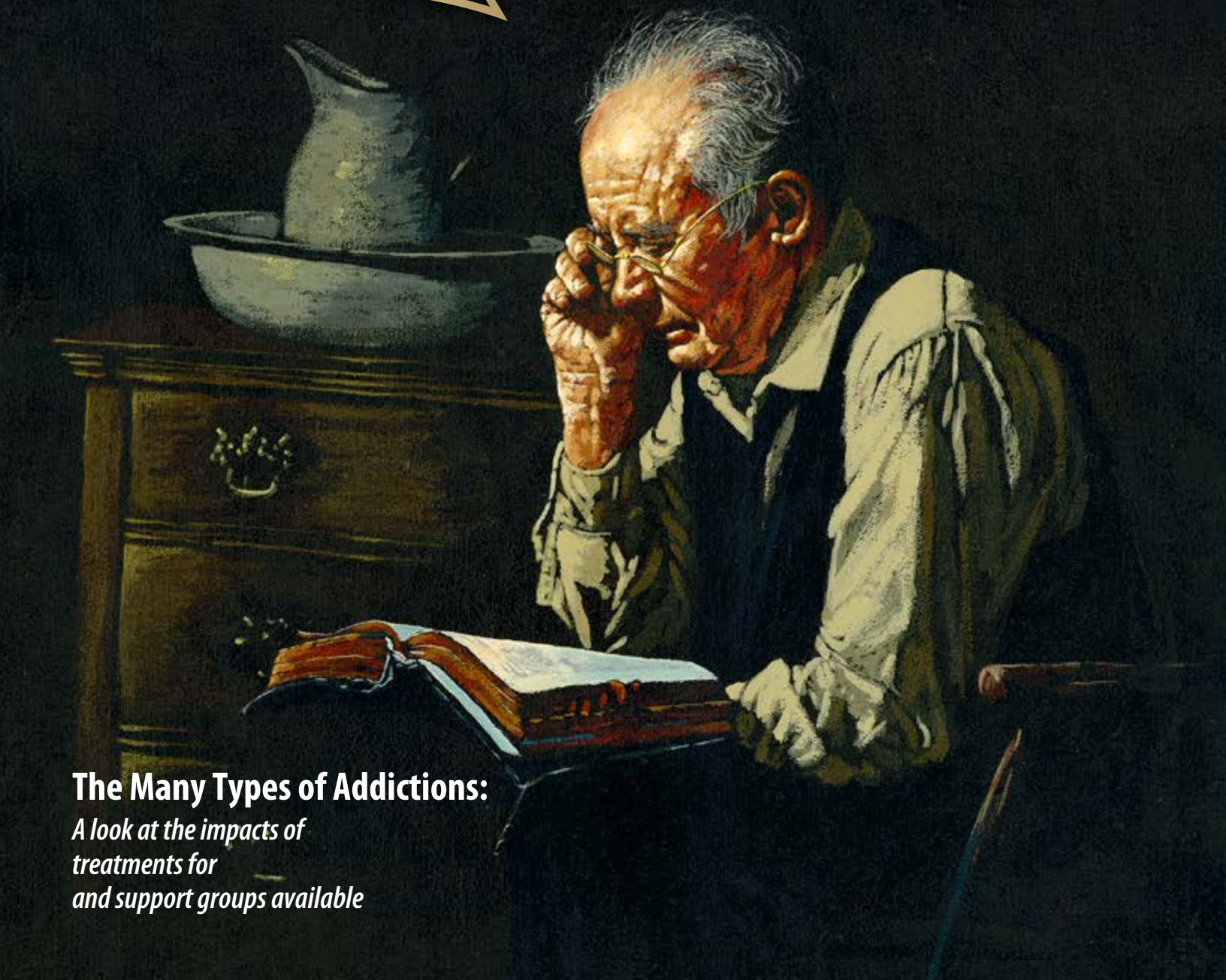
PANHANDLE HEALTH

A QUARTERLY PUBLICATION OF THE POTTER-RANDALL COUNTY MEDICAL SOCIETY

WINTER 2015 | VOL 26 | NO. 1

Celebrating 25 Years of Success in Our Medical Community



The Many Types of Addictions:

A look at the impacts of treatments for and support groups available

PROTECTION *when* YOU NEED *it most.*

To hackers, your patient data is more valuable (and easier to get) than the credit card numbers stored on a retailer's website.

TMLT's Cyber Liability coverage is designed to protect you and your patients if you experience a data breach or theft of medical data. We can also provide you with the tools and services to help prevent a cyber attack. Prevention and protection are all part of your TMLT coverage. Learn more at www.tmlt.org or call 800-580-8658.

TMLT
Texas Medical Liability Trust

PROTECTION FOR A NEW ERA OF MEDICINE.

Our new freestanding ER will offer you and your family high-quality, around-the-clock care that's convenient. **... 24 hours a day ... 7 days a week ...** including specialty pediatric emergency care.

Located at Hillside and Soncy, Northwest Emergency at Town Square will offer a range of emergency services under one roof!

As a part of Northwest Texas Healthcare System, we can assist you in a direct admission if necessary by ambulance to a private room at our hospital.

Easy to find ...
Easy access to
the care you need.

Northwest Emergency
at Town Square
Hillside/Soncy • Amarillo, TX 79106
www.nwtexashealthcare.com


GIFTS
GALORE
&
MORE
GB
GRAHAM
BROTHERS
JEWELERS
HERRING BANK TOWER
2201 CIVIC CIRCLE | SUITE 505 | AMARILLO, TEXAS
806.352.0080
GRAHAMBROTHERSJEWELERS.COM
open Saturdays until Christmas

PANHANDLE HEALTH

A Publication of the Potter-Randall County Medical Society

WINTER 2015 | VOL 26 | NO. 1

CONTENTS

25 Year Anniversary

On The Cover: *"The Doctors Assistant"* 1980, by Kenneth Wyatt

PANHANDLE HEALTH is published quarterly by the Potter-Randall County Medical Society, (806) 355-6854. Subscription price is $12.00 per year. POSTMAN: Send address changes to PANHANDLE HEALTH, 1721 Hagy, Amarillo, Texas 79106. ISSN 2162-7142

PHOTOCOMPOSITION AND PRINTING BY CENVEO.

President's Message:
AS WE MOVE ON!

by Tarek Naguib, M.D., M.B.A., F.A.C.P.

Young or old, men or women, healthy or ill; we are bombarded with the presumed "benefits" of calcium supplements. The recommendations seem to stem from the knowledge that our bones' strength depend on calcium and that our muscles –including the heart muscle– use calcium to contract. However, when scientists studied the death rates as they relate to calcium intake, they were in for a surprise of a lifetime!

Last summer, Leslee Shaw et al. identified a new risk factor to predict mortality up to 15 years: coronary artery calcification (CAC) score, which is calculated by computed tomograms that detect and measure calcium spots in the coronaries [1]. The authors compared CAC with our wealth of risk factors that predict 10-year death (obtained from the Framingham study) i.e. age, cholesterol, smoking, diabetes, hypertension, and family history of premature coronary disease. The aim was to find out if CAC is any better in predicting mortality.

They grouped 9715 persons with no known coronary disease, (in a clinic in Nashville, Tenn) into 4 groups based on the expected risk of death in 15 years according to CAC scores: <3.2%, 3.21-9.8%, 9.81-10.1%, and >10.1%. Both traditional and CAC mortality risks were measured for all persons; whereas, time to all-cause mortality was ascertained by the National Death Index that showed the death of 936 persons in 15 years.

The authors elegantly showed a progressive increase in death proportional to the predicted risk in all groups with further hike of death with higher CAC scores, highlighting calcium scoring as a predictor of death. The data dovetail with earlier reports that show the harm of calcium intake to the heart, where women who consume calcium rich diet had more risk of cardiac mortality; the risk doubled when they added a daily calcium supplement [2,3]. When we consider the new data that refute the benefit of calcium to the bones [4] – the only reason one would use such supplements – we see the big picture.

In view of these studies, the United States Preventive Services Task Force recommended to be cautious with calcium intake [5], as we now realize that calcium supplements (similar to multivitamins) do not seem to benefit our bodies; and actually, calcium increases the risk of dying of heart disease. It is high time for the medical profession to move on, taking the lead in the paradigm shift, and to restrict the liberal use of calcium supplements; as times have changed and we now count the calcium score in order to predict death!

Along the same theme of moving on, I would like to express my gratitude to the Board of Directors, Executive Director, the staff of the society, and the all physicians for being there to support our medical community and myself, during my year of service as a president of the society. Please, join me to welcome Dr. Ed Dodson as he takes the helm of our society and wish him and the society the best as they chart through the waves of 2016.

References

1. Shaw JS, et al. Long-term prognosis after coronary artery calcification testing in asymptomatic patients: a cohort study. Ann Intern Med. 2015; 163:14-21 doi: 10.7326/M14-0612

2. Li K, et al. Association of dietary calcium intake and calcium supplementation with myocardial infarction and stroke risk and overall cardiovascular mortality in the Heidelberg cohort of the European Prospective Investigation into Cancer and National study (Epic-Heidelberg). Heart. 2012;98:920-925 doi:10.1136/heartjnl-2011-301345

3. Michaelsson K, et al. Long term calcium intake and rates of all cause and cardiovascular mortality: community based prospective longitudinal cohort study. BMJ. 2013;346:f228 doi: http://dx.doi.org/10.1136/bmj.f228

4. Bolland MJ. Calcium intake and risk of fracture: systematic review. BMJ. 2015;351:h4580 doi: http://dx.doi.org/10.1136/bmjh4580

5. U.S. Preventive Services Task Force. Vitamin D and Calcium to Prevent Fractures: Preventive Medication. Release date February 2013. Uspreventiveservicestaskforce.org. Accessed October 2, 2015

Alliance News

by Irene Jones, Co-President

2015-2016 OFFICERS

Co Presidents:
Irene Jones & Shelby Neichoy

Past President:
Kiki Brabham

VP of Memberships/Fundraising:
Jamie Williams & Lacie Schniederjan

Treasurer:
Amy Slaton

Community Grants/Scholarships:
Kensie Wolcott

Medical Liaison/Community Outreach:
Courtney Wagner & Elisia Miller

Members at Large:
Kasey Daniels and Anna Holland

UPCOMING EVENTS

December 17th: Holiday Party @ Dr. & Mrs. Sloan Teeple's home

March 8th: SNACK PAK 4 KIDS

March 30th: Doctor's Day

April 21st: Ladies Spring Social @ Dr. & Mrs. Scott Miller's home

We are looking to partner with local organizations to create more volunteer opportunities. If you know of any particular ones that could use the extra hands or help, please contact us: *potterrandallalliance@yahoo.com*

The Potter-Randall County Medical Alliance is looking forward to seeing all of you at the Holiday Party on December 17th @ 7pm. Kristi Aragon will be catering a delicious meal to include beef tenderloin sliders, charcuterie board, baked french brie, spinach artichoke dip, caramelized onion and mushroom tart, Asian meatballs and a medley of treats and sweets. Don't forget to bring restaurant and movie gift cards to donate to the Children's Home this season.

In August we hosted our Family Event at the Amarillo Thunderheads stadium. Special thanks to "Circle of Friends" for their contribution. There were several new faces, familiar faces and lots of children who enjoyed the baseball game, food and camaraderie.

We volunteered at SNACK PAK 4 KIDS on two different occasions. We hope you will make plans to join us on March 8th. We helped sack 4,000 bags in under 45 minutes. These bags will be delivered to schools across Amarillo to ensure students have food for the weekend.

If you have had any changes to your home address and/or email address please email us at potterrandallalliance@yahoo.com with the correct information. If you would like to be added to our closed Facebook group, please email us. We will make sure to get you included! If you are interested in being more involved, please let us know. We would love to have your support and input.

-Irene Jones (Co-President)

Executive Director's Message

by Cindy Barnard, Executive Director

The articles in our Winter issue of Panhandle Health/2015 deal with addiction. Addiction has virtually touched everyone's life in some way, whether it is alcohol, drugs, gambling, eating disorders, or many more. The American Society of Addiction Medicine (ASAM) defines addiction as "a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations, reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors." The individual is unable to consistently abstain and is impaired in behavioral and emotional control. As in other chronic diseases, addiction often involves relapse as well as remissions (temporary or, hopefully, permanent). When treatment does not result in recovery, addiction is usually progressive and can result in personal, family and financial disaster, disability, and/or premature death.

Addiction was once viewed as a social problem with social solutions (i.e. incarceration), but scientific evidence argues that addiction is a brain disease. Addicts actually suffer from a brain disorder regardless of the substance that is abused. Recovery is most certainly possible through a combination of professional care, self-management, and a continuing support system.

As the year ends, I want to thank the 2015 Board of Directors for their service and dedication to our Medical Society. Under the leadership of our President, Dr. Tarek Naguib, 2015 has been an exceptional year. The following physicians deserve a big thank you for their support as well:

Executive Committee 2015 : President Elect: Ed Dodson and Secretary/ Treasurer: Rouzbeh Kordestani, M.D.

TMA Delegates: Brian Eades, M.D., Rouzbeh Kordestani, M.D., Robert Gerald, M.D., Ryan Rush, M.D., Jay Reid, M.D., and Rodney Young, M.D.

TMA Alternate Delegates: David Brabham, D.O., Ed Dodson, M.D., William Holland, M.D., Richard McKay, M.D., Tarek Naguib, M.D., and Victor Taylor, M.D.

Board of Censors: Edward Dodson, M.D., Ryan Rush, M.D., David Brabham, D.O., Victor Taylor, M.D., William Holland, M.D., and Michael Manderson, M.D.

Alliance President: Kiki Brabham

Committee Chairmen: *Panhandle Health* Editor, Rouzbeh Kordestani, M.D., Mediations, Nathan Goldstein, M.D., Physician Health and Rehabilitation, Robin Martinez, M.D., and Retired Physicians, Mitch Jones, M.D.

Another thank you goes to the 2015 *Panhandle Health* Editorial Board, led by Dr. Rouuzbeh Kordestani, Editor, and Dr. Ellen Hampsten, Associate Editor. Other members are Walter Bridges, M.D., Tarek Naguib, M.D., Steve Urban, M.D., Paul Tullar, M.D., Soleil Arrieta, M.D., and Traci Crnic, M.D.

A final thank you goes to our 2015 "Circle of Friends" for their continued financial support and generosity. Their commitment is absolutely essential to the success of all our events. They are Amarillo National Bank, Caprock Home Health Services, Neely, Crag & Walton Insurance Agency, Texas Medical Association Insurance Trust, Texas Medical Liability Trust, First Bank Southwest, Happy State Bank, and The Cottages at Quail Creek.

The title of our Winter cover is entitled "Physican's Assistant" by Dr. Kenneth Wyatt, D.F.A. Dr. Wyatt is one of today's most well-known and prolific Western artists. His career has spanned over 40 years and includes a monumental body of work, exceeding over 9,000 originals. Wyatt's working career has been versatile as he has been a farmer, rancher, roofer, Scoutmaster, magician, a member of the Armed Forces, and an ordained Methodist minister. His work hangs in many nationally-recognized museums, foundations, and collections. Dr. Wyatt and his wife, Veda, live in Tulia TX. Wyatt Galleries own and operates gallery location in Amarillo, Tulia, Red River NM, and Ruidoso NM.

Guest Editor's Message

by Robin Martinez, MD

In 1956, the American Medical Association declared alcoholism as disease. Dr. William Silkwood had declared alcoholism a disease in 1933. Dr. Silkworth's theory was that alcoholism was a matter of both physical and mental control: a craving, the manifestation of a physical allergy (the physical inability to stop drinking once started) and an obsession of the mind (to take the first drink).

Today, there still remains much misunderstanding and shame concerning the disease of addiction. Addiction is a chronic disease and, like all chronic diseases, is characterized by exacerbations (relapses) and remissions (recovery). Addiction need not be chemical, but may be related to behaviors such as gambling, relationships, overeating, and shopping.

Not only does the diseased individual feel isolated and outcast by society; friends and relatives feel isolated, misunderstood, and shamed. Treatment centers and 12 Step programs have helped to bring recovery to those afflicted and those impacted by another's addiction.

It is a great honor that I have been asked to serve as the Guest Editor for this edition of *Panhandle Health*. I have been privileged to be on the Physician Health and Wellness (PHW) committee both on the county level and state level. The Potter Randall County Medical Society PHW serves as an advocate for the physician struggling with addiction. Our goal is to have a healthy physician, thereby having healthy patients and a healthy community. The PHW committee is anonymous; we meet with physicians at least quarterly, follow urine drug screens, follow 12 Step meeting attendance, and offer our experience, strength, and hope so that recovery can occur. The TMA PHW offers loans to physicians struggling with addiction, so that they may have some financial peace while they are early in recovery.

It is my hope that, after reading this edition of *Panhandle Health*, we can all be educated about addictions and each of us find spiritual growth and health.

From the Big Book of Alcoholics Anonymous (1939):

Abandon yourself to God as you understand God. Admit your faults to Him and your fellows. Clear away the wreckage of your past. Give freely of what you find and join us. We shall be with you in the Fellowship of the Spirit, and you will surely meet some of us as you trudge the Road of Happy Destiny.

May God bless you and keep you—until then.

Are you accepting new patients? Looking to enlarge your practice?

ENROLL IN THE PRCMS REFERRAL SERVICE!

PRCMS receives calls each day from patients looking for a physician who:

1. Accepts new patients
2. Is near their home or office
3. Performs a certain procedure
4. Accepts their insurance
5. Speaks a second language
6. Accepts medicare or medicaid

Call the Potter-Randall County Medical Society at 355-6854 for more information and the referral service. Remember the referral service is voluntary, and is free of charge to the physician and the patient.

Addictive Personality

by Pam Kirby, Clinical Psychologist

It would be convenient if there were a way to reliably predict which of our patients would develop substance abuse disorders. For professionals who prescribe benzodiazepines, stimulants, or opioid pain medications, the question takes on particular salience. It is difficult to sort out the patient who uses the medical system to pursue unhealthy goals (i.e. addictive needs) rather than recovery and wellness (i.e. relief from pain, or relief from unnecessary anxiety). Unfortunately, there is no easy formula.

Addiction appears to be the final common pathway for a variety of problems, personalities, and circumstances. There is most often a complex interplay of biological, psychological, and social factors leading to a patient who is prone to abuse prescription medications. Also, there are many patients who will mix needed prescription medications with alcohol (or worse) and the efficacy of the medication is thus compromised.

Biological variables that predispose a patient to substance abuse have been studied most extensively for alcohol, and alcoholism is relatively heritable. A June 2015 article in Nature entitled *Genetics: No More Addictive Personality* cites the following:

> Joni Rutter, director of the Division of Basic Neuroscience and Behavioral Research at the US National Institute on Drug Abuse in Bethesda, Maryland, says that regardless of the drug involved, about 50% of the risk is genetic, within a range of about 40–60%.

Social factors also play a significant role in substance abuse disorders. This social variable is aptly demonstrated in Japan, a group genetically prone to a slower metabolism of alcohol, leading to accretion of noxious chemicals in the bloodstream. For the Japanese, the physical reward of alcohol is reduced, a variation that is typically protective from alcohol abuse disorders. However, the abuse of alcohol in Japan went from 2.5% in 1979 to 13% in 1992, reportedly due to changes in the culture of businessmen where alcohol use became more prevalent. At times, the social variable overrides physiological discomfort.

Psychological factors make an impressive contribution to the development of substance abuse as well. A study of the Swedish population (n = 1,409,218) conducted between 1995 and 2011 finds that drug use disorders were TWICE as likely for persons who suffered traumatic stress in childhood. The "traumatic stresses" preceding the increased risk included death of an immediate family member, serious accident, illness, or injury, being the victim of assault, including being a witness to parents' assault of each other. [The variables parental divorce, the premorbid psychological health of the family, and family substance abuse were controlled for in this study.]

Substance abuse risk is higher for all mental health patients who suffer from anxiety or depression, and for patients with personality disorders. Sansone and Sansone (2011) report a cumulative negative impact of multiple psychiatric diagnoses:

> Explicitly, having no psychiatric disorder resulted in odds ratio for lifetime substance dependence of 1.0; having one disorder 2.7, two disorders 3.9, and three or more disorders 9.1 (95% confidence interval).

One of the most difficult subtypes is the anti-social personality, a personality characterized by an impulsive, insensitive style, a personality type noted in 18% of substance abusers. [A common misunderstanding is that anti-social refers to someone who is introverted, and enjoys being alone. This is not correct in psychology circles. Someone with an anti-social personality is a person who goes against society and established norms, is often thrill-seeking, is willing to break the rules, and may be associated with a criminal population.]

A second personality disorder associated with substance abuse disorders is borderline personality. This makes intuitive sense when you are familiar with borderline personality disorder: it is characterized by a chaotic life, with internal problems of self regulation and self esteem and external signs of impulsivity and desperate efforts to maintain connection to others who assist in self regulation. Patients with borderline personality are more likely to initiate suicidal behaviors and cut on themselves to manage painful states, and sometimes to coerce supportive others in coming to assistance. Of course suicidal and cutting behaviors, even if intended as a "gesture," are much more dangerous when substance abuse is part of the picture.

The lifetime prevalence of substance abuse in the population of patients diagnosed as borderline across eight studies with various sample types is 14 percent (current substance abuse), and up to 72% over the course of life. While typically substance abuse predominates with males, when it comes to patients with borderline personality, substance abuse is equally common in women. Also, there is some indication that women with borderline personality are more prone to abuse prescription medication than men with borderline personality.

Psychologists of a psychodynamic perspective offer helpful insights about the underlying psychological factors that contribute to the compelling nature of substance use, and these insights can be put to work in the therapeutic treatment of 'addicts." For instance, substance abuse is the effort to find a way to "self-medicate," to find a way to tolerate the intolerable emotions a patient feels. Also common in patients is an overall impairment in self-regulation, common to children raised by caregivers who cannot form secure attachment relationships with their children due to their own disturbed

pattern of attachment.

Where does all of this information leave the practitioner when it comes to determining how concerned to be about prescribing medications that are highly prone to abuse by vulnerable persons?

