THE BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY

MARCH / APRIL 2022

SPECIAL CARE

Making A Difference

INTRODUCING

Tina Ipe, MD, MPH

New Chief Medical Officer, Oklahoma Blood Institute

Oklahoma Blood Institute

Dr. Tina Ipe joins the Oklahoma Blood Institute as the chief medical officer after nearly a decade of hospital service in Texas and Arkansas. She specializes and is certified in Pathology and Transfusion Medicine.

Throughout her career, she has received many honors and awards in her field including the Departmental Faculty Excellence in Clinical Research Award at the University of Arkansas for Medical Sciences. She serves on several national organization committees including the Annual Medical Education Committee at the AABB. She is an adjunct associate professor at UAMS.

She joins our lifesaving mission as a passionate blood donor. She is well-suited for our community and we are very pleased to welcome her to our team!

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THE BULLETIN

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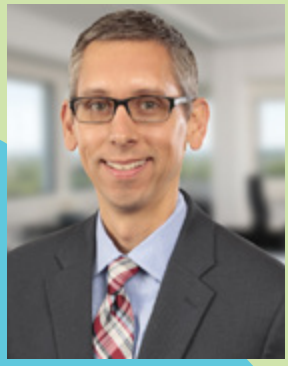
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Sumit K. Nanda, MD

President's Page

Sumit K. Nanda, MD

If the steady rate of decline in membership in the OCMS and OSMA over the past thirty years wasn't enough, the pandemic has accelerated this attrition. Many physicians who are busy caring for their patients and families may feel squeezed for time and resources … yet another meeting to attend and another dues statement to pay. Our membership numbers began a slow decline in the 1990s and have been cut in nearly a half over the past decade. In 2011, we had 1,004 OCMS members compared to only 545 members last year. Membership dues, however, have not increased since the 1990s.

This alarming trend calls into question the *raison d'etre* of organized medicine. The first is advocacy. If we don't advocate for ourselves and our patients, no one else will: not the hospitals, not the paramedical professionals, not the government or insurance companies, and certainly not the trial lawyers. Neither political party is particularly friendly to medicine. Insurance companies are happy to pay us less and to increase our administrative burdens. Paramedical professionals are pleased to take a greater share of our patient care responsibilities. With the OSMA's active lobbying efforts, many bills harmful to physicians and patients in the state legislature have been successfully blocked. At the national level, the AMA is promoting legislation to improve physician reimbursement (Medicare physician reimbursement has increased an average of 0.5% percent per year for the past 20 years), reduce prior authorization burden, and improve telemedicine access post-pandemic.

The second purpose of a medical society is connection with colleagues and networking. Patient care is enhanced when physicians know each other and trust each other. A young (or established) practice grows through physician referrals, the lifeblood of a medical practice. The OCMS fosters these networking opportunities through its membership meetings and the highly successful (prior to the pandemic) collegiality dinners. The networking dinners are targeted for specific groups (Women in Medicine, LGBTQ+, Empty Nest physicians) and OCMS plans to expand these when COVID threats wane.

A third benefit of OCMS is physician wellness. OCMS launched the Physician Wellness Program in 2017. The PWP offers completely free and confidential sessions with a psychologist either virtually or in a private location, with appointments convenient for physicians. There is no insurance billing, no records, and no reporting. OCMS receives funding for this program from donations from OCMS members and the OSMA Foundation.

A fourth benefit is OCMS' promotion of physician leadership development. OCMS launched the highly sought-after Physicians Academy that provides members with training and resources to prepare for leadership roles professionally and personally. Faculty-led live meetings help fill gaps in physician leadership knowledge. Each local leadership class is chosen by alumni and led by a committee of talented physicians.

A fifth reason for OCMS to exist is that it serves as a vehicle for doing good in our community and state. Through active physician engagement and leadership, OCMS has spawned several philanthropic organizations including the Oklahoma Blood Institute and the Health Alliance for the Uninsured. OCMS was established in 1900 by physicians coming together to solve a public health crisis in Oklahoma territory. Our medical society must grow in numbers for us to be able to thrive. The OCMS Board is eager for fresh input and ideas from our members and non-members. We want to be better. We want to improve. We want to be relevant. Please ask your colleagues to join us!

OCMS
OKLAHOMA COUNTY MEDICAL SOCIETY

Spring Membership Meeting

Monday, March 21

OSMA Building 313 NE 50th

Dinner service begins at 6:30 p.m.

Program begins at 6:55 p.m. with guest speaker,

Governor Kevin Stitt

Due to limited seating for this event,
only members are permitted to attend.

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

One of the many gratifying aspects of providing healthcare in an academic setting is that it allows for research-driven innovation. This means that we can model different structures of care and use research to identify best practices for the patients we serve and then share those with practices locally and nationally. As a College of Medicine, we are grateful for this opportunity and our ability to serve our state in this way. For this month's message, I would like to share just a bit about one example of how this works — our Pediatric Psychology Team in Department of Pediatrics, an example of truly integrated healthcare.

The Pediatric Psychology Team is comprised of 11 psychologists who have faculty appointments in the Sections of General and Community Pediatrics and Hematology-Oncology. Team members are integrated within Oklahoma Children's Hospital OU Health and across multiple primary care and specialty clinics. Here they collaborate with our physicians and other healthcare professionals to provide the mental and behavioral health services that are so important for the well-being of children and their families, as well as conducting the research that demonstrates impact on important outcomes.

This biopsychosocial model of care has been shown to have numerous benefits, including helping children adjust to life with chronic medical conditions. Our psychologists often help children work through the stress and fear that comes with a new diagnosis. In addition, because most chronic conditions require some type of behavior change, psychologists help patients and families overcome barriers to change and learn what will be required to manage a medical condition over the long term. This support has been shown to result in improved treatment adherence.

Pediatric psychologists also play a critical role in helping young people learn to manage chronic conditions on their own as they get older and prepare to transition to an adult services provider. Sometimes, young adults who are living on their own end up needing emergency care for situations that could have been prevented. A pediatric psychologist begins working with patients on transition readiness several years before they "age out" of their pediatric clinic, helping them understand their medication dosages and lab reports, for example, and prioritizing their mental health as part of managing their medical condition.

The college's pediatric psychologists are fully embedded in primary care clinics, as well as specialty clinics focusing on cancer, gastroenterology, rheumatology, endocrinology, nephrology, cystic fibrosis, and other disciplines. They also see patients and provide consultations in the hospital.

When a child is diagnosed with cancer, psychologists meet with the patient and family not only to help them cope with the bad news, but to assess their needs, including where the family can stay during the child's treatment if they live hours away. Providing practical support is often very

important as the family adjusts to the situation. Psychologists also play an important role once a child's treatment has ended. Many children who have been treated for cancer have problems with mood, memory and attention, and they are at risk for secondary cancers and illnesses.

In our primary care clinics, psychologists care for patients with depression, anxiety, trauma and school problems, typically seeing them the same day they see their medical doctor. Psychologists also help with behavioral health issues such as weight management, vaccine hesitancy or smoking cessation, working in concert with physicians for the patient's best care. Integrating psychologists into our pediatric primary care clinics also helps families understand that both physical and mental health services are standard components of overall healthcare.

Additionally, what adds substantial value to our state is our ability to weave a learning environment into all of this. Trainees pursuing various degrees work with our psychologists, including family medicine and pediatrics residents. They learn the importance of mental health expertise on an interdisciplinary care team and will carry that insight into their own careers. Even if they don't ultimately practice in an integrated care setting, they will have a deeper understanding of what an integrated model of practice offers and will be more likely to coordinate care with a mental health provider.

Integrating mental health services into care teams is the future of medicine. Although there are barriers to implementing integrated care in community practices, the benefits are great. This type of care decreases stigma, increases access to care, improves care management, and is cost-effective. Physicians have a limited amount of time to address the gamut of a patient's needs, but psychologists can delve deeper and enhance treatment. A patient whose mental health needs are addressed will be more likely to have better physical health outcomes.

I am proud that our pediatric teams are modeling this holistic approach to patient care. With determination and innovative thinking, I believe we can eventually create this framework across both pediatric and adult services. The mind and the body are inextricably linked, and our patients deserve care that supports them as a whole.

