THE BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY

MARCH/APRIL 2018

SEE WHAT'S NEW AT THE ZOO!

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OKLAHOMA COUNTY MEDICAL SOCIETY

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THE BULLETIN

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ABOUT THE COVER

GO WILD THIS SPRING AT THE OKLA

The Oklahoma City Zoo and Botanical Garden is Oklahoma's premier destination connecting people and our world's vanishing wildlife and wild places. This spring, there's never been a better time to see what's new at the OKC Zoo.

Meet Azinza! The OKC Zoo's newest resident was born in the Zoo's Great EscApe habitat to first-time mother Mikella, 14, and father Togo, 29, on Dec. 13 and is the 26th Western lowland gorilla born at the Zoo since 1974. OKC Zoo's gorilla troop is now home to three generations of her family. Mikella was born at the Zoo in 2003 to 32-year-old mom, Emily and is the older sister of two-year-old, Rubi.

Zoo Blooms, Oklahoma's biggest botanical bash, is back! From Saturday, March 17 until Sunday, April 15, the largest tulip festival in the state features over 130 acres of floral fireworks. In addition to planting more bulbs in bigger beds, the displays will incorporate decorative seating for some outstanding photo opportunities.

HOMA CITY ZOO!

The best deal is the biggest deal at the Zoo! Purchase a **Zoo-It-All** pass and receive Zoo admission plus all rides, all attractions, all feedings and all shows! You can do it all with Zoo-It-All!

Spring into savings! During the month of March, you can save $10 on a **ZOOfriends' membership**. A membership provides unlimited admission to the Zoo for a year, a beautiful and safe recreational outlet, and opportunities to learn the importance of and participate in wildlife conservation. Offer valid online at zoofriends.org, by phone at (405) 425-0618 or in the ZOOfriends' membership office.

WILD NOISE is the OKC Zoo's new 21+ concert series event featuring beloved local musicians like Samantha Crain and Kyle Reid & the Low Swinging Chariots. WILD NOISE events take place every Friday evening in May at our new picnic grounds overlooking the lake. In addition to live music, libations and great food, enjoy wild photo backdrops celebrating wildlife and wild places. Plus, net proceeds benefit the Zoo's local and global conservation efforts.

Opening in late June, **Sanctuary Asia** is the new 6.6 acre, $22 million expansion that will create an expansive environment where endangered animals from the Asian continent can thrive while receiving world-class zoological animal care. The new habitat will feature a lush, stimulating natural environment can be admired by new audiences in new ways.

Located at the crossroads of I-44 and I-35, the Oklahoma City Zoo is a proud member of the Association of Zoos and Aquariums, the American Alliance of Museums, Oklahoma City's Adventure District and an Adventure Road partner. Hours of operation are 9 a.m. to 5 p.m. daily. Regular admission is $11 for adults and $8 for children ages 3-11 and seniors ages 65 and over. Children two and under are admitted free. To learn more, call (405) 424-3344 or visit **okczoo.org**.

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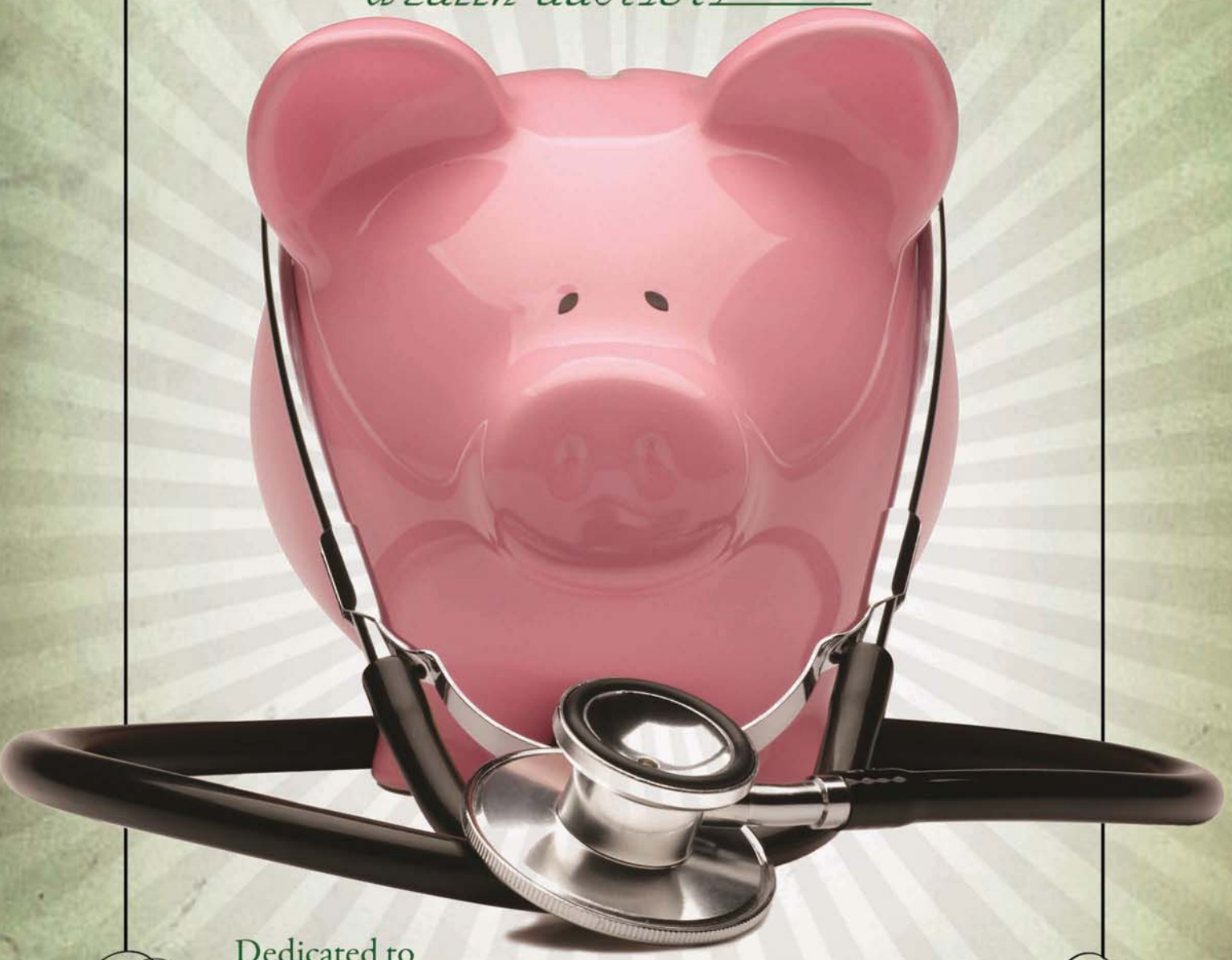

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PRESIDENT'S PAGE

Sam S. Dahr, MD

"TECHNOLOGY AND ART, IN THE MOVIES AND IN MEDICINE"

"The Last Jedi," the second installment of the "reboot" Star Wars series that started in 2015 with "The Force Awakens," recently hit theaters. This recent series of films has received good reviews, in contrast to the previous reboot series that started in 1999 with "The Phantom Menace." That series, which also included "Attack of the Clones" (2002) and "Revenge of the Sith (2005)," was panned by critics and audiences alike, despite being produced and directed by George Lucas, the creator of Star Wars. How did George Lucas get it wrong, and what has the new set of movies done right?

In the 1980s, George Lucas started a movie technology company called Industrial Light and Magic that harnessed modern microprocessor power and software design. Breathtaking visual effects subsequently became a staple of modern movies such as "Jurassic Park" and "Men in Black." Perhaps a little bit too enthralled with his technology, Lucas stuffed The Phantom Menace and its brethren with fancy special effects (remember Jar Jar Binks?), to the detriment of story and character. He was seduced by his own technology and lost sight of the art of movie making.

Unfortunately, health care policy makers in government and influencers in industry were similarly seduced by the promise of EHR technology. EHR was supposed to make health care better, safer, more efficient, more friendly, for patient, nurse, and physician alike. Well, we all know how things have turned out – poorly designed EHRs have elevated process over people and created frustration for patient, nurse, and physician alike. The original sin here was focusing on the technology rather than the art. In movies, as the new Star Wars series has demonstrated, story and character are the art. In health care, listening, communication, and human interaction are the art. Rather than serve those artistic qualities, poorly designed technology ran roughshod over them.

To their credit, physicians pointed to this shortcoming early on but were stereotyped as anti-technology, non-modern, not cooperative, protecting their turf, etc. by the Silicon Valley crowd. Ironically, in the modern medical era, physicians have embraced productive technology at every turn--the heart bypass pump, the coronary cath lab, modern ultrasound and MRI, the list goes on and on. Physicians are pro-technology and usually quite visionary with respect to applying technology within the practice of medicine. When the application of technology becomes less about the science and art of medicine and more about creating a new business, however, that's when things go wrong, and that is what happened with EHR. A lot of work is going on to fix EHR, and it will eventually happen, but it's going to take a long time and a lot of effort.

As for me, I'm blessed with a new baby and can't make it to the movies, so I'll wait until the Last Jedi comes out on Apple TV!

