



2013 Oklahoma Chapter Scientific Meeting

October 18, 2013

**University of Oklahoma– Samis Education Center
Oklahoma City, Oklahoma**

Highlights include:

Cutting Edge Scientific Presentations:

- **Recurrent Migraines**
- **Handle with Care: New Oral Anticoagulants**
- **Updates in Osteoporosis & Antimicrobials**
- **Advances in Cardiovascular Interventions**

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*Kay Bickham
Executive Director*

**2nd Annual Doctor's
Dilemma Competition
— "Battle of the Turn-
pike". Can Tulsa cap-
ture the trophy from
Oklahoma City??**

**Residents and Fellows
Poster Competition.**

Awards Presentation

**Choosing Wisely: High
Value Cost- Conscious
Care**

**Join your colleagues
Visit the new Samis
Education Center in the
University of Oklahoma
Health Sciences Center**

Inside this issue:

	Page
Governors letter — James Baker, MD, FACP	2—3
ACP Leadership Day by Dr. Matlock Jeffries	4
Editorial by Dean Drooby MD,FACP	5
Editorial by Vermont Senator Bernie Sanders	6
Tribute to Eldon V. Gibson	7
Tulsa Residents attend Annual Session in S.F.	8—9
Protect Children and Families	10
Pictures from San Francisco	11
Agenda for Oklahoma Chapter Annual Meeting — October 18, 2013	12

Registration will be online.

A thirty-five year old, female patient presents to the office with right-sided headache lasting 4-8 hours. Headaches occur every one to two weeks for the last two to three months. She has no identifying triggers and has mild relief with acetaminophen. She is not sexually active and not using any contraceptives. She denies fever, visual loss, focal weakness, paresthesias, neck pain, recent head trauma, or contributory past medical/family medical history.

Her physical exam reveals a healthy appearing female with normal blood pressure, normal eye exam (including funduscopic), no temporal artery tenderness, no bruits, and no focal neurologic findings.

What would you do?

- Prescribe NSAIDS for symptomatic treatment;
- Prescribe a triptan for abortive therapy;
- Order a Brain MRI;
- or order a Brain CT?

We have been making jokes about SGR since it was put in place as a part of the Balanced Budget Act in 1997. Dr. Dean Drooby, our immediate past Governor, went to Washington DC twenty-three times. I have been two times—and each of us hearing the same old Capitol Hill talk. Each time, congress tells ACP Leadership Day groups of their dislike for the SGR, but there has never been a sign of SGR repeal. **Why?** We have no money to pay for the repeal. In the past, the Congressional Budget Office (CBO) has estimated that the

Governor's Column

By James Baker, MD, FACP
Governor, Oklahoma Chapter



cost for full SGR repeal has a 244 billion dollar price tag. We have good news for 2013. The CBO estimated price tag for full SGR repeal has dropped this year to 138 billion.

So, how will physicians get paid? We cannot continue 'fee for service' as we know it. ACP is pushing for the bipartisan legislation HR 574 Medicare Physician Payment Innovation Act, submitted last year and modified this year by Schwartz (D-PA) and Heck (R-NV). The "Energy and Commerce Committee" and "Ways and Means Committee" also have a joint draft for SGR repeal, ensuring a transparent process. They are seeking

With SGR Repeal, We Must Choose Wisely

input on how to reform and improve the system of Medicare physician payments. This committee and its subcommittee on health are looking for a 'modified' fee for service focused on improving quality and outcomes through performance measures.

All seven of our Oklahoma representatives, senate and house, support repeal and felt it would happen in the late Summer or early Fall of 2013 if/when it comes to vote. Senators Coburn, Inhofe, and their teams have told us of their

desire to repeal SGR. Our House Representatives and their teams have conveyed similar messages of repeal. So, if/when this happens, what does this mean to you and your practice?

My point is, "With SGR Repeal, We Must Choose Wisely." With SGR repeal, you will see predictability in your office finance without the ever-looming Medicare cut from SGR. **Our job is "We must choose wisely"**.

This entails a responsibility to use high-value, cost-conscious care. ACP calls this Choosing Wisely. See an analysis of the costs for treatment for the case presented at the beginning of this Column on page 3.

I will give a few more case studies on "**Choosing Wisely**" at our ACP Oklahoma Chapter Fall 2013

Scientific Session on Friday, October 18, 2013, at the Samis Education Center on the OUHSC/OKC campus. You will want to be a part of this meeting.

SAVE THE DATE: Please come join me at the Samis Education Center, OUHSC/OKC for more of "Choosing Wisely" on Friday, October 18, 2013. I look forward to seeing you there.

