PANHANDLE HEALTH

A QUARTERLY PUBLICATION OF THE POTTER-RANDALL COUNTY MEDICAL SOCIETY

WINTER 2024 | VOL 34 | NO.1

MEDICAL PRACTICE IN THE PANHANDLE: 1980-2010

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Erratum:

In our last issue, "Zombie Diseases: The Resurgence of Old Diseases" the article entitled "Climate Change and its Effect on Infectious Diseases" was wrongly attributed to Dr. Brian Weis. The correct author was Dr. Marge Weis, PhD of Texas Tech School of Pharmacy. We apologize for this error.

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On The Cover: ***"Owl" Meet You Under the Mistletoe*** by Marsha Clements

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President's Message

by Nicole Lopez, MD, FAAFP

Fall is in full swing and we are currently flying through the calendar months of another year. For entering premedical students and fourth year medical students, interview season has arrived as well. As faculty at TTUHSC School of Medicine, I have had the privilege to be able to interview the best and brightest of today's youth. Many of these students have near-perfect grade point averages, excellent research experience, many hours invested in shadowing the field of medicine and have served as leaders on their college campuses--several have earned their Master's or are dual applying for a degree in Public Health, Business, or Engineering. I often ask the students that I interview why they chose to pursue a career in medicine, and many of them replied either that they had a physician who served as a role model and mentor or that they have chosen a role where they felt like they could have an impact on the community that they serve.

Kirstie Smith, DO, a current intern in the TTUHSC Department of Family Medicine said, "If I am being honest, there are really two things that made me decide to go into medicine, and both relate to my background in exercise physiology. The first was just pure amazement at the complexity and adaptability of human physiology and the handiwork of our creator. The second was the role that preventative care, and more specifically living a healthy and active lifestyle, has in preventing so many of the chronic disease complications that we see every day in both the clinic and the hospital. I am of the opinion that primary care physicians are in the optimal role to make a major impact on the trajectory of a patient's health, not only by taking care of patients' existing medical conditions, but also by helping them optimize their lifestyle from a physical and psychological standpoint."

One MSIV student stated that she had difficulty accessing care as a minority in her hometown and that this experience led her to seek a career to be able to provide care to the underserved. Many of the students who are accepted volunteer in the student-run Free Clinic in Lubbock or for the Refugee Clinic in Amarillo because they actually do want to serve those in need who would otherwise not have access to healthcare.

The Texas Medical Association has a very robust Medical Student Section, and students serve in designated seats on boards, councils and have voting representation in TMA's house of delegates. Alisa Pierce reported in a recent article for TMA that, at last year's TexMed conference, medical students advocated with the TMA's Committee on Medicaid, CHIP and the Uninsured to push a resolution to create a place-of-service code for street medicine, thus making it possible for physicians to get paid for services provided to people who are currently homeless, and that this change has been approved by the Centers for Medicare and Medicaid Services (CMS). According to J. Hunter Scarbarough, MD, a fellow in the street medicine fellowship program at JPS, "Now that we have this specific code, it will be easier to pull data about how effective street medicine teams are, how cost-effective providing care is, and what kinds of patients we're seeing."

The headlines are full of stories of war, crime and hate, and it is easy to get discouraged. As we approach the upcoming holiday season, however, it is important to remember that there is still hope in this world and that there is still a future in medicine. The young people that I interview and teach today will be the doctors of tomorrow, and they still hold a lot of promise. I am very thankful for the physicians in this community who were willing to let me shadow them when I was in college and who taught me in medical school 25 years ago. I am thankful for the physicians mentioned in this issue of Panhandle Health who have dedicated their lives and careers to taking care of my family and my friends in Amarillo. I strive to do the same for the medical students and residents that I teach. I hope that this season brings you a sense of hope, peace and encouragement.

Merry Christmas.

Our Next Issue Of *Panhandle Health* Features:

Update in Cardiovascular Diesease

Executive Director's Message

by Cindy Barnard, Executive Director

As the year ends, I want to thank the 2023 Board of Directors for their service and dedication to our society. Under the leadership of our president, Dr. Nicole Lopez, we have enjoyed an exceptional year. We are getting our groove back and having board meetings, committee meetings, and special events.

The following physicians deserve an enormous thank you for their support as well:

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Another thank you goes to the 2023 Panhandle Health Editorial Board, led by Sheryl Williams, M.D. Members of the Editorial Board are Steve Urban, M.D. (Copy Editor), Rouzbeh Kordestani, M.D., Paul Tullar, M.D., Skye McLaurin-Jiang, M.D., Scott Milton, M.D., Marge Weis, Ph.D., Christine Garner, Ph.D., and Basak Basbayraktar, M.D. resident.

Again, a big thank you to our "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, Baptist Community Services, Neely, Craig, & Walton Insurance Agency, Texas Medical Association Insurance Trust, Happy State Bank, Boxwell Brothers Funeral Home, Daryl Curtis, Northwest Physicians Group, and Pat Davis.

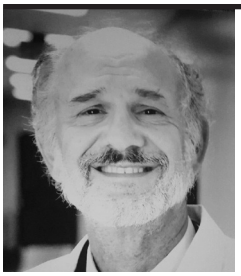
Last but not least, I want to thank all of the 100% membership group practices whose entire physician staff are members of the Potter Randall County Medical Society and TMA. These groups are Amarillo Family Physicians Clinic, Amarillo Heart Group, Amarillo Medical Specialists, Amarillo Urology, Cardiology Center of Amarillo, High Plains Radiological Association, Panhandle Eye Group, Texas Oncology, Women's Healthcare Associates, and Amarillo Anesthesia Consultants.

Message from the Potter-Randall County Medical Alliance

by Tricia Schniederjan, President

The Alliance will be joining the Northside Toy Drive on December 16th for our Hard Hats for Little Heads event. This will be our third year to participate in fitting and handing out bike helmets to children who will be going home with brand new bikes, scooters, and hoverboards. Join us to help fit and hand out bike helmets for the children. Look for an email to sign up to volunteer, or email me at tschnied@gmail.com.

I'm proud to announce the new Potter-Randall County Medical Society Alliance Board. Madeleine Lennard and Alena Martin will serve as Co-Presidents, Rachel Mckenna is our new Treasurer, Audra Kirkendall and Jennika Patel will help with Membership, and I'll be the Past President. If you are interested in joining us in a board position, feel free to reach out. We look forward to our new leadership! Thank you so much!



Guest Editorial

by Steve Urban, MD, MACP

The winter 2023 issue of Panhandle Health is devoted to recording and honoring the practice lives of local physicians. Several prior issues have dealt with this theme (see below), but this time the editorial board wanted to focus on doctors who were most active from approximately 1980 through the 2010s. We wanted to sample a diversity of practices—from academicians (e.g., Rick Jordan, Hal Werner, Tom Hale) to private practitioners (Charles Wike, John David, Gayle Bickers)--and a diversity of specialties. We asked these doctors to look back on their careers in medicine. We wanted them to tell us (and you) how they got interested in science and medicine, how they came to the Panhandle, and what their professional lives were like--how their specialties changed and how the business and practice of medicine changed. Some preferred to be interviewed; others told their stories autobiographically. But we believe that all the articles are interesting and informative.

As you will see, some common themes emerge—for instance, the very mixed benefits of the intrusion of the electronic health record (more accurately, the electronic billing record) and the bureaucracy of supervised care (pre-approvals, denials and resubmissions, restrictive formularies, etc.) into their practices. You will read how technological advances (e.g., MR scanning, laparoscopy) have made procedures and diagnosis safer and more reliable. You will learn what it was like to start a research program at a new medical school, what it has been like to supervise and teach fundamental principles to new generations medical students, what it was like to be there at the foundation of a new subspecialty (pediatric radiology), how to balance family life with the time demands of medical practice. And more.

This is the eighth issue of Panhandle Health devoted to history of medicine in the Panhandle of Texas. Our first such issue came out in the winter of 1998. Those articles focused on institutions—the histories of Baptist-St. Anthony's Hospital (St. Anthony's founded in 1901, High Plains Baptist Hospital in 1968), Northwest Texas Hospital (1924), and the Amarillo VA Hospital (1940), for instance. This first foray into Panhandle medical history also included articles about the Texas Tech School of Medicine in Amarillo, Coffee Memorial Blood Bank, and the Harrington Cancer center—as well as a still-fascinating article by journalist Gene White about the first medical specialties in the Panhandle.

An issue devoted to the histories of individual physicians came out in the spring of 2012. This issue included articles about early Ob/gyn specialist Dr. Earley B. Lokey, medical school dean and hospice pioneer Dr. Gerry Holman, Dr. Mubariz Naqvi (the man who brought modern neonatal care to Amarillo), Henry Martinez, Dan Epley, William Klingensmith, Mitch Jones and more. Bob Stafford, himself a legendary orthopedist, wrote a fascinating article about the challenges faced by first four orthopedic surgeons (Drs. Sadler. Thomas, Citron, and Hyde) to come to Amarillo. And John and Rachel Andrew told the inspiring story of pioneer developmental pediatrician Dr. Leora Andrew.

This issue proved so popular with our readers that we published a follow-up issue in the fall of 2013 about iconic doctors in smaller communities of the

Panhandle—Pampa's Dr. Ray Hampton, Perryton's Dr. Roy Sanford, Canadian's Dr. Rush Snyder Sr., Canyon's Dr. Dudley More and others. An issue devoted to retiring doctors (fall, 2016) included a bio of Amarillo neurosurgeon and collector of fine art, Dr. Bill Price. In the fall of 2020, we published articles about several important Amarillo physicians, including the founders of the Amarillo Diagnostic Clinic (Tom Duke, John Milton, and Wayne Smith), oncologist Phillip Periman, pediatrician Holley Reed, orthopedist Dick McKay, anesthesiologist Tom Easley and others.

We have published two issues recounting stories of physicians who came to Amarillo from an international setting. The first of these, published in the fall of 2000, described how doctors from Canada, India, Nigeria and other homelands brought new dimensions to medical care in the Panhandle. A similar issue, entitled "Diversity in Medicine", came out in the spring of 2021 and recounted stories of women physicians (7 in all) as well as practitioners from other cultures and backgrounds. Our fall 2014 issue (fall seems to be a good season for this kind of thing) was specifically devoted to the challenges facing women in medicine; this issue included an article about three early women physicians in Amarillo (Drs. Ernestine Smith, Nan Gilkerson, and Evelyn Powers).

The current issue is meant to follow up on the successes of these prior efforts. We hope that, by reading these articles, you will learn about some of Amarillo's most gifted and influential doctors—some in their own words and some through the interview process. We hope that, despite the challenges facing Panhandle Health (and all other print journals), we will continue periodically to devote issues to honoring the work—at times tedious, at times disheartening, but often rewarding and (as in the pandemic) even heroic--that characterizes the daily lives of working doctors in the Panhandle of Texas.

Addendum: If you are interested in rereading any of these articles, the Harrington Library at Texas Tech has hard copies of all issues of Panhandle Health from the fall of 1990 to the present. In addition, you can easily access scanned copes of issues dating back to the summer of 2013 by going to the Potter-Randall County Medical Society website (https://www.prcms.com, select "Magazine", scroll back through the index, and click on whatever issue you want to look at).

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Rheumatic Fever To Radiology

by Gayle Holberg Bickers, MD

LAURA BICKEL, THANK YOU

The bed by the front porch window limited my four year-old world. For three or four months, I could not even walk to the bathroom. Like many children in the mid-1940s, I had post-streptococcal rheumatic fever. Penicillin reached the US civilian population by March 1943. It was too late for me--but I had Laura Bickel MD (1). This tall brunette calmly directed my distraught mother how to care for a very lively little girl who did not want to stay in bed. She advised her to teach me to read. Fortunately, I recovered with no cardiac damage and a voracious appetite for books.

Dr. Laura Bickel graduated from the then Medical College of Wisconsin and opened her pediatric practice in Houston, Texas in the early 1940s. Her clinic boasted exam rooms decorated with large framed posters of Mother Goose Land and Grimm's fairy tales. I never dreaded my visits because I roamed those places in my imagination. As I grew older, she encouraged my vague interest in medical things. She shared stories of her time as a female student when men and women could not share call facilities – except on the Ob-gyn rotation. The steel in her voice as she described her experiences unconsciously prepared me for medical school in the 1960s.

Thanks to Dr. Bickel's care, I thrived, loved my cats and dogs, and set my sights on vet school. I still wanted to be a doctor, just for different species. That dream collided with reality in my junior year of high school. The only vet school in Texas, Texas A & M, did not admit women as undergraduates. No other state schools offered the required pre-vet courses, and my parents certainly could not afford out of state tuition to other vet colleges.

