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TABLE OF CONTENTS

Thank You to Sponsors and Advertisers	6
President's Page	8
Dean's Page	10
About The Cover	12
2023 OCMS Inauguration	14
Law & Medicine	16
Clinical Capsule: Resistant Hypertension & Primary Hyperaldosteronism.....	18
Clinical Capsule: Rapid Eye Movement Sleep Behavior Disorder	20
Director's Dialogue	24
The World's Greatest Secret.....	26
Doctor of the Day 2023	31
In Memoriam.....	31
The Poet's Spot.....	32

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Dr. Claire Atkinson, our newest provider, is now board certified in allergy and immunology in addition to pediatrics. She has been serving patients at our main clinic and she will start seeing patients at our Yukon satellite clinic in January.



Dr. Dean Atkinson



Dr. Laura Chong



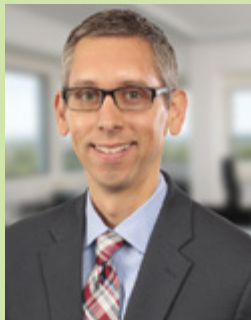
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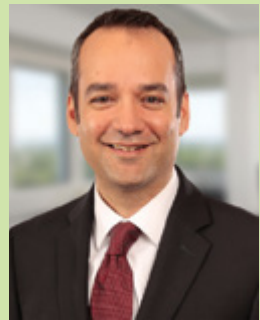
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Michelle Powers, MD, MBA

President's Page

MICHELLE POWERS, MD, MBA

Physician, Heal Thyself

"Physician, heal thyself!" is generally an expression referencing when we, as physicians, treat ourselves for our own medical issues. As a pathologist, I certainly do very little prescribing of medications, or test ordering, so I am not at risk for that behavior as much as those who see patients daily.

However, after practicing during the stress of the pandemic, then during the post-pandemic times, and then struggling with and finishing therapy for stage IV Hodgkin lymphoma, I am now striving to adopt a different strategy for "healing myself." During my tenure as the Oklahoma County Medical Society president in 2023, I plan to share with others a set of strategies for helping to address physician stress, burnout, and mental health. This article is a starting point to share recent things I have used to help myself.

I certainly am no expert in this field, and many things that I could do to improve my own mental health, I am not adopting very firmly. However, I am a lifelong learner. And as such, I am committed to helping myself be well.

My first thing I do to help with my own self care is this: I take vacation. It sounds so basic. So easy. Take vacation—but as physicians, we receive daily external pressures—staff, coworkers, patients, the electronic

medical record. All of these, without implicitly stating it, tell us—we need you! You must work! You must take care of these patients! Nobody can do this job the way that you do!

It has taken me years of life coaching, yoga and self-reflection, but I can honestly say that while it is certainly tempting to tell myself that only I can do certain tasks, it's actually not true. If I do not come to work for a day, for a week, for 2 weeks, even a month, the patients still get care. Processes exist to make sure this happens. I have amazing partners in my group, and the two hospitals where I primarily work, have amazing staff who keep this happening.

And so for Thanksgiving week, I took a Disney cruise with my 9 year old. Now before your eyes glaze over—Disney, ugh! I see you! Don't knock it. Getting to see Mickey, some princesses, Captain Jack Sparrow – it was good for my soul. Time with my son, time to myself, and most importantly, time where my cell phone is in airplane mode--it is a game changer. I came back feeling blessed for the time off, and also ready to take care of my patients again.

Please, physicians, take care of yourself first. We cannot take care of our patients, nor our families if we do not take care of ourselves first.



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John P. Zubialde, MD

Dean's Page

JOHN P. ZUBIALDE, MD
EXECUTIVE DEAN AND PROFESSOR,
FAMILY AND PREVENTIVE MEDICINE
UNIVERSITY OF OKLAHOMA
COLLEGE OF MEDICINE

In this message to you, I want to specifically recognize the faculty of the OU College of Medicine and those who support them. One of the great privileges of serving as executive dean of the College of Medicine is working with our dedicated faculty, both full-time and volunteer, to educate the next generation of physicians and researchers. Without them, we would have no medical school. They are truly the unsung heroes of our profession. Each brings a deep passion and commitment to training our students, residents, fellows and graduate students.

One of the most important tools we have for recognizing excellence in teaching and fostering faculty development is the Jerry Vannatta, M.D. Academy of Teaching Scholars, a group that is going strong more than a decade after it was formed. Now housed within the college's Office of Faculty Affairs and Professional Development, the Academy of Teaching Scholars has only become more valuable since the first members were inducted. The Academy was originally formed to acknowledge and honor educators, who work hard day after day with little recognition. Each year, we now have the ability to present the Dewayne Andrews, M.D. Excellence in Teaching Award, named for our former dean and Academy founder, to excellent educators on both the Oklahoma City and Tulsa campuses. Awards are given in the areas of preclinical, clinical and graduate medical education, as well as

the physician associate program. During these awards ceremonies, we also induct new faculty members who apply for and meet the criteria for membership.