Jim Baker

So, back to the case study and clicker results.**What would you do?**

20% chose the correct answer— Prescribe NSAID for symptomatic treatment

11% — Prescribe a triptan for abortive therapy

29% — Brain MRI

40% — Brain CT

What is the estimated cost of a brain CT scan?

—\$350 —\$550 —\$750 —\$1150

25% chose A) \$350

30% chose B) \$550

5% chose C) \$750

40% chose the correct answer, D) \$1150

What is the estimated cost of a brain MRI?

—\$550 —\$1000 —\$2000 —\$2,500

Estimated cost of a brain MRI is

25% chose A) \$500

25% chose B) \$1000

29% chose C) \$2000

21% chose the correct answer, D) \$2500

The number of CT scans ordered per year in the US has tripled in the last decade. CT scans deliver 100-500 times the radiation of a chest x-ray. 1.5% of cancers in the US are attributed to CT scan radiation.

The patient is found to have a small mass in the left parietal region. The mass is 1.5 cm and peripheral but cannot be well categorized on the non-contrast CT. The radiologist recommends further categorization of the mass with a contrast enhanced CT scan or an MRI.

What is the rate of incidental findings on brain CT?

—5% —10% —15% —20%

The rate of incidental findings on brain CT is

9% chose A) 5%

12% chose B) 10%

13% chose C) 15%

66% chose the correct answer, D) 20%

Incidental findings on imaging studies are increasingly common and vary with the type of study ordered, the location of the study, and the age of the patient.

Incidentalomas are costly for doctors, patients, and the healthcare system as they generate the costs of downstream testing, time, and anxiety. The rate of incidentalomas is higher in women than in men and increases with increasing age.

Total cost for this patient's common headache includes:

- Approximately \$6,000 in radiology test (one brain MRI, three brain CT scans - initial and follow up).
- Four patient days missed from work for testing.
- Staff time for calls regarding scheduling/ explaining abnormal results.
- Radiation exposure from three brain CT scans equates with 6mSv = 60 CXR.
- Lastly, our patient suffers from severe anxiety, being diagnosed with a 'brain tumor.'

Practicing physicians report performing behaviors "some of the time" when caring for patients, including 74% ordering an additional test because of diagnostic uncertainty, 65% ordering an additional test to protect against a malpractice suit, 59% ordering an additional test out of concern about inadequate patient follow up or access, and 50% ordering basic tests because it saves time.

We will break the bank if we continue this insane status quo. ACP is also seeking legislation on malpractice reform and health courts. We cannot continue and our country cannot afford this escalating defensive medicine.

Choose Wisely

Plan to attend our ACP Oklahoma Chapter Fall 2013 Scientific Session on Friday, October 18, 2013, at the Samis Education Center on the OUHSC/OKC campus.

[You will want to be a part of this meeting.](#)



**ACP Leadership Day —
Washington D.C.**

By Mattlock Jeffries, MD

Dr. James Baker, Governor for the Oklahoma chapter of the ACP and myself recently visited Washington, D.C., where we participated in the annual Leadership Day on Capitol Hill. This annual gathering collects members from all walks of Internal Medicine, including a cohort of medical students and Associates alongside ACP Fellows, Masters, and Governors from each of the fifty states to present a united message to our respective Senators and House Members.

The two-day meeting began with an extensive update of the present state of health care legislation and its relevance to us as internists and culminated with Hill visits the following day. This year, our message included:

Elimination of the SGR with transition to better payment systems via ensuring stable, positive payments for all physicians for five years, with higher updates for E/M codes. We particularly pushed HR 574, the Medicare Physician Payment Innovation act, a bipartisan piece of legislation.

Ensuring funding for essential health programs; particularly, reducing the impact of across-the-board cuts implemented by the sequester. For our Oklahoma Senators and Representatives, we focused on full funding for the NIH and CDC, both of which have direct relevance in our state.

Authorization of a pilot for no-fault health courts, a proposal to bypass the impasses faced in tort reform by the creation of an alternative, expeditious, experienced court system focusing on medical issues.

Reforming and sustaining GME funding, including halting defunding mandated by sequestration and sponsoring the Resident Physician Shortage Reduction Act, S. 577 / H.R. 1180, and increase the payer pool to GME by introduction of more transparency and accountability, as well as requiring that all payers contribute to GME funding.

Finally, I will argue one more point: the absolute necessity of having constituent physicians lobby for these reforms.

