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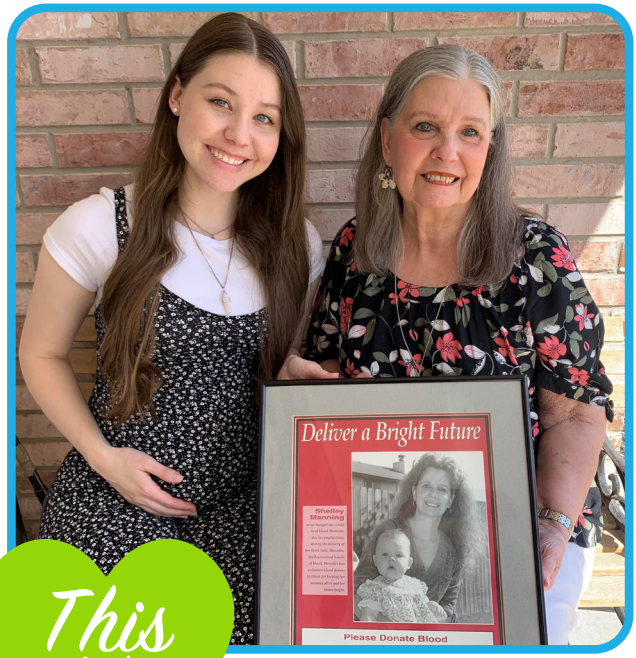

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THE BULLETIN

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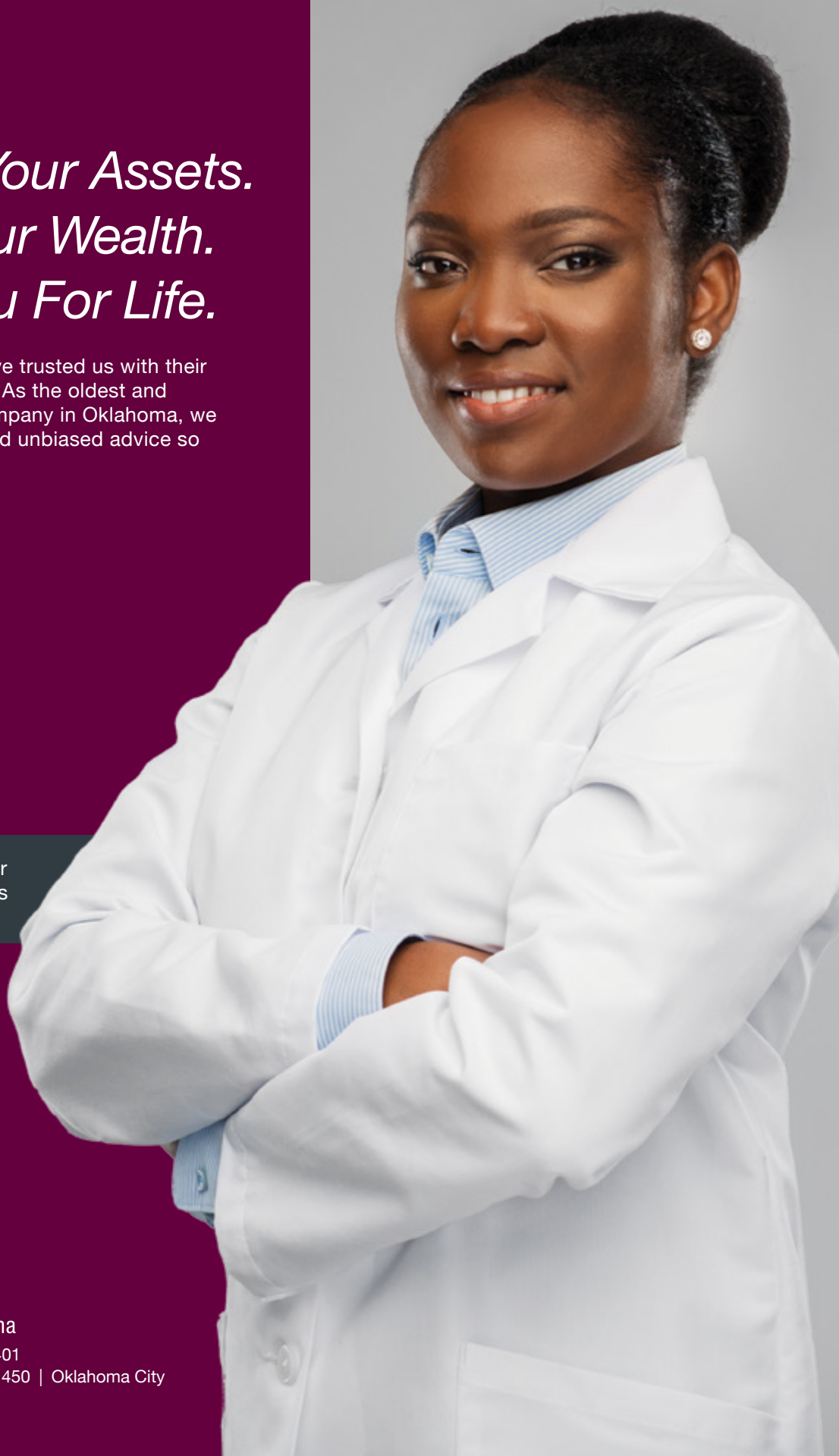

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Sumit K. Nanda, MD

President's Page

Sumit K. Nanda, MD

At the core, the annual OSMA meeting is a legislative assembly. It is a social event and a great networking opportunity, to be sure, bringing together physicians of different specialties throughout the state. But the key agenda of the meeting is for delegates to discuss and ratify various resolutions that are proposed by members.

The authors of these resolutions must first seek the support of their respective caucus (OCMS, TCMS, or rural), and then these resolutions are discussed at the general body meeting of the OSMA. The "bills" or resolutions passed by the OSMA reflect its priorities and its philosophy. They represent the tone and message that the OSMA wishes to convey to its lobbyists and to state legislators. These resolutions may affect state legislative outcomes. OSMA endorsed resolutions also communicate our priorities and interests to other state medical associations and to the AMA. The AMA, of course, wields some influence in effecting healthcare policy at the federal level. By authoring a resolution which is ultimately endorsed by the OSMA, a single OCMS/OSMA member has the power to affect health care policy at the state and national level.

The following resolutions were "passed" at this year's annual OSMA meeting:

Resolution #1: The OSMA eschews the term "provider" to describe us as this term has been historically demeaning to physicians and is imprecise in identifying our specific role in the healthcare system. The resolution advocates the elimination of the term "provider" often used by payers, hospitals, and governmental bodies and substitute it with the term "clinician" or "health care professional."

Resolution #2: OSMA will fiercely protect physicians' right to advocate on behalf of patients, other physicians, and themselves without fear of retaliation from any healthcare system, employer, or insurer.

Resolution #3: OSMA opposes placement of gabapentinoids, medications with little addictive or habit-forming potential, into Schedule V of the Controlled Substances Act. The placement of

gabapentin in the Schedule V category would make it more difficult for patients to receive treatment and cause an unnecessary barrier to care.

Resolution #4: OSMA supports hospital medical staff self-governance and opposes a hospital's unilateral amendment of medical staff bylaws without physicians' consent. The OSMA will assist medical staffs by providing legal support if a hospital board unilaterally (without physician input or consent) changes the medical staff bylaws.

Resolution #5: OSMA advocates for physician-led team based care and promotes transparency regarding healthcare practitioners' education and title. OSMA opposes legislation that would allow for the independent practice of advance practice registered nurses and physician assistants.

Resolution #6: OSMA recognizes broadband internet access as a social determinant of health and the lack of affordable, reliable broadband internet as a barrier for equitable access to healthcare. OSMA promotes legislation to increase access to stable, reliable broadband internet including subsidizing the costs of these services for underserved populations.

