# THE BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY

JANUARY/FEBRUARY 2018

2018 OCMS PRESIDENT
SAM S. DAHR, MD,
WIFE LANA TOLAYMAT, Ph.D.
AND SON ADAM

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# THE BULLETIN

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# ABOUT THE COVER

Pictured on the cover is the 2018 OCMS President Sam S. Dahr, M.D. with his wife Lana Tolaymat, Ph.D. and their baby boy Adam.

Dr. Dahr founded his ophthalmology practice in 2006, specializing in medical and surgical retina, uveitis/autoimmune eye disease, and ocular oncology. As the only NIH-trained ophthalmologist in the state, he is the regional expert for autoimmune eye disease, treating patients from Oklahoma, Kansas, Arkansas, and north Texas. He takes particular pride in taking care of patients with Vogt-Koyanagi-Harada (VKH) disease, a severe form of autoimmune eye disease that affects young patients in their teens and twenties. VKH disease is of increased prevalence in individuals of Native American ancestry and thus exerts a disproportionate visual burden in Oklahoma.

The son of Dr. and Mrs. A.S. Dahr, life members of OCMS and OCMS Alliance, respectively, Dr. Dahr is a native Oklahoma Cityan and graduate of Heritage Hall School. During his four years at Stanford University, he earned his B.S. in Biological Sciences and an M.S. in Management Science/Engineering-Economic Systems. He subsequently attended the University of Oklahoma College of Medicine, followed by a residency and fellowship at the University of Cincinnati and a fellowship at the National Eye Institute of the National Institutes of Health.

Committed to public service, he has served as the principal retinal consultant to the Ophthalmic Device Division of the U.S. Food and Drug Administration (FDA) since 2007. In that role he reviews clinical trials for medical devices and evaluates those devices for safety and efficacy. In 2013 he received a special commendation for public service from the FDA for this work. In 2017, he was named to a four year term as one of seven ophthalmologists and the only retina surgeon on the FDA Medical Device Advisory Committee.

Dedicated to education, Dr. Dahr serves as Clinical Associate Professor at the University of Oklahoma College of Medicine. He treats patients in the uveitis clinic at the Dean McGee Eye Institute and teaches autoimmune eye disease to residents and fellows. As a member of the American Academy of Ophthalmology, he is one of seven ophthalmologists on the writing committee for that organization's uveitis textbook, which is used internationally for resident and continuing medical education.

A graduate of OCMS Leadership Academy, he is currently Chairman of the Department of Ophthalmology at Integris Baptist Medical Center and a member of the board of directors of the Oklahoma State Medical Association.

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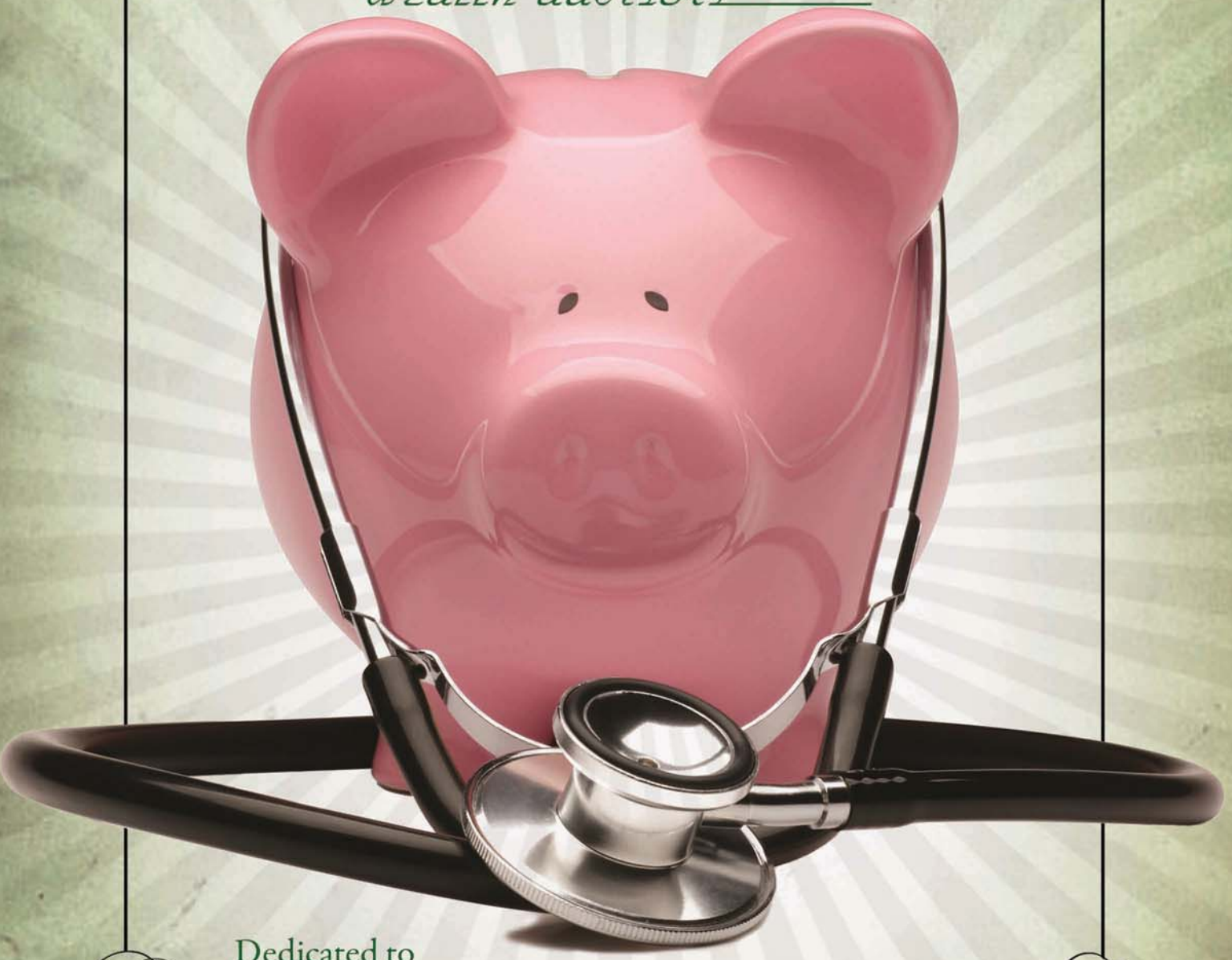

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# PRESIDENT'S PAGE

Sam S. Dahr, MD

**Happy New Year!** Thank you for the honor of serving as your president for 2018. On January 19th, a newly titled "Celebration of the Oklahoma County Medical Society" will replace our traditionally titled inauguration event. Medicine is changing, and OCMS is evolving as well. As a healing profession, medicine has traditionally focused on the outstanding individual – the gifted surgeon or the brilliant diagnostician. Appropriately, the shift in the last few years emphasizes the healing team, acknowledging that each individual contribution is critical yet the collective effort of colleagues determines success or failure. Likewise, for OCMS, the physician members of the society, the professional staff, the officers, and the Alliance compose that team.

