THE BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY

NOVEMBER/DECEMBER 2021

LYRIC THEATRE

A Christmas Carol

COMING SOON
TO A BLOOD DRIVE NEAR YOU

DEBUTS NOVEMBER 20

ALL DONORS RECEIVE THEIR CHOICE OF LONG SLEEVE T-SHIRT AND A FREE COVID-19 ANTIBODY TEST.*

CALL 877-340-8777 OR VISIT OBI.ORG TO MAKE YOUR LIFESAVING APPOINTMENT TODAY!

*While supplies last. Photo ID required. Donors ages 16 or 17-years old need parental consent to be screened for COVID-19 antibodies. This test has not been FDA cleared or approved. It has been authorized by the FDA under an EUA (Emergency Use Authorization) for use by authorized laboratories. The test has been authorized only for the detection of the IgG antibody against SARS-CoV-2, not for any other viruses or pathogens.

Oklahoma Blood Institute

EVEN SANTA NEEDS A LITTLE HELP!

6471 AVONDALE DRIVE NAIFEHFINEJEWELRY.COM 405.607.4323

OKLAHOMA COUNTY MEDICAL SOCIETY

313 Northeast 50th Street, Suite 2
Oklahoma City, OK 73105-1830
phone: 405-702-0500 fax: 405-702-0501
email: ocms@okcountymed.org

www.okcountymed.org

Ideas and opinions expressed in editorials and feature articles are those of the authors and do not necessarily express the official opinion of the Oklahoma County Medical Society.

THE BULLETIN

November/December 2021
Volume 94 Number 6
Six Annual Publications Circulation 1500

TABLE OF CONTENTS

ON THE COVER

Taking It Outside Again for
Lyric's 'A Christmas Carol'

LOCAL

LEADERSHIP DECISION MAKING OWNERSHIP

Quail Creek Bank

12201 N. May Avenue | OKC | 405.755.1000 | quailcreek.bank | Member FDIC

OKLAHOMA'S LUXURY CABINET & DESIGN AUTHORITY

- design + build controls •
- new construction •
- remodel •
- fine cabinetry and finishings •

EKB HOME
edmond kitchen bath home llc

243 N Broadway
Edmond
405.285.1926
Edmond Kitchen.com

OCMS
OKLAHOMA COUNTY MEDICAL SOCIETY

THANK YOU TO OUR 2021 SPONSORS!

GOLD

Oklahoma Blood Institute

BRONZE

First Liberty Bank
McBride Orthopedic Hospital
OU Medicine
PLICO

THANK YOU TO OUR ADVERTISERS!

EKB Home	Naifeh Fine Jewelry	OSMA Health
Engel & Völkers, Amy Stoker	NBC Oklahoma	Pro Realty
Geno's Furs	OK Allergy & Asthma Clinic	Quail Creek Bank
INTEGRIS Hospice	Oklahoma City Ballet	Valliance Bank

Our Healthcare Banking Division has a Physician Home Mortgage with *up to 100% Financing.*

Available to both physicians & medical residents.

Michael Levine, Senior Vice President
Healthcare Banking Division Manager
405-608-1048 • mlevine@myfirstliberty.com
NMLS #1125959

Jamie Vafadar, Vice President
Healthcare Banking Relationship Manager
405-608-0689 • jvafadar@myfirstliberty.com
NMLS #799925

FIRSTLIBERTY
HEALTHCARE BANKING

9601 N. May Avenue, OKC 73120

Basel S. Hassoun, MD

President's Page

Basel S. Hassoun, MD

Artificial intelligence-based solutions are changing healthcare for the better. We saw it coming over the past years, and as COVID-19 has put an extra accent on the use of such tools, that initial wave grew into a tsunami. But would this mean that surgeons are not needed anymore?

Of course not.

Artificial Intelligence, machine learning, deep learning, and natural language processing

The term artificial intelligence (AI) was first coined by John McCarthy in his Dartmouth Summer Research Project in 1956, but the foundations for the concept date back to the famed Alan Turing. AI is the marriage of numerical calculations done with the aid of a computer to create a form of intelligence. Some authors like to think that AI creates simulations, again done on a computer, with three main objectives: to analyze, to understand, and to predict. Another definition has been proposed that describes AI as machines that function "appropriately" and with "foresight." When these definitions are taken as a whole, it becomes fair to say that AI involves the use of a computer to interpret a situation and/or help accomplish a task and, in short, to make our lives easier and better. Two branches of AI in medicine that are often discussed are machine learning and deep learning. Machine learning is a field analyzing how computer algorithms and statistics can be used to autonomously improve through trial and error with pattern recognition. Deep learning, or deep structured learning, is a vaster application of machine learning concepts whose basis is centered around the formation and utilization of artificial "learning" or "neural" networks (ALNs and ANNs) that are based on the structure of biological brains, such as being multi-layered. Natural language processing deals with pattern recognition of data that comes in unstructured formats.

Machine learning, deep learning, and natural language processing have enormous potential to improve surgical decision-making pre-operatively and post-operatively. By analyzing big data, these branches of AI have enormous potential to improve decision-making on even a global public health level, which has been laid bare during the COVID-19 pandemic. Unfortunately, surgeons already have limitations in their understanding of regressions such as relative risks and odds ratios, and even in the

interpretation of P-values. Currently, there are many limitations to AI, as current regression models are imperfect, making it increasingly important for modern surgeons to know and understand certain fundamentals of statistics. The hope is that AI can interpret regression analysis for us via machine learning and deep learning, thus, bypassing the need for surgeons to understand regression models that are hard to grasp for the everyday practicing clinician.

Curiously, surgeons are reluctant to accept anything less than totally autonomous surgery as AIS and researchers have even coined a term to describe this reluctance, "the trough of disillusionment." Part of the Gartner Hype Cycle, described by a technology firm of the same name, the AI "hype cycle" goes through several general phases before true innovation can occur. It broadly includes: (1) a peak of inflated expectations; (2) machine learning, deep learning; (3) natural language processing; (4) computer vision; (5) a trough of disillusionment; and (6) a slope of enlightenment followed by a long plateau phase where the real work begins known as the "plateau of productivity" [Figure 1]. By modifying the surgeon's expectations, it is believed that the phase of enlightenment can be entered and the slope improved, which is why every device or innovation that provides any form of automation and improves patient care must be celebrated, studied, and if appropriate embraced.

The newer generation of surgeons is embracing AI even though there is a healthy fear of the privacy implications because of the sheer amount of patient data that is needed to create these algorithms. An article looking at attitudes of neurosurgical teams found that 66% of them were open to autonomous surgery. Perhaps the simplest argument for increased AI in surgery comes from breast surgery. Breast specialists lose enormous amounts of time analyzing breast imaging for screenings and diagnosis, and as a result, have very little time to actually counsel and talk with their patients. The hope is that AI can liberate breast surgeons from these time-consuming tasks, which can then be used for actual doctor-patient interactions. Ultimately, it is hoped that AI can liberate the surgeon to be the doctor that they always dreamed of being, and at the same time decrease physician "burnout," a scourge that has only gotten worse during the COVID-19 pandemic.