I believe five sets of questions are valuable in discerning drug abuse potential in the patient.

1) What is your personal history with alcohol and drug use, both street and prescription medications? Do you have any legal issues related to substance use? [The best predictor of future behavior is past behavior, so this is an obvious beginning.]

2) What is your mental health status? Are you suffering from anxiety, depression, or any other psychiatric illness? What is your daily stress, and how are you coping with it? (should you recommend the use of quick normed screening instruments vs relying on the patient to just tell you?)

3) What is your biological family's history of substance use and abuse, and addiction?

4) Have you suffered traumatic stress in childhood or adolescence, including being the victim of assault, losing an immediate family member to cancer or other death, suffering a life-threatening accident or illness, or witnessing parental domestic violence?

5) What are the substance use habits in your family, your business associates, and among your closest social circle?

Two protections for the medical practitioner seem wise to me. Educating patients about the adverse physical effects of mixing alcohol with all prescribed medications, and the negative impact on sleep, is advised. I am impressed how few patients know: 1) that alcohol is disruptive to sleep (and so to all health and recovery), 2) that alcohol can reduce the effectiveness of their medical regimen, and 3) that biochemically alcohol will increase depression.

Secondly, when needing to prescribe substances that are prone to addictive misuse, it may be advisable to refer the patient with some of the risk factors for psychotherapy. The therapist can be an ally who can help a patient monitor and stay conscious about their use of medications. Of course the antisocial patient will rarely follow through with such a referral because they have limited motivation to change and minimal insight. In contrast, the anxious, depressed individual will perhaps appreciate such a referral and can use it for good outcome. It is harder to predict what response a patient with borderline personality will have to recommendations for treatment. Openness to treatment likely depends on prior experiences of the patient as well as severity of the illness and current condition. It is wise to refer such a patient to a clinician who is experienced, and to communicate with the therapist about what you need from them.

One serious conundrum arises when a patient with chronic pain also has a history of substance abuse. Surely the patient must be treated, but how can the overuse of pain medications be avoided? Fortunately, there are mental health options that help here, both in supporting the patient in responsible use and in teaching non-medicinal pain management interventions. Mindfulness-Based Stress Reduction, Cognitive Behavioral Therapy, Relational Therapies, acupuncture, and Therapeutic Lifestyle Changes can be used to treat pain and increase self-efficacy.

Ever increasing sophistication in our understanding of the patterns that influence substance use and abuse can only increase the ability of mental health practitioners to help. This in turn can improve psychotherapeutic support given to the medical practitioner as they strive to alleviate suffering, without being coopted into self-destructive patterns of substance abuse.

Articles:

1. Giordano GN, Ohlsson H, Kendler KS, Sundquist K, Sundquist J. Unexpected adverse childhood experiences and subsequent drug use disorder: a Swedish population study (1995-2011). Addiction. 2014; 109: 1119-27.

2. Sansone RA, Sansone LA. Substance use disorders and borderline personality: Common bedfellows. Innov Clin Neurosci. 2011; 8(9):10-13.

3. Szalavitz M. Genetics: No more addictive personality. Nature. 2015; 522: S48-S49.

4. Walsh R. Lifestyle and mental health. American Psychologist. 2011; 66: 579-592.

Books:

1. Nakken C. The Addictive Personality: Understanding the Addictive Process and Compulsive Behavior. Center City, MN: Hazelden: 1996.

Sexual Addiction

by Kaye Renshaw, M.A. Ph.D., Gerald Rogers, M.A., M.S.W.,Ph.D.

Sexual addiction, also known as compulsive sexual behavior and hypersexuality in the field of treatment of sexual behaviors, continues to present an elusive if not impossible diagnostic formula for classification. Once again, sexual addiction has failed to be acknowledged in the latest edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association in 2013. The DSM-V is the current standard for all mental health professionals to diagnose, classify and communicate regarding mental illnesses. (1) In the field of diagnosis and treatment, there is limited consensus on the nature of sexual addiction. Professionals cannot agree on the questions of whether sexual addiction stands alone as an addictive disease, co-occurs with chemical or other addictions, is paired with a compulsive disorder or is considered an impulse control disorder. Consequently, agreement on diagnostic criteria and formal diagnosis of Hypersexuality was rejected by the American Psychiatric Association, despite a field trial suggesting that proposed diagnostic criteria were valid and reliable. It appears that Hypersexuality will not be included in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, until: (1) defining features of sexual addiction have been identified (2) reliability and validity of specific sexual addiction criteria have been obtained cross culturally, and (3) prevalence rates of sex addiction are determined in representative epidemiological samples across the world, and finally (4) etiology and associated biological features are evaluated. (2)

Clinical Features of Sexual Addiction

Despite the absence of a formal diagnosis, the problematic behaviors associated with Hypersexuality continue to rise. Technology has played a role in increased concerns about sexual addiction. Pornography sites, sexual chat rooms, and other cyber sexual behaviors have become available at the flip of a switch and the touch of a fingertip. It is estimated that there are over 4 million pornography sites on the Internet, and over 2,000 new sites are added on the Internet every week. The late Dr. Alan Cooper, sex researcher, coined the phrase "The Triple A Engine", referring to the use of the Internet in facilitating sexual addiction. The Triple A Engine refers to accessibility, affordability, and anonymity. Prior to the development of the Internet, individuals had to go to great lengths to fulfill the needs of their sexually addictive behaviors. One could not easily talk to someone face-to-face about sexual desires, could not easily set up a rendezvous for sex with a stranger, and could not easily find pornography that would address sexual behaviors beyond the imagination.

Easy accessibility to a myriad of sexual behaviors, can lead to excessive time taken away from family and work responsibilities. The accessibility can damage marriages, friendships and day-to-day functions. The organization "Sexual Addicts Anonymous," uses a 12 step approach to sexual addiction. Their first step is: "We admitted we were powerless over addictive sexual behavior – that our lives had become unmanageable." (3).

A sexual addict's life becoming unmanageable is what leads to marital breakups, destruction of families, and occasionally legal entanglements for illicit sexual behaviors. This also leads the individual to seek professional intervention for their sexual behaviors.

The ease of access, affordability and anonymity associated with online sexualized sites has further increased the need for structured and consistent diagnostic criteria. Although these diagnostic criteria have not been formally endorsed by the American Psychiatric Association, they have informally been agreed upon by numerous clinicians in the field, faced with providing treatment to patients and families seeking interventions for problems related to hypersexual issues. In assessing an individual with complaints of sexual addiction, it is important to determine if the individual experiences recurrent and intense sexual fantasies, sexual urges, or sexual behaviors lasting more than six months, and at least three of the following are present:

- Time consumed by sexual fantasies, urges or behaviors repetitively interferes with other important obligations such as work or family life.
- Repetitively engaging in sexual fantasies, urges or behaviors in response to negative mood states such as anxiety, depression, boredom or irritability.
- Repetitively engaging in sexual fantasies, urges or behaviors in response to stressful life events.
- Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges, or behaviors.
- Repetitively engaging in sexual behaviors while disregarding the risk for physical or emotional harm to self or others.

There is significant personal distress or impairment in social, occupational, or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges, or behaviors. Further,these sexual fantasies, urges, or behaviors are not due to the direct physiological effect of a drug

of abuse or a medication.

These criteria are assessed specifically, but diagnoses for treatment generally take the form of another mental condition such as unspecific disruptive, impulse control, and conduct disorder as sexual addiction often cooccurs with additional mental or emotional conditions. (3)

Clinical Assessment of Sexual Addiction

Assessment of sexual addiction provides a further dilemma in the arena of patient management. Frequently the patient has been coerced, at the direction of the courts, an unhappy spouse, an employer or other entity whose assessment of the behavior is a much greater problem than the patient acknowledges. Further, the patient will likely engage a protective stance of denial well before the behavior is exposed or treatment is engaged. Frequently, the patient is not acknowledging a problem and, unless the courts are involved or the family is upset, there is no motivation for treatment. However where there is legal, family, or employment disruption, there may be multiple starts and stops to treatment before the identified patient acknowledges a problem. Provided the patient recognizes that there is a problem, assessment takes the form of self-report through multiple forms of sex history, trauma history, review of comorbid addictions and compulsions, history of traumatic brain injury and history of mental health disorders. There are few formal screening instruments available for assessment of sexual addiction. More research is currently being geared to this field, but there continues to be a lack of reliable resources for assessment. Screening checklists are available online and in a number of magazines. Screening checklists are not based on empirical data, and can lead to misdiagnosis of oneself, or misdiagnosis by a spouse or family member. Quickly administered checklists are not a substitute for professional assessments and opinions. Self labeling oneself as a sexual addict, or labeling by a family member as a sexual addict, can have far-reaching social implications.

Treatment of Sexual Addiction

The treatment of sexual addiction in no way fits the brief treatment model of standard counseling and therapy. Treatment of Hypersexual behaviors takes the form of individual therapy, group therapy and couples therapy. Cognitive Behavioral Therapy is the recommended therapeutic approach for treating addiction. CBT looks at the emotions and events that reinforce the desire to engage in the behavior and identifies alternative behaviors to short circuit the compulsive process. Focused group therapy can be helpful in providing external

reinforcement and support. Twelve-step programs, behavior modification programs, rational behavior programs, and biofeedback are also treatment modalities used in treating sexual addiction. Psychoactive medication is frequently indicated, with antidepressant medications, anti-anxiety medications, and medications identified specifically for compulsive disorders. When indicated, inpatient treatment may be recommended to reduce the outside stress of the patient while allowing focus on the treatment process. Treating sexual behavior problems requires careful consideration of the needs of the individual. Consideration must be given to avoidance of misdiagnosing individuals. Patients seeking treatment for sexual addiction must be given adequate informed consent regarding their diagnoses and treatment.

References

1.American Psychiatric Association: Diagnostic and Statistical Manual Of Mental Disorders, Fifth Edition. Arlington VA, American psychiatric Association, 2013.

2.Reid,RC,Kafka,MP. Controversies about Hypersexual disorder and the DSM-5. Curr Sex Health Rep (2014) 6:259-264. doi:10.1007/s11970-014-001-9.

3. Sex Addicts Anonymous, Third Edition. Houston TX, Sex Addicts Anonymous, 2012.

4.Kafka, MP. What happened to hypersexual disorder? Arch Sex Behav. doc:10. 1007/s 10508 – 014 – 0326 –y.

Kaye Renshaw, M.A. Ph.D. *received her bachelor of science degree in psychology from West Texas State University, and her master of arts degree in Psychology from West Texas A & M University. She received her Ph.D. in Human Sexuality from the Institute for Advanced Study of Human Sexuality. She is in full time private practice as a counselor.*

Gerald Rogers, M.A., M.S.W.,Ph.D*., received his Bachelor of Science degree in psychology and his Master of Arts degree in Counseling from West Texas State University. He also received a Master of Social Work degree from Our Lady of the Lake University. He received his Ph.D. (not CHEA recognized) in Human Sexuality from the Institute for Advanced Study of Human Sexuality. He is in full-time private practice as a Clinical Social Worker.*

Juvenile Drug Use in the Panhandle

by Sargent Brent Barbee, Public Relations Advisor and Liaison of the Amarillo Police Department.

Edited by Dr. Steve Urban

Editor's note: This article was provided by Sargent Brent Barbee, of the Amarillo Police Department, in order to update our readers about trends in illicit substance use, especially in the juvenile population of our area. It reviews recent APD experience with various agents of abuse.

Alcohol, in my opinion, continues to constitute the most widespread threat to juveniles across the social spectrum, for the same reason it has for years. Alcohol enforcement against minors tends to be strict when use is discovered, but permissive parent/public attitudes such as "At least they are doing it at home instead of out driving around" and restricted police resources limit the consequences that juveniles face. It is worth mentioning that, from January 1 to July 14, 2015, the City of Amarillo Municipal Court showed 23 citations for minor in possession of alcohol and 49 for minor consuming alcohol. These figures do not include custodial arrests which can result for the 17-20 year olds.

Marijuana use

As expected, marijuana is the most common illegal substance seized from juveniles. One Liaison officer described some of the difficulty in dealing with certain attitudes when juveniles are caught with marijuana. The juvenile's response is often that "it's natural" and "it's going to be legal some day anyway," or "it's already legal in Colorado." When some parents are contacted to take custody of a juvenile caught possessing the drug, those parents offer the same reactions or justify the use in a way that leads officers to believe that the parents themselves are users or at least not convinced of the danger or the propriety of illegality. I believe that marijuana advocates have used the "medical use" of marijuana to allow it to get a grip in current culture as possibly beneficial, or at least not as bad as alcohol--a weak justification. Marijuana advocates have established a persistent social media presence, and appear to be taking advantage of any opportunity in any story to post pro-pot comments. Social media's Astroturf roots are another way to convince everyone by making them think, "Well, if everybody else thinks it's okay…maybe I'm wrong?"

The 2014 study by the Prevention Resource Center, Region 1, Texas, "Trends of Teen Marijuana Use" gives

| *continued on page 18*

Happy • Abilene • Amarillo • Borger • Canadian • Canyon • Dalhart • DFW Metroplex • Dumas • Floydada • Hereford
Higgins • Lockney • Lubbock • Olton • Pampa • Panhandle • Plainview • Silverton Stratford • Sunray • Texline

Working to Keep You

HAPPY STATE BANK
EST. 1908
HAPPY, TEXAS

Happy

HAPPY STATE BANK
AND TRUST COMPANY

happybank.com

Member FDIC

For quality Skilled Nursing and Rehabilitation in the Texas Panhandle, trust The Arbors of Amarillo.

Locally owned and located next to Amarillo's Medical Center, The Arbors offers a quiet, comfortable and friendly place to help area residents get back on their feet.

Our skilled team of professionals put the patient first, providing exceptional results after a hospitalization.

- PHYSICAL THERAPY
- OCCUPATIONAL THERAPY
- SPEECH THERAPY
- SKILLED NURSING
- RESPIRATORY SERVICES
- WOUND CARE SERVICES
- INFUSION THERAPIES
- DIGESTIVE DISEASE SERVICES

THE ARBORS

SKILLED NURSING & REHABILITATION

1910 Medi-Park Drive | Amarillo, Texas 79106 | 806.457.4700
Referral line: 806.626.8641 | ArborsAmarillo.com

An affiliate of the Baptist Community Services Family, and a part of the Baptist General Convention of Texas Family

| *continued from page 15*
insight into local adolescents' opinions about marijuana. In that study, data concluded that the perceived risk of harm by marijuana went down from 75.9% in 2010 to 69.9% (number of adolescents who consider it either dangerous or somewhat dangerous). This is below the state average of 72.4%.

"Synthetic marijuana" and related substances

One problem still present is the use, but not just by juveniles, of "K2", which is now a generic word for JWH-018 and related compounds, often called synthetic marijuana or "spice" in the earliest references. They were, until 2011, referred to as "legal marijuana." When the DEA secured an emergency designation of them as illegal, makers changed the formula just enough to allow a technical designation as another chemical, in most jurisdictions muting the law or making prosecution very difficult. The chemical--or whatever chemical is now used to replace it--is still added to potpourri-like material and sold as "room deodorizer" or incense. Packaging it and selling it as "not for human consumption" can make prosecution difficult. In the recent past, shops have been known to sell products labeled "not for human consumption" but as incense that users buy and smoke in an effort to get their K2 high. Some shops investigated by APD narcotics have taken steps to show that they are selling it to people who are made aware very directly that it is "sold as incense, not for human consumption." If nothing else, this adds a layer of difficulty to prosecution.

APD Narcotics investigators have sent samples of "K-2" purchased in local stores to the state lab, but so far the tested samples have not turned up specifically barred chemicals. They have been shown to contain varied identifiable and non-identifiable additives, including in one case a prescription antibiotic. There has been a great deal of education of the dangers of these substances through local resources such as the Impact Futures Coalition. Lawmakers are making efforts to understand and overcome the effort by sellers to provide these substances.

Officers assigned to the Amarillo Independent School District (APD School Liaison officers) believe that K2 use has declined. When asked why, one officer remarked, "I think it is getting around that this stuff just does not get you high." The officer explained that juveniles see other juveniles having adverse reactions severe enough to generate medical response--agitation, racing heart, sweating, confusion, and other similar responses which can include an ambulance trip to the hospital. They have firsthand, personal knowledge that it is harmful. This is not to say that the substance is not used at all, as students have been brought to the department's attention not just due to illness but with visible signs of intoxication. Despite a lack of criminal cases, there are police reports of people, including juveniles, self reporting reactions that that they attribute to K2, reactions that qualify them for medical attention.

Locally, the Winter 2015 study provided by the Prevention Resource Center, Region 1, Texas concluded that consumption of synthetic cannabinoids is down 4.4% in this area, though state wide, exposures have sharply increased. Perhaps the local kids are ahead of the curve on not using it, and the Liaison officer's impressions and the study are correct.

National figures (not confined to juveniles) may not reflect this trend. CDC figures point to an actual increase in telephone calls to U.S. poison control centers due to these substances in the first quarter of 2015. The question I would ask would be "Does the CDC confirm the calls made are about substances in the JWH "family," or for substances that we have not indentified except that the callers said it was K2?"

Recently, Impact Futures has reported 15 cases in which K2 was used by/possessed by someone, either by itself or in conjunction with other substances. They reported 7 public intoxication arrests, 5 DWI arrests, and 2 for warrants or unrelated charges. One case involved no arrest, just medical transport. A total of 8 patients were treated or transported by ambulance in connection with their ingestion of K2 or what the officers believed to be K2. One case mentioned bath salts; one case mentioned smoking a prescription pain killer with the K2 substance. Alcohol was involved in one by admission and was probably involved in others.

Prescription drugs: diversion and abuse

Prescription pill usage, though not specifically separated out of case data, is anecdotally the next most commonly seen youth choice. As with adults, juveniles obtain the drugs "on the street" after small quantities are stolen from anyone who leaves a prescription bottle accessible. Hydrocodone has in the past been most highly visible, but increasingly, what they call Xanax "bars" are being seized from younger drug users. Muscle relaxers also have been seized, but the recovery of the drugs is probably in proportion to what can easily be stolen rather than actual popularity or use. Officers theorize that the increased restrictions on prescription of Hydrocodone are having an effect in limiting supply. Seizure of prescription pills from juveniles is most commonly limited to a few pills at a time, often recovered in a school setting as a result of a tip to administrators.

Hydrocodone and OxyContin have been preferred targets in pharmacy burglaries. After a large pharmacy burglary, I have always expected to see an increase in local availability, but have not in the past been able to detect a surge in local arrest or seizure levels. This leads me to believe that the "take" from these burglaries is already sold or on the way out of town with an established buyer, explaining why they may not be immediately visible in the hands of local juvenile users.

In the past few years, I have seen one or two clusters of overdoses of Fetanyl in young people, sometimes three or four in a week or two, often with fatalities. In these cases, the victims are *older than school age, usually late teens to early twenties.* With this type of overdose, it seems to all happen within a compressed period of time, leading me to suspect a common source. To my knowledge, investigators have not tracked the source down to prove that. Witness cooperation is limited in these events, but when officers respond, they find the youthful victim dead or unconscious. In some cases, the Fetanyl patch or part of one has been chewed and is in the victim's mouth. Officers look for the patch wrappers that

are usually in a nearby trash can. Again, I need to stress that these have not been juveniles, but young adults.

Methamphetamine, cocaine, and other "hard" drugs

I spoke to Juvenile, School Liaison, and Narcotics Unit officers about what appears to be a very limited number of arrests or detentions of juveniles using methamphetamine or other hard drugs. This information only deals with the juveniles we catch, obviously, but the number of reports showing use of cocaine, methamphetamines, and other drugs indicates the comparative rarity of use compared to that by adults. In speaking to officers from all three units that deal with juvenile offenders, they recalled only a couple of juveniles have been arrested for methamphetamine use. No one that I talked to could recall recently catching a juvenile with methamphetamine, at least not a "legally defined" juvenile, a person 16 or under.

A couple of cases of hard drug use/possession by juveniles were reported in 2014, one involving methamphetamine and one cocaine. Those two instances arose from car stops, one of armed robbery suspects with a juvenile involved, and another of a traffic stop. Narcotics Unit investigators recalled at least one past instance of a juvenile suspect with a methamphetamine smoking pipe, but this was in a house where other hard drugs were present, and drug use was probably an acceptable behavior. Narcotics investigators usually direct efforts toward distributors rather than simple users, so that tends to take them away from the juvenile suspects who are not at this point found to be active dealers or steady users of methamphetamine, heroin, or cocaine. Perhaps alcohol and marijuana's comparative ease of access and level of satisfaction with the readily available contraband discourages them. I'm not convinced that the lack of visibility of these cases means they don't exist.

"Vaping" and illicit drug use

Officers have recently seized one "vape," in this case a home crafted version of the device normally used to vaporize and inhale nicotine, being used by juveniles to inhale a liquid that tested positive for marijuana or related substances. This was on a school parking lot. These items, normally used by juveniles to inhale flavored vapor, are not permitted in schools. It's not practical to field test those seized by school personnel to determine if they have residue that indicates contraband use, but officers have some concern that they may allow people to more easily use illegal substances like marijuana in the oil form or other drugs dissolved in liquid. At this point, this is more of a concern than a documented threat. The "vapes", commercially promoted as "safer" than cigarettes despite containing substances you wouldn't want in your child's body, may also appeal to young people as a "safer" way to use drugs. This is a more technical/commercial version of the drug users' belief that smoking methamphetamine is less dangerous than intravenous use of the drug.

In summary, the comparative ease and low expense of alcohol make it the most widespread problem. Marijuana can be purchased in an inexpensive quantity. Pills can be stolen from friends and relatives. I think the availability of each of these substances, and the satisfaction by the relatively inexperienced, youthful drug user, will continue to keep them as the most commonly abused substances for the foreseeable future.

Addendum on the consequences of marijuana legalization in Colorado, from LaViza Matthews, project director of Impact Futures *(www.impactfutures.org)*. She thanks Patrick Kennedy for sharing this information.