OCMS will continue to build on its successes. The Physician Wellness Program, designed by physicians for physicians, renders confidential, convenient, and critical counseling services. The program is now up and running and accessible by calling (405) 340-4321. Independent Transportation Network (ITN) of Oklahoma provides transportation to senior citizens and the visually impaired. The Health Alliance for the Uninsured facilitates quality preventive care for the medically underserved. The Open Arms Clinic will celebrate its twenty-five year anniversary in 2018. This year's OCMS Leadership Class is our largest.

Many challenges lie ahead, for physicians and for our keystone organizations such as OCMS and OSMA. At the federal level, nearly eight years after passage of the Affordable Care Act, health care policy remains unsettled. We wait to see which direction the political winds will blow and what will come next. This turbulence buffets our practices every day, creating stress for patients and physicians. At the state level, an unresolved budget crisis and an accounting controversy within the Department of Health have created tremendous uncertainty.

We endure and excel because of our mission: to care and to heal. We care for our patients, number one. But we also care for each other, as colleagues, as teammates, and that drives our success. OCMS helps us care for our patients and helps us care for one another. Let us celebrate the success of OCMS and our physician community!

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# DEAN'S PAGE

Russell G. Postier, MD, FACS
David Ross Boyd Professor and
Interim Executive Dean
University of Oklahoma College of Medicine

On Thursday, January 25, 2018, the College of Medicine will hold its 34th annual Evening of Excellence research fund dinner sponsored by the College of Medicine's Alumni Association. This event brings together the medical, business, and philanthropic communities of our city and state for the purpose of fostering new and growing research at the medical school. The first such event in 1985 was initiated by a dedicated group of visionary alumni and has since evolved into an annual fund raiser which provides small seed grants to assist our young faculty scientists in establishing their scientific careers. Past support has contributed to major successes among our researchers, providing more than $3.2 million in seed grants to 150 junior investigators. This investment has been repaid many times over by the subsequent success of these investigators in obtaining NIH and other nationally competitive research grant funds.

In a few weeks, the Evening of Excellence will recognize Oklahomans who have contributed to the betterment of health and well-being in our state. The award for distinguished medical service will be presented to physician and Dean Emeritus, M. Dewayne Andrews, M.D., and the award for outstanding community service will be presented to community leader David Rainbolt. The recipients of the special recognition awards are chosen by vote of the Alumni Association's Board of directors and we are extremely grateful to the College of Medicine Alumni Association for its sponsorship of this extraordinary annual event and for their continuing support of the College in this endeavour and so many countless other ways….which brings me to another example of what is possible because of the steadfast support from our alumni and friends: It is my pleasure to share with you, for the 2017-2018 academic year, the College of Medicine awarded $2,284,235 in scholarships to more than 250 medical students. This is a significant increase from just 10 years ago, when the college awarded $650,000 for the 2007-2008 academic year, and bespeaks of the great impact of those who answered our call during the Second Century Scholarship Campaign.

Medical school applications have continued to increase over the past few years - notably, during this 2017-2018 application cycle, we have a record number of 2,322 applications. The Admissions Board will complete interviews with approximately 300 of those applicants by the end of January. We are deeply appreciative of the +2,000 hours faculty, volunteer community doctors and our Admissions staff selflessly commit to this process as we eagerly look forward to the Class of 2022 matriculating in August.

Students at the OU Health Sciences Center (OUHSC) have the opportunity to learn to work with their peers in different health professions through an interprofessional training program. Interprofessional education occurs when students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes. Incorporation of interprofessional education into student training is now a requirement in the accreditation standards of nearly all health professions colleges. Through the vision of Dr. Peggy Wisdom and with funding from the Wisdom Family Foundation, OUHSC faculty have developed an interprofessional education program that brings students from all of the OUHSC Colleges (Medicine, Nursing, Pharmacy, Allied Health, Dentistry, Public Health, and the Anne and Henry Zarrow School of Social Work on the Norman campus) together to learn about interprofessional roles and working in interprofessional teams.

One component of this training which is very popular with students is EPIC (Empowering Patients through Interprofessional Education) Clinic. This is a clinical experience utilizing eight teams each composed of up to 10 students from all of the disciplines represented on the

*Continues on page 8…*

# 2018 RHINEHART AWARD RECIPIENT

## WILLIAM L. PARRY, MD

Dr. Parry, a native of Elmira, NY, attended the University of Rochester School of Medicine, followed by his internship, residency and fellowship all at Yale. During the Korean Conflict, he was Chief, Urology Section and with the Streptococcal Research Unit at Warren AFB in Wyoming. Over the next several years, he earned a national reputation for prevention of acute renal failure and for drawing attention to transsacral prostatectomy and an additive to radical pelvic surgery. As Associate Professor at Rochester, he performed the renal vascular surgery for hypertension and was chosen to be the renal transplantation surgeon.

After deciding to join the OU College of Medicine Faculty in 1962, he worked diligently to earn support from local urologists. He attended their meetings, assisted in encouraging more extensive surgeries and expanded the residency to Baptist, St. Anthony and Mercy hospitals. Dr. Parry was later elected as the first chief of staff for the university, where he initiated the Renal Dialysis Program, recruited psychiatrists to help residents be comfortable with all emotional situations, and continue kidney studies. He also produced many publications on renal lymphatics, vascular dynamics and partial nephrectomies and conducted studies. He has served on numerous community and regional boards and has been a part of several national programs in research.

Dr. Parry and June Howoth have been married for 66 years. Daughter Barbara is a Professor of Psychiatry at UCSD, daughter Marjorie is a Professor of Architecture at OU and son Richard is the CEO/Owner of a national investment management firm in OKC. When Dr. Parry retired as Chairman in 1994, honored as a Professor Emeritus, he had the longest tenure of a urology chairman in the U.S.