Continues on page 10 …

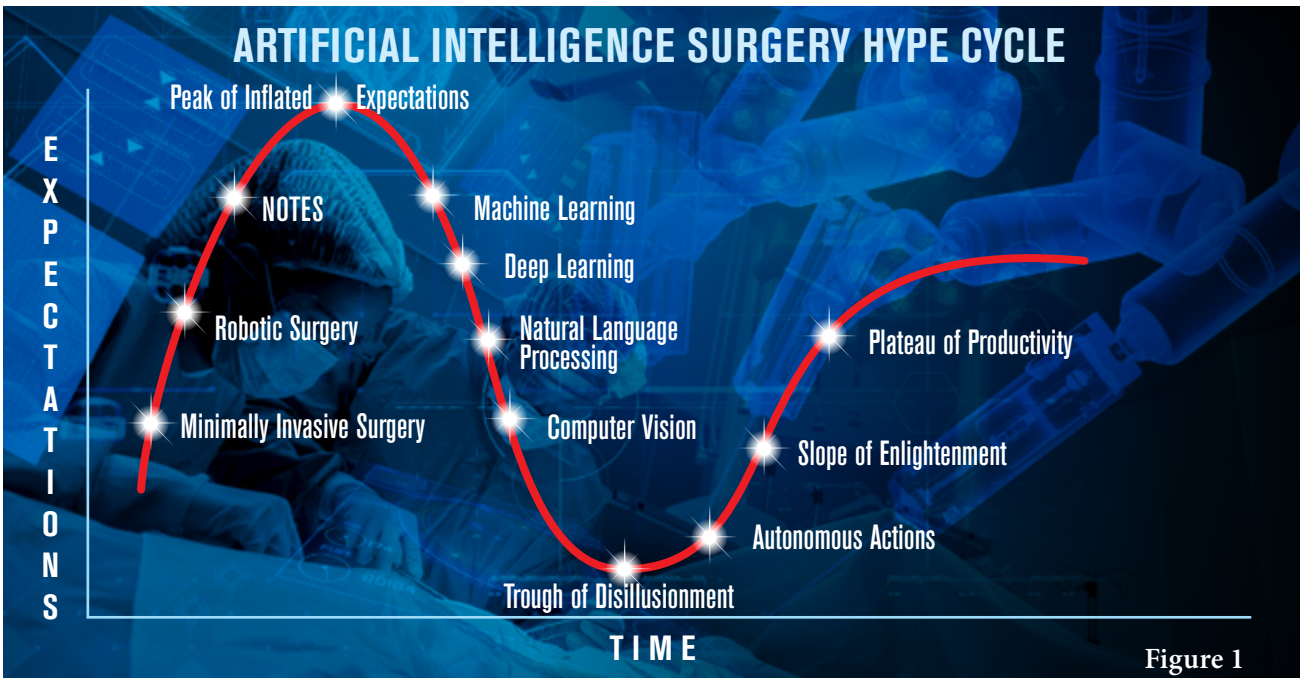


Figure 1

Diagnosis: social media and radiomics

As mentioned above, the COVID-19 pandemic has exposed the need for AI in the medical field, both to deal with radically changing public healthcare emergencies and to help quell the rampant physician burnout that is becoming a global problem. Fortuitously, the technology now exists to develop new forms of healthcare delivery. Telemedicine long hailed as the future of healthcare did not truly become realized until 2020. Researchers even used social media and the Patient-Reported Information Multidimensional Exploration (PRIME) framework to track the well-being of cancer patients during the lockdown. They identified areas of anxiety in large populations and were able to plan and provide for interventions of emotional support. Even Instagram images have been able to be used to identify signs of depression, revealing that AI has entered the phase of computer vision in the Hype Cycle. It is in the cauldron of desperate times that some of the most innovative discoveries have taken place.

Researchers from Switzerland were even able to use radiomics, a form of computer vision, to develop methods to instantaneously diagnose COVID-19 patients using CT imaging alone, this finding which was published in December of 2020 less than 12 months after the start of the pandemic, elucidates the fundamental role that AI can hold in healthcare and public health in the future. Radiomics uses imaging and algorithms to enhance diagnostic accuracy via the interpretation of vast amounts of imaging data. It is perhaps best known for its use in oncology. Recent studies using a radiomics risk score and an associated nomogram for lung cancer have been able to predict whether or not adjuvant chemotherapy would have benefit in patients who had undergone surgical resection for early-stage non-small cell lung cancer.

This is perhaps most clearly seen in the finding that AI and machine learning can predict fractures of the spine, ankle, and upper extremity better than orthopedic surgeons and that as of 2020, over 3,300 articles on AI in orthopedics alone have been published.

Surgical decisions

In addition to improvements in diagnosis, ascertainment of the efficacy of treatment and autonomous actions, AI has the potential to improve surgeons' ability to better decide if acute surgery is indicated or not. Bayesian networks or decision networks have been used to help determine if patients with arterial injuries due to limb trauma would benefit from revascularization. Bayesian networks are directed acyclic graphs that are utilized to understand the probability of something occurring based on multiple variables. Directed acyclic graphs are essentially decision trees that when powered with computerized algorithms can help quickly predict outcomes. Using a 10-Predictor Bayesian network, researchers from the United States and the United Kingdom created a website (https://www.traumamodels.com), accessible to all, that can help surgeons more accurately predict the probability of success of lower limb revascularization upon initial evaluation when compared to clinical acumen alone.

Pre-operative planning/practice

Simulators, or virtual reality, have been available in surgery for decades; however, the simulators with complete surgical systems are perhaps the most interesting. Unlike laparoscopic simulators that are placed into box trainers, robotic simulators are attached to the actual robotic console and more accurately represent what the surgeon will feel and experience in the operating room. Regardless of the type of simulator used, simulation is a computerized method of training surgeons and must be acknowledged as a form of AI training. Unlike previous generations of surgeons that were limited to practicing on cadavers or live animals, the AI generation has potentially unrestricted, or at least greatly increased, access to the simulator and can repeat practice sessions over and over at no additional cost. Virtual reality training was compared to traditional apprenticeship training in a meta-analysis published in 2020, and the authors found that virtual reality training improved trainee efficiency, improved tissue handling, and reduced errors when compared to the traditional apprenticeship method of surgical training.

Another benefit of AI in surgical training is the development of 3-D printing. The potential benefits in creating a 3-D image that patients can hold and see cannot be over-emphasized as it must be remembered that

patients do not have the same experience as doctors at looking at and understanding anatomic images on a flat-screen. Furthermore, by unifying simulator technology and 3-D imaging, it is hoped that hospitals will be able to scan patients, develop 3-D images and reprogram simulators so that anatomically accurate surgeries of actual patients can be simulated before doing the surgery on actual patients. Although time constraints will probably limit this to only the more complex cases, its potential for training residents and younger surgeons who will not be able to do the actual procedure is incalculable.

Intra-operative aids: augmented reality

Unlike hybrid operating rooms that combine image-guided interventional suites with traditional operating rooms, AI operating rooms also use machine learning and deep learning to improve the workflow and resource utilization in the operating room, pre-operative area and post-anesthesia care unit. Although the initial and most obvious benefit of operating room resource optimization is economic, increased economic resources translate into increased funds for more advanced AI platforms. Additionally, time saved in between cases and during procedures can reduce burnout and increase time for doctor-patient interactions.

Unlike simulators, augmented reality (AR) can superimpose images onto structures during operations either during open or minimally invasive procedures. AR has often been used in liver surgery during hepatectomy for liver tumors. These AR systems are essentially guidance systems that enable the surgeon to see the tumor and its relationship to major intra-parenchymal vascular structures in real-time. Although initially 2-D, images can now be created for open and laparoscopic liver resection using stereoscopic surface reconstruction and semi-automatic registration in combination with deep learning to create 3-D AR intra-operative images (SmartLiver). Other teams have confirmed this concept; however, AR remains in the domain of feasibility as confirmation of the AR image still needs to be done by the surgeon via standard intra-operative ultrasound and via visual confirmation using pre-operative cross-sectional imaging.

Continues on page 12 …

Additionally, the ease of use of these technologies can shorten the learning curve and help promote the use of minimally invasive techniques, which has been shown to have clear benefits to patients in terms of decreased post-operative pain scores, loss of workdays, and narcotic usage.

Why robotics is AI

Robot is originally a Slavic word and means "slave." In its current form, robotic surgery uses a tele-manipulator to move robotic arms enabling surgeons to perform minimally invasive surgery, specifically laparoscopy. The robotic arms enable surgeons to do minimally invasive surgical procedures with 4 main additional advantages, 3-D imaging, better ergonomics for the surgeon, the ability to control a third arm and 7 degrees of articulation; but at the cost of loss of haptics and the inability of the surgeon to be in constant contact with the actual patient. Currently, robotic surgery seems like a form of minimally invasive surgery or simply mechatronics, the fusion of mechanics and electronics, however, this is an oversimplification of current robotic surgical systems because the true power of robotic surgery exists in its potential to create autonomous actions. The current da Vinci complete surgical system (Intuitive Surgical, Sunnyvale, Calif.) already has an operating room table that is linked with the robotic arms and laparoscope, when the surgeon moves the table/patient the entire robot also moves in conjunction, in effect, autonomously. Furthermore, automatic stapling devices exist that have sensors and that can adjust the rate of stapling based on the thickness of the tissue to be stapled.