DEAN'S PAGE

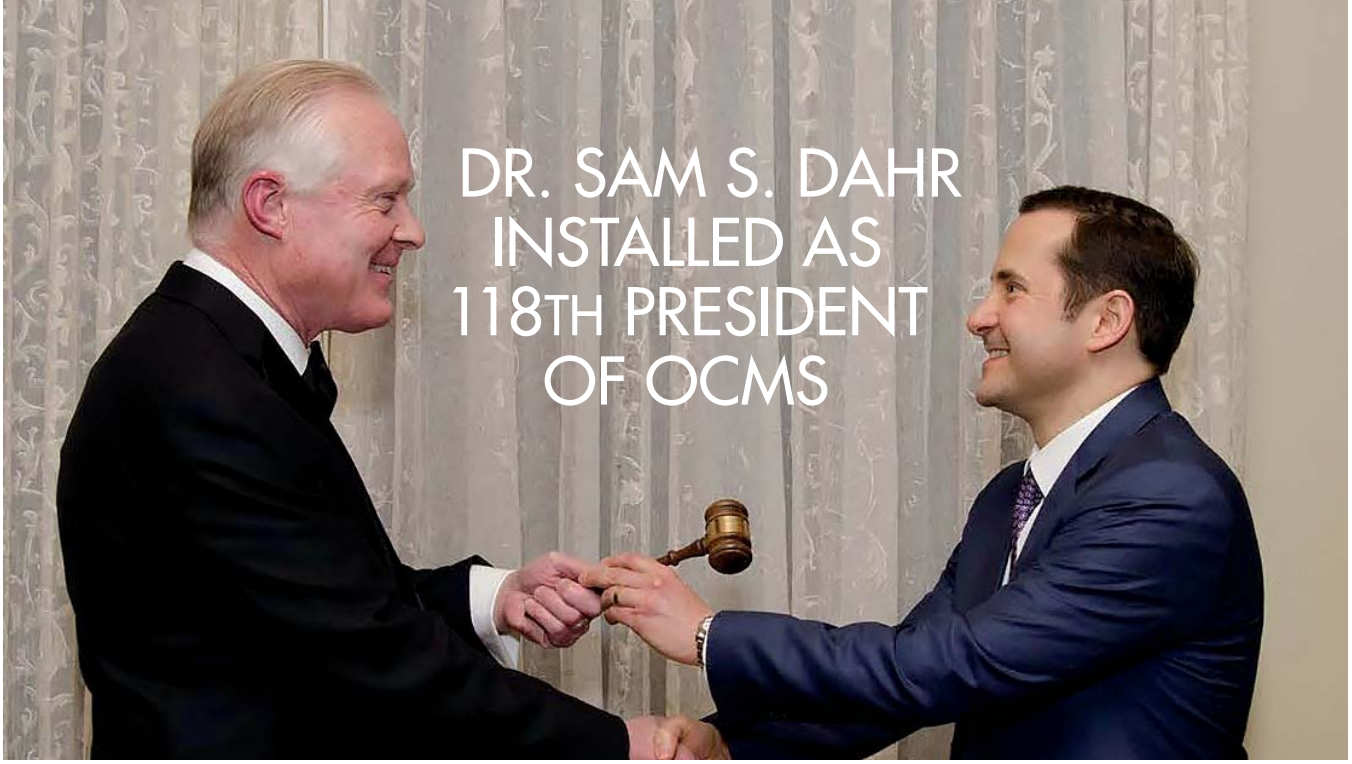
Russell G. Postier, MD, FACS
David Ross Boyd Professor and Executive Dean
University of Oklahoma College of Medicine

With this writing, I have been with you now for one year – first as the College's Interim Executive Dean, and as of January 24, 2018, the Executive Dean for the College of Medicine. Wonderful changes have occurred and continue to occur on our campus and I will take this opportunity to share but a few!

On February 1, 2018, we celebrated the beginning of the new, Oklahoma-based nonprofit, OU Medicine, Inc., which assumed ownership and day-to-day operations of the OU Medical System facilities. We believe this approach will advance health care in Oklahoma by supporting the highest-quality patient care, critical training for future physicians and other health professionals, and cutting-edge medical research. Optimization of overall clinic processes and procedures is at the heart of our practice modernization efforts and our priority is the patients, families and communities whom we serve. Along with more than 200 added jobs and another 100 more by the end of 2018, OU Medicine recently broke ground on a new 450,000 square-foot patient bed tower at the OU Medical Center. Among other things, the new structure will include 21 new operating rooms and 144 patient beds, making it one of the largest, if not the largest, healthcare building project in the state.

It is March – and that means "Match" time as senior medical students and teaching hospitals await the outcome of their applications and rankings for residency training positions in the National Resident Matching Program. Some students participating in the "early match" held for a few specialties already know their residency-training match, but most students are involved in the general match. Match Day results will be known to them during the week of March 12, this year. While I am on the topic of our residency program, I am pleased to share with you the American Council for Graduate Medical Education (ACGME) – the body responsible for accrediting the majority of graduate medical training programs for physicians in the United States – recently granted continued accreditation to the University of Oklahoma College of Medicine. The Review Committee commended the institution for its demonstrated substantial compliance with the ACGME's Institutional Requirements without any citations and all of the College of Medicine ACGME accredited programs were granted continued accreditation. To conclude my segment centering on our Graduate Medical Education program, the College of Medicine Resident Council and Graduate Medical Education (GME) Office will be hosting the second annual Graduate Medical Education Quality Improvement and Patient Safety Symposium on April 16 and 17. This symposium will provide an excellent opportunity for trainees to present their research and plans for improvement to stakeholders from the College of Medicine, and across the campus, and highlight the importance of quality improvement and patient safety in GME training while recognizing the contributions of residents and fellows in improving quality and patient safety at the College of Medicine.

We are pleased to announce the appointment of Morris R. Gessouroun, M.D. as the Chair for the Department of Pediatrics, at the University of Oklahoma College of Medicine. He holds the Children's Hospital Foundation Patricia Price Browne Distinguished Chair in Pediatrics and serves as the Children's Practice Division Chief for OU Physicians.

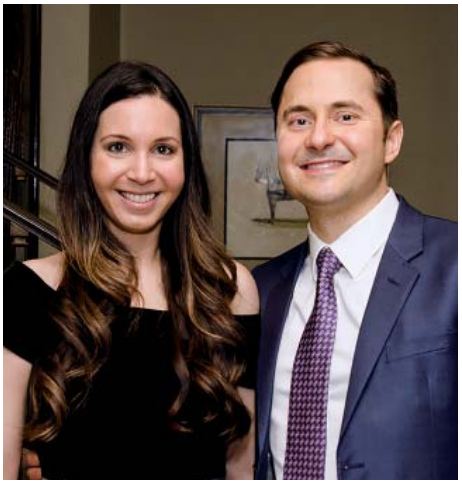


DR. SAM S. DAHR INSTALLED AS 118TH PRESIDENT OF OCMS

OKLAHOMA COUNTY MEDICAL SOCIETY

Sam S. Dahr, MD, was inaugurated as the 117th President of the Oklahoma County Medical Society on January 19, 2018 at the Oklahoma City Golf and Country Club at the OCMS Inaugural Dinner.

The event had nearly 200 supporters of Oklahoma County Medical Society, including physicians and partners. The semi-formal event featured DJ from M&M Productions, where attendees danced into the night. The room featured black linens, with pops of gold. The flowers were white hydrangeas and white roses, with hints of green nestled in gold bowls and table candelabras. The group dined on steak and salmon, with a sweet potato and root vegetables. Desserts were bite sized and featured on the dessert bar.



Top Photo: 2017 President David Holden, MD, presents gavel to 2018 President Sam Dahr, MD.

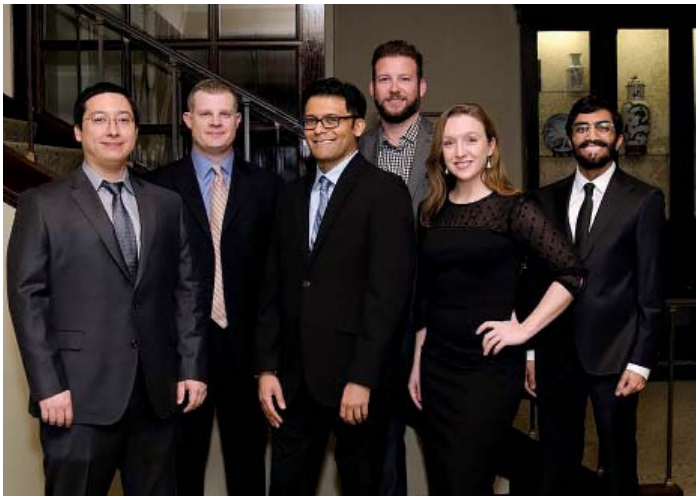
Above: David Holden, MD presents Rhinehart Award to William Parry, MD.

Left: Sam Dahr, MD and wife Lana Tolaymat, PhD.

Above: President-Elect Kevin R. Moore, MD; President Sam Dahr, MD; Past-President David Holden, MD.