RICE UNIVERSITY YEARS

To my parents' delight, Rice University accepted me for the class of 1964, and college searches came to a screeching halt. Due to the Great Depression, my Dad left high school to help support his family. My mother graduated from high school and immediately took secretarial classes and a job. For many months she was the sole bread winner for a family of eight. They were proud of me, but I think the relief that Rice University was tuition-free outweighed the pride. I lived at home and used the money from a Houston endowment scholarship that supported education and other philanthropic causes in Texas. It's hard to believe that $400 per semester covered books and lab fees. My parents thought they had died and gone to financial heaven!

My first year at Rice ate my lunch. All freshmen had to take calculus, and algebra II was the highest level of mathematics in my high school. To make matters worse, all 100 and 200 level courses were not independent semesters but required a single-year passing grade. Fortunately, my miserable first semester calculus grade, averaged with the second semester's solid geometry grade, allowed me to pass the course. (That single class grade kept me off of the Honor Roll my freshman year--obviously still a sore point.)

Rice Institute had admitted women since its opening in 1912. In the 1960s, men outnumbered women by about 3 to 1 due to the strength and appeal of the engineering and science departments. I never felt any discrimination as a woman but some of the "hard" science students aiming for a PhD were a bit condescending to mere pre-meds.

By my sophomore year, I decided that I wanted to doctor people instead of pets. That meant taking all the required pre-med science classes plus the ones that I really enjoyed (like history and literature).

In addition to the usual chemistry, biology and physics classes, pre-meds had to take comparative anatomy. This was the "cut course" that dictated whether or not you could be a zoology major and proceed to a B.A. in biology. I loved this class despite it being one of the hardest I ever took. Correctly identifying the unknown skeleton on the final practical exam was a high point of my college career. (Did you know that wombats have pelvic spurs?) My love of anatomy led me to consider becoming a pathologist. Unfortunately, the formalin-induced asthma from the dissection lab changed that plan. I applied to medical schools with a shiny B.A. in biology and minors in history and English.

MED SCHOOL WITH SEVEN OTHER WOMEN

I fully expected to go to UT Southwest or UT Galveston but applied to Duke University and Emory School of Medicine at my advisor's suggestion. To my surprise, Duke accepted me to the class of 1968. My parents sold a small lot they had purchased on Lake Buchanan (now Lake LBJ) to pay my expenses and off I went to Durham, North Carolina on a Greyhound bus.

The freshman class included eight women in a class of 80, more than were in the other 3 classes combined. This sudden interest in increasing the number of female students resulted from 3 nearly simultaneous events: 1. The highly qualified daughter of the chairman of the anatomy department failed to match at several prestigious east coast medical schools; 2. A female faculty member joined the medical admissions committee; and 3. The mother of a female applicant was a

Duke University trustee. A few problems did exist for the female freshmen. A daily annoyance was the bathroom trek. The only women's restroom was on the first floor of the 4-story building. Males had one on every floor.

All eight women graduated in 4 years and practiced until death or retirement. Two were married before medical school, one was divorced, and the other five married after graduation. My husband-to-be and I were assigned to the same cadaver our freshman year. We have been married for 53 years.

Choosing a specialty posed no challenge. Pediatrics appealed to me from my first pediatric rotation. Several of my classmates immediately pointed out that small children and pets share a lot of things in common. Both groups are usually non-verbal and they bite! The Duke pediatric faculty prioritized teaching as well as research but realized that most students would become community physicians, not academics, and stressed clinical training. Duke attracted a wide range of pediatric inpatients but most required tertiary care and specialty follow up. My now husband and fellow MD decided we needed residencies that dealt with a wider patient population--more horses and fewer zebras. Be careful what you wish for!

THE WORLD'S MOST STRESS-FREE INTERVIEW

Our three years spent at the Baylor College of Medicine pediatric program prepared us to deal with everything from colds and constipation to congenital adrenal hyperplasia and worms. A tall distinguished gentleman, Edward Bivins Singleton, MD (2), who looked like a senator from central casting, directed the radiology department at Texas Childrens Hospital. Dr. Singleton had trained with John Holt MD, a pioneer in a new discipline, pediatric radiology. A born teacher, Dr. Singleton welcomed questions from house staff with the same attention that the senior faculty received. I was interested to the point of being a pest. He encouraged my interest and suggested that I consider this new specialty that combined pediatric knowledge with diagnostic radiology. In his department, children's bones and insides were not just miniatures of adult anatomy.

A few children's hospitals in the US and Canada had begun to offer pediatric radiology fellowships after a radiology residency. Dr. Singleton gave me a list of the available programs, and I began to gather the paperwork needed to apply. Before I completed the forms, though, I got a call one afternoon asking if I could come to the radiology department and meet a colleague from Cincinnati, Ohio. So began the most stress-free residency interview in history! Unknown to me, Benjamin C. Felson, MD, (3) Chairman of Radiology at the University of Cincinnati School of Medicine and affiliated hospitals (including Cincinnati Childrens Hospital), was a radiology rock star. I had no idea that this pleasant, short, slightly bald person was one of the most famous radiologists in the world. We chatted for about half an hour, and then he jotted down my name and invited me to apply to his program. Dr. Singleton appeared and reminded Dr. Felson that they were expected elsewhere. I thanked them both (mom taught me manners as well as how to read) and returned to the ward, blissfully ignorant that I had just won the lottery. My professional trajectory had been set.

LIFE WITH FRED

The radiology residency at Cincinnati was a four year program, two years of basic instruction followed by two years of fellowship for the pediatric radiology track. Like Dr. Felson, Fredrick N. Silverman, MD (3), Chief of Radiology at Cincinnati Childrens Hospital, was world-renowned. He had helped establish pediatric radiology as one of the first fellows of John Coffey, MD, the founder of pediatric radiology. Fred, as he was called in the reading room, alternately nurtured and pushed his fellows to be the best clinicians possible. "You have three patients, the child and their parents" he reminded us frequently. Fred combined his love of teaching with his pursuit of knowledge in a way that is almost impossible in today's medical climate. He also was a great joker who once "crashed" a fellows' trivia contest in a Zorro costume, complete with mask and wig. Being his fellow was a priceless privilege.

The life lessons of these three radiology mentors, plus many other teachers and patients – a sense of humor, patience with others and yourself, a willingness to say "I may be wrong" – have guided my entire career. I haven't always met these standards, but I have tried.

WHERE HAVE FORTY YEARS GONE….

After completing our Cincinnati training in 1968, my husband Peter and I moved to Omaha, Nebraska, where we taught at the University of Nebraska Medical School, had two children and a large garden.

After nine years on the Nebraska faculty, we moved to Amarillo to join the Texas Tech Medical School. My practice became a hybrid of pediatric and general radiology in a community hospital, as opposed to a purely academic setting. I continued to teach pediatric, family

medicine and internal medicine residents and medical students - a challenge that I loved. Many of them taught me as much as I taught them.

New technologies demanded that I keep learning. That 3D CT scan that's acquired in minutes was a gleam in an engineer's eye in 1968. Ultrasound and MRI required me to learn new image interpretation and a new vocabulary. Subspecialties such as interventional radiology, neuroradiology, and musculoskeletal radiology joined GI, GU, nuclear medicine and radiation therapy in the radiology buffet. This has not been a free lunch.

Now more than ever, patients and their families need the traditional skills of a physician, not a "provider". All the elegant images available on our digital devices do not benefit a patient if we don't take the time to explain in understandable words what our medicalese means. No AI can ever replace the one thing that we can offer our patients – the gifts of our knowledge and our time. Here endeth the lesson.

BACK TO BOOKS

Giving away books was the best thing I ever did (outside of keeping up to date medically) to improve my practice. Six year-old Sarah was one of my first fluoroscopy patients here in Amarillo. Her family drove all the way from Kansas for Sarah's voiding cystourethrogram (VCUG) and she was scared. I explained the procedure including bladder catheterization to Sarah and her mom. I addressed Sarah directly and assured her that her discomfort would be short-lived. She whimpered but cooperated as I distracted her with questions about her life, a technique I called "verbal anesthesia". When the test was over, I thanked Sarah for her cooperation and reviewed the study with her family.

Later that week I found "Sarah, Plain and Tall" by Patricia McLachlan in a book store. On impulse I bought the book and sent it to my little patient. Her mother wrote to thank me for the gift and said that Sarah's enjoyment of the book overshadowed the unpleasantness of the VCUG. From that day until I retired, I tried to give a post-procedure book to every child – toddler to teen. This small investment paid enormous dividends, as children who needed repeat studies often recalled getting the book more than the exam.

If I have a legacy as the first pediatric radiologist in the Panhandle, I hope it is the joy of learning for both residents and readers.

1. Laura Bickel MD (1912 – 1977) – practiced general pediatrics in Houston, Texas. In addition to her clinical practice, she did considerable work in both rubella and congenital diseases. TMC Library, McGovern Historical Center, Houston, Texas.

2. Edward B. Singleton MD (1920 – 2015) – the very first physician hired at Texas Children's Hospital in 1954. He taught until his death in 2015.

3. Ben Felson MD (1913 – 1988) – received every possible award in radiology, wrote best-selling texts including Humor in Medicine. That best seller cost $20 in 1988, today it's $100 if you can find it. He would be thrilled!

4. Fred Silverman MD (1915 – 2006) – published a landmark article on child abuse with coauthor Henry Kempe MD in JAMA in 1962. Child abuse is known as the Silverman syndrome in France.

(Editor's note: Dr. Gayle Bickers grew up in the Heights neighborhood in Houston, Texas. She attended undergraduate school at Rice University and graduated from medical school at Duke University. After completing a pediatrics residency at Baylor, she went on to do another residency in diagnostic radiology, followed by a fellowship in pediatric radiology, both at the University of Cincinnati. She came to Amarillo to start her radiology practice at Northwest Texas Hospital in 1983; later she switched over to Baptist St. Anthony's, where she continued until her retirement in 2013.)

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Family, Friends, Colleagues & Medicine:
How They Fit Together For A Satisfying Career

by Richard Jordan, MD

God cannot give us a greater gift than having a wonderful mother and father. This was so true for me. My parents guided me toward correct paths in life. They didn't decide the path or clear it for me, but encouraged me to choose and clear my own path. My mother, Margaret Jordan, was a school teacher licensed to teach English, French, literature and math. She gave me discipline and a love of learning. My father, Maurice "Pete" Jordan, was a great college basketball player at Earlham College and played professional basketball in the forerunner of the NBA. His team, the Richmond Kings, competed against the New York Knicks and the Fort Wayne Pistons (before they moved to Detroit). However, he left professional basketball because of the travel and the time away from his family. He became a businessman in bus manufacturing, and he coached high school basketball for several years. As busy as he was, he totally involved himself in the lives of my brother Dave and me. He was my Little League, Pony League and Babe Ruth League baseball coach. He refereed for my youth league basketball games. I learned his coaching/teaching techniques, competitive instincts and a healthy desire to win. But more important than winning to Dad was that you always put forth your maximum effort and always demonstrated sportsmanship. In high school and college, I was on the varsity football team (running back/defensive back) and the track and field squad (sprinter). My parents almost never missed a game or track meet. Their devotion to family and their parenting style (be reasonable, be patient, be fair but be firm) became my model for parenting. We are happier in medicine if we make time for family and are devoted parents. A caring parent is likely to be caring physician.

EDUCATION AND TRAINING AS A PHYSICIAN

Early on, I wanted to be a veterinarian because I loved dogs. It was in high school that I first considered becoming a physician, and I entered DePauw University as a pre-medicine major. Talks with pre-med fraternity brothers kept my interest in medicine strong. I had a wonderfully personable college professor who taught an endocrinology course. But his lectures were almost entirely done by reading out of our textbook. Most students thought they were boring (they were), but I still loved studying the material. The human menstrual cycle was particularly fascinating to me--how everything in a biologic system could work together in sequence with such precision. My desire to be an endocrinologist never wavered afterwards.

I did my internship at the Queens Medical Center in Honolulu. You might expect that I would have seen exotic topical diseases there. Although I did treat a man with leprosy, most patients had typical disorders seen in mainland hospitals. Many were elderly tourists who wanted to see Hawaii before they died. Sadly, some did die during their Hawaii trip. Drug problems were in high gear then (1971-1972). Once I was called to the ER for a young man with a drug overdose. I intubated him, took him to the ICU and stabilized him on a ventilator. Afterwards, I continued my hospital rounds but, in about an hour, the ICU nurse called me and said my patient woke up, pulled out all his tubes and ran out of the hospital in only his underwear. After a while, few things surprise you during internship--so I continued on my rounds. However, in another 45 minutes or so, I was again paged urgently to the ER to evaluate another drug overdose. When I arrived I found it was the same young man that I just previously intubated! That did surprise me.