Although some automation is occurring, machine learning and deep learning is not yet ready for fully autonomous surgical maneuvers. However, this does not diminish the advances that have been made and only emphasizes the need to understand the steps that are needed to get to automated surgery. A recently published article looking at fellowship-trained minimally invasive surgeons found that use of the complete robotic surgical system can shorten the learning curve for sleeve astrectomy done by newly minted surgeons as early as the first year of independent practice when compared to more experienced surgeons. For years, the proponents of the robot have praised the potential benefits of robotics in minimally invasive surgery, however, cost constraints and lack of clear advantages hindered wider implementation. Currently, the newer models of complete surgical systems demand a re-appraisal of the true potential of the robot and behoove a more active embracing of this technology because many signs indicate that the next revolution in surgery is here and it involves computer-assisted technology/AI. This is perhaps best appreciated by the observation that even open surgical procedures such as breast surgery are being done with robotic assistance.

One aspect of robotics that has hindered many surgeons from embracing robotics in its present form must be considered, the lack of haptics or the sensation of touch in modern-day robotics. The reality is that most robotic surgeons that use the complete robotic surgical system describe the existence of visual cues that make haptics unnecessary. Furthermore, the dawn of AI in surgery has turned the assumption that haptics is necessary in robotics on its head. If it is possible that surgical dissection can one day be done robotically and autonomously, perhaps an insistence on haptics is unfounded. Possibly, researchers need to focus on improving how robots can respond to resistance, and less on how to transmit this sensation to humans.

AI in surgery is not limited to machine learning, deep learning, natural language processing, and computer vision. The dream of autonomous actions in surgery is already here, albeit, in limited ways. Surgeons must understand the basics of AI and learn to better understand its potential benefits instead of insisting on resisting innovation. Robotic surgery in its present form is a form of AIS and a necessary step towards fully autonomous actions in surgery. AIS has the potential to improve surgical outcomes, doctor-patient relationships, and job satisfaction for surgeons in all phases of surgical care. Acceptance and embracing AIS is a prerequisite for surgeons to understand that we have already entered the "slope of enlightenment" as described in the Gartner Hype Cycle and that the future is very bright indeed.

WE ARE ENGEL & VÖLKERS.

Buying or selling a home isn't just business, it's personal.

That's why the service I provide is tailored to your specific needs and delivered with care. I am proud of my in-depth knowledge of my hometown market, Edmond, Oklahoma, and my experience of exceeding the expectations of my clients to guide them in following their dream, home.

Amy Stoker, Engel & Völkers Edmond
405-531-7663 or 405-888-8701
102 S Broadway, Suite 100
amy.stoker@evrealestate.com
amystoker.evrealestate.com

ENGEL&VÖLKERS®
AMY STOKER

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

Even as the COVID-19 pandemic has challenged medical schools in ways we never expected, the OU College of Medicine has made significant advancements in key areas over the past year and a half. Oklahomans deserve the finest professionals who will serve our patients well into the future. Therefore, the college's dedication to our students and delivering the highest quality education remains first and foremost in all that we do.

We recently received results of a survey that the Association of American Medical Colleges (AAMC) sends each year to all newly graduated medical students. We couldn't be prouder of these results. The OU College of Medicine's overall student satisfaction rate is again above the 75th percentile. Notably, 74% of our courses and clerkships were ranked in the top quartile nationally, and 33% of those were above the 90th percentile.

This student satisfaction survey is especially important to schools of allopathic medicine because our accrediting body, the Liaison Committee on Medical Education (LCME), places as much weight on these scores as any other outcome, including standardized exam scores. Students take the survey in August, just a few months after they graduate, and the results are anonymous, allowing them to be as frank as they'd like. That they gave our college such high marks is a testament to our faculty, our curriculum and curriculum support services, our Student Affairs staff, and many others throughout the college.

These excellent student satisfaction ratings came during an extraordinarily busy and demanding year for the college. In addition to the overall challenges presented by COVID-19, we transitioned to a virtual process for our admissions and residency interviews. We also implemented a complex multi-campus student management system, and we instituted a major curriculum transformation at the OU-TU School of Community Medicine on our Tulsa campus. In addition, we revamped our Continuous Quality Improvement and Curriculum Evaluation processes, and our Student Affairs office implemented new academic advising and wellness activities.

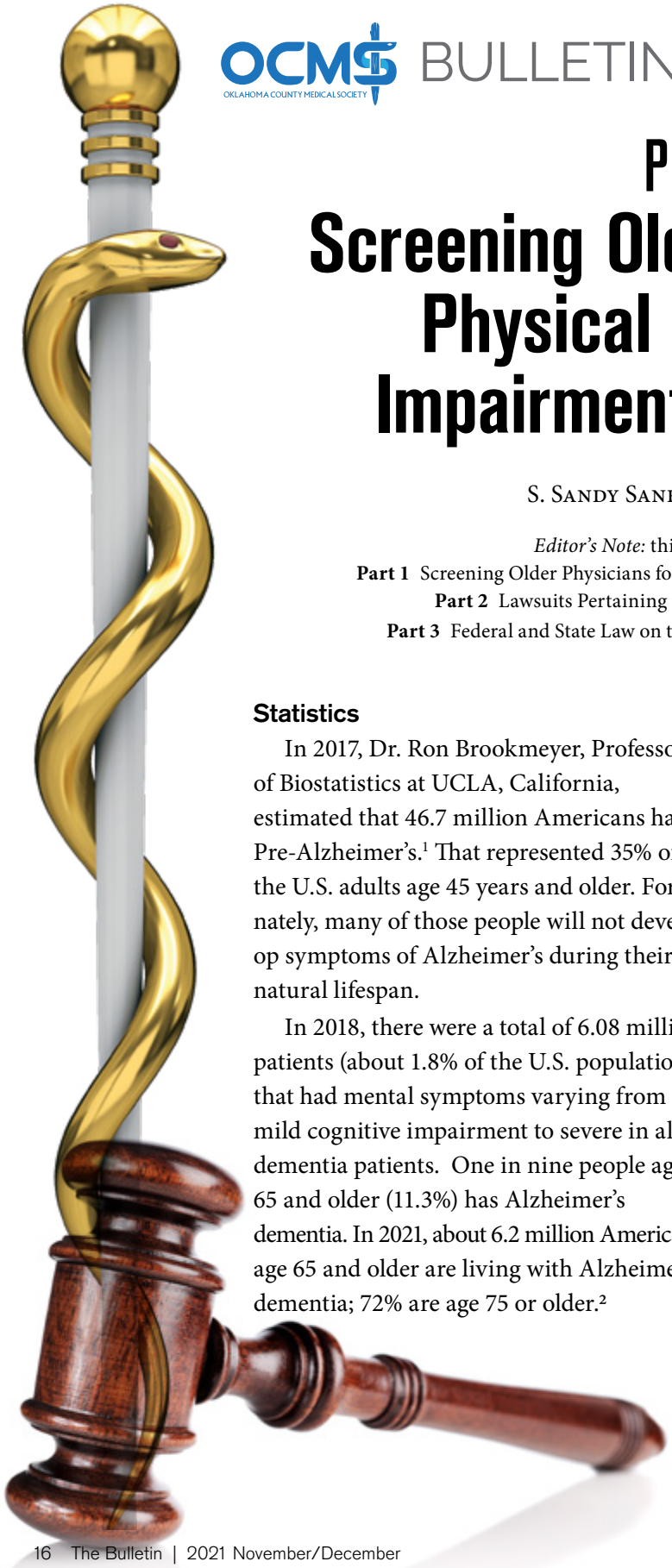
Our college is also seeing progress toward our goal of creating a more diverse faculty and future physician workforce. For our current first-year class, we have 12 students who identify as African American, the highest number ever. We also had our highest number of applicants who live in Oklahoma. This is a testament to the work of our Office of Diversity, Inclusion and Community Engagement. They have launched a variety of programs and mentoring opportunities to recruit and retain a more diverse student body, especially from Oklahoma, where we know that a large percentage will eventually practice and thus serve a more diverse community of patients.