Over the years, the Academy has expanded its mission in several important ways. Beyond recognizing teaching excellence, we now offer a variety of resources to help educators improve their teaching skills. Whether through a one-hour lunch and learn, a half-day boot camp, or online modules, the Academy provides evidence-based learning opportunities tailored to meet the needs of our faculty. Wide-ranging topics include "Giving Feedback in the Clinical Setting," "How the Brain Processes Information," "Teaching Millennials," "Essentials of Team-Based Learning," and much more.

In the Academy's Peer Observation Program, a colleague observes a faculty member's lectures and provides constructive feedback. In another program, senior faculty members serve as mentors to younger faculty with a passion for education. Many other resources are available to fit the schedules and needs of our Academy members. Faculty members are always eager to improve their teaching skills and support one other through that process. But the Academy serves another important role by filling a gap in medical education. Most medical educators have a clinical or research background, not in education itself. By providing educational development resources, the

Academy gives faculty the tools they need to provide high-quality medical education and meet the needs of our learners.

The Academy has also broadened to provide grants to faculty members who want to pursue educational scholarship. Many faculty members have ideas about how to improve various aspects of the educational process, and a grant allows them to carry out a research project to gather data. Each year, we have a poster session featuring those projects, several of which have gone on to be published and presented nationally.

The OU College of Medicine has supported the Academy of Teaching Scholars consistently throughout its existence because it brings very tangible value to our educators. The Academy is also well-positioned to serve them in the future and grow in new ways thanks to the generosity of Jerry Vannatta, M.D., for whom the organization is now named. Dr. Vannatta, a David Ross Boyd Professor Emeritus and former college dean, gave a generous gift to the Academy last year to further its work. His gift is supporting several

initiatives, including a self-paced medical teaching certificate and a teaching scholars program aimed at developing future leaders in medical and healthcare education, with a focus on the core components of educational scholarship, curriculum development and the humanities.

In closing, I want to again emphasize how very proud I am of all our faculty, both full-time and volunteer, who make our mission of educating the next generation of physicians and physician associates possible. Many have always wanted to be a part of an academic setting, while others have found a newly discovered love for teaching. All bring a dedication and enthusiasm to what they do, whether in the lecture hall or at the patient's bedside. The work that our faculty are committed to today is ensuring that we will have skilled and compassionate healthcare providers in the future. Lastly, I am also grateful to the Academy for the value it brings to our medical educators as well as the many loyal supporters of our college who help make our missions possible.



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About the Cover

Our New President

Dr. Michelle Powers is president of the Pathology Group, PC in Oklahoma City, serving as lab medical director at SSM Saint Anthony Hospital and also pathologist at Mercy Hospital OKC. She is originally from Perryton, Texas, and she attended Texas Tech University, followed by Baylor College of Medicine and then residency and fellowship at Barnes-Jewish Hospital/Washington University in St. Louis. She is a devoted wife and mother and enjoys travelling with her son, Houston.

Cover Photo By Laura Eckel Photography



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Sanbar Selected For 2022 OCMS Rhinehart Award

The Oklahoma County Medical Society is pleased to recognize S. Sandy Sanbar, MD, PhD, JD, as the 2022 Rhinehart Award recipient. The Rhinehart Award is presented to an OCMS member, active or retired, who has demonstrated significant involvement in projects to help health care, the community, or the state. The award was named for Don F. Rhinehart, MD, an outstanding OCMS physician who was dedicated to the community.

Dr. Sanbar has practiced in Oklahoma City both as an Attorney at Law and Internal Medicine and Cardiology. He is a Past President of the American College of Legal Medicine (1989-1990) and he has received numerous Awards, including Gold Medal Award (2000), Distinguished Service Award (2007), and 'In deep appreciation for three decades serving as Editor of the Textbook of Legal Medicine' (2015) of the American College of Legal Medicine. In 2007, he was elected as the Chairman of the American Board of Legal Medicine (ABLM), and President of the American Board of Medical Malpractice (ABMM). He is a Diplomat of both the ABLM and the ABMM. He performed Consultative Examinations (for 6 ½ years) then served as a Medical Consultant (2 ½ years) for the Department of Disability Services, Social Security Administration in Oklahoma City. Since March 2008, Sanbar has been in private practice in Oklahoma City.

Sanbar is a prolific author of over 200 articles, and author or editor of eleven Books. His books include Hyperlipidemia & Hyperlipoproteinemia; Medical and Hospital Law; Editor, LEGAL MEDICINE, nine Editions from 1987-2007; Editor, MEDICAL MALPRACTICE SURVIVAL HANDBOOK, 2007; and Editor, ABLM BOARD REVIEW EXAM & STUDY GUIDE, 2007 & 2012, and LEGAL MEDICINE & MEDICAL ETHICS, 2010 & 2015. He publishes articles for the LAW & MEDICINE section of the Oklahoma County Medical Society publication, the BULLETIN. He is an Associate Editor of the BULLETIN, and Associate Editor of the Oklahoma State Medical Association Journal. He is a member of the Oklahoma Bar, the Oklahoma County Bar, the Oklahoma State Medical Association, and the Oklahoma County Medical Society. He is a State, National and International Lecturer on Legal Medicine and Medical Ethics, and he generally serves as Seminar Program Chairman. He is married to Dorothy J. Sanbar, an Oklahoman, and has two children and three grandchildren.