The above resolutions passed by the OSMA this year represent our values and priorities. I urge OCMS members to author new resolutions in time for next year's OCMS caucus in February and OSMA meeting in April.

OCMS
OKLAHOMA COUNTY MEDICAL SOCIETY

Keuchel Named Director of INTEGRIS Graduate Medical Education

Mark Keuchel, D.O., FACEP, FACOEP has been selected as the Designated Institutional Official and Graduate Medical Education Medical Director for INTEGRIS Health.

Dr. Keuchel attended Oklahoma State University for both his bachelor and medical degrees. He is currently pursuing a Masters of Healthcare Administration degree from OSU as well. Following medical school, Dr. Keuchel began his residency at INTEGRIS Southwest Medical Center where he was selected as Chief Resident in 2016. He has been the Associate Program Director of the INTEGRIS Emergency Medicine Residency program since 2018 and also serves as an Adjunct Clinical Professor of Emergency Medicine at Oklahoma State University in Tulsa as well as an Adjunct Clinical Professor of Emergency Medicine at Kansas City University of Medicine and Biosciences. He currently lives in Edmond with his wife, Azure, and two daughters, Kirby and Ellie.

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

As a medical community, while we are not far removed from the immediate effects that COVID-19 had on our patients and communities, we are also facing the long-term consequences of COVID, both on individual health and public health. The understanding of these long-term effects is critical to better understanding the full spectrum of outcomes associated with this disease. In that regard, our campus is playing a national role through our participation in the RECOVER (Researching COVID to Enhance Recovery) Initiative of the National Institutes of Health, which aims to better understand why some adults and children have prolonged or returning symptoms, known as "long COVID," after the acute phase of infection from SARS-CoV-2.

Members of our faculty, administration and staff at the OU College of Medicine are helping to lead two clinical research studies, one for adults and one for children. The adult study launched first and continues to enroll individuals in several cohorts, including those with a past COVID-19 infection who still have symptoms; those with a recent COVID-19 infection who may or may not continue to have symptoms; and a control group of people who have never had COVID-19.

COVID-19 has resulted in long-term symptoms that we have rarely seen with other viral infections. The most common symptoms in adults include pain, headaches, fatigue, "brain fog," shortness of breath, anxiety, depression, fever, chronic cough, and sleep problems. What we don't yet fully understand is why these symptoms persist long after infection in some individuals and why others have little to no symptoms. Thus far, it appears that 10% to 30% of adults infected with the virus will develop long COVID symptoms. If we can better understand the biological underpinning of these symptoms, we may be able to more effectively treat our patients.

A separate pediatric study is now underway and enrolling children, adolescents and young adults from newborns to age 25 with and without infection and at varying stages before and after infection. Enrollment will also include individuals ages 3 to 25 with a history of post-COVID vaccine myocarditis; infants born to a mother who was infected by the virus during pregnancy; and children with a history of MIS-C, or Multisystem Inflammatory Syndrome in Children.

MIS-C, recognized in April 2020 with the first reports coming from Europe, has become a distinct manifestation of long COVID in children. It was initially defined as a multisystem hyper-inflammatory syndrome in children and adolescents temporarily related to COVID-19, with features overlapping with Kawasaki disease and toxic shock syndrome. The case definition was revised by the Centers for Disease Control as a disease of youth under 21 characterized by fever, laboratory evidence of inflammation, and clinically severe illness with multisystem

organ involvement requiring hospitalization within four weeks of a laboratory-confirmed COVID infection.

Less well characterized are the pediatric clinical manifestations of long COVID not related to MIS-C. Various studies have reported pediatric symptoms as including chest tightness and pain, nasal congestion, fatigue, difficulty concentrating, muscle pain, difficulty breathing and sleep disturbance. This study will allow us to better understand long COVID symptoms in youth, along with risk and resiliency factors associated with the severity of long COVID. Importantly, the study is also considering sex and racial and ethnic disparities in risks and outcomes. Both studies will last up to four years.

The OU Health Sciences Center is uniquely qualified to serve as a study partner for research such as this by leveraging the existing infrastructure of the Oklahoma Clinical and Translational Science Institute (OCTSI), which unites universities, nonprofit organizations, American Indian communities, public agencies and primary care providers in research addressing the health outcomes of Oklahomans. By using OCTSI infrastructure, we can enroll patients from multiple different communities and populations across the state. This brings a much more robust set of important information to bear and makes the results of this study even more powerful.

I am proud that the OU College of Medicine is playing such a critical role in this national effort to better understand the long-term effects of COVID-19 infection. Because long COVID holds the potential to increase morbidity, mortality, disability and healthcare utilization in both adults and children, it is imperative that we identify new ways to prevent and treat it. As part of an academic healthcare enterprise, we are well-situated to contribute to the global need for knowledge on such important and timely public health issues.

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The University of Oklahoma College of Medicine

Class of 2022 Public Match List

The third Friday of each March is marked prominently on each graduating student at The University of Oklahoma College of Medicine's calendar. It is on this day that medical students officially learn the identity of their specialty and its location through the National Residency Matching Program (NRMP). Below is a list of the 2022 OU College of Medicine graduates with their Match Day results. The students are listed by name, OU campus of study, specialty, and the institution and city where they have been matched.

Samira Ali (OKC) Family Medicine
Pomona Valley Hospital
Pomona, CA

Kareem Aly (OKC) Urology
Ascension Macomb-Oakland Hospital
Warren, MI

Meagan Angiel (OKC) Pediatrics
OU College of Medicine
Oklahoma City

Anna Ardoin (OKC) Pediatrics
OU College of Medicine
Oklahoma City

Ashley Bailey (OKC) Neurology
Barrow Neurological Institute at SJHMC
Phoenix, AZ

Brandon Baker (OKC) Pediatrics
OU College of Medicine
Oklahoma City

Jacob Bardell (OKC) Urology
University of Kansas Medical Center
Kansas City, KS

Christopher Barker (OKC) Anesthesiology
OU College of Medicine
Oklahoma City

About the Cover

Annah Baykal (OKC) Ophthalmology
OU College of Medicine
Oklahoma City

Jeremy Bernhardt (OKC) Orthopaedic Surgery
OU College of Medicine
Oklahoma City

Anisha Bhanot (OKC) Medicine-Preliminary
OU College of Medicine
Oklahoma City

Gabriel Bolender (SCM) Internal Medicine
OU College of Medicine
Tulsa

Adam Bouvette (OKC) Internal Medicine
OU College of Medicine
Oklahoma City

Philip Boyne (OKC) Medicine-Preliminary
HCA Healthcare/USF Morsani GME-Citrus
Inverness, FL

Steven Bozell (OKC) General Surgery
University of New Mexico SOM
Albuquerque, NM

Jordan Brannan (OKC) Pediatrics
OU College of Medicine
Oklahoma City

Continues on page 14 …

William Patrick Browne (OKC) Surgery-Preliminary
OU College of Medicine
Oklahoma City

Blake Bulard (OKC) General Surgery
University of South Florida Morsani COM
Tampa, FL

Virginia Busby (OKC) Pediatrics
Case Western/University Hospitals
Cleveland Medical Center
Cleveland, OH

Dylan Cannon (OKC) Orthopaedic Surgery
OU College of Medicine
Oklahoma City

Hunter Chalfant (OKC) General Surgery
University Hospitals
Columbia, MO

James Charles (SCM) General Surgery
Louisiana State University SOM
New Orleans, LA

Ameel Chaudhary (OKC) Family Medicine
Northwestern McGaw/NMH/VA-IL
Geneva, IL

Preston Choi (OKC) Ophthalmology
University of Texas Southwestern
Dallas, TX

Ryan Christie (SCM) General Surgery
OU College of Medicine
Tulsa

Adam Chutek (OKC) Pediatrics
Tower Health/St. Christophers Hospital-PA
Philadelphia, PA