Section 1 – Impaired Driving:

- Traffic fatalities involving operators testing positive for marijuana have increased 100 percent from 2007 to 2012.
- The majority of driving-under-the-influence-of-drugs arrests involve marijuana and more than 25 percent were marijuana alone.
- Toxicology reports with positive marijuana results for driving under the influence have increased 16 percent from 2011 to 2013.

Section 2 – Youth Marijuana Use:

- In 2012, 10.47 percent of youth ages 12 to 17 were considered current marijuana users compared to 7.55 percent nationally. Colorado, ranked 4th in the nation, was 39 percent higher than the national average.
- Drug-related suspensions/expulsions increased 32 percent from school years 2008/2009 through 2012/2013. The vast majority were for marijuana violations.

Section 3 – Adult Marijuana Use:

- In 2012, 26.81 percent of college age students (ages 18 – 25 years) were considered current marijuana users compared to 18.89 percent nationally. Colorado, ranked 3rd in the nation, was 42 percent higher than the national average.
- In 2012, 7.63 percent of adults ages 26 and over were considered current marijuana users compared to 5.05 percent nationally. Colorado, ranked 7th in the nation, was 51 percent higher than the national average.
- In 2013, 48.4 percent of Denver adult arrestees tested positive for marijuana which is a 16 percent increase from 2008.

Section 4 – Emergency Room Marijuana Admissions:

- From 2011 through 2013, there was a 57 percent increase in marijuana-related emergency room visits.
- Hospitalizations related to marijuana have increased 82 percent from 2008 to 2013.
- In 2012, the City of Denver rate for marijuana-related emergency visits was 45 percent higher than the rate in Colorado.

Our Next Issue Of

Panhandle Health

Features:
Nutrition approaches to disease management

Happy Holidays

from the Potter-Randall County Medical Society Active Members

Ismaile H. Abdalla	M.D.	Londa G. Carrasco	M.D.	Adan Gonzalez	M.D.
Anthony Agostini	D.O.	Debora E. Carrizo	M.D.	Stephen J. Griffin	M.D.
Syed H. Ahmed	M.D.	Ricardo J. Carrizo	M.D.	Robert D. Gross	M.D.
Subhan Ahmed	M.D.	Rhodesia A. Castillo	M.D.	Jill A. Gulizia	M.D.
MD Jewel Ahmed	M.D.	Harry J. Cazzola	M.D.	Christopher Gulley	M.D.
Brendan C. Albracht	D.O.	Pamela A. Chandler	M.D.	Eric C. Guy	M.D.
Douglas A. Albracht	D.O.	John Richard R.Chandler	M.D.	John Gwozdz	M.D.
Walter M. Allison	M.D.	Richard D. Chandler	D.O.	Stephen O. Haas	M.D.
James R. Allman	M.D.	David L. Chastain	M.D.	Rolf Habersang	M.D.
Julie Allman	M.D.	Ben Chavez	M.D.	Jon L. Haddad	M.D.
Masoud A. Alzeerah	M.D.	Ming Chen	M.D.	William P. Hale	M.D.
John L. Andrew	M.D.	David M. Childress	M.D.	James D. Hale	M.D.
Carin C. Appel	M.D.	Alfred A. Chu	M.D.	Michael Jay Hall	M.D.
Gary L. Aragon	M.D.	Joyce C. Chuachingco	M.D.	Ruba A. Halloush	M.D.
Antonio V. Aragon	M.D.	Crandon F. Clark	M.D.	Ellen Hampsten	M.D.
Branch T. Archer	M.D.	Kathleen A. Clark	M.D.	Victor V. Hands	M.D.
Estelle Archer	M.D.	David B. Clarke	M.D.	John P. Harvey	M.D.
Richard K. Archer, Jr.	M.D.	Jeffrey D. Cone	M.D.	Brian J. Haseloff	M.D.
Lova T. Arenivas	M.D.	Elaine R. Cook	M.D.	Raj Hashmi	M.D.
Cesar J. Arias	M.D.	Stanley D. Cook	M.D.	Joseph P. Heitzman	D.O.
Assadour Assadourian	M.D.	John L. Coscia	M.D.	Daniel J, Hendrick	M.D.
Peter L. Baay	M.D.	S. Lane Cox	M.D.	Hillary Hendrick	M.D.
Mohammed Bahaa Al-Deen	M.D.	Eric C. Cox	M.D.	Marc Henson	M.D.
T. Bruce Baker	M.D.	Dhana Cox	M.D.	Pedro R. Hernandez-Lattuf	M.D.
Teresa E. Baker	M.D.	Peter B. Craig	M.D.	Randy Hines	M.D.
Christi A. Baker	M.D.	Tracy C. Crnic	M.D.	M. Cameron Hodges	M.D.
Kuldip S. Banwait	M.D.	Reagan L. Crossnoe	M.D.	William M. Holland	D.O.
Brian F. Barkley	M.D.	Samuel J. Cunningham	M.D.	Joseph D. Hollingsworth	M.D.
George Barnett	M.D.	Albert Cura	M.D.	Shane Holloway	M.D.
Bill Scott Barnhill	M.D.	Tully J. Currie	M.D.	Heather J. Holmes	M.D.
Scott Bass	M.D.	Bejan J. Daneshfar	M.D.	Andrew Hoot	M.D.
Perry E. Bassett	M.D.	Michael E. Daniel	M.D.	R. Cullen Hopkins	M.D.
Andrew W. Bauer	M.D.	John L. David, Jr.	M.D.	Brett W. Horn	M.D.
Richard H. Bechtol	M.D.	Prakash K. Desai	M.D.	Luzma M. Houseal	M.D.
Jesus R. Benitez	M.D.	Pablo R. Diaz-Esquivel	M.D.	Debbie P. Hoving	M.D.
Mike Preston Berry, Jr.	M.D.	Nam Do	M.D.	Amber M. Howell	M.D.
Ravindra M. Bharadwaj	M.D.	Amber Dobler-Dixon	M.D.	Curtis R. Hudson	M.D.
Chand Bhasker	M.D.	L. Edwin Dodson	M.D.	Melburn K. Huebner	M.D.
William C. Biggs	M.D.	Chuck A. Duke	M.D.	James M. Hurly	M.D.
Keith D. Bjork	M.D.	Keith Dyer	M.D.	Dennis A. Ice	M.D.
William H. Bordelon	M.D.	John P. Dzik	D.O.	Esther O. Iheukwumere	M.D.
David Brabham	D.O.	Brian J. Eades	M.D.	Marc David Irwin	M.D.
Ako D. Bradford	M.D.	William R. East	M.D.	Chance L. Irwin	M.D.
Todd W. W. Bradshaw	M.D.	Susan E. Ellington	M.D.	Mouin M. Jaber	M.D.
Ken M. Brantley	M.D.	Aaron Elliott	M.D.	Ali Jaffar	M.D.
Victor L. Bravo	M.D.	Bret D. Errington	M.D.	Daniel G. Jenkins	M.D.
Walter J. Bridges	M.D.	W. Vance Esler	M.D.	Michael D. Jenkins	M.D.
David E. Brister	M.D.	Anthony J. Fillmore	M.D.	Richard L. Jennings	M.D.
Bart A. Britten	M.D.	Rex A. Fletcher	M.D.	Paul Jew	M.D.
Charles D. Brooks	M.D.	Ronald W. Ford	M.D.	Thomas L. Johnson	M.D.
Gary L. Brown	M.D.	Leonardo Forero	M.D.	Jason K. Jones	M.D.
David H. Bruton	M.D.	Jeffrey L. Foster	D.O.	Robert P. Kauffman	M.D.
James D. Bryan	M.D.	Christina G. Fox	M.D.	Alan W. Keister	M.D.
Bill F. Byrd	M.D.	Dudley E. Freeman, III	M.D.	Kyle Kennedy	M.D.
Agustin Cabrera-Santamaria	M.D.	J. Brett Gentry	M.D.	James A. Kenney	M.D.
Jon L. Caldwell	M.D.	Robert E. Gerald	M.D.	Richard C. Khu	M.D.
Turner M. Caldwell, III	M.D.	James E. Gibbs	M.D.	Richard G. Kibbey, III	M.D.
J. Taylor Carlisle	M.D.	Milton A. Giron	M.D.	Hee Won Kim	M.D.
Roberto B. Carrasco	M.D.	Susan Goetz	M.D.	John W. Klein	M.D.

Rouzbeh Kordestani M.D.
Dianne S. Lackan-McKenzie M.D.
Ronald R. Lacy M.D.
Michael O. LaGrone M.D.
Michael J. Lamantee M.D.
Angela B. Lampkin M.D.
David C. Langley M.D.
Michael A. Lary M.D.
Abby S. Leake M.D.
Nam K. Lee M.D.
Benjamin J. Leeah M.D.
Jake C. Lennard M.D.
Douglas E. Lewis D.O.
Sien H. Lie M.D.
Jerod Lunsford M.D.
James E. Lusby M.D.
Stacia Lusby M.D.
Lewis C. Lyons M.D.
Lyudmyla Lysenko M.D.
Taghreed N. Maaytah M.D.
Georges M. Maliha M.D.
James "Brian" Malone M.D.
Michael S. Manderson M.D.
Todd H. Martin M.D.
Reg C. Martin M.D.
James B. Martindale M.D.
Robin Martinez M.D.
Joaquin Martinez-Arraras M.D.
Sambasiva Rao Marupudi M.D.
James W. Mason M.D.
Gregorio Matos-Serrano M.D.
Nazre Mawla M.D.
Gregory May M.D.
Farley E. Mba M.D.
Lawrence R. McAfee M.D.
Morgan H. McCaleb M.D.
Rebecca Archer McCarthy M.D.
Edward M. McCarthy M.D.
C. Allan McCarty M.D.
Allan J. McCorkle M.D.
James Scott McCown M.D.
John P. McKinley M.D.
Kathryn E. McNeil M.D.
David G. McNeir M.D.
Shari Medford M.D.
Clyde Meeks M.D.
Rahul C. Mehta M.D.
Daniel J. Merki M.D.
Thomas E. Merriman M.D.
Scott D. Miller M.D.
Sean M. Milligan M.D.
Jennifer Milner M.D.
J. Scott Milton M.D.
Hernan E. Miranda M.D.
Holly Mitchell M.D.
Timothy S. Mooring M.D.
Marc Moreau M.D.
Darrell Morgan M.D.
Stacie S. Morgan M.D.
R. Thane Morgan M.D.
Sergio E. Muniz M.D.
Amanda D. Murdock M.D.
Richard G. Murray M.D.
John W. Murrell M.D.
Brian S. Murrell M.D.
Suhasini Nadesan M.D.
Stuti Nagpal M.D.
Tarek H. Naguib M.D.
Rajesh Nambiar M.D.
Suresh B. Neelagaru M.D.
Susan L. Neese M.D.
Bo T. Neichoy M.D.
Mike S. Nguyen M.D.
Lyle J. Noordhoek M.D.
Steven K. Norris M.D.
Joshua D. North M.D.
Izi D Obokhare M.D.
Abdel Rahman Omer M.D.
Joel C. Osborn M.D.
S. Carl Paetzold M.D.
Robert W. Paige M.D.
Paul F. Pan M.D.
James R. Parker M.D.
Virgil A. Pate M.D.
Vinod S. Patel M.D.
Srinivas Pathapati M.D.
Wayne C. Paullus III M.D.
Wayne S. Paullus Jr. M.D.
Phillip O. Periman M.D.
Jeffrey S. Pickens M.D.
Ruth Pilco-Jaber M.D.
Robert L. Pinkston M.D.
Robert T. Pinson D.O.
Mary Ann Piskun M.D.
Carlos A. Plata M.D.
Dennis P. Plummer M.D.
Gary R. Polk M.D.
Amber M. Price M.D.
Liana H. Proffer M.D.
Patrick J. Proffer M.D.
Paul L. Proffer M.D.
Brian Pruitt M.D.
Nandkishore Raghuram M.D.
Ron K. Rankin M.D.
Anita Ravipati M.D.
Arunava D. Ray M.D.
Srini B. Reddy M.D.
James F. Reid M.D.
Mark Wayne Richardson M.D.
Kevin J. Rickwartz M.D.
Joan E. Riker M.D.
Timothy (Toby) M. Risko M.D.
Robert H. Ritter M.D.
Ernesto Rivera M.D.
Larry C. Roberts M.D.
Pablo S. Rodriguez M.D.
Elise Roe M.D.
Jeri K. Rose D.O.
J. Avery Rush M.D.
James A. Rush M.D.
Sloan W. Rush M.D.
Ryan B. Rush M.D.
Constantine K. Saadeh M.D.
Jesus N. Sahad M.D.
Armando Salcido, Jr. M.D.
Thomas A. Sames M.D.
Raj Saralaya M.D.
Shilpa R. Saralaya M.D.
Ruby Saulog M.D.
Evelyn D. Sbar M.D.
Matthew C. Scalapino M.D.
Lawrence A. Schaeffer M.D.
Daniel L. Schneider M.D.
Brian M. Schneider M.D.
Matthew B. Schniederjan M.D.
Janet Schwartzenberg M.D.
Rebecca Scott M.D.
Michael D. Sennett M.D.
Usha Sethi M.D.
Rakesh Shah M.D.
Stewart A. Sharp M.D.
Isaac Siew M.D.
Jerry G, Simpson M.D.
J. Brian Sims M.D.
Manu Singh M.D.
John Slaton D.O.
Monte L. Slatton M.D.
Aubrey Smith M.D.
Earl C. Smith M.D.
Kent K. Sorajja M.D.
D. Gary Soya M.D.
James S. Spurlock M.D.
C. V. Sreenivasan M.D.
James Stafford M.D.
Mark E. Stevens M.D.
Randy L. Stewart M.D.
Grace L. Stringfellow M.D.
Robert H. Stroud M.D.
Sivaram Sudhakar M.D.
Jan Swan M.D.
Andrew B. Tatah M.D.
Victor M. Taylor M.D.
C. Sloan Teeple M.D.
Hagos Tekeste M.D.
Hena Tewari M.D.
Abdul S. Thannoun M.D.
Margaret Thurmond-Anderle M.D.
Stephen T. Tidwell D.O.
Robert M. Todd M.D.
Amit K. Trehan M.D.
Salil K. Trehan M.D.
Paul E. Tullar M.D.
Praveen K. Tumula M.D.
Matthew Turney M.D.
David L. Tyson M.D.
Robert S. Urban M.D.
Stephen J. Usala M.D.
Martin Uszynski M.D.
Julito P. Uy M.D.
Bradley B. Veazey M.D.
Lisa E. Veggeberg M.D.
Neil Veggeberg M.D.
Nika Vinson M.D.
Meganne Walsh M.D.
Bang Wan M.D.
Kimberly Waugh M.D.
Bruce L. Weinberger M.D.
Cody J. Welch M.D.
Carmen M. Werner M.D.
Jeffery T. Whelchel M.D.
David M. Wilhelm M.D.
Michael D. Wilkerson M.D.
Clyde M. Williams M.D.
Michael D. Williams M.D.
Sheryl L. Williams M.D.
Anwar C. Wilson M.D.
Joanna D. Wilson D.O.
Susan T. Wingo M.D.
Joseph J. Wolcott M.D.
Geoffrey L. Wright M.D.
Angela Wright M.D.
Christopher C. Wright M.D.
Douglas B. Wyatt M.D.
John M. Young M.D.
Rodney B. Young M.D.
J. Edward Ysasaga M.D.
Lawrence P. Zarian M.D.

Marijuana: Impact of Legislation in Colorado on Law Enforcement in Texas

by Representative from the District Attorney's Office

On January 1, 2014, Colorado legalized the sale of marijuana for recreational use to anyone over the age of 21.[1] In the great state of Texas marijuana use, possession, and sale is still illegal. This is codified in laws against both marijuana and THC. Health and Safety Code Section 481 criminalizes possession of marijuana and delivery of marijuana to an adult or to a child.[2] Marijuana is defined as "the plant Cannabis sativa L., whether growing or not, the seeds of that plant, and every compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds."[3] In comparison, THC is listed as a penalty group 2 substance, which carries significantly higher penalties than possession of marijuana itself.[4] Penalty group 2 substances are illegal to manufacture, deliver, or possess. [5]

This distinction between marijuana and THC plays out in important ways when considering the impact Colorado's laws are having in Texas. The laws concerning THC apply to what are generally called "edibles." Edibles are simply food products that have been infused with THC, the primary psychoactive ingredient in marijuana, and they make up approximately 45% of the legal cannabis marketplace in Colorado. One reason edibles might be so popular is that they are easy to consume, and have been referred to as "pot for beginners."

The first impact that Texas prosecutors have seen from Colorado's legalization of marijuana is a somewhat increased caseload. When Colorado legalized the sale and recreational use of marijuana estimates varied about the degree of impact the decision would have on surrounding states. Would there be an influx of people going to Colorado specifically so they could legally use marijuana or would the impact be primarily on Colorado residents themselves? The Marijuana Enforcement Division in Colorado estimates that as of summer 2015, close to 90% of recreational sales in areas like mountain towns and ski resorts are made to tourists visiting the state. Out-of-state visitors to Colorado are able to purchase not only marijuana for smoking, but edibles that contain THC.

Anecdotally, here in the Panhandle we have had a number of cases that involve individuals travelling to or from Colorado. Those cases generally begin with a traffic stop, usually on an interstate highway. A search of a vehicle will yield marijuana or edible products purchased legally in Colorado but that are still illegal here in Texas. We have also seen cases where the person is transporting hash oil or hash wax. Both contain THC. The oil can be smoked in an e-cigarette or infused into any other product, and the wax can be vaporized and ingested. While most people know that obtaining marijuana or THC products is legal in Colorado, many have not given much thought to the legality of traveling with those products back to their homes. Similar problems arose when states legalized medical marijuana. People traveling through Texas attempted to use their medical marijuana cards as a defense to being prosecuted for possessing and/or transporting marijuana in and through this state. Legal marijuana and edibles in Colorado leaves prosecutors with the question of how to best deal with people who have purchased a product legally in another state and then committed a crime by coming into our state.

The problem is complicated further by the way Texas law treats edibles versus regular marijuana. The degree of offense on a controlled substances case in Texas is dependent upon the weight of the substance that is possessed. The weight includes adulterants and dilutants, or anything the substance is mixed with.[9] Edibles that are legally produced and sold in Colorado are defined in Texas as THC with adulterants and dilutants. That means that a marijuana infused cookie or brownie is going to be classified as a Penalty Group 2 substance, and the entire weight of the food item will count in determining what level of felony possessing the item is. A relatively small amount of THC, then, infused in an edible, can carry a very significant punishment range that would normally be reserved for larger amounts of pure THC.

The second potential impact on Texas prosecutors from Colorado's legalization of marijuana is that we'll see an increased argument for legalization here as well. One of the major arguments made in favor of legalizing marijuana is that it will benefit the state financially. As of July 2015, a little over a year and a half into the "legalization era" in Colorado, the state had issued close to 2500 licenses for marijuana cultivation, production, testing facilities, and retail stores.[10] Those new business have brought in over $79 million in taxes and fees during fiscal year 2015.[11] Proponents of legalization are quick to point out the many ways that money could be used throughout Texas. However, the financial data about revenue does not account for the costs that the state of Colorado has incurred from the legalization of marijuana. Such costs include associated medical costs,[12] enforcement costs, and regulation costs. It is impossible to say how much of the profits are being funneled into associated costs and how much the state is benefitting financially overall.

The third impact that Texas will likely see from Colorado's legalization of marijuana is an increased focus on drug policy nationwide. Already the issue is getting national attention, with President Obama and members of the Justice Department pushing for a nationwide reduction of sentences for non-violent drug offenses.[13] Texas law already accounts for the needs of non-violent drug users (not dealers) to have access to rehabilitation. Probation is mandatory for possession of less than a gram of a controlled substance so long as the offender has never before been convicted of a felony.[14] The same is true for possession of marijuana, so long as the amount is less than two pounds. These mandatory probation cases show that Texas has already addressed the concerns

that are being discussed nationwide. People in Texas who are getting lengthy prison sentences for drug-related offenses are either dealing drugs, have a lengthy criminal history, or some other aggravating factor. Low-level drug users with no criminal history are required to be given an opportunity at probation by law.

The final impact that I'd like to discuss about the legalization of marijuana deals more specifically with health care professionals, not prosecutors. Although it is early in the process to be drawing any definitive conclusions about the long-term effects marijuana legalization will have in Colorado, some early data indicates that health care professionals will be severely impacted. The Rocky Mountain High Intensity Drug Trafficking Area (RMHIDTA) tracks the impact of legalization through the early medical marijuana era all the way through legalization and the present.[15] Their findings show that since retail marijuana business opened shop in 2014, there has been a 32% increase in marijuana related traffic deaths as compared to 2013.[16] It is likely that traffic accidents that involve injury and not death have increased as well, putting an increased burden on hospitals. Apart from just traffic related incidents, 2014 saw a 29% increase in the number of emergency room visits and a 38% increase in hospitalizations that were related to marijuana.[17] Specific instances that received heavy media coverage include a Wyoming college student who died after eating a marijuana cookie and then jumping off a hotel balcony in Denver and an increase in the number of kids brought to emergency rooms for accidental marijuana ingestion.[18] These types of problems and studies have resulted in calls for stricter labelling of edibles and increased regulation of THC levels. Additionally, there are potential health risks associated with the food that the THC is infused into. A lack of current regulation on THC edibles could present medical issues from the food items themselves as opposed to the THC.

Despite any such increased regulation, however, health care providers should be aware that an increase in access to these products is likely to result in an increase in associated medical problems. Legal marijuana and THC-products mean more people have access to those products, and that increases the likelihood of impaired driving, accidental overdoses, and other associated health problems. Even veterinarians in Colorado have seen an increase in animals presented for accidental marijuana ingestion and related health problems.[19] Only more time will tell if these accidental ingestions and overdoses continue to increase or can be combated with stricter regulations and oversight.

[1] "10 things to know about nation's first recreational marijuana shops in Colorado," by Michael Martinez, CNN.com, posted January 1, 2014.

[2] Health and Safety Code Sec. 481.120 is Delivery of Marihuana, Section 481.121 is Possession of Marihuana, and Section 481.122 is Delivery of Controlled Substance or Marihuana to Child.