The Queens Hospital was unusual. The wards were named after Hawaiian royalty (King Kamehameha and Queen Iolani). Some windows were permanently open to the fresh air. It was never too hot but in winter (such as winter was in Hawaii), it could get cool at night. One ward on the first floor was completely open to the air, and patients could have their beds rolled into the sunshine. When it rained, I had to run from the covered nursing station to the covered part of the patient area. Birds and large insects could fly into the ward and an occasional rodent also got in. It probably wouldn't pass a Joint Commission Review now!

My internal medicine residency and endocrine fellowship were done at the University of Oregon. I had a career-changing experience during my residency. One night we had an extraordinarily heavy admission night--12 very sick patients by 2:00 am. At 2:30 am, I was called for another patient with severe angina. I arrived at the ER feeling very discouraged, angry and thinking how unreasonable this was. And then I encountered my patient. She was in her mid-forties and had thromboangiitis obliterans. She had lost all four of her extremities due to the disease. She was completely helpless and could not even clutch her chest in pain. I was greatly ashamed for feeling so angry about having another admission. I had a wonderful family to live for and a rewarding career in front of me. In contrast, my patient had so little to look forward to in life. This memory returns whenever my workload is heavy and I begin to feel sorry for myself. I tell this story when I lecture to

students about resilience. We are so privileged and fortunate to be physicians and to have the knowledge and skills to help patients.

My endocrinology fellowship was the most enjoyable time of my training. During fellowship, I demonstrated that the largest molecular weight forms of prolactin in blood were the result of binding to blood proteins rather than separate pituitary secretory products. We also demonstrated that pituitary hormones were found in cerebrospinal fluid only when there was suprasellar extension of a pituitary tumor. No CTs or MRIs back then, just a painful pneumoencephalogram. I also wrote a widely-referenced review article about the "Empty Sella Syndrome".

Changes in endocrinology and metabolism are fast-paced. But more than any other area, I am amazed at the advances and valuable treatment options for diabetic patients. There are new, more effective oral medications, insulin pumps, inhaled insulin, pancreatic transplantation and islet cell transplantation. Perhaps a cure for insulin- dependent diabetes is in sight?

ACADEMIC PRACTICE, FROM JUNIOR FACULTY MEMBER TO REGIONAL DEAN

After fellowship, I served four years in the Air Force as an endocrinologist. From there I joined the faculty at the University of Arkansas from 1980 to 1987. I was then recruited by Dr. Steve Berk to East Tennessee State University (ETSU) as Chair of the Division of Endocrinology and Chief of the Medical Service at the Quillen VA Medical Center, where I served from 1987 to 2007. Dr. Berk left ETSU and became the Regional Dean of Texas Tech School of Medicine in Amarillo and subsequently the overall Dean of the School of Medicine in Lubbock. Dr. Berk recruited me to fill his prior position as Regional Dean in Amarillo. And I continued to serve veterans by being on the Amarillo VA physician staff. In November 2022, I received the Brick and Elm Award, given to Amarillo citizens still serving our veterans--which I have done for a total of four decades. Upon leaving the Quillen Veterans Medical Center in Tennessee, I received a Veterans Administration Commendation and was given the American flag that flew over VA Medical Center on my last day of service there. On my retirement from Texas Tech on September 1, 2023, I also received a commendation from our state representative, Mr. Four Price, for my 16 years of service and leadership as regional dean. It included the Texas state flag that flew over the capital on July 4, 2023. Receiving the flags and commendations were very humbling honors for me.

The physicians I have most respected during my career are Dr. Steve Berk and Dr. Steve Urban. Dr. Berk mentored me in all aspects of administration in academic medicine in Tennessee (Chief of the VA, Residency Program Director, and Chief of Endocrinology) and in Texas (Regional Dean). More than anyone else, he had the greatest impact on my career. He died unexpectedly on May 26, 2023, and Texas Tech lost its most talented and valuable leader. A month before his death, he presented me with the School of Medicine Lifetime Achievement Award, recognizing Amarillo accomplishments during my time as regional dean. Included were establishing a state- of-the-art simulation center (SimCentral), starting a Simulation Internship for incoming interns, initiating Emergency Medicine Day with simulation experiences for students, and the vision and effort to establish an OB/GYN Clinic in Canyon, TX (which has been used as a model for our Pediatric Clinic in South Amarillo and our Surgery Clinic in Herford, TX). There was expansion of the Clinical Research Unit with Dr. Tom Hale to accommodate over 100 student/resident/faculty posters and research projects per year. Also recognized was my establishment of a Sunday after-church Covid-19 vaccine program. The total Amarillo effort to fight Covid-19 was officially recognized by the Texas State Legislature. Along with Ms. Angela Knapp of the Laura W. Bush Institute for Women's Health, we also established a recurring Human Sex Trafficking Symposium. And the Amarillo campus has had long-term financial success. Almost none of these advances would have occurred without the collaborative effort of my talented colleagues on the Amarillo Campus. This form of cooperative management encouraging independent development is a great legacy of Dr. Berk.

My admiration of Dr. Urban is due to his total command of internal medicine and his incredible ability as a teacher to inspire students, residents and colleagues. Also he is completely honest with interpersonal communication. He always tells it like it is, calmly and without prejudice. Texas Tech is incredibly fortunate that he continues to teach into retirement. There is no better physician role model than Dr. Urban.

LIFE OUTSIDE MEDICINE: BMX RACING WITH MY BOYS

A non-medical part of my life that I

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can't conceive of missing is my two son's bicycle motocross (BMX) racing career. It started off with their interest in doing tricks on bikes. But, as they read bicycle magazines, they became excited by the racing articles. On a trip to a bike shop in Little Rock, Arkansas (where we lived at the time), I commented to the clerk "It is too bad there are no BMX tracks in the area." He said "Oh, but there is--it is Bonsai BMX"! We went to the last race of the year in mid-December 1986. It was very cold, but my boys were hooked and stayed the whole afternoon, huddling by trash fires to stay warm. Dana was 10 years old and Erick was 9. They both got racing bikes that year for Christmas. The season started up again in mid-January, and on most Saturdays and Sundays for the next nine years we went racing--at first at the local track but soon at tracks across Arkansas. We moved to Johnson City, Tennessee in 1988, and my sons quickly moved from the novice class up to the intermediate class and then to the expert class. We developed BMX friends from across Tennessee with sons and daughters who were also very fast riders and excellent jumpers. We decided to form our own team. We began to win state-wide races, and our riders won individual, age-range state championships. Soon a bike shop, Pro Cycles, wanted to sponsor our team, and the Pro Cycles BMX Team was born. I became the team manager.

After winning the Tennessee State Team Championship and our riders winning individual state championships, we began racing nationally in the National Bicycle League's Bike Shop Division. We won the Bike Shop Division National Championship in 1994 and 1995. Since our riders were very competitive with the factory riders and college was on the horizon for some of our team, we decided to move up into the Factory Racing Division, the highest and most competitive amateur racing class. The factory riders are generously sponsored by their bicycle company teams such as GT Bicycles, Powerlite, Schwinn, Diamondback and others. Many of the factory riders were from California, the original home of BMX. Our team was primarily family-sponsored and mostly from Tennessee.

In 1996, our first year in the Factory Division, we did much better than most racing fans expected. We were in second place just before the final points race of the year, the Grand National Championship in Louisville, KY. The overall team championship is decided by team finishes in major national races during the year, similar to the NASCAR Championship for stock car racing. I told our team before the race that "We didn't come to be the bike shop team that almost beat the factories. We came to win it all!" Our riders had an incredible day at the Grand Nationals and ended up winning many of their races or placing very high in them.

Their effort produced a win at the Grand Nationals and secured enough points to vault us into first place at the end of season. And we became the Factory Division BMX National Champions! The National Bicycle League Magazine stated "Pro Cycles did what most of the BMX world thought impossible. Their first year in the Factory Division, they shocked the big factories and unseated power house teams like GT Bicycles, Powerlite, Diamondback, Haro and Cycle Craft to win the Factory Championship. They stomped their factory competition by an astounding 85 points! Pro Cycles is definitely the best team in BMX." What a lifetime thrill to have achieved that with my two sons, our team members and their parents. We all had a special bond of friendship, purpose, and determination.

Because of our success in National BMX Racing, I was asked to manage the United States National Team in 1994 and 1995. My sons were team members. Those World Championships Races were in Schijindel, Holland (1994) and Waterford Oaks, Michigan (1995). The Netherlands was the favorite to win in 1994, but the US prevailed. The US was the favorite in 1995, and we didn't disappoint.

Why include this dive into BMX as a perspective on my career? Because devoting time to a worthwhile family pursuit outside of medicine made my overall career much richer and more rewarding.

INTO THE FUTURE

As physicians, we may wonder if we took the best career path and what the future holds. My concern for the future is Artificial Intelligence and what impact it will have on physicians, especially diagnosticians. Having a medical industry centered on Google, Amazon, IBM or a similar business conglomerate in the next 5-10 years seems very possible to me. Patients may go to local centers and present their history to a supercomputer that would have an extensive medical information data base, imaging capability and diagnostic examining equipment. A human assistant would help with minor needs and make the system seem more human-connected. This is potentially faster, more accurate and less expensive than our present system. Hospitalized patients could have more human contact, but major diagnostic and therapeutic decisions would come from AI or need to be approved by it. Science fiction? I worry that it will be medical reality in the near future.

(Editor's note: Dr. Rick Jordan grew up in Richmond, Indiana. He attended undergraduate school at DePauw University in Greencastle, IN and graduated from medical school at the University of Indiana School of Medicine. He completed his internal medicine residency and endocrinology fellowship at the University of Oregon. Rick came to Amarillo in 2007 as Regional Dean of the Texas Tech School of Medicine and retired in 2023.)

A Conversation with Dermatologist Dr. Turner M. Caldwell III

Interviewed by Steve Urban, MD, MACP

From the time I arrived in Amarillo in 1981, our community has been blessed with high-quality specialists and subspecialists. Although an occasional patient with a rare or complicated disease would have to go to Houston, Dallas, or Rochester, most patients could be expertly managed with local practitioners. We had (and still have) well-trained and skilled general and thoracic surgeons, urologists, surgical and medical subspecialists (such as oncologists and nephrologists), and many more. One area that has been particularly well-served is dermatology, starting with Fred Johnson and Bill Laur and proceeding over the years to our current expert practitioners. One of the linchpins of high-quality dermatology has been Dr. Turner M. Caldwell III, who came back to the Panhandle in 1983, practicing clinical dermatology until 2014 and dermatopathology until 2016. Although most of the articles in this issue will be autobiographical, Turner preferred to be interviewed. The following article is a distillation of a fascinating and informative interview with Dr. Caldwell.

UPBRINGING AND EARLY EDUCATION

Turner Caldwell was born in 1949 to a well-established Panhandle family. His mother Genevieve's grandfather had founded the famous Britt ranch in the eastern Panhandle in 1913; on his father's side, his great-grandfather, James Leslie Caldwell, was a pioneer Amarillo newspaper editor, arriving in 1890. Genevieve and T. M. "Red" Caldwell, Jr were important civic leaders in both their home town of Clarendon and the larger Amarillo civic and philanthropic community, actually moving to Amarillo in 1997. I knew them both (through their church and community efforts), and they were wonderful examples to my children and to the community at large.

Turner's family life was a strong and supportive one. Although he was encouraged to excel (which he did, as you will read), his parents allowed him to follow his own dream. One aspiration that came to Turner early on was his interest in becoming a doctor, an interest that was encouraged by his contact with two Clarendon family practitioners, Dr. George Smith and Dr. Richard "Rip" Gilkey (both of whom were practicing when I came to town in 1981—Dr. Smith as Chief of Staff at the Amarillo VA Hospital and Dr. Gilkey as a solo practitioner in Clarendon). Turner particularly remembers Dr. Smith, who lived next door and frequently made house calls with his black bag in hand-including seeing Turner as a patient-and who treated everyone (even little kids!) with kindness and consideration. Both were friends of the family and important members of the Clarendon community. By the third or fourth grade, Turner knew that he wanted to be a doctor.