Jordan Conley (OKC) Family Medicine
HealthONE
Aurora, CO

Deanna Dang (OKC) Ophthalmology
OU College of Medicine
Oklahoma City

Bailey Davis (OKC) Psychiatry
OU College of Medicine
Oklahoma City

John Dooley (SCM) Family Medicine
CHRISTUS Health
Corpus Christi, TX

Madeleine Duarte (OKC) Pediatrics
Oregon Health & Science Center
Portland, OR

William Dudney (SCM) Family Medicine
OU College of Medicine
Tulsa

Caleb Duggan (OKC) Transitional
St. Anthony Hospital
Oklahoma City
Radiology-Diagnostic
INTEGRIS Health
Oklahoma City

Jaisa Evanoff Kaufmann (OKC) Urology
OU College of Medicine
Oklahoma City

Emily Ferrari (SCM) Emergency Medicine
Hennepin County Medical Center
Minneapolis, MN

Hunter Ford (OKC) Surgery-Preliminary
UC Davis/Travis AFB
Travis AFB, CA

Jacob Fox (OKC) Orthopaedic Surgery
Vanderbilt University Medical Center
Nashville, TN

Emily Frech Preciado (OKC) Internal Medicine
NYP Hospital-Weill Cornell Medical Center
New York, NY

Andre Galis (OKC) Med-Prelim/Nuerology
Zucker SOM-Northwell Lenox Hill Hospital
New York, NY
Nuerology
Zucker SOM-Northwell Staten Island University
Staten Island, NY

James Gatewood (OKC) Child Neurology
University of New Mexico SOM
Albuquerque, NM

Asad Ghani (OKC) Internal Medicine
OU College of Medicine
Oklahoma City

Hussan Gill (SCM) Internal Medicine
OU College of Medicine
Oklahoma City

Amy Gin (OKC) Surgery-Preliminary
OU College of Medicine
Oklahoma City

Victoria Gonzalez (OKC) Surgery-Preliminary
University of Colorado SOM-Denver
Aurora, CO

Ashton Gores (SCM) Psychiatry
Johns Hopkins Hospital
Baltimore, MD

Ryan Grantham (OKC) Psychiatry
OU College of Medicine
Oklahoma City

Erin Grey (OKC) Neurology
OU College of Medicine
Oklahoma City

Joshua Hardage (OKC) Internal Medicine
OU College of Medicine
Oklahoma City

Catherine Harlan (OKC) Anesthesiology
OU College of Medicine
Oklahoma City

Jeffrey Harman (OKC) Family Medicine
University of Wyoming
Cheyenne, WY

Matthew Hart (OKC) Family Medicine
INTEGRIS Health
Oklahoma City

Landon Hester (OKC) Psychiatry
University of Nevada Reno SOM
Reno, NV

Kyle Hickey (OKC) Medicine-Preliminary
OU College of Medicine
Oklahoma City

Natalie Hills Chakraborty (OKC) Surgery-Preliminary
Case Western/University Hospitals
Cleveland Medical Center
Cleveland, OH

Erik Holbrook (OKC) Family Medicine
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Savannah, GA

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Jackson, MS

Kendall Hughes (OKC) Ophthalmology
University of Texas
Houston, TX

Alexandra Hylton (OKC) Anesthesiology
OU College of Medicine
Oklahoma City

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Juyoung Sam Inn (OKC) Pediatrics
Phoenix Childrens Hospital
Phoenix, AZ

Christopher Jarrett (SCM) General Surgery
HCA Healthcare Kansas City
Overland Park, KS

Jane Jarshaw (SCM) Pathology-Anatomic and Clinical
Mayo Clinic School of Graduate Medical Education
Rochester, MN

Tyler Jones (OKC) Internal Medicine
UMass Chan Medical School
Worchester, MA

Jessica Justus (OKC) Pediatrics
Baylor Scott & White Medical Center
Temple, TX

Mason Kennon (SCM) Psychiatry
HealthONE
Lone Tree, CO

Omar Khattab (SCM) Internal Medicine
Kettering Health Network
Kettering, OH

Audra King (OKC) Surgery-General
University of North Dakota SOM
Grand Forks, ND

Jacob Klamm (OKC) Pediatrics
Brooke Army Medical Center
San Antonio, TX

Uday Kohli (OKC) Neurology
University of Utah Health
Salt Lake City, UT

Adam Konen (OKC) Psychiatry
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OU College of Medicine
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Matthew Krutz (OKC) Otolaryngology
OU College of Medicine
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Michael Kutteh (OKC) Surgery-Preliminary
OU College of Medicine
Oklahoma City

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San Francisco, CA

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Salt Lake City, UT

Amanda Roehrkasse (OKC) Neurological Surgery
National Institute of Health
Bethesda, MD

Jacob Rogers (OKC) Family Medicine
Oregon Health & Science University
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Ohio State University Medical Center
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Rachel Synar (SCM) Emergency Medicine
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Tulsa

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Bomaonye Tienabeso (OKC) Internal Medicine
Oklahoma State University Center for Health Sciences
Stillwater

Oliver Ting (OKC) Family Medicine
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Los Angeles, CA

Cassandra Velasco (OKC) Pediatrics
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Oklahoma City

Travis Vernier (OKC) Surgery-Preliminary
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Ashley Vo (OKC) Family Medicine
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Oklahoma City

Colton Want (OKC) Family Medicine
INTEGRIS Health
Oklahoma City

Elizabeth Wells (SCM) Surgery-Preliminary
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Anesthesiology
Brown University/Rhode Island Hospital
Providence, RI

Alison Westrup (OKC) Neurological Surgery
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Oklahoma City

Marielle Wilkerson (OKC) Obstetrics-Gynecology
University of Texas HSC
San Antonio, TX

Caleb Wilson (OKC) Otolaryngology
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Winston-Salem, NC

Yung Shu Wong (OKC) Anesthesiology
University of Alabama Medical Center
Birmingham. AL

Summer Wright (OKC) Family Medicine
OU College of Medicine
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Law and Medicine

2022 CDC Guideline for Prescribing Opioids

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

In 2016, the CDC Guideline for Prescribing Opioids for Chronic Pain were issued.[1]

In January 2020, the advisory CDC Opioid Workgroup (OWG) was appointed by the Board of Scientific Counselors (BSC) of the CDC to oversee and evaluate a new revision draft of the CDC guidelines for prescribing opioids.

On July 16, 2021, the Board of Scientific Counselors (BSC) of the CDC National Center for Injury Prevention and Control (NCIPC) held a public meeting to review the draft findings by the CDC OWG.[2]

The final revised CDC guidelines are expected to be published in July 2022. The following are the twelve recommendations verbatim:

1. **ACUTE PAIN**
   "Nonopioid therapies are preferred for many common types of acute pain. Clinicians should consider opioid therapy for acute pain only if benefits are anticipated to outweigh risks to the patient."

2. **SUBACUTE AND CHRONIC PAIN**
   "Nonopioid therapies are preferred for subacute and chronic pain. Clinicians should only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient.

   Before starting opioid therapy for subacute or chronic pain, clinicians should discuss with patients known risks and realistic benefits of opioid therapy, should establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. If opioids are used, they should be combined with other therapies as appropriate."

3. **IMMEDIATE-RELEASE AND EXTENDED-RELEASE OPIOIDS**
   "When starting opioid therapy for acute, subacute, or chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids."

4. **OPIOID-NAÏVE PATIENTS**
   "When opioids are started for opioid-naïve patients with acute, subacute, or chronic pain, clinicians should prescribe the lowest effective dosage.

If opioids are continued for subacute or chronic pain, clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to > 90 MME/day."