[3] Health and Safety Code Section 481.002(26).

[4] Penalty Group 2 substances are listed in Health and Safety Code Section 481.103. f

[5] Manufacture or Delivery of a Substance in Penalty Group 2 is criminalized by Health and Safety Code Section 481.113, and Possession of a Substance in Penalty Group 2 is criminalized by Section 481.116.

[6] "New rules in effect for Colorado marijuana edibles Feb. 1," by Ricardo Baca, The Cannabist, thecannabist.com, posted January 29, 2015.

[7] "New rules in effect for Colorado marijuana edibles Feb. 1," by Ricardo Baca, The Cannabist, thecannabist.com, posted January 29, 2015.

[8] "Colorado profits, but still divided on legal weed," by Clarissa Cooper, The Center for Public Integrity, publicintegrity.org, posted August 16, 2015.

[9] Health and Safety Code Section 481.002(49) defines adulterant or dilutant as "any material that increases the bulk or quantity of a controlled substance, regardless of its effect on the chemical activity of the controlled substance."

[10] "Colorado profits, but still divided on legal weed," by Clarissa Cooper, The Center for Public Integrity, publicintegrity.org, posted August 16, 2015.

[11] "Colorado profits, but still divided on legal weed," by Clarissa Cooper, The Center for Public Integrity, publicintegrity.org, posted August 16, 2015.

[12] See discussion at the end of this article.

[13] "Obama cuts sentences of 46 drug offenders," by Colleen Nelson and Byron Tau, The Wall Street Journal, *www.wsj.com*, posted July 13, 2015.

[14] Texas Code of Criminal Procedure, Article 42.12, Sectional 15(a).

[15] "The legalization of marijuana in Colorado: the Impact Volume 2," created by analysts at the Rocky Mountain high Intensity Drug Trafficking Area, available at rmhidta.com, published September 2015.

[16] "The legalization of marijuana in Colorado: the Impact Volume 2," created by analysts at the Rocky Mountain high Intensity Drug Trafficking Area, available at rmhidta.com, published September 2015.

[17] "The legalization of marijuana in Colorado: the Impact Volume 2," created by analysts at the Rocky Mountain high Intensity Drug Trafficking Area, available at rmhidta.com, published September 2015.

[18] "New rules in effect for Colorado marijuana edibles Feb. 1," by Ricardo Baca, The Cannabist, thecannabist.com, posted January 29, 2015.

[19] "CVMA Summary: pets and accidental ingestion of marijuana," Colorado Veterinary Medical Association, *www.colovma.org*, last accessed September 30, 2015.

Cannabis Induced Myocardiopathy "An old acquaintance rediscovered as a new evil"

Authors: Mohammed Bahaa Al Deen, M.D., Nibras Talibmamury, M.D., Essam Nakhla, M.D., Roger Smalligan, M.D., Rahul Chandra, M.D.

Introduction

Cannabis is Schedule I controlled substance according to Controlled Substance Act 1970, yet there is a bill processing currently in American congress about legalizing it for medical and non-medical purposes. American states that have legalized marijuana for both medical and non-medical use include Oregon, Colorado, Washington, and Alaska, with 23 other states legalizing it for medical purposes only. Although often considered a relatively benign drug, serious complications of cannabis use have been described. Here we report a case of probable cannabis-induced cardiomyopathy and briefly review the cardiac effects of marijuana use.

Case Report

A 21--year-old African American woman with no past medical history, on no prescription medications, presented with nausea and vomiting that started a few hours after smoking marijuana. She was seen in the ER and sent home with pantoprazole. The patient returned 8 hours later with severe mid-chest tightness, 10/10 in intensity, which woke her up from sleep. The pain radiated to both shoulders and jaw with some shortness of breath, sweating, nausea and non-bloody vomiting. There were no aggravating or relieving factors. She denied any history of trauma or of previous chest pain/heart attack. She denied any family history of premature MI or CVA. She used occasional alcohol but denied binge drinking. She admitted to smoking marijuana for the last 2 years. Physical exam: BP 124/77, heart rate 90/min, respirations 14/min, temperature 98.1F, O2 saturation 100% on room air. Heart examination showed regular rate and rhythm without murmurs, gallops, or rubs. Lung and abdominal exams were normal. She had normal distal pulses, no calf tenderness, no leg edema, and no skin rash.

Laboratory studies included: normal WBC and differential, hemoglobin 13.4 gm/L. Electrolytes, liver function and lipase were all normal. Troponin was elevated at 0.78 ng/L and 2 hours later was 1.56 ng/L . Urine toxicology was positive for only cannabis. Alcohol level was zero. Pregnancy test was negative. Chest X-ray was normal. The first EKG was normal sinus rhythm with prolonged QT interval of 549 ms, but a few hours later she developed diffuse ST wave changes and multiple ventricular ectopic beats with QT interval of 586 ms. Later, she developed runs of non-sustained ventricular tachycardia (NSVT).

Hospital Course: The patient was initially treated as acute coronary syndrome with full dose heparin, aspirin, ACEI, statin, beta blocker, nitroglycerine and amiodarone drip for her NSVT. Echocardiogram showed normal left ventricular ejection fraction at 60%, mild ventricular enlargement, a small pericardial effusion and mild tricuspid regurgitation.

Left heart catheterization/Venrticulogram was done within few hours and showed normal R/L coronary circulation but decreased left ventricular compliance. Her HIV, hepatitis, Coxsackie, West Nile virus, Mycoplasma and Chlamydia testing were all negative. After the heart catheterization, the patient developed pleuritic chest pain. Her EKG showed tall T waves in V2-V5, and questionable ST elevation on antero-lateral leads. These changes responded to ibuprofen.

In light of acute cannabis abuse with positive troponins, diffuse ST changes/NSVT on EKG/Telemetry, ventricular enlargement and poor left ventricular compliance by TTE, but with negative cardiac catheterization for atherosclerosis, the patient was diagnosed with acute cannabis induced myocarditis. Her condition was stabilized and she was discharged in good condition three days later.

Three months later, she was seen again in ED for pleuritic chest pain. This time her troponin was normal and her EKG showed only early repolarization. She again improved with ibuprofen.

Discussion

Cannabis sativa or marijuana has been known to man since 800 A.D, as a substance that alleviates pain and cures insomnia. Over time cannabis developed into one of the most widely misused recreational drugs. It has a dose-dependent acute effect on the autonomic nervous system. At low doses it causes an increase in sympathetic activity and a decrease in parasympathetic activity. This causes tachycardia and increased cardiac output. High doses of cannabis inhibit sympathetic activity and increase parasympathetic activity leading to bradycardia and hypotension. There have been reports of reversible EKG abnormalities affecting P waves, T waves, ST segment, and an increase in supra-ventricular and ventricular ectopic activity. Acute cardiac effects of Cannabis occur commonly in the first 2- 72 hours of intoxication. In very rare cases, it can cause permanent damage to myocardial cells.

Cannabis has been linked to acute coronary vasospasm manifesting as acute coronary syndrome. Peripheral arteriopathy (Cannabis arteritis) has also been reported. There are also case reports of cardiac muscle damage manifesting as myocarditis, myopericarditis and serious cardiac arrhythmias, including sudden cardiac death, especially if combined with alcohol. The severity of myocarditis is variable with occasional permanent damage leading to heart failure, with one report of a patient requiring a left ventricular assist device. Myocardial biopsy pathology has shown sparse

| *continued on page 26*

WESTERN BUILDERS
LEGACY OF 60 SERVICE

1955 - 2015

Celebrating 60 Years of Excellence throughout the Region

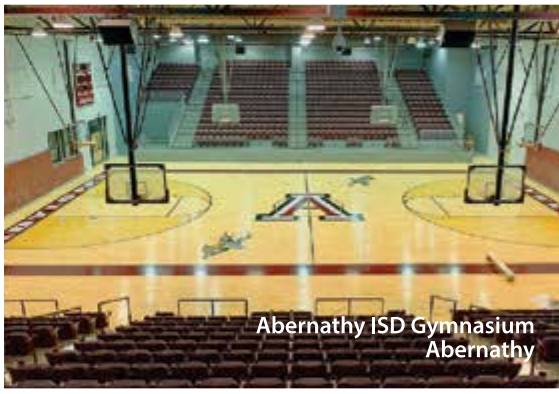

Wal-Mart Stores, Inc. / Sam's Club
Fort Worth


Meadow Lake
Retirement Community
Tyler


Mesa View Assisted Living
Canadian


Yellowhouse Machinery Co.
Lubbock


Midland Christian School
Midland


Abernathy ISD Gymnasium
Abernathy


Mid-Cities Community Church
Midland

wbamarillo.com

WESTERN BUILDERS
700 South Grant Amarillo, TX 79101 806.376.4321

ATHLETIC ◆ COMMERCIAL ◆ EDUCATIONAL ◆ FINANCIAL ◆ HEALTHCARE ◆ INDUSTRIAL ◆ RELIGIOUS ◆ RETAIL ◆ RETIREMENT

| *continued from page 24*
lymphocytic myocardial infiltrates, as well as sub-endocardial and interstitial fibrosis with normal vasculature. The reason that more cardiovascular effects have been reported in recent times may relate to the increased content of marijuana in each smoked joint (100-150 mg per joint compared to10 mg/ joint in the 1960's). Another concern is that the street cannabis available today often contains additives intended to increase the psychotropic effects. These substances may have concomitant cardiac side effects. Typical additives include industrial etchants, solvents, micro glass beads, pesticide derivatives and chemical sugars. Cannabis has classically not been considered in the medical community as a potentially fatal substance of abuse; hence, its association with fatal outcome is often underreported. However, over the past 8 years, autopsy studies in Ireland and addict surveillance programs in France have raised concerns about cannabis as a lethal agent.

Conclusion

Our case reminds physicians of a rare but potentially serious toxic effect of cannabis use which may be seen more and more as legalization is granted or considered in various states in the US. The increasing concentration of tetrahydrocannabinoids in current cannabis preparations should make the practitioner vigilant for complications of marijuana use.

References

1. Wong K, Asiner RW, Marriot HJ. ST-segment elevation in conditions other than acute myocardial infarction. N Engl J Med 2003; 349-2128.

2. Leontiadis E, Morshuis M, Arusoglu L, Cobaugh D, Koerfer R, El-Banayosy A. Thoratec left ventricular assist device removal after toxic myocarditis. Department of Thoracic and Cardiovascular Medicine, Heart and Diabetes Center North-Rhine Westphalia, Ruhr-University of Bochum, Bad Oeynhausen, Germany April 25, 2008.

3. Rodríguez-Castro C, Alkhateeb H, Elfar A, Saifuddin F,Abbas A, Siddiqui T . Recurrent myopericarditis as a complication of marijuana use, Department of Internal Medicine, Texas Tech University Health Science Center, El Paso, TX, U.S.A.2/2014.

4. Angelini A, Calzolari V, Calabrese F, et al. Myocarditis mimicking acute myocardial infraction: role of endomyocardial biopsy in the differential diagnosis. Heart 2000;84:245.

5. Nakashima H, Katayama T, Ishizaki M, et al. Q wave and non Q wave myocarditis with special reference to clinical significannce. Jnn Heart J 1998; 39:763.

6. Dec GW Jr, Waldman H, Southern J, et al. Viral Myocarditis mimicking acute myocardial infarction. J Am Coll Cardiol 1992; 20:85.

7. Sarda L, Coli P, Boccara F, et al. Myocarditis in patients with clinical presentaion of myocardial infarction and normal coronary angiogram. J Am Coll Cardiol 2001; 37:786.

8. Miklozek Cl, Crumpacker CS, Royal HD, et al. Myocarditis presenting as acute myocardial infarction. Am Heart J 1988; 115: 768.

9. Karialainen J, Heikkila J. Incidence of three presentaion of acute myocarditis in young men in military service. A 20 year experience. Eur Heart J 1999; 20:1120.

Alcoholics Anonymous and Al-Anon

by Robin Martinez, M.D.

Alcoholics Anonymous (AA) is a 12 Step program where self-insight, self-awareness and spiritual growth are of paramount importance. It is a gathering of people with alcoholism who share their Experience, Strength, and Hope with the intention of healing from the cunning, baffling, progressive, and deadly disease of alcoholism. When it was founded in 1935, it was said that one alcoholic impacted twenty other people. I submit that with today's mobile society, social network, changes in societal norms, changing careers, longer lifespan, and treatment a person suffering with the disease of alcoholism can impact many more people. Al-Anon is a 12 Step program fashioned after AA for the friends and relatives of people who suffer from alcoholism. It, too, is a spiritual program of self-discovery. Both AA and Al-Anon focus on learning healthy coping skills as the disease of alcoholism is a heavy burden for both the person with alcoholism and the person impacted by the alcoholic. The primary spiritual foundation is anonymity: what is said member to member in the meetings and who is a member of the program is held in strictest confidence, thus a safe environment is created for recovery.

Other 12 Step groups have sprung from Alcoholics Anonymous and Al-Anon such as Narcotics Anonymous (NA), Overeaters Anonymous (OA), Gamblers Anonymous (GA), Sex Addictions Anonymous (SAA) along with their respective Anon groups. In this paper, one can change the word alcoholic for addict.

The purpose of these 12 Steps group is to provide fellowship, recovery, and freedom from shame, humiliation, and self-loathing. While some treatment centers may not agree with the 12 Step approach, almost all are in favor of the fellowship, accountability, and safety that 12 Step programs provide.

History of AA

Bill Wilson (Bill. W.) and Dr. Bob Smith (Dr. Bob) founded Alcoholics Anonymous (AA) in 1935. The Oxford Group, a religious movement popular in the United States and Europe in the early 20th century, heavily influenced AA. Members of the Oxford Group practiced a formula of self-improvement by performing self-inventory, admitting wrongs, making amends, using prayer and meditation, and carrying the message to others. By practicing these principles, many were able to abstain from alcohol. One of the notable members of the Oxford Group was Edwin (Ebby) Thacher (Ebby T.), a recovering alcoholic. Ebby was one of Bill W.'s first mentors. Bill W. was a brilliant stockbroker whose career was lost to his chronic alcoholism. He had attended law school previously, but did not graduate, as he was too drunk to pick up his diploma. It is noted that Bill W. suffered from depression and panic attacks. Bill W. understood that Ebby T. had found recovery through spiritual growth and the Oxford Group, but did not believe that it could happen with him as he believed that he was too far gone.

In 1933, Bill W. was committed to the Charles B. Towns Hospital for Drug and Alcohol Addictions in New York City four times under the care of Dr. William D. Silkworth. The Charles B. Towns Hospital was known at the time to be a hospital that catered to the wealthier sector of society. Dr. Silkworth's theory was that alcoholism was a matter of both physical and mental control: a craving, the manifestation of a physical allergy (the physical inability to stop drinking once started) and an obsession of the mind (to take the first drink) (Alcoholics Anonymous, 1939). Bill W. was told that he would either die from his alcoholism or have to be locked up permanently due to Wernicke encephalopathy (commonly referred to as "wet brain").

The treatment for alcoholism at that time was to be 'purged & puked.' The purging was most probably the effect of the liberal doses of castor oil that the patients were given, together with belladonna. The belladonna treatment at Towns had been Δdeveloped by Dr. Sam Lambert, "a reputable N.Y. physician...." (Barefoot Bill, n.d.)

December 1934 was Bill W's. final hospitalization. During this hospitalization, the belladonna cure was prescribed. Hallucinations were common with the belladonna treatment. During this time, Bill W. had a spiritual awakening. According to him, while lying in bed depressed and despairing, he cried out, "I'll do anything! Anything at all! If there be a God, let Him show Himself!" He then had the sensation of a bright light, a feeling of ecstasy, and a new serenity. He never drank again for the remainder of his life. Bill W. described his experience to Dr. Silkworth, who told him, "Something has happened to you I don't understand. But you had better hang on to it" (AAWS, Inc., 1984).

Bill W. attempted to help other alcoholics recover by using the Oxford Principles; however, he was not successful. It was thought that the religious component was off putting. In May 1935, Bill W. was in Akron on a business trip. He was fearful of relapse, as the business trip had gone poorly. In order to maintain his sobriety, he asked about local alcoholics that he could speak with. He was referred to Dr. Bob Smith (Dr. Bob) by the Akron Oxford Group.

Dr. Robert Holbrook Smith (Dr. Bob) was a colorectal surgeon in Akron, OH. He had been admitted into more than a dozen hospitals and sanitariums in an effort to stop his drinking. He met with Bill W. and had his last drink June 10, 1935. The fellowship of one person suffering from alcoholism helping another sufferer was begun. Alcoholics Anonymous was created. Dr. Bob remained sober from that day forward until his death from colon cancer in 1950.

Principles of Recovery In AA

As Bill W. and Dr. Bob went to fellow sufferers of alcoholism, the 12 Steps were created. AA is not allied with any religion,

| *continued on page 30*

BSA

NAMED ONE OF THE NATION'S

100 Great Community Hospitals

THANK YOU EMPLOYEES AND PHYSICIANS!

BECKER'S Hospital Review

Professional Healthcare Management

Physician Management Services
Medical Billing and Collections
Practice Startup
Billing and Collections Assessments

Customized Services to meet the needs of your practice.

---

www.professionalhealthcaremanagement.com

Professional Healthcare Management, LLC
2750 Duniven Circle, Suite C
Amarillo, TX 79109
806-381-1155

| *continued from page 27*
denomination, or political group. Agnostics, atheists, Buddhists, Christians, Hindus, Muslims, or Rastafarians can find recovery and not feel that their religion or lack thereof is compromised. The 12 Steps offer a guide for self-discovery, self-insight, and self actualization. A sponsor (a member of AA who has worked the steps) is suggested to help the person with alcoholism work the 12 steps, offer support, and a reality check. Meetings are necessary so that one can discover fellowship, acceptance, accountability, and compassion (for oneself and others).

The 12 Steps of Alcoholics Anonymous (Alcoholics Anonymous, 1939)

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood Him.*
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Many believe that the first three steps address surrendering to the truth of the disease of alcoholism and the inability to control it; then surrendering to a Higher Power, seeing that the alcoholic will have to depend on something besides his/her own will and knowledge to stay sober and develop spiritually. Steps four through nine deal with investigation and responsibility. As the person with alcoholism investigates and takes responsibility for his/her past actions, shame is banished and he/she is no longer dogged by secrets ort guilt. Steps ten through twelve are the culmination of the spiritual path. The person suffering form alcoholism learns to maintain the honesty and responsibility that was developed in the earlier steps, to deepen the spiritual connection, and to serve others. These last three steps are the cornerstone to maintenance and are also the bridge to a life that is happy, joyous, and free. The spiritual awakening brings liberation, as the alcoholic enters a new life, one free from the encumbrances of addiction, and one guided by the principles of wisdom and compassion (Griffin, 2004).

The Big Book of Alcoholics Anonymous promises recovery to anyone who is willing to work the program. One must he Honest, Open-minded, and Willing. Chapter Five states: "Rarely have we seen a person fail who has thoroughly followed our path. Those who do not recover are people who cannot or will not completely give themselves to this simple program, usually men and women who are constitutionally incapable of being honest with themselves." The Big Book of Alcoholics Anonymous (1939) promises recovery: "If we are painstaking about this phase of our development, we will be amazed before we are half way through. We are going to know a new freedom and a new happiness. We will not regret the past nor wish to shut the door on it. We will comprehend the word serenity and we will know peace. No matter how far down the scale we have gone, we will see how our experience can benefit others. That feeling of uselessness and self pity will disappear. We will lose interest in selfish things and gain interest in our fellows. Self-seeking will slip away. Our whole attitude and outlook upon life will change. Fear of people and of economic insecurity will leave us. We will intuitively know how to handle situations which used to baffle us. We will suddenly realize that God is doing for us what we could not do for ourselves."

History of Al-Anon

As Dr. Bob and Bill W. were counseling fellow alcoholics and laying the foundation of AA, Dr. Bob's wife, Annie S., began to have the spouses of the alcoholics into her home to provide emotional support and to share experience, strength, and hope. Family groups began in 1935 when relatives of the alcoholic would accompany him/her to AA meetings. At this time the friends and relatives realized that they, too could find comfort and recovery in the 12 Steps.

In 1951, Lois W. (Bill W.'s wife) created what is now known as the Al-Anon Family Groups. In 1957, Al-Ateen was created for teenagers and children whose parents suffered from alcoholism. The Al-Anon Family Groups believe that alcoholism is a family disease and that changed attitudes and behaviors can aid recovery for those who are impacted by a person suffering from alcoholism. Many times, when dealing with a person who has alcoholism, poor coping skills emerge (enabling the alcoholic, becoming controlling, anxious, angry, worrying about outside appearances, etc.). By working the 12 Steps of AA themselves, coupled with attending meetings and hearing other's stories, healing occurs.

Like AA, Al-Anon's primary spiritual foundation is built upon anonymity. Al-Anon is not allied with any religion, political entity, or denomination. Each group is autonomous and is fully self supporting (as is AA).

Other Programs of Recovery

Many other addiction programs have adopted and adapted the 12 Step program of Alcoholics Anonymous. AA, Al-Anon, and other 12 Step programs focus on the triad of health in three domains—physical, emotional, and spiritual.

The spiritual growth gained by working the steps, the new behaviors learned, and the healthier coping skills can be utilized with any of life's problems. The fellowship of fellow sufferers allows for a sense of community, as they understand as perhaps no one else can.

References

Alcoholics Anonymous. (1939). The big book of Alcoholics Anonymous. New York City: Alcoholics Anonymous World Services, Inc.

Alcoholics Anonymous World Service, Inc. (1984). 'Pass It On': The story of Bill Wilson and how the A. A. message reached the world. New York City: Alcoholics Anonymous World Services, Inc.

Barefoot Bill (n.d.). Detoxing in the 1930's. retrieved from http://www.a-1associates.com/aa/INFO%20LIST/detoxinthe30s.htm

Treatment of Addiction

by Taryn B. Bainum, Pharm.D.