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About the Cover

Special Care

An Inclusive Environment For Special Needs Children

Spend just a few minutes inside the doors of Special Care and you will suddenly realize you are in a special place.

Since 1985, Special Care has provided specialized care for children with and without special needs. But the most obvious difference maker comes for families who have children with special needs. Co-founders Pam Newby and Joe Dan Trigg knew they wanted to create a high-quality early education learning environment for children of ALL abilities.

In 2021, Special Care (with its home near Western and Northwest 122nd) was selected as one of the recipients of the OCMS Community Foundation grant, which go to community organizations who are supporting the health of the community.

With its unique inclusive environment, Special Care has grown from serving 12 children to now giving care to more than 200.

Since opening, Special Care has also trained approximately 7,000 childcare professionals and practicum students from Oklahoma and surrounding states in the skills of caring for children with special needs. Special Care has been a model site for the Department of Human Services' Oklahoma Center for Early Childhood Professional Development and is a proud United Way Partner Agency.

Here is a glimpse of two families impacted by the work of Special Care and its staff:

LIZZIE & CHOCK DANIELS

"Special Care is worth the wait," says Lizzie Daniels, whose youngest son, Chock, was on the Special Care waiting list for two years.

When pregnant with Chock, Lizzie had a "perfect pregnancy," but on day ten, something changed. Chock started showing signs of developmental abnormalities. "There was no trauma, no illness. It was confusing," said Lizzie. "We were doing everything right, but his (Chock) body was failing him."

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SPECIAL CARE *Continued from page 13 …*

After many doctors, genetic testing, and a trip to the Mayo Clinic, the Daniels family got the news that Chock has a rare metabolic disorder that creates global developmental delays, low muscle tone and immune system deficiencies. "After Chock's diagnosis, we switched from getting answers to advocating for him," said Lizzie. "I would ask our doctors, 'if this was your child, what would you do?' and Special Care kept coming up." Lizzie put Chock on the waiting list at Special Care.

While waiting for a spot to open at Special Care, Lizzie cared for Chock at home. "He seemed happy, but it was very stressful," said Lizzie. "Before Special Care, my life was about shuffling my child with special needs from doctors, therapy and school. That's not what we wanted for our family."

In August of 2014, Chock entered the Pre-K Program at Special Care. "We have seen the greatest developmental improvements in the past six months than any other time in Chock's life," said Lizzie. "Chock loves his school! I literally have to lure him out of the building with juice boxes and snacks, because he doesn't want to leave!"

In his first six months, Chock has excelled in his classroom and also in the occupational, physical and speech therapy he receives at Special Care. Although Chock is considered "non-verbal," he has learned to communicate with both words and technology, thanks to his hard work with his Special Care speech therapist. "His therapist suggested that we use an iPad for Chock to communicate," said Lizzie. "We downloaded the app his therapist suggested and within weeks, he was using the iPad to communicate in full sentences." Now that Chock can communicate with others, the stress level in the Daniels' home has plummeted. Chock is now able to communicate and play with his older brother in new ways, strengthening their family bond.

"Special Care has changed our lives," said Lizzie. "It (Special Care) isn't curing him, because there is no cure, but they are greatly improving our family's quality of life."

THE HEAD FAMILY: KELSEY & MEL WITH BEN & ELI

Ben and Eli Head, twin boys, are one in a million. Actually, they are two of only 60 children in the world diagnosed with Neonatal Progeria.

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Neonatal Progeria is an extremely rare, progressive genetic disorder that causes children to age rapidly. At birth, Ben and Eli entered the foster care system. Although, they did not know the cause or have a diagnosis of the boys' medical conditions, Ben and Eli's needs were great and their birth family was simply not able to provide sufficient care for a child, let alone twins with significant special needs. Luckily, news about these two sweet boys in need of a home traveled through the neonatal intensive care unit and throughout the hospital. When Kelsey Head, a Nursing Assistant at the hospital, heard about the boys she knew that they would be loved in her family. Kelsey talked with her wife, Mel, about the boys and her plan for she and Mel to become their foster parents. Without hesitation, Mel agreed, and they became Ben and Eli's foster mothers.

"We were able to bring Ben home when he was two months old and Eli when he was three months old," said Kelsey. "Ben was just 4 pounds, 6 ounces when he came home and Eli was just 4 pounds and had a g-tube. I was terrified." (A gastrostomy tube or "g-tube" is a tube inserted through the abdomen that delivers nutrition directly to the stomach).

Kelsey and Mel searched for answers as to what was affecting their boys. After countless tests and meetings with geneticists, Ben and Eli were given a clinical diagnosis of Neonatal Progeria. "It was good to finally have an answer, but the wind is knocked out of you, because you now know that they aren't always going to be around," said Kelsey. Ben and Eli's medical needs were great and their days were filled with appointments, treatments, and tending to numerous daily needs. The family made the decision that Mel would leave her job as an Emergency Medical Technician and stay at home with the boys so someone could make sure they received their treatments, therapies, and were safe and cared for while Kelsey could work to support the family. Then they heard about Special Care.

"When I first walked through the doors at Special Care, it was not like anywhere I have seen," said Kelsey. "I don't know how else to put it other than it felt like family. There was a sense of familiarity in this place that I had never been before. I felt at home and was so thankful that a place like this existed for kids like ours."

Ben and Eli have excelled at Special Care, developmentally and socially. "They get so excited in the morning getting ready to go to school," said Kelsey. "They love their teachers. They love their friends. They love it because they get to feel it back. At Special Care, they are loved without reservation."

Kelsey is able to work outside the home and Mel is able to attend school full-time now that they know that their boys are safe, loved, and succeeding at Special Care. "We, as parents, want nothing but the best for our twins. Ben and Eli attending Special Care is exactly what we have, the absolute best," said Kelsey. "They are our family…Our boys will not live a full life, but we know that whatever time God allows us with them on Earth will have been filled with love, learning and joy."

Aggressive Terminal Palliation of Pain and Suffering:

IS IT MURDER?

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

On December 5, 2017, a 74-year-old patient was brought in critical condition to the emergency department of Mount Carmel Medical Center, a 136-year-old Catholic hospital owned by the Trinity Health system in Columbus, Ohio. He had diabetes and was previously hospitalized for treatment of a gangrenous foot. Upon arrival at the ER, he had acute renal failure and hypotension. He also had two cardiac arrests. The patient was intubated in the ER and sent to the ICU during the evening shift. He was placed under the care of William Husel, DO, the sole physician on duty in the ICU.

At approximately 9 p.m., the family members were at the patient's bedside. The patient was unconscious and on the ventilator. Dr. Husel told the family that patient's organs were shutting down and he was brain damaged. He discussed the patient's "grim prognosis" and advised the patient's family that he had "minutes to live." Then Dr. Husel asked the family, "How would you want him to take his last breath: on the ventilator or without these machines?" The family agreed to ***palliative extubation***. The patient's ventilator was discontinued and the endotracheal tube was removed because he was expected to die.

Just prior to extubation, and to relieve the patient from pain and suffering, Dr. Husel verbally ordered the nurse to administer 1mg (1000 micrograms) of fentanyl, followed by 2 mg of hydromorphone, and 4 mg of midazolam.

The medical center's 2016 guidelines for IV administration of fentanyl specified a dosage range of 50 to 100 micrograms for relieving pain, and its 2018 guidelines reduced that to 25 to 50 micrograms. The nurses on duty skipped the standard non-emergency process of getting pre-approval from the pharmacist. Instead, they used the override function on the automated Pyxis system to withdraw the drugs from the dispensing cabinet and avoided pharmacist review. The nurse that administered the drugs to the patient said later that Dr. Husel told him the pharmacist had said, "It is okay." According to the pharmacy board report, the pharmacist wrote in the medical record system that he did not agree to the fentanyl order. However, his dissent came as the drugs were being administered and the breathing tube was being removed. The patient died approximately one hour after the ***palliative extubation.***

About Dr. Husel

Dr. Husel was a former high school basketball star. He is married and his wife is a nurse.