Continues on page 26 …

5. LEGACY PATIENTS ON OPIOIDS

"For patients already receiving higher opioid dosages (eg, >90 MME/day), clinicians should carefully weigh benefits and risks and exercise care when reducing or continuing opioid dosage.

If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids."

6. THE 3-7 DAY PRESCRIPTION LIMIT

"When opioids are used for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. One to three days or less will often be sufficient; more than seven days will rarely be needed."

7. ONGOING OPIOID THERAPY

"Clinicians should continue opioid therapy for subacute or chronic pain only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for subacute or chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently."

8. OPIOID RISKS, OVERDOSE, AND RELATED HARMS

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss with patients.

Clinicians should incorporate into the management plan, strategies to mitigate risk, including offering Naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present."

9. DRUG MONITORING

"Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose.

Clinicians should review PDMP data when starting opioid therapy for acute or chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months." July 2021 CDC OWG Draft Recommendation #10:

10. DRUG TESTING

"When prescribing opioids for chronic pain, clinicians should use drug testing before starting opioid therapy and consider drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs."

11. BENZODIAZEPINES AND OPIOID USE DISORDER: DRUG-DRUG INTERACTIONS

"Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants."

12. PATIENTS WITH OPIOID USE DISORDER

"Clinicians should offer or arrange treatment with medication for patients with opioid use disorder."

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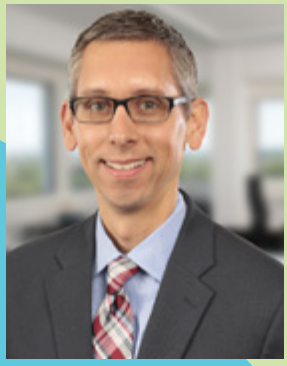
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DIRECTOR'S DIALOGUE

Summertime, and the Livin' is Easy

Recently, someone inquired about our summer activities in the office since there are few meetings and events. The OCMS staff is constantly on the go – and with a staff of two we never really have 'down time.'

One of our focuses this summer is reinstating our Physician Collegiality Dinners. Our dinners focus on many unique issues that impact physicians with networking, collegiality and dinner. We are working on several, including one that is focused on newly retired physicians and a repeat of our incredibly successful Women in Medicine dinner.

Community is another focus of our summer activities. OCMS collects donations for its Community Foundation, which benefits worthy organizations in Oklahoma County and is awarded 100% from member donations. Your donations benefit organizations like Special Care, The CARE Center, Health Alliance for the Uninsured, the Independent Transportation Network and more.

This summer, OCMS staff will also be developing a database of non-members. June and July are when OCMS prepares for upcoming billing and recruitment is on the forefront of our minds. Longtime Executive Director Jana Timberlake painstakingly created a database of practices around Oklahoma City, and it's our goal to build on the list she created to appeal to groups that are physician owned and demonstrate the benefits of membership in OCMS and OSMA combined. If you are a member of a physician-owned group, we would love your support through this process.

We are prepping for our highly rated Physicians Leadership Academy (PLA), which is holding its first session in August. Designed by OCMS, PLA targets current and future physician leaders. The curriculum is designed by physicians to equip, educate, and empower physicians as they take on increasing leadership and administrative responsibility. Our alumni have become enterprise-wide leaders. Our goal is to develop leadership skills so that physicians may advance their careers, bolster the physician community, and improve health care in Oklahoma. It is led and moderated by physicians. I ask you to encourage colleagues to apply through our website.

In the summer, the OCMS Board election takes place – check your emails for the ballot. Better yet, consider running for election in the future to represent the interests of physicians in Oklahoma County. We are always seeking leaders from across the metro area.

Last, but certainly not least, the summer season ends with collecting dues from the people we value the most – you, our member. Dues are the most integral part of our day-to-day activities at OCMS, and we value every member. It is incredibly important to us to represent you as the only organization in OKC designed for all physicians who practice in Oklahoma County, no matter the specialty.

If you opt for a vacation this summer and realize you need therapy to help you achieve your goals, manage your work/life balance, and deal with stress, our Physician Wellness Program is available to all Oklahoma County physicians and provides free counseling sessions. Confidential and private. Full disclosure – I am taking my first vacation since 2018 and I hope you take time for yourself, too. The last few years have been incredibly stressful, and we all need a moment to recharge and reconnect. Maybe listen to some "Summertime" covers.

WILLIAM HUSEL, MD | VERDICT:

On April 20, 2022, Dr. Husel, was found not guilty on all 14 murder charges and lesser charges of attempted murder. He would have faced a sentence of life in prison with parole eligibility in 15 years had he been found guilty of just one count of murder.

- Defense attorney Diane Menashe said, "I mean my reaction is 'what an incredible moment,' not just for William Husel but, let me pause there for Dr. William Husel, a moment he deserves you know he had faced face this whole time."
- Defense attorney Jose Baez said, "This was a scary trial for me and for all of us involved because we knew what was at stake. It was the future of comfort care. And the future of many healthcare professionals to put their lives at risk for us, daily and over the last two years. If there's anything we've seen it's that."
- Judge Michael Holbrook said jurors told him that the procedures for the dispensing of fentanyl and other drugs at Mount Carmel weren't properly explained to them during the trial, and that they were confused by the large number of prosecution witnesses. And he said that the jurors were confused that no one had stated a maximum dosage for fentanyl.
- The prosecutors in the case accepted the verdict without additional comment.

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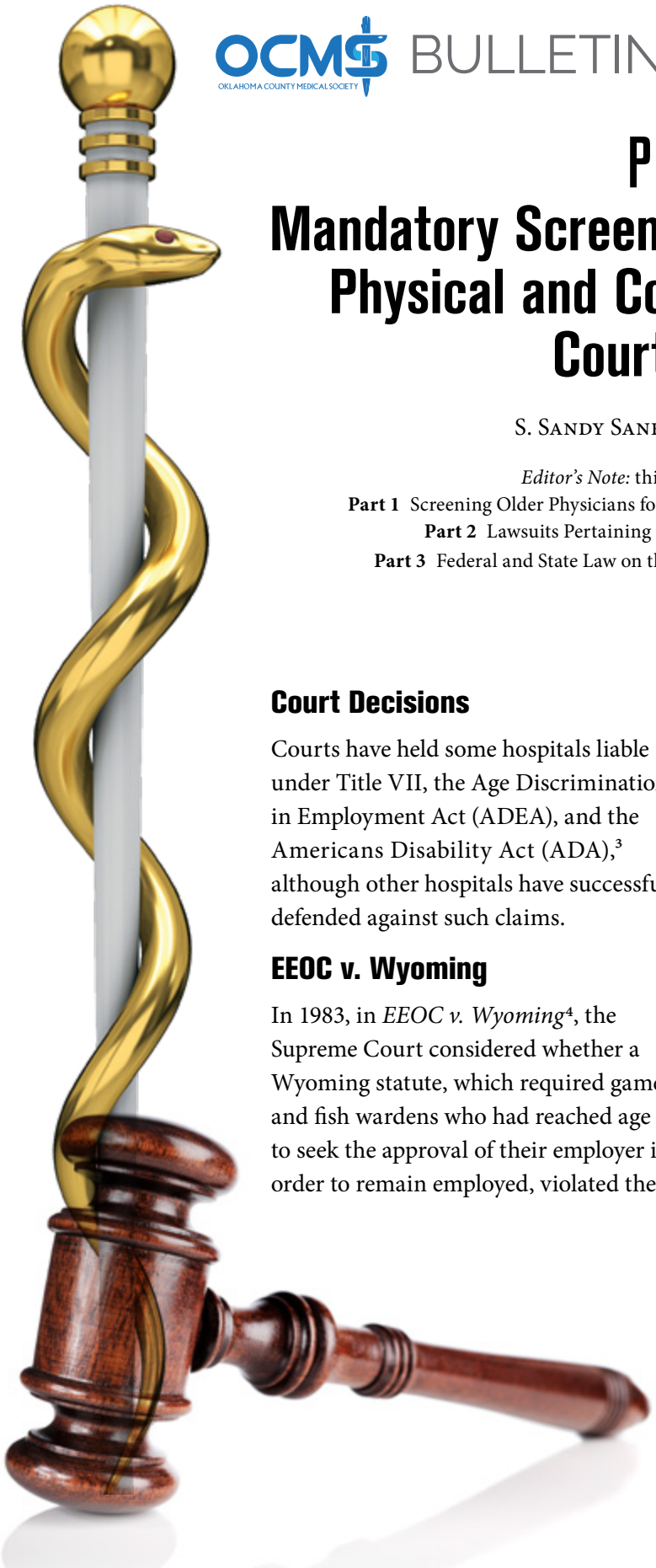