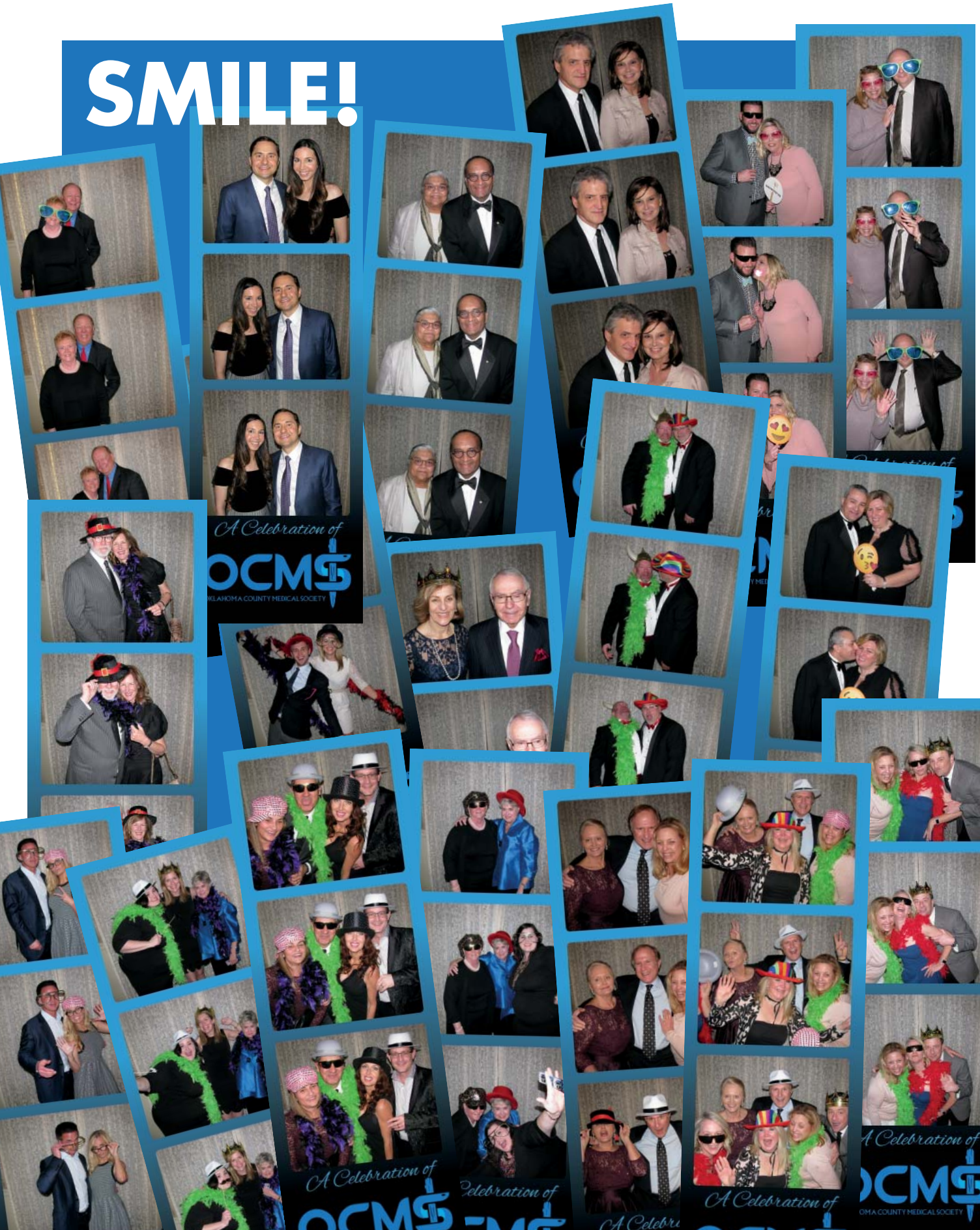
Left: OCMS Board of Directors – Front row: Jeffrey Cruzan, MD; Lisa J. Wasemiller-Smith, MD; Sam Dahr, MD; Betsy Jett, MD; Anureet Bajaj, MD; Tabitha Danley, DO; Ralph Shadid, MD. Back row: Basel S. Hassoun, MD; David Holden, MD; R. Kevin Moore, MD; Amanda Levine, MD; Don Wilber, MD.

Below: OCMS Executive Committee: David Holden, MD, Immediate Past-President; R. Kevin Moore, MD, President-Elect; Sam Dahr, MD, 2018 OCMS President; Lisa J. Wasemiller-Smith, Vice-President; Basel Hassoun, MD, Secretary/Treasurer.



Leadership Academy (from left to right): Alexander Davis, MD; Timothy Vavricka, MD; Nigam Sheth, MD; Chad Smith, MD; Janine Collinge, MD; and Nimish Parekh, MD

The family of OCMS President: Sam S. Dahr, MD, Lana Tolaymat, PhD, Bushra Dahr, and A.S. Dahr, MD.


SMILE!
A Celebration of
OCMS
OKLAHOMA COUNTY MEDICAL SOCIETY

ADMINISTRIVIA AND OTHER ASININE ACTIVITIES, PART DEUX

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

Welcome back for more belly-aching! It doesn't solve a thing, but it sure makes you feel better!

Caveat emptor: many of these tasks are necessary, sometimes justifiable or even beneficial; the rub is when they become a huge proportion of your time expenditure.

That being said, here are other administrivia tasks worthy (or rather, unworthy) of mentioning:

Prior authorizations (PAs). This is from the 9th circle of hell, per Mr. Alighieri!

These were known as "medical necessity" letters. We are all very familiar with them. Suffice it to say that, at first, there is a denial of coverage of certain drug/lab/procedure ostensibly because a less expensive alternative exists. The denial theoretically can be 'overcome' by a letter of necessity/prior auth. Considering the "M" in MD stands for medical, and I am finding the drug to be necessary (and thence wrote a script for it) it never made any sense to me that I should repeat myself by filling out one of these forms. The obvious evolution and euphemizing led to the moniker PA.

You know a patient, have been their doctor for years or decades, know their pathology and understand the particularities that pertain to the situation, yet, when you prescribe x, y or z it requires a PA. Well, in many circumstances it does make sense to encourage use of other agents (though I'm at a loss to see how the labor cost would make it worthwhile, in some instances – unless those letters are computer generated now).

I use generics almost exclusively and actually support the Tier system. In general, a Tier 1 drug requires no PA, Tier 2 does, and Tier 3 requires 3 Saints (can't use St. Christopher), two Popes and a Minister to approve, sometimes even requiring the Almighty to intervene. Drugs are overemphasized in western medicine, are often extraordinarily expensive and are known to create as many problems as they fix. I do believe the aphorism "The first duty of the physician is to educate the masses not to take medicine" - Unknown (misattributed to Sir William Osler) yet I object to the approach. It would be perfectly fine by me if the insurer just said 'that's a Maserati drug and you have a Hyundai plan', but no, they reassure the patient that they could get 'whichever agent they want or need' provided the doctor writes a PA. Parenthetically, sometimes a dependable Hyundai fits the job better than a fancy Maserati.

But the truly abhorrent part of this saga is dealing with the constant changes. If you happen to have a patient that takes testosterone, the wheelings and dealings of the insurer's pharmacy plan make the preferred agent change about every 60 days, consequently, you would need a PA today for the Tier 1 agent of last month. Another hassle: getting a PA for an agent that is already economical. They can easily tell

the patient to get fluticasone propionate-nasal for about $10 OTC and that they (the insurer) would not cover it; but no, they rather tell the patient that their doctor has to send a PA so they can get it for an $8 co-pay. The PAs usually have you address agents you have tried before. Fairly nonsensical when the agent is a first line drug!