In 2013, after completing a residency and fellowship in critical care medicine and pain management at the Cleveland Clinic, Mount Carmel West hired him to work the late-night shift in its ICU. That was his first job as a full-fledged physician. He was a hard worker. He was popular with the ICU nurses and staff, who looked to him as a teacher and mentor. In 2014, Dr. Husel was chosen by his hospital colleagues as physician of the year. He was again nominated in 2018.

Before October 2018, there were no complaints about his care. When he applied for his medical license, he declared that in 1996, he pleaded guilty to a federal misdemeanor for improperly storing explosive materials. He received a 6-month sentence followed by supervision. Mount Carmel checked his background the previous 10 years and found nothing on him that would preclude his employment.

Investigation, Discharge, License Suspension and Indictment of Dr. Husel

In 2017, Mount Carmel Medical Center launched a "Zero Harm" patient safety program, and medical staffers were supposed to report safety concerns up the chain of command. Dr. Husel's cases were reviewed from 2014-2018. There were 34 other ICU patients who were gravely ill who died minutes after receiving a single dose of 0.5mg or more of Fentanyl, often combined with other drugs while being removed from the ventilator and extubated.

In December 2018, Mount Carmel concluded that the opioid dosages used by Dr. Husel were "significantly

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excessive and potentially fatal," and "went beyond providing comfort." Dr. Husel's employment was terminated, and he was reported to the Ohio Medical Licensing Board. His Ohio medical license was suspended.

In June 2019, Dr. Husel was indicted and charged with 25 counts of murder. The prosecutors alleged that he ordered excessive or potentially fatal doses of fentanyl to be given by the nurses to patients under his care, and all of them died. *Dr. Husel is the only person facing criminal charges.* On August 28, 2019, Dr. Husel pleaded not guilty in court.

Ripple Effect

1. In June 2019, after threatening to cut off Medicare and Medicaid payments to Mount Carmel, CMS accepted the hospital's correction plan, which (1) restricted use of verbal drug orders and prohibited Pyxis system overrides for opioids except in life threatening emergencies, (2) physicians must receive permission from a physician executive to order painkilling drugs that exceed hospital-set dosage parameters for palliative ventilator withdrawal, and (3) pharmacists must immediately report concerns about drug prescribing safety up the hospital pharmacy chain of command.
2. Mount Carmel's CEO acknowledged that "processes in place were not sufficient to prevent these actions from happening." He stepped down as CEO in June 2019.
3. The Chief Clinical Officer, and other physician, nursing, and pharmacy leaders, as well as two dozen nurses and two pharmacists had their employment terminated or entered into retirement. A total of 23 healthcare employees were fired.
4. The ICU nurses that administered Fentanyl and the pharmacists faced disciplinary action, mostly license suspension for 1-3 years, for failing to inform their supervisors about the incident and preventing the use of those high drug dosages for the ***palliative extubation***. *None of the nurses or pharmacists has been criminally charged.*
5. Federal and State agencies cited the Mount Carmel for faults in its patient safety systems and culture causing a breakdown in oversight. Many of Dr. Husel's drug orders were given verbally instead of through the standard process of entering the orders into the electronic health record.
6. Numerous wrongful death lawsuits were filed by the decedents' families against Mount Carmel and Dr. Husel alleging no record of anyone supervising Dr. Husel or monitoring his care. Mount Carmel and Trinity have settled so far a number of the lawsuits for nearly $20 million.
7. The Ohio Board of Pharmacy fined Mount Carmel $477,000 for pharmacy rules violations.
8. In December 2019, Dr. Husel sued the Mount Carmel Health System and its parent company, Trinity Health in Franklin County Common Pleas Court, for *defamation* claiming that he was falsely accused of intentionally murdering 25 patients, and these statements were repeated on numerous occasions in "non-stop" press releases and other public statements. In 2014 and 2015, Mount Carmel Health responded to Dr. Husel's *defamation* lawsuit by saying:

   "Our priority at Trinity Health and Mount Carmel is the overall care and well-being of our patients and the health and wellness of the entire community we serve. All that we have done and continue to do reflects this commitment. Dr. Husel's defamation lawsuit has no merit, and we will defend our position vigorously."
9. Dr. Husel also sued Mount Carmel's parent company, Trinity Health, arguing that the company's insurance policy should pay for his criminal defense fees. The hospital rejected that claim in federal court filings and said that the allegations of murder are not insurable.

Allegations, Defenses and Burden of Proof

The prosecution alleges that the doctor is a ***serial killer***. The defense counters that Dr. Husel's actions were compassionate and appropriate, and he never wanted to see any of his patients suffer, nor their family. His actions were in keeping with statutory immunity under the "dual effect' principle.

The prosecutors must prove ***beyond reasonable doubt*** that (1) the drugs Dr. Husel ordered were what directly caused these critically ill patients to die, and (2) he intended to kill the patients. The prosecutor has to prove that the drugs hastened the patients' deaths, and by how much, and that the doctor is criminally responsible.

The defense contends that physicians and other medical providers have certain legal protections under the double effect principle for administering drugs to patients for the purpose of relieving pain and suffering, even if the drugs hasten the patients' deaths, as long the intent was not to cause death and the drugs were properly used.

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In the civil cases, there is also the issue of how much a few more minutes, hours, days or weeks of life are worth in terms of monetary damages.

On November 30, 2021, Dr. Husel's legal team argued in court that the 25 murder charges filed against him should be tossed out. They raised accusations of prosecutorial misconduct as a basis for their argument. They alleged that the prosecutor's office misled the grand jury and withheld evidence about a patient who received a larger dose of fentanyl than the other patients tied to the criminal case.

Statements by ICU Nurses

Former Mount Carmel nurses testified in depositions that the amounts of drugs given to Dr. Husel's patients were not excessive. In response to a question about why a patient would need 500 micrograms of fentanyl when their ventilator was being withdrawn, one of the nurses stated that in her view the dosage was not inappropriate. She stated at deposition, "So now he is going to be palliatively withdrawn. I am going to take away his breathing, take away the pressure that's keeping his lungs open. I am going to take all of that away and he is going to be on room air. He's going to suffocate to death. So 500 micrograms of fentanyl was not a large amount at all."

During their appearances before the state board of nursing, two nurses addressed the nursing board before their licenses were suspended for one year praised Dr. Husel, characterizing him as a doctor many nurses trusted because of his training and expertise in anesthesia and time spent working in Mount Carmel's intensive care unit. One of the nurses said: "I watched Dr. Husel go above and beyond to try and heal patients, and we fought for their lives. I watched him perform miracles when other doctors couldn't or wouldn't try, and for these reasons, to hear and learn that he may have not been doing things within the standard of care has been very challenging to accept."

Cause of Death and Trial

What exactly killed the patients remains in dispute. Mount Carmel acknowledged in 2018 and early 2019 that the patients "should not have been given excessive doses of fentanyl…" However, the probate court records state that since litigation was filed, the hospital has now "argued that fentanyl did not prematurely end (the patient's) life…"

In January 2022, 11 counts of murder were dropped against Dr. Husel. But the judge allowed the prosecutors to present evidence that jurors could consider lesser offenses like reckless homicide in Dr. Husel's upcoming murder trial. The trial was set to begin on February 14, 2022, in Columbus on 14 counts of murder.

Is Dr. Husel a Serial Killer?

That is a question for the jury to decide. Serial killing is the rarest form of homicide making up no more than 1% of all homicides committed in the U.S. It occurs when an individual has killed three or more people who were previously unknown to him or her, with a 'cooling off' period between each murder.[1] The U.S. has more serial killers than any other place in the world. As of December 22, 2020, the total number of U.S. serial killers was 3,204.

The FBI defines 'serial killings' as a series of three or more killings, not less than one of which was committed within the United States, having common characteristics such as to suggest the reasonable possibility that the crimes were committed by the same actor or actors.[2] The serial killer's behavior is generally regarded as unfathomable, decontextualized and sociopathic. Additionally, anonymity, the culture of celebrity enabled through the rise of mass media, and specific cultural frameworks of denigration, each provide key institutional frameworks, motivations and opportunity structures for analyzing such acts.