In January, the college will begin the second iteration of OU Med REV UP!, an intensive five-month course that prepares college students to apply to medical school. The medical readiness program breaks down some of the barriers that underrepresented minorities face when considering medical school, particularly preparation for the Medical College Admission Test (MCAT). Scores on the MCAT are a significant factor in admission to medical school, yet many people from rural and underrepresented populations can't afford the price tag for prep courses, which often cost thousands of dollars. OU Med REV UP! is free and gives students one-on-one mentoring and guidance as they prepare for the MCAT and create a medical school portfolio.

The program's launch consisted of 148 students who represented 20 counties and 17 universities in Oklahoma. Forty-two students identified as African American/Black, 32 as Hispanic, 17 as Native American, and 45 as other ethnicity/race. The group included 95 females, 49 males and two students who identified as gender non-conforming. Nine of the students identified as LGBTQ+. Another great group is now being accepted into the program, and we are excited to work with them as they pursue their dreams of becoming doctors.

We know that when underrepresented minorities and people from rural areas train at the OU College of Medicine, they are more likely to return to their communities to practice, and studies show that healthcare outcomes improve when the healthcare workforce is more diverse. Although we still have progress to make in creating a more diverse study body, we have taken important steps and have gained momentum.

As we head into the winter months, there are still many unknowns about how COVID-19 will affect our college. But what we do know is that we have dedicated faculty, staff and a student body who have proved that they not only meet the challenges that come their way, but go the extra mile to create successes like those we've seen. I'm proud to work alongside them every day. I also want to personally thank those of you who assist with our admissions process and also in the training and mentoring of our students. This is a team effort, and by working together, we are building a healthier Oklahoma.



PART 1: Screening Older Physicians for Physical and Cognitive Impairment – Assessment

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

Editor's Note: this is Part 1 of a four-part series.
Part 1 Screening Older Physicians for Physical and Cognitive Impairment -- Assessment
Part 2 Lawsuits Pertaining to Age Discrimination of Older Physicians
Part 3 Federal and State Law on the Subject **Part 4** Review of Court Decisions

Statistics

In 2017, Dr. Ron Brookmeyer, Professor of Biostatistics at UCLA, California, estimated that 46.7 million Americans had Pre-Alzheimer's.[1] That represented 35% of the U.S. adults age 45 years and older. Fortunately, many of those people will not develop symptoms of Alzheimer's during their natural lifespan.

In 2018, there were a total of 6.08 million patients (about 1.8% of the U.S. population) that had mental symptoms varying from mild cognitive impairment to severe in all dementia patients. One in nine people age 65 and older (11.3%) has Alzheimer's dementia. In 2021, about 6.2 million Americans age 65 and older are living with Alzheimer's dementia; 72% are age 75 or older.[2]

In 2018, over 900,000 physicians were licensed to practice medicine in the United States.[3] About 15% of the practicing physicians were over 65 years of age, 44% of physicians are over 55 years of age. Over 50% of practicing pulmonologists, cardiologists, neurologists and orthopedists were over 55 years. But only 35% of practicing emergency physicians were over 55 years.[4] Because the elderly physician population in the U.S. has increased, evaluating competence of late-career or older physicians has become increasingly important for both clinician wellness and patient safety. The concern about the health and wellness of older clinicians is no different from that of any older patient. Indeed, every physician who is on Medicare who undergoes an annual wellness examination should be assessed for both physical and mental impairment or disability.

Center for Medicare and Medicaid Services (CMS) Requires Cognitive Assessment

Detecting cognitive impairment in older patients is a required element of Medicare's Annual Wellness Visit (AWV).[5] Effective January 1, 2021, Medicare:

(1) Increased payment for Cognitive Assessment when provided in an office setting,
(2) Added these services to the definition of primary care services in the Medicare Shared Savings Program, and
(3) Permanently covered these services via telehealth. Any clinician eligible to report evaluation and management (E/M) services can offer this service. The clinician should use CPT code 99483 to bill for both in-person and telehealth services.

CMS cognitive assessment includes:

1. Observing patient cognition;
2. Patient's history, reports, and records;
3. Functional assessment of Basic and Instrumental Activities of Daily Living, including decision-making capacity;
4. Use of standardized instruments for staging of dementia like the Functional Assessment Staging Test (FAST) and Clinical Dementia Rating (CDR);
5. Reconciling and reviewing for high-risk medications, if applicable;
6. Use standardized screening instruments to evaluate for neuropsychiatric and behavioral symptoms, including depression and anxiety;
7. Conducting a safety evaluation for home and motor vehicle operation;
8. Identifying social supports including how much caregivers know and are willing to provide care; and
9. Addressing Advance Care Planning and any palliative care needs.

The care plan includes initial plans to address: (a) Neuropsychiatric symptoms; (b) Neurocognitive symptoms; and (c) Functional limitations.

Assessment of Competence of Older Physicians

When credentialling or recredentialling clinicians, hospitals and other health care organizations have an obligation to address concerns relating to competence and safety of older physicians. This task has been accomplished in one of three main approaches:

(1) Case-by-case assessment of older physician competence

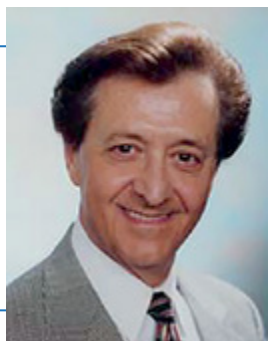
a. Clinicians have an obligation to maintain their health and wellness and obtain appropriate medical treatment when needed. They should also be honest when assessing their ability to continue practicing safely. Physicians who develop age-related cognitive or neurological conditions may not self-report. They may neither discern their own health impairment nor the potential impact on the care and safety of their patients.

b. Physicians generally have an obligation to report impaired colleagues when they believe a possible impairment interferes with the clinician's ability to practice medicine safely. Whether due to empathy or respect, physicians avoid reporting colleagues who may suffer from age-related impairment. Failure to report an impaired colleague may expose the physician to professional liability lawsuits or disciplining action by the medical licensing board.

Continues on page 18 …

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.



c. Hospitals are also required to verify the health status of all physicians, employed or independent contractors, seeking medical staff appointment and reappointment.

(2) Mandatory age-based retirement

a. Patient safety advocates favor an across-the-board mandatory retirement age for physicians.

b. Physicians generally oppose a mandatory retirement age.

c. There is a shortage of physicians in the U.S. and a mandatory retirement age for physicians is unrealistic.

(3) Mandatory Screening based on age of the physician

a. About 5 to 10 percent of U.S. hospitals mandate screening of late career physicians as a condition of renewing clinical privileges. The reasons are patient safety and risk management concerns.

b. Physician screening often includes a history and physical examination, assessment by peers and other co-workers, and cognitive assessment by a specialist.

c. Screening policies must comply with current state and federal laws and regulations.

d. For example, the California Public Protection & Physician Health, Inc. ("CPPPH") guidelines for drafting such policies suggest that the policy should state clearly that it applies equally to all practitioners over a certain age, is based solely on age, regardless of performance, and that the policy is based on current literature on the subject. It should also specify, among other things:

- The frequency of assessment;
- Who bears the cost;
- That the physician must sign a release allowing evaluators' reports to be shared with the medical staff;
- That a committee will review the information and may recommend further evaluation; and
- That information will remain confidential. The policy must explain clearly the rationale, how the age-based screening will work, and how it could impact clinical privileges.

e. The AMA and the American College of Surgeons ("ACS") support age-based screenings to evaluate physicians' mental health and review of their treatment of patients.

Federal and state governments have enacted some form of prohibition against age discrimination in employment. Older physicians who are negatively impacted by age-based policies may sue employers based on employment claims including Title VII, the federal Age Discrimination in Employment Act (the "ADEA"), and the Americans with Disabilities Act of 1990 ("ADA").

ENDNOTES

[1]https://www.mic.com/articles/186744/alzheimers-is-already-a-serious-problem-in-the-us-and-numbers-will-double-by-2060#.zDZD1hnkW

[2]https://www.alz.org/alzheimers-dementia/facts-figures#:~:text=More%20than%206%20million%20Americans%20of%20all%20ages%20have%20Alzheimer's,11.3%25)%20has%20Alzheimer's%20dementia.