His military service in the U.S. Army Medical Corps included time at Fitzsimmons General Hospital in Denver and, in 1970 after being promoted to Lt. Colonel he served in the U.S. Army Medical Corps, U.S. Army Hospital, in Danang, Vietnam. He was awarded the Bronze Star Medal Award for his efforts in Vietnam. He was Honorably Discharged on July 4, 1970.

The Digital Doctor and AI Medical Devices

S. SANDY SANBAR, MD, PhD, JD

Artificial intelligence (AI) is not going to replace physicians, but physicians who use AI are going to replace physicians who don't.¹ Advances in Healthcare Technology should never be viewed as *Doctor v. AI*. Digital medical devices and algorithms are merely newer health technology tools for use by doctors and healthcare workers.

Doctors are actually seeing the value in digital health tools. In 2022, an AMA survey of 1,300 doctors found an increasing use of digital health tools in telemedicine/telehealth, and in remote patient monitoring. In 2022, 80% of doctors engaged in telehealth visits, and 30% are using digital tools to help care for patients remotely. Interestingly, 93% of the surveyed primary care physicians and specialists said digital health tools can improve patient care. But the use of augmented intelligence in medical practices is lagging behind.² Remote patient monitoring allows physicians and health systems to use AI medical devices to help track patients with chronic conditions, such as diabetes or hypertension, and potentially intervene earlier as needed.

AI and its subsets, Machine Learning (ML) and Deep Learning (DL), are playing major roles in automated imaging disciplines in

radiology, ophthalmology, dermatology and pathology, among others. ML has been applied to tasks involving signal processing, such as electrocardiography and audiology, and in jobs where integration with other datasets helps clinical workflow.

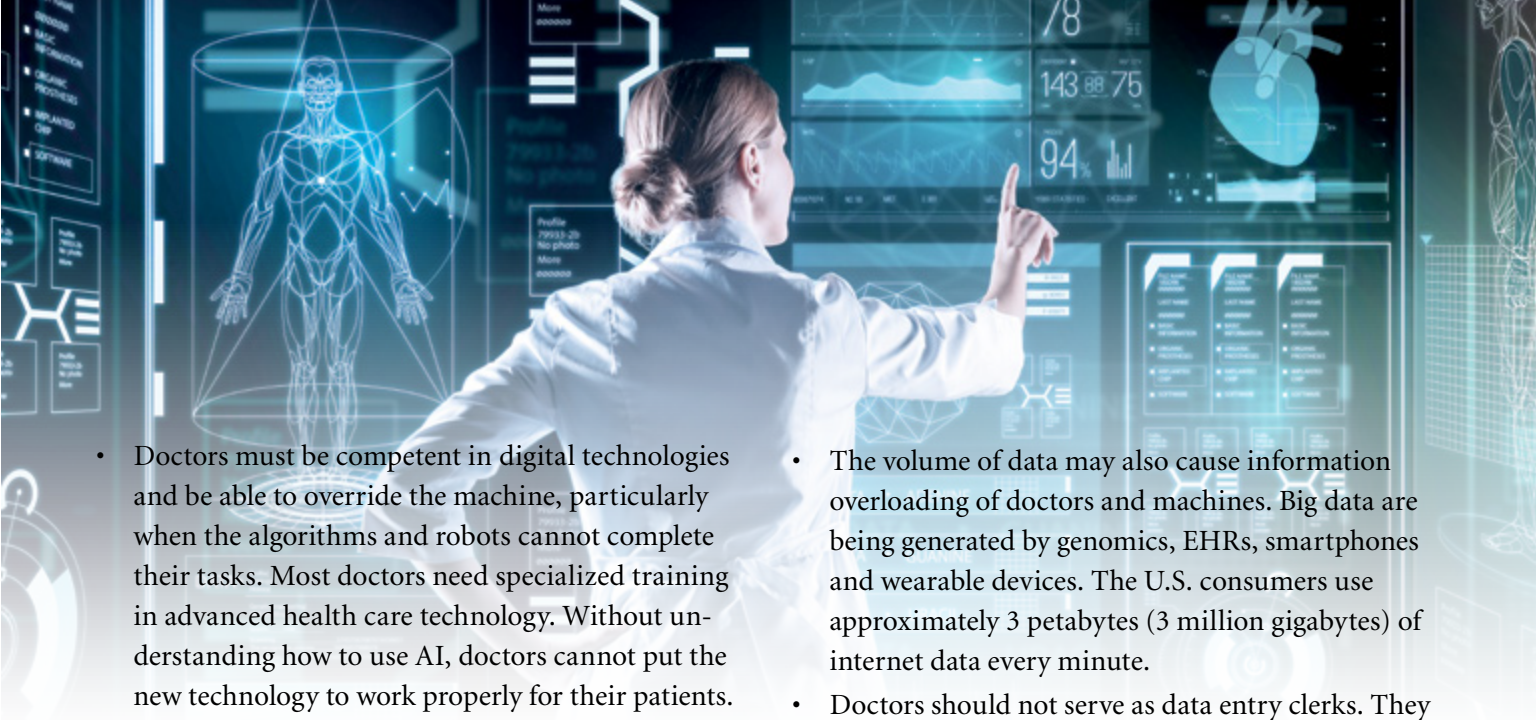
Doctors who use AI medical devices should keep in mind the following:

- Doctors and AI devices can work together and excel in ways that individually they cannot.
- The doctor is dexterous, works in a non-linear method, and adapts to ever-changing conditions and evolving situations. It is difficult to teach dexterity to a computer.
- Doctors are difficult to replace. They have empathy when caring for the patient. It is difficult for an AI medical device to have empathy.



Law and Medicine

*Dr. Sanbar is an Adjunct Professor of Medical Education, University of Oklahoma Health Sciences Center; Executive Director and Past Chairman and Diplomat, American Board of Legal Medicine; and Past President and Fellow, American College of Legal Medicine. He is a health law attorney and a retired cardiologist.



- Doctors must be competent in digital technologies and be able to override the machine, particularly when the algorithms and robots cannot complete their tasks. Most doctors need specialized training in advanced health care technology. Without understanding how to use AI, doctors cannot put the new technology to work properly for their patients.
- Health systems should provide proper training to practicing doctors before using digital health tools effectively on their patients.
- AI devices may require human assistance or prompting. Computers can rapidly compile and evaluate datasets much quicker than humans. However, speed and efficiency may not always translate to accuracy. Because bad or biased data may be inputted, albeit inadvertently, machines may get it wrong.
- A federal report on National Survey Trends in Telehealth Use in 2021 found that Black, Hispanic and Asian patients were less likely to use video telehealth services.³ Digital tools must be used to help close disparities in healthcare among disadvantaged groups and advance health equity.
- The volume of data may also cause information overloading of doctors and machines. Big data are being generated by genomics, EHRs, smartphones and wearable devices. The U.S. consumers use approximately 3 petabytes (3 million gigabytes) of internet data every minute.
- Doctors should not serve as data entry clerks. They should focus on actual care and use virtual assistants to collect and condense data, then entered virtually into the EHRs. Both the quality-of-care patients receive, and the work/life balance for clinicians are critical for everybody.
- Artificial intelligence can help reshape healthcare, particularly in identifying patients before adverse events. For example, Mayo Clinic researchers⁴ have found AI could help spot patients at risk of stroke or cognitive decline,⁵ and identify complications in pregnant patients.⁶

Employed physicians do not buy the computers that they use. Hospitals and other medical organizations do, and they may be held accountable vicariously for the actions of the employed physicians and other health care providers in those organizations. AI liability will be discussed separately in another article.



1 <https://nihrecord.nih.gov/2020/09/18/former-niher-horvath-explains-why-machines-wont-replace-doctors>
2 AMA digital health care 2022 study findings | American Medical Association ([ama-assn.org](https://www.ama-assn.org)).
3 [telehealth-hps-ib.pdf](https://www.hhs.gov/telehealth-hps-ib/pdf) (hhs.gov).
4 Price, W. Nicholson; Gerke, Sara; and Cohen, I. Glenn, "Liability for Use of Artificial Intelligence in Medicine" (2022). Law & Economics Working Papers. 241. https://repository.law.umich.edu/law_econ_current/241.
5 Artificial Intelligence-Enabled Electrocardiogram for Atrial Fibrillation Identifies Cognitive Decline Risk and Cerebral Infarcts ([elsevier-health.com](https://www.elsevier.com)).
6 Impact of labor characteristics on maternal and neonatal outcomes of labor: A machine-learning model | PLOS ONE.

Resistant Hypertension & Primary Hyperaldosteronism

BY HANNA SAADAH, MD

Essential hypertension remains a major cause of cardiovascular disease. Primary hyperaldosteronism—a commonly missed diagnosis responsible for up to 50% of resistant hypertension cases—is associated with heart failure, stroke, myocardial infarction, atrial fibrillation, and end-organ damage. Primary hyperaldosteronism is common, and remains undiagnosed for many years¹.

In his seminal article of 1965, Jerome Conn (of *Conn's Syndrome*) stated that overproduction of aldosterone, in the presence of suppressed plasma renin activity, is specific for an aldosterone-producing adrenal cortical tumor, even when the level of potassium is normal².

Screening for primary hyperaldosteronism is as low as 1/550 cases of essential hypertension, even though up to 50% of essential hypertension patients may have primary hyperaldosteronism¹. Clues to the presence of primary hyperaldosteronism are: poorly controlled blood pressure despite multiple medications, diuretic induced hypokalemia requiring potassium supplements, obesity, obstructive sleep apnea, atrial fibrillation, history of strokes, and history of heart attacks.