Deaths in ICU

Most patients dying in contemporary intensive care units succumb after limitation or withdrawal of life-sustaining therapy rather than during aggressive therapeutic care. Withdrawal of mechanical ventilatory support is often an integral component of the care of end-of-life care of critically ill, dying patients. Caring does not cease during these final moments of life. Compassionate care at the EOL includes offering opioids to control suffering from pain and dyspnea.

In 2010, Mazer et al, reported that higher doses of morphine are associated with a longer time to death. The patients dying after ***palliative extubation*** received 10.6 mg/hour just before death. The mean time to death after terminal extubation was 152.7±229.5 minutes, and after extubation, each 1 mg/hour increment of morphine infused during the last hour of life was associated with a delay of death by 7.9 minutes (P=0.011). Dr. Husel worked in the ICU only and cared for critically ill patients.

Supreme Court Decisions

The 'dual (or double) effect' principle means that sedation will help relieve pain and provide comfort, but it may also depress respiration and possibly lead to the

patient's death. In 1997, the U.S. Supreme Court strongly approved aggressive palliation of pain in *Glucksberg*[3], and in *Vacco*.[4] The Court argued that it is "widely recognized that the provision of pain medication is ethically and professionally acceptable even when the treatment may hasten the patient's death, if the medication is intended to alleviate pain and severe discomfort, not to cause death." Justice O'Connor stated, "A patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, even to the point of causing unconsciousness and hastening death." Aggressive pain palliation is lawful and the state could not, consistent with the Constitution, prosecute a physician for causing a patient's death, where that death was a secondary consequence of aggressive pain management.

Physicians' Attitudes

There are significant variations in physicians' attitudes and practice relating to withholding and withdrawing mechanical ventilatory support. In 1994, some 273 critical care physicians involved in ventilator management were surveyed regarding the clinical management of dying patients receiving mechanical ventilation.

- 15% almost never withdrew ventilators from dying patients foregoing life-sustaining treatment;
- 37% did so less than half the time.
- 26% believed there was a moral difference between withholding and withdrawing ventilators.
- Of physicians who withdrew ventilators, 33% preferred terminal weaning, 13% preferred extubation. The reasons for preferring extubation included the directness of the action (72 percent), family perceptions (34 percent), and patient comfort (34 percent).
- Morphine and benzodiazepines were used frequently by 74 percent (morphine) and 53 percent (benzodiazepines) of physicians when withdrawing ventilators; 6 percent used paralytics at least occasionally.

Toxic Dose of Fentanyl

The toxic dose, LD_{50}, of Fentanyl in humans is unknown.[5] The lethal dose for the average person is estimated to be 2 mg.[6] The intravenous LD_{50} of Fentanyl in rats is 2.91mg/kg.[7] The calculated safety index (Odds Ratio of antinoceception/Odds Ratio of respiratory depression) for fentanyl is 1.20, suggesting that fentanyl has a low safety margin.

In animals, the intravenous dose causing 50% of opioid-naive experimental subjects to die (LD_{50}) is 3 mg/kg in rats, 1 mg/kg in cats, 14 mg/kg in dogs, and 0.03 mg/kg in monkeys."[8] The LD50 in mice has been given as 6.9 mg/kg by intravenous administration, 17.5 mg/kg intraperitoneally, and 27.8 mg/kg by oral administration.[9]

In 2021, Algera *et al*[10] published a pharmacokinetic-pharmacodynamic analysis of the respiratory effects of fentanyl in chronic opioid users and opioid-naïve subjects to quantify tolerance to respiratory depression. Apneic events occurred in opioid-naïve subjects after a cumulative fentanyl dose (per 70 kg) of 225 to 475 µg, and in 7 chronic opioid users after a cumulative dose of 600 to 1,800 µg. The authors stated that despite higher tolerance to fentanyl-induced respiratory depression, apnea still occurred in the opioid-tolerant population indicative of the potential danger of high-dose opioids in causing life-threatening respiratory depression in all individuals, opioid-naïve and opioid-tolerant.

Dr. Husel's murder trial was set to begin February 14, 2022.

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[1]https://www.crimeandjustice.org.uk/publications/cjm/article/social-study-serial-killers

[2]https://www.fbi.gov/stats-services/publications/serial-murder#two

[3]117 SCt 2258 (1997).

[4]117 SCt 2293 (1997).

[5]Vardanyan RS, Hruby VJ (March 2014). "Fentanyl-related compounds and derivatives: current status and future prospects for pharmaceutical applications". Future Medicinal Chemistry. 6 (4): 385–412. doi:10.4155/fmc.13.215. PMC 4137794. PMID 24635521

[6]"Fentanyl. Image 4 of 17". Drug Enforcement Administration

[7]https://go.drugbank.com/drugs/DB00813

[8]"Fentanyl Citrate Injection, USP" (PDF). US Food and Drug Administration.

[9]Yadav SK, Maurya CK, Gupta PK, Jain AK, Ganesan K, Bhattacharya R (June 2014). "Synthesis and biological evaluation of some novel 1-substituted fentanyl analogs in Swiss albino mice". Interdisciplinary Toxicology. 7 (2): 93–102. doi:10.2478/intox-2014-0013. PMC 4427721. PMID 26109885

[10]https://pubmed.ncbi.nlm.nih.gov/32865832/

Alison Fink

DIRECTOR'S DIALOGUE

When I was a child, my whole family liked to tell stories of my ancestry. They spoke of this distant ancestor and that relative's origins, but there was no proof from the elaborate stories. Spoiler alert – none of the stories were quite true. On the flip side, my husband expected nothing interesting from his test, but learned that who he thought was his biological grandfather was impossible according to the DNA test. He shared this shocking information with a younger family member who responded with a complete lack of interest. We realized, reluctantly, that we are older and have a different perspective.

I thought of association membership and how our values shift through generations. It's not just professional organizations that are losing out by not appealing to younger prospects; a friend who works in the arts says they are struggling to appeal to younger groups as well. It is time for us to reframe our views.

OCMS tends to communicate 'networking' around as a benefit. To me, networking is an opportunity to meet up with people who share similar challenges and opportunities. To my closest friend, networking is an insufferable evening of awkward conversations. She wants to know who is attending and where they are from, so she is prepared when she sees their name tag. Bridging the connection between generations, and varying perspectives, is our job as staff and leadership of this organization. Targeted networking may help reduce the pain of forced socialization for many and allow those extroverts to do what they do best — network. Newly retired? First five years in practice? Minorities in medicine? All ideas for networking events that OCMS wants to foster in the next few years.

As values shift for physicians, our perspectives must shift as a medical society. What may be incredibly important to one generation or group of physicians might not have any relevance to another. We are at a unique time in history where four generations are in the workforce and our evolvement must take in all perspectives. There's not a test we can give all members to learn more about them, but we can through the targeted action or process of interacting with others to exchange information and develop professional or social contacts, aka, networking. Maybe the icebreaker can be discussing DNA test results surprises.

It's not about giving up hope, but about

living each day to the fullest.