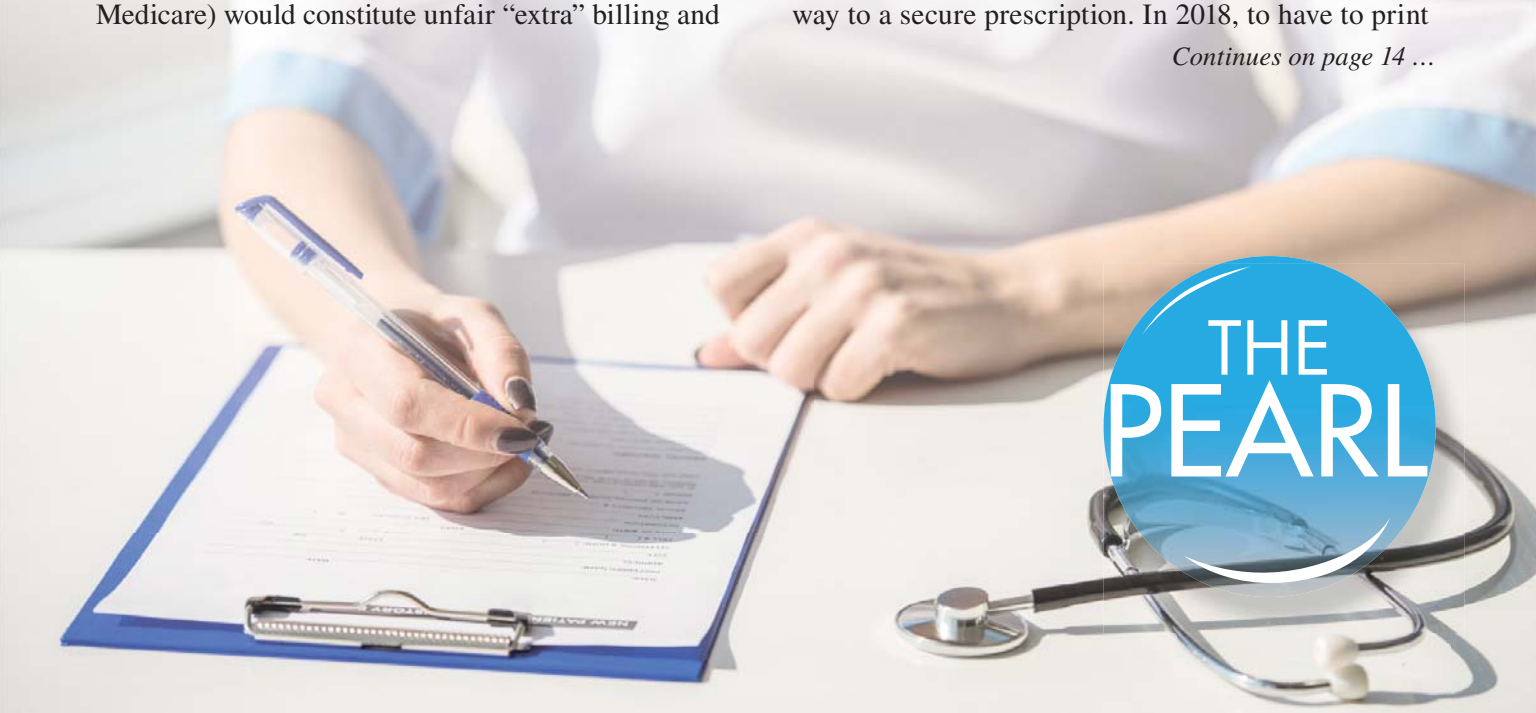
Once you send a PA, you have to wait for a reply. In the meanwhile, the patient is both without necessary treatment and calling your office twice daily.

Attending physician attestations. If a resident sees a patient, we must cosign (see last issue's comments about that one) and make an attestation. Attestation (Merriam Webster): the process of validating that something is true[2]. It seems then, that up until you make the Attestation, the history, physical and plan on that patient is not true. What is it? Make-believe? The attestation says something to the effect of "I have examined the patient with Dr. A, reviewed her medical note and agree with her findings and plans". I am fully and unequivocally responsible for all patients seen by resident, with or without that added note.

The history on this is long and convoluted. Before CMS, there was HCFA, and before that, the Bureau of Health Insurance. In 1969 this agency published Intermediary Letter 372 (IL-372) ostensibly in response to both a concern that billing for the patient care given by a resident (already supported in part by Medicare) would constitute unfair "extra" billing and the idea that the public would insist that an attending physician was immediately and directly involved in the care of the patient under this new-at-the-time governmental insurance. IL 372, using not the best-worded language, suggested that the attending physician would re-write the resident note in order to bill the case, using the following wording: the attending physician would "render sufficient personal and identifiable medical services to the Medicare beneficiary to exercise full, personal control over the management of the portion of the case for which a charge can be recognized"[3]. In time, the ludicrousness of this approach became evident to all and that suggestion was largely ignored until 1998 when it was unearthed[4] following a supervision impropriety at a major program (which led to a major fine from CMS). What followed was a cottage industry of 'advisers' to every national program suggesting that IL-372 would be interpreted in one way or another and that something should be done to prevent penalties. Thence, born is the attestation. Eventually, several variants, according to the level of care that would be billed, were hatched.

Printing controlled substances prescriptions. The most insecure way of producing a script is to print it. It makes zero sense for the US government not to pursue electronic prescribing as the ultimate way to a secure prescription. In 2018, to have to print

Continues on page 14 …



it and give it to the patient to physically take to the pharmacy is unwise.

Three-midnight rule for Skilled Nursing Facility (SNF) admissions. A patient admitted to the hospital must stay three midnights before being eligible to SNF transfer under CMS rules. The original idea being that in that span, many enough patients might improve sufficiently to go home instead; and that would save a lot of money, i.e., two extra hospital days being cheaper than however-many the patient would spend in SNF. Ironically, the very institution that insists that you know-for-certain how long a patient will need to be in the hospital for (see last month's commentary); balks when you commit to saying they will benefit from SNF from day one of admission. The truth is, it's rare for a patient that you have clinically considered eligible and in need of SNF to get well in the following 48 hours and go home without assistance. Two extra, unneeded hospital days serve no purpose other than heightening the risk of complications for the patient and delaying the start of their formal rehabilitation and/or their long-term care management. Dismissal prior to the 3rd night without transfer to SNF can many times cause complications and home and costly readmissions. The SNF cost issues are way more complicated than the 3-night rule, but the rule certainly adds to the hindrance.

Admission "appropriateness" evaluators. Hospital systems find themselves getting denials of payment for certain admissions on the basis of 'inappropriateness'. Since this happens retroactively, your facility hires a consultant company to review admissions real-time and prevent this. That is, to not admit the patient at all.

Two years ago, I got one of those calls for an 86 year-old patient admitted for stroke. Being in that kind of philosophical frame, I politely (yes, I can do that!) asked the 'consultant' some questions back (after the obligatory litany of inquiries made to me): are you a real doctor?, if so, what is your area of practice?, and, have you admitted a patient with a stroke? Answers: yes, a real doctor (graduated previous year from a residency in obstetrics) and had never admitted a patient with a stroke. Need I say more?

For the record, I ended up admitting this patient, who developed severe dysphagia by day two and was discharged to SNF (after her three midnights – see above), where she stayed 12 days and then transitioned to long-term care.

My interaction with the rather mannerly and agreeable young physician was slightly less nettlesome than my first queue at Disney's Space Mountain, midsummer, with two small children in tow. Time stolen from the care of another patient in need.

I can go on about the well-intentioned Peer Review Organizations. Suffice it to say, that my partner once replied to a criticism with the 2014 Standard of Care Recommendations from an authoritative world-renowned US subspecialty academy. The basis of the reviewer was 1998 guidelines. Good outcome, lots of time wasted.

EHR inefficiencies. This could take two volumes, and I'm running out of space. Additionally, is not gentlemanly to take advantage of the most-challenged associate there is nowadays. So, there you go IT friends, you get a pass!

I must mention though, that the price paid for the eradication of the doctor-handwriting jokes has been steep, as Dr. Terrence Truong exemplifies by saying that rather than professing to be an MD, I should now sign as T.P. Owens, M.C. (medical clicker).

Referrals. In the days of shared electronic medical records, why not just click Dr. A and be done with it? You have already chosen an expert that you know and trust, and that person can, ideally, readily read your note and see the exact concern and question and/or see your letter to her/him. Why add more "paperwork"? Oftentimes your patient can see you, but your consultants are "out of network", which leads to the rebounding of forms that occupies more of your time (and that of a number of able co-workers).

Diagnosis 'finessing' in the hospital. This is a noble action that chews-up a lot of your time. Because hospital payments are DRGs (Diagnosis-Related Groups)-based[6], it is indispensable that the diagnostic list is exhaustive and that it reflects the highest severity. Staff is not permitted to add diagnoses that are clearly depicted in the corpus of the record, so you must

clarify retroactively that indeed this person whose ejection fraction was 10% has systolic congestive heart failure. But guess what?, better if you add hypertensive cardiomyopathy NYHA Class IV. It is in several parts of the record, but not re-listed for this admission. Got to live with that, but don't have to agree is good use of the energy.

To make matters more vexatious, every other month it seems, there are adjustments to the relative 'values' of the terminology: renal insufficiency becomes 'not sick enough' and is replaced by renal failure which eventually implies no malady at all, as acute on chronic kidney disease 3b becomes the only acceptable choice to explain that this person has very bad renal function that complicates their care.

Billing queries. Most doctors undercode. There, I said it. We are very practiced at what we do, and after some years of clinical work find

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diabetes mellitus type 2 complicated with nephropathy, neuropathy, retinopathy, severe essential hypertension, onychomycosis, Charcot joints, colonic dysmotility, coronary artery disease and gastroparesis fairly straightforward, and code it as such. Scrutiny and revision of the billing is essential to the survival of a practice, but alas, it takes more minutes. Medical school started our learning of the art and science of medicine, but never prepared us for this.

Letter of every sort. Many are actually purposeful (not necessarily useful) mind you, but time-consuming nonetheless. A regular week includes: survey letters to fax back (and I thought fax was dead), reminder letters about the fact that your patient is still taking antidepressants, thyroid medication or hypertensive agents; reminders about preventive cares that, in most instances, have been rendered but either were not properly mined-off the chart or occurred after the original review that leads to this belated letter; letters of change of insurance coverage, medications' new black boxes, medications that had mishaps in production; new regulations, kind reviews of the patient's medication lists or problem lists; additional requirements or recommendations. Patient's requests for work-releases, state forms, explanations to their insurers, guardianship, legal forms… And that doesn't include your renewals of boards, CME, etc, etc.