Primary hyperaldosteronism is caused by small aldosterone-producing adenomas, usually considered adrenal incidentalomas, or caused by adrenal hyperplasia of the aldosterone producing cells. Primary hyperaldosteronism caused by an aldosterone-producing adenoma is called *Conn's Syndrome*. Aldosterone receptors are widely distributed throughout the body, including cardiac myocytes, endothelial cells, distal convoluted and collecting tubules, vascular smooth muscles, neurons, and macrophages.

Aldosterone is regulated by the renin-angiotensin system. Hypovolemia or hyperkalemia cause renin to rise, which in turn causes aldosterone to rise, thus increasing renal sodium reabsorption and potassium excretion. Physiologically, renin and aldosterone rise and fall together. When aldosterone rises and renin falls, it implies that unphysiological amounts of aldosterone are suppressing renin, which is the case in primary hyperaldosteronism.³

The diagnosis of primary hyperaldosteronism requires a high index of suspicion. Poorly controlled hypertension—despite adequate medical therapy with three or more medications, the need of potassium replacement to curtail diuretic hypokalemia, and history of strokes, heart attacks, or atrial fibrillation—should arouse suspicion. A low renin activity is a useful laboratory test for suspected primary hyperaldosteronism, whether it is or is not accompanied by a high serum aldosterone. In 1972, researchers (Carey, et al.) recognized that spironolactone could normalize blood pressure in patients with suppressed renin activity but not in those with higher renin activity⁴. Measuring the aldosterone/renin ratio has a low sensitivity, which means it cannot be used to rule out primary hyperaldosteronism; it can only support the diagnosis if the ratio is high.

The workup needed to confirm the diagnosis of primary hyperaldosteronism is complex, elaborate, and requires endocrine consultation. It may not be practical when one considers that about 45-50% of patients with essential hypertension suffer from aldosterone excess, and some may also have high cortisol levels. A continuum of renin-independent

aldosterone production was observed to parallel the severity of hypertension in the Annals of Internal Medicine 2020 study⁵.

A simplified primary-care, clinical approach for diagnosis and treatment, without resorting to laboratory tests, was suggested by Hung⁶. Replace the patient's thiazide diuretic with spironolactone or aprenone, reduce potassium supplement, monitor electrolytes, and observe the slow therapeutic response, which may take six to twelve weeks to occur. A therapeutic trial can give a positive response even if the laboratory workup is not diagnostic because primary hyperaldosteronism is not always diagnosable with tests.

Adrenal imaging to rule out the rare possibility of adrenal carcinoma is required. Most aldosterone producing adenomas are very small and may not be detected. However, if clearly visualized, laparoscopic surgery may be curative.

For specific details of diagnosis and management, please refer to these five references:

1. Primary Aldosteronism at the Tipping Point. John Funder (Editorial). Annals of Internal Medicine, May 2020.
2. Normokalemic Primary Aldosteronism. Jerome Conn. JAMA, July 19, 1965, Vol 193, No 3.
3. Primary Aldosteronism, Practical Approach to Diagnosis and Management. James Brian Byrd et. al. Circulation, August 21, 2018.
4. The Syndrome of essential hypertension and suppressed plasma renin activity. Normalization of blood pressure with spironolactone. Cary et. al. Arch Intern Med. 1972; 130:849-54.
5. The Unrecognized Prevalence of Primary Aldosteronism. Jenifer Brown et al., Annals of Internal Medicine, May 2020.
6. J Clin Endocrinol Metab 2021, August 26. Hung A et al.



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Rapid Eye Movement Sleep Behavior Disorder Harbinger of future Conditions?

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TR is a 64-year-old male whose wife reported his apparent nightmares and whole body jerking in sleep for several years, including kicking and hitting her. He delayed seeking help until symptoms worsened, as he had attributed sleep difficulties to PTSD. His PTSD and depression were treated with sertraline, bupropion, and prazosin. Due to memory lapses and some disorientation while driving, neuropsychological assessment was ordered. On exam he reported increased distractibility by external stimuli or when interrupted, being more reliant upon notes to remember important tasks and increase delegation of tasks to others. He endorsed speech changes with occasional slurring, losing train of thoughts mid-sentence and word-finding difficulties. He also reported occasional running into doorframes, decreased balance, occasional stumbling and tripping. Neurocognitive profile revealed primary deficits in processing speed, nonverbal

(visual) memory, and select executive functions (cognitive flexibility, verbal fluency, response inhibition.) Lateralization within motor and memory profiles was suggestive of greater right hemisphere dysfunction. It was recommended referral to neurology to rule out the prodromal phase of an extrapyramidal degenerative disorder or frontal-subcortical process. Brain MRI showed chronic microvascular changes. Sleep study identified severe obstructive sleep apnea and large leg movements, increased motor tone and lack of atonia during REM sleep.