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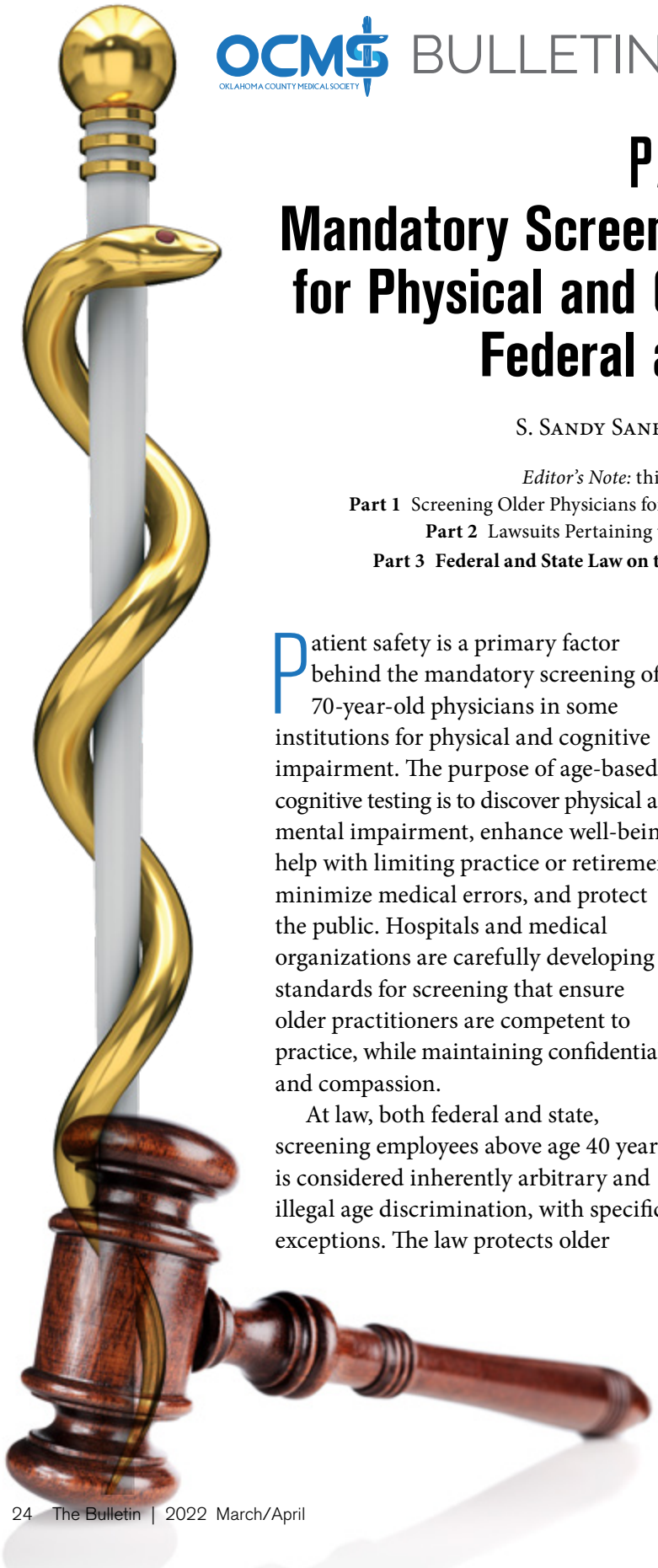


PART 3: Mandatory Screening of Older Physicians for Physical and Cognitive Impairment – Federal and State Law

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

Editor's Note: this is Part 3 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

Patient safety is a primary factor behind the mandatory screening of 70-year-old physicians in some institutions for physical and cognitive impairment. The purpose of age-based cognitive testing is to discover physical and mental impairment, enhance well-being, help with limiting practice or retirement, minimize medical errors, and protect the public. Hospitals and medical organizations are carefully developing standards for screening that ensure older practitioners are competent to practice, while maintaining confidentiality and compassion.

At law, both federal and state, screening employees above age 40 years is considered inherently arbitrary and illegal age discrimination, with specific exceptions. The law protects older employees, including physicians, from being stigmatized or penalized because of growing older. Additionally, ageism and unnecessary reductions in the physician workforce are avoided.

Federal Law

Some form of prohibition against age discrimination in employment has been enacted by the federal government and the majority of states[1].

In 1967, the Age Discrimination in Employment Act (ADEA) was enacted in part "to promote employment of older persons based on their ability rather than age [and] to prohibit arbitrary age discrimination in employment . . . ."[2]. The Act made it "unlawful for an employer . . . to fail or refuse to hire or to discharge any individual or otherwise discriminate against any individual with respect to his [or her] compensation, terms, conditions, or privileges of employment, because of such individual's age."[3]

The ADEA is not an unqualified prohibition on the use of age in employment decisions. The ADEA provides a lawful

defense which permits employers to set maximum age limits for employees if the employer can show that age is a ***bona fide occupational qualification (BFOQ)*** and is reasonably necessary for the operation of the business.[4] However, this defense has "limited scope and application" and "must be construed narrowly.[5]" For example, a federal regulation is "relevant evidence" in a BFOQ defense, but "it is not to be accorded conclusive weight.[6]

The Equal Employment Opportunity Commission (EEOC) enforces the ADEA. Complainants must first file a claim with the EEOC or their state's employment or Human Rights[7] commission before filing a lawsuit. The EEOC attempts to resolve the dispute through voluntary compliance on the part of the employer, conciliation, or other persuasive measures. The employee does not have to wait for a final determination from the EEOC, that is exhaust administrative remedies, before filing a lawsuit. However, if the EEOC decides to bring an action against the employer, the employee's right to sue is extinguished.

According to the U.S. EEOC[8]:

1. "Age discrimination involves treating an applicant or employee less favorably because of his or her age."
2. "The Age Discrimination in Employment Act (ADEA) forbids age discrimination against people who are age 40 or older. It does not protect workers under the age of 40, although some states have laws that protect younger workers from age discrimination."
3. "The law prohibits discrimination in any aspect of employment, including hiring, firing, pay, job assignments, promotions, layoff, training, benefits, and any other term or condition of employment."
4. And, "An employment policy or practice that applies to everyone, regardless of age, can be illegal if it has a negative impact on applicants or employees age 40 or older and is not based on a reasonable factor other than age (RFOA)."[9]

State Law

The majority of states have age discrimination laws. In 2019, the state of Utah passed a specific law[10] prohibiting certain age-based physician testing. The law states that,

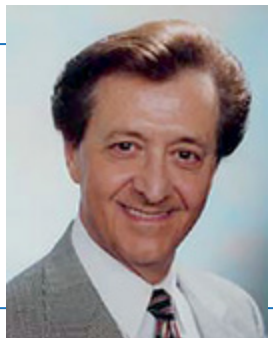
1. "A health care facility may not require for purposes of employment, privileges, or reimbursement, that a physician … take a cognitive test when the physician reaches a specified age, unless the test reflects nationally recognized standards adopted by the American Medical Association for testing whether an older physician remains able to provide safe and effective care for patients."
2. The law also states that, "A managed care organization or other third party may not require for purposes of reimbursement that a physician, … take a cognitive test when the physician reaches a specified age… ".

Nevertheless, mandatory screening of older physicians for physical and cognitive impairment is on the rise. Part 4 will depict the decisions of the courts in this matter.

[1]Employment Discrimination Coordinator Analysis of State Law § 1:14 (Sept. ed. 2018). 1-6, (2012)
[2]29 U.S.C. § 621(b)
[3]29 U.S.C. § 623(a)(1)
[4]29 U.S.C. § 623(f)(1)
[5]Criswell, 472 U.S. at 412
[6]Id. at 418
[7]Human Rights - History, The United States And Human Rights, Nongovernment Organizations, Further Readings - Laws, Freedoms, Law, and Trial - JRank Articles
[8]https://www.eeoc.gov/age-discrimination#:~:text=The%20Age%20Discrimination%20in%20Employment,younger%20workers%20from%20age%20discrimination.
[9]Federal Register :: Disparate Impact and Reasonable Factors Other Than Age Under the Age Discrimination in Employment Act
[10]26-21-31. Prohibition on certain age-based physician testing. https://le.utah.gov/xcode/Title26/Chapter21/C26-21-S31_2019051420190514.pdf

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.



THE POWERS OF LOVE

Hanna A. Saadah, MD

Oklahoma City VA Hospital, 2019

"I can't talk with all them women in the room," he blushed. "I'm sorry, Doc," he frowned.

I gulped, surveying the disconcerted faces of our psychologist, nurse, social worker, and pharmacist, wondering how to politely ask my Geri-PACT providers to leave us alone for a moment.

As if afraid to awaken his dormant emotions, the psychologist stood up, nodded to the three other feminine faces gazing at her, and tiptoed out of the room. When the door closed behind all four women, Mr. Crassus sighed, and the frowning blush faded from his face.

"I'm sorry, Doc," he reiterated, "but I just couldn't expose my soul to all them women."

"None of us is sorry, sir," I reassured, hoping to assuage his angst.

Mr. Crassus maneuvered his scooter as close to the designated, oversized chair as space allowed, examined the chair's large dimensions with circumspect eyes, and declared, "I'm way too big for this chair. I've not been able to sit in any kind of chair for years."

"Don't worry. I can examine you on your scooter," I reassured.