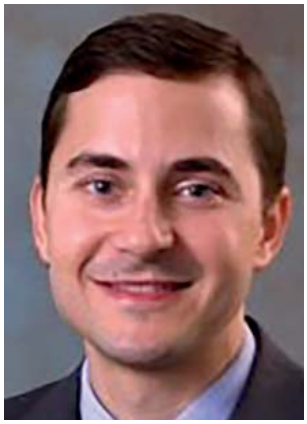
## DEAN'S PAGE *Continued from page 7...*

OUHSC campus which provide longitudinal care to patients at the Good Shepherd Ministries, a clinic in Oklahoma City that serves only uninsured patients. Each team is facilitated by a faculty member from the College of Medicine and by faculty members from the other health professions colleges. The goal of the clinic sessions is to provide students the opportunity to apply principles of interprofessional care to the management of patients with complex chronic conditions. Students are expected to design and deliver effective and efficient care to the patients while addressing their comprehensive needs. Each student on the EPIC teams is allowed the opportunity to interact with patients and with students from other disciplines in a clinical setting to promote the health of patients as they had been trained to do in their respective field of practice. Students are very enthusiastic about the benefits – both to the populations we serve and professionally – of this successful program.

Congratulations and kudos are in order to the Irwin H. Brown Office of Continuing Professional Development (CPD) for receiving the Accreditation Council for Continuing Medical Education's (ACCME®) award of Accreditation with Commendation. This accreditation status is the highest level the ACCME® awards and is effective until 2023. Over the past year, the CPD has served over 15,320 physicians and other healthcare professionals, and issued 757.75 AMA PRA Category 1 Credits™. This office continues to be one of the gems in the College of Medicine's crown.

Roughly twelve-and-a-half years ago, we proudly announced that we had concluded the search for a distinguished neurosurgery chairman for the College of Medicine: Dr. Timothy Mapstone, recruited from Emory University School of Medicine in Atlanta, was appointed to the Harry Wilkins Chair in Neurosurgery and as Professor and Chair for the Department of Neurosurgery. We now ask you to join us in thanking Dr. Mapstone for his service to the Department of Neurosurgery as he has announced his retirement effective June 30, 2018. The Neurosurgery Department has grown in stature and reputation during Dr. Mapstone's tenure here and I am deeply grateful for his service to the University of Oklahoma College of Medicine. A search committee has been formed and a national search is under way to begin to look for his successor. In addition to the chair for neurosurgery search, a national search is in progress for the geriatric medicine chair, which is currently held by Interim Chair, Dr. Donald L. Courtney.

## EXECUTIVE COMMITTEE 2018



# OKLAHOMA COUNTY MEDICAL SOCIETY ANNUAL MEETING NOVEMBER 6, 2017

*Above, Dr. Sam Dahr presented Dr. Apple Rice a plaque in recognition for serving as Oklahoma City Clinical Society president during 2016.*

At the November 6, 2017 Annual Meeting, the OCMS slate of officers were elected: Sam S. Dahr, MD - President; R. Kevin Moore, MD – President-Elect; Lisa J. Wasemiller-Smith, Vice-President; Basel S. Hassoun, MD – Secretary/Treasurer.

In addition to the OCMS slate of officers, the following candidates were elected to the Oklahoma City Clinical Society: Sam S. Dahr, MD, President; Sarah Yoakam, MD, President-Elect; Randy C. Juengel, MD, Vice-President; and Pooja Singhal, MD, Secretary-Treasurer.

# IN MEMORIAM

## Hugh M. Conner
## 1923-2017

Leadership Academy Class VIII

# FEATURED MEMBER PROFILES

Name: **Janine Collinge, MD**
Specialty: Ophthalmology

*Where do you practice?*
University of Oklahoma & Dean McGee Eye Institute

*Why do you feel physicians need leadership training?*
It is helpful to learn what is going on in the community and what resources are available. Most of us are working so hard to take care of our patients, our families, and ourselves that we are unaware of the opportunities around us.

*Any other life details to share? Hobbies, family, interests?*
I enjoy cooking and eating good food. Because of this I also enjoy running and fitness classes. I spend my free time enjoying Oklahoma with friends and spending time with my dog, Wally.

Name: **Chad Michael Smith, MD, FACOG**
Specialty: OB/GYN

*Where do you practice?*
Mercy Hospital OKC

*Why do you feel physicians need leadership training?*
It is critical that physicians achieve leadership training so that we can better advocate for our patients within the hospitals we practice our trade and within our local community. Through physician leadership development there is also opportunity to impact change within the government, also to better advocate for our patients.

*Any other life details to share? Hobbies, family, interests?*
I have a wife, Jamie, and three sons, Kaedyn, Paxton, and Emerson. They are the source of my inspiration, drive, and determination to be the best husband, father, physician, administrator, and person I can be. I have a healthy love for golf, OU Sooner football, and Thunder basketball. Gardening is a true catharsis and weekend hobby.


THE
PEARL

# ADMINISTRIVIA AND SENSELESS REGULATIONS VS. GOOD MEDICAL CARE

Tomás P. Owens, MD
Chair, Family Medicine
INTEGRIS Baptist Medical Center

**Yep, they are mutually exclusive.** The former takes time, energy and the very spirit from the latter.

A term lying quiescent in the pages of Merriam Webster's – the first English notation is believed to come from the International Journal of Ethics in 1937 – (incidentally, the same year that *blitzkrieg* came to the US lexicon); **administrivia** has resurrected to be in the forefront of all that is annoying about medical practice today and indeed feels as an intense military campaign against medicine.

It is defined as "administrative tasks that are regarded as uninteresting and time-consuming while being trivial" in the relevant scheme of things[1]. My preferred definition comes from Oxford Dictionaries: "Trifling administrative tasks, especially those which take a significant amount of time to complete" and are peripheral in importance[2]. An online medical student and resident-led site defines it as: "pointless emails and notices that clog up real medical work"[3].

A study by Dr. Catherine Sinsky et al, in the Annals of Internal Medicine in December of 2016, reviewed 57 practices of family physicians, internists, cardiologists and orthopedic surgeons and found that for each hour of clinical face-to-face contact with patients, a physician accrued two additional hours of EHR and desk work within the clinic day. In addition, doctors accumulate between one and two extra hours of deskwork, after the daytime workday is over. Physicians used 27.0% of their time with the clinical encounter and 52.9% with desk work during an average day[4]. A great proportion of this non-medical 'paperwork' (ironically many times not involving actual paper anymore) is indeed administrivia.