[3]Association of American Medical Colleges. 2018 Physician Specialty Data Report. 2018. http://aamc.org/system/files/reports/1/2018-aamc-physician-specialty-data-report.pdf

[4]Young A, Chaudhry HJ, Pei X, et al. A census of actively licensed physicians in the United States, 2016. J of Med Regulation. 2017;103(2):7-21.

[5]Medicare Wellness Visits - ICN MLN6775421 February 2021 (cms.gov)

THE Private Bank
AT VALLIANCE

COMMUNITY BANK ADVANTAGES WITH A PRIVATE BANK EXPERIENCE

TAILORED BANKING FOR THE BUSY EXECUTIVE

Samantha Robertson

& Stephanie Comer

VALLIANCE.BANK | 405.792.6400

Member FDIC

MY DAD

I really love my Dad –
He's given me all I have!
Through tough times where we've been –
He's there through thick and thin!

He taught the fifth-grade kids –
That's no easy shift!
He taught them discipline
And how to grow within!

He likes to ride his bike
Around the Hefner hike!
It keeps him in good shape
And helps the world to take!

He likes to play guitar –
A real musical star!
And to my daughter Sage-
He really is the rage!

When I moved out of town to medical school
I needed someone my kids to rule!
My Dad moved in the house
To help the kids to roust!

He takes his insulin
Since the age of ten –
Juvenile diabetes
Can give you the heebie-jeebies!

Lately my Dad's been sick –
His kidneys want to quit!
I'd like to help him out –
When trouble is about!

Transplants have helped him out
But they eventually lose their clout!
Two lasted ten years at the most
Before they begin to reject their host!

We're the same blood type
And the conditions are just right –
A kidney I can give
To help my Dad to live!

It's the least that I can do
For all that we've been through!
I can give part of myself
To try and help him out!

That what love is for –
Sometimes we forget and ignore –
True love is more than emotion –
It involves complete devotion!

Lyrics by Bill Truels, MD

EDITOR'S NOTE: This work from Dr. Truels was written in salute to Dr. Savannah Coote, who will soon be sharing one of her kidneys with her father.

MY DAD

Above: Chris Simon with his grandchildren
Left: Dr. Savannah Coote with her parents, Dawn and Chris Simon, and sister Bailey Simon, who will graduate with her doctorate in audiology in 2023.

The cast of Lyric's A CHRISTMAS CAROL at the Harn Homestead

About the Cover

The Outsiders

Lyric Headed Back to Harn Homestead for Another Unique Holiday Experience

Fast on their feet, the folks at Lyric Theatre went on the march to find a safe social distancing option to keep its popular magical holiday village afloat. The friendly, open air confines of the Harn Homestead allowed the 2020 show to go on, bringing holiday cheer to a city in need in the midst of the pandemic.

An annual Oklahoma City favorite, A Christmas Carol, is back for another yuletide trip to the great outdoors. The historic Harn Homestead, 1721 N. Lincoln Blvd., once again will be reimagined as the Victorian Era setting for Ebenezer Scrooge, Jacob Marley, magical spirits, and a host of unforgettable characters. Patrons will follow Charles Dickens' timeless tale of transformation and redemption, as they are guided from scene to scene at the homestead. Last year's family-friendly production garnered praise from both The New York Times and BBC News for being among just a select number of theatres in the world staging the holiday favorite.

Performances of Lyric's A Christmas Carol – now in its 11th year – will be November 17-December 23. Presented by Devon Energy, tickets to the immersive production are now available.

"We've brought artists together to create a 360-degree holiday experience that sparks the true spirit of the holidays through timeless storytelling, joyous music, beautifully decorated trees and dazzling costumes in a most unique panoramic setting," said Lyric Producing Artistic Director Michael Baron. "Expect surprises around every corner at the Harn Homestead where Dickens' story unfolds at Scrooge's office, Jacob Marley's house, the magical grove of The Ghost of Christmas Past, Fezziwig's party at the barn, the torch-filled graveyard of The Ghost of Christmas Future, and so many more reveals along the way."

Continuing an equally cherished holiday tradition, audiences are invited to contribute to the Regional Food Bank of Oklahoma following each performance. During the past 10 years, Lyric Theatre patrons have donated nearly $200,000 to help feed thousands of Oklahomans in need. Last year's attendees helped provide meals for more than 64,000 people.

Tickets will be limited to 200 guests for each performance. To purchase, or for more information, visit LyricTheatreOKC.org, or call Lyric's Box Office at (405) 524-9312. The 75-minute performance is staged in the open air to allow parties to social distance. Patrons are encouraged to arrive early for refreshments and photo opportunities. Free parking is available at the entrance to the homestead.

PHOTOS BY K. TALLEY PHOTOGRAPHY

W. Jerome Stevenson as Ebenezer Scrooge

Stephen Hilton as Mr. Fezziwig

W. Jerome Stevenson as Ebenezer Scrooge

Kristin Küns as Ghost of Christmas Past

Above, L to R, Chris Shepard (Topper), Lexi Windsor (Mrs. Fred's Aunt), Kristin Küns (Fred's Wife) and Andi Dema (Fred).

LTOK

Lyric's 2022 Homecoming Season

Head Over Heels
February 16 - March 6
Lyric at the Plaza

Distant Thunder
March 23-27
Lyric at the First Americans Museum

Roald Dahl's Matilda
June 21-26
Lyric at the Civic Center

Rodgers and Hammerstein's Carousel
July 5-10
Lyric at the Civic Center

Kinky Boots
July 19-24
Lyric at the Civic Center

The Rocky Horror Show
October 5-30
Lyric at the Plaza

Lyric's A Christmas Carol
November 16 - December 23
Lyric at the Harn Homestead

DIRECTOR'S DIALOGUE

Alison Fink

When I was a child, we watched the Murrah Building aftermath on live television for days. A teacher gave us an extra credit assignment: listen to a song in real time and write as many lyrics as possible.

The song was "We Didn't Start the Fire" by Billy Joel. For anyone not familiar with the song, it references 118 significant political, cultural, scientific, and sporting events between 1949 and 1989. Joel conceived the idea for the song after meeting with someone who assumed that the 1950s were a quintessential time for youth without any life-changing public events. It is no musical masterpiece, but it was written in the spirit that assumptions made regarding past events are often inaccurate without diligent research.

Most people remember the major cultural references in the song, but there are several medical references, all part of the 'fire.' Joel's song mentions vaccinations (specifically, the polio vaccine); Thalidomide; birth control without government restriction; homelessness among Vietnam veterans; AIDS; and the syringe tide. The list is not all-encompassing of every health matter, but all mentioned were discussed at some point by OCMS members and most likely every other medical society at the time.

Since Joel released the song in 1989, an entire generation has grown up with their own defining cultural and scientific events. Perhaps today, if young musician Taylor Swift (b. 1989) wrote a song like Joel's it may address the eradication of smallpox, HIPAA, the treatment of HIV/AIDS, CHIP and COVID-19. Perhaps tort reform! Again, OCMS has discussed and acted on all these items over the past thirty-two years.

Every major public health effort over the past 100 years has been addressed by OCMS members, whether through support of legislation, advocating for protocol changes, promoting the need for vaccinations among children, or scientific research. Participating in medical societies outside of specialty organizations gives members the perspective to see the impact that unification has on medicine and public health endeavors. Five generations of physicians make up the OCMS membership, and their perspectives are uniquely valuable to the future of the society.

As for the extra credit assignment, AIDS was included on my list. At the time, it was a scary, seemingly uncontrollable condition to me that I was too young to understand. Now, children probably have the same thoughts about COVID-19. As members, you can have a strong voice for the next generation to hear when navigating their own pandemic. No one necessarily started the fires, but we must keep fighting them – together.

Amy Hall
Vice President
Commercial/Private Banking
ahall@nbcok.com
405.748.9187

Sheila Heim
Senior Vice President
Commercial/Private Banking
sheim@nbcok.com
405.748.9133

Happy Holidays

Wishing you the peace and joy of the season.

NBC
PEOPLE YOU CAN BANK ON

nbc.bank

EQUAL HOUSING LENDER Member FDIC

Being married to medicine, Alliance members share a bond like no other.

alliance

Join the Oklahoma County Medical Society Alliance.