Then, of course, late in the day, you find a note topped by a KitKat bar from a patient thanking you for your care, and doctoring is worthwhile again!

1. https://it.wikipedia.org/wiki/Divina_Commedia
2. https://www.merriam-webster.com/thesaurus/attestation
3. https://www.cga.ct.gov/PS98/rpt%5Colr%5Chtm/98-R-1057.htm
4. https://oig.hhs.gov/oas/reports/region3/39400016.pdf
5. https://www.ahcancal.org/advocacy/solutions/Documents/Congressional%20Research%20Services%20Report%20on%20Three-Day%20Stay%20Requirement.pdf
6. https://www.ehealthmedicare.com/faq-what-are-diagnosis-related-groups/

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OKLAHOMA COUNTY MEDICAL SOCIETY

WELCOME NEW MEMBERS!

Jesse Campbell, MD is board-certified in both internal medicine and pediatrics, and is employed with Mercy. He completed medical school and his residency with the OU College of Medicine.

Jeffrey Floyd, MD is a board-certified family medicine physician with Crossway Medical Clinic. He completed medical school at West Virginia University, and a residency at the Family Medicine Residency Area Health Education Center in Jonesboro, Arkansas.

Amy Gumuliauskas, MD is a board-certified pediatrician with St. Anthony's She completed her medical degree at the University of Oklahoma College of Medicine, followed by a residency at Children's Hospital at OU Medical Center.

Laurie Jill Hast, MD is a board-certified radiologist with Comprehensive Diagnostic Imaging. She completed medical school at the University of Chicago Pritzker School of Medicine, residency at Michael Reese Hospital and internship at Louis Weiss Memorial Hospital, both in Chicago.

Timothy R. Jones, MD is both board-certified otolaryngologist and plastic surgeon. He completed medical school at the University of Oklahoma, an ENT residency at the University of Virginia; a plastic surgery residency at the University of Pittsburgh, and a surgical internship at the University of Virginia.

Robert E. Leonard II, MD is a board-certified vitreo-retinal surgeon with Retinal Associates of Oklahoma. He completed medical school at the OU College of Medicine and a residency at the University of Miami – Bascom Palmer Eye Institute.

Stuart W. Schrader, DO is a board-certified pediatrician with Crossway Medical Clinic. He completed medical school at the Des Moines College of Osteopathic Medicine and a residency with the University of Minnesota.

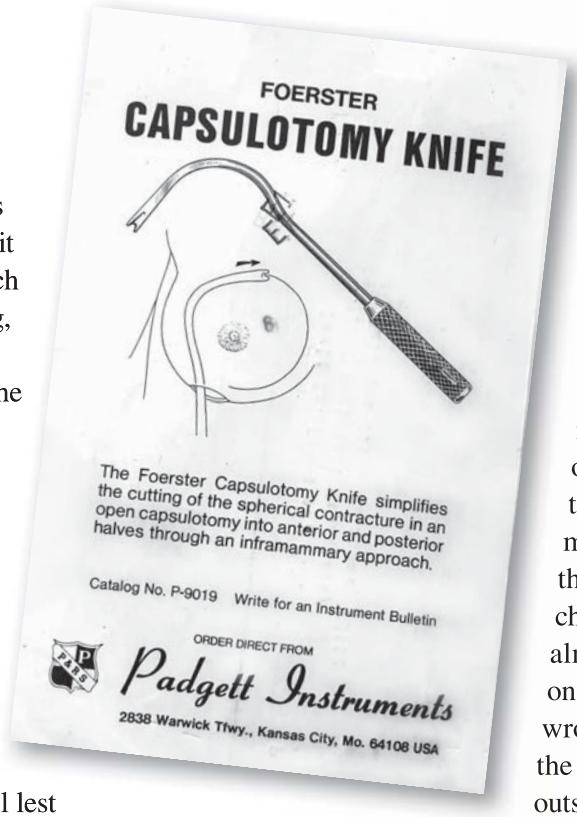
Christopher C. Shadid, MD is a board-certified anesthesiologist in Oklahoma City. He completed medical school and residency at the OU College of Medicine, and an internship a the University of New Mexico.

Mary Stockett, MD is a with OU Children's. She completed her medical school, residency and internship all with the University of Oklahoma.

The Implant that Changed the World for Women

David W. Foerster, MD

The year was 1964. Dr. Thomas Cronin had just put the first silicone breast implants in place two years earlier. Silicone had been known to be extremely inert and acceptable as a human implant. Being a polymer, it had some unique qualities in so much as the longer the molecular coupling, the firmer the implant. The shortest lengths resulted in a liquid and, as the coupling increased, it became a gel and eventually a firm, solid, rubber-like product. Dr. Cronin, working with Dow Corning, had developed a firm, rubbery shell shaped like a breast and filled with the gel linked polymer to mimic the soft, yet firm, consistency of breast tissue. He attached a large sheet of Dacron® mesh to the back of the implant that needed fixation to the chest wall lest it slip out of position.



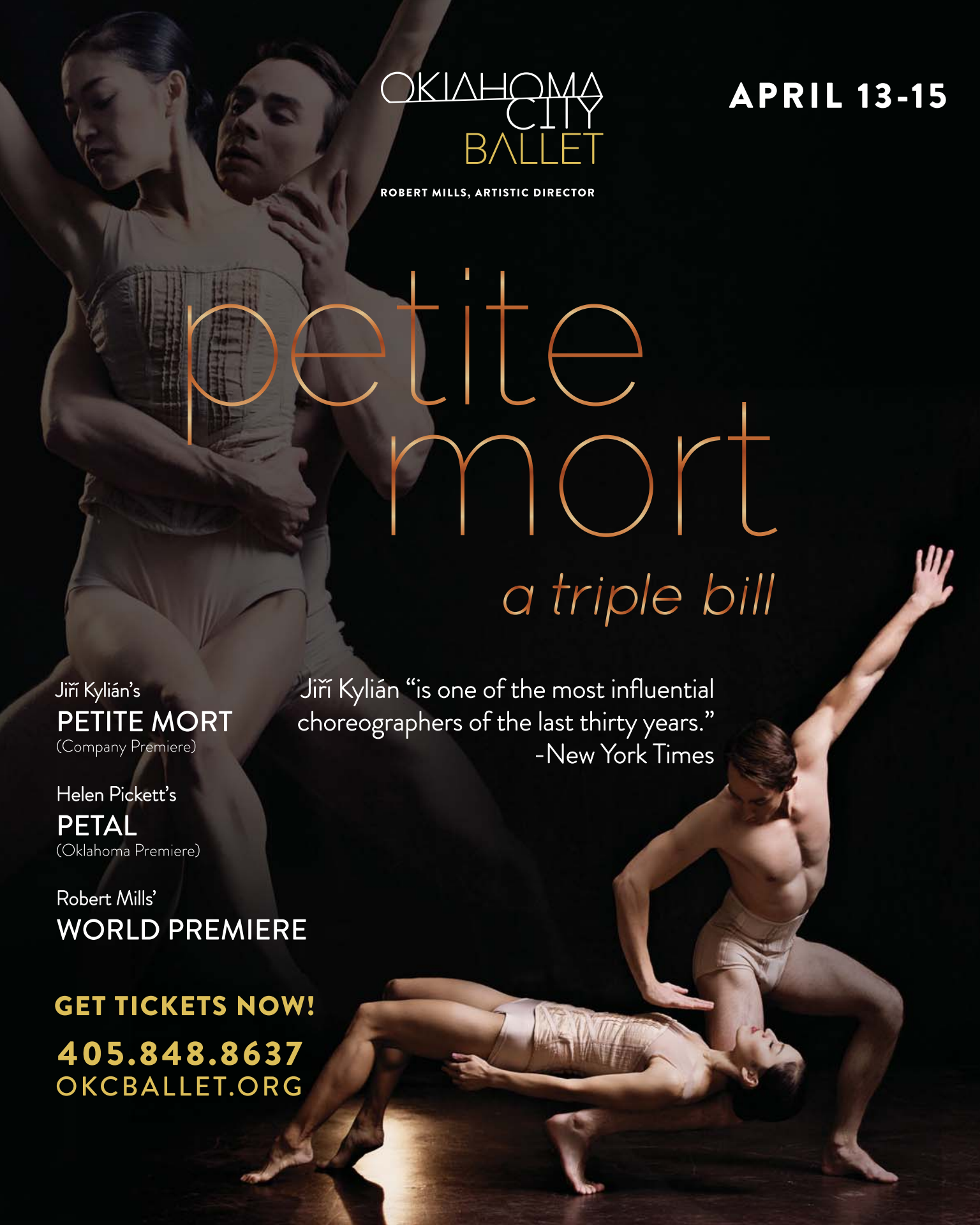
I came into his practice that summer as his senior preceptee and was greeted with a patient of Dr. Ray Braver's (his associate) whose infected implant required removal. This seemed to set the scenario that change was needed to improve the implant design as the large Dacron® patch was both easily palpable and subject to occasional infection. Furthermore, the seams, where the implant shell was fused together, left additional palpable edges that were undesirable. As the senior preceptee, I was given the challenge to better the design (with their help of course). We first began by removing the large Dacron® patch on the posterior wall and substituting five small round patches set one and one-half centimeters inside the outer edges in a circular manner, thus eliminating the palpability and reducing chances for infection. Then, almost by epiphany, it dawned on us that by turning the shell wrong side out before filling, the seams were no longer on the outside and thus non-palpable! And so, the new and improved version came into production.