Unfortunately, our meetings came on the heels of the devastating Moore tornadoes, so we were unable to meet with most of our legislators in person. We did, however, meet with **Senator James Inhofe** (shown in photo), Josh Trent in Sen. Coburn's office, Steve Waskiewicz in Rep. Cole's office, Ben Couhig in Rep. Bardenstine's office, Kevin Kincheloe in Rep. Lankford's office, Jason Grassie in Rep. Lucas's office, and Representative Marwayne Mullin himself. Although we met with the expected pushback when it came to increasing federal funding, our message was generally well received. Reassuringly, to a person, each legislator and their staff agreed that the SGR was unsustainable and must be revoked; with many hopeful that it will occur this term.

Finally, I will argue one more point: the absolute necessity of having constituent physicians lobby for these reforms. Having constituent physicians whose practice and daily life are directly impacted by the policies we hope to change imposes an aura of knowledge and real-world experience that elevates our message above the fray and allows us to be much more effective. Both Dr. Baker and I strongly encourage members of the ACP's Oklahoma delegation, at any point in their career, to consider spending two days in Washington as participants in this vital program.



Oklahoma Chapter Governor James Baker MD and Mattlock Jeffries, MD with Senator James Inhofe during ACP Leadership Day in Washington, DC

Dear Colleague,

Our Governor, Dr. James Baker, will give you a political activity update since he has just attended the ACP Leadership Day together with Dr. Jeffries. Instead, today, I will just write to you from the trenches, primarily about the practice environment and give you some unsolicited advice to survive if you are still in a small to solo practice fee for service general internal medicine.

My advice is limited to those old fashioned traditional internists because as you well know, many Internists have become hospitalists and they are ruled by other work environment obligations. Our academic General Internists colleagues are primarily living by the rules of the training program requirements and graduate medical education rules.

Those of us that are still in private practice are in a good place, contrary to what most think, if we face the challenge and see the opportunities in today's practice environment. I anticipate that there will be a significant lack of capable, accountable, amiable, and available general internists to take care of the folks with multiple comorbidities requiring complex chronic disease management. I also think that these same internists are best qualified to take care of these folks when they need to be hospitalized and when they enter the end of life care phase of their diseases. This is a professional niche that you should be able to fill if you are willing to pay attention to details of practice management to include cost cutting where necessary, and giving up some procedures in your practice so that you can concentrate on practicing compassionate thorough Internal medicine

For example, I have given up giving vaccines to my patients and instead I just recommend that they go and get it at a local pharmacy. While this removed a small stream of income from my pocket, I no longer have to worry about an allergic reaction occurring in my office and having to resuscitate the patient in case of anaphylactic shock. I also no longer have to order, store, ac-

count for and record vaccines being given.

I have also given up on performing all procedures with the exception of bone marrow biopsy under conscious sedation because I was taught to do it well using intravenous Valium and intramuscular morphine. This is definitely not a major income producer and I could certainly live without it since I do no more than four such procedures a year. I am now required to recertify ACLS so that I can give conscious sedation and I am thinking very hard about giving that skill up as well.

More importantly, if you have not bought an EBMR, now is the chance for you to back off and not commit \$30,000 to \$45,000 plus the monthly licensing fee in order to make a measly 2% on your Medicare reimbursement. The electronic prescription of another 1% has to also be looked at as unworthy of a major commitment in time, money and peace of mind when going to an EMBR that has been not only costly in dollars but a massive waste of good physician eye contact time with our patients. I have elected to stay with the old fashioned dictation. My staff transcribes it using a computer but it is printed on paper and finds its way to good old fashioned paper charts. In turn, I can take the chart with me to the hospital whenever I admit one of my own and the system works quite well. Both of my transcription computers are not connected to the Internet: I therefore do not have to worry about unintentional EBMR HIPPA violations

It is imperative that you surround yourself with two dedicated, competent, reliable, intelligent, medical office staff members who allow you to take care of your patients and maintain a good patient flow that will give your patients a good medical office experience. This will earn you the loyalty of your patients and their appreciation.

I would urge you to look very carefully at your patient mix and to consider

not renewing any contracts that you have with managed care organizations that are just following Medicare's lead and ratcheting down your reimbursement. Life is undoubtedly possible without paying for somebody to bird-dog pre-authorizations and another person to keep track of all the billing requirements of the various managed care organizations.

As you may know, I opted out legally from the Medicare program in 2008. This still allows me to take care of my Medicare patients. However, when they see me in the office, the hospital, in their own homes or in assisted living facilities, their expense to me is a purely discretionary matter. That means neither I bill Medicare, nor do they bill Medicare. I just have to prove to them that I am worth my professional fee and I do not think that is hard after 32 years of practice supplemented with an immense amount of self directed continuing medical education. I realize that this is not something that you can do in every zip code in Oklahoma, but I know that it has allowed me to look forward to practicing until the age of 75 with far less grey hairs amongst the few hairs that I have left on my head. I am 59 now.