We celebrate the joys and understand the demands of the profession. Such similarities encourage valuable networking, heartfelt mentoring and lifelong friendships among members. We support each other while we work together to promote health and wellness in our community.

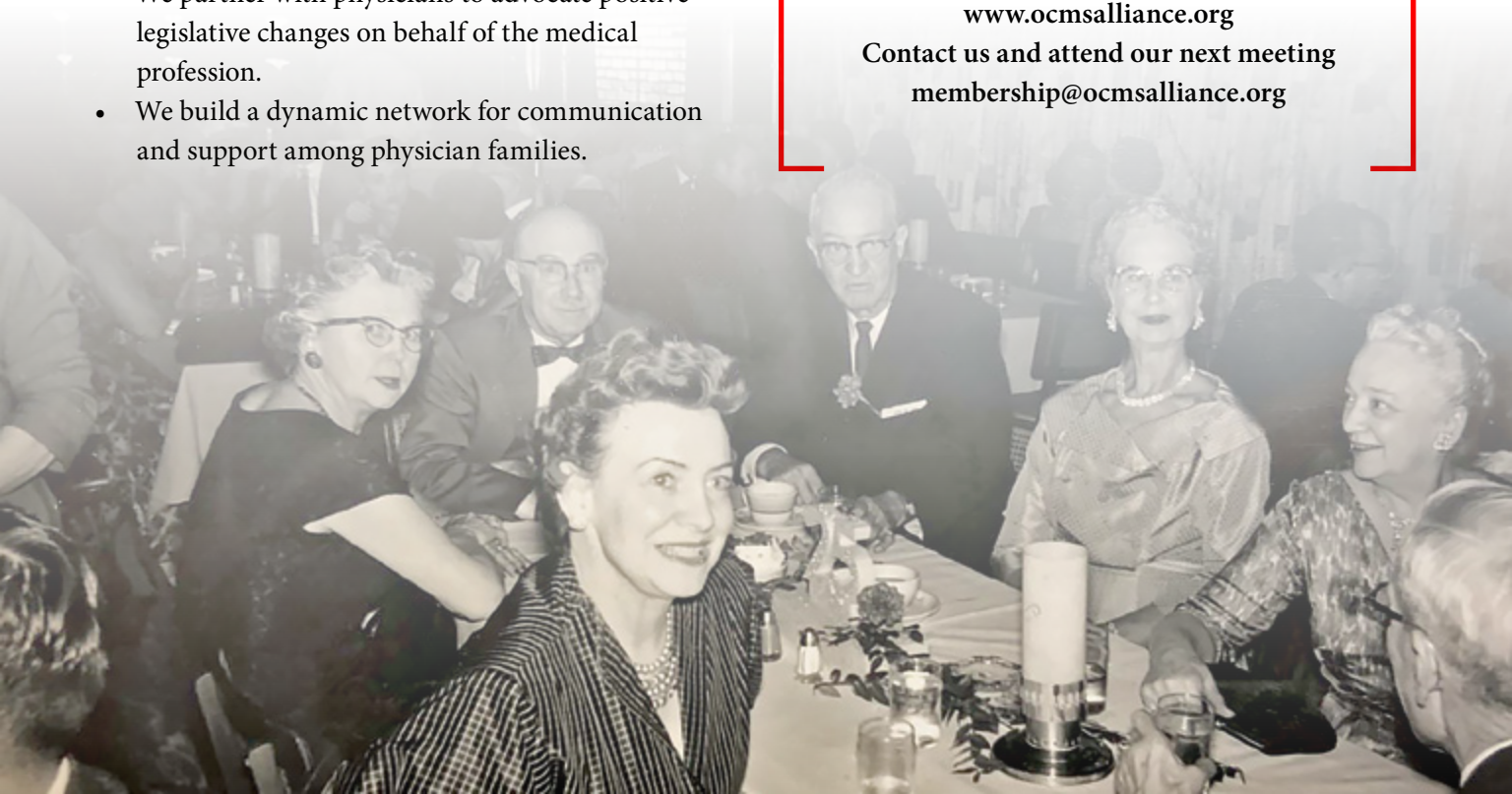
Our Purpose

- We enrich our community through awareness and education about health and wellness.
- We assist non-profit organizations that meet health-related needs in Oklahoma County.
- We partner with physicians to advocate positive legislative changes on behalf of the medical profession.
- We build a dynamic network for communication and support among physician families.

Our Benefits

- Community service with coordinated group volunteering activities
- Fundraising for non-profit health services, through the annual Kitchen Tour
- Enriching and educational programing at monthly luncheons
- Friendships and organized social gatherings (Book Club, anyone?)

Learn more and join online
www.ocmsalliance.org
Contact us and attend our next meeting
membership@ocmsalliance.org



Oklahoma Allergy & Asthma Clinic

Accepting New Patients!

Follow us on Twitter @okallergyasthma
and like us on Facebook for daily allergy reports
@oklahomaallergyasthmaclinic on Instagram

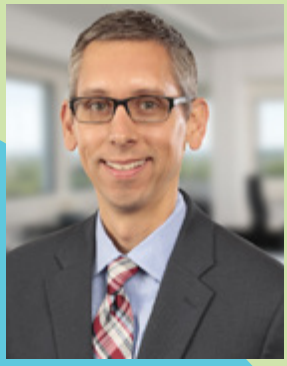

Dr. Dean Atkinson


Dr. Laura Chong


Dr. Maya Gharfeh


Dr. Richard Hatch


Dr. Bret Haymore


Dr. Gregory Metz


Dr. Patricia Overhulser


Dr. Shahan Stutes


Karen Gregory, DNP


Chelsea Robinson, APRN, CNP


Stefanie Rollins, APRN, CNP, AE-C


Elisa Thompson, APRN, CNP

Main Office
at the Oklahoma Health Center
750 N.E. 13th

Edmond at Fisher Hall
3560 S. Boulevard, Suite 150

Midwest City
8121 National Avenue

Yukon
1601 Health Center Parkway, Building 1200

Norman
Healthplex Parkway in Medical Park West
3580 R.C. Luttrell Drive

Appointments 405/235-0040 • www.oklahomaallergy.com

Anticlimax

By Hanna A. Saadah, MD

OKLAHOMA CITY, 1996

During her annual exams at my office, Wilhelmina Moorhead and I climbed together up the ladder of her fifties, sixties, and seventies but, despite our long-term relationship, she never delved into intimate conversations until Cecil, a WWII Veteran, and her husband of 50 years, died after a protracted battle with rectal cancer.

She seemed confused when I hugged her after the funeral, a confusion that mixed salty tears with quivering smiles and contracted her face into remorseful frowns. Her speech, as fragmented as her breath, came out in disconnected gasps.

"I devoted my entire life to him yet still I feel that I didn't do enough because he always seemed sad. He fought so hard to live but was so happy to die. I feel that something was missing between us, something essential, something untouchable. But I have an appointment with you next month, and we can talk about it," she whimpered. "Thank you, for coming."

When a month later I walked into the exam room, I was struck by the dark clouds that shrouded Wilhelmina's face, angry clouds that were not present at the time of Cecil's funeral.

"Wilhelmina, are you sick?" I gasped.

"Yes, I'm sick Doctor, sick of life because life sucks."

Slowly, solemnly, I sat down, held her fisted hand, and inquired, "Is it the children?"

"No, they're fine," she muttered, "and they'll be fine as long as I don't tell them."

"Tell them what, Dear?"

"Tell them that their father lived a lifelong lie with me."

While Wilhelmina Moorhead told me her story, she cried acid tears, harsh tears that left red tracks on her cheeks. Going through her husband's things, she discovered that he had been unfaithful to her throughout their marriage. He had a lover before they married with whom he continued to have an affair for several years. After him, other lovers came and left Cecil's double life until he developed rectal cancer.

She thought he was a perfect husband and father but never understood why they only had sex just to have children. For fifty years she would reach for him, and he would turn his back to her. For fifty years she felt rejected as a woman until the day she discovered that he preferred men. That was when she understood, and that was when anger set her soul on fire.