Turner went on to graduate as valedictorian of his Clarendon high school class and thence to Southwestern University, a small, well-respected private Methodist college in Georgetown, TX. Genevieve, and later Turner, were loyal supporters of Southwestern, serving for many years on the Board of Trustees of that school. Like many of us, Turner had to adjust from a small-town upbringing to cosmopolitan university life-he remembers being impressed and a little shocked by worldly-wise classmates from Houston and Dallas—but he profited from the individual attention that a smaller university provided. He developed student-mentor relationships with his freshman chemistry professor as well as several other professors in his upper-level science classes. Turner took his classwork seriously and frequented the library, realizing that academic excellence would be a foundation to achieving his dream of becoming a doctor. In this he succeeded, again graduating at the top of his class at Southwestern University.

MEDICAL SCHOOL, RESIDENCY—AND AN INTERESTING FELLOWSHIP YEAR

Turner was accepted into medical school at the University of Texas Southwestern Medical School in Dallas, attending UT Southwestern from 1971-1975. Again, he experienced another quantum leap in competition and expectations; Turner remembers "studying all the time" in Dallas. But again he was up to the task, graduating with the Ho Din Award from the Southwestern Medical Foundation and #1 in his class (having taught several classes of students during my IM residency at UT Southwestern, I will simply state that this is an amazing accomplishment). Under the leadership of the redoubtable Dr. Donald Seldin, UT Southwestern was known then (as now) as an internal medicine-intensive school. Turner loved the analytical and diagnosis-centered approach in his sophomore-level Introduction to Disease lectures, but presentations by chief of dermatology Dr. Jim Herndon were especially lucid and invigorating. While on most of his 3rd year core clerkships, Turner remembers thinking, "I really can't see myself doing THIS for the rest of my life", but with dermatology as his first senior elective, his interest in that specialty was confirmed. Turner enjoyed the Parkland consult rounds, where patients with complex medical problems and unusual skin manifestations abounded. Again, the faculty members

took him under their wings, counseling him personally about career and residency choices. With his stellar academic record, many top programs were available to him, and he accepted the offer of a residency slot at the prestigious University of California at San Francisco program.

Dermatology residency at UCSF was everything that Turner had hoped for. There was even an inpatient dermatology ward at the University Hospital. In those days, inpatients could be kept in the hospital, sometimes for weeks, for conditions such as mycosis fungoides or bullous diseases; Turner remembers patients with extensive plaque psoriasis being admitted for the (fortunately, now rarely needed) Goeckerman regimen of daily crude coal tar applications and UVB light treatments. Turner was chosen as one of the co-chief residents of the program in San Francisco and, after his fellowship, was invited to join the academic faculty, where he stayed on for 2 ½ years.

During residency, Turner had an interesting experience which furthered his professional interest in dermatopathology. He applied for and received the Osborne Fellowship in Dermatopathology from the Dermatology Foundation and used the stipend to study at St. John's Hospital for Diseases of the Skin in London, England, one of the most prestigious dermatology centers in the UK. Turner spent a year in London, seeing all manner of unusual and rare pathology (e.g., xeroderma pigmentosum, epidermolysis bullosa, folliculotropic mycosis fungoides) and taking ample opportunity to see the sights, history and culture of London and surrounding areas before returning to UCSF. His brief tenure in academic dermatology made Turner realize that he preferred patient care; so, in 1983, he began to look for practice opportunities closer to home in the Panhandle.

THE CHANGING PRACTICE OF DERMATOLOGY

It didn't take Turner long to find a compatible group of dermatologists in Amarillo, with pioneer dermatologist Dr. Bill Laur, as well as Randall Posey and Jack Waller. Dr. Laur had been Amarillo's second dermatologist, starting his practice in 1952, 3 years after Dr. Fred Johnson--back when specialty practice was a new thing to the Panhandle. They were an interesting group. Randall Posey had a particular interest in the interplay of psychological stress and skin conditions, and Jack Waller had an interest in just about everything in the world. In 1986 they were joined by Larry Roberts. After Bill Laur's retirement in 1988, the four remaining doctors at High Plains Dermatology Center practiced state-of-the-art dermatology for many years. Turner valued the camaraderie and various areas of expertise of his partners. He retired from clinical practice in 2014, finally able to recruit well-qualified young dermatologists to the practice (after 5 years of trying!), and from his dermatopathology practice in 2016.

Although I don't think of dermatology as the most relational of specialties, Turner enjoyed and valued his 30 years of interacting with patients. Perhaps due to his Panhandle upbringing and willingness to spend a little extra time, Turner established patient-physician relationships that lasted for decades, with patients from a five-state region. The frequency of skin cancers in our sun-exposed population, as well as the tenacity of certain skin diseases such as psoriasis and atopic dermatitis, ensured that Turner would see patients back many times over the years. He appreciated getting to know them personally and getting to learn their stories.

The practice of dermatology has, of course, changed dramatically over the past 30 years, as has almost every other field of medicine. The oral vitamin A derivative isotretinoin (commonly known as Accutane) was released in 1982 and began to transform the treatment of severe forms of acne (it was later found useful in treating some other very difficult conditions as well). Turner can remember times during his training when patients with severe inflammatory acne had to be admitted to the hospital--this no longer happens. The teratogenicity of isotretinoin sent dermatologists back to their Ob-Gyn textbooks to remind themselves and their patients about the complexities of secure contraception. The treatment of other often-refractory skin diseases has changed as well. As mentioned above, the treatment of severe psoriasis in the 1980s was unpleasant and often ineffective—weeks of disgusting and smelly coal tar applications and UVB light therapy or multiple PUVA treatments—and the topical steroids then available were only modestly effective. The introduction of ultra-high potency topical steroids (clobetasol was introduced as Temovate in 1986) made a difference, but a quantum leap in effective treatment came with the introduction of biologic agents in the early 2000s. Psoriasis is an inflammatory disease with dysregulated cell proliferation as one manifestation, and understanding the basic science of cytokine pathways and regulation of cell growth has led to important innovations in its treatment (as it has in many other inflammatory and neoplastic diseases). The TNF inhibitors adalimumab (Humira) and etanercept (Enbrel) were the first biologics available; now dermatologists have a panoply of effective agents. Second generation IL-17 and IL-23 inhibitors, as well as JAK/tyrosine kinase and phosphodiesterase inhibitors, have been added to the armamentarium, and, although very costly, these drugs can achieve 90+% clearance, making refractory psoriasis increasingly uncommon.

The treatment of other difficult-to-treat skin diseases has also improved during Turner's practice lifetime. This would certainly include atopic dermatitis, where the benefits of tacrolimus and pimecrolimus as steroid-sparing agents, as well as biologics such as dupilumab (an IL-4 and IL-13 blocker), can be dramatic. Skin infections are also easier to treat. Turner mentions the development of antivirals for herpes infections

(especially herpes simplex and zoster) and effective oral antibiotics (from old doxycycline all the way to linezolid) for MRSA infections. Turner is eager to mention that the new Shingrix vaccine should make painful and sometimes debilitating shingles much less common. It is safer and much more effective than the old live attenuated vaccine (Zostavax). The treatment of the dreadful condition hidradenitis suppurativa, as well as some other very difficult-to-treat conditions, has also improved in recent years.

Skin cancer is, of course, very common in the Panhandle region. The development of excellent and highly effective sunscreens in the last few decades has been a real blessing, even though getting some patients to use them can still be a challenge! Although the initial treatment of most lesions is still destruction (e.g., cryosurgery) or excision of the primary lesion, methods of treatment of complicated skin cancers have improved greatly. We have a better understanding of the best approaches to treat melanoma, and we now have physicians who are well-trained in the subspecialty of Mohs micrographic surgery for basal cell and squamous cell cancers primarily. Turner recalls having to refer patients to Dallas, then Oklahoma City and Lubbock, for Mohs surgery, but now local dermatologic surgeons Dr. Liana Proffer and Dr. Summer Clark are able to provide expert Mohs treatment here in Amarillo.

Although treatment for advanced skin cancers often devolves to surgical and medical oncologists, Turner's former patients are now benefitting from more effective therapies for complicated squamous and basal cell cancers (e.g., the hedgehog pathway inhibitor vismodegib and the checkpoint inhibitor cemiplimab) and the profusion of effective therapies for advanced melanomas. Now, immune checkpoint inhibitors and targeted therapy can lead to long term control or even cure of these heretofore often untreatable cancers. The drawback to the use of these cancer treatments, as Turner points out again, is their expense—what some people call the "economic toxicity" of modern agents. It is not uncommon for the cost of even one of the checkpoint inhibitors to be in the $50,000 to $100,000 per year range--think of the cost if several different drugs are required!

CHANGES IN THE BUSINESS OF MEDICINE

A huge change in Turner's practice over the years was how the administrative burden of practice has proliferated. In the late 1990s Medicare and then private insurance companies began requiring an explosion of documentation to determine the "medical necessity" of recommended treatments. Denial of payment, often for frivolous reasons, became common and required incessant resubmission of claims. As a result, the number of staff at High Plains Dermatology Center doubled and more over the years. They now have a staff person whose sole job is getting prior authorization for needed medications or treatments and challenging denials of service by insurance companies and Medicare. Negotiating contracts with the

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numerous insurance companies has also become extremely complex, and High Plains Dermatology Center now hires specialists to review the fine print of each and every contract.

Another modern trend that Turner strongly decries is the situation where venture capitalists buy up private practices and turn them into money-generating machines where patient care is deemphasized. The doctor is encouraged to see more patients in a shorter period of time, and the provision of care is primarily judged by the bottom line. Turner says that the American Academy of Dermatology (AAD) has begun to take a stand against such practices, warning of the hazards of such a brazenly transactional view of medical care. Another professional issue that shakes the house of dermatology is the proliferation of cosmetic-only dermatologists who only want to deal with cash-on-the-barrelhead cosmetic procedures, to the exclusion of Medicare or indigent patients. These professional issues generate vigorous discussion at national AAD meetings

As mentioned above, Dr Caldwell retired from his clinical practice in 2014 and stopped reading path slides in 2016. Looking back on his career, he is happy with his 30 years of practice in the Panhandle. He loved patient care and the relationships he made with his patients. He is pleased that the life of a dermatologist is conducive to life-work balance— dermatologists rarely have to go to the hospital at night or on the weekend! For challenging clinical cases, he had the benefit of well-trained colleagues who could step in to see a complicated patient. Turner would sometimes fret over a tough slide, but he was never afraid to send a case out to a consultant dermatopathologist for a second opinion. Now, Turner and wife Trina enjoy good health and get to spend their time travelling and visiting family members. They are still involved with the Panhandle community and with properties in Donley county and Colorado.

In my opinion, the Panhandle community was blessed to have a physician as committed as Turner Caldwell to the service of his patients. His academic record was incredible, his training was top-notch, and his commitment to Amarillo and to his patients was heartfelt. In my practice of general internal medicine, I encountered many patients with complicated skin conditions over the years; I can remember a patient with scleromyxedema, several patients with bullous pemphigoid, and a number with vasculitis or complicated drug reactions. I always knew that I could call on Turner—or Randall Posey, Jack Waller or Larry Roberts; often the patient would be seen that same day or the next, and excellent care would be rendered. And Turner feels confident that the legacy of care at High Plains Dermatology Center is being carried forward by the current dermatologists. He is excited that young Dr. Tyler Enos has joined the practice to carry on the dermatopathology expertise of the clinic. As mentioned above, he is so pleased to have the skills of Mohs surgeons Dr. Liana Proffer and Dr. Summer Clark locally available. And he is very confident that Drs. Scott Miller, Jason Jones, Christi Baker and Tyler Enos are continuing his commitment to patient care and to excellence in the practice of dermatology.

(Editor's note: Dr. Turner Caldwell. grew up in Clarendon, Texas. He attended undergraduate school at Southwestern University in Georgetown TX and graduated from medical school at UT Southwestern Medical School in Dallas. After completing a dermatology residency at the University of California at San Francisco and a dermatopathology fellowship at St. John's Hospital for Diseases of the Skin in London, England, he started his Amarillo practice in 1983. Dr. Caldwell continued in the private practice of dermatology until 2014 and continued his dermatopathology practice until 2016.)