As a result of all of the above, I come to work happy and looking forward to being of service to my patients. I cannot think of anything else that I would rather do and I cannot think of anything more rewarding than to take good care of appreciative patients until the end of their life.

I urge you to take a hard look at your practice because we need you in our midst. Our workforce is declining and while many people have called us dinosaurs, we definitely still can do a good job, which is, after all, what it is all about in life.

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Legislative Chair and former Governor of Oklahoma Chapter.

"I urge you to take a hard look at your practice because we need you in our midst."

A view from another state

Primary physician shortage calls for intervention

By: **Sen. Bernie Sanders**
May 7, 2013 09:34 PM EDT

The American approach to primary health care is one of the more glaring failures of a dysfunctional health care system that costs almost twice as much per capita as that of any other major country — often with worse results.

Tragically, some 45,000 Americans die each year because they don't see a doctor until it's too late. Many others unnecessarily end up in hospitals at great cost and suffering because their illnesses were not diagnosed and treated at the appropriate time. Every day, tens of thousands of men, women and children who lack a primary care medical home flood emergency rooms across the country for nonemergency care at 10 times the cost of a visit to a primary-care facility.

Instituting major reforms in primary care and enabling people to see a doctor when they need one will save lives, ease suffering and save billions of dollars in wasteful health care costs. What should we do?

First, we need to substantially increase the number of primary-care practitioners. In most countries, about 70 percent of doctors practice primary care while 30 percent are specialists. We have it backward. Only 30 percent of doctors in America practice primary care. According to the Health Resources and Service Administration, we need 16,000 more primary-care practitioners to fill gaps in care that exist today. That number will significantly increase in the years to come, beginning next year when 30 million more Americans get insurance under the Affordable Care Act.

Second, we must implement a major change in the culture of our medical schools. Some medical schools do an excellent job educating primary-care physicians, but too many do too little and some — believe it or not — do nothing at all. In 2011, about 17,000 doctors graduated from American medical schools. Only 7 percent of those graduates chose a primary-care career. A big reason is the way American doctors are paid. We must change the reimbursement rates which create incentives for medical

students with high debt to go into the well-paid specialties rather than primary care. We also must address the absurdity of Medicare providing \$10 billion a year to teaching hospitals — with no demands that they increase the number of primary-care physicians we desperately need. Dr. George Rust at the National Center for Primary Care asked the right question: “Why pay to train doctors we don't need to practice in places they are not needed?”

Third, we need to greatly expand the Federally Qualified Health Center program which today provides high quality and affordable health care, dental care, mental health treatment and low-cost prescription drugs to 22 million Americans, regardless of income. This is a program that provides some of the most cost-effective health care in the country and serves as a medical home for millions with nowhere else to go. Today, there are more than 1,200 community health centers located in every state in the country. This excellent program has been expanded in recent years, but much more needs to be done. The goal should be a federally supported community health center everywhere in America that is medically underserved.

Finally, we should greatly expand the National Health Service Corps, which provides loan-forgiveness and scholarships to students who are prepared to provide medical, dental and mental health care in underserved areas. Like the community health center program, the health service corps has expanded in recent years. In 2012, the corps provided financial help to nearly 10,000 clinicians, nearly three times more than in 2008. That's a good step forward, but nowhere near enough. Because of inadequate funding, thousands of medical school students who would like to go into primary care do not receive the financial support they need to be able to make that choice.

The bottom line is that we need a revolution in primary health care services and accessibility. Providing all Americans access to health care when they need it will keep people healthier and substantially reduce health care costs. It's a win-win proposition that we should embrace.

Sen. Bernie Sanders (I-Vt.) is chairman of the Subcommittee on Primary Health Care and Aging of the Senate Health, Education, Labor and Pensions Committee.

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Dr. Eldon Van Gibson

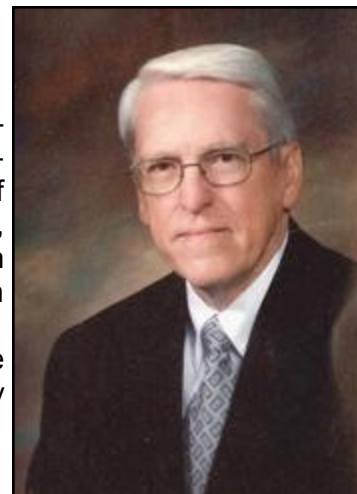
(December 25, 1940 - April 20, 2013)

With much sorrow, we pay tribute to a very special physician and friend. Dr. Gibson has been a member of the Oklahoma Chapter of the Oklahoma Society of Internal Medicine (OSIM) and ACP since the early 1980s. He served as President of OSIM from 1993 - 1994 and Governor of ACP-ASIM from 1999 to 2003. In 2003, he was presented with the Laureate Award for his contributions to the profession of medicine and to the Oklahoma Chapter. This is the highest honor that is given to a member of the Chapter.