The main hallmark of Rapid Eye Movement Sleep Behavior Disorder (RBD) is multiple “episodes of vocalizations and/or complex motor behaviors” that occur during REM sleep.¹ While the vocalizations are usually loud, profane, and emotion-filled, the motor behaviors seem to be reactions to the content of the dream, which seem to be violent or full of action, involving the dreamer being attacked or put in a threatening scenario. These actions can result in injury

to the patient or their bed partner. However, the vocalizations and motor behaviors can also be relatively subtle and may not even be the main sleep complaint that a patient is presenting with. This condition cannot be attributed to a substance's physiological effects nor a different medical condition, though studies have found an association in some cases with antidepressants, autoimmune diseases, and brainstem lesions.^{2,3} Though the patient's eyes are closed during the behaviors and vocalizations, upon awakening, they are typically awake immediately, alert, and oriented. They are also usually able to recall what was happening in their dream, which often explains the correlating behaviors.

To diagnose RBD, there needs to be observed absence of atonia with enactment of dream behaviors during REM sleep on a polysomnogram. Alternatively, for a provisional diagnosis, there can be a history suggestive of this disorder alongside an established synucleiopathy diagnosis, such as multiple system atrophy, Parkinson's disease, or Lewy Body Dementia. In addition to either of these situations, there must also be clinically significant impairment or distress due to the behaviors or vocalizations, whether of that of the patient or other household members.

There are an estimated 40-100 million individuals affected by RBD worldwide, but studies claim the vast majority go undiagnosed.⁴ However, there is a significantly high association with the manifestation of an underlying neurodegenerative disorder later in life for patients with RBD. In the 10-15 years following diagnosis, there is a 75% chance of a defined neurodegenerative disorder manifesting, most commonly a synucleiopathy in patients with idiopathic RBD.^{1,2} For this reason, individuals should be monitored closely, especially given that this sleep disorder can manifest a decade or more before any sign of these disorders. Non-motor signs of Parkinson's disease, specifically impaired olfactory function, anosmia, or constipation, can also co-occur with RBD, though these are sometimes attributed to other etiologies or just deemed clinically insignificant.^{5,6} Additionally, the progression of prodromal to full RBD and neurodegenerative disease

is predictive, so even if a patient is not experiencing REM sleep without atonia but is enacting their dreams, they should still be monitored long-term.⁷

When considering the differential diagnosis, one must include other parasomnias, such as sleep terrors, sleep walking, and confusional arousals. A difference between these and RBD is that they occur during NREM sleep which is earlier in the sleep cycle than REM. They also usually involve the patient waking up feeling disoriented, confused, and unable to completely recall what was happening in their dream. Atonia is also present and normal in these patients' REM sleep stages.

Another possibility is medication-induced sleep disorder. This may occur with acute administration of several classes of antidepressants (i.e. SNRIs, SSRIs, and TCAs), cholinesterase inhibitors, beta blockers and caffeine, or withdrawal from ethanol, benzodiazepines, barbiturates, tramadol, meprobamate and pentazocine.⁸ It is unclear whether they cause REM sleep without atonia or if they just unveil an underlying condition or predisposition.

Asymptomatic REM sleep without atonia is a possible explanation for when a polysomnogram reveals REM sleep without atonia but there is no dream enactment behavior; there is no known clinical significance with this finding yet. Nocturnal seizures can seem similar, though patients with epilepsy usually do not have REM sleep without atonia.

Obstructive sleep apnea may also elicit similar vocalizations and motor behaviors and can be difficult to tell apart from just the history. A polysomnogram can reveal that these behaviors and vocalizations occur at the end of obstructive sleep apneic events during arousals, and once again REM sleep without atonia typically does not occur in these individuals. Treatment of obstructive sleep apnea resolves these events.

Other specified dissociative disorders, such as sleep-related psychogenic dissociative disorder, could also be considered, though this occurs during well-defined wakeful periods in the sleep cycle.

Continues on page 22 ...

There is no FDA approved medication for RBD, but several have some evidence for benefit, including clonazepam and melatonin.⁸ In addition, sodium oxybate, a drug approved by FDA for the treatment of narcolepsy, has been used «off label» for a few cases of severe RBD, with reported effectiveness and tolerability.⁹

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DIRECTOR'S DIALOGUE



We spend January 1st walking through our lives, room by room, drawing up a list of work to be done, cracks to be patched. Maybe this year, to balance the list, we ought to walk through the rooms of our lives ... not looking for flaws, but potential. – Ellen Goodman

If 2020 was the year our world changed, and 2021 was the year we adjusted to the 'new normal,' then 2022 was the year that the changes and challenges of the prior two years really became noticeable. Members seek new types of connections with customizable options for memberships. Members are seeking to build deeper connections and participate more actively in caring for themselves *and* their patients.

Finally, for the first time since late 2019, we held a collegiality dinner – Women in Medicine – in November. The feedback from attendees was incredible. After so long, many of our members (and a few new ones) were delighted to enjoy an evening discussing life, medicine, and the future with fellow physicians. In 2023, we'll hold our 50 under 50ish collegiality dinner for physicians of all ages who want to meet and chat with fellow physicians. Introverts welcome.

This year, we had more enrolled in our Physician Leadership Academy than ever before. The class has been immensely engaging and our faculty has been incredible. We were delighted to have Scott Mitchell and the Honorable Frank Keating discuss conflict

management at our December session, and legislation will take front and center at our January meeting.