Addiction can sneak into anyone's life and manifest in hundreds of different ways. The broad definition of addiction is a substance or activity that, with continued use, becomes compulsive and interferes with daily life. This can be seen with anything from a medication to a gambling problem. Addiction can refer to a physical dependence or psychological dependence. In physical dependence, the body adapts to the presence of a stimulus, such as a drug, and tolerance develops. With psychological dependence, a compulsion to perform a certain activity are felt in response to emotional stress.[1]

When thinking of addiction, our minds often gravitate towards substance abuse. Since substance abuse situations are often encountered in practice, it is important to know the best methods of treatment for different types of addiction.

Alcohol Abuse

Alcohol abuse is a fairly common condition in the United States. In 2013, 16.6 million adults over the age of 18 years had an alcohol use disorder (AUD). About 1.3 million of these received treatment for an AUD in the same year.[2] Abuse of alcohol can lead to serious, potentially fatal complications such as end-stage liver disease and poses a significant financial burden as well. There are, however, options for those who suffer from this affliction.

A class of medications called benzodiazepines can be used in an acute setting to treat alcohol withdrawal, and there are a handful of pharmacological options used in the outpatient setting that are available and FDA-approved for the treatment of alcohol dependence. These include naltrexone, acamprosate, and disulfiram. Though data on the efficacy of these medications is somewhat conflicting, they can be useful for AUD in certain situations.

Naltrexone is an opioid antagonist that has an oral (ReVia®) and a long-acting injectable (Vivitrol®) dosage form. Naltrexone decreases the reward neurobiological effect created by ingesting alcohol and decreases heavy drinking in patients with an AUD. This medication has been extensively studied since its FDA approval for this indication in 1994. Most studies have shown favorable outcomes when naltrexone is used as a part of treatment for alcohol dependence; however, a few trials have cast doubt upon its efficacy. Of note, medication nonadherence has been cited as a common cause of naltrexone therapy failure. Some trials that found no overall benefit to naltrexone therapy in regards to heavy drinking did note a significant benefit in the subgroup of patients that reliably took the study medication. Based on the available evidence, it appears naltrexone is a beneficial medication for the treatment of alcohol abuse when taken as prescribed.[3]

Acamprosate (Campral®) has a complex mechanism of action that is not fully understood; however, it is thought that this medication restores the balance between gamma-amino butyric acid (GABA) and glutamate processes that may be disrupted in the presence of alcohol dependence. Studies have shown this medication reduces the risk of any drinking and increases the abstinence duration when compared to placebo. Based on the findings of several trials, acamprosate is said to be an effective and safe treatment for abstinence following alcohol detoxification, with diarrhea being the only side effect significantly increased over placebo.[4]

Disulfiram (Antabuse®) inhibits aldehyde dehydrogenase, an enzyme involved in the metabolism of alcohol. When this enzyme inhibited and alcohol is ingested, acetaldehyde builds up and results in nausea, vomiting, tachycardia, and flushing. This reaction is meant to deter patients from ingesting alcohol while on the medication. Adherence is paramount to the success of this medication. Many studies have attempted to evaluate the efficacy of this medication in the treatment of alcohol dependence, however several of these had significant limitation in trial design. A recent meta-analysis concluded that disulfiram is beneficial in the treatment of this condition and had no differences in serious adverse effects when compared to placebo. Less serious adverse events were reported more frequently with disulfiram than placebo. As mentioned before, the success of this treatment is especially dependent on adherence.[5]

Topiramate (Topamax®) and selective serotonin reuptake inhibitors (SSRIs) can be used to treat alcohol dependence as well, though they do not have FDA approval for that indication. Topiramate is thought to reduce dopamine release in the corticomesolimbic system by multiple mechanisms. Trials have suggested that this medication reduces the percentage of heavy drinking days along with other self-reported drinking outcomes when compared to placebo and is therefore a promising treatment for alcohol dependence.[6] SSRIs have been suggested to be of benefit as they inhibit the reuptake of serotonin from the synaptic cleft, therefore increasing the levels of this chemical. SSRIs have limited data to support their use in this condition, however they may have a mild beneficial effect and can be considered when there is a comorbid psychological condition such as depression.[7]

Opioid Abuse

Another ongoing battle in the healthcare setting is addiction to opioid medications. This encompasses both prescription medications, such as hydrocodone and morphine, and illicit drugs such as heroin. Prescriptions for opioid medications have increased from a yearly total of 76 million in 1991 to 207 million in 2013. This accounts for almost

100% of the world total for hydrocodone prescriptions. Opioid abuse can lead to complications from overdose and even death.[8]

One option for treating opioid dependence is methadone (Dolophine®, Methadose®). Methadone is an opiate receptor agonist and has weak N-methyl-D-aspartate (NMDA) antagonism. This medication has a long half-life, and can therefore be administered once daily when treating physiologic opioid dependence. This medication has been well-studied and has been used for many years for this indication. Methadone is a safer alternative to illicit drugs such as heroin and can help stave off opioid withdrawal symptoms. Methadone is a dangerous medication in and of itself as it is subject to similar adverse effects as other opioids. Use of this treatment method should be supervised either in an inpatient setting or through outpatient clinics.[9]

Buprenorphine (Buprenex®, Butrans®) is a partial mu opioid receptor antagonist that has a ceiling effect for respiratory depression. This plateau effect may make this medication a slightly safer alternative to methadone for the treatment of opioid dependence. Studies have evaluated buprenorphine for opioid dependence and compared it to methadone. The results from literature are inconclusive regarding the efficacy of these medications compared to one another. Methadone was found to be superior to buprenorphine for treatment retention in a systematic review, however other studies found no difference between the two when flexible dosing was permitted in the buprenorphine group. As methadone was found to be superior for treatment retention when buprenorphine is administered at a fixed dose, it seems methadone is likely still the first-line treatment for opioid dependence.

Naltrexone can be used to prevent relapse in opioid dependence in addition to its use in alcohol abuse disorders. The data examining how effective this medication is for this indication is somewhat conflicting, however it remains a viable option for the treatment of opioid dependence.[10]

Nicotine Abuse

Currently over 16 million Americans have a smoking-related disease. Smoking is the leading cause of preventable death claiming nearly 6 million lives per year worldwide. Tobacco use results in cancer, heart disease, and lung disease all of which significantly decrease quality of life and can cause death.[11]

Nicotine replacement therapy (NRT) is one FDA-approved approach to treating tobacco abuse. NRT come in many different dosage forms such as transdermal patches, gum, lozenges, and nasal sprays. These therapies deliver small amounts of nicotine in order to decrease withdrawal symptoms associated with smoking cessation. These therapies do not provide the same pleasurable effects as tobacco products, so the potential for abuse is minimal.[12]

There are two antidepressants FDA-approved for aiding in smoking cessation—bupropion (Wellbutrin®) and varenicline (Chantix®). These medications can both be used in conjunction with other therapies to help patients quit smoking. Bupropion should be avoided in patients with seizure disorders as this medication can lower the seizure threshold.[13] Varenicline should be used with extreme caution in patients with behavioral or mood disorders as this

| *continued on page 34*

Introducing...

MY HEALTHCARE IN ONE LOCATION

VALMED *plus*

Taking medication as directed is an important step toward a longer, healthier life. Our new VALMED*plus* program synchronizes medications so that they get refilled on the same day each month, ensuring that medications never run out and it is.....

CONVENIENT
Fewer trips to the pharmacy.

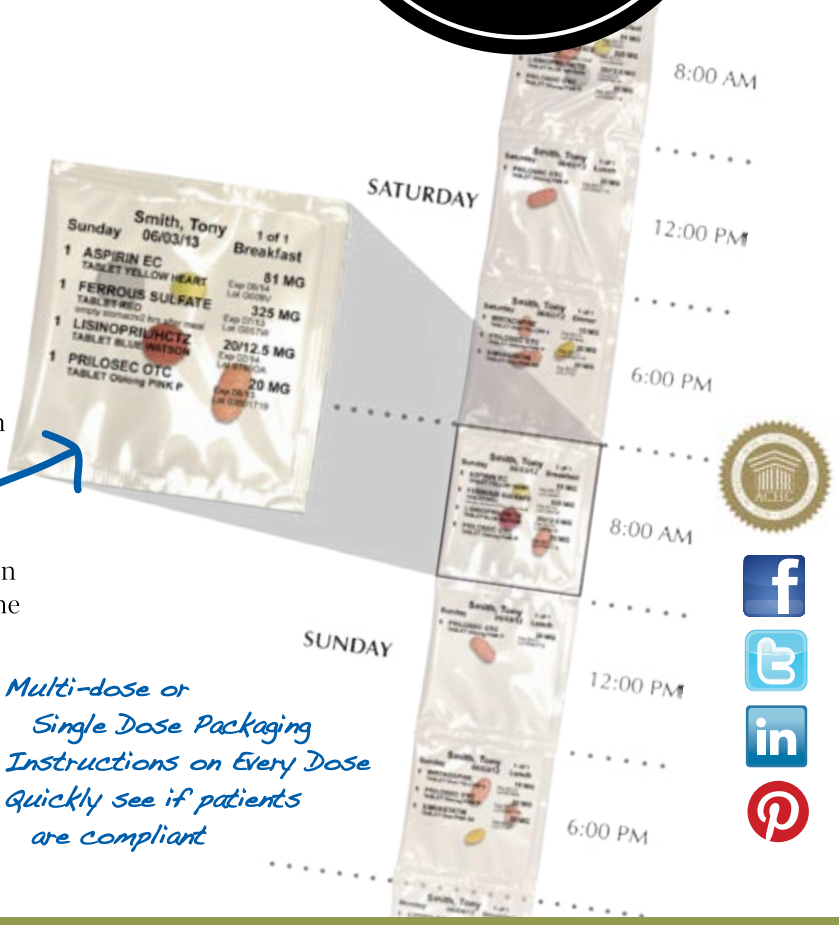
PERSONALIZED
Monthly pharmacist consultation.

EASY
Eliminates last minute phone calls to physician offices for refills or prior authorizations and requires fewer chart pulls.

CUSTOMIZED
PASS customized packaging takes the confusion out of taking medications, vitamins and over the counter medicine, *plus* it improves adherence and health.

ONE LOCATION
Home medical equipment and oxygen consultation provided as needed.

FREE!



- Multi-dose or Single Dose Packaging
- Instructions on Every Dose
- Quickly see if patients are compliant

BRINGING HOME ALL OF YOUR MEDICAL & PHARMACEUTICAL NEEDS

VALMED
OXYGEN • MEDICAL EQUIPMENT • INFUSION • PHARMACY

3 Care Circle • Legacy Square Professional Park
Monday-Friday 8 AM to 5PM
Pharmacy open until 6PM
806.350.MEDS (6337)
806.352.9456 (Home Health Fax)
806.350.6344 (Pharmacy Fax)

VALMED-HHS.COM

PHARMACY
Individualized, Professional Services
Compounding *Individualized Dosing & Unique Delivery Methods*
Immunizations
Written Education in English and Spanish

HOME INFUSION
Antibiotic Therapy, Chemotherapy,
Enteral Nutrition & Specialty Injectables

OXYGEN, MEDICAL EQUIPMENT & SUPPLIES
Respiratory, Rehabilitation & Mobility Equipment

BREAST PUMPS, BREAST-FEEDING SUPPLIES & APPAREL
Medela Breast Pumps *Purchase or Rental*
Scales to Weigh Baby

CONVENIENT DRIVE-UP & DELIVERY

| *continued from page 32*
medication can precipitate or worsen these symptoms.[14]

Other Illicit Substances

While alcohol, opioid, and nicotine abuse may be the most common and most recognized forms of substance abuse, other substances can cause problems as well. Cocaine and methamphetamine are both stimulant drugs that can lead to several health issues when abused. While amphetamines can be used in a legal capacity at lower doses to treat conditions such as Attention Deficit Hyperactivity Disorder (ADHD), they are often used in an illegal manner. These substances pose significant risks to health as they can constrict blood vessels and result in decreased blood flow to tissues.

There are currently no FDA-approved pharmacological options to treat cocaine dependence. A variety of medications have been reported to decrease cocaine use. These include vigabatrin (Sabril®), modafinil (Provigil®), tiagabine (Gabitril®), disulfiram, and topiramate. As with any addiction, behavioral therapy is extremely important.[15]

Similarly, the treatment for methamphetamine abuse revolves are behavioral modification treatments. There are not currently any medications which counteract the effects of methamphetamines or have proven useful in the treatment of dependence.[16]

Behavioral Addictions

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) has changed the way gambling addiction is classified. This disorder is now classified as a Substance-Related and Addictive Disorder rather than an Impulse Control Disorder. Other behavioral addictions, such as internet gaming disorder, are now being researched to determine if they should be classified in a similar manner. Studies have shown that the mesolimbic dopamine pathway, which is essentially the brain's "reward system" is stimulated in gambling disorder similarly to the way it is stimulated in substance addiction. Other behavioral issues that could fall into the same category as a gambling addiction include obesity and binge eating, compulsive shopping, and internet gaming disorder. The study of these addictions is relatively new and therefore there is much more to be discovered.[17] Presumably the treatment of choice for these disorders would be cognitive behavioral therapy.

So What's the Solution?

With any addiction, behavior therapy is key. Finding a local program that offers rehabilitation from for different types of addiction is an important part of treatment. The Pavilion at Northwest Texas Healthcare System offers a 28 day rehabilitation program for alcohol and substance dependence that can be done in an outpatient setting and includes group therapy, education, and medication support.[18] Therapists can also be of use for managing addiction through counseling and cognitive behavioral therapy.

Addiction can affect anyone and is not limited to substance abuse. Research is ongoing in this area of healthcare to illuminate the process of addiction as well as to produce new pharmacological therapies. It is important to remember how serious addiction can be and the importance of cognitive behavioral therapies. Often times rehabilitation programs will include therapy as well as pharmacological options if needed. This is an area of healthcare where tailoring treatment to patient-specific needs is extremely important and can be the difference in continued addiction or the path to recovery.

1. What is Addiction? Psychology Today website. https://www.psychologytoday.com/basics/addiction. Accessed October 28, 2015.
2. Alcohol Facts and Statistics. National Institute on Alcohol Abuse and Alcoholism website. http://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/alcohol-facts-and-statistics. Accessed October 28, 2015.
3. Pettinati HM, O'Brien CP, Rabinowitz AR, et al. The status of naltrexone in the treatment of alcohol dependence: specific effects on heavy drinking. *J Clin Psychopharmacol*. 2006;26(6):610-25.
4. Rösner S, Hackl-Herrwerth A, Leucht S, Lehert P, Vecchi S, Soyka M. Acamprosate for alcohol dependence. *Cochrane Database Syst Rev*. 2010;(9):CD004332. doi: 10.1002/14651858.CD004332.pub2.
5. Skinner MD, Lahmek P, Pham H, Aubin HJ. Disulfiram efficacy in the treatment of alcohol dependence: a meta-analysis. *PLoS One*. 2014;9(2):e87366. doi: 10.1371/journal.pone.0087366. eCollection 2014.
6. Johnson BA, Rosenthai N, Capece JA, et al. Topiramate for treating alcohol dependence: a randomized controlled trial. *JAMA*. 2007;298(14):1641-51.
7. Litten RZ, Allen J, Fertiq J. Pharmacotherapies for alcohol problems: a review of research with focus on developments since 1991. *Alcohol Clin Exp Res*. 1996;20(5):859-76.
8. Volkow ND. America's Addiction to Opioids: Heroin and Prescription Drug Abuse. National Institute on Drug Abuse: The Science of Drug Abuse & Addiction website. https://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2015/americas-addiction-to-opioids-heroin-prescription-drug-abuse. Accessed October 28, 2015.
9. Kampman K, Jarvis M. American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. *J Addict Med*. 2015;9(5):358-67.
10. Veilleux JC, Colvin PJ, Anderson J, York C, Heinz AJ. A review of opioid dependence treatment: pharmacological and psychosocial interventions to treat opioid addiction. *Clin Psychol Rev*. 2010;30(2):155-66.
11. Smoking & Tobacco Use. Centers for Disease Control and Prevention website. http://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/. Accessed October 29, 2015.
12. Are There Effective Treatments for Tobacco Addition? National Institute on Drug Abuse: The Science of Drug Abuse & Addiction website. https://www.drugabuse.gov/publications/research-reports/tobacco/are-there-effective-treatments-tobacco-addiction. Accessed October 29, 2015.
13. Wilkes S. The use of bupropion SR in cigarette smoking cessation. *Int J Chron Obstruct Pulmon Dis*. 2008;3(1):45-53.
14. Important Safety Information and Indication. CHANTIX® website. http://www.chantix.com/. Accessed October 29, 2015.
15. What treatments are effective for cocaine abusers? National Institute on Drug Abuse: The Science of Drug Abuse & Addiction website. https://www.drugabuse.gov/publications/research-reports/cocaine/what-treatments-are-effective-cocaine-abusers. Accessed October 28, 2015.
16. What treatments are effective for people who abuse methamphetamine? National Institute on Drug Abuse: The Science of Drug Abuse & Addiction website. https://www.drugabuse.gov/publications/research-reports/methamphetamine/what-treatments-are-effective-methamphetamine-abusers. Accessed October 29, 2015.
17. Clark L. Disordered gambling: the evolving concept of behavioral addiction. *Ann N Y Acad Sci*. 2014;1327:46-61.
18. Chemical Dependency and Detoxification. The Pavilion at Northwest Texas Healthcare System website. http://pavilionnwtexashealthcare.com/inpatient-services/chemical-dependency-and-detoxification/. Accessed October 28, 2015.

Roles and Responsibilities of the Physician Health and Rehabilitation Committee in Addiction and Recovery

Reprinted from *Panhandle Health*, Summer 2004 Revised, 2015.

Robert P. Kauffman, MD., *Professor and Regional Chairman, Department of Obstetrics and Gynecology*
Texas Tech University Health Sciences Center School of Medicine

The lifetime incidence of chemical dependency (alcohol and drug addiction) among practicing physicians in the U.S. is estimated to fall somewhere between 8 and 12 percent. Although the incidence of alcoholism among physicians closely mirrors that of the general population, addiction to drugs (primarily prescription drugs) is more pervasive in physicians. Aside from alcohol, doctors most frequently list opiates and benzodiazepines as their "drugs of choice". Not surprisingly, abuse and dependency to "street drugs" (cocaine and methamphetamines) abound in structured physician recovery programs in the United States. Regrettably, the recent legalization of marijuana for medical and recreational use in some American jurisdictions can be expected to increase the number of impaired physicians in practice.

Certain specialties appear to be more susceptible to chemical dependency, specifically anesthesiologists, family physicians, emergency physicians, and psychiatrists. Addiction among anesthesiologists is predictable given ready access to a wide range of intravenous anesthetic drugs with abuse potential that anesthesiologists must administer in the normal course of practice. The reason behind the higher rate of substance abuse among the other medical specialties is more obscure, but the most cited reasons include job stress and relatively easy access to alcohol and prescription drugs (access to drug samples, self-prescribing, and diversion from "office stock"). Even though the general public may perceive a difference between drug and alcohol abuse, the neuropsychiatric mechanisms and treatments are nearly identical.

It is worth noting that periodic use of psychoactive drugs prescribed by another physician does not imply addiction or impairment, but the practice of self-prescribing such drugs is at best, troubling, and at its worst, unethical. The practice of self-medicating with other drugs such as antidepressants and hypnotics is another disquieting practice since the prescriber/user may lack proper judgment and objectivity to determine the underlying diagnosis, proper treatment, and dosage compared to an unbiased colleague.

Common sequelae associated with addiction among physicians include (1) secondary medical and psychiatric disorders (liver disease, pancreatitis, hypertension, depression, etc.), (2) dysfunctional relationships with family, office staff, and colleagues, (3) spiritual conflicts, (4) physical harm to patients and employees, (5) financial consequences suffered by physicians, employees, and their families, (6) accidental death by overdose or automobile accident, (7) professional consequences including loss of hospital privileges and licensure, and (8) suicide. Suicide among physicians is roughly twice that of the general population.

Physicians must deal with a unique catalog of stressors (long hours, fatigue, life and death issues, dealing with insurance and governmental requirements, difficult and demanding patients, running a business, and maintaining clinical competence). All too often, healthy compensatory mechanisms for dealing with such stressors fail, leading to burnout and maladaptive behaviors.

"Burnout", a state of mental and physical exhaustion caused by excessive stress, is common among medical professionals and a major risk factor for drug dependency and impairment. A physician unable to practice medicine with reasonable skill and safety because of physical or mental illness may be defined as "impaired". Physician impairment takes on other shapes as well – mood disorders, sexual boundary violations, cognitive degeneration, neuromotor disorders, and disruptive or violent behavior. These topics, albeit important, are beyond the scope of this discussion.

Physician addiction to drugs and/or alcohol frequently goes undetected for years before identification, intervention, and treatment is initiated. The explanations are complex. First of all, the most physicians see themselves as healers (rather than the infirmed) and historically are reluctant to seek help for personal problems. (Interestingly, psychiatrists are the most likely to avoid treatment for substance abuse and dependency.) Narcissism, professional grandiosity, and exaggerated self-importance are further impediments. Patients prefer to see their personal physicians as bastions of strength and wellness (and somehow immune to plebeian weaknesses). Some self-appointed guardians of the public welfare have suggested that a conspiracy of silence exists among healthcare workers which impedes early confrontation and intervention. The reluctance to report or confront a colleague is largely emotional (fear-based): (1) fear of creating economic maelstrom for the physician, his family, and his office staff, (2) fear of retaliation or ostracism by the medical community, (3) fear of legal retribution, and (4) fear of "what if I am wrong about Dr. X?"

Texas physicians are particularly fortunate to have a well organized network of Physician Health and Rehabilitation committees (PHR committees) structured under the auspices of the Texas Medical Association (TMA) and local county medical societies including the Potter-Randall County Medical Society (PRCMS). State and local PHR committees are dedicated to the continued mental and physical health of physicians who may suffer from impairments of any type. Like the Texas Medical Board (TMB), PHR committees are committed to maintaining optimal physician competency and patient safety.

| *continued on page 38*

HAVEN HEALTH

because your health matters

HAVEN HEALTH

Long-Acting Reversible Contraception (LARC) is now offered by Haven Health to qualifying women throughout the Texas Panhandle.