I have understood patients to value how personable the physician is, how good her/his diagnostic skills are and how sharp his/her technical procedural dexterity is. The

*Continues on page 14 …*

ailing seek the thoughtfulness of the doctor's therapeutic approaches, and the ability to explain those and the alternatives to them. I am yet to hear a patient ask me if the consultant I'm referring them to is "good at getting the placement orders in time" or capable of fulfilling all the Electronic Health Record properly or a 'high scorer in MIPS'. The patients' professional expectation of us revolves about our clinical acumen, technical adroitness and relational skills.

The number and variety of activities that are now in the way of our taking care of the patient is extraordinary. Some are simply things that do not require training in medicine, others are just inane, others yet, designed to save a third party money or effort. Whichever the reason, they misuse our expertise, delay our clinical actions and interfere with our fiduciary duties.

Let's start with signatures. In an average week, I get to co-sign several hundred of my residents' patient encounter notes and orders. The patients have been seen, evaluated by the resident in conjunction with me, their treatments have been fulfilled and sometimes several days later, I get to the ever-so-critical action of cosigning their note. As if signing makes the illness retroactively get better. I guess if you don't sign afterward, the gallbladder was never taken out, the furosemide will return to the bottle and the cyst will return to the subcutaneous. Signatures change 'pretend' actions into reality maybe?

Every one lab or x-ray order, though already forwarded and likely performed, has to be cosigned after the fact. Ditto for the actual results. Ironically, co-signing has become so entrenched in our day-to-day that we don't even think of it as bootless.

Leastwise, some of these actions have a possibility, albeit slight, of generating important feedback to the learner and actually improving patient care. Not so much for most of the others.

One of the latest administrivia tasks happens in the hospital since about 2013. It also happens to be a senseless time-wasting fatuous extra step.

After you have given a direct order to admit a patient to the hospital, presumably because they are sick, mind you, you have to add a "Placement Order". Haven't you already ordered that patient to be placed in a hospital bed at your facility? Isn't that redundant?

It used to be that being called from the floor meant a question about potassium, medication or intravenous fluid. During my last 3 hospital-service stints, the number one call to me has been 'update the placement order'. Really?

If you haven't done hospital medicine for a while (and I clearly understand why you wouldn't any longer), the "Placement Order" is a relatively new variant of a longer-existing requirement from CMS (of course, given the opportunity, some private insurers have jumped on to capitalize on that).

You are to reiterate the fact you want this patient admitted, but also qualify the patient as one that will 'likely' require a hospital stay of 1-2 nights, 3-4 nights or longer; by doing a "Medicare Inpatient Certification". You are forced by CMS to speculate, at the time of admission and before many tests are back, how quickly a patient will improve sufficiently to no longer need hospital care (and be dismissed). Anyone with hospital experience can tell you this is a senseless exercise, as it is nearly impossible to predict that early in most cases.

Don't take me wrong, I am in the business of trying to predict dismissal times, in order to set up follow-up care, but I don't hold myself up as an oracle of when that outcome will occur, let alone at the very time of admission. More importantly, my laser-focused priority is to heal the patient, not doing foreboding. This physician-as-a-clairvoyant bit is quite amusing. If I could, I would rather use those skills to predict Powerball® numbers.

This "Placement Order" deal is a variant of the Observation (inconceivably termed "outpatient admission") vs. "Inpatient admission" gig, once known by the "23:59" vs "full admit" or "inpatient" verbiage. Interestingly, the erstwhile instructional lectures about the 23:59 canon where in direct contradiction of the ones we receive about today's version.

Unbelievably, the very Medicare webpage states: "you're an outpatient even if you spend the night at the hospital"[5]. Come again? This from the agency that abbreviates Center for Medicare and Medicaid Services with 3 letters! J

Why in the world would you be asked to guesstimate how long the patient will be in need of hospital care? And what happens is you are wrong?

*Continues on page 16 …*

## ADMINISTRIVIA *Continued from page 15 …*

It used to be that your primary duty was to figure out the correct diagnosis and treatment. I would argue that patients would appreciate your incisiveness in emphasizing that angle. Like Dr. William Mayo aphorism goes: "The best interest of the patient is the only interest to be considered …"[6]

How could it possibly matter whether you estimated someone was to take one day or three days to improve? And if you estimated 3 days and the patient got well enough to go home in say, 2 days, how can that possibly be a bad thing? The only thing that should matter is whether you actually got the patient better, in the fastest possible time.

Not so fast … one of the goals of this activity is increasing the number of so called 'outpatient' admissions or 'observation services'. Under current Medicare rules, the patient pays a copayment for each individual 'outpatient' hospital service (x-rays, lab, etc) which varies per service. For "inpatient" hospital services you pay the deductible. But the 'total copayment for all outpatient services may be more than the inpatient hospital deductible', explains the Medicare website.

Then, outpatient 'admissions' can generate higher payments from patients resulting in both more financial returns to Medicare and a sort of deterrent to hospital visits. At least that's the way I understand it.

Medicare being near-bankrupt, I understand and even support conjuring machinations to decrease cost. And yes, there are the patients that overuse the services. We need to save Medicare, but this is hardly the way to deal with this crisis.

Notice that the doctor is the one 'determining' the placement order and certification. If you get somebody in for an overnight rehydration stay, the patient could interpret that an extra night would have turned the "outpatient" admit into an 'inpatient' category and cost them less. Suddenly, we are unwilling 'gate keepers' again. You remember how that went in the 1990s.