"I knew he loved me," she sobbed, "and I loved him with all my heart, loved him more than my own children, more than I loved myself. But now, I want to un-love him because he betrayed me, because I can't confront him, because I can't scream my anger in his face, but, most of all, I'm angry at myself because I was too naive to suspect the obvious."

I don't recall how I assuaged Wilhelmina Moorhead's pain, but I think I did it by listening. She fumed for a long time and the catharsis from expressing herself must have diffused her anger because we hugged at the end, and she managed a faint smile before she left.

Continues on page 30 …

ANTICLIMAX *Continued from page 29 …*

It was Antiphon of Rhamnus (Athenian orator 480-411 BC) who taught us that, by talking about their problems, people sometimes get better.

Several months later, Wilhelmina Moorhead came in for no health issue, looking spry and replenished. Her shroud of dark clouds was replaced by clear blue skies, and there was a peculiar freshness in her expression and a pink hint of elegance in her attire.

"Wilhelmina, I am happy to see you looking well."

"I turn seventy-five in one week," she smiled, "but that's not why I'm here."

"Well, tell me then, tell me," I quipped.

"I'm getting married on my birthday and Henry wants me to have a thorough checkup before."

"Henry?"

"Henry Wilburn. He's wonderful and we're in love. He calls me Queen Wilhelmina of the Netherlands and calls himself Duke Henry Mecklenburg, the husband the queen married at age 21. Did you know that Queen Wilhelmina reigned for 58 years, longer than any Dutch monarch? As you can guess, Henry is a history buff and you're seeing him tomorrow for his thorough checkup."

Joie de vivre had triumphed over dark disillusionment, I surmised, as I escorted Wilhelmina out after her exam. Living a second adolescence—surging with new excitement like a blossomed almond tree, noisy with bird gossip—she never mentioned Cecil or the children during her visit. Living a sunny spring after a long, bleak winter, she had no space in her soul for past realities.

*

The next day, Mr. Henry Wilburn charmed the office. Handsome, tall, smartly dressed, and gregarious, he made friends with everyone in the waiting room and announced that he was getting married in a week. He had no health issues, took only one medicine, was five years older than Wilhelmina, and had been widowed for three years. In jest, I addressed him as Duke Henry Mecklenburg, which made him scintillate with embarrassment.

"I feel wonderful, Doctor, but I've not had a checkup since my wife died. We saw so many doctors while she struggled with melanoma and that's why I took a three-year-long medical respite."

"How long have you been on cortisone?" I asked when I saw his pill bottle.

"I've been on 10 mg/day for more than twenty years, Doc."

"Twenty years on 10 mg a day?" I gasped.

"It's the only thing that has ever worked for my asthma. My doctor tried to stop it on several occasions, but each time he reduced the dose, the asthma would return with a vengeance. By the way, my dear doctor retired last month, and I'll be needing refills soon."

"Have you ever been checked for osteoporosis?"

"I have it, Doctor, but I feel too good to be taking treatments that have so many side effects. Besides, my dentist is against it."

I tried to help Mr. Henry Wilburn understand the dangers of long-term cortisone, but his naive nonchalance defied scientific evidence. His gut feelings were his guiding star; his confidence in his own knowledge was his unsinkable ship; and his logical argument, that cortisone had always helped instead of harmed, was all he needed to extrapolate that it never would.

"Mr. Wilburn," I asked. "Have you ever died?"

"No," he giggled.

"Does that mean that you never will? For the same reason, if you've never had a fracture from osteoporosis, does that mean that you never will?"

He smirked with discomfort, the discomfort of realizing that his logic was warped, and retaliated by telling me that I worried too much for my own good. Then, when I handed him his cortisone-taper schedule and offered him safer inhalers, he said, "I like you, Doc, and I respect your opinion, but I can't taper. I'll just have to find me another doctor."

I was invited to the wedding but declined because it would have made Duke Henry uncomfortable. Enlightenment provokes existential pain when it confronts false beliefs, I surmised. The human brain, despite modern advances, remains vulnerable to magical thinking, superstitious notions, and gut solutions.

Twenty years of cortisone and Henry's brain remained impenetrable to modern scientific evidence. "What we think is obvious is so far beyond our comprehension," said the great Urdu poet Ghalib (1797-1869). "We are still dreaming even when we dream we are awake."

Two years passed before I heard from the Wilburns again. It was Wilhelmina who called to make Henry's appointment. Her voice trembled with urgency, and she asked that we see him immediately. "I'll have to drive him," she told the receptionist.

I saw him after hours the very same day. That once handsome, tall, smartly dressed, gregarious man stumbled into the office, stooped to half his height, salivating in a towel, with head below shoulders, and eyes facing his feet. Wilhelmina led him by the arm into the examination room, helped him sit down, and said, "Just wait for me, darling. Don't move because you'll fall."

"What happened?" I whispered when we were alone in the hall.

"His back collapsed," she whispered back. "About a year ago, he started falling, shaking, drooling, complaining of backache, and would stoop to ease the pain. It didn't take long before he was so stooped that he couldn't straighten up. I took him to the back doctor who did x-rays and told us that his vertebral bodies had collapsed because of osteoporosis. He then referred us to a neurologist who diagnosed him with rapidly progressive Parkinson's Disease plus Parkinsonian Dementia. He has lost so much weight because he's short of breath and cannot eat. When I try to feed him while on his back, he aspirates and has a hard time coughing it up because of his contracted chest. It's much easier for him to spit out his saliva than to swallow it and that's why he carries a towel."

"How are you coping with all this?" I ventured.

"Not well, Doctor. I'm exhausted and I don't think I can take care of him any longer."

"You may have to put him in a skilled nursing facility because he's going to need total care," I cautiously suggested.

Continues on page 32 …

"He half knows that when he has a clear day, and I'm sure ready for it."

"Is he a Veteran?"

"Yes. He was one of the pilots who dropped Agent Orange on Vietnam, and his neurologist thinks there's a connection between Agent Orange and his Parkinson's Disease and perhaps his asthma."

"The Veterans Hospital takes excellent care of disabled Veterans," I reassured. "I believe it's best to take him there."

A year later, Wilhelmina looked well when she came for her appointment. She told me that Henry was admitted to the Veterans Hospital, placed in their Palliative Care Unit, and a few weeks later died a peaceful death on hospice.

There was no grief in her animated eyes, perhaps because she'd been unburdened after prolonged exhaustion or perhaps because Henry never betrayed her. To fall in love again after Cecil's lifelong betrayal must have required great courage and blind faith.

"I miss him, though," she moaned. "He made me laugh and we had a fun year together before he got sick."

"How are the children and grandchildren doing?"

"We go to the same church, and I cook lunch for them every Sunday."

"Do you feel lonesome during the week?"

"I'm fine by day but I feel terribly alone at night."

"You must hate sleeping alone."

"Indeed, Doctor. You've hit the nail on the head. I've slept alone all the years I was married to Cecil. Even though we were in the same bed, we slept miles apart in intimacy," she stuttered, and her words quivered as they left her lips.

A sallow smirk glinted on Wilhelmina's lips after this doleful declaration. She paused in thought as though she were trying to come to terms with her extemporaneous, half-century-long confession.

Reticent to rub the sore, I held my tongue and waited. Fifty years of lost intimacy, of imprisoned lightning, of touch starvation, and of disconsolate discontent were all thundering inside her heaving chest. The stalemate of silence grew between us until it became bitterly brittle. She sighed and almost spoke. I took the hint and cracked her shell.

"I take it then, that unlike Cecil, Henry valued intimacy."

"We always slept naked," she blurted out, bit her lip, and blushed. We cuddled and fondled all night long. It was so much better than sex."

"Better?" I smiled.

"Oh, yes, Doctor. At our age, intimacy is far better than sex."

"How so?" I asked, intrigued.

"Sex is born of desire and with it dies. Intimacy is born of love and with it lives. Henry and I could cuddle and fondle as long and as often as we wanted," she blushed again.

"I'm thrilled to hear that," I affirmed, hoping to temper her discomfort.

"I never felt unwanted or discarded with Henry. We were insatiable for one another."

She paused and looked intently at my face. I smiled approvingly and waited.