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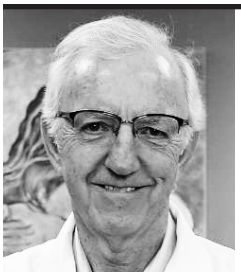

A Pharmacologist's Dream Job

by Tom Hale, PhD

I am a third-generation pharmacist. My grandfather arrived in Texas via train from Indiana in 1899. Finding a beautiful and open country, he decided to open one of the first drug stores in the Texas Panhandle in the small community of Hansford (now a ghost town) south of Guymon, Oklahoma. My father was raised in this small drugstore and became a licensed pharmacist in 1948. When I graduated from high school, I spent my first year of college at Texas Tech University in Lubbock. The next year I decided to go into pharmacy school myself, and I entered Southwestern Oklahoma State University School of Pharmacy. In pharmacy school I absolutely adored pharmacology and organic pharmaceutical chemistry. During my last summer there, I worked in a laboratory under the direction of my pharmacology professor on a rodent model system for hypertension. In an attempt to induce hypertension, we surgically placed a restriction in the renal artery. It worked well but required a lot of skill to accomplish. This summer job remained in my memory and led me to my ultimate career.

PHARMACY PRACTICE AND ADVANCED TRAINING

I graduated from pharmacy school in 1968 during the middle of the Vietnam War. I joined the U.S. Navy and was shipped to San Diego. After boot camp, they transferred me to the pharmacy at Balboa Naval Hospital.

At this time, this was the largest hospital pharmacy in the world, filling more than 2000 prescriptions daily. We had a 20-foot moving belt with prescriptions on them. The pharmacy techs would place a bottle of pills on the prescription as it moved down the belt. Located at the end of the belt, I would check each prescription for accuracy and then counsel the patient. After a year or so, they transferred me into the "compounding" room, where I was responsible for making over 22 different ointments and creams, as well as thousands of gallons of liquid preparations such as potassium supplements, cough syrups, etc.

After I was discharged from the Navy, I left San Diego with a wife and newborn son and drove home to Texas. We still remember this wonderful trip home. On a back road in rural Texas, having been in California for years, a farmer in a pickup truck waved at us as we drove along. My wife and I instantly looked at each other… we knew we were home.

I travelled back to Texas and worked in a small-town pharmacy for 3 years. I became quite disenchanted with the daily process of filling prescriptions, as I kept thinking of my time in the research laboratory in pharmacy school. So, I began the search for a doctoral program in pharmacology. I found one at Kansas University School of Pharmacy, in Lawrence Kansas. After acceptance, I loaded my wife and three young children in the car and spent the next 4 years in an intense study of clinical pharmacology and toxicology. After graduation with a Ph.D., I subsequently joined a distinguished lipid research group in a post-doctoral position for the next 3 years. At this time, we knew little about hyperlipoproteinemia. Separating the lipoproteins by ultracentrifugation was challenging, and few assays were available. During my stay at the University of Missouri, I set up radioimmune assays for detecting the various lipoproteins. These assays were subsequently used in the study of hyperlipoproteinemia in many of our projects.

But after 3 years of intense research in a postdoctoral position, it was time to get a job.

My brother Selden, an attorney in Amarillo, called one night and said he'd met a professor at Texas Tech School of Medicine who was trying to recruit a pharmacologist to teach his medical students. This led to a job at TTUHSC in 1981.

JOINING TTUHSC AMARILLO

I enjoyed the clinical environment of the pediatrics department enormously because it was all about disease and pharmacology. During my first 10 years at Texas Tech, I was teaching students and faculty and at the same time building a clinical pharmacology laboratory. My chairman, Dr. Rolf Habersang, and I set up a pharmacology laboratory with the intent to analyze specific drugs, particularly caffeine (which was just then being used in the NICU) and chloramphenicol (rarely used by then). At this time, Dr. Habersang managed numerous cases of pediatric encephalitis, and the only antibiotic he had to use in the 1980's was ampicillin, which no longer worked. So, in desperation, we decided to try an old but somewhat dangerous antibiotic, chloramphenicol--but only if we could accurately measure plasma levels in these infants. At that time, no clinical assay was available for chloramphenicol. It turned out that, if used appropriately with close monitoring of plasma levels, it was a lifesaver for many of these sick infants. Only later was ceftriaxone (Rocephin) introduced for treatment of meningitis, and we

ceased using chloramphenicol. Thus, we established my laboratory with personnel and a new high pressure liquid chromatograph to routinely monitor this antibiotic. In addition, data about the use of caffeine to suppress neonatal apnea in premature infants had just been published, and we decided to use this drug in our NICU--again, with close monitoring of caffeine levels in the infant. It worked well and is still used and monitored today.

LEARNING ABOUT THE PHARMACOLOGY OF HUMAN BREAST MILK

In 1992, Dr. Habersang and Dr. Mubariz Naqvi walked into my office and said that the field of pediatrics was becoming interested in human milk as therapy in newborn infants. But no one knew how to safely treat breastfeeding mothers with medications while breastfeeding, and they wanted me to start lecturing on the use of drugs in breastfeeding mothers. I knew nothing about human milk-- and, believe me, no one else did either! So, I began an intense study to learn how human milk is synthesized and controlled in the human breast, and how drugs enter this compartment. I was totally overwhelmed with the incredible beauty and elegance of human milk, and I soon realized that, even though nothing was published concerning medications, the breast was just another physiological compartment and should be investigated as such. Thirty years later, we still have to guess at how "new" drugs enter the milk compartment.

Thus began a career change for me--the study and understanding of pharmacotherapy in breastfeeding mothers. I began to collect information on a small number of drugs that seemed safe and put these on my computer. One day I received a call from a nurse in Oklahoma who asked about using some medications in one of her patients. After we discussed the case, I told her that I had a list of drugs on a floppy disk that I could send her. She told me "Doc, I don't even have a computer. Why don't you put it in a book?" I liked her idea, and in 1992 I printed a small first edition of "Medications and Mothers' Milk". The State Board of Health somehow obtained a copy of this first edition and ordered a thousand copies. This book completely changed my career. I began traveling the world, lecturing on drugs and their use in pregnant and breastfeeding mothers. After touring all over the USA, in 2015 I was invited to tour 6 cities in Australia. Previously, I'd seen an excellent publication by a pharmacologist in Perth, Australia, and I asked my tour sponsor to set up a visit with this professor. When I visited his office, I noted that he had all the same textbooks that I had. He was also working with a wonderful analytical chemist who was very accomplished in analyzing drugs in human milk. My new colleague, Dr. Ken Ilett, was brilliant in pharmacokinetics.

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LIFE ★ HEALTH ★ INCOME ★ PRACTICE

The year before I visited Australia the first time, a colleague on the Lubbock campus told me they were having difficulty getting faculty members to take sabbaticals. After my visit to Australia and my meeting with Dr. Ilett, I requested and was granted a 6-month sabbatical to study in Perth. This sabbatical was wonderful. For the first time in years, I had a colleague with whom I could discuss the most minute details concerning the analysis of drugs, their use in breastfeeding mothers, pharmacokinetic evaluation and methods, and general clinical pharmacology in breastfeeding mothers. Together we published one book and 6 articles from this sabbatical. Since then, I have toured all of Europe multiple times--and Australia 16 times.

Following the worldwide sale of my book, my office was inundated with callers (nurses, NICUs) asking questions about their patients. The burden of calls became so heavy that I changed my university telephone number, only to find they were calling the Chancellor's office in Lubbock. He politely told me to get my "own" telephone number and take care of my own problems. This led to the creation, in 2008, of the InfantRisk Center, which was manned by 3 nurse call specialists, with me as a backup for difficult questions. The InfantRisk Center was initially funded by Dean Richard Jordan and the Laura W. Bush Institute for Women's Health and remains funded today by grants, projects, clinical trials, and two local funding agencies. With this funding, I was able to hire nurses, write the software needed to run the center, and begin the process of funding the center for the next 14 years. About this time, I was joined by Dr. Teresa Baker, who would become a co-director and valuable clinical colleague. Presently we've had almost 30 million visitors to our website and over a hundred thousand calls to the center. In the last 10 years, we have completed more than 10 clinical trials in breastfeeding patients. The center continues to grow and develop and serve this vital service to the world.

CREATION OF THE CLINICAL RESEARCH UNIT (CRU)

In the early 2000's many of our faculty members went up for promotion, but, without publications, they were denied. Dr. Steve Berk was concerned and called me in to talk about a project I had proposed some years before--the creation of a clinical research center to help our faculty and students publish papers and abstracts. Dr. Berk gave me a budget and told me to see if we could help our faculty with promotion. I hired a center director, and we began to set up the CRU to help students, residents, and faculty with development of abstracts and papers. Fortunately, the department chairs were very supportive, and, in the first year, we had our first 10 abstracts ready to go. With this center in place, I also established a 'research day' each year, where we invited an accomplished, highly-published academician who was well recognized in their field. Their job after arriving was to advise the students how to find interesting cases, write them up, and publish them as abstracts. This was exciting for me, as I was able to bring in some of the world's best academic medical scientists to Amarillo. I first had them lecture and talk with our 3rd year medical students and then give a lecture for all community physicians and faculty members. Many of these top-of-their-field scientists were warm and gave excellent lectures. After the lecture, we then escorted the speaker to the academic building where all the posters were displayed, and they were asked to walk to each poster and talk with the students. The Clinical Research Unit has been very effective. Many faculty have since been promoted. Many students have told me that, during their residency interviews, most interviewers wanted to talk about their posters and publications, thus helping the student with acceptance into good residencies. In the first year of the Clinical Research Unit, we had 10 posters. Ten years later, we had more than 130 posters presented on "Research Day". The clinical research unit continues today to exert a profound influence on research and career advancement for our medical students and faculty.

(Editor's note: Dr. Tom Hale grew up near Gruver TX. He received his BS in pharmacy from Southwestern Oklahoma State University and went on to earn a PhD in pharmacology and toxicology from the University of Kansas and to do three years of postdoctoral research at the University of Missouri. Dr. Hale came to Amarillo as a faculty member in the pediatrics department in 1981. By the time of his retirement in 2023, he was Assistant Dean for Research in Amarillo and held the prestigious Grover E. Murray Professorship in the School of Medicine.)

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Hard Hats for Little Heads is supported in 2016 through a TMA Foundation grant thanks to top donors — Blue Cross and Blue Shield of Texas, an anonymous physician and spouse, TMAF Make-A-Difference donors, and the Baptist Health Foundation of San Antonio — and generous gifts from TMA and TMA Alliance members, and friends of medicine.

Becoming A Breast Cancer Medical Oncologist

by Brian Pruitt MD

Breast medical oncology is a specialty that combines a knowledge of breast pathophysiology with proficiency in breast cancer treatment. A key role of the breast oncologist is to work with other specialists—pathologists, breast cancer surgeons, radiologists, radiation therapists, and others--in breast cancer management. This article will summarize some of the life events and advice that led me to become a breast medical oncologist. I will also mention a few important changes in breast cancer management that came about during the years of my practice in Amarillo.

CHILDHOOD & EARLY EDUCATION

My paternal great-grandparents, Tom and Maude Pruitt, were farmers in rural east Texas. Their first-born son, George--my grandfather--would likely have lived his life as a farmer were it not for the prodding of his wife Jewel. She persuaded him that school teaching could provide opportunities in their lives. They enrolled at Sam Houston State Teachers College and graduated with master's degrees. While in school they had an only child, Jack (who would be my father). After graduation they moved to Tatum, Texas, to teach. Their work in their classrooms led to benefits for the generations that followed.

Jack attended the same school in Tatum where his parents taught (usually not in the same classes), and he did very well. On finishing high school, he was valedictorian of his class. From there he went to the University of Texas in Austin, followed by medical school at the University of Texas Medical Branch (UTMB) in Galveston. On a rotating internship at Hermann Hospital in Houston, he met and married my mother, Betty; I was firstborn of their three children. He practiced general medicine for a few years and then returned to Houston for a residency in pathology.

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I was surrounded by good parenting. Jack was strict, holding high expectations for his children. Betty's cheerful kindness balanced Jack's forceful personality. My grandparents remained highly involved; they changed their jobs several times to move near where we were living.

After my dad completed his residency, we moved to Lufkin, Texas, where he began a life-long practice of general pathology. I would sometimes help him at his office on weekends by taking notes while he cut specimens. I began to think then about what kind of work I would do when I was grown. My dad recommended that I pursue medicine, but I doubted that I would like it. He seemed to work all the time. He was always being called away from family events to perform forensic autopsies. When I expressed these concerns, he told me how much he enjoyed his work. He said that medicine offers a wide variety of interesting careers, with the freedom to choose between them.