PART 4:
Mandatory Screening Older Physicians for Physical and Cognitive Impairment – Court Decisions

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

Editor's Note: this is Part 4 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**

Court Decisions

Courts have held some hospitals liable under Title VII, the Age Discrimination in Employment Act (ADEA), and the Americans Disability Act (ADA),[3] although other hospitals have successfully defended against such claims.

EEOC v. Wyoming

In 1983, in *EEOC v. Wyoming*[4], the Supreme Court considered whether a Wyoming statute, which required game and fish wardens who had reached age 55 to seek the approval of their employer in order to remain employed, violated the ADEA. The Court stated that, "Wyoming] remain[s] free under the ADEA to continue to do precisely what [it is] doing now, if [it] can demonstrate that age is a **"bona fide occupational qualification"** [BFOQ] for the job of game warden..."

Trans World Airlines v. Thurston

In 1985, in *Trans World Airlines v. Thurston*[5], the Supreme Court found TWA guilty of age discrimination for refusing to transfer pilots to the position of flight engineer after they reached age 60, which was the Federal Aviation Administration's (FAA's) mandatory retirement age for pilots. TWA had allowed younger pilots who had become disabled to transfer automatically to the position of flight engineer, but did not allow pilots and copilots past the age of 60 to do the same. The Court held that the airline must give the same opportunity to retiring pilots and copilots as it had given to younger disabled pilots.

Western Air Lines v. Criswell

Western Air Lines required flight engineers, who were members of the flight crew but generally did not operate flight controls, to retire at age 60. The Western Air Line policy was challenged, but the airline maintained that the age limit was a BFOQ ***(bona fide occupational qualification)*** necessary to ensure safety.

In 1985, in *Western Air Lines v. Criswell*[6], the Supreme Court disagreed and set out guidelines for defending an age limit based on the BFOQ exception. In a unanimous decision, the Court announced a two-pronged test to be applied when evaluating a BFOQ based on safety:

1. Whether the age limit is reasonably necessary to the overriding interest in public safety; and
2. Whether the employer is justified in applying the age limit to all employees rather than deciding each case on an individual basis.

Public Employees Retirement System of Ohio v. Betts

In 1989, in *Public Employees Retirement System of Ohio v. Betts*[7], the U.S. Supreme Court overturned a series of courts of appeals decisions, including EEOC and Labor Department regulations that required employers to justify any age-based distinctions in employee benefit plans by showing a ***"substantial business purpose."*** In Betts, the Court shifted the burden of proof to the plaintiff to show that the disputed plan was a «subterfuge» for discrimination.

Hoffmann-LaRoche v. Sperling

Also in 1989, in *Hoffmann-LaRoche v. Sperling*[8] the Supreme Court relaxed the procedural rules governing class actions alleging age discrimination. The Sperling decision made it easier for plaintiffs to join a class action suit against an employer after the suit has been filed.

Public Employees Retirement System of Ohio v. Betts

In 1990, the U.S. Congress responded to the decision in Public Employees Retirement System of Ohio v. Betts with a compromise between employee advocates and business interests. Congress amended the ADEA with the Older Workers Benefit Protection Act (OWBPA)9 which prohibits discrimination against older employees in the provision of fringe benefits unless the benefit differences are due to age-based differences in cost.

EEOC v. Commonwealth of Massachusetts

In 1993, in *EEOC v. Commonwealth of Massachusetts*[10] the U.S. Court of Appeals, First Circuit, overturned the district court that sided with the state and granted a summary judgment. Massachusetts required all

Continues on page 32 …

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.

state employees to undergo a physical examination at age 70 in order to keep their jobs. The appellate court stated, "That was exactly the type of arbitrary age discrimination that the federal age discrimination employment act was enacted to prohibit." The Court stated that,

> "… the Commonwealth of Massachusetts allows age to be the determinant as to when an employee's deterioration will be so significant that it requires special treatment. Such a conception of and use of age as a criterion for decline and unfitness for employment strikes at the heart of the ADEA. The entire point of the statute is to force employers to abandon previous stereotypes about the abilities and capacities of older workers. Employers may still regulate and condition employment, but they may no longer immediately turn to age as a convenient, simple criterion. They must be prepared to justify their use of age rather than individualized factors."

The Court of Appeals held that,

> "…no employer may discriminate against any individual because of age with respect to compensation, terms, conditions or privileges of employment, while at the same time requiring employees seventy years of age or older to pass an annual medical examination as a condition of continued employment…"

EEOC v. Exxon Mobile Corporation

In 2014, The EEOC challenged Exxon's mandatory retirement policy requiring its corporate pilots to retire at age sixty as a violation of the ADEA. Exxon asserted a BFOQ as an affirmative defense and relied on a similar rule utilized by the FAA (Federal Aviation Administration) for commercial pilots. Following a summary judgment in favor of Exxon Mobil Corporation[11], based on BFOQ, the EEOC appealed.

A panel of the U.S. Court of Appeals for the Fifth District reversed and remanded the case for additional discovery and a decision addressing the full BFOQ analysis.

Evidence showed that the Age 60 Rule had remained intact until 2007, when Congress passed the Fair Treatment for Experienced Pilots Act (FTEPA). The Act repealed the FAA's Age 60 Rule and generally permitted pilots to fly until age 65;[12] that was applicable only to operations and not piloting. Subsequently, the FAA placed this change in its regulations[13].

On remand, the district court allowed additional discovery but again granted summary judgment to Exxon. The EEOC appealed again, but the appellate court affirmed the district court. The Court of Appeals concluded that Exxon had established that its mandatory age retirement rule was a BFOQ, and the EEOC had not demonstrated a genuine issue of material fact.

And as of October 2021, the EEOC v. New Haven Hospital case is still pending.

[1]https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm Center for Disease Control and Prevention, Recommendations and Reports / March 18, 2016 / 65(1);1–49

[2]https://www.cdc.gov/injury/pdfs/bsc/BSC_NCIPC_Meeting_Minutes_7_16_2021_Final.pdf NCIPC Board of Scientific Counselors Open to the Public July 16, 2021, National Center for Injury Prevention and Control Centers for Disease Control and Prevention, Atlanta, Georgia

[3]Michael R. Lowe, Stirring Muddled Waters: Are Physicians with Hospital Medical Staff Privileges Considered Employees under Title VII or the ADA Act When Alleging an Employment Discrimination Claim?, 1 DePaul J. Health Care L. 119, 121 (1996), https://via.library.depaul.edu/cgi/viewcontent.cgi?article=1295&context=....