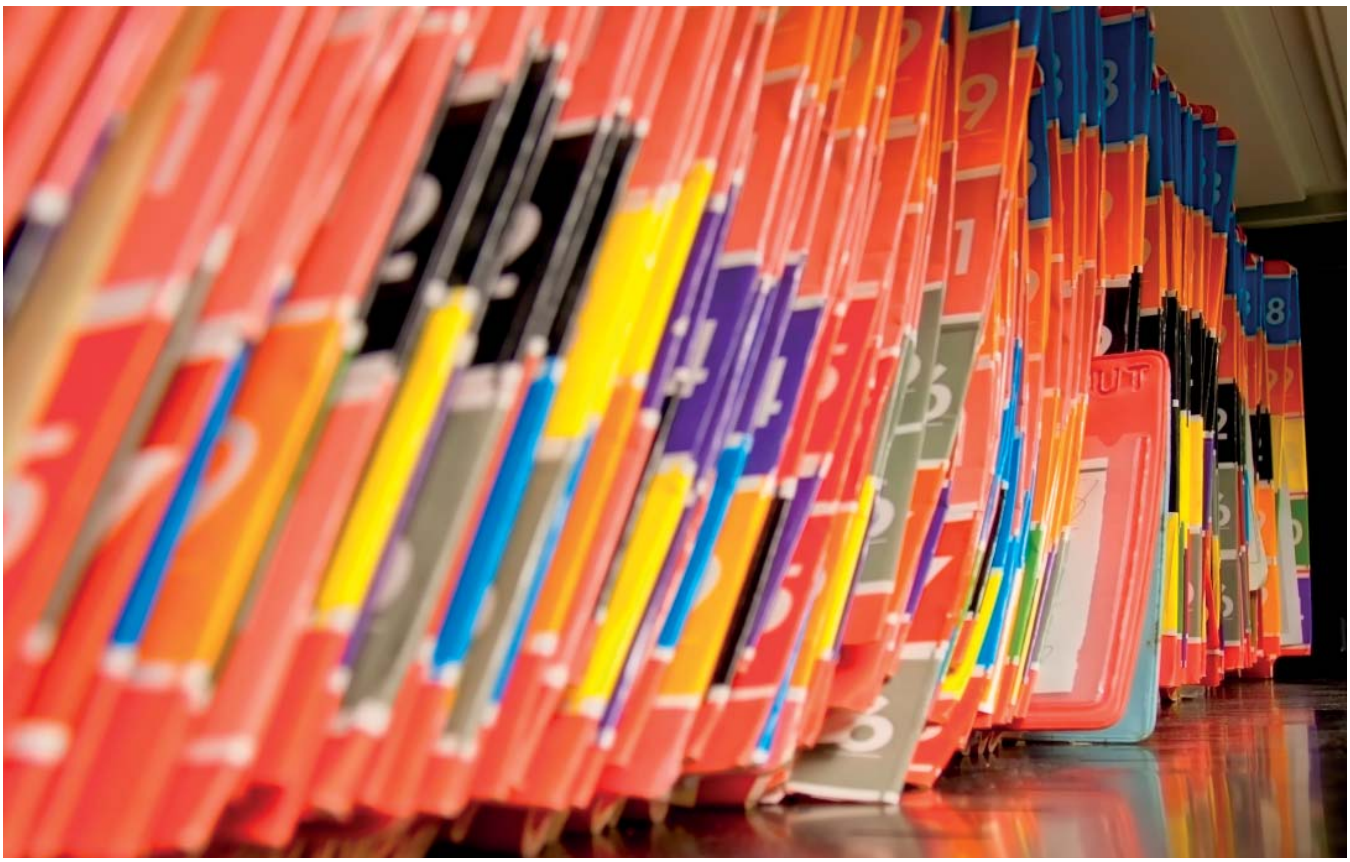
But wait, there is more. Since someone (likely The Joint Commission née JCAHO) has told hospitals that 'uniformity' of tasks and menial check-marking is paramount, ALL patients require a 'placement order', whether they are insured under Medicare or not. The order sets are, of course, separate and named differently: Placement Order and Medicare Inpatient Certification. That is surely a good use of all that medical education.

Our ED colleagues have to send the patients the way of the hospitalist and often times do the Placement Order. Since they have seen the patient at the very earliest, their task if even harder. Once consultations have occurred, results are back and the interventions started at the ED have come to fruition; the patient often requires an adjustment of the placement order, which has to follow a certain set of steps and timing. What are the chances that treatments actually improve the patient? Wow, who would have ever guessed that the proper implementation of treatments would expedite the healing of the patient?!

What if you divine that the patient will be there 3 nights but he/she actually improves rapidly and is dismissed earlier? No, you won't get the CMS Award for Excellence in Medical Care. Instead, the patient will get a "Code 44". What? Is that a variant of "A Few Good Men" - Code Red? (when I heard about it the first time, I thought they were telling me the truth, but felt like yelling "You can't handle the truth!" instead).

A Code 44 is a form that explains to the patient that, although you had them as inpatient admission (because they were very ill), they just got well too quickly – darn it! – and now could be responsible for extra costs (mind you, if you had admit them under observation in the first place the cost to them would be similar – I know, none of this makes any sense, bear with me). Having patients arrive to this situation is bad for the facility, as CMS will then deny any payments, other than ancillary services, to the hospital for that admission (yes, they deny payments for life-savings actions actually done to individuals); thence, you have to make every effort to avoid it. One way to do so, is to add specific verbiage to the last note on the chart reflecting that 'the patient improved much more rapidly than expected' (to no fault of their own or the doctor's, I guess). Typically this is an exercise that is kindly added to your busy day and involves re-opening a note and putting the extra wording. Since this is time-sensitive (literally), you may want to stop conversing to that patient in your office about the importance of blood pressure control and get back to the EHR to profess the surprising improvement of the patient in room 777 (picked the 'lucky' room for effect) and avert the "code".

***Continues on page 18 …***



But, if you were, God-forbid, actually doing a procedure or helping another patient – gasp!, and did not get to the chart in time … a "Code 44" will happen. Now, because of the pressures borne upon medical centers, this business has created a whole slew of professionals bird-dogging the faithful accomplishment of correct Placement Orders and Medicare Certifications. In my setting, they are very nice, helpful, kind and generous people that simultaneously understand the futility of the action to the patient's wellbeing and its importance to the viability of the hospital. Bless their hearts! Yet sometimes they don't get to correct our misdeeds on time.

Once a Code 44 occurs, and I'm not kidding about this, you will get another gift to entertain yourself with, like in the Jack Nicholson/Demi Moore version, there is a beating: to the physician, in the form of a missive sent to you, incomprehensibly named "Provider Liable" letter. Only someone from outer space would come up with the "L" word as the moniker for a letter to physicians. It is actually CMS (I guess some would argue that CMS is indeed outerspace). The provider is now 'liable' for the payments not given to the facility. Yes, the facility that dutifully served and healed this patient, and worse: faster than expected.

I'm not sure what exactly happens to the physician when they get one, but they're forwarded to me in my supervisory capacity, so they must have some deleterious effect. Maybe a Court Martial if you get more than a certain number? We'll report back to our readers later this year …

In part two: Medicare 3-midnight rule, referrals, prior authorizations and other tortures …

THE BULLETIN

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# WELCOME NEW MEMBERS!

**Lance M. Bradt, MD** is an anesthesiologist with Affiliated Anesthesiologists. He graduated medical school from the OU College of Medicine and completed his residency and internship at Scott & White in Temple, Texas.

**William K. Wood, MD** is an anesthesiologist with Affiliated Anesthesiologists. He graduated medical school from the OU College of Medicine and completed his residency at the University of Alabama-Birmingham.