COLLEGE & MEDICAL TRAINING

I gradually decided to follow in my father's footsteps. I went to the University of Texas in Austin as premed with a math major. I then chose the same medical school that my dad had attended--UTMB. In medical school, I liked all my clinical rotations and had difficulty choosing a favorite. But then, during an internal medicine rotation in my senior year, I realized how much pleasure I experienced while interacting with adult patients. That observation led to my choosing internal medicine. In my senior year of medical school, I talked with my faculty advisor in Galveston about where to do my residency. He told me he had previously worked at the University of Wisconsin (UW) in Madison. He said that Madison is like Austin, an interesting place to live. He thought I would like their internal medicine program because of the size and diversity of their patient population. He also emphasized UW's esteemed comprehensive cancer center. Based on my medical school evaluations, he thought I would be well-suited for medical oncology. That was the first time I had ever thought about oncology.

I applied to internal medicine residencies and chose UW in Madison. During the first year (1972-73) of my medicine residency, I took an oncology elective and liked it very much. At that time, relatively healthy patients could be admitted to the hospital for evaluation and initiation of cancer treatment. All my patients on that early rotation were ambulatory. They would meet regularly as a group, sharing their experiences with each other and with us. I found their feedback to be enlightening.

Many of my patients on that rotation had breast cancer. New developments were transforming breast cancer treatment. For example, breast biopsies were being sent for estrogen receptor (ER) status. When a cancer was ER-positive, the patient could take tamoxifen, a well-tolerated oral medication, often without needing chemotherapy (1). While these early advances are old news today, they were exciting at the time. That first-year oncology elective was the turning point that ultimately led me to choose medical oncology as a career.

In another oncology elective during my second year of residency, I had sicker inpatients, some terminally ill. My attending physician would take me along for serious patient discussions. He showed me how to explain diagnosis, prognosis, and treatment without damaging a patient's sense of hope. Those experiences made a deep impression on me.

Following my internal medicine residency, I began a two-year medical oncology fellowship, also in Madison. The

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clinical program emphasized general cancer management, and fellows were also required to do research. The department chair recommended that I spend my research time in a breast cancer lab, studying how endocrine agents affect breast cancer cells. I became more and more interested in breast cancer during that lab experience.

After finishing the medical oncology fellowship and passing my boards, I arranged to stay in Madison for another two years, continuing in the breast cancer research lab while also working with a breast medical oncologist in a weekly outpatient setting. After those two years I was ready to return to Texas. I began looking for medical school work that was mostly clinical. I came across an ad submitted by Dr. Phillip Periman describing just what I was looking for.

ONCOLOGY PRACTICE IN AMARILLO

In 1981, I moved to Amarillo to join Dr. Periman, working as a Texas Tech faculty member while practicing oncology at the new Harrington Cancer Center. In addition to my oncology practice, I started a breast cancer laboratory research project, and I directed the internal medicine student program. I liked the medical school activities but found them prohibitively time-consuming while caring for patients.

In the 1990s, I switched my employment completely over to the Harrington Cancer Center. I continued to manage all types of malignancy, but gradually saw more and more breast cancer. Looking back to that time, I realize how many advances in breast cancer management were being made. Here's one example: a patient with an abnormal mammogram in the 1980s or 90s would almost always see a surgeon straight away. She would routinely undergo an open surgical breast biopsy in the operating room with general anesthesia, and, if the biopsy showed breast cancer, she would then have a second operation. The practice change that developed during that time was to replace surgical biopsies with ultrasound- guided core needle biopsies. The needle biopsies were found to be highly accurate in the hands of expert breast radiologists and pathologists. The result was that women with breast cancer would no longer require back-to-back surgeries in their routine evaluations.

In 2007 it became possible for me to limit my practice entirely to breast cancer. Major scientific findings continued to improve breast cancer management during the years that followed. Breast cancer turns out to be not just one disease, but four or more molecularly-separate diseases, each with a different prognosis and treatment. One type, for example, is HER2-positive breast cancer. This subtype is driven by a mutated gene which encodes large quantities of a growth factor on the cell membrane. The resulting rapid growth rate accounts for a poor prognosis in untreated HER2+ patients (1). Treatment of this cancer type often requires chemotherapy, but additional anti-HER2 antibody and/or growth factor inhibitor treatment is essential. Targeting the cancer's HER2 system brings about a prognosis that is actually better than that seen with other breast cancer subtypes.

Another example is ER positive/HER2 negative breast cancer, the most common subtype. In early stages. most of these cancers do well with oral antiestrogen therapy. However, some ER positive/HER2 negative breast cancers have a high risk of recurrence and require the addition of chemotherapy. For years it was difficult to distinguish which of these patients would need chemotherapy. Then, a gene-expression panel was developed to determine whether the RNA produced by a patient's cancer is favorable or unfavorable. Patients with the highest levels of unfavorable RNA in their cancers had a high recurrence rate, with a clear need for chemotherapy. Disappointingly, though, a large number of patients fell in an inconclusive, intermediate group on this assay, leaving an uncertain need for chemotherapy. But more recently, a clinical trial (2) with more than 10,000 subjects proved that a large majority of patients in the intermediate RNA assay group do not require chemotherapy. This study led to a vastly decreased use of chemotherapy for this common breast cancer subgroup.

And finally, a multidisciplinary approach (3) has provided a framework for excellent care at centers all over the world. In our program, a breast radiologist, pathologist, breast surgeon, plastic surgeon, one or more medical oncologists, a radiation oncologist, and others would meet weekly to discuss the new cases. The group used high-quality clinical trial data and national guidelines to establish each patient's best management strategy.

My choice of a career in breast oncology came about gradually. At each step during my training, I based career decisions on personal happiness (rather than financial success). When I began my involvement with breast oncology, I found myself enjoying it more and more. The science of the field was fascinating. With the increasing breakthroughs in treatment, my patients did better and better. I felt satisfied that my work was helping a lot of people. I would recommend breast oncology to any young doctor with the same views

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(Editor's note: Dr. Brian Pruit. grew up in Lufkin, Texas. He attended undergraduate school at the University of Texas in Austin and graduated from medical school at the University of Texas Medical Branch in Galveston. After completing an internal medicine residency, followed by an oncology fellowship, at the University of Wisconsin in Madison, Brian came to the Panhandle to join the Harrington Cancer Center in 1981. Dr. Pruitt practiced medical oncology with a focus on breast cancer until his retirement in 2021.)

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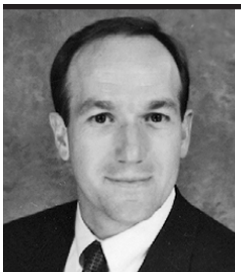

Progress and Changes in OB/GYN from the 1980s to 2023 in the Texas Panhandle: A Perspective

by John David, MD

The medical specialty of obstetrics and gynecology (OB/GYN) has changed steadily throughout my life and career in the Amarillo area. I was raised in a small town with exposure almost exclusively to general and family practitioners. General practitioners--having a medical school degree plus one year of rotating internship—are a thing of the past. Family practice has replaced this and now is a three-year residency training program after generally a four-year medical school degree. My first thoughts about being a physician began at age 14 with the goal of becoming a family physician. My family physician was Dr. John Cunningham, a general practitioner in Dalhart. When I was a child, he was my pediatrician as well as the obstetrician for my mother. Family practitioners throughout the United States also did varying amounts of surgery, depending on their training and experience. This variety of practice seemed extremely exciting when I first considered a career in medicine, but by the time I entered medical school in 1978 and progressed through the first two years, it was obvious to me this was a thing of the past, and almost an impossibility to provide the appropriate standard of care. It certainly seemed overwhelming to be a "jack of all trades" by the time I was a fourth-year medical student. To this day, I still think that being a good family physician is in some ways the hardest of all specialties to do well.

MEDICAL EDUCATION AND RESIDENCY TRAINING

I continued to pursue family practice until March of my fourth year of medical school, when one of my best friends (also the valedictorian of our class) suggested that I would probably be happier being in surgery or OB/GYN. He felt that it matched my personality and skill set and, after sleeping on this for two weeks, I dropped out of the computer match for family practice with the goal of going into OB/GYN. This meant I had to take my chances and hope that I could get into a training program that didn't fill. The specialty of OB/GYN at that time had become very competitive, and on the day of the match there were only three openings west of the Mississippi River. These positions filled within one hour. East of the Mississippi there was one spot in Knoxville, Tennessee, and one in South Carolina, as well as three in the Northeast in inner-city hospitals (One of these was Johns Hopkins, which was surprising to me, but often times programs with highly regarded names can be grueling or less than ideal from a practical standpoint). With the help of my advisor, I made some quick phone calls and set out on a flight to interview for a position in Columbia, South Carolina and then another in Knoxville, Tennessee. Knoxville was interviewing over 15 people for this one spot, and they chose me. It turned out to be a good place to train for four years.

One of the major changes in residency programs since my day is that there are now limits to the number of hours that can be required of physicians in training. We were on call every third night for four years, except for two weeks of vacation per year. This meant that every three days you would be at the hospital from seven in the morning till five the next day. The amount of sleep was frequently minimal on call during your first year, and gradually more sleep could be expected as you progressed through the next three years. I remember specifically having almost no sleep when I was scheduled to perform my first hysterectomy as the primary surgeon, but I was running on adrenaline and things went well. You always have somebody assisting and a staff man available, but this would be unacceptable by today's standards.

Knoxville served most of east Tennessee, with a population that was approximately three times the size of the Texas Panhandle. As today at Texas Tech in Amarillo, we had three residents per level, but many more patients, so the patient volume for education was better than most programs with regard to training and exposure to pathology.

Faculty supervision during residency is another area that has changed. OB/GYN faculty are now required to stay in the hospital, but in the 80s they typically only came in for problems or surgeries. Some faculty at times could be borderline abusive, but overall it was a great experience, because you were learning to do what you had dreamed of doing.

EARLY PRACTICE IN AMARILLO

My wife, Leslie, and I were both from Dalhart, so starting private practice in Amarillo in 1986 was coming home. Dr. James Glenn allowed me to share his office, which saved me from going into debt, as well as providing some security for a new physician. This was before computers were commonplace in a medical office and before managed care-so it was easier for a solo practitioner to start on his own. Insurance was traditional, and, as a result, the free market was more in play, with the patient able to choose their doctor and check prices and choose their hospital. The common rate for obstetrical care and delivery in Amarillo was $1200 in 1986, and I set my price at $950 to help get business. These days with managed care, your listed rate is almost a non-factor. There is a range of allowed fees and you are either in somebody's plan or you're not, so you can't charge more or less hoping to get more or less business. Patients today rarely know exactly what the physician or hospital is getting paid; as a result, the economics of healthcare don't seem related to the economics of society- housing, clothing, groceries, etc.--where the free market is allowed to come in to play. No system of medical care is

perfect, but prior to 1990 the patient was self-policing and as such more in charge of their healthcare costs and quality control, at least with regard to picking their physician and hospital.

CHANGES IN CARE AND PRACTICE OVER THE PAST 40 YEARS

Technology in surgery is probably the area where I've seen the biggest change over the last 40 years, specifically increasing amounts of laparoscopic surgery and, more recently, the use of robotic surgery. OB/GYN was a pioneer in laparoscopic surgery, starting with scope use for simple procedures such as tubal ligation and diagnostic laparoscopy to evaluate pain or problems with a small surgical port rather than a large laparotomy incision. There was no camera system, so we looked directly into a scope eyepiece when performing tubal ligations, etc. Hysterectomy in the 80s was typically performed with traditional surgery, using an abdominal approach or the original minimally-invasive surgery, which was a vaginal hysterectomy. Vaginal hysterectomy avoided an abdominal incision and as such the patient typically recovered quickly. The American College of OB/GYN still feels this should be the preferred type of hysterectomy when appropriate. The scope approach to hysterectomies was first performed using a stapling transection device for vascular pedicles in the upper pelvis, which allowed a laparoscopically assisted vaginal hysterectomy (LAVH). Shortly thereafter, the harmonic scalpel (which used harmonic vibration to dissect and transect the tissue) and the Ligasure (which used focused heat to cauterize and ligate vessels) allowed more agile dissections and increased surgical options. This led to many total laparoscopic hysterectomies (TLH).

The robot was first used in gynecologic oncology surgeries that required difficult dissection and was considered excessive and too expensive to use for benign gynecologic hysterectomies and surgery. This has changed, and the use of the robot has become commonplace for benign hysterectomies. This is a common pattern in medicine, especially surgery, where technology provides new "toys" for special procedures but is quickly incorporated into common practice. I have mixed feelings about this, as surgery has become more and more expensive. Traditional surgeries are sometimes required, but new physicians are often less adept at performing a vaginal hysterectomy, for example, which is still an excellent operation. All surgery requires a learning curve, but commonly less time is required to learn an operation using new technology. I would commonly feel that using the harmonic scalpel was almost cheating, it was so easy. I think most new physicians are commonly comfortable using laparoscopic approaches to surgery and even the robot, but in difficult cases when they have to resort to traditional laparotomy their comfort level is less than ideal. For this reason as well as others, most newly-trained physicians prefer to be in a group where more experienced partners can assist when needed in surgery.