[4]460 U.S. 226, 103 S.Ct. 1054, 75 L.Ed.2d 18 (1983)

[5]469 U.S. 111, 105 S. Ct. 613, 83 L. Ed. 2d 523 (1985)

[6]472 U.S. 400, 105 S. Ct. 2743, 86L. Ed. 2d 321 (1985)

[7]492 U.S. 158, 109 S. Ct. 2854, 106 L. Ed. 2d 134 (1989)

[8]493 U.S. 165, 110S. Ct. 482, 107 L. Ed. 2d 480 (1989)

[9]29 U.S.C.A. § 626

[10]987 F.2d 64

[11]http://www.ca5.uscourts.gov/opinions%5Cunpub%5C13/13-10164.0.pdf

[12]49 U.S.C. § 44729

[13]14 C.F.R. § 121.383(d)(1)

IN MEMORIAM

Mary Lloyd FROW

January 13, 2022

Mary Lloyd Apple Frow, of Oklahoma City, was born in Tulsa to parents, Harold and Nell Apple. She died on January 13, 2022. She was a graduate of Tulsa Central High School, Oklahoma Christian University, and Oregon State University. Mary taught middle and high school science in Thackerville, Yukon, and Putnam City. She married Frank Roy Frow in August of 1970. In 1976, Mary Lloyd made the bold (and pioneering) decision to enter the University of Oklahoma Medical School. She was a teacher at heart, so it wasn't surprising to those who knew her that she brought this passion for teaching into her Family Medicine practice. She especially cherished delivering babies and selflessly helped those who needed it without regard to their ability to pay. Mary is preceded in death by her husband, Frank; parents; and an infant brother. She is survived by her daughters, Emily and Susan; son, Michael; and her siblings, Linda (Don), Milton (Jan), and Janie. Viewing was held January 22 at St. Benedict Orthodox Church (3900 Jones Blvd, Oklahoma City, OK 73135) with the Funeral Service after. Burial followed at Memorial Park Cemetery. In lieu of flowers, donations can be made to OkCity Crisis Nursery (2524 NW 52nd St, Oklahoma City, OK 73112).

Kent Harris WEBB, M.D.

January 18, 1957 – March 6, 2022

Kent Harris Webb, M.D., 65, of Nichols Hills, Oklahoma, went to be with the Lord on March 6, 2022.

Kent was born January 18, 1957 in Guthrie, Oklahoma, to Charles Wesley Webb and Kay Donna Webb. He spent his early childhood in Texas and his high school years in Edmond, Oklahoma. Throughout his youth, baseball played a dominant role and he developed into an accomplished pitcher, playing for the Edmond Memorial Bulldogs. He attended the University of Oklahoma, where he was a member of Sigma Alpha Epsilon fraternity and served as chapter president. The friendships Kent formed with his fraternity brothers were some of his most cherished relationships and lasted a lifetime. Following undergraduate at OU, he attended the OU College of Medicine.

Upon graduation from medical school, Kent established his practice in Oklahoma City. He became a highly skilled general and vascular surgeon and member of the American College of Surgeons. Kent's selfless dedication to the care of others guided his entire adult life. Following a pulmonary injury in 2010, Kent was unable to continue his practice as a general surgeon, but he moved forward with a positive attitude and resilience – a testament to his tenacity and love of life. Kent continued practicing medicine until shortly before his passing. Kent was a generous man who was known for his kindness and good humor. His Christian faith and beliefs guided him, and he often shared encouraging Bible verses with family and friends, and prayed with patients and their families. Kent is survived by his wife Devorah, and his five children: Jessica, Aubrey, Connor, Victoria and Solomon; his brother, Drew; and many wonderful friends. The Celebration of Kent's life was held Saturday, March 12, at Matthews Funeral Home, in Edmond. Interment followed at Summit View Cemetery, 1808 N Pine St, Guthrie, OK.

A Worthless Death

by Hanna A. Saadah, MD

Oklahoma City VA Hospital, 2019

"I don't know what to do with him," said the emergency-room physician. "He's not imminently dying and doesn't meet criteria for admission."

"We can admit him to our Palliative Care Unit (PCU) while we make arrangements for nursing-home hospice," I suggested.

"He doesn't want to go to a nursing home and doesn't want to die at home alone."

Mr. Sterben Leiden was an unmarried, childless, live-alone, 82-year-old Veteran, dying of Merkel Cell Carcinoma. When he could no longer care for his dog, home, and self, he gave his dog and belongings to his neighbor (who was not his friend) and came to the VA Hospital to die.

When I explained to him that he was not imminently dying, that we cannot keep him more than three weeks in our PCU, and that we will have to move him to a nursing home with hospice, he protested.

"Then help me get it over with while I'm here, Doc."

"What do you mean?"

"I know that I'm dying too slowly, but I don't want to die in a nursing home. Why don't you be merciful and help me die quickly instead?"

"I can't do that, Mr. Leiden."

"We euthanize dogs, for God's sake," he barked. "Treat me like a dog; that's all I ask."

⚜

At the PCU, Mr. Leiden and I had daily conversations. His mind, after an uneventful life, echoed with worthlessness. He said that he had never had a girlfriend, never fallen in love, never married, never seen combat, never been to church, and never held an important position. After high school and thirty-four years in the Army, he worked as a security guard in sundry establishments. Having no friends, no hobbies, no passions, and no faith, he lived a reclusive life of platitudes, spending his free time reading magazines and watching television.

"Doc, I've nothing to live for and nothing to die for. Living is hard and few people do it well. Dying must be easy because everyone does it. Why don't you just help me do it so I can be done with it?"

Mr. Leiden lived, dreaming of death, not because death would lead to heaven or would end his suffering, but because it would end his feelings of worthlessness. I had trouble finding a counterargument to his worldview. Since he felt that he had led a "worthless life," hoping for a meaningful death never occurred to him. Happy at having terminal cancer, which provided him with the honorable discharge he needed, he now wanted to hurry up and get it over with.

His underdeveloped sense of worth mirrored by an equally underdeveloped ego offered him no alternatives. Thinking logically but from the wrong starting point caused him to arrive at the wrong conclusion, and there was nothing I could do to change his mindset. Dying was his ticket out of a "meaningless life" and that's what he wanted. The words of Simone Weil, a French philosopher-rebel, who died of tuberculosis in 1943 at the young age of 34, echoed in my ears:

"Death is the most precious thing which has been given to man. That is why the supreme impiety is to make bad use of it. To die amiss."

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Laboring under the heft of Mr. Leiden's moral dilemma, I began to feel that I was the one who really needed help. My aching conscience could not countenance Mr. Leiden's wish to seal his "meaningless life" with an equally "meaningless death." Dr. Nadel Kunst, our PCU psychologist, came to my mind because on similar occasions she had helped me with ethical dilemmas that were equally vexing.

She was on the phone, having a death-and-dying discussion with a patient's daughter, when I walked into her office, wearing an anguished aspect. Scanning my face with circumspect eyes, she motioned for me to take a seat. When her conversation ended, she sighed and knowingly asked, "So, what's bothering you this time, Doctor?"

When I finished relating Mr. Leiden's story, she shook her head and said, "That's not possible."

"What's not possible?" I asked, a bit bewildered.

"Nature does not constitute such men."

"I'm lost, Dr. Kunst. What are you trying to tell me?"

"I'm telling you that Mr. Leiden is not telling the whole truth. Our ego defenses, which are mighty, are constituted to magnify self-worth, not to diminish it. Even when the entire world thinks that someone is worthless, that one person will continue to esteem himself as a misunderstood paragon of the highest worth."

"So, what you're telling me is that Mr. Leiden is concealing something?"

" 'The truth is rarely pure, and never simple,' said Oscar Wilde. Your patient is hiding behind convenient illusions and concealing many more things than you realize, Doctor. Hardly a man passes through youth without having sex and falling in love—and hardly a man grows old without friends, interests, desires, biases, and beliefs. Mr. Leiden has buried his secrets deep within his unconscious mind so that he would not have to deal with them. I don't think he's aware that he's hiding anything, though. If he were, he would be in continuous emotional torment. His mind is just like a dusty, old attic in which one puts away things that one no longer wishes to see but, nonetheless, things that one is unable or unwilling to discard. Once they are tucked away into that dusty attic, they are soon forgotten, never to be again remembered unless one is forced to do an attic search.