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OKLAHOMA COUNTY MEDICAL SOCIETY

THE BULLETIN

# SINGHAL RECEIVES AWARD FROM THE AMERICAN COLLEGE OF GASTROENTEROLOGY

Pooja Singhal, M.D. was recently awarded with the American College of Gastroenterology 2017 Scopy Award.

The Scopy award is a service award for colorectal cancer outreach, prevention and year-round excellence. It recognizes the achievements of American College of Gastroenterology (ACG) members, in their community engagement, education and awareness efforts for colorectal cancer prevention.

Dr. Singhal won for best original event concept and community engagement. The event was a Colon Cancer Awareness Month event which took place last March. She was honored during the ACG Scopy Award Ceremony and Workshop at the World Congress of Gastroenterology at ACG in Orlando, Florida. Dr. Singhal has a great passion to educate her community, as Oklahomans have one of the lowest colorectal cancer screening rates in the country. "Colorectal cancer can be prevented through screening but is still the second leading cause of overall cancer deaths in the United States," said Dr. Singhal. "It's important that we do our part to educate and help create a future free of colon cancer."

She is an active member of OCMS and a graduate of the OCMS Leadership Academy Class VII. Dr. Singhal is a board-certified gastroenterologist with St. Anthony Physicians Gastroenterology.

THE BULLETIN

# MY FIRST GRAND ROUNDS IN SURGERY

WILLIAM TRUELS, MD, FACS, CWS

*I remember it well – my first Grand Rounds conference in surgery. I had moved to Oklahoma from Chicago to start my surgery residency training. With a rotating internship, I was finally getting to start my surgery rotation by November. I walked into the Grand Rounds conference room with fear and trepidation. It was all fit and proper – you had to learn the rules and go by the book.*

The dress code was quite rigid. You wore scrub clothes in surgery, but you could not leave the surgery suite without being properly dressed. Men wore shirt and tie, and women were required to wear a dress. This often involved changing clothes several times a day, but you got good at it.

Seating at the Grand Rounds conference was somewhat regimented. The Attending surgeons sat up front – they were at the top of the heap and lived in Nickel Heights or Gaylordia. Next came the Chief residents, followed by the Junior residents, and so on. Being a first year resident, or intern, I dutifully sat in the back row. Actually, I was a "rotating intern" which meant I rotated through a new specialty every two months.

Anyway, I sat down next to Herb, a fellow intern who had dreams of being a plastic surgeon. This was a "pyramid" surgery program, which meant you started out your first year with 16 interns, which dwindled down to four chief residents in the fourth and final year.

"Better get rid of that coffee, Dr. Truewater," Herb warned me. "You're not allowed to drink beverages during Grand Rounds. This is all quite serious, you know."

"Where're you from?" Herb asked. "I noticed you talk funny."

"Chicago," I replied. "I've got that Midwestern accent."

"By the way," Herb warned me, "be prepared for any pop questions you might be asked while in front of the group."

"That sounds embarrassing," I quipped. "Only if you don't know the answer!" Herb said.

"But here's a little tip," Herb added. "I learned this from the cadaver lab. If you don't know the answer to a research question, use the rule of thirds."

"The rule of thirds?" I asked.

"Whatever the question, look directly at the examiner, but pause, as if you're reviewing your knowledge. Use "Sir" when addressing an attending surgeon, and always stand up. Then report that approximately one third of patients had a positive result, one third were negative and one third were indeterminate, based on one Johns Hopkins study that's waiting publication."

"Thanks for the tip, Herb," I replied.

Just then the department chairman walked in. All conversation stopped as he ascended to the podium. A few of the attending surgeons and the four chief surgery residents, and two chest surgery residents clapped. I later learned there was a lot of friction among the attendings, and the few that clapped were the ones pretending to show their support for the Chief.

"What's that on his head?" I asked.

*Continues on page 24 …*

"This is football Saturday and it's Nebraska week-end!" Herb replied. "Nebraska-Oklahoma is a football rivalry, a Thanksgiving tradition that'll last forever! Our goal today is to beat those Nebraska Cornhuskers!" Herb replied.

"You see, it's money from the football and basketball programs that helps the entire University! We're all expected to show our loyalty!"

"And we've got a new head football coach," Herb added. "Chuck Fairbanks went to the University of Houston, and Barry Switzer is the new head coach. I hope he works out, even though he's from Arkansas!"

"But, what's that silly red thing on the Chief's head?" I asked again. "It looks like a covered wagon!"

"Oh, that's the Sooner wagon," Herb replied. "To an outsider, that looks silly. But to an Oklahoma fan, it's the symbol of our team!"

"But, why a covered Conestoga wagon?" I asked.

"You see, on April 22, 1889, you had the first of seven Oklahoma Land Runs, where the state opened the Indian territories. The Sooners were people who jumped the gun and settled early. In fact, the two horses that pull the Sooner wagon are named "Boomer" and "Sooner!"

"I guess there wasn't enough room on that hat to put those two horses!" I quipped.

"And you're telling me that the state was named after people who were more aggressive and broke the law?" I added.

"That's right," Herb replied. "Only with all these Indian casinos, the Indians are finally getting their revenge!"

"And that aggressive attitude also carried over into surgery," Herb added.

"How's that, Herb?" I asked.

"We're taught that as a surgeon, it's better to be aggressive and a little intimidating. That's part of the Alton Ochsner tradition!"

Suddenly, the surgery Chief noticed me from the podium, perhaps because I was talking, and I still had a cup of coffee in my hand.

"Dr. Truewater!" he bellowed. "Today's Grand Rounds surgery patient has fulminate pancreatitis. Name the causes of pancreatitis!"

I looked very serious, as I paused, with everybody staring at me, and looked straight at the Chief.

"Be quick about it, Dr. Truewater!" he snapped.

"Very well, Sir," I replied, as I stood up.

It was hard to be serious and keep from laughing, as I looked at that Conestoga wagon, complete with wheels that spin, perched on top of his head, but I knew my future career in surgery depended on keeping a straight face.

"According to a recent Hopkins study, about one third of pancreatitis cases are due to gall bladder disease, one third due to excessive alcohol consumption, and one third are idiosyncratic," I replied.

"Go Boomer Sooners!" I exclaimed. "Beat them Cornhuskers!"

"Excellent response!" the Chief answered, as he re-adjusted the wagon on top of his head.

"I'll be keeping my eye on you!"

As I think about my first day in surgery in Oklahoma, and all the traditions I hadn't yet learned, I sometimes think I landed in another country, or maybe even another planet. But then, it all worked out for the better.

Now, 40 years later, when I go to Chicago to visit my relatives, I'm surprised to hear them talk with that funny accent!