There still remained an unsolved problem. After several months or longer, the implant lost its softness and became hard. This was the result of an unyielding "capsule" of scar tissue that eventually formed around the implant that caused compression and bound the soft implant contents into a hard mass much like the soft center of a golf ball is made solid by layers of

binding and a hard shell. It did not occur to us that the Dacron® patches were playing a major role in this problem.

In 1971 at the National Meeting of Plastic Surgeons, a paper was presented in which Dr. Williams, a prominent Hollywood plastic surgeon, had Dow Corning remove the patches on the back of the implant, and he found that this increased the softness and thereby gave a better result. Tom Cronin was sitting by my side at the meeting and I remembered, again in a moment of enlightenment, telling him that I think I know why the improvement: the free-floating prosthesis inside the surgical packet, by its mobility, "tricked" the capsule formation into believing the prothesis was "bigger" and thereby prevented the compression of the prothesis allowing it to have room to continue to feel soft. Incidentally, Dow Corning had learned to build seamless shells, a definite improvement.

Many other designs were developed including using saline inside the shell (not too successful due to leakage), using a "fuzzy" silicone surface to the implant (which seemed to help) and then out of the ashes of trial lawyers' conflagration of lawsuits which almost ruined the industry came the modern prosthesis that has solved most of the old problems. It contains a cohesive gel (like a really soft artgum eraser) that has no "gel bleed" (often felt to cause long term capsulary contracture) that is usually implanted behind the pectoralis muscle in a large pocket. These prostheses have resulted in a much improved and less complicated outcome with the end result of thousands of happy women, who are now buoyed with self-confidence and improved self-esteem. Hopefully, in the not too distant future, medical science will be able to utilize stem cells to grow the perfect breast, and silicone, like the dinosaur, will be a thing of the past.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Bill Kinsinger, MD
1962-2018

William LaFon, MD
1913-2018

Marvin K. Margo, MD
1923-2018

Howard Jarrell, MD
1950-2017

James Rosacker, MD
1946-2018

IN MEMORIAM

Remembering A Great Friend

by Sen. Ervin Yen

I have always said to my physician colleagues that if any of them should end up in the news, they would show up on the front page of the newspaper listed as "a prominent physician, etc." Unfortunately, my friend Bill Kinsinger did show up last week on the front page. In this case, prominent would be appropriate.

Bill was the kind of guy who tackled issues with everything he possibly had. He wasn't afraid to grab the bull by the horns, whether it was as chairman of the Oklahoma State Board of Medical Licensure or as a volunteer for rescue dogs across the country or as the chief of obstetrical anesthesiology at Integris Baptist Hospital or as the president of the Oklahoma Society of Anesthesiologists or advocating for patient safety in a multitude of ways (including at the Legislature).

I always thought Bill would someday be an outstanding legislator, which was something we chatted about frequently. In fact, four-and-a-half years ago, when I spoke with folks about running for office myself, only two of my friends said I should do so. Bill was one of those. He not only said yes, he said something like "absolutely, you should do it. That is brilliant. You will have no problem winning and I will support you in every way I possibly can, including a maximum campaign contribution," and of course, he did. His oldest son, Jake, even drove me in his pick-up truck at the Bethany Fourth of July parade the next year. Bill and I even talked about taking me up in his new airplane that he had fairly recently acquired.

I don't know what happened in that airplane, or why, and I suspect we'll never know. But what I do know is the medical community, Bill's friends, Bill's patients and all Oklahomans, lost not only a prominent physician, but a great man. I am devastated. My condolences go out to his family. Rest in peace Bill, we miss you dearly.

Yen, R-Oklahoma City, represents District 40 in the Oklahoma Senate. Kinsinger's plane disappeared over the Gulf of Mexico on Jan. 3, the same day he left for Georgetown, Texas, to pick up a rescue dog.

Leadership Academy Class VIII

FEATURED MEMBER PROFILES

Leadership Academy VIII

Leadership Academy VIII

Name: **Timothy A. Vavricka, MD FACS**
Specialty: General Surgery
Where do you work? Oklahoma Surgical Group
Why do you feel physicians need leadership training? To allow physicians to continue to be the driving force in shaping the healthcare landscape as it evolves.
Any other life details to share? Hobbies, family, interests? Married to Dr. Beverly Vavricka, MD and father to Ellie, 7, and Caden, 5. I enjoy hunting and fishing and spending time with the family on the lake.

Leadership Academy VIII

Name: **Benjamin Panter, MD**
Specialty: Orthopedic Surgery
Where do you work? McBride Orthopedic Hospital/ Clinic; Norman Regional HealthPlex
Why do you feel physicians need leadership training? Everyone could use a good dose of leadership training. It doesn't matter what profession or walk of life one is in. It's mainly continuing to learn as a physician and maturing in our field in order to be as beneficial to society as possible.
Any other life details to share? Hobbies, family, interests? I have a wife, Meagan, and daughter, Arlie Beth. I am a former OU football player. LOVE OU athletics and the Thunder. Have very much enjoyed helping cover OU athletics as one of the team physicians. Enjoy playing golf, of course, a doctor's cliché. I love to cook and also enjoy travel and spending time with friends and family.

THE BULLETIN

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NEW AMA PODCAST SERIES HELPS PHYSICIANS NAVIGATE DIFFICULT CONVERSATIONS

For many physicians, having difficult conversations with patients is a part of daily practice. That's why the American Medical Association recently launched a new podcast series, **AMA Doc Talk**, which features physicians' eye-opening encounters with patients and their real-world solutions and insights. Inspired by research and feedback from physicians, topics range from talking with patients who don't heed your medical advice to helping patients manage the challenges of chronic disease. The interview-style series is hosted by Dr. Rajesh S. Mangrulkar, associate dean for medical student education, University of Michigan. Learn more by visiting **www.ama-assn.org.**

Are you anxious about mandates and the impact on your career?

Are you concerned about pending litigation?

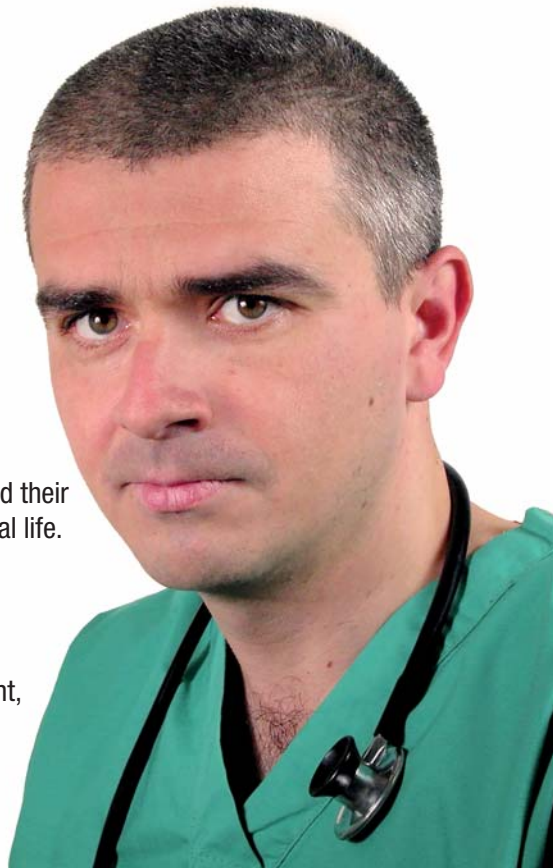
Do you feel caught in a cycle of new mandates?

Do you feel sad, irritable, isolated or alone?

Do you feel as if your life and practice are in total chaos?

Do you think about leaving it all?

Is uncertainty about the direction of your career keeping you stuck?



If you answered yes to any of these questions, you are not alone. Most physicians struggle to find a balance between the intense demands of practicing medicine and their personal lives. No physician is unaffected by transitions in their career and personal life.

If you are overwhelmed, overworked or overstressed, OCMS provides up to 8 free and confidential counseling sessions with a licensed psychologist. It's completely confidential and offsite, giving you extra privacy to discuss anything that may be weighing heavily on you. For more information and how to make an appointment, visit **www.okcountymed.org/pwp**.

alliance UPDATE

Cara Falcon, OCMSA President

January of 2018 brought a few changes to our Board of Directors. The Alliance is excited to welcome Amani Nassar, Georgia Scherlag, Valerie Visor and Suzanne Reynolds (back after a brief absence), joining Angela Chambers, Amy Bankhead, Stacie Evans, Deanna Carey, Stephanie Kazenske, Paula Scott, Jennifer Tortorici, Mucki Wright, Anita Verma, Dinah L'Heureux, Maria Abbott, Nicole Cook, Margo Ward, Sandy Beall, Tessa Wicks, Traci Walton, Natasha Neumann, Barbara Jett, Jeary Seikel and Karen Gunderson. It is with heartfelt thanks we bid farewell to Berna Goetzinger, Rick Knapp and Joan Larson as they roll off the board having served a three-year term. Their service is truly appreciated.