Across all age categories, women who choose LARC methods have significantly lower pregnancy rates, 20 times less than those using a pill, ring or patch.

For more information or to find out if you qualify for LARC, call 806.322.3599.

Now accepting
NEW PATIENTS
&
REFERRALS
for the following services:

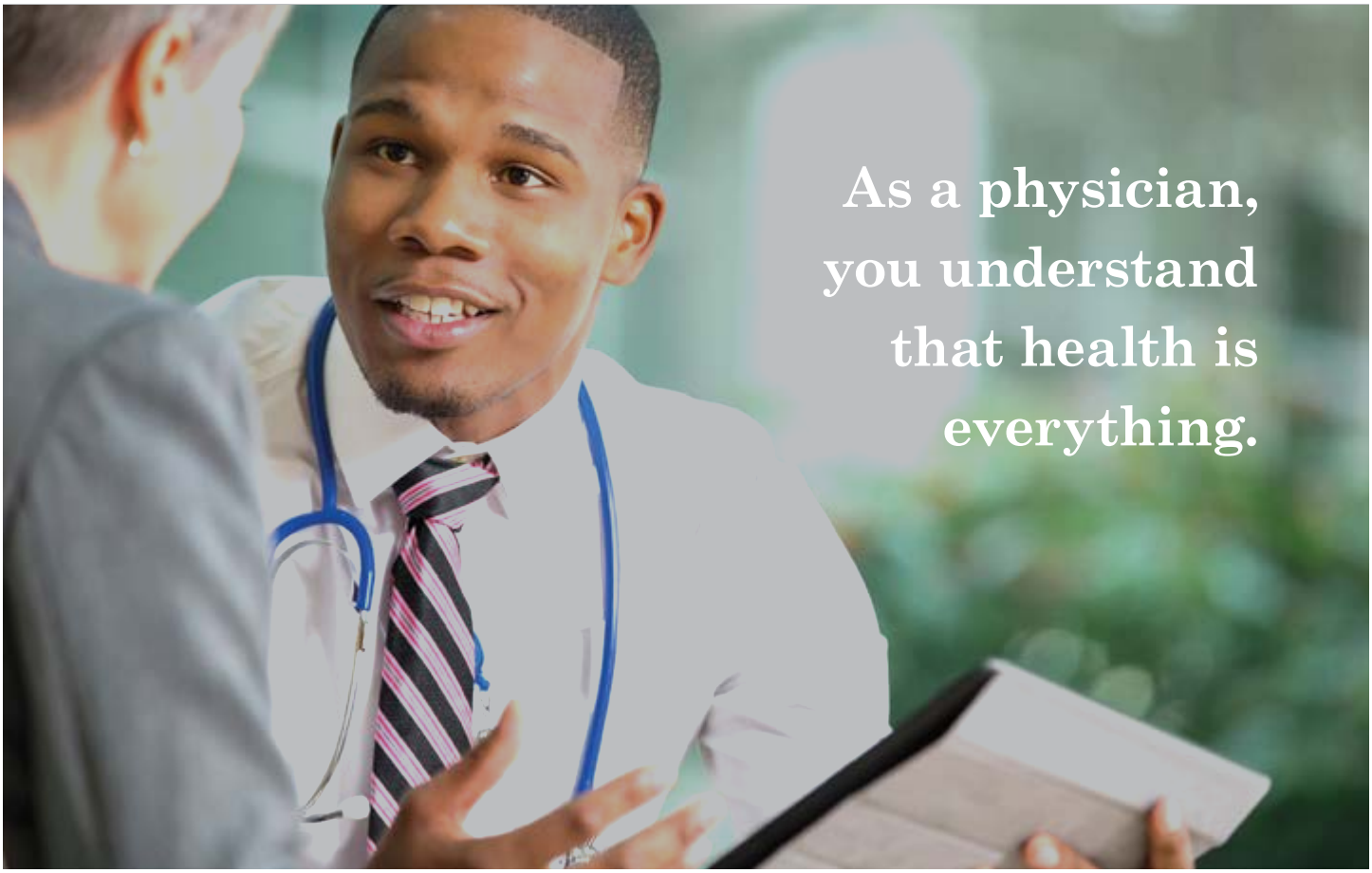
Breast Cancer Screenings
Cervical Cancer Screenings
High Blood Pressure Screenings
Nexplanon
Other Contraceptives
HIV / STI Testing
Pregnancy Tests
Reproductive Life Planning

Providing QUALITY CARE throughout Amarillo and the Texas Panhandle SINCE 1968

Schedule an appointment today at HavenHealthAmarillo.com
#1 Medical Drive • Amarillo, TX 79106 • 806.322.3599

TMA
INSURANCE TRUST

Exclusively Endorsed by the Texas Medical Association



TMA Insurance Trust advisors have decades of experience matching Texas physicians with the health insurance coverage that meets their unique and individual needs. If you need help securing coverage during the annual ACA open enrollment, or coverage for your employees, our advisors will shop the open market and choose from the major insurance carriers to find a suitable plan for you.

Call us today
1-800-880-8181
or visit us at
www.TMAIT.org.

| *continued from page 35*

Unlike the TMB, PHR committees serve as advocates and supporters of physicians in need of evaluation, treatment, education, family support, and monitoring after treatment. Committee members are composed of physician volunteers from the medical community. Some members are recovering physicians while others have an interest or expertise in helping other physicians with medical, psychiatric, or spiritual disorders.

Referrals to the PHR committee may originate from concerned colleagues, office staffs, families, medical and mental health practitioners, the TMB (as part of an "agreed order"), the Texas Physician Health Program (TXPHP), and even the impaired physician himself. In fact, when a program is perceived as helpful and non-punitive, self-referrals increase. PHR committees are structured to respect and maintain physician confidentiality. Names of those who request and receive help are known only to the committee's members and the Executive Director of the Potter-Randall County Medical Society.

In general, punitive measures have been shown to be counter-productive to physician recovery and have no place in the work of county PHR committees. Recovery programs administered by medical societies have proven, in large, more successful in producing long-term sobriety than disciplinary boards. In most cases, a contract or agreement is initiated between the physician and the Committee as a blueprint to recovery and to assure compliance to a sobriety or behavioral program. In cases of addiction, random drug testing under the TMA-facilitated monitoring program is required without exception. Since the TMA and local medical societies have the duty to uphold the quality and safety of medical care rendered to Texans, strict compliance to the contract is paramount and expected. Texas statutes (Vernon's Texas Codes Annotated, Occupational Code §160.003(b)) require PHR committees to contact the TMB for continued behavior that might injure the public once the physician has been identified and entered into a contract with the PHR committee. For those who do not wish to participate in TMA programs, referral to the TXPHP (an arm of the TMB) may be made. Fortunately, recovering physicians enjoy sustained sobriety (as high as 77%) more than any other profession, perhaps because the medical license and livelihood is at stake.

PHR committees can also lend assistance in finding appropriate medical treatment facilities, referrals to local or regional physicians with an interest or expertise in caring for impaired physicians, assist families of physicians who need short term financial assistance (through the TMA) during inpatient treatment, and reacclimatizing back into medical practice. Participation in a 12-step program is strongly encouraged as part of the recovery plan. PHR committees are pleased to advocate for recovering physicians before hospital committees, managed care organizations, and state and federal regulatory bodies. Medical students and resident physicians who need assistance and direction are also strongly encouraged to participate in local PHR programs. (Additionally, Texas Tech University Health Sciences Center at Amarillo has a similar institutional program which often works with the PRCMS PHR).

CME courses dedicated to understanding the nature of physician stress and addiction are also provided by the TMA. These programs may be accessed via the TexMed website and through traditional TMA-sponsored CME courses. TMA and PRCMS PHR Committees stand ready to help physicians and physicians-in-training with physical or mental impairments. *Schadenfreude* serves no purpose in the work of this committee (or in a civilized society for that matter).

Finally, PHR committees also provide guidance to physicians struggling with medical disorders that affect practice (dementia, tremors, stroke, cardiac issues, etc.), behavioral issues (disruptive behaviors, sexual boundary issues), and other psychiatric disorders (depression, bipolar disorder, schizophrenia, etc.),

We seek to help, not to punish. The TMA PHR Committee operates a 24 hour hot-line at (800) 880-1640. Similarly, interested parties may confidentially contact the PRCMS PHR committee by calling the medical society office. Local physicians who are interested in serving on our PHR committee are welcomed and should contact Cindy Barnard at the PRCMS. No particular experience is required, only a willingness to help in the physical, mental, and spiritual recovery of a colleague. The intangible benefits you will receive are priceless.

References

1. Texas Medical Association. Committee on Physician Health and Wellness. At: *www.texmed.org/phw* via the Internet. Accessed 30 September 2015.
2. Centrella M. Physician addiction and impairment—current thinking: a review. J Addict Dis 1994; 13(1): 91-105.
3. Brooke D, Edwards G, Taylor C. Addiction as an occupational hazard: 144 doctors with drug and alcohol problems. Br J Addict 1991; 86(8): 1011-6.
4. Franke J. Stress, burnout, and addiction. Tex Med 1999; 95(3): 43-52.
5. Collins GB. New hope for impaired physicians: helping the physician while protecting patients. Cleveland Clin J Med 1998; 65: 101-6.
6. Googins JC. The conspiracy of silence. Tex Med 1999: 95(3): 30-32.
7. Simpson LA, Grant L. Sources and magnitude of job stress and its relation to some physiological stress indicators. Behav Med 1991; 24: 89-94.
8. Conde C. Repairing the impaired. Tex Med 2010; 106(12): 43-6.
9. Braquehais MD, et al. Dual diagnosis among physicians: a clinical perspective. J Dual Diagn 2014; 10(3): 148-55.
10. Braquehais MD, et al. Doctors admitted to a Physician Health Program: a comparison of self-referrals versus direct referrals. BMJ Open 2014; 4(7): e005248.
11. Braquehais MD, et al. Psychiatrists admitted to a physicians' health program. Occup Med (London) 2015; 65(6): 499-501.

Robert P. Kauffman, MD
Member and Former Chairman, Physician Health and Rehabilitation Committee
Potter-Randall County Medical Society

Professor and Regional Chairman
Department of Obstetrics and Gynecology
Texas Tech University Health Sciences Center
School of Medicine
Amarillo, Texas

The Impaired Physician

by Robin Martinez, M.D.

At some point in his or her career, a healthcare executive will have to deal with an impaired physician. In 2010, The American College of Healthcare Executives stated, "healthcare executives have a professional responsibility to create and maintain an organizational culture that promotes quality patient care and a healthy work environment that protects staff from inappropriate and disruptive behavior. The purpose of this paper is to educate how to recognize, confront, support, and manage the impaired physician.

Introduction

The American Medical Association (AMA) defines an impaired physician as one unable to fulfill professional or personal responsibilities due to psychiatric illness, medical illness, or chemical dependency (Anonymous, 1973). Approximately 15 percent of physicians will be impaired at some point in their careers (Boisaubin & Levine, 2001). The lifetime prevalence of substance use disorders for physicians is similar to that of the general population, which is 16 percent (Schorling, 2009). The prevalence for other medical disorders is similar to that of the general population; however arguments have been made that physicians may have a higher incidence of psychiatric disorders such as depression and Post Traumatic Stress Disorder than the general population. This is due to physician personality types, which often include compulsive personality traits, marked by a triad of self-doubt, guilt over perceived deficiencies, and an excessive sense of responsibility. As physicians are frequently overloaded with the demands of caring for sick patients within constraints of fewer organizational resources, they are at high risk for burnout. Burnout is associated with impaired job performance, poor health, anxiety, depression, and may contribute to substance use (alcoholism and drug addiction).

Impaired persons are at danger to others and themselves. The ramifications of impaired physicians include, of course, patient care errors, unsafe work environment for other ancillary healthcare workers, and increased risk of litigation. Other ramifications of impairment for the physician include loss of collegial respect, personal losses (family and friends), financial losses, loss of medical license and pharmaceutical prescribing license, loss of health, and death, either from the disease process or suicide. As mentioned earlier, depression is high in the medical profession and an estimated 400 physicians suicide annually (the actual number is probably higher). Male physicians have a 70% higher suicide rate than males in other professions and female physicians have a 400 % higher rate of suicide than females in other professions.

The Joint Commission made a requirement that hospital organizations had to have the medical staff implement a process to identify and manage matters of individual licensed independent practitioners which was independent from disciplinary review on January 1, 2001 (MMS, 2015). This requirement is Joint Commission Requirement (JCR) MS.11.01.01 that set up hospital Physician Health and Wellness (PHW) committees. State and county medical societies also implemented Physician Health and Wellness committees. These Physician Health and Wellness committees helped physicians who had impairment issues, boundary issues, and interpersonal issues. Many times, these PHW committees can manage physicians before being sent to the state Medical Board.

Types of Impairment

Some of the common disorders encountered in impaired physicians include substance use disorders, clinical depression, bipolar disorder, generalized anxiety disorders, adjustment disorders (e.g. Post Traumatic Stress Disorder), dementias, Parkinsonism and other neurologic disorders, diabetes mellitus, seizure disorders, cardiovascular diseases, and pulmonary disease (TMA, 2012). The cognitive and physical decline associated with the normal aging process can cause impairment, also. A physician is said to be impaired when he or she is unable to practice medicine with reasonable skill and safety to patients due to the before mentioned processes. It is important to remember that the presence of a disease or disability is not equivalent to impairment.

Nearly 90 percent of physicians with substance use problems also have a comorbid psychiatric illness, usually depression, anxiety, or bipolar disorder (Cicala, 2003). Other factors associated with substance use disorder include divorced or separated marital status, family history of alcoholism or substance abuse, family history of psychiatric illness, history of childhood or adolescent abuse, and male gender. Cicala (2003) writes that physician-specific factors associated with substance use disorder include cigarette use > 1 pack per day, high stress or long work hours, history of multiple affairs and/or multiple marriages, history of multiple jobs (especially in multiple communities), occupational access to controlled substances, practice in academic medicine, practice in emergency medicine, anesthesiology, or psychiatry, and self-medicating or self prescribing behavior. Data from state physician health programs have shown that alcohol or opioids are the drugs of choice for physicians enrolled for substance use disorders. Among 2429 physicians followed by the Georgia Program from 1975 to 1995, alcohol was the drug of choice for 47%, opioids for 30%, cocaine for 7%, and 16% for all others. The drugs of choice were similar among 292

healthcare professionals followed by the Washington Program from 1991 to 2001, including 232 physicians: alcohol, 56%; opioids, 32%; cocaine, 3%; and all others, 9%. A recent study of 125 women and 844 men in 4 state physician health programs found that the female participants were younger (40 vs 44 years old), more likely to abuse sedative-hypnotics (11% vs 6%), and more likely to have a comorbid psychiatric disorder (42% vs 27%) (Schorling, 2009).

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* addresses substance use disorder resulting from the use of ten separate classes of drugs: alcohol, caffeine, cannabis, hallucinogens (phencyclidine or similarly acting arylcyclohexylamines), other hallucinogens such as LSD, inhalants, opioids, sedatives, hypnotics, anxiolytics, stimulants (including amphetamine-type substances, cocaine, and other stimulants), tobacco, and other or unknown substances. In order to be diagnosed with Substance Use Disorder the patient must meet at least 2 of the 11 criteria for the diagnosis. A patient meeting 2-3 if the criteria indicate mild substance use disorder, meeting 4-5 criteria indicates moderate, and 6-7 indicates severe (American Psychiatric Association, 2013).

Diagnostic Criteria

- Continuing to use substance despite negative personal consequences
- Repeatedly unable to carry out major obligations at work, school, or home due to substance use
- Recurrent use of substance in physically hazardous situations
- Continued use despite persistent or recurring social or interpersonal problems caused or made worse by substance use
- Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount
- Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal
- Using greater amounts or using over a longer time period than intended
- Persistent desire or unsuccessful efforts to cut down or control substance use
- Spending a lot of time obtaining, using, or recovering from using substance
- Stopping or reducing important social, occupational, or recreational activities due to substance use
- Consistent use of substance despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids
- Craving or a strong desire to use substance (*Note - This is a new criterion added since the DSM-IV-TR)

Recognition

In physicians, impairment may present with changes in personality, mood swings, frequent medical illness or exacerbation of known medical illness. The most consistent initial symptoms of substance use problems involve changes in personal relationships and community activities with increasing isolation being a common sign. Ancillary staff may notice that the physician is sleepy, has slurred speech, is late to see patients, leaves early, takes long breaks, or does not come to see patients at all. Many times, a problem is not suspected until a physician has criminal charges from self-prescribing or driving while intoxicated, loss of hospital privileges, malpractice suits, suicide attempts, or hospitalization for underlying illness.

Confrontation

The American Medical Association (1992) states that physicians have an ethical obligation to report impaired or incompetent colleagues. The duty to report under such circumstances, which stems from physicians' obligation to protect patients against harm, may entail reporting to the licensing authority (Opinion E-9.0305 and Opinion 9.031). If a physician is suspected of being impaired, referral should be made to the Physician Health and Wellness (PHW) committee. This can be done through the hospital or county medical society. Many states medical societies (e.g. Texas Medical Association) have a 24-hour toll free number that can be called at any time should a physician be suspected of impairment. A meeting is called where the physician suspected of impairment meets with concerned physician peers of the PHW committee. During this meeting, information is gathered regarding health, stressful events, coping skills, criminal charges, substance use, interpersonal relationships, financial worries, and other factors that may be contributing to the physician's poor performance. It is imperative that this meeting is not punitive, judgmental, or shaming. Ideally the committee should include members who have been impaired themselves and are in recovery; they can share their experience, strength, and hope with the suspected impaired physician and create an environment of safety. The impaired physician can be rehabilitated and continue to be a valued member of the medical community and the community at large. The information obtained at the PHW committee meeting is held at strictest confidence, unless of course, the physician is at immediate danger to himself or others. If that is the case, then immediate psychiatric intervention is mandatory.

After meeting with the PHW committee, recommendations are made, which include a physical exam and appropriate testing to rule out various disease processes or cognitive impairments. Psychiatric evaluation is recommended as well. Since many people use substances to self-medicate, urine drug testing can be performed to rule out substance use. The PHW committee will select examining physicians to perform these evaluations in a time sensitive and confidential manner. Many times, while the medical and psychiatric workup is being done, hospital privileges are "suspended" to allow the physician suspected of impairment to be evaluated. This "suspension" is not punitive and is not reflected in the National Physician Data Base or in hospital communication. If the physician is in private practice, patients can be diverted to partners while the workup is being completed. After the data from the medical and psychiatric workup is reviewed, the PHW committee meets again with the physician to review the results and formulate a treatment

| *continued on page 42*

Renew Your PRCMS & TMA Dues

Your PRCMS/TMA membership renewal is due Dec.31, 2015. If you have not paid your 2016 membership dues, renew online at www.texmed.org/JoinRenew.aspx.

For more information, contact Cindy Barnard at 806-355-6854 or prcms@suddenlinkmail.com

| *continued from page 40*
plan. Medical or psychiatric care can be initiated to treat the underlying disease process. During this time, the PHW committee informs the physician that the executive committee will be informed of the findings and treatment plan. If the workup reveals dementia or a debilitating, degenerative disease process, then the PHW committee will counsel the physician about this diagnosis and inform the physician that the hospital executive committee will be informed. Should substance use disorder be suspected, the PHW committee would recommend evaluation and treatment through a drug and alcohol rehab facility.

Based upon the PHW committee findings and recommendations, the hospital executive committee may counsel the impaired physician to resign his or her privileges should dementia be present or if the debilitating, degenerative disease process be so severe that the physician may no longer practice medicine in a safe manner. The executive committee may counsel the impaired physician to complete treatment and provide documentation of continued treatment of the underlying medical or psychiatric disorder to remain on the hospital staff. Once again, none of this is punitive. The communication is presented in a way so that the impaired physician feels nurtured and accepted.

Management

The impaired physician's physician manages medical and psychiatric disease processes. Treatment and follow-up is documented and the physician sends documentation to the hospital credentials committee. For substance use disorders, the impaired physician attends a drug and alcohol treatment facility for evaluation and treatment. These usually are residential and require three months of treatment. There are rehab facilities especially geared for physicians; however, this is not mandatory. Insurance will help pay for the drug and alcohol treatment and for physicians that are financially strapped, some of the state Physician Health and Wellness committees have loan opportunities to help. If a physician is in private practice, he or she can hire a locum tenems provider to cover the practice or if there is a call group, many times the call group will cover the practice while the physician is in rehab. Many of the clientele at drug and alcohol rehabs have dual diagnoses; a psychiatric condition (depression or generalized anxiety disorder) in addition to the substance use disorder.

Most drug and alcohol rehabs are based in the Twelve Step programs such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). The approach is a three pronged to address emotional, physical, and spiritual health. While in rehab, the impaired physician will receive psychotherapy, learn coping mechanisms, and have psychiatric and medical matters addressed. Family days are held so that the physician can be with his or her family, damaged relationships can heal, and education provided. Alcoholism and drug addiction are progressive, debilitating diseases and the impaired physician's family and support group need to be educated on the disease process of alcoholism and drug addiction.

Follow-up

At discharge from the alcohol and drug treatment facility, a copy of the discharge is sent to the impaired physician's physician and/or psychiatrist. The impaired physician is now said to be recovering. He or she will follow-up with his or her physician and/or psychiatrist. The recovering physician is required to report to the Physician Health and Wellness committee, usually though a county or state medical society, or to the state Physician Health Program (PHP). The Physician Health Programs were started in the 1970s due to the initiatives taken by the American Medical Association (AMA) that focused on rehabilitation and monitoring of physicians with substance use disorders. These entities operate independently of the state Medical Boards.

In a landmark policy paper prepared by the AMA Council on Mental Health, "The Sick Physician: Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence," the AMA acknowledged physician impairment. In 1974, model legislation was developed that offered a therapeutic alternative to discipline, recognizing alcoholism and other drug addictions as illnesses. The AMA held a Physician Health Conference in April 1975 and a second in 1977 where it officially recognized the psychiatrically disturbed physician. A flurry of articles published in the late 1970s increased education and awareness about physician addiction. By 1980, less than a decade after the AMA's policy paper, "all but three of the 54 U.S. medical societies of all states and jurisdictions had authorized or implemented impaired physician programs." Today, all states have responded and developed programs, which operate within the parameters of state regulation and legislation and provide many different levels of service to physicians in need (FSPHP, n.d.).