'In the practical use of our intellect, forgetting is as important as remembering,' said William James.' "

"So, the reason he's seeking a quick death is because death insulates him from life and ensures absolute, irrevocable oblivion?" I philosophized, trying to match her intimidating, psychoanalytical and literary wit.

Instead of answering me, Dr. Kunst simply stood up, smirked, and said, "Let us go and make our visit." Then, in passing, she recited the first stanza from T. S. Eliot's Love Song of J. Alfred Prufrock:

" 'Let us go then, you and I,
When the evening is spread out against the sky …
Oh, do not ask, What is it?
Let us go and make our visit.' "

On the way to Mr. Leiden's room, I asked Dr. Kunst how I should introduce her, knowing that I had not prepared Mr. Leiden for the consult. Rather than responding, she shrugged her shoulders and hastened her pace.

"Mr. Leiden, I have with me Dr. Nadel Kunst, our CLC Professor of Psychology, who is here to help us make some important decisions about your care."

Mr. Leiden seemed astonished but not because of Dr. Kunst's comely, commanding stature, nor because of her almond-blossom smile. His aspect was that of a lost soul who has just had an epiphany.

While I shadowed in the background, Dr. Kunst gracefully sat at Mr. Leiden's bed, held his hand, smiled blue with her eyes, and whispered, "Are you having a good morning, sir?"

"Oh, yes, yes, Doctor. Thank you for asking," he blurted out.

"May I ask you a few questions, then?"

"Sure, Doctor, sure," said Mr. Leiden, straightening his position in bed as if readying himself for a television interview.

"At what age did you join the Army?"

"I was eighteen, ma'am."

"Um, that was 1954, wasn't it?"

"Yeah, one year before the Vietnam Conflict began."

"You had a high-school sweetheart when you joined, didn't you?"

Mr. Leiden's words froze between his pale-blue lips.

"Do you remember her name?"

After a long, solemn pause, tears welled in Mr. Leiden's vacuous eyes and, unwiped, dripped down his cheeks. Dr. Kunst handed him a tissue, which he received with tremulous fingers. Shadowing behind the scene, I eased myself into a corner chair and watched the magic of a seasoned interviewer scroll before my eyes.

"Do you remember her name?" Dr. Kunst asked again.

Mr. Leiden stuttered a long, lingering sigh. His lips quivered with unsaid words. Then, all of a sudden, he covered his eyes with both hands and burst into uncontrollable sobbing, which took a long time to die down.

Silence like a distant airplane droned, bespeaking the solemnity of the moment.

"What was her name?" whispered Dr. Kunst.

"Linda Marquez," he whispered back, then as an afterthought, he added, "and we shared the same birthdate."

"Linda means beautiful in Spanish. Was she Colombian?"

Mr. Leiden, seeming astonished that Linda's nationality was known to Dr. Kunst, nodded a meek yes.

"Would you like to tell me about her?"

"No," he replied, assertively shaking his head.

"In that case, would you like me to leave you to your thoughts and perhaps return later?"

"No," he assertively shook his head again, tightening his clasp on Dr. Kunst's hand.

"Did you love her?"

"Uh-huh," he nodded.

"Did you love her a lot?"

"Uh-huh," he nodded again, taking a deep, doleful breath.

"What happened to her?"

"I lost her."

"Why?"

An uncertain, pensive pause furrowed across Mr. Leiden's face, lingering for a long, long while. Then, his lips pursed, his eyes blinked, and his breaths became deep and rapid like a diver, preparing for a deep dive. Dr. Kunst patiently stroked his hand as a solemn smile shone from her kind, calming face. It was a shared moment of reflection with each of us having different thoughts about that very same "Why?"

"When I returned from my first tour in Vietnam," stuttered Mr. Leiden, "I got, I got, ah."

"Did you get drunk?"

A yes nod.

"Did you have a fight with Linda?"

Another yes nod.

"Did you hit her?"

In response, Mr. Leiden burst into loud, screeching sobs and could not stop. Dr. Kunst knelt her head down as if in prayer and let his avalanche of tears flow down his face, inundating his shirt, his sleeves, and his bed sheets. This cataclysmic catharsis continued unabated until he ran out of tears and his eyes, glazed with remorse, stared like a searchlight into his deep, dark, dusty attic.

"Mr. Leiden, you need to rest now," whispered Dr. Kunst, as she tried to withdraw her hand. "I'll return later to finish our conversation."

"No," he pleaded, tugging tighter on her holding hand. "I'm not finished yet."

Mr. Leiden's painful confession lasted a longsuffering hour. Back from his first tour in Vietnam, he went out with the boys and returned intoxicated to find Linda worried and extremely upset. They had a terrible argument and "she started wailing like them Vietnamese women when we would overrun their little villages." When he couldn't stop her Vietnamese wailing, he lost his temper, hit her, and then he collapsed into bed. When he awakened the next morning, Linda was gone

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and so were her clothes and her few belongings. She left no note and he never could find her.

Heartbroken, he volunteered for five more tours in Vietnam, hoping he would get killed. Many of his friends were, but he escaped unscathed. When, after thirty-four years in the service he returned to civilian life, he felt like a released prisoner let out into a world that he no longer understood and no longer belonged to. His parents had died, he was an only child, his friends were all married and gone, and what was left of life had no meaning left in it.

He still carries a picture of Linda Marquez in his billfold, still thinks about her many times a day, and still hopes to find her to explain what Vietnam had done to him and to say how remorseful he had been ever since their fateful, sixty-year-old argument.

He became elated when he found out that he had cancer because it was a certain way out of his silent suffering, a suffering that had festered and sprawled all over his life, a suffering that was caused by not knowing his Linda's fate, a most bitter unknown that he no longer could endure.

Dr. Kunst's last words to him before he let go of her hand were, "Just give me some time to think about all this. I'll be back soon."

"What do you have in mind?" I asked Dr. Kunst as we walked back to her office.

"I have to find his Linda."

"If she's still alive, she would be eighty-two. She could be demented or sick or back in Colombia."

" 'Ultimately, literature is nothing but carpentry. With both, you are working with reality, a material just as hard as wood.' "

"What on earth does this mean?" I asked, feeling frustrated.

"It's a quote from Gabriel Garcia Marquez."

"Who on earth is Gabriel Garcia Marquez?"

"The Colombian author who was awarded the Nobel Prize for Literature for his masterpiece novel, *One Hundred Years of Solitude*. Mr. Leiden has had sixty years of solitude and the name of his Colombian girlfriend was Linda Marquez. Do you see the connection?"

"Was it the Marquez name that helped you surmise that Linda was Colombian?"

"It was a good guess, you must admit."

"For a while, you sure had me baffled."

Dr. Kunst sat down behind her desk and nervously scribbled on a yellow sheet of paper. She appeared to be in a pressured moment, perhaps reflecting on what Mr. Leiden had said and on what she could possibly do to help him.

After a few minutes of intense thinking, she raised her eyes, glanced at my baffled face, threw her paper and pencil into the trash, and announced:

"No Veteran should die alone, and no Veteran should die feeling worthless or unloved. I am going to find Linda Marquez because she holds the key to Mr. Leiden's self-worth."

"And how on earth are you going to find her after sixty years of solitude?"

"I have police connections inside and outside the VA. They'll do everything in their power to save a dying Veteran from loveless worthlessness."

I deferred the investigation of the life and whereabouts of 82-year-old Linda Marquez to Dr. Kunst and went about my work, doubtful that her efforts would prove worthwhile. That Mr. Leiden never had a girlfriend, never fell in love, and never saw combat—were the denials he needed to sustain his pacifying feelings of worthlessness. Feeling worthless protected him from guilt, from remorse, from responsibility, and from the painful processes of a civilian life, which he felt estranged from.