"There's not much to examine, Doc. My heart and lungs are fine. I don't smoke or drink. I don't have diabetes or cholesterol or high blood pressure. The only thing wrong with me [sic] is my knees."

"How long have you been on a scooter?" I asked while wondering why he was reticent to discuss his knees with the four women in the room.

"I've been living on my scooter for the past two years, Doc. Before that, I could walk short distances. Now, it's scooter to bed, scooter to bathroom, and scooter to car."

"What happened, Sir?" I asked, still wondering why he wanted the women out of the room.

Mr. Crassus dripped silent tears while telling me his story. After 22 years in the Marines, his football knees retired him, but he was too young then for surgery. Slowly, because he could walk less and less, he gained more and more weight, surrendering his Marine figure, over time, to overwhelming obesity.

Continues on page 28 …

"I used to be a tall, handsome, muscular, ladies' man, Doc. Then, as if all of a sudden, I became too old and too fat to even have knee surgery. In 30 years, I transitioned from jogging to scooting, moved from athletic to obese, and aged from attractive to repulsive."

At 71, Mr. Crassus weighed 388 pounds and was scooter bound. His belly poured forward like a swollen lip, covering his pelvis and thighs. He could no longer clean himself and had to use a special-order bathtub to maintain his independence. He had had many girlfriends but never married, had no children, and lived alone in a house with a ramp and specially built, wide doors.

"Unless you help me get new knees, I'm doomed to drown in my fat, Doc," he proclaimed with a supplicating voice. "If I could walk again, I might start losing weight. I have no life now and no woman will have me. I love women and I'd love to have a girlfriend again. It has been so long since I've been able to have sex that I've almost forgotten what it felt like to have women in my arms."

"Is that why you became uncomfortable with four women in the room?"

"If you were my size, Doc, would you not have felt embarrassed, telling four women, staring at you, that you've not had sex or seen your genitals for more than a decade?"

Mr. Crassus made his point with raw, graphic eloquence. In my long, medical life, I had never heard this kind of truth expressed so forcefully, so painfully, and so three-dimensionally. Time had diminished him by enlarging him, trapping him inside a massive body, rendering him precarious emotionally and infirm physically. This once virile, gregarious, attractive, sensual man had ungracefully aged, becoming dulled by pain, pounds, and poverty of soul. What he wanted from me was to help him get new knees because he thought that, with a pair of new knees, he could lose enough weight to become eligible again. I did not have

the heart to tell him that with the best of efforts, which include bariatric surgery, one cannot expect to lose more than 25% of one's body weight after five years. If he were to lose from 388 to 291 pounds, he would still be morbidly obese at 76, not to mention the age-related decay, muscle wasting, and frailty, which inexorably accelerate as years accumulate.

"Mr. Crassus, I don't think that you're operable," I said with a subdued, sympathetic tone.

"That's what they always tell me, but I don't see why. They need to operate on my knees, not on my belly. Give me back my knees and I can do the rest."

"How much did you weigh when you retired from the Marines?"

"188 pounds."

"That means you are 200 pounds overweight."

"So what? Give me new knees and I can easily lose that weight."

"But how could I convince the orthopedists to operate on you when you're such a high surgical risk?"

"The worst thing that can happen is that I would die. So what? I'm already dead anyway. I've nothing to lose if they put me to sleep and I never wake up."

"Mr. Crassus," I gasped. "Are you contemplating suicide?"

"No, Doc. I want to live again. I want to chase women again. I want to have girlfriends again. I want to go to sleep with women in my arms again. I have plenty of money, but I can't use it. Do you call this living?"

Mr. Crassus exposed his bare heart to me. To him life was women. To live again he needed to have women again. If he couldn't have women, then life was not worth living. Throughout his long, detailed discourse, he always referred to women in the plural. He never used the singular form and never used the word intimacy or relationship. He used the word sexy when he meant beautiful and the word love when he meant lust. He was a true philogynist, through and through.

"Mr. Crassus, have you ever fallen in love?" I asked, deliberately, because he never evinced love when he was telling me his life story.

"I loved them all, Doc, every one of them."

"But, Mr. Crassus, have you ever fallen in love with one woman to the point that no other woman on earth, no matter how lovely or beautiful, could take her place?"

"I loved them all, as I said, but I couldn't take any one of them too seriously. Attraction came and attraction left. Nothing really lasted long enough to make a life out of it."

"I'd like to call the team's women back," I suggested. "From here on we are going to talk about your knees and not about women, agreed?"

"Whatever you say, Doc. I'm in your hands and your team is my last hope."

I walked out and went to our team's office, not knowing how to apologize. What Mr. Crassus had told me in confidence was not to be revealed. But I still had to make an excuse for him, even when the team knew that I was making an excuse. I just needed something warm to break the ice of rejection, which my female team must have suffered.

I walked into the team's office to find four, pensive, feminine faces working their magic on their computers. They must have been annoyed with me for not forcing the issue that we are one, united team and not five, separate individuals. I cleared my throat twice yet none of them took notice or looked my way. Finally, I fractured the still life with, "Mr. Crassus apologized for not being able to reveal his intimate feelings about women to four, highly educated women. He begs your forgiveness, begs you to return, and hopes that you will be able to help him with his quest."

Our psychologist sneered, and, without lifting her head from the computer, declared, "One of you is not telling the truth."

"You are correct," I confessed.

"Well, who is it?" asked our social worker.

"It's privileged information," I smiled.

"He's taking too much Tylenol and Motrin," observed the pharmacist with a surprised voice.

Continues on page 30 …

"When I called him yesterday to ask about doses, he told me that he took Tylenol and Motrin by the fistfuls when he needed pain relief, and that he did not bother counting how many pills he took per day."

"Let's go see what's going on in his mind," encouraged the nurse as she rose from her chair. "Obviously, he has issues, and we shouldn't take his rejection of women personally."

Back in the room, our psychologist asked Mr. Crassus enough questions to determine that he was mentally competent. The social worker determined that his home environment was safe. The pharmacist determined that he was overdosing on Tylenol and Motrin. And the nurse reminded us that if his surgery were to be considered lifesaving, it could not be refused. Hearing that, Mr. Crassus jumped at the idea and proclaimed that his surgery would, indeed, be lifesaving because it would re-ambulate him and help him lose weight. I nodded and promised that I would emphasize to the orthopedists that bilateral knee replacements in his case would, indeed, be lifesaving.

Our encounter ended up on a keynote of hope. Mr. Crassus thanked all four women and apologized again for not sharing some of his personal details with them. Then, before leaving, he pulled a picture out of his wallet and passed it around. It showed him still lithe and handsome at the time he was honorably discharged from the Marines.

"See what a hunk I was thirty years ago?" he giggled with pride. "I'll need your help, ladies, to get me back to what I used to be."

When Mr. Crassus returned for his appointment in a month, his eyes were full of expectation.

"Well, Doc, when do they plan to do my lifesaving, knee-replacement surgery? I've done my homework. They usually do one knee at a time, starting with the worst knee. Then after full recovery, they do the second one."

"Mr. Crassus, I tried my best to convince the orthopedic surgeons to operate, but they declined because of your weight. They calculated that your post-operative mortality risk would be close to 65%, which is prohibitive. I even called the Chief of Orthopedics and defended your plea for the lifesaving surgery. He said surgery would be tantamount to euthanasia because if you were to survive the operation, you wouldn't survive the post-operative rehabilitation process."

"I'm dying anyway, Doc. So, why should it matter if I die of surgery instead of morbid obesity? At least with surgery, I stand a 35% chance of surviving. With the way my morbid obesity is gaining on me, I'm 100% doomed."

"We all understand your plea, sir, but the decision is not ours to make," I apologized.

"Well, since y'all can't help me, I'd better go on home, take a bunch of pills, and end my own suffering with my own hands."

"Is this a suicidal threat with a suicidal plan?" asked the psychologist with a firm voice.

"Yes, ma'am. Indeed, it is," affirmed Mr. Crassus. "You've left me no other choice."

"In that case, we can't let you go home, sir," instructed the psychologist.

"You can't do that. I'm a free man and no one can stop me from going home."

"We have our rules, sir. We'll have to admit you to 8-East and treat your suicidal depression before you can return home."