On February 10, we will hold our celebration of OCMS and the Inaugural of 2023 President Michelle Powers, MD. This event not only celebrates another year in our organization, but it also recognizes the graduates of the Physician Leadership Academy. This event is incredibly beneficial to OCMS and we hope you'll attend to support our mission.

We have recently launched a text message service. Members can learn about relevant events and possibly even legislative alerts. Importantly, you can pay your dues through this text message! If you want to receive the non-annoying, occasional text from OCMS, then send a message to 405-390-7218 and to ensure we have the correct number.

We will not stop talking about how COVID affected us in 2023, but one thing we can guarantee is change. OCMS will continue to find innovative ways to connect. More than anything, I want our physicians to be happy and healthy, and reach out to the OCMS staff with concerns, questions, or ideas.

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The World's Greatest Secret

BY HANNA SAADAH, MD

“What’s the world’s greatest secret, the secret that everyone knows?” asked Professor Zontanós Thánatos.

Our Humanities class giggled, and no one ventured an answer.

Grace, after a long pause, inquired with a jovial voice, “How can it be a secret if everyone knows it?”

“Well. We all know that our parents had sex to have us, but we never talk about it. That’s an example of a secret that everyone knows.”

Grace blushed and the class giggled again.

“Life is full of secrets that everyone knows,” affirmed the professor. “I’d like three of you to come up with examples.”

A pensive pause followed, punctuated by contrived throat clearings.

“My mother is paranoid, but we never talk about it,” said Helen with embarrassed tone.

“A good example,” nodded the professor.

A silent pensive pause followed.

“My sister had a baby out of wedlock, but we never talk about it,” said Linda. “Another good example,” affirmed the professor.

Another pensive pause...

“My brother spent two years in jail because he was caught with drugs, but we never talk about it,” said Sam.

“Another good example. Thank you—Helen, Linda, and Sam—for sharing your intimate secrets. We all have intimate secrets that everyone knows, but we still treat them as if they were highly confidential. So then, what’s the world’s greatest secret, the secret that everyone knows?” queried the professor, with questing eyes.

Silence...

“Let me give you a hint. What’s the primary source of world suffering? Go round the table and voice your individual conjectures.”

“Hate. Armed conflict. Aggression. Crime. Drugs. Theft. Speeding. Deceit. Misperception. Fear. Anger. Greed. Injustice. Human-rights violation. Oppression. Vengeance. Cruelty. Child abuse. Ignorance. Poverty. Unsanitary conditions.”

“Good,” said the professor, “but not good enough. I’ve asked you to divine the secret source of world suffering but, instead, you’ve enumerated some of the causes of world suffering.”

Pensive silence...

The professor smiled and paced the floor.

Marcus cleared his throat but decided not to speak.

“Love,” cried James, with a quivering face.

“The primary source of world suffering is the lack of love.”

Nods of approval vibrated around the table.

“We all know that *Homo sapiens* are supposed to love one another, but history has shown us that universal love cannot be taught,” declared the professor. “For millennia, our religions have been instructing us to love one another but still we don’t. Wars, genocides, armed conflicts, terrorism, homicides, crimes, legal battles, groups united by hate, and all kinds of aggressions abound around the world. Here’s what Thomas Hardy said in his poem, *Christmas: 1924*,

Continues on page 29 ...

We need to be more vocal, more active in advocating for our own and our patients' interests. We need new physicians to join us. We need younger physicians to step up and assume leadership positions. There is no specialty organization that can fully meet the advocacy needs of all physicians. Organized medicine (AMA, OSMA, OCMS) is indispensable. We provide advocacy, education, and networking opportunities.

— Sumit K. Nanda, MD, OCMS President



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*“ ‘Peace upon Earth!’ was said. We sing it,
And pay a million priests to bring it.
After two thousand years of mass
We’ve got as far as poison gas.’*

“Indeed, history has repeatedly shown us that teaching and promoting hate is far simpler than teaching and promoting love. There are times when love can subside to hate, but hate can seldom rise to love. Therefore, since the world has always been deficient in love, and since teaching and promoting hate has always been easier than teaching and promoting love, what can we do about this human plight?”

Silence...

I’ll give you a hint. To conquer the world, love needs an ally.

Silence...

After a long, sighing pause professor Zontanós Thánatos stunned us with this complex quotation:

*“ ‘Love without kindness is harsh with
ruthless passions.*

*And although love can be without
kindness, kindness itself cannot be
without love—for kindness needs a
heart to nest in.*

*Without Kindness—love cannot heal,
mercy cannot act, compassion cannot
touch, shame cannot cry, anger
cannot die, vengeance cannot forgive,
faith cannot conquer, and humility
cannot be spontaneous.*

*And just as anger begets anger, kindness
begets kindness and more; it begets love,
sweetened and tame.*

*But, alone, love cannot beget love because it
needs kindness to light the way.*

*And whereas love can only talk to the heart,
kindness visits the soul.*

*And love, in the name of Love, can go to
war, whereas kindness only strives
for peace.*

*And love concerns itself only with those it
cares to reach, whereas kindness reaches
out to all humanity.*

*Kindness is the great mother of life and love
is her beautiful child.*

*And whereas love is an attribute of
the heart, kindness is an attribute
of magnanimous spirits.*

*And whereas love mainly dwells within us,
kindness, like the sun, shines out upon
the entire world, giving warmth and light
without discrimination.’ ”*

Silence...