The Caesarean section rate has risen steadily over the last 60 years. The main reason for this, I believe, is fetal monitoring and the malpractice climate, although some of it is due to a hesitancy to learn or use breech delivery and vaginal twin delivery skills (which also relates in part to fear of litigation as well). The C-section rate in the period before the 1960s was amazingly low--less than 3%. With fetal monitoring, we became more aware of just how stressful the laboring process can be for some infants, and we became unwilling to take a chance on the health of a baby with a fetal heart pattern that was difficult to evaluate. (It is interesting to know that in 1938 only half of American babies were born in a hospital--by 1955 this percentage was over 95 percent.) The C-section rate in 1970 was about 5%. As fetal monitoring became more commonplace in the 70s, there was steady increase in the C-section rate. During my training, we were constantly concerned that the C-section rate was hitting double digits. Throughout the majority of my career, C-section rates were typically in the 12 to 20% range for most obstetricians. Recently C-section rates, especially when caring for high-risk preterm infants, has resulted in even higher rates. The national C-section percentage is now about 32 percent.

Neonatal intensive care has improved dramatically over the last 60 years. In the 1960s, the chance of survival for premature infants weighing less than 1000 grams (generally the weight of a healthy 28 week infant) was than 10%. In the mid-1970s, neonatal ventilator support dramatically improved the chances for smaller, younger babies. Survival became more optimistic beginning at 26 weeks in 1980 to as low as 23 weeks (or even 22 weeks at times) now. Improvements in ventilator support along with advancements in steroid therapy for pregnant women and neonatal surfactant, etc. sometimes enable survival of infants under 1 pound.

CHANGES IN PRACTICE MANAGEMENT

Malpractice has become an increasing concern during my career. My favorite story that illustrates how the legal climate has changed is from Dr. James Glenn, who was a family physician delivering babies in Dalhart in the late 1950s before he did an OB/GYN residency in Denver. He and his partner carried no malpractice coverage at that time, and a salesman came to town offering him coverage for $35 per year. He remembers debating whether it was really needed. Pregnancy is risky--one only has to look at old cemeteries to see how risky it was in the past for both the mother and infant. Fortunately, I never went to court, but I know several physicians who did. It was

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traumatizing for them and may have even cut their careers short.

Group practices now make up the majority of OBGYN offices in Amarillo. When I came to Amarillo in 1986, there were only solo practitioners. It was a bastion of independence with multiple different personalities. We migrated to call-sharing groups, trying to find people we felt comfortable with caring for our patients. I generally only asked another physician take care of my patients (especially deliveries) if I were out of town or had a special event such as an anniversary. Patients expected their physician to be there when it was time to have their baby and, most of the time, this is what I preferred. This physician-patient relationship was very special, especially if you had known a family for a long time and delivered all their kids and maybe some of their grandkids. I did not want to be just the doctor on call. Over the years, I had a good call-sharing group of 3 to 5 fellow physicians that I trusted caring for my patients if I was out of town. We alternated phone coverage on the weekends. At times, we felt isolated in solo practice, but we helped each other on difficult cases and surgeries. Business and office decisions were at times quicker with a solo practice. All that said, if I were starting out today, I would try to find 3 to 5 fellow OB/GYN doctors who were compatible and form a group. A group practice has economies of scale, especially important in dealing with big-ticket items, such as computer systems and sonograms.

Hospital care has changed over the last 40 years as well. Hospitalists now manage a large percentage of patients admitted to BSA or NWTH, with the help of consulting specialists. Obstetricians in Amarillo still admit and care for their patients in labor, unlike some cities that frequently have laborists on call. We manage antepartum problems such as preterm labor, second trimester bleeding, hyperemesis, and pregnancy-induced hypertension etc. OB/GYN remains a specialty with more continuity of care than most.

CHANGES IN DEMOGRAPHICS AND THE USE OF TECHNOLOGY IN OB/GYN

OB/GYN has become a female-dominated specialty, which I can understand. Texas A&M College of Medicine had about 70% male and 30% female students when I started in 1978. My residency program had one female and 11 males when I started and 33% females when I finished four years later. Amarillo had no female OB/GYN's in active private practice in 1985. Dr. Emily Archer and I arrived in 1986. I would estimate today that 2/3 of the OB/GYN physicians in Amarillo are female. Nationally the percentage of females in OBGYN is 57% and the percentage coming out of training is 85 percent.

Diagnostic imaging has had a dramatic effect on obstetrics, with the right-hand technology of any obstetrician being a sonogram. Sonography has progressed from a poor image of a pregnancy in the 70s and early 80s, to a highly-detailed image of today, frequently with a 3-D option. Sonograms started appearing in OB/GYN offices in the early 90s and have become a required part of obstetrical care. Sonography is integral in evaluating appropriate fetal growth and amniotic fluid volume, as well as vascular problems and bleeding problems that can complicate pregnancy. It allows evaluation of pelvic masses in the office, providing convenient, accurate, and oftentimes immediate information to patient and physician. MRIs have also developed in the last 40 years and have transformed evaluation, primarily in neurologic problems but also in gynecologic evaluations.

Cell phones have also been an extreme change for physicians. When I first came to town in 1986, we used beepers and had to run to a phone if we were called for an emergency. I remember running across the golf course for a supposed emergency when someone just wanted an excuse not to go to work. A few physicians had the Motorola "brick", which weighed almost 5 pounds and cost over $4000 (about $10,000 in today's dollars). The flip phone came out in the mid-90s and then the iPhone in 2007. The iPhone not only was a lighter, better way to communicate, but with time the internet provided access to medical information in your hand. It's amazing how much the smart phone has changed society in just 16 years.

I've always felt blessed that I was able to practice medicine for many reasons, but the most important was aiding a family with having a healthy child safely. Having a child is one of the most memorable events in the lives of most families and, thankfully in modern medicine, it is usually successful. Unfortunately, every obstetrician will encounter some sad situations, but with time the family and the physician usually heal.

My career was at times demanding and stressful but, overall, very fulfilling. I was blessed with my wife Leslie who understood my career and raised 3 children despite the inconvenience of my specialty.

In summary, there have been many changes within modern medicine in the last 50 years and OB/GYN has been a leader in change and progress. One thing that has not changed is the importance of relationships. Psychological research has shown that relationships are the backbone of happiness and satisfaction in life for most people. Relationships with my patients, my staff and fellow health care professionals were the most valuable things in my professional career.

(Editor's note: Dr. John David. grew up in Dalhart, Texas. He attended undergraduate school at Texas A&M University in College Station and graduated from medical school at TAMU as well. After completing an obstetrics and gynecology residency at the University of Tennessee in Knoxville, John returned to the Panhandle to start his Amarillo practice in 1986. Dr. David continued to deliver babies and to take care of his women patient's needs until his retirement in 2022.)

I Have Seen A Revolution

by Rush Snyder, MD

"I have seen a revolution!" remarked one of my professors at Washington University School of Medicine, returning from a demonstration of CT brain imaging. The year was 1973--my first year of neurology residency. His introduction to CT brain imaging heralded a revolution in the evaluation of many neurologic disorders. Brain imaging prior to CT—isotope brain scans and pneumoencephalography—were indirect and did not achieve the resolution of even those very early CT scans. Yes, there were experts who could interpret images from those earlier techniques and were remarkably good in doing so. But CT scans did not require that level of expertise. Imaging with CT (and later with MR imaging) improved, as did interpretation.

Vascular imaging of neurologic structures has been supplanted by CT and MR angiography. These techniques, together with older catheter angiography, led to novel therapeutics—stenting of extra-cranial arterial lesions, coiling of intracranial aneurysms and obliteration of arterial-venous malformations. Imagine how different the lives of our patients would be absent those innovations. Imagine how narrow would be our range of diagnostic certainty. Neurologists in 1973 did not have to imagine that world--they lived it. I was unaware of those earlier techniques. In the interval since that first primitive scan, CT and MRI have become indispensable to virtually all areas of medicine.

REVOLUTIONS IN THERAPEUTICS

Another revolution which had started less than ten years prior to that of CT was in neuro-therapeutics, with the introduction of levodopa for the treatment of Parkinson disease. It remains the mainstay of Parkinson therapy.

Advances in the diagnosis and management of multiple sclerosis (MS) have been more evolutionary than revolutionary but not less dramatic. ACTH, Cytoxan and, to a lesser extent, steroids have been nudged aside by interferons, monoclonal antibodies and other therapies that modify the immune system. As it is now understood, MS is a disorder of the immune system. None of these therapies is curative, but the improvement in relapse rates and reduction in disability has been gratifying.

Stroke diagnosis, treatment and prevention have seen remarkable advances as well. The morbidity and mortality of carotid endarterectomy have been reduced dramatically. Clot dissolution with urokinase was introduced early in my training but did not bear fruit until decades later. Now, prompt treatment with tissue plasminogen activator (t-PA) has improved outcome in many stroke patients. Arterial stenting and clot extraction have come on the scene to supplement and at times to replace thrombolytics. These treatments have reduced disability and mortality in many stroke patients. Stroke prevention remains at the top of the list of stroke management—strict control of hypertension, treatment of dyslipidemia, control of diabetes, and changes in patient behavior all contribute to a reduction in stroke incidence.

A number of neurologic diseases remain challenging—motor neuron disease (ALS), various Parkinson-like disorders, peripheral neuropathies and a host of diseases which genetics is helping to elucidate. A particularly dramatic consequence has been the management of a previously uniformly fatal disease of infants, spinal muscular atrophy. Gene therapy has virtually eliminated this disorder.

CHANGES IN THE PRACTICE OF NEUROLOGY

Other changes outside direct patient care have emerged. Solo practice was the rule when I came to Amarillo. That practice type has largely been replaced by group and corporate practice. Decision making, once the province of individual practitioners, has been ceded to corporate "actors" remote from direct patient care—to payors, both government and private. There has been a proliferation of services, many of which did not exist when I entered practice. At that time, physicians were responsible for duties such as finding nursing home placement. Other services (such as home health care, mobile radiology, and case management) did not exist or were early in their availability.

Telemedicine could not even be imagined until computers and cellular phones were in general use. This has been a boon to patients with those neurologic disorders that can make office visits difficult in the best of circumstances.

Hospice care has expanded well beyond its early availability. In-home hospice allows patients with terminal illnesses to remain in the familiar surroundings of the home.

Alongside these changes has been a remarkable increase in neurologic subspecialization. Clinics devoted to the care of specific illnesses (such as MS, movement disorders, peripheral neuropathies, diseases of muscle, and dementia) bring research and care together. Stroke centers have brought uniformity to treatment and permit analysis of treatments over a broad range of patient populations.

To paraphrase an observation of Michael Ryan M.D., my colleague during my career in neurology, one of the

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problems with progress is what is lost. Innovations such as the foregoing are expensive. They can be subject to utilization review, often by persons without medical training.

The wholesale replacement of not-for-profit hospitals and hospices with for-profit counterparts is worrisome. The profit motive is an incentive for innovation and remarkable medical advances. However, the evaluation and treatment of patients should be the province of physicians and those closely supervised by physicians. If for-profit settings lead to improved efficiencies in care delivery, let there be fewer of them, so those few can be learning centers for the not-for-profits. The foregone profits can then be used to augment nursing staff and others involved in direct patient care and to respond to ever-changing equipment needs.

What else has happened to the delivery of care? All of us are aware of the decline in the performance of histories and physical examinations—once, pillars of medical education. These have been replaced by payment-driven evaluations and with a glut of often- useless information. At the same time, there has been much more reliance on testing (especially imaging) to reach a diagnosis. This is particularly true in neurology. The skills required to develop a history and perform a physical examination are taking a back seat to testing, often with a decrease in diagnostic efficiency.

Medical educators can reverse much of this decline if given the time to carefully train students. Now, those educators must generate income to pay their salaries. Time for training is sacrificed. The solution is obvious if we are to improve medical training. My professors were expected to teach and many had research duties with limited time devoted to administration. This practice should be reviewed by administrative and academic medical staff to search for alternative sources of funding.

I too have witnessed many amazing "revolutions" in medicine. More are to come. It has been rewarding for me to see those changes benefit our many wonderful patients.

These reflections are dedicated to the memory of C.J. Batson, M.D., who was the sole neurologist for the Panhandle community for many years and, later, my colleague. His wit, wisdom and expertise are missed.