Mr. Crassus became irate when he realized that he was no longer free to leave and that he was going to be admitted to the psych ward instead. While the psychologist called the VA police, I called the admitting psychiatrist who came down right away and read Mr. Crassus the rules …

I visited Mr. Crassus daily and watched his slow recovery. When it was time to discharge him, his psychiatrist and I agreed that sending him directly home from the psych ward would not be a safe transition. Admitting him to our Community Living Center (CLC) for a few weeks of rehab would be the preferable choice. Mr. Crassus did not decline our offer, especially when I told him that I was the CLC attending for that month.

After the CLC nurses admitted Mr. Crassus, the head nurse informed me that, because of his size, he could not possibly participate in the group physical therapy sessions, and that I had to make special arrangements with Norma, the head of the PT Department. When she pronounced the name Norma, a smirk escaped from her serious lips.

"Why did you say Norma with a smirk?" I asked, bemused.

"He'll soon find out," she smirked again.

Norma was a 63-year-old, lithe, petite, no-nonsense widow. In the Physical Therapy Department, she was known as The General because she did not allow her patients to make excuses. She pushed them to the limits, got the best out of them regardless of their disability, gave them tough love instead of sympathy, and insisted on maximum independence with minimum assistance. Her disabled veterans at first left her department angry because she refused to enable them, but later on, they became grateful because she revived the strong soldier, taking refuge behind disability.

When Mr. Crassus scooted down to physical therapy for his first session, Norma met him at the door with a smile that belied her resolve.

"Why don't you park your scooter there and walk back here to my station," she commanded.

"Oh no, you don't understand, ma'am. My knees are too bad to walk that far," he smiled.

"Nonsense," she smiled back. "If you're not an amputee, you can walk."

"But you don't understand, ma'am. I've been s cooting for over ten years."

"Nonsense," she reiterated. "Get off your scooter and grab that walker."

"But, ma'am…"

"Don't but-ma'am me, soldier. Just do what I say. Come on. Get up. Up. Yes. Yes. Here we go. Now, hold

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 Continued from page 31 …

on to that walker. Come on. Take your first step. Good. One more step. Good. Keep going. Come on …"

Standing side by side, Mr. Crassus looked like Goliath and Norma like little David. This proverbial scene was not lost on anyone. The entire department, with all its physical therapists and patients, stopped what they were doing and watched what was transpiring between Norma and Mr. Crassus with gaping, incredulous eyes.

The next morning, when I made rounds on Mr. Crassus, he greeted me with, "Did you intentionally choose The General for me?"

"Yes," I confessed with a smirk.

"I don't think I can handle her, Doc. I've never met a woman that harsh. I'd like to change therapists."

"She made you walk longer than you've walked in ten years."

"Yes, but it hurt like hell, and you're not giving me enough Tylenol and Motrin to cope with that kind of pain."

"Do you mean we're not giving you fistfuls of Tylenol and Motrin?"

"Well, for a man my size, two tablets four times a day don't do it."

"Mr. Crassus, as long as you are with us, you'll have to abide with what we think is best and safest for you."

Our VA dieticians put Mr. Crassus on a strict diet, intended to make him lose two pounds per week. Norma added ten steps for each pound he lost. He protested vehemently but obeyed because, deep inside, he knew that he was wrong, and she was right. When we reviewed his case at our monthly meeting, he had lost nine pounds and was walking 200 steps a day. He was also making voluntary trips to the physical therapy department to chat with Norma. When we informed him that we usually discharge our CLC patients after one month he became disconcerted.

"Why can't I stay longer? I feel the best I've felt in years," he protested.

"We're trying to help you become independent, not enable you to become dependent," I replied. "Sooner or later, you'll have to learn to be your own physical therapist."

"You mean that I won't be allowed to visit the P hysical Therapy Department after I'm discharged?"

"If you don't mind the drive, we can arrange for you to have a weekly PT appointment."

"But that won't be enough. To maintain my progress, I'll need to have daily PT visits."

"Let me see what I can do about that," I appeased.

"While you're thinking about this issue, may I have a half-day pass, please? There's something I need to buy, something that no one else can buy for me."

"This would be a good thing," I encouraged. "It would prepare you for regaining your independence."

Near the end of the second month, I saw Mr. Crassus in the hall walking with his walker.

"You don't seem to be in pain anymore," I remarked.

"Two Tylenol and two Motrin four times a day keep my knees lubricated. It makes no sense, but the more I walk, the less pain I seem to have. I'm hardly using my scooter," he declared with pride.

"Well then, you should have no trouble going home next week."

"Oh, no. Please, Doc. Don't discharge me that soon. Give me one more month, please," he pleaded.

For a brief moment I thought I saw tears shimmer in his eyes. I was dumbfounded because I could not understand his strong, resurgent feelings of attachment. This was the man who wanted to go home to commit suicide by taking a fistful of pills, who was angry because we had him admitted to the psych ward, angry because he couldn't have bariatric or knee surgery, angry because he couldn't regain his hunk figure and be a ladies' man again, and angry because Norma had forced him to walk instead of ride his scooter.

As he and I stood in the hall, trying to find our words, I could see discomfort crawling over his face, the discomfort of having something to say but being unable to verbalize it.

Continues on page 34 …

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"Would you like to walk with me to the cafeteria to share a cup of coffee?" I invited, knowing that the cafeteria, being no-man's land, would replace our therapeutic relationship with a friendlier one.

"I'd love it, Doc, but you'll have to put up with my slow pace," he smiled, turned around, and walked toward the door.

We found a quiet, corner table with benches on each side, for he was still far too large to sit in a regular chair. I told him how proud we were of his progress and of his resolve to become independent. "But, I'm unable to reconcile your resolve to become independent with your resistance to discharge," I probed.

"I can reconcile the two," he sighed, as if inhaling back the words he had just spoken.

"Are you afraid?" I guessed.

"Yes," he sighed again.

"Afraid of failing after you return home?"

"Not really."

"What are you afraid of, then?"

"Afraid of leaving."

"Of leaving the VA?"

"No, Doc. You don't understand and I am having a real hard time telling you."

After a long, gasping pause, Mr. Crassus tilted his bulk to one side, put his hand into his pant pocket, retrieved a small, blue-velvet case, and placed it on the table with a thud.

"Is this a ring?" I asked with astonished voice.

Without answering, he carefully opened the case and turned it toward me.

"It's a diamond ring," I chortled.

"I couldn't get myself to propose. I've had ample opportunities, but I always seem to cower at the last moment."

"Is it one of the CLC nurses?" I giggled, admiring the ring.

"You know, Doc, I've never proposed to any of the many women I've dated. But here I am, wanting to and afraid to propose to a woman I've never dated. Life does make fun of us, doesn't it?"

"Are you in love, Mr. Crassus?"

"For the first time in my life, Doc, yes. I had no idea what love was until now."

"You mean to tell me that you've never fallen in love before."

"I've fallen in lust but never in love and that's why I don't know how to handle it. All I have in me, now, is love. Love without lust. It seems so odd to love without lust when I had spent most of my adult life lusting without loving and dating without proposing."

"Does she share your feelings?"

"I think she does, but I don't know for sure. What woman would want a man as huge as I am?"

"What does she call you?"

"She calls me Tiny."

"Oh, how lovely. And what do you call her?"

"I call her Davidene."

"Is that her real name?"

Mr. Crassus giggled at my ignorance and his eyes gleamed with the excitement of a secret about to be revealed.

"I call her Davidene because we look like David and Goliath when we stand together. I've been vanquished by the most petite woman in the VA Hospital, Doc."

"Norma?" I gasped.

"Yes," he nodded with flaming cheeks.

Mr. Crassus stayed with us at the CLC for three full months. On his last day, the chaplain married Norma and him in the hospital chapel after which the CLC nurses gave him a going-away party. Speeches were made and tears surprised the eyes.

For Mr. Crassus, it was the crowning triumph of love over lust and life over form.

For Norma, it was love's triumph over a Sisyphean challenge, because as Greek mythology has it, Sisyphus, notorious as the most cunning knave on earth, was punished to an eternity of rolling a boulder uphill then watching it roll back down again and again.