After his terms as President and Governor, Dr. Gibson continued to serve on the Oklahoma Council in whatever capacity he was asked — Chair of the 3rd Party relations committee and most recently as treasurer.

This year he was nominated for Master of the American College of Physicians.

His obituary which was posted in the Shawnee newspaper is copied below.



Dr. Eldon Van Gibson, age 72, passed away April 20, 2013. He was a devoted son, husband, father, grandfather and great-grandfather. Dr. Gibson was born December 25, 1940 in Blackgum, OK to Earl and Verbie Gibson. After graduating high school Eldon attended college at Northeastern Oklahoma University where he met the love of his life, Patricia Sue Prado. Eldon and Pat married on June 8, 1959. Eldon attended medical school at the University of Oklahoma where he received his M.D. degree in 1965. Dr. Gibson proudly served in the US Military from 1965-1971. Eldon completed his internship at William Beaumont General Hospital, in El Paso, Texas as Chief Medical Resident. He then completed his residency as an Internist at Reynolds Army Hospital, Fort Sill, Oklahoma as Chief, Department of Medicine. He retired from his Internal Medicine practice at Shawnee Medical Center Clinic after 32 years of distinguished service. Amongst numerous accomplishments and achievements Dr. Gibson served as Oklahoma's Governor of Internal Medicine from 1999 to 2003. He served on the Board of Trustees at Oklahoma Baptist University for a four-year term and also served on the Advisory Committee for the University. Eldon was a committed church member where he devoted 27 years as a Sunday School Teacher and was currently serving as the Chairman of the Deacons at Immanuel Baptist Church.

Eldon's life demonstrated a true reflection of Christ through his service to others. He was committed to finding ways to ensure all received quality medical services. He was instrumental in establishing the Volunteer Health Clinic of Pottawatomie County and continued to serve there after his retirement. Dr. Gibson was a recipient of the Humanitarian Service Award presented by Shawnee Ministers Association in 2002. In 2003, he also received the Laureate Award presented by the American College of Physicians. For the past three years he served on the medical mission team in Ecuador.

Eldon Van Gibson was preceded in death by his parents, Earl & Verbie Gibson, his brother Hubert Gibson, and his son Mark Gibson.

He is survived by his wife, Patricia Sue Gibson of the home, daughters Marcia Thomason, and Cindy and her husband John Yarbrough and daughter-in-law Sue Gibson. "Poppa" was blessed with twelve grandchildren, Joshua and wife Brittany Gibson, Julie Gibson, Jordan Gibson, Chevy and wife Amber Thomason, Ashley & husband Jeremy Bridges, Hanley and wife Kaytlin Kincaid, Bradley and wife Lacy Kincaid, and Kristin Kincaid, Amy Yarbrough, Melissa and husband Randy Whiteside, Katie Yarbrough and Tyler Yarbrough. He was blessed with five great-grandchildren, Finley Christian Thomason, Blakely Rose Gibson, Bryton October Bridges, Lily Bryn Kincaid, and Weston Cole Wheat. Poppa's example as a devoted servant of Christ has touched his family, friends, and colleagues. His deep relationship and commitment to Christ has inspired each of us to be a reflection of Christ through God's Word. Poppa will be dearly missed and our memories will be cherished forever.

Visitation will be held Wednesday, April 24 from 5-7 p.m. at Walker funeral Service in Shawnee, OK. Funeral services will be held 10:00 a.m. Thursday, April 25, 2013 at Immanuel Baptist Church in Shawnee, Oklahoma with Rev. Todd Fisher officiating. Graveside services will follow at Resthaven Memorial Park in Shawnee, Oklahoma.

In lieu of flowers, the family respectfully requests donation be made to Immanuel Baptist Church Missions Fund in memory of Dr. Eldon V. Gibson.