After reporting to the Physician Health and Wellness committee or the state Physician Health Program, the recovering physician signs a contract for monitoring. The contract is usually for five years. Recovering physicians are extremely compliant with the monitoring process, as they do not want to be reported to the state Medical Boards and jeopardize their medical license. Should the recovering physician be in breach of the contract, the state Medical Board may be notified. The recovering physician is monitored with random urine drug screens (UDS) during the five-year contract. Initially, the frequency of the UDS is high (~96/year), but the frequency lessens to as few as 26/year as the contracted time period continues. Also the recovering physician is required to attend a set number of AA or NA meetings weekly (usually 5-7) initially and then decreasing to 3-5 weekly per the contract. If the recovering physician lives in a larger city, there may be Caduceus meetings held. The Caduceus meeting is a physician only AA meeting. Some recovering physicians are required to attend a set number of Caduceus meetings in the contract. The recovering physician is required to obtain a mentor to help them with the recovery process and follow-up with set or *ad-hoc* meetings with the Physician Health and Wellness committees or the Physician Health Program.

If the physician tests positive on a UDS, an *ad hoc* or emergency meeting of the PHW committee or PHP is called.

The recovering physician meets with the committee to determine triggering events, whether or not the UDS is a false positive, patient care issues, and status of recovery. The PHW committee or PHP may then elect to notify the state Medical Board of the UDS result, require more extensive monitoring, or make other suggestions or amendments to the contract.

Studies have shown that physicians who are monitored have a greater chance of recovery than the general population. Cicala (2003) writes that physicians who go through the intensive residential alcohol and drug treatment, outpatient monitoring have a 90% success rate. Many of these recovering physicians are happy to share their recovery with other impaired physicians by sitting on their local Physician Health and Wellness committees or by becoming involved on state or national levels.

Summary

With proper education and awareness, impaired physicians can be confronted and managed so that an environment of safety is present. This will allow for better patient care, healthier interpersonal relationships, and healthier physicians.

The Joint Commission has been instrumental in adopting policies to help with this. Leadership standard, which was created by Joint Commission Sentinel Event Alert of 2008 requires all hospitals and organizations to have a code of conduct which defines acceptable, disruptive, and inappropriate behaviors (Element Performance 4) as well as a process for managing disruptive and inappropriate behaviors (Element Performance 5) should they wish to be accredited. In addition, the Joint Commission formed Requirement (JCR) MS.11.01.01 to set up hospital Physician Health and Wellness (PHW) committees should the hospital organization wish to be accredited.

With treatment, impaired physicians can continue to be a valued member of the medical society. Education of disease processes and substance abuse are key. The Physician Health and Wellness committees along with state Physician Health Programs play important roles in physician health and recovery.

With proper support and management, impaired and recovering physicians can continue to contribute to the health-care milieu in a safe, effective manner.

References

American Medical Association. (1992). Opinion 9.031 - Reporting Impaired, Incompetent, or Unethical Colleagues. *American Medical Association Code of Medical Ethics.* Retrieved from http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9031.page

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Anonymous. (1973). The sick physician: Impairment by psychiatric disorders including alcoholism and drug dependency. *Journal of the American Medical Association*, 223, 684-687.

Boisaubin, E.V. & Levine, R.E. (2001). Identifying and assisting the impaired physician. *The American Journal of the Medical Sciences*, 322, 31-36. Retrieved from http://ovidsp.tx.ovid.com.proxy.libraries.uc.edu/sp-3.15.1b/ovidweb.cgi?QS2=434f4e1a73d37e8c9ea8b035782f3c43d21110454a8583e30af62a7f9ffc7710b34fcbe562b239aa86f0ed948931604d8a196ad18ef1a9fc36734a7f7b2bb15097f3e7e6d

Cicala, R.S. (2003). Substance abuse among physicians: What you need to know. *Hospital Physician.* Retrieved from http://www.turner-white.com

Federation of State Physician Health Programs. (n.d.). Federation of state physician health programs: History. Retrieved from http://www.fsphp.org/History.html

Institute of Medicine. (1999). *To err is human: Building a safer health system.* Washington, DC: National Academy Press. Retrieved from http://books.nap.edu/openbook.php?record_id=9728&page=R1

Joint Commission. (2008). *Behaviors that undermine a culture of safety.* Retrieved from http://www.jointcommission.org/assets/1/18/SEA_40.pdf

Lubin, G. 2015. The 19 jobs where you're most likely to kill yourself. *Business Insider.* Retrieved from http://www.businessinsider.com/most-suicidal-occupations-2011-10?op=1

Massachusetts Medical Society. (2015). Joint Commission requirement-MS.11.01.01. *Physician Health Services, Inc.* Retrieved from http://www.massmed.org/Physician_Health_Services/Joint_Commission/Joint_Commission_Requirement_-_MS_11_01_01/#.VSkQOBeSOJY.

Schorling, J.B. (2009).Physician impairment due to substance use disorders. *Medscape Internal Medicine.*Retrieved from http://www.medscape.com/viewarticle/712291_2

CliffNotes

Insurance Made Simple

Professional Liability
Commercial
Personal
Employee Benefits

Get it All with One Call

n&w INSURANCE

Cliff Craig, CPCU, CIC
(806) 376-6301
ccraig@neely.com

William Halsted: A Study in Addiction

by Rouzbeh K. Kordestani, MD, MPH

William Halsted (1852-1922) is regarded as the founder of the modern American surgical services. He is credited with much of our understanding of aseptic technique, invasive operations of the gallbladder, abdominal wall and thyroid surgery. Most important, his understanding, studies and contributions in breast cancer and breast extirpative surgery are considered the standards of what we now use to treat all women with breast cancer.

Amongst Halsted's stories and his achievements, though, lies a secret. It is not as much a secret as a necessary evil, one that has been ascribed by the most senior surgeons and the most astute historians—the secret that Halsted was a drug addict and was an addict until the day he died.

In the Beginning

William Halsted career began as an aspiring student at Yale University. At Yale, he was thought to be an intellectual drifter. Not much was thought of him. In fact, he was often described as lazy. He came from a wealthy family and had every opportunity. His father was an established businessman and was a trustee of the Colleges of the City of New York and of the Medical School there (later named Columbia College of Physicians and Surgeons). Towards the end of his stay at Yale, he found his calling. He became interested in anatomy and physiology. Through these initial studies and attendance of some primary classes at Yale Medical School, he decided to pursue medicine as a career choice.

In the 1900's, a pursuit of medicine was not a lofty affair. In fact, many of the medical schools required the applicant only to be able to read and to fill out the application in order to be accepted. The medical school curriculum was in disarray and the teachings were lackluster. In this setting, Halsted entered the medical school in New York (later named Columbia) in 1874. In New York, at Columbia, he did very well and distinguished himself as a perceptive mind and graduated with honors in 1877.

After medical school, he was given one of the prestigious intern positions available at Bellevue Hospital in New York City. He interned there for a year and spent an additional year as a house surgeon. He soon understood that the great minds of surgery and medicine lived across the Atlantic. So in 1878, he grabbed his bags and went off to Europe. Like many before him, he spent the next few years in the hallways of medical schools in Austria and Germany. There he met and studied under surgeons such as Drs. Theodore Billroth, Edoardo Bassini, Heinrich Braun, Hans Chiari, Friedrich von Esmarch, and Richard von Volkmann. This continued until 1880.

Upon his return from Vienna, Halsted became a house surgeon at Bellevue and quickly moved up the ranks. He also operated at Roosevelt Hospital, the Emigrant Hospital, the Charity Hospital and the Chambers Street Hospital, all in New York. He established himself as an excellent surgeon with a keen mind and great hands. It was during these years that he performed the one of the first gallbladder operations in the United States (on his mother). He also performed one of the first blood transfusions in the United States, again on a family member, his sister, to prevent her from dying after giving birth. Because of such feats of daring, Halsted soon developed a following and many young surgeons looked to him as the leader. It was during these years that he would develop many of his techniques in surgery. It was also during these years that he was introduced to cocaine.

In 1884, Dr. Carl Koller of Vienna conducted a live demonstration using cocaine as an anesthetic for work on the cornea and conjunctiva. Dr. Henry Noyes of New York who attended the meeting noted these findings and further described his observations in a letter to *The Medical Record*. Through this reading, Halsted was intrigued. Now a surgeon at Roosevelt Hospital, he decided to experiment with this new drug cocaine, on patients, on himself, on his fellows and on 25 to 30 medical students under his tutelage. This was to evaluate the possible usefulness of cocaine in general surgery. In an effort to understand the drug and its usefulness, the group used the drug freely and in every indication possible. Since the "evils" of cocaine had not been defined, Halsted and his colleagues quickly became addicted. This soon affected their performance. His surgery lectures became erratic and his contributions slowed.

Fall From Grace

There is a famous story that depicted Halsted's fall. On May 5th, 1885, Halsted was at Bellevue Hospital. A man was injured in lower Manhattan and was quickly rushed to the hospital. He had a compound fracture as could be seen with the bone already through the skin and with profuse bleeding. The younger surgeons and orderlies were looking for Halsted to take the case. Meanwhile, Halsted was in the midst of one of his new bliss moments after taking cocaine. When he heard his name, he came to the Emergency Room. But this was not the Halsted of old. As Markel describes in his book: "The pupils of his (Halsted's) eyes looked like gaping black holes, his speech was rapid-fire, and his whole body seemed to vibrate as if he were electrified. Upon entering the accident room, Halsted was confronted with the acrid smell of blood. Halsted could feel the sharp ends of a shattered shinbone, or tibia, thrusting its way through the skin. Halsted stepped back from the examination table while the nurses and junior physicians awaited his command. To their astonishment, the surgeon turned on his heels, walked out of the hospital, and hailed a cab to gallop

him to his home on East Twenty-fifth Street. Once there, he sank into a cocaine oblivion that lasted more than seven months."

Feeling a breakdown approaching, Halsted fled to Vienna in 1885 in hopes of being able to grasp some sense of control over his addiction. He did this also that his colleagues would not see him in such a state. He was back soon but without any semblance of a resolution to his problem. In fact, there are descriptions of meetings with him during this time that led to the conclusion that he was still using cocaine on a daily basis.

By 1886, Halsted had fallen out of favor and his erratic behavior had cost him his career. He was asked to contend for the Chair of Surgery at the Columbia College of Physicians and Surgeons. Unfortunately, his "illness" precluded him from an attempt at this position.

In the same year, a friend and life long colleague, Dr. William Welch, a pathologist, looked favorably on Halsted. They too were friends since early on and Welch was known as having a good eye for talent. In Halsted, he saw greatness—Welch decided to become Halsted's saviour. Even though he knew of Halsted's addiction, he had bigger plans for Halsted. But these could not be done with Halsted's addiction. For this reason, Dr. Welch initially hired a schooner and sailed his friend to isolation on the Windward Islands with hopes that the time away would help wean his addiction. This did not work. Records claim that in fits of withdrawal, Halsted simply pilfered the stash found on board. He soon returned, still addicted.

By now, Dr. Welch had been appointed by a group of wealthy benefactors to become the organizer and the mastermind behind the Johns Hopkins School of Medicine and Hospitals. Dr. Welch was to be the Chief of Pathology. In Halsted, he saw the future Chief of Surgery. In 1886, he encouraged Halsted to voluntarily admit himself into Butler Hospital, an institution in Rhode Island reserved for the mentally ill and at times for those addicted to alcohol and drugs. There, he began to deal with his addiction. However, in severe withdrawal episodes, he was given morphine to help him with the pains. The physicians at Butler reasoned that by switching him off the cocaine, they could possibly soften the symptoms with the use of another drug or possibly a combination of other drugs. They customarily used morphine. Morphine, or better known as morphia at that time, was a regular intervention used to help with addictions of any kind. Halsted learned to deal with his addiction. At Butler Hospital, Halsted learned to handle the beast of his addiction with cocaine. Unfortunately, he was now addicted to cocaine AND morphine.

To Baltimore and Johns Hopkins

In December 1886, Dr. Welch convinced Halsted to move to Baltimore and help him in the Department of Pathology with various projects and, in this way, show his slow return to clinical medicine. While there, he was kept on close watch with his addiction. He worked closely with Dr. Welch's assistant, Dr. Franklin Mall. He was there until April 1887, at which time he again voluntarily admitted himself back into Butler Hospital. This time, he was discharged after 9 months. He left not because he was cured but because he ran out of funds to pay the hospital. The specifics of his treatment course during his second tenure are obscure. When he returned to Baltimore, he again joined Dr. Welch's group and worked closely in the Pathology Labs with the likes of Drs. Mall, Abbott and Walter Reed.

Many observers have commented that Halsted's meticulous and dogmatic research in the laboratories at Johns Hopkins on canines laid the foundation for many of the scientific studies done today, specifically with attention to methods, details and application. Others claim that Halsted's attention to detail showed his needed focus and concentration on his own methods to make sure that his addiction was under control. In other words, he was no longer the same Halsted—he was now quiet, meticulous, slow and careful. He paid attention to his own every move to make sure it was controlled far beyond the aspects of surgery. He was this meticulous because he was scared of his habit and that its aspects would reappear.

After two years in the laboratory, and after being under the watchful eye of Dr. Welch and members of the trustees of Johns Hopkins, Dr. Halsted was made Surgeon-In-Chief at Johns Hopkins Hospital for a one year trial period. After this trial period, he was made the Surgeon-In-Chief for good and became Professor of Surgery. Unfortunately, even though his prowess and his reputation grew, his addiction continued. In April 1891, he wrote a letter to the Board of Trustees of Johns Hopkins and asked them for a leave of absence for what he noted were symptoms like malaria. He did not show up back in Baltimore until October 1891. His series of absences continued from there until his death. At times, he was thought to be at High Hampton, his secluded home. At times, he would simply go missing. These absences caused problems for him with the trustees, the hospital and the Medical Board. As for the younger surgeons at Johns Hopkins, they simply learned to expect his absences. The younger surgeons would comment (Markel's book): "At times, a week or more might go by without his (Halsted) appearance at the hospital."

Addicted To The End

The frequent absences demonstrated that Halsted continued to have problems with his addiction. The writings of two individuals allude to the persistence of the problem. Dr. Osler, the Professor of Medicine at Johns Hopkins, wrote in his memoirs, that Halsted was thought to no longer be addicted. However, this was not the case. He corrected this and added: "About six months after the full position (Surgeon in Chief) had been given, I saw him (Halsted) in severe chill, and this was the first indication I had that he was still taking morphia. Subsequently, I had many talks about it and gained his full confidence. He had never been able to reduce the amount to less than three grains daily." This was not revealed until well after Halsted's passing. The other instance of proof was seen in the writings of Dr. Harvey Cushing, one of Halsted's early pupils. Dr. Cushing, himself another meticulous surgeon, noted irrgegularities with his Professor's behaviors. He initially thought Halsted was lazy. However, he soon diagnosed the actual problem. He and another surgeon, Cutler, at the

Brigham and Women's Hospital in Boston, discussed their observations about Halsted. In his letter to Cutler, Cushing noted (Markel excerpt):

"There are many instances in support of this (Halsted's addiction). Shortly after accepting the Hopkins post, he took a big trip to South America and took with him not quite enough cocaine to make the trip, hoping that he could cut his daily dose. But he could not do this and found himself about the Equator sailing home with no cocaine. He rifled the captain's store and stole what was there. Moreover, his change in philosophy is entirely in keeping with the cocaine habit. There are stories of him going home at 4:30 every day and locking himself in his room an hour and a half before dinner. And on his many trips to Europe each summer, he never saw anyone but locked himself in a hotel room and took his drug.

There is another very interesting side to this story. Note that Halsted, before this addiction with cocaine was brilliant, a rapid, spectacular operator. Just as he changed his character and his dress to that of a fastidious person, paying great attention to details—a matter which characterizes cocaine addicts—so his outlook on surgery itself was changed, and he, in turn, devoted himself to the infinite precision of little details of surgery. There was no longer the picture of the brilliant operator but the cautious individual with tremendous and profound devotion to the little things. His fastidiousness in disposition was carried to fastidiousness in technical surgery, and this change in character, which has given rise to the greatest school in surgery this country has ever seen, may have been due to cocaine addiction. What a romance! And what a wonderful example of how destinies of men are influenced by extremely little things.

In Conclusion

William Halsted is thought to be one of the greatest surgeons to have ever lived. He was a scientist throughout his life. His addiction to cocaine was started as an experiment on himself, and his affliction continued as the side effect of his experiment. Once he learned of the addiction, he tried often to control it. He did so with morphine. Once he learned he could not control it, he learned to understand his own limitations as an addict and a compromised physician/surgeon. Nevertheless, he continued to contribute to the field of surgery. But as if seen as a real version of a Jekyll and Hyde character, whenever he felt his demons taking over, he withdrew from the operating room and from Johns Hopkins until he felt he could regain control. His series of disappearances and absences attest to this pattern.

Dr. Halsted died having contributed much to the success of Johns Hopkins and to the field of surgery. However, he died still afflicted with the disease of addiction.

Bibliography:

1. Markel, H. An Anatomy of Addiction: Sigmund Freud, William Halsted and the Miracle Drug Cocaine, Pantheon Books/Random House, 2011.
2. Osler, W. Inner History of the Johns Hopkins Hospital, 1969.
3. Nunn, D. "Dr. Halsted's Addiction," Johns Hopkins Advanced Studies in Medicine, Vol 6 (3), 106-108.

Food Addiction (BINGE EATING)

Based on uptodate.com database – accessed on 11/16/2015

Reported by Tarek Naguib, MD, MBA, FACP

Why Binge Eating?

About 2.6% of the population in the United States report binge eating in their lifetime. Females are more affected than males. The total number exceeds 7 million Americans. In weight loss programs the binge eaters make up almost a third of all participants. Although not always associated with overweight, binge eating may be associated with other psychiatric disorders.

What is Binge Eating?

Binge eating episodes are defined as consuming an amount of food in a discrete period of time (e.g. 2 hours) that is definitely larger than what most people would eat in a similar amount of time under similar circumstances. During episodes, patients feel they cannot stop eating or control the amount or type of food. Patients may eat rapidly until they are uncomfortably full and may feel disgust with themselves and embarrassment from others.

How severe is Binge Eating?

The severity of binge eating is classified according to the number of episodes per week:
Mild – 1 to 3
Moderate – 4 to 7
Severe – 8 to 13
Extreme – 14 or more

How is Binge Eating Diagnosed?

Binge eating is diagnosed when a person reports the above pattern of eating. Many cases are not diagnosed due to underreporting by the patients. Obesity in the binge eater is not different than in the general population, about 50%.

What Other Problems Take Place in Binge Eating?

Nearly a third of binge eaters suffer from phobias, social anxiety, major depression, posttraumatic stress disorder, and diabetes mellitus type 2. Also, 20% have alcohol abuse or attention deficit disorder.

What is Bulimia Nervosa?

The criteria for bulimia nervosa include recurrent episodes of both binge eating and inappropriate compensatory behavior to control weight gain e.g. inducing vomiting, occurring on average at least once per week for three months.

How do Doctors Treat Binge Eating?

Therapy to treat binge eating is called cognitive behavioral therapy. It is either administered by a therapist or done on the internet as self-therapy. Both methods have shown success. The patient should realize that the eating impulse is actually a temporary urge. The therapy puts emphasis on the decreasing the over value of body appearance and avoiding restriction of food intake that may cause a rebound phenomenon.

How Can I Help Prevent Binge Eating?

Avoid substance abuse and severe food intake restriction. Realize that health is important for body function and performance but do not over-value the body image.

More Texas Physicians Texas Medicine (9/1) – The average Texas medical liability trust premium (for physician malpractice) in Texas went down 42% since tort reform, helping attract many physicians to Texas over the last 11 years - 5,149 new physician applied in the last year only. Physician growth exceeded that of the population need and increased for both rural and urban specialists.

Certification Cost for Internists Ann Intern Med (9/15) – For an already board-certified internist, the current average cost to renew the American Board of Internal Medicine Certification is $ 23,607 every 10 years. This includes costs of education, missed work, and administrative fees.

A New Insulin JAMA (11/3) – A new form of basal insulin called insulin degludec was marketed. The product can be used alone or in combination with other pills or bolus insulin for type 1 or 2 diabetics. It has a long duration of action of at least 42 hours.

ACOs improve quality JAMA (10/27) – Medicare released a report that multispecialty alliances of doctors registered with Medicare (called accountable care organizations) improved quality according to preset criteria and saved over $411 million in 2014.

Natural Product Research JAMA (10/27) – NIH awarded $35 million to 5 research centers to study the safety of natural products including dietary supplements, fish oil, omega-3 fatty acids, and probiotics.

Plague Up in Western US JAMA (10/13) – Eleven cases of plague were reported in 6 states from April to August in Arizona, California, Colorado, Georgia, New Mexico, and Oregon. Three patients have died. The median has been 3 cases per year in the US for the previous decade.

The State of Global HIV JAMA (10/20) – New HIV infections have dropped by a third in the last 15 years and the death rate by a fourth over the last several years, resulting in 29.2 million persons living with HIV in the world, compared with 8.7 million in 1990.

The State of Global Dementia JAMA (10/20) – According to the "World Alzheimer's Report", there are 47 million people around the world with some form of dementia, which is expected to double in 20 years.

Polio-Free Africa in 2014 JAMA (10/20) – No cases of polio were reported in Africa in 2014. The only 2 countries left with endemic polio in the world now are Afghanistan and Pakistan.

Vitamin D NOT for Postmenopausal Women JAMA (10/27) – High dose of vitamin D supplements for post-menopausal women did not improve bone density, muscle function, or falls!

Tampons Again! JAMA (10/13) - Congresswoman Maloney (D, NY), along with 6 colleagues, implored the NIH to initiate research into the hazards of female hygiene products after a severe case of toxic shock syndrome caused a woman to lose both her feet. The letter cited lack of research in the safety of these products!