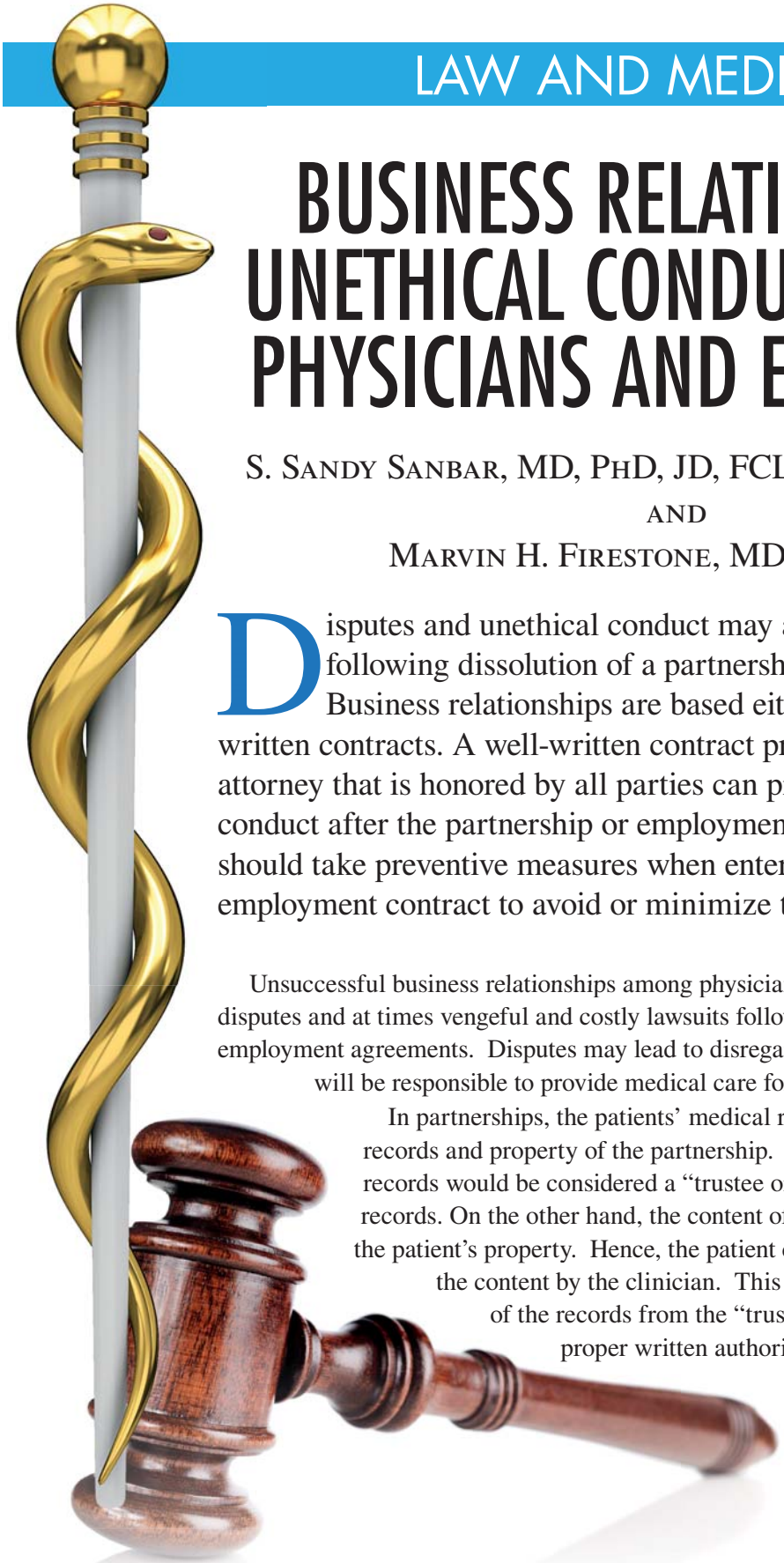
Programs for our general meetings are set for the year. We started off with Julia Kirt from the Oklahomans for the Arts presenting a program at our January meeting on "The Impact of the Arts on Oklahoma". Upcoming meetings for this spring will include: "Behind the Scenes at the Academy Awards" with Elizabeth Anthony; a visit from Rustic Cuff CEO and founder, Jill Donavan; medical historian and author Sarah Tracy who will be speaking to us at the former John A. Brown mansion. And then in September, we will learn about DNA and Genealogy from Dr. Ruth Oneson.

We are in the midst of our annual membership drive. If this publication was mailed to you, your spouse is eligible to join us! In addition to the above-mentioned programming, we also volunteer in our community, support health- related non-profits through our annual Kitchen Tour and, of course, support our medical families and each other! For information on how to join, please visit our website, ocmsalliance.org, or email Margo Ward at margoward@hotmail.com. You may also reach me at cfalcon@cox.net for any questions.

ocmsalliance.org

BUSINESS RELATIONS AND UNETHICAL CONDUCT AMONG PHYSICIANS AND EMPLOYERS

S. Sandy Sanbar, MD, PhD, JD, FCLM, DABLM, DABFM
and
Marvin H. Firestone, MD, JD, FCLM[1]



Disputes and unethical conduct may arise among physicians following dissolution of a partnership or employment contract. Business relationships are based either on implied or express written contracts. A well-written contract prepared by an experienced attorney that is honored by all parties can prevent disputes and unethical conduct after the partnership or employment terminates. Physicians should take preventive measures when entering into a partnership or employment contract to avoid or minimize the risk for later disputes.

Unsuccessful business relationships among physicians and employers may result in disputes and at times vengeful and costly lawsuits following the breakup of partnerships and employment agreements. Disputes may lead to disregard of the safety of the patient. Who will be responsible to provide medical care for the patient?

In partnerships, the patients' medical records may be considered the business records and property of the partnership. The partnership that holds medical records would be considered a "trustee or custodian" of the patients' medical records. On the other hand, the content of the medical records are considered the patient's property. Hence, the patient can provide any clinician access to the content by the clinician. This is accomplished by requesting copies of the records from the "trustee or custodian" with the patient's proper written authorization.

A dispute over who will provide medical care for the patient is decided by the patient, if competent or alternatively

the patient's health care proxy. If medical records are needed for ongoing patient care following the termination of a partnership or employment, the physician who retains possession must release copies of those medical records pursuant to a signed authorization from the patient.

Some situations are considered unethical and/or illegal. For example,

- It is both unethical and illegal to refuse to provide a copy of the medical records if presented with a legal authorization.
- It is unethical for a physician to refuse to provide a patient with contact information for another physician that the patient chooses to see. The treating physician should try to provide reasonably requested information by the patient.
- Non-competition clauses in a contract prohibit past employees from practicing within a specified geographic area and over a length of time following termination of the partnership or employment. Such contracts should be initially drafted and negotiated by attorneys representing each clinician. Courts will enforce limited geographic areas and time periods. On the other hand, where a contract includes a non-competition clause in a contract prohibiting past employees from practicing within an unreasonably large specified geographic area and over an unreasonable length of time following termination of the partnership or employment, the courts will find that contract illegal and unenforceable.
- Some contracts include a provision specifying which clinician retains or possesses the physician-patient relationship. Despite a clear provision in the contract specifying who should possess that relationship, disputes may arise between clinicians regarding the care relationship. The decision as to who will provide future care is always the patient's.
- Defamation, which is a derogatory statement made in writing (libel) or orally (slander), of former partners or employees to discourage patients from leaving the practice is both unethical and illegal. Physicians should never rely on a patient's statements about the care they received and avoid spreading hearsay criticism of the competence of other physicians.
- Interfering with a competitor's ability to earn a living can be an unfair business practice. It is unethical for physicians to attempt to influence patient's decisions to change physicians by distorting the legal implications of leaving the practice. For example, it is improper to tell a patient that a lawsuit is planned or filed against a physician or employer, and that the patient may be a witness if the patient changes clinicians.
- It is unethical to misuse authority by physicians on a hospital staff, medical group, or medical society to impugn a competitor. Such conduct may appear to be an unfair business practice. For example, an unwarranted attack on the benefits of the competitor within the organization, asserting pressure on other members of the staff or group to act against or harass the competitor, and use of your authority as an officer or peer-review committee member to limit or terminate the staff privileges or membership of a competitor. Threatening to withdraw consultation referred business if the consultant accepts consultation requests from the competitor is unethical.
- Making complaints with no factual bases and no reasonable supporting evidence against competitors for unprofessional or unlawful conduct is unethical.
- Finally, it is also unethical for a physician to testify as an expert witness against a competitor with neither factual nor legal basis for the rendered opinion. The opinion is likely to be attacked during cross-examination.