Residents from Tulsa participate in Internal Medicine 2013 in San Francisco

David Lazar M.D.
PGY2, Internal Medicine Resident
University of Oklahoma School of Community Medicine, Tulsa

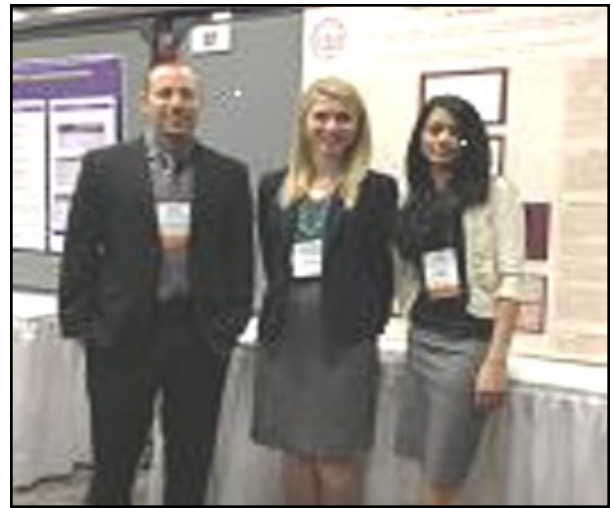
This past April I was fortunate to represent our Internal Medicine Residency Program at ACP Internal Medicine 2013 in San Francisco. This was my first time attending a national ACP conference, and I plan to continue following residency. Learning from colleagues across the country enhanced my knowledge as I participated in many lectures, workshops, clinical skill labs, and clinical symposiums.

During one of these workshops, we collaborated in small groups to discuss **ACP's High-Value, Cost-Conscious Care curriculum**. With the initiation of the affordable care act, this topic is particularly relevant and, arguably, an essential component of residency education. Accordingly, we will work on integrating this curriculum into our residency program.

I also attended a symposium sponsored by the American College of Rheumatology. The focus was to provide internists better information to treat common rheumatologic diseases. This symposium was especially important to me because I plan to pursue a rheumatology fellowship.

Additionally, the Herbert S. Waxman Clinical Skills Center provided several valuable training simulations for internists. These included skin biopsy, musculoskeletal ultrasound, joint and soft tissue injections, central line placement with ultrasound, incision & drainage, and several others. These simulations offered practical experience and engaged internists from across the country to learn and share different techniques for performing procedures.

Overall, the convention was a fantastic learning experience, integrating lectures with practical experience and clinical symposiums. The ability to speak with and learn from colleagues across the country is an invaluable opportunity that I recommend to all internists. Regardless, I am thankful and excited for the opportunity to deepen my medical knowledge.



David Lazar, MD (PGY2); Krystina Estes (MSIV); and Deepna Jaiswal, DO (PGY2).

Deepna Jaiswal, DO
PGY2, Internal Medicine Resident
University of Oklahoma School of Community Medicine, Tulsa

In the midst of consults, I distractedly noticed the ding of my phone's email notification. I thumbed through and noticed the title, "ACP National Abstracts Competitions 2013" congratulating me on being selected to present my clinical vignette at ACP Internal Medicine 2013 in San Francisco. A mix of surprise, excitement, and gratification rushed over me, knowing that my abstract was chosen among thousands of other qualified submissions. In anticipation of the national conference, I diligently worked to polish my poster and presentation skills and felt ready to tackle San Francisco.

April arrived and I found myself in a convention center with over eight thousand other physicians. I stood among an amalgam of young and old, some seasoned professionals in attendance to brush up on clinical expertise, while others—like myself, just starting the lifelong journey of medicine.

I tried to participate in as many workshops and courses as I could. I fine-tuned my technique on ultrasound-guided central venous line placement and reacquainted myself with the basics of cardiac auscultation skills in the Herbert S. Waxman Clinical Skills Center. I attended various lecture series and interacted with fellow residents to learn how to integrate ACP's High-Value, Cost Conscious care curriculum into our residency program.

(Continued on page 9)

(Continued from page 8)

Even though I was busy enriching my medical education with these various activities, I had a knot in the middle of my stomach that was slowly growing. The scheduled time for my presentation was fast approaching. I found myself in front of a group of inquisitive physicians. They seemed interested in my poster, and I enjoyed my conversation with them.

One of the judges took a particular liking to my poster and made suggestions to improve my poster and case presentation for publication.

Once I arrived back home in Tulsa, I continued with the momentum I gained. I reworked my clinical vignette and with high hopes I submitted my case for publication. A part of me felt like this was a reach, but I was once told that you should always shoot for the stars. After a rejection, I was crestfallen but undeterred and I resubmitted the case to another journal. And like my previous email that had me distracted during consult rounds, I received another 'ding' from my phone. I scrolled through my inbox half expecting another email from Bill and Ruth's diner about today's special, but instead I had a much better surprise: acceptance of my manuscript for publication in *Mayo Clinic Proceedings*!