Obesity May Fuel Breast Cancer JAMA (10/6) – a recent study suggests obesity alters breast fatty tissue and promotes extracellular stiffness, which increases chances of breast cells becoming malignant.

Obesity NOT Decreasing New York Times (11/12) – Despite efforts to reduce obesity, federal health officials reported that the share of Americans who were obese had not declined in recent years. Approximately 38% of American adults were obese in the last 2 years!

Bariatric Surgery for Obese Teens Chron (10/10) – The largest, longest study of teen obesity surgery shows huge weight loss and health gains can last at least three years, and many say it's worth the risks!

Heart Strain in Obese Children Time (11/10) – Researchers in the last American Heart Association Annual meeting in Florida reported obese children as young as 8 to have 27% thicker left ventricles, a potentially harmful change that was shown historically to increase death rate related to heart disease.

Free Child Health Program in Amarillo – Potter-Randall Bi-city County Health Department offers a free program to promote children's health of ages 7-13. The program, which is called MEND, builds better nutrition and exercise habits to combat overweight among children. If interested call (806)378-6363.

PROFESSIONAL CARDS

Cardiology

AMARILLO HEART GROUP
Joaquin Martinez-Arraras, M.D.
Marc Moreau, M.D.
Prakash K. Desai, M.D.
Jon Luigi Haddad, M.D.
D. Gary Soya, M.D.
Agustin Cabrera-Santamaria, M.D.
Ismaile S.H. Abdalla, M.D.
Ernesto Rivera, M.D.
Arunava D. Ray, M.D.
A. Alan Chu, M.D.
Rajesh Nambiar, M.D.
1901 Port Lane
Amarillo, TX 79106-2430
(806) 358-4596 • 1-800-355-5858
www.amarilloheartgroup.com

Cardiovascular & Thoracic Surgery

Masoud A. AlZeerah, M.D., F.R.C.S.C.
Radiofrequency ablation for varicose veins & spider veins
1301 S. Coulter, Suite 103
Amarillo, TX 79106
(806) 463-1712 • Fax (806) 463-1715
www.amarilloveins.com

Dermatology

HIGH PLAINS DERMATOLOGY CENTER, P.A.
Turner Caldwell III, M.D.
Larry C. Roberts, M.D.
Scott D. Miller, M.D.
Jason K. Jones, M.D.
Christi A. Baker, M.D.
4302 Wolflin Ave.
Near I-40 & Western
355-9866

Gastroenterology

Abdul Thannoun, M.D.
3501 S. Soncy Road #107
Amarillo, TX
(806) 354-2400 • Fax (806) 354-8070
www.amarillogastro.com

Hearing

PHYSICIANS HEARING CENTER
Royce A. Armstrong, Au.D., CCC-A
Steven Allred, Au.D., CCC-A
3501 S. Soncy Road #140
Amarillo, TX
(806) 352-6901 • Fax (806) 352-2245

Hospice/Palliative Medicine

GENTIVA HOSPICE
Eric Cox, M.D.
Board Certified in Hospice & Palliative Care
3232 Hobbs Road
Amarillo, TX 79109
806-372-7696 (ofc)
800-572-6365 (toll free)
806-372-2825 (Fax)
www.gentiva.com

Internal Medicine

Ruth Pilco-Jaber, M.D.
Board Certified in Internal Medicine
3501 Soncy Road, Suite 131
Amarillo, TX 79119
(806) 467-9111 • Fax (806) 467-9333

Mouin M. Jaber, M.D.
Board Certified in Internal Medicine
3504 N.E. 24th
Amarillo, TX 79107
(806) 381-1732 • Fax (806) 381-0748

AMARILLO DIAGNOSTIC CLINIC
6700 W. Ninth
Amarillo, TX 79106
(806) 358-0200

Endocrinology
Susan T. Wingo, M.D.

Gastroenterology
Daniel A. Beggs, M.D.
R. Todd Ellington, M.D
Jake C. Lennard, Jr., M.D.
James E. Lusby, M.D.
Thomas L. Johnson, M.D.

Infectious Disease
J. Taylor Carlisle, M.D.

Internal Medicine
Holly Mitchell, M.D.
Joanna Wilson, D.O.

Neurology
Douglas Lewis, D.O.
Sean Milligan, M.D.

Nuclear Medicine
Bill F. Byrd, M.D.

Pulmonary Diseases
Bruce Baker, M.D.
Timothy S. Mooring, M.D., D, ABIM
Gary R. Polk, M.D., D, ABSM
Javier Dieguez, M.D.

Rheumatology
Ming Chen, M.D., Ph.D

Sleep Disorders
Timothy S. Mooring, M.D., D, ABIM
Gary R. Polk, M.D., D, ABSM

Physician Extenders
Tiffany Ferrell, RN, MSN, FNP-C
William A. Ledford, RN, MSN, FNP-C
Teresa Pattison-Thomas, P.A.-C
Cindy Anderson, RN, MSN, FNP-C
Kyla Beedy, RN, MSN, FNP-C
Ashley Quillin, RN, MSN, FNP-C

Neurosurgery

Jeffrey D. Cone, M.D., F.A.C.S.
Neurological & Spinal Surgery
Board Certified - American Board of Specialization
6822 Plum Creek Drive
Amarillo, TX 79124
(806) 373-3177 • Fax: (806) 373-0423

Bret D. Errington, M.D.
Board Certified by the American Board of Neurological Surgery - Cranial and Spinal Neurosurgery
7120 W. 9th
Amarillo, TX 79106
(806) 463-2251 • Fax: (806) 463-2252

J. Brett Gentry, M.D.
Neurological & Spinal Surgery
Board Certified - American Board of Neurological Surgery

Wayne S. Paullus, M.D.
Neurological & Spinal Surgery
Board Certified - American Board of Neurological Surgery

PROFESSIONAL CARDS

Wayne "CP" Paullus III, M.D.
Neurological & Spinal Surgery
#11 Medical Drive
Amarillo, TX 79106
(806) 353-6400 • (800) 358-2662
www.swneuro.com

Obstetrics & Gynecology

PANHANDLE OBSTETRICS & GYNECOLOGY
Dudley E. Freeman, M.D.
Gregory A. May, M.D.
Cullen Hopkins, M.D.
George Barnett, M.D.
Jamie Wilkerson, M.D.
Sarah Bergeron, RNC, WHNP
Brenna Payne, RNC, WHNP
Haylee DeVries, PA-C
7620 Wallace Blvd.
Amarillo, TX 79124
(806) 359-5468 • Fax (806) 358-1162

WOMEN'S HEALTHCARE ASSOCIATES, P.L.L.C.
Carin C. Appel, M.D.
Rhodesia A. Castillo, M.D.
Pamela A. Chandler, M.D.
David L. Chastain, M.D.
Brian J. Eades, M.D.
Jill A. Gulizia, M.D.
Clyde A. Meeks, M.D.
Amanda Murdock, M.D.
Stephanie Crockett, MSN, RN, FNP, BC
Brenna Melugin, FNP, BC
Brooke Hillard, FNP, BC
1301 Coulter, Suite 300
Amarillo, TX 79106
(806) 355-6330 • Fax (806) 351-0950
whaonline.net

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
Amarillo Campus
1400 Coulter • 414-9650
www.ttuhsc.edu/amarillo/som/ob

Obstetrics & Gynecology
Hena Tewari, M.D.
Teresa E. Baker, M.D.
Paul E.Tullar, M.D.
Usha Sethi, M.D.
Nika Vinson, M.D.
Catherine Wheatley, M.D.
Jeffrey Wang, D.O.
Chad Winchester, MSN, WHNP
Diana R. Parker, RNC, WHNP
Carisa Sullivan, RNC, FNP

Gynecologic Surgery
Hena Tewari, M.D.
Teresa E. Baker, M.D.
Paul E. Tullar, M.D.
Robert P. Kauffman, M.D.
Catherine Wheatley, M.D.
Nika Vinson, M.D.
Jeffrey Wang, D.O.

Menopausal Management
Robert P. Kauffman, M.D.
Reproductive Medicine & Infertility
Pediatric Gynecology
Gynecologic Ultrasound
Robert P. Kauffman, M.D.

Urodynamic Testing & Incontinence Management
Paul E. Tullar, M.D.
Nika Vinson, M.D.

Maternal Fetal Medicine
Obstetric Ultrasound
Heather J. Holmes, M.D.
www.ttuhsc.edu/amarillo/patient/obgyn/ultrasound

Genetic Counseling
Shirley Karr, MSN
Heather Wheeler, RN

Ophthalmology

PANHANDLE EYE GROUP, L.L.P.
Specializing in the Diseases & Surgery of the Eye
www.paneye.com
Amber Dobler-Dixon, M.D.
Glaucoma Laser & Surgery
Amarillo: 7411 Wallace Blvd.
(806) 350-1100 • (866) 567-0948
Robert E. Gerald, M.D.
Comprehensive Ophthalmology, Cataract & Refractive Surgery
7308 Fleming Ave.
Amarillo, TX 79106
(806) 359-7603 • (800) 283-8018
John W. Klein, M.D.
Comprehensive Ophthalmology, Cataract Surgery
13 Care Circle
Amarillo, TX 79124
(806) 353-2323 • Fax (806) 351-2323
(888) 393-7488

C. Alan McCarty, M.D.
Comprehensive Ophthalmology, Cataract Surgery
7411 Wallace Blvd.
Amarillo, TX 79106
(806) 351-1177 • (800) 782-6393
W. John W. Murrell, M.D.
Comprehensive Ophthalmology, Cataract & Oculoplastic Reconstructive Eyelid Surgery
7411 Wallace Blvd.
Amarillo, TX 79106
(806) 351-1177 • (800) 782-6393
J. Avery Rush, M.D.
Cataract & Refractive Surgery
Sloan W. Rush, M.D.
Cornea, Cataract & Refractive Surgery
7308 Fleming Ave.
Amarillo, TX 79106
(806) 353-0125 • (800) 225-3937
Bruce L. Weinberger, M.D.
Comprehensive Ophthalmology, Cataract & Refractive Surgery
700 Quail Creek Dr.
Amarillo, TX 79124
(806) 353-6691 • (800) 637-2287
J. Edward Ysasaga, M.D.
Antonio V. Aragon, II, M.D.
Ryan Rush, M.D.
Diseases & Surgery of the Retina, Vitreous, & Macula
7411 Wallace Blvd.
Amarillo, TX 79106
(806) 351-1870 • (888) 404-1870

Oncology

HARRINGTON PHYSICIANS, INC.
Power of ONE
Medical Oncology
Brian Pruitt, M.D.
Medical Oncology/Hematology
Stewart Sharp, M.D.
Suhasini Nadesan, M.D.
Anita Ravipati, M.D.
Harrington Cancer Center
1500 Wallace Blvd.,
Amarillo, TX 79106
(806) 359-4673 • Fax (806) 354-5888
www.harringtoncc.org

PROFESSIONAL CARDS

Orthopaedic Surgery

Michael O. LaGrone, M.D.
Reconstructive Spine Surgery, Scoliosis, Pediatric Orthopaedics Board Certified
1600 Coulter, Bldg. B
Amarillo, TX 79106
(806) 354-2529 • Fax (806) 354 2956
www.scoliosismd.com

Michael S. Manderson, M.D.
Adult Reconstructive Spinal Surgery Board Certified
13 Medical Drive
Amarillo, TX 79106
(806) 322-1333 • Fax (806) 322-1334

James R. Parker, M.D.
Board Certified Specializing in Sports Medicine & Total Joint Replacement
7000 W. 9th Ave.
Amarillo, TX 79106
(806) 350-2663 • Fax (806) 350-2664

Aubrey L. Smith, M.D.
Orthopaedic Surgery, Arthroscopic & Reconstructive Surgery / Shoulder Surgery Board Certified - Fellow of the Academy of Orthopaedic Surgeons
1600 Coulter, Bldg. B
Amarillo, TX 79106
(806) 359-0718 • Fax (806) 359-9613

Otolaryngology (ENT)

PANHANDLE EAR, NOSE & THROAT
3501 South Soncy Road, Ste. 140
Amarillo, TX 79119-6405
(806) 355-5625 Fax (806) 352-2245
Stacie Morgan, M.D.
Amber Price, M.D.
Geoffrey Wright, M.D.

Pain Management/ Treatment

AMARILLO PAIN ASSOCIATES
Thomas E. Merriman, M.D.
1901 Medi Park Place
Suite 2002
Amarillo, TX 79106
(806) 353-4699 • Fax (806) 353-4551

ADVANCED PAIN CENTER
Robert Paige, M.D.
6819 Plum Creek
(806) 463-1789 • Fax (806) 355-2469

Victor M. Taylor, M.D.
7910 SW 34th
(806) 352-7431 • Fax (806) 352-2374

Pediatrics

Meganne Walsh, M.D.
716 North Polk
Amarillo, TX 79107
(806) 374-5900 • Fax (806) 374-5914

TEXAS TECH PHYSICIANS OF AMARILLO
Pediatrics/Pediatric Subspecialties
1400 S. Coulter • (806) 354-5437
Children with Special Needs/ Pediatric Surgery
1400 S. Coulter, Suite 1300
(806) 356-4760
Neonatal Intensive Care Service - (NWTH)
(806) 354-1390
Pediatric Intensive Care Service - (NWTH)
(806) 354-1585
Adolescent Medicine
Marita Sheehan, M.D.
Pediatric Behavior/Development
Angela Huang, M.D.
Pediatric Cardiology
Srilatha Alapati, M.D.
Pediatric Gastroenterology
Abiodun Johnson, M.D.
Pediatric Genetics
Golder Wilson, M.D.

TEXAS TECH PHYSICIANS OF AMARILLO
Pediatric Hematology/Oncology
Curtis Turner, M.D.
Pediatric Nephrology
Tetyana Vasylyeva, M.D.
Emily Howard, PA
Pediatric Pulmonary (Cystic Fibrosis)
Adaobi Kanu, M.D.
Pediatric – General
Todd Bell, M.D.
Oluyemisi Fatunde, M.D.
Amanda Griffin, M.D.
Shannon Herrick, M.D.
Vinod Sethi, M.D.
Marita Sheehan, M.D.
Andrew Relph, D.O.
Huang Petersen, NP
Brittany Thomas, PA
Pediatric Surgery
Janet Meller, M.D.
Jason Nirgiotis, M.D.
Children with Special Needs
Walter Bridges, M.D.
Rolf Habersang, M.D.
Pediatric Endocrinology
Alison Lunsford, M.D.
Sue Rankin, R.N., M.S.N., F.N.P.

Plastic & Reconstructive Surgery

Mary Ann Piskun, M.D.
Board Certified by the American Board of Plastic Surgery
1801 Halstead, Ste. B
Amarillo, TX 79106
(806) 358-8731 • Fax (806) 358-8837

Rouzbeh Kordestani, M.D., M.P.H.
Plastic, Aesthetic, Reconstructive & Hand Surgery
3501 Soncy, #137
Amarillo, TX 79119
(806) 322-5438 • Fax (806) 322-5505
www.drkordestani.com

PROFESSIONAL CARDS

Plastic & Reconstructive Surgery

Patrick Proffer, M.D., F.A.C.S.
Cosmetic, Reconstructive & Hand Surgery
Board Certified by
The American Board of Plastic Surgery
Member of the American
Society of Plastic Surgery
1611 Wallace
(806) 352-1185 • Fax (806) 352-4987
www.drproffer.com

Radiology

HIGH PLAINS RADIOLOGICAL ASSOCIATION
1901 Medi Park, Suite 2050
Amarillo, TX 79106
(806) 355-3352 • Fax (806) 355-5367
John Andrew, M.D.
Gary Aragon, M.D.
Branch Archer, M.D.
Richard Archer, M.D.
Gayle Bickers, M.D.
Charles Brooks, M.D.
Crandon Clark, M.D.
Stanley Cook, M.D.
Tully J. Currie, M.D.
Michael Daniel, M.D.
Aaron Elliott, M.D.
Christina Fox, M.D.
Stephan Haas, M.D.
Michael Hall, M.D.
Arouj Hashmi, M.D.
Richard Khu, M.D.
Rahul Mehta, M.D.
Paul Pan, M.D.
Robert Pinkston, M.D.
Matthew Scalapino, M.D.
Rakesh R. Shah, M.D.
Martin Uszynski, M.D.
Kimberly Waugh, M.D.
Lawrence Zarian, M.D.

Surgery

Victor V. Hands, M.D., F.A.C.S.
Peripheral Vascular Surgery,
General and Laparoscopic Surgery
BOARD CERTIFIED
2418 S.W. 8th Ave.
Amarillo, TX 79106
(806) 376-4385

Surgery

AMARILLO SURGICAL GROUP
6 Medical Drive
Amarillo, Texas 79106
(806) 212-6604 Fax (806) 212-0355

Peter Baay, MD
Cardiothoracic Surgery

David Langley, MD
General / Vascular Surgery

Shane Holloway, MD
Surgical Oncolory / General Surgery

Michael Lary, MD
General Surgery

Chance Irwin, MD
General / Vascular Surgery

John McKinley, MD
General Surgery

MOVING?

Please Note Change of Address

NAME_____

NEW ADDRESS_____

CITY_____STATE_____

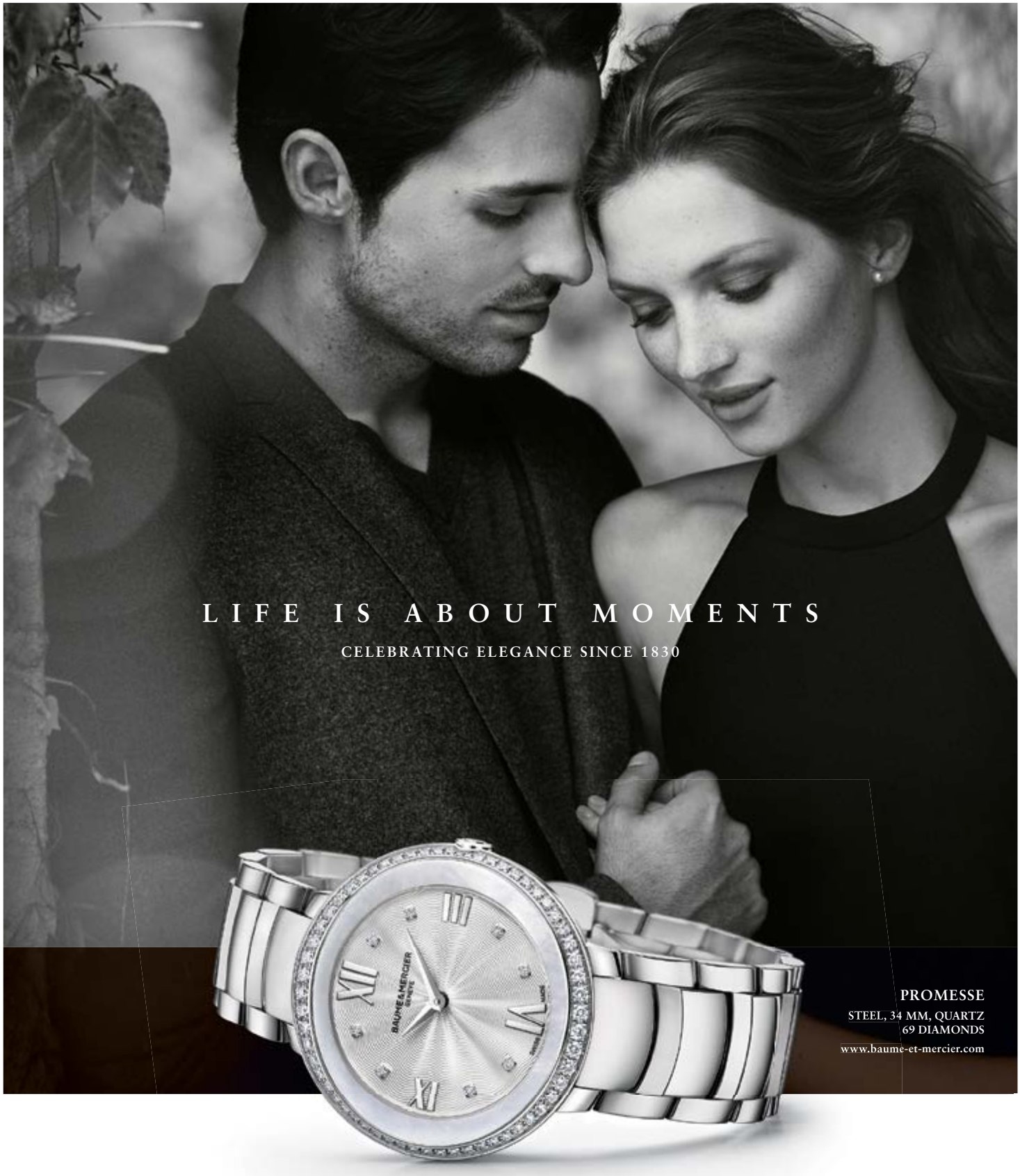
ZIP_____PHONE_____

MAIL THIS FORM TO:

PANHANDLE HEALTH

1721 Hagy

Amarillo, Texas 79106



DUNCAN & BOYD
JEWELERS
FINE JEWELERS SINCE 1967

MEMBER AMERICAN GEM SOCIETY
809 South Tyler • Amarillo, Texas
806-373-1067 • 1-800-540-8590 • www.duncanandboyd.com

BAUME & MERCIER
MAISON D'HORLOGERIE GENEVE 1830

TWO LOCATIONS,
Same Personal Care

Open Air MRI
7400 Wallace Blvd. • 806.353.8333

Advanced Imaging
7010 W. 9th • 806.351.8480

We are proud to be your local team for your High-Tech Radiology needs.

AmarilloImaging.com

ADVANCED IMAGING
CENTER OF AMARILLO

PANHANDLE HEALTH
A QUARTERLY PUBLICATION OF THE POTTER-RANDALL COUNTY MEDICAL SOCIETY

1721 HAGY
AMARILLO, TEXAS 79106

Non-Profit
Organization
U.S. Postage
PAID
Permit No. 247
Amarillo, Texas