professor of pediatrics at the USC Keck School of Medicine. Noting that overweight women are more likely to have diabetes, Bouret also has found that diabetes during pregnancy triggers obesity in babies. Today, about one-third of women are overweight when they become pregnant; almost one-third of U.S. babies are too fat by nine months. Today's average 10 year olds are heavier (boys 85 pounds, girls 88) than their 1963 counterparts (boys 74 pounds, girls 77).

Sothern's prescription? Women should be physically active and have a healthy diet for at least a year before pregnancy. Significantly overweight women should not have babies. Women should breast feed for at least six months or, better yet, "take one year off from work and breast feed." They should not smoke. Toddlers should have 60 minutes of recess and 40 minutes of physical education class each day. ❑

Oklahoma City-County Health Department
Epidemiology Program
Communicable Disease Surveillance

COMMONLY REPORTED DISEASES	*Monthly*			*YTD Totals^*	
	Jan'12	Jan'11	Dec'11	Jan'12	Jan'11
Campylobacter infection	5	5	2	5	5
Chlamydial infection	N/A	N/A	N/A	N/A	N/A
Cryptosporidiosis	2	1	2	2	1
E. coli (STEC, EHEC)	2	0	0	1	0
Ehrlichiosis	0	0	0	0	0
Giardiasis	0	0	0	0	0
Gonorrhea	N/A	N/A	N/A	N/A	N/A
Haemophilus influenzae Type B	0	0	0	0	0
Haemophilus influenzae Invasive	0	2	0	0	2
Hepatitis A	0	0	0	0	0
Hepatitis B*	11	10	9	11	10
Hepatitis C *	16	20	10	16	20
HIV Infection	N/A	N/A	N/A	N/A	N/A
Lyme disease	0	0	0	0	0
Malaria	2	0	0	0	0
Measles	0	0	0	0	0
Mumps	0	1	0	0	1
Neisseria Meningitis	0	0	0	0	0
Pertussis	0	3	0	0	3
Pneumococcal infection Invasive	1	0	0	1	0
Rocky Mtn. Spotted Fever (RMSF)	0	0	0	0	0
Salmonellosis	6	9	4	6	9
Syphilis (primary/secondary	N/A	N/A	N/A	N/A	N/A
Shigellosis	22	9	29	22	9
Tuberculosis ATS Class II (+PPD only)	42	50	34	42	50
Tuberculosis ATS Class III (new active cases)	2	1	0	2	1
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	1	135	0	1	135
Influenza, Novel Virus	0	0	0	0	0
Strep A Invasive	0	0	0	0	0
Legionella	0	0	0	0	0
Rubella	0	1	0	0	1
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*

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

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