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# *Terra Firma*

# Terra Firma

*"Regretfully, throughout all your high-school years, I have only taught you Newtonian physics. Today, in our last class of your last year, I'm going to broach the concept of metaphysics, that life dimension that eludes our five senses but, nevertheless, rules our minds.*

*"Who are we, anyway? Are we only physical beings, or do we also possess ultra physical dimensions? Are we merely physical facts, or are we also beliefs that masquerade as facts? Are we not but our beliefs, and are not our beliefs but our dearly held superstitions?"*

These two excerpts – of Mr. Michael's good-bye lecture, which he delivered to our graduating class of the American Evangelical School in Tripoli, Lebanon, on June 21, 1963 – still cling, like drowning arms, to my memory.

Mr. Michael traveled with me throughout college, medical school, residency, fellowship, marriage, children, career, aging, and retirement for he was the one teacher who challenged me to dare think for myself. He loved to quote Immanuel Kant's aphorism: *"Sapere Aude – dare to know, have the courage to use your own understanding – that is the enlightenment's motto."*

*"A wise man,"* he would say, *"tries to prove himself wrong whereas a common man tries to prove himself right. Don't fall in love with your own ideas merely because you were the one who conceived them. Spend time collecting evidence to disprove your own points of view and learn as much as you can from those who disagree with you because those who agree with you, teach you nothing."*

Fifty years after graduation, we held a high school class reunion in North Carolina, because most of us had been refugeed by the Lebanese Civil War. Mr. Michael, at ninety-two, came from Los Angeles with his American wife who was eighty-five and with his Lebanese cane, which he had whittled out of an olive branch from a piece of land that he had inherited from his father. Mr. Michael, my classmates, and I filled in the gaps across half a century of absence, told stories, laughed, lamented, comported ourselves with the abject abandon of children, and, after three frolicsome days, returned back to our sundry lives feeling enriched and rejuvenated.

It was two years after that expatriate reunion that I received the tremulous call:

"Doctor, this is Mr. Michael's wife, Marybeth. He's very sick and is asking for you."

"What's going on?" I gasped.

"He's sick with so many things and may not be around very long."

"Is he not happy with his doctors?"

*Continues on page 24 …*

# Terra Firma

*Continued from page 27 …*

"Oh, no, we have wonderful doctors. When I ask him why is he insisting on seeing you, he tells me that it's personal."

"May I talk to him, please?"

"He has been restless, perturbed, and not himself for about a year now. He hardly speaks and keeps babbling that he needs to see you. His doctors think he's delusional, but I know better. He's distressed about something and won't tell me because, being American, he thinks I wouldn't understand."

The Friday after that call, I flew to L.A. His eyes lit up when I walked in and he said, "Thank you for coming. I have inconvenienced you with a great hardship, but I had no one else I could turn to but you."

His wife seemed stunned by his sudden clarity and terse eloquence. I sat by his bed and held his extended hand. He looked at his wife and kindly asked, " How about some coffee, dear?"

"I'll take my time," she replied with a knowing smile, and left the room.

I looked into his eyes, brimming with excitement, and smiled back to hide my own surprise. He got out of bed, marched steadily to his desk, sat down, opened a drawer, pulled out an envelope, and handed it to me.

Standing before him, like I had for so many years as an obedient student, I took the sealed envelope and waited.

"Please sit down," he motioned. "When I fled Lebanon thirty-five years ago, I owned a large piece of land near our hometown, Kahloon, which I had inherited from my father. When, after many years, we realized that we were never going back, Marybeth, convinced me to sell the land, and with the money buy a piece of property here. I resisted, but after I ran out of excuses, I reluctantly sold the land, about a year ago, and I have been miserable ever since."

"To whom did you sell it, sir?"

"To my youngest brother, who is eighty now. I'm fourteen years his senior and too old to make that trans-Atlantic, trans-Mediterranean trip again. When I went back a year ago to complete the sale, I realized that I was no longer fit for travel."

I looked at the envelope in my hand and politely waited for him to tell me what to do.

# Terra Firma

"I have felt naked ever since that sale, like a homeless man, wandering aimlessly without his clothes. I don't want to die homeless and naked. I want to don my clothes before I am returned home, for I wish to be interred in Lebanon."

"I'm going to Lebanon next month to see my mother who is ninety-five," I volunteered

"I knew that you go back every year for her birthday. You told me so during the class reunion. That's why I wanted to see you. I've talked to my brother and he's willing to sell me back the land for the same price. In this envelope is a power of attorney for you to act on my behalf and a cashier's check made out to my brother. My hometown is only a ten-minute drive from yours. Here's his telephone number and I have already given him yours."

Flying back to Oklahoma, I contemplated the plight of refugeed immigrants like us, immigrants who arrive at foreign shores with their suitcases but leave their hearts and earth-bound roots in their homelands. And buried with their hearts and roots they also leave their dreams of returning home. Wars do continue to devastate long after they end:

Because I have two hearts
Because I straddle oceans
Because I am both banks of life
The froth, the currents in between
The dissonant emotions
I see beyond the mighty walls of time
Beyond the eyes, the made-up lips, and faces
Beyond the borrowed sentiments and faint laces
Because I have two hearts
My soul is vagabond
It camps in many places.

In Lebanon, after I completed the land transaction, I called Mr. Michael to congratulate him. With a moist, raspy voice, he thanked me and asked when would I be back.

"I'll be back in Oklahoma in a week, and I'll mail you the title deed as soon as I arrive."

"That will put my heart at ease," he sighed. "Did you walk the land before you bought it back."

"No, I'm afraid not, sir."

"Oh, but you must. It's beautiful, full of olive trees, grape vines, almond trees, and my father's long, lasting labors. Please walk it and take pictures. That would bring me great joy."

"I will, sir," I promised.

Back in Oklahoma, I mailed Mr. Michael the title deed, some photographs of his land, and a short poem, which I had penned many years earlier, when I realized that, because of that Lebanese Civil War, I too would not be able to go back home. When he received the registered envelope, he called and we chatted. His voice chimed like birdsong and his words rippled like springs.

"I am finally at peace and have regained my *joie de vivre*," he chortled. "I know that I will never see my land again, but I have it tucked underneath my pillow, with the pictures and your poem. I feel safe again, and content that my life cycle has been completed. My fears of dying without my land, fears that had haunted me for an entire year, have dissipated. Indeed, we are our beliefs, and our beliefs are but our dearly held superstitions."

Mr. Michael went smiling into death and was buried in his Lebanese hometown, Kahloon. In his will, he left the piece of land to his wife with instructions never to sell it. In Mrs. Michael's will, since they had no children, the land was to be returned to his brother after her death.