And for us it was a great lesson, a reminder that the mighty powers of love can always help a sinking soul, no matter how deep its ocean.

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IN MEMORIAM

WILLIAM GENE BERNHARDT, MD

January 12, 1946 – August 7, 2021

Dr. William Gene Bernhardt died peacefully on July 20, 2021, at the age of 95. Bernhardt was born near Hitchcock on June 27, 1926. He grew up on his father's farm where he performed his daily chores, rode his horse, Ribbon, and learned to play the piano, becoming accomplished enough to play on an Oklahoma City radio show. His aspirations reached beyond his father's farm. He admired local physicians and longed for a position that would allow him to help others and become a prominent member of the community. He was an excellent student with a superb memory. When he was only sixteen, he started college at Southwestern in Weatherford. Because the U.S. had entered World War II, he found himself one of the few men on campus and attracted a lot of attention, at one time being named "Mr. Southwestern."

He served in the U.S. Navy and later retired a Major in the National Guard. While working as a pharmacist's apprentice in a Weatherford drugstore, Bernhardt met his future bride, Theta Juan Sickles, who came into the store one day with her mother for a Coke float. Before long they were dating and about a year later they married. On June 30, 2021, he and his wife celebrated their 73rd anniversary. Bernhardt graduated from Southwestern with B.S. degrees in Chemistry, Biological Sciences, and Pharmacy. He worked as a pharmacist, but still harbored his dream of becoming a physician. After several years' work, he saved enough money to enter medical school at the University of Oklahoma, a financially risky but ambitious move. This decision marked a big change for the entire family. Bernhardt liked to tell friends he started medical school, his wife started teaching in Midwest City, his daughter Michel started kindergarten, and his daughter Valerie started nursery school—all on the same day.

Bernhardt graduated from medical school in 1958 and began practicing as a family physician in Midwest City. He also performed surgery and obstetrics. He said that the achievement he was most proud of was that he had brought more than 2,500 babies into the world. He practiced for many years and became a prominent, well-respected, trusted citizen. Bernhardt held many community-service positions, including Chairman for the Board of Regents at Rose State College and President of the local PTA. He was named Oklahoma Family Physician of the Year in 1986 and was a runner-up for National Family Physician of the Year. He received awards from the University of Oklahoma, the Oklahoma Academy of Family Physicians, and the School of Medicine Alumni Association. He was named a Distinguished Alumnus at Southwestern, where he and his wife founded a prize to reward outstanding teachers. He also served as Chief of Staff for Midwest City Regional Hospital. In 2015 he and his wife received the Rose State College Tower Award. Bernhardt continued practicing medicine until 2012, finally retiring at the age of 86. "Dr. Bill" will be remembered fondly by his patients, friends, and family as a good man with a good heart who led an exemplary life and inspired many. His easy smile and twinkling eyes quickly put people at ease. His life is a testament to courage, to the benefits of hard work, and to the value of blazing your own trail and creating the life you want to have.

He was preceded in death by his parents, Samuel and Bertha, his sister Georgene, and his brother Dr. Keith, who practiced medicine with him for many years. He is survived by two brothers, Dr. Samuel (Geri) of Oklahoma City, Jerald (Ellen) of Edmond, and many nieces and nephews. He is also survived by his wife, Theta Juan, and his four children, Michel (Dr. Braden) Cross in Norman, Valerie (Bill) Lorenz in Norman, William II (Lara) in Choctaw, and Dr. Karis in Choctaw. He is also survived by twelve grandchildren: Dr. Cory Cross, Dr. Conner (Ashley) Cross, and Dr. Christopher (Rachel) Cross, Dr. Landon (Barbie) Lorenz, Lane (Jon) Straughn, William Bernhardt III, Alice Bernhardt, Ralph Bernhardt, and Curran Steele, Katharine Steele, Elizabeth Steele, and Michael Kenny.

Viewing took place at Barnes Friederich, 1820 S. Douglas Blvd. (Midwest City), on Sunday, June 25. A funeral service was held at the First Baptist Church, 705 E. Rickenbacker Dr. (Midwest City) on Monday, July 26. A private interment followed. His wife has requested that in lieu of flowers, those wishing to honor Dr. Bernhardt's memory make a donation to the church or, if they prefer, to the charity of their choice.

IN MEMORIAM

JOHNNY BERNARD ROY, M.D, F.A.C.S., Sigma Xi
January 21, 1938-December 11, 2021

Dr. Roy can be remembered as an exceptional individual contributing to five areas of the community: Professor of Urology, Long-term and Full-Time, at the OU College of Medicine (OUCM). President and Board Member of the Oklahoma County Medical Society (OCMS) and the Oklahoma Clinical Society (OCU) plus Associate Editor and Page Writer for the Journal "Bulletin". He was a politically active M.D.: state-wide involvement, delegate to Washington, D.C. "action meetings" and twice a candidate for Congress. Dr. Roy was an early member in the development of the Edmond Medical Center as a Chief of Surgery. He also served in roles of added support for Christ the King Church over many years.

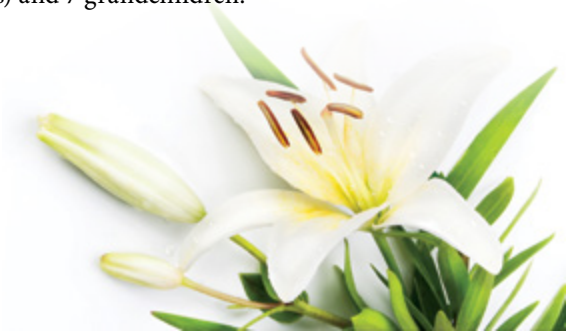
Outside the Center, Dr. Roy was elected President of the State Urological Association and Oklahoma/Southern Kansas Chapter of the National Kidney Foundation. Nationally, he was admired personally in serving on Committees of Urology (5 organizations), the College of Surgeons, and the AMA.

Dr. Roy was born in Iraq as the 5th of 7 siblings. His father, an engineer from England, met his mother on a military mission and together had established a business in Iraq. Johnny attended private catholic schools and graduated from college and medical school in Baghdad, serving a short time in the military. Migrating to the U.S., he had a general internship in Chicago, surgical training in NYC and his residency in Urology at the University of Kentucky. Awarded an NIH Urology 2-Year Fellowship, he chose to come to Oklahoma. Given faculty leave to obtain vascular experience with a surgeon at the University of Hawaii, he became appointed Chief of the Urology Service at the Kaiser Permanente Hospital in Honolulu. Two years later he returned to OUMC to head the Renal Transplantation Program. New Interests led him to develop the Indology/ Fertility and Urodynamic Programs and a chromosomal analysis laboratory for Urology. Appointed Chief of Urology at the VAMC, he later served for six months as Acting Chairman of the Department of Urology of the OUCM.

Dr. Roy deserves to be remembered also as a clinical investigator. He received funding from the NIH for Multi-Center Urology Group Studies of malignancies, infection and prostatic hyperplasia; VA Central Office Projects such as chromosomal analysis of veterans exposed to agent-orange; and major pharmaceutical companies for evaluation of new medications. His CV cites nearly 100 scientific publications and prizes for 7 exhibits shown at annual medical conventions.

The art of writing was a passion for him. It moved from writing his so labeled "Pearls" in local journals to enjoying being on the Editorial Board of the Journal of Urology, the prime publication of his specialty. Johnny loved also a mission of "educating the public." How he liked giving civic talks. His remarkable CV lists over 100 official medical meeting presentations. Adding further interest to his background were visits to 20 countries.

Dr. Roy was an engaging person in all types of conversation. He particularly liked the privacy aspects of his practice with patients. Visitors to his home would always remember being given little roses he had grown. Musically, he played the accordion. Personally, "family and home" always came first in enjoyment of life. Busy as he was, he made sure these responsibilities were given full attention. Noteworthy, he provided for his parents to live in OKC and kept in touch with siblings, all successful. Too early, Dr. Roy developed a neurologic disorder, then dementia and died in a coma. True to his nature, he had donated his body to the OU Willed Program. He is survived by a beloved wife, Sandy; children John, Jennifer and Jeffery (with spouses) and 7 grandchildren.



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