My journey that started with an interesting case ended up taking me to San Francisco and ended with a publication in a respected journal. I feel fortunate to be part of a program that allows its residents to participate in national conferences and encourages scholarly activity.



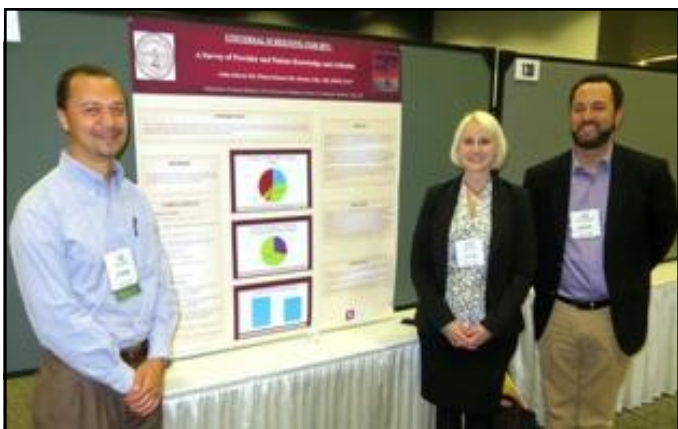
Dr. Michael Bronze with residents Dr. Jordan M. Morton (Associate Poster presenter in Basic Research), and Dr. Matlock Jeffries.

Note from ACP

The College wants to express sympathy to those Oklahomans who lost family and property as a result of last month's F4 tornados.

Our records indicate that we have approximately 30 members in the City of Moore area. There certainly may be more from the surrounding areas of El Reno, Shawnee, and OKC. Please convey to your Chapter members the College's willingness to help out in any way that we can.

If the practices or homes of any members were affected, we will gladly waive their membership dues for the upcoming year or until they get back on their feet. We will do this on an "as requested" basis so simply have them contact Rebecca Moore or Joyce Crist and we'll facilitate this on our end. Also, we're happy to replace any College materials that may have been lost or destroyed. Again, just contact us.



Erik Wallace, MD, FACP is shown above with Erika C. Johnson, DO (Medical Student Poster presenter in Clinical Research) and John Schumann, MD, FACP OUHSC faculty.

Protecting Children & Families from Tobacco: Leadership Advocacy Training

April 26-27, 2013 | Washington, DC

Chris Sudduth, MD MPH
Internal Medicine-Pediatrics PGY-1
OU School of Community Medicine

“We don’t smoke the shit, we just sell it. We reserve the right to smoke for the young, the poor, the black and the stupid,” replied an RJ Reynolds representative when asked why none of the company’s executives smoked. Big Tobacco hits hard, and does so with breathtaking commercial and political savvy. The 2013 *Protecting Children & Families from Tobacco: Leadership Advocacy Training*, a joint-venture of the ACP, AAP, AAFP, ACOG, and AMA, brought together physicians from across the nation to study Big Tobacco’s playbook and to network with tobacco control advocacy experts in effort to become equipped with knowledge, tools, and resources to effectively collaborate with local and state anti-tobacco groups.

Tobacco companies engineer very efficient and highly effective drug delivery devices, aggressively marketing the only legal product that kills when used as intended. In my home state of Oklahoma, where 26% of the adult population smokes, the health and economic burden of tobacco use is crushing. This year, 5,000 Oklahoma youth will become new daily cigarette smokers. Even more appalling, 6,200 Oklahomans will not see 2014 because of tobacco use; a loss of life that exceeds 3 Oklahoma City bombings every month. Smoking-caused productivity losses in Oklahoma will exceed \$1.73 billion this year.

Big Tobacco has dominated the Oklahoma Legislature as evidenced in a leaked industry document, “... Under both Republican and Democratic governors...members of the tobacco team in Oklahoma work extremely well together and appear to have a considerable amount of strength in the political process there.” With an unprecedented 16-registered lobbyists, the industry used its playbook of lying, litigation, lobbying and law breaking over the last 2 months to promote Senate Bill 802, which later became House Bill 2097. If approved, Oklahoma would be the only state in the country to provide such far-reaching special taxation and regulatory treatment to a new generation of untested, candy-like tobacco products including colorful and flavorful sticks, dissolvable orbs, and “snus” that are marketed to hook a new generation of users. Among many things, the bill would result in lower taxes and cheaper products making it easier to hook kids; the sale of addictive tobacco products without a license; promotion of smokeless tobacco products and e-cigarettes that have not been evaluated by the FDA; and lost revenue from lower tobacco taxes that would cause long-term cuts to the state’s breast and cervical cancer screening program, tobacco prevention and cessation services, Insure Oklahoma, and other vital health programs. Although the bill was killed on the House floor, its language and intent lives on in an

unknown committee with threat of it reappearing in a special Legislative session. Tobacco control advocate, stand guard! Big Tobacco’s bold assault on our children is far from over.