Familiar faces
I have lived and loved and reasoned
Traveled wide till open-eyed and seasoned
Now, after scorching years and tears
And merciless, erosive fears
I have come to understand
That home is always love and land
That love alone is homeless and
Land alone is loveless and
Home is always love and land.
Familiar faces
Let us not pretend
Though life may decimate and send
Our unsuspecting souls across
Uncharted times and unfamiliar places
Wherever we are loved, we end.

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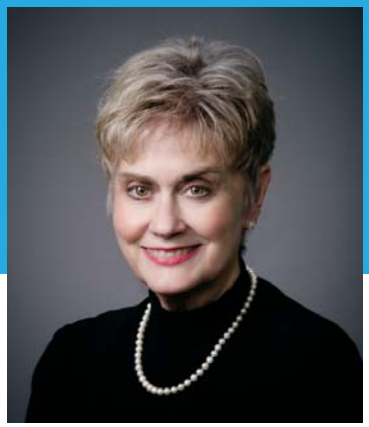


By Jana Timberlake,
Executive Director

**A NEW YEAR'S BLESSING**

*"Think good, speak good and do good.*
*May your thoughts always be full of compassion, may you always*
*speak nice things and may you always care for others.*
*The good that you do will come back to you manifold with blessings.*
*Stay blessed."* – Latika Teotia

## To the physicians of Oklahoma County,

bless you for your commitment and compassion towards your patients. This community is fortunate to have the number of excellent physicians to provide care to its citizens.

To the physicians of Oklahoma County, bless you for the many hours spent at the bedside of a dying patient, giving comfort not only to the patient but the family members who are struggling to make sense out of why there will be an empty chair at the table where their loved one once sat.

To the physicians of Oklahoma County, bless you for the many of hours donated to charity care in the free clinics and your office as you are caring for the least among us.

To the physicians of Oklahoma County, bless you for your contributions to the Physician Wellness Program, giving your colleagues a path to confront issues that have so long remained beneath the surface.

To the Oklahoma County physicians' family members, bless you for sharing the time spent away from you while your loved one is saving a life, delivering a baby, or perhaps helping a child hear for the first time.

To the OCMS Alliance, bless you for your community service activities and fund-raising efforts to benefit health-related nonprofit.

To the physicians of Oklahoma County, bless you for your continued support of organized medicine that addresses issues on your behalf while you are doing what you were trained to do – practice medicine.

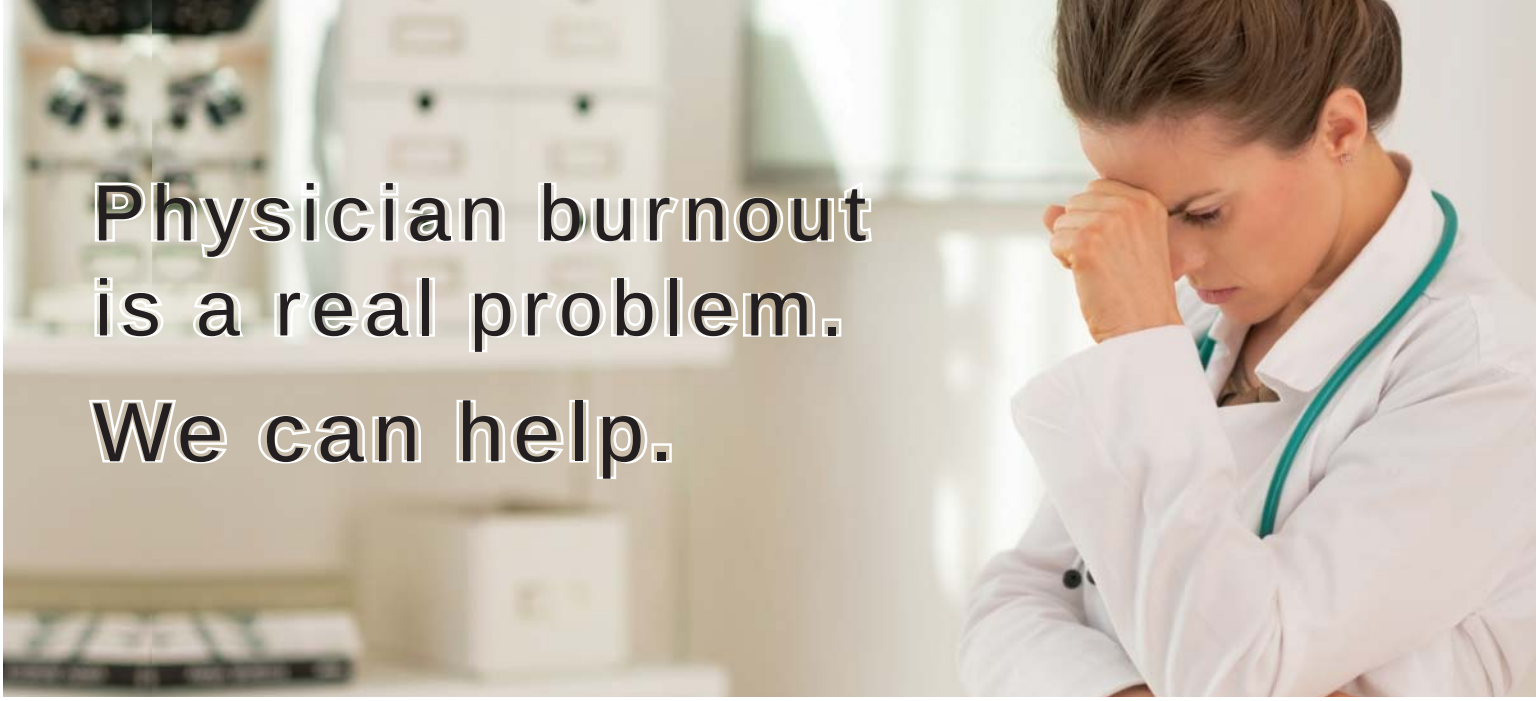
Having worked for physicians since the mid-80's, I have witnessed the many frustrations resulting from interference by insurance companies, government regulations, and decreased reimbursements. Sometimes it seems as if the pressure is coming at you from all sides. But the thing that remains constant is your commitment to provide your patients the care they need.

At the end of a frustrating day, it might benefit you to think about the following quote by Lailah Gifty Akita…

"To be content is to count your blessings."

***Wishing you a year filled with blessings … keep counting!***

– Jana Timberlake, Executive Director

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