Regrettably, the above described ethical misconduct is not uncommon. It frequently backfires on the person responsible and can lead to distrust and dislike by other physicians in the community.

Drs. S. Sandy Sanbar (Board Member) and Marvin H. Firestone (President) are presenters of professional boundary courses at the Western Institute of Legal Medicine (WILM), 1700 S. El Camino Real, Suite 204, San Mateo, CA 94402. Phone: (650) 212-4904, Fax: (650) 212-4905, Email: Administrator@WILM-Ed.org. WILM offers ACCME AMA PRA Category 1 accredited CME courses in the areas of: Medical Record Keeping, Prescribing Practices and Management of Chronic Pain and Substance Abuse Disorder, Pain Management, and Practical Medical Ethics and Professionalism.

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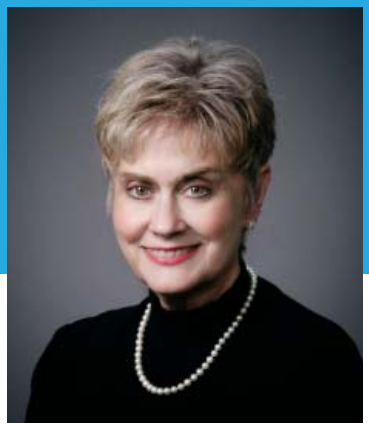
DIRECTOR'S DIALOGUE



INTENT reveals desire;
ACTION reveals commitment.
~ Dr. Steve Maraboli

By Jana Timberlake,
Executive Director

Spring is almost here! And you know what that means … the OSMA Annual Meeting and House of Delegates is right around the corner. While many physicians have been elected as delegates, more are needed for the Society to reach its full representation.

Elected delegates have received reminder emails that include the meeting information below:

DATE:	Saturday, April 28, 2018
LOCATION:	Embassy Suites Downtown Medical Center 741 N. Phillips Avenue Oklahoma City, OK
TIME:	7:30 a.m. - Registration and Breakfast 8:30 a.m. - OCMS Caucus 10:00 a.m. - House of Delegates

Delegates represent our membership in deliberations on issues facing organized medicine and our state association at OSMA's House of Delegates meeting. Resolutions will be debated, OSMA bylaws amendments will be considered and elections will be held for multiple positions in both the AMA and OSMA. The only members not eligible to serve are those who have received a hardship exemption. If you are not an elected delegate but would like to be credentialed, please notify Alison Fink, afink@okcountymed.org , as soon as possible.

To cap off the day's activities, the Inaugural Reception is set to begin at 6:00 p.m., with the Awards Ceremony and Inaugural Dinner celebration Jean Hausheer, MD, ophthalmologist from Lawton, starting at 7:00 p.m. This is always an incredible event I hope you will plan to attend to show your support for the new OSMA president.

Please **TAKE ACTION** and make the **COMMITMENT** to participate in organized medicine's largest event in Oklahoma. As the Uncle Sam poster says, "We Need You!"

I hope to see you there!

Jana Timberlake, CAE, Executive Director

MEMBERSHIP MEETING

& 50-YEAR PHYSICIAN *Celebration*

Monday, March 26, 2018 - 6:00 p.m.

Speaker: Jason Sanders, MD, MBA, OUHSC Provost
Topic: Transformation of OU Health Sciences Center

OSMA Headquarters – 313 NE 50th

***RSVP – 702-0500 or**
email ewright@okcountymed.org by March 22

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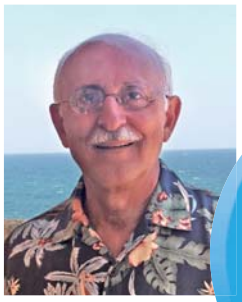

THE POET'S SPOT

We pass through the seasons of life,
one at a time. Spring is birth and growth;
summer is work and production;
autumn is maturity and retirement; and
winter is old age and death.
Throughout this entire journey,
our most significant joys come from
our loves and passions.
Indeed, it is these simple feelings that
render our journey tolerable.

Butterflies

I watch you move like autumn through my life
An interlude of butterflies and leaves
From summer's feverish wrath and charring strife
To winter's bleak and cyanotic eves.

Life is a year; a birth-full, mirthful spring
A summer parched with toil and sobering
Then autumn's harmony and graying ease
Ere winter executes with cutting freeze.

With weightless grace you love, so silently
Like butterflies that stroke the autumn breeze
Your April hands, they hatch me tenderly
To wine upon you palms unto the lees.

When winter darkness comes to shut my eyes
I'll think of you and all the butterflies.

Hanna Saadah, M.D.

OKLAHOMA STATE MEDICAL ASSOCIATION

PRESENTS:

RINGING THE ALARM

ADDRESSING THE OPIOID EPIDEMIC

APRIL 27, 2018 • 8:30 a.m. to 4:45 p.m.

Embassy Suites Downtown Medical Center • 741 N. Phillips Ave., Oklahoma City, OK

CME Event Schedule

7:45 a.m.	**CME Registration and Breakfast**
8:30 a.m.	**Kevin McCauley, M.D.**, "The Brain and Recovery, an Update on Addiction: There is Hope"
10:15 a.m.	**Break**
10:30 a.m.	**Patrice Harris, M.D., M.A.**, Immediate Past Chair, Board of Trustees, American Medical Association, "Opioid Abuse in America and How We Change This"
12:00 p.m.	**Lunch**
1:00 p.m.	**Carol Havens, M.D.**, Director of Physician Education and Development, The Permanente Medical Group, "How to Monitor Patients on Ongoing Opioids and When to Discontinue Before It Gets Out of Hand"
2:45 p.m.	**Break**
3:00 p.m.	**Joseph Rannazzisi, J.D., Pharm.D.**, Former DEA Deputy Assistant Administrator, DEA Whistleblower featured on *60 Minutes*,"Getting to the Root of the Opioid Epidemic"
4:00 p.m.	**Panel Discussion: Q and A with Speakers**
4:30 p.m.	**Wine and Cheese Reception**

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Disclosures:
The Faculty, CME Planning Committee, Reviewer and Moderator have no relevant financial Relationships to disclose.
Accreditation Statement:
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Oklahoma State Medical Association (OSMA) and Physicians Liability Insurance Company (PLICO). The Oklahoma State Medical Association (OSMA) is accredited by the ACCME to provide continuing medical education for physicians.

The OSMA designates this live activity for a maximum of *7 AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
"The Oklahoma State Medical Association has been surveyed by the Accreditation Council for Continuing Medical Education (ACCME) and awarded Accreditation with Commendation for six years as a provider of continuing medical education for physicians.
The ACCME accreditation seeks to assure the medical community and the public that the Oklahoma State Medical Association provides physicians with relevant, effective, practice-based continuing medical education that supports US health care quality improvements.
The ACCME employs a rigorous, multilevel process for evaluating institutions' continuing medical education programs according to the high accreditation standards adopted by all seven ACCME member organizations. These organizations of medicine in the US are the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association for Hospital Medical Education, the Association of American Medical Colleges, the Council of Medical Specialty Societies, and the Federation of State Medical Boards of the US, Inc."

Accreditation Statement: The Osteopathic Founders Foundation is accredited by the American Osteopathic Association to provide osteopathic continuing medical education for physicians. The Osteopathic Founders Foundation designates Ringing the Alarm Addressing the Opioid Epidemic for a maximum of six and a half (6.5) AOA Category 1-A credits and includes one hour of proper prescribing education which will allow osteopathic physicians to fulfill their Oklahoma licensure requirement. The Osteopathic Founders Foundation will report CME and specialty credits commensurate with the extent of the physician's participation in this activity.

CME INFORMATION

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Contact: **Maggie Kane, BSN, RN**,
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Medical Staff Services Coordinator
Phone: 610-8011

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Contact: **Samantha Elliott**, Director of Membership
Phone: 842-0484
Email: elliott@okafp.org
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OU Medicine

Adult Urology

Michael S. Cookson, MD, Chairman
Urology Department, Urologic Oncology/Robotics

Ash Bowen, MD, General/Oncology/Robotics

Brian Cross, MD, Urologic Oncology/Robotics

Daniel Culkin, MD, Men's Health/Stones/Oncology

Jonathan Heinlen, MD, Urologic Oncology/Robotics

Mark Lindgren, MD, Infertility/Men's Health

Charles McWilliams, MD, General Urology/Male & Female

Sanjay Patel, MD, Urologic Oncology/Robotics

Mohammad Ramadan, MD, General/Oncology/Robotics

Kelly Stratton, MD, Urologic Oncology/Robotics

Gennady Slobodov, MD, Male/Female/Reconstructive/ Incontinence/Neurogenic Bladder

Eric Wisenbaugh, MD, Male Reconstructive

OU Physicians:
Adult Urology 405-271-6452
Edmond 405-340-1279
Stephenson Cancer Center 405-271-4088

Pediatric Urology

Dominic Frimberger, MD
Pediatric Urology/Reconstructive Surgery/Spina Bifida
Pediatric Urology/Robotics

OU Children's Physicians:
Urology 405-271-2006
Edmond 405-340-1279

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