“Now that you’ve heard this thought-provoking quotation, what’s the world’s greatest secret, the secret that everyone knows?” re-asked the professor with an inviting smile.

“The lack of kindness, sir, is the world’s greatest secret,” said Omar.

“Indeed,” affirmed the professor. Teach and promote kindness in schools and in colleges, and you will bring up a kind generation. Just as hate can be taught to impressionable minds, kindness can also be taught to similar minds. Lamentably, hate is actively taught all over the world whereas kindness is not. It is very difficult for a kind person to behave unkindly whereas it is not hard at all for a loving person to turn hateful. Unlike love, which is a labile emotion, kindness is a staple attribute that defines character.”

Continues on page 30 ...

"Sir," asked Muhammad. "Are you suggesting that kindness is more important than love?"

"Yes, I am. Think about these thirteen desirable traits—*Courtesy, Welcoming Smiles, Reassuring Touch, Gentleness, Empathy, Friendliness, Generosity, Helpfulness, Mercy, Forgiveness, Tolerance, Patience, Humility*—and you will realize that they are all different manifestations of kindness."

"How can you tell, sir, that these traits are manifestations of kindness?"

"Simple. Reverse them and you will get unkindness. A—discourteous, unwelcoming, un-reassuring, ungente, un-empathetic, unfriendly, ungenerous, unhelpful, unmerciful, unforgiving, intolerant, impatient, arrogant—person is basically an unkind person."

"But that sounds too simple to believe," protested Mohammad.

"Well, try to describe the world as a kind world and see how many will believe you. You can call our world a beautiful world, a wonderful world, a bountiful world, and a magnificent world but you cannot call it a kind world because the world's history reeks of cruelty."

Silence...

"Sir," asked Norma. "Why has the world not grown any kinder? Why does it still suffer from acrimony? Why is it easier to teach hate than kindness?"

The professor surveyed our tired faces and asked, "Who would like to hazard an answer?"

Roaming eyes...

"Evolution," suggested Omar.

"Good but not clear. Clarify what you mean."

"*Homo sapiens* conquered the world with group power. It seems that an ethos of kindness is not favored by evolution because it weakens group power."

"How unfortunately true," cried the professor.

"Individuals can be kind, but nations cannot, especially if they feel threatened. There has never been a kind war; there are no kind conflicts, weapons, riots, mobs, or revolutions; and politics has never been kind."

The class held its breath. No words were uttered. Facing ugly truths left us stunned.

The professor, seeing our disheartened faces, tried to console us with morsels of wisdom. "Better endure truth than be twisted by falsehood. Better bow to reality than elaborate superstitions. '*Man will become better when you show him what he is like,*' said Anton Chekhov."

Marcus was the one who asked the final question. "Sir. When will kindness win the battle against aggression?"

"When kindness to our planet and all of life on it becomes the sole means to avert annihilation. Kindness is the world's greatest secret, the secret that everyone knows, the secret that no one talks about."

*"We dance round in a ring and suppose,
But the Secret sits in the middle and knows."*

Robert Frost



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THOMAS LEROY WHITSETT, MD

JULY 14, 1936 - NOVEMBER 15, 2022

PATIENTS FOR DOCTORS OR DOCTORS FOR PATIENTS



Our worth is not a cumulation of past decisions
Sometimes things result in unfair collisions
When patients need lifestyle revisions
We mustn't only focus on anatomical fissions.

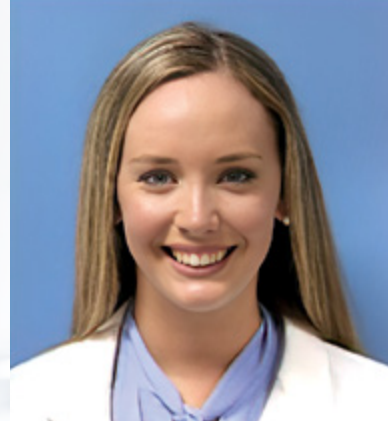
Everyone has feelings comfort food drowns
It is a medication that fixes frowns
This patient is not defined by her pounds
This patient deserves full attention during rounds.

Malignancy can't always be kept at bay
It is not a fun game to try and play
This patient is not an impending terminal day
This patient deserves comfort during her stay.

In the crossfires, things get caught
It's a genetic lottery that no one sought
This patient's renal function failed, but she did not
This patient's mental battles still deserve to be fought.

Plans are notorious for derailing
It is hard to watch a patient wailing
This patient is not doomed because her heart is failing
This patient deserves support although times are not smooth sailing.

Financial burdens are something people often lug
It is hard to push these problems off with just a shrug
This patient should not have to worry about the payment for her drug
This patient still deserves the healing of her bug.



BY ANN ELIZABETH TEBOW, MSIII
OUHSC



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