The conference provided physicians with essential tools for the fight back home. Avenues for community advocacy were highlighted, including serving on the board of a volunteer health agency, writing a letter to the editor (LTE), providing testimony in legislative committee, calling and visiting policymakers, and hosting breakfasts or lunches. Advocacy in the clinic was also emphasized with best practices for smoking cessation. The national text-to-quit program serves as a powerful cessation support tool through interactive, daily text messaging. Enrollment is as easy as texting “QUIT” to the number “I QUIT”. Additionally, transdermal and oral forms of nicotine replacement therapy is newly recommended. Duration of therapy has been extended up to 1 year if needed. Finally, data of 1 (800) QUIT-NOW participation revealed an increase in patient participation from 5% to 50% by filling out and faxing in the enrollment form during the office visit as opposed to merely providing the patient with the quit line number.

The Smoke-Free Oklahoma Coalition is the state’s leading tobacco control group. Key players include the American Cancer Society, American Heart Association, and American Lung Association among others. I have fought Big Tobacco as a member of this coalition and am reenergized and better equipped to lead in ongoing tobacco control efforts. Please contact me at Christopher-Sudduth@ouhsc.edu for more information or interest in tobacco control advocacy.



The Oklahoma Chapter Reception at the 2013 Internal Medicine Meeting was held in the middle of San Francisco Bay. What a great time was had by all 27+ participants.

At Left: Jim Baker watches the sunset over the Golden Gate. At Right, Dr. Dennis and Tonye Kolokolo (Formerly Nigeria, now Tulsa, Oklahoma).



Below Dr. and Mrs. Mike Weisz are seen with Dr. and Mrs. Bob Wortmann (formerly from Tulsa).

More pictures can be found on the ACP, Oklahoma Chapter

Facebook page.



Pictured above are Dr Frank and Helen Dunn (Glasgow, Scotland), Dr. Neil and Elspeth Dewhurst (Edinburgh,Scotland),.

Sunset Cruise on San Francisco Bay



Oklahoma Chapter Scientific Meeting

Schedule of Events
October 18, 2013

Morning Session ACP

8:00 a.m. Welcome

James Baker, MD, FACP
ACP Governor, OK Chapter

8:15 – 9:00 a.m.

**Your Difficult Patient with Recurrent Spells
Has Migraine**

*David Lee Gordon, M.D., F.A.A.N.,
F.A.N.A., F.A.H.A.*

Professor, The
Kathryn G. & Doss Owen Lynn, MD,
Chair in Neurology, Department of
Neurology; Director of Medical Student
Education, OU Medical System;
Chief of Neurosciences Service,
OUHSC – OKC

9:00 – 9:45 a.m.

**The New Oral Anticoagulants – Handle with
Care**

*Philip C. Comp, M.D.,
Ph.D., F.A.C.P.*

Associate Chief of Staff for Research,
Oklahoma City VA Medical Center;
Professor of Medicine, Hematology
Section, Adjunct Professor of Pathology,
OUHSC – OKC.

9:45 – 10:15 Break/Visit exhibits

10:15 - 11:00 a.m.

Update in Osteoporosis

Mary Zoe Baker, M.D.

David Ross Boyd Professor of Medicine, Director of Clinical Services, Section of
Endocrinology and Diabetes, OUHSC -- OKC

11:00 – 12:00

Doctors Dilemma Competition

Afternoon Session

12:00 pm -- Awards Luncheon/

Business Meeting/Town Hall

**Choose Wisely: High Value, Cost
Conscious Care**

2:00 – 2:45 pm

**Advances in Cardiovascular Interventions
that an Internist Should Know About**

*Mazen Abu-Fadel, M.D., F.A.C.C.,
F.S.C.A.I.*

Oklahoma City VA Medical
Center, Oklahoma City

2:45 – 3:30 pm

2013 Antimicrobial Update

Michelle Salvaggio, M.D., F.A.C.P

Program Director, Infectious Diseases
Fellowship Training Program, Infectious
Diseases Section, The University of
Oklahoma, Oklahoma City

3:30 – 4:30

Associates' Oral Presentations

4:30 – 6:00

Poster Presentations/ Reception

**Watch for registration materials which
will be posted on the ACP Chapter
Website**

http://www.acponline.org/about_acp/chapters/ok/