But now, with his mental attic explored and excavated, making rounds on him became a painful routine. Every morning he would ask me if Dr. Kunst had located Linda, the Linda he loved, the Linda he hurt because she wailed like a Vietnamese-village-woman, the Linda who was still as young and as beautiful as the day she left him. Rather than respond to his

lamentations, I inquired about his symptoms and kept him comfortable. I treated his pain, nausea, swelling, headaches, weakness, muscle wasting, imbalance, shortness of breath, and double vision.

Like him, I wanted to know how Dr. Kunst's investigation was proceeding but was afraid to ask. Like him, I began thinking about Linda Marquez several times a day and could not get her off my mind. But, unlike him, I understood that the drama of their last night was a flash explosion of his Post-Traumatic-Stress-Disorder Syndrome. And unlike him, I understood that wailing-like-a-Vietnamese-village-woman was his alarm button, his call-for-action siren, and his combat-reflex trigger. And unlike him, I also understood his protective feelings of worthlessness, feelings that had sustained his sanity, feelings that had been pounded flat by a wood-hard reality.

My doubts became my demons. Did we save him from apathetic worthlessness to condemn him to agonizing guilt? Would he have been better off having a painless, "worthless death" than a painful, remorseful one? My conscience ached each time I visited him, empathized with his interminable pain, rolled over with his tumbling soul, and was scalded by his loveless inferno.

Words from Fyodor Dostoevsky's novel, The Brothers Karamazov, paraphrased themselves out of my memory:

Where is Heaven, asked Alyosha, one of the Karamazov brothers? Heaven is in every one of us, waiting to be reached, answered Father Zossima. What is Hell then, asked Alyosha? Hell is the suffering of being unable to love, answered Father Zossima.

The end of the third week in the PCU portended the transferring of Mr. Leiden to a nursing home with hospice. But I could not face him with the exigencies of this bureaucratic reality. My daily rounds and his dedicated nurses' kind attention provided him with emotional support that the nursing home environment could not emulate. We had become his hospital family, and estranging him from us would be a cruel, undeserved punishment. I pleaded my case with the Chief of Staff, Dr. Stabschef, and she was sympathetic.

"He doesn't have much longer to live. Let's continue to provide him with team compassion. For all that he had been through, we at least owe him a peaceful dying and a painless death."

I never bothered Mr. Leiden with these issues; the less he knew, the more at peace he seemed. Except for an occasional deep discussion, his life and ours had settled into equanimity with salutary routines, courteous conversations, and occasional laughs. Nevertheless, he still asked me about Linda Marquez every morning, and every morning I responded with the same answer: "Since you and she have the same birthdate, surely Dr. Kunst will be able to locate her." That answer not only appeased him, it also gave him hope, which sustained and supported him against his growing frailty.

One Sunday morning, lightning struck and the earth quaked.

"You need to meet us at the hospital."

"Dr. Kunst. I'm not on call this weekend."

"You may not know it, but for Mr. Leiden, you're always on call."

"You found Linda Marquez, didn't you?"

"No, she died in Bogota last year."

"So why do you need me in the hospital then?"

"Because Linda Marquez's grandson is flying in from Houston for the pinning ceremony this afternoon. All arrangements have been made. We need you with us in Mr. Leiden's room at 4 p.m."

"What does Linda Marquez's grandson have to do with Mr. Leiden?"

"Mr. Leiden is his grandfather. Linda found out she was pregnant a few days after she left, but she never answered Mr. Leiden's calls and never told him that she was carrying his child. She did tell her son, though, who his father was, and her son, before he died, did in turn tell his son who his grandfather was. She was so angry with Mr. Leiden that she made both

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son and grandson promise never to contact him, and she clung to her bitter anger until the day she died. I had to do a lot of explaining before the grandson agreed to visit."

"What role would you like me to play in the pinning ceremony?"

"Say something worthy of the occasion."

"Does Mr. Leiden know?"

"I've told him everything and he can't wait to spend time with his grandson. That's all he really cares about now. The other arrangements for the pinning ceremony were left to my discretion."

At 4 p.m. we walked in as a team into Mr. Leiden's room. His grandson, tall and handsome, bore a striking resemblance to his grandfather. Mr. Leiden's sunken eyes popped out of their sockets when he saw Juan, leading the team, wearing full military uniform, holding the American flag, and marching with regular, measured tread.

Struggling against unforgiving gravity, Mr. Leiden, clean-shaven, labored out of bed, steadied himself, stood at attention, and saluted.

The VA chaplain started the ceremony with a reading from Saint Paul, 1 Corinthians 13:4-8:

Love is patient, love is kind. It does not envy, it does not boast, it is not proud. It does not dishonor others, it is not self-seeking, it is not easily angered, it keeps no record of wrongs. Love does not delight in evil but rejoices with the truth. It always protects, always trusts, always hopes, always perseveres. Love never fails …

Next, CLC Nurse Angela sang with her opera voice, O Fortuna from Carl Orff's Carmina Burana:

"O Fortune, like the moon, you are changeable, ever waxing, ever waning …"

Next, Juan read the Soldier's Creed:

"I am an American Soldier.
I am a warrior and a member of a team.
I serve the people of the United States and live the Army Values.
I will always place the mission first.
I will never accept defeat.
I will never quit …"

Next Dr. Kunst pinned the American-Flag button on Mr. Leiden's pajama shirt, presented him with a quilt made by the VA Lady Volunteers, and proclaimed with a voice vibrant with awe:

"Only the deserving receive this quilt, only the honorable, only those who served our country and whose worth to us and the future generations is beyond verbal expression. A soldier lives in our collective consciousness unto infinity; he could never fathom the far-reaching influence of his actions."

Then Dr. Kunst motioned for me to say my few lines, which I had prepared that morning. I read them slowly to give Mr. Leiden enough time to absorb them:

"If we fill our souls with love
We'd have no room for hate;
If we fill our hearts with passion
We'd have no room for apathy;
If we fill our spirits with faith
We'd have no room for despair;
And if we fill our lives with God
We'd have no room for fear."

When the pinning ceremony was concluded, we walked out in the same order we had entered, leaving Juan with his grandfather to fill in the gaps astride sixty years of solitude.

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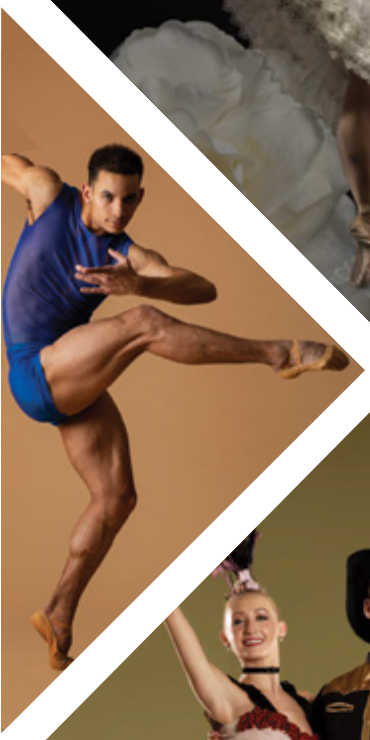

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New-Sky Sonnet

I wish for us to retain our newness
We can't be ordinary and sustain
This vibrant tension and delicious pain
This daily rediscovery of us.
Be new to me each time we talk or touch
Be ever changing, seasonal, like skies
Be different every time we kiss or clutch
I want to find the seasons in your eyes.
Surprise me daily with what you create
Secure my imperfections with your trust
Consume me, force me to regenerate
I wish to shine with you and never rust.
My ever dawning love, crimson my sky
And love will keep us new until we die.

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