"With Cecil, the anticlimax, which was ice-cold and humiliating, left me vacant and livid. I'm sorry to say so, Doctor, but it left me feeling like a discarded, dirty rag."

She paused again and let out a deep sigh while she composed her last thought. Then, with bright, flickering eyes she proudly proclaimed, "With my Duke, there was never distance, dispassion, rejection, indignity, or anticlimax."

These violent delights have violent ends
And in their triumph die, like fire and powder,
Which as they kiss, consume…
Therefore, love moderately. Long love doth so.
Too swift arrives as tardy as too slow.

Friar Lawrence, Romeo and Juliet, Shakespeare

THE NUTCRACKER

PRESENTED BY DEVON ENERGY

OKLAHOMA CITY BALLET

ROBERT MILLS, *ARTISTIC DIRECTOR*

DEC. 11-19

CIVIC CENTER MUSIC HALL

LIVE MUSIC BY

OKCPHIL

CANTERBURY VOICES

OKLAHOMA CITY'S MAGICAL HOLIDAY TRADITION

All will be merry and bright as *The Nutcracker* fills the Civic Center in a warm glow this December. Tchaikovsky's familiar score and Artistic Director Robert Mills' delightful staging come together as Clara and the Nutcracker Prince journey to adventurous places beyond anyone's wildest dreams.

Get your tickets now!

(405) 848-8637

OKCBALLET.ORG

SCAN ME

devon

CME INFORMATION

INTEGRIS HEALTH

Contact: **Jill Mayes, M.Ed.**, System Director of Continuing Medical Education
Phone: 522-0926

MERCY HOSPITAL OKC

Contact: **May Harshburger**, CME Coordinator
Phone: 752-3390

ALLIANCE HEALTH MIDWEST

Contact: **Pam Spears**
Medical Staff Services Coordinator
Phone: 610-8363

SSM HEALTH ST. ANTHONY HOSPITAL

Contact: **Sam McAdams**, Director of Medical Staff
Phone: 272-6053

OUHSC-IRWIN H. BROWN OFFICE OF CONTINUING PROFESSIONAL DEVELOPMENT

Contact: **Susie Dealy** or **Myrna Rae Page**
Phone: 271-2350
Check the homepage for the latest CME offerings:
http://cme.ouhsc.edu

OKLAHOMA ACADEMY OF FAMILY PHYSICIANS CHOICE CME PROGRAM

Contact: **Kari Webber, CAE**, Executive Director
Phone: 842-0484
Email: webber@okafp.org
Website: www.okafp.org

ORTHOPAEDIC & RECONSTRUCTION RESEARCH FOUNDATION

Contact: **Kristi Kenney**, CME Program Director
or **Tiffany Sullivan**, Executive Director
Phone: 631-2601

PROFESSIONAL REGISTRY

ALLERGY

OKLAHOMA ALLERGY & ASTHMA CLINIC, INC.

Dean A. Atkinson, M.D. *
Laura K. Chong, M.D. *
Maya Gharfeh, M.D.*
Richard T. Hatch, M.D. *
Bret R. Haymore, M.D.*
Gregory M. Metz, M.D. *
Patricia I. Overhulser, M.D. *
Shahan A. Stutes, M.D. *
Karen Gregory, DNP
Chelsea Robinson, APRN, CNP
Stefanie Rollins, APRN, CNP, AE-C
Elisa Thompson, APRN, CNP

** Diplomate, American Board of Allergy and Immunology™*

750 N.E. 13th St.
Oklahoma City, OK 73104
405-235-0040

ENDOCRINOLOGY DIABETES & METABOLISM

MODHI GUDE, M.D., MRCP (UK), FACP, FACE

Diplomate, American Boards of Internal Medicine and Endocrinology, Diabetes & Metabolism

South Office:
1552 S.W. 44th
Oklahoma City, OK 73119
405-681-1100

North Office:
6001 N.W. 120th Ct. #6
Oklahoma City, OK 73162
405-728-7329

Practice limited to Endocrinology, Diabetes and Thyroid only.

Special Procedures:
Bone densitometry for osteoporosis detection and management.
Diagnostic thyroid fine needle aspiration biopsy.
Diagnostic endocrine and metabolic protocols.

PLASTIC SURGERY

OU PHYSICIANS PLASTIC SURGERY

Kamal T. Sawan, M.D.

Christian El Amm, M.D.

Suhair Maqusi, M.D.

Adult Clinic Location
OU Physicians Building
825 N.E. 10th St., Suite 1700
Oklahoma City, OK 73104

To schedule an appointment for Adult Services call

405-271-4864

Adult Services

Facelifts
Endoscopic Brow Lifts
Nose Reshaping
Eyelid Surgery
Liposuction
Breast Augmentation
Breast Reconstruction
Breast Reduction
TummyTuck
Skin Rejuvenation
Laser Hair Removal
Botox & Fillers
Body Contouring
After Weight Loss
Birth Defects
Hand Surgery - Dr. Maqusi
Microsurgery
Burn Reconstruction
Skin Cancer Excision
MOHs Reconstruction

Pediatric Clinic Location
OU Children's Physicians Building
1200 N. Phillips Ave., 2nd Floor Suite 2700
Oklahoma City, OK 73104

To schedule an appointment for Pediatric Services call

405-271-4357

Pediatric Services

Secondary Burn Reconstruction
Cleft Lip & Palate
Congenital Nevi
Craniosynostosis
Craniofacial Syndromes
Hemangiomas
Traumatic Defects
Vascular Lesions

UROLOGY

Urologists at OU Medicine

Adult Urology

Michael S. Cookson, MD, Chairman
Urology Department, Urologic Oncology/Robotics
Ash Bowen, MD, General/Oncology/Robotics
Nathan Bradley, MD, General Urology
Brian Cross, MD, Urologic Oncology/Robotics
Daniel Culkin, MD, Men's Health/Stones/Oncology
James Furr, MD, Male Reconstructive/Robotics
Jonathan Heinlen, MD, Urologic Oncology/Robotics
Daniel Parker, MD, Urologic Oncology/Robotics
Sanjay Patel, MD, Urologic Oncology/Robotics
Mohammad Ramadan, MD, General/Oncology/Robotics
John Ross, MD, General Urology
Kelly Stratton, MD, Urologic Oncology/Robotics
Gennady Slobodov, MD, Male/Female/Reconstructive/
Incontinence/Neurogenic Bladder
James Wendelken, MD, General Urology

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
Adam Rensing, MD, Pediatric Urology/Robotics
Bhalaajee Meenakshi-Sundaram, MD, Pediatric Urology/Robotics

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

OCMS
OKLAHOMA COUNTY MEDICAL SOCIETY

For the Two of Us

THE Poet's SPOT

Earth was formed 4.5 billion years ago
It took the crust one billion years to cool enough for life to begin
Single life cells appeared 3.5 billion years ago
Organisms appeared 570 million years ago
Mankind appeared 250 thousand years ago.

My love, it took two continents, 250 thousand years
And several billion coincidences, to bring us together.
See how tedious the Lord's work had been
How meticulously exacting, all for one couple to fall in love
And for that love to blossom into worship.
Praise Him, my love and thank Him with all your joys
For He has manipulated the entire creation for the two of us.

Four and a half billion years
I have waited for you.

Hanna A. Saadah, MD

PEOPLE YOU KNOW.

COVERAGE YOU CAN TRUST.

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

OSMA HEALTH is a health benefits program created by physicians and available exclusively to members of the Oklahoma State Medical Association, their employees and their families.

At OSMAHealth, we believe in the power of a shared vision. We are built and governed by physicians; looking toward the future with the same focus and same intention that, like you, seeks to make a difference.

OSMA HEALTH

osmahealth.com

Contact us today for more details: **405.290.5666** Toll-Free **888.244.5096**

ESSENTIAL PPO I ADVANTAGE PPO I HDHP for HSAs I RETIRE 65+ PLAN I DENTAL PLAN

OCMS
OKLAHOMA COUNTY MEDICAL SOCIETY
Oklahoma County Medical Society
313 N.E. 50th St., Suite 2
Oklahoma City, OK 73105-1830

Address Service Requested

PRESORTED
STANDARD
U.S. POSTAGE
PAID
OKLAHOMA CITY, OK
PERMIT NO. 381