(Editor's note: Dr. Rush Snyder Jr. grew up in Canadian, Texas, the son of a pioneer general practitioner for that community. He attended undergraduate school at Rice University and graduated from medical school of Washington University in St. Louis. After completing a neurology residency at Wash U, he came to Amarillo in 1977. Dr. Snyder continued in the private practice of neurology until 2011 and delivered care to our veterans at the Amarillo VA Medical Center until 2018.)

Reversing the 1968 Revolution in Medical Education:
My Quest at TTUSOM from 1992 to the Present

by Harold (Hal) Werner, MD and Gina Werner, MA, LPC

It was May of 1967, the final month of my internship at Northwestern University in Chicago. The loud speaker sounded, "We now have available the SMA-6 clinical chemistry profile". It was the new "Sequential Metabolic Analysis" chemical test with 6 results on one blood sample, instead of only one chemical test at a time. It was unforeseen at the time, but this new technology would soon change irrevocably the method of diagnosis for all clinicians in the United States, even up to 2023. This was a countrywide revolution, as evidenced by the dramatic changes in the American Board of Internal Medicine (ABIM) examination that occurred soon thereafter. Changes in the ABIM exam were made to eliminate a candidate's ability to short-circuit answers to test questions by using the SMA method.

What exactly was this revolution? There were none of the usual provocations to instigate a revolution, such as new knowledge, ideology, or philosophy. The SMA simply was an advance in technology designed to screen for early disease in populations of healthy people, not for diagnosis in the hospital. The goal was to identify disease early, so treatment could be more effective.

HIPPOCRATIC METHOD OF DIAGNOSIS, 450 BC-1970 AD

The revolution of 1968 was a reaction against the status quo method of diagnosis. In 1910, Abraham Flexner had established the Hippocratic method as the scientific method necessary for reform of American medicine: "The physician confronts the illness in the person by his powers of observation and seizes its details. The patient's history, conditions, symptoms (and signs) form his data. He frames his working hypothesis, now called a diagnosis…Does the diagnosis fit the facts (differential diagnosis)? Response of the illness to treatment is a judgment of the physician's competency."

Inherent in the Hippocratic method are both the centrality of the "doctor-patient relationship" and the necessity to get all the facts from the sick person for a scientifically correct diagnosis by differential diagnosis. Both are absent when using the SMA method (see below). The 2500-year-old Hippocratic method was still dominant during my years in medical school (1964-1966), and it ended in my last year of internship.

SMA METHOD OF DIAGNOSIS: A TECHNOLOGICAL REVOLUTION, 1970-2023

Because of the long involved "workup" by the traditional Hippocratic method (see below), internal medicine residents in 1970 immediately used the SMA as a shortcut to diagnosis. With the patient's admission SMA-20 chemistry results in hand (20 chemistries from 1 ml of blood), the resident could simply get a very brief presentation about the illness from the patient to order more tests if necessary to make a diagnosis. Often, a resident in daily practice made a final diagnosis without talking to, examining, or even meeting the patient! The SMA represents extreme reductionism (i.e., analyzing a complex illness in terms of its simpler components, in order to get a sufficient explanation of the cause of the illness).

MY OUTPATIENT CLINIC (OPC) EXPERIENCES WITH THE SMA METHOD, 1992-2023

Only 5 years later, after internship and then biochemical research studies in St. Louis, Montreal, and Oakland (US Navy), was I able to start my residency at Northwestern. The SMA-6 had become the SMA-20. The method of diagnosis no longer was Hippocratic. What a shock! I termed the SMA method the "TechFirst" method, because the technology precedes any "doctor-patient contact".

Then, after training, I came to Texas Tech (Amarillo) in 1992. The residents, students, and most faculty already used

Comparison of the Hippocratic Method and the SMA Method

Hippocratic	SMA Method
Chief complaint, then	SMA results, then
History of the illness, then	Minimal history (to order tests), then
Physical exam, then	Final Diagnosis, in less than 3 days
Review of systems, then	
Personal history, then	
Family history, then	
Social history, then	
Labs/imaging, then	
Working diagnosis, then	
Treatment, or non-treatment, then	
Diagnosis confirmation by patient, then	
Final diagnosis, after days-weeks	

the 20-year-old TechFirst method, and they considered it the traditional method of diagnosis to be used with all patients. In teaching third-year students in the outpatient clinic (OPC) at Texas Tech, however, I discovered a blind spot in diagnosis when using TechFirst in the OPC. For example, a young adult presents with episodic abdominal pain. All blood tests and imaging are negative, and the resident says, "Well, it must be irritable bowel syndrome (IBS)", or "We need to do more tests." No differential diagnosis, no thought of alternative diagnoses (such as Crohn's disease)! Instead, the usual explanation of the patient's symptoms at that time: "It's in your head" or "It's not really a disease", thus invoking dualism (to emphasize body and minimize mind) and completely deprecating the "doctor/patient relationship".

Some 30 other illnesses like IBS above, such as fibromyalgia, migraine, depression, panic disorder, etc. compose a category called "medically unexplained symptoms" (MUS). Every subspecialty has patients with at least one of these mystery illnesses. These MUS illnesses are not considered diseases because of the still-dominant influence of the 400-year-old philosophies of dualism and reductionism. The diagnosis of any MUS means that no lab test, imaging, or physical exam (or any combination) is able to reach a positive diagnosis of an MUS. Thus, only by accurate history can the diagnosis of any MUS be made. If we do not use the Hippocratic method, and persist with "TechFirst" method in the OPC, there can be diagnostic error in up to 70% of all new or recurrent illnesses. I concluded, "You must not use the TechFirst method in the OPC; you must use some variant of the Hippocratic method".

MY REMEDY TO TEACH DIAGNOSIS IN THE OUTPATIENT CLINIC (OPC)

This severe indictment of the TechFirst method of diagnosis dictated in my mind that some changes in medical education were imperative. As clerkship director, I split the traditional hospital-based 3-month internal medicine rotation for third-year students to 2 months at the hospital, and 1 month in the OPC with me for about 50 hours each month, seeing typical ambulatory sick people. Limited internal medicine literature existed about MUS, let alone how to diagnose any MUS. I needed a new method of diagnosis to supplant the faulty TechFirst method in the OPC. This new method must meet 4 criteria: 1) a very shortened variant of the Hippocratic method, which eliminates the reductionism of TechFirst; 2) a focus on differential diagnosis; 3) an elimination of the dualism blocking the MUS as legitimate illnesses; and 4) an acknowledgement of the patient's worries about the illness, to reestablish the "doctor-patient relationship" as foremost.

To remedy these 4 deficiencies of the TechFirst approach, I gave a handout to students each week on a different common symptom seen in the OPC (headache, abdominal pain, chest pain, dizziness, etc.). Ten years later, in 2004, I collected the handouts into a book titled "Werner's Office Diagnosis". For each symptom, I provided the 3-4 common causes of the symptom. To limit dualism, at least one cause was an MUS. For each cause, then, I provided 1-2 symptoms that would separate each cause from the other 2-3 causes (the process of differential diagnosis). I showed the student how to listen for these 1-2 key differentiating symptoms (without biasing the patient with questions) from thepatient's presentation of the many symptoms of the illness. The students quickly could get a tentativediagnosis, which often was the final diagnosis. "The best clinician in the office is the one making a clinical diagnosis using the history (positive diagnosis) and physical exam (negative diagnosis)" (from the preface of my book). To strengthen the "doctor-patient relationship", a "Worries and Wants" section in each chapter of my book addresses the effects of the patient's symptom complaint on the patient's daily life.

LONG-TERM CONSEQUENCES OF USING THE TECHFIRST METHOD OF DIAGNOSIS

The TechFirst method benefits the doctor, but patients and students are losers. The students lose because the dysfunctional reductionistic method of diagnosis, TechFirst, is the only method presented to them by almost all faculty and residents (Who will teach the teachers?). The patients lose because diagnosis is made with only a cursory one-sided conversation. The doctor is not listening to the patient, but only thinking about which test(s) to order next. The historically invaluable "doctor-patientrelationship" has become precarious in 2023. The patient gets minimal feedback from the doctor, just test results. The diagnostic process is reductionistic--that is, diagnosis reduced to changes in chemicals in 1 milliliter of blood from a sick patient representing a "doctor-blood chemistry relationship", akin to 16th century iatrochemistry.

Second, diagnosis today is defined by authorities as "identifying the disease causing the illness." This definition urges the clinician to find the lab test that can most quickly identify the disease. "The best diagnostician in the hospital is the one consistently ordering the right technology first" (preface of my book)--but this is not true in the OPC.

Third, there is a regression so that almost all learning experience is now located in the hospital, where students are taught the TechFirst method by residents whose "ancestor residents" took a wrong turn and started the 1968 revolution. As a result, students today have no contact in the OPC to learn about human beings and their common illnesses, despite the fact that the majority of sick people come to the OPC first for diagnosis and treatment.

Fourth, throughout the history of medicine, a final diagnosis of a disease must include all three of the following to confirm a correct diagnosis: 1) Clinical diagnosis by history & physical exam (history for positive diagnosis, and physical exam for negative diagnosis) to exclude mimics in the differential diagnosis process; and 2) Technology (lab tests, imaging) only if necessary for confirmation of the working diagnosis; and 3) Appropriate response of the patient's

illness to a specific treatment or non-treatment. Failure to adhere to these rules risks many errors in diagnosis. The scandal of high rates of errors in modern diagnosis recently has been highlighted in a book from the Institute of Medicine, "To Err is Human". In addition, a new monthly journal entitled "Diagnosis" publishes studies examining why our expensive technological diagnostic methods still result in so many errors.

MY SCIENTIFIC METHOD OF DIAGNOSIS IN THE OUTPATIENT CLINIC (OPC)

Because of almost total reliance on batteries of blood tests, imaging, and the TechFirst method today, the dehumanizing effect of technology has become a major reason for much patient discontent. By understanding the Ionian philosophy underlying Hippocrates in the 5th century BC, I have tried to reverse the 1968 revolution in medical education. Specifically, I was able to: 1) recognize the fallacy of using the nonscientific TechFirst method; 2) elaborate a short variant of the Hippocratic method, relying on data elicited from the patient; 3) attend to the worries of patients in order to mend the "patient-doctor relationship"; and, finally, 4) eliminate dominance of the dualism and reductionism that are being misapplied to diagnosis of human illnesses. Only by teaching doctors how to return to the ancient principles of the Hippocratic method of diagnosis can future enlightened doctors help their patients survive their modern illnesses—both physically and emotionally.

(Editor's note: Dr. Hal Werner grew up in Huron, SD. He attended undergraduate school at Huron College and the University of South Dakota and graduated from the Northwestern University Feinberg School of Medicine. He completed an internal medicine residency and endocrinology/metabolism fellowship at Northwestern as well. Hal came to Amarillo as an internal medicine faculty member in 1992. He continues to work and teach at Texas Tech SOM, where he is a full professor in the department of internal medicine. Dr. Werner has been a towering figure in the teaching program at Tech for over 30 years.

Gina Werner earned her Bachelor's Degree from the University of Texas at Arlington (UTA) and her Master's Degree in Counseling (MA) from West Texas A & M University (WTAMU). She graduated Summa Cum Laude with each degree. While at WTAMU, she was awarded the Ken Waugh Outstanding Counseling Award for best counseling student in the program. After meeting the criterion of 3000 clinical hours of counseling clients, Gina became a Licensed Professional Counselor (LPC) and is currently licensed in the State of Texas.)

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Be a part of the circle. In 2006, Potter-Randall County Medical Society introduced the Circle of Friends, a program designed with the business of medicine in mind. Members of the Circle of Friends are companies that pay an annual fee to participate in Medical Society events. Their financial commitment allows PRCMS to provide quality programs throughout the year, such as the Annual Meeting, Doctors Day, Resident Reception, Family Fall Festival, Retired Physicians Lunch and Women in Medicine. In return, these companies are invited to attend these events and discuss with the physicians the benefits that their companies offer a physicians practice.

We are grateful for the support of these organizations and anticipate another great year of serving the needs of our members. The purpose for Circle of Friends is to provide a valuable base of resources to assist the physician in the business of medicine so their practice of medicine can improve.

This program has proven to be a valuable resource of services such as liability insurance, accounting, banking and much more. This year, we hope to expand the Circle to include services the physician may use in his or her personal life. Through this program, we can invite businesses serving physicians to support the Society and increase their visibility among its members. Corporate support contributes to the Society's ability to advocate and care for physicians and patients in Potter and Randall Counties.

The Medical Society thanks all of its supporters as it offers new opportunities to its membership.If your business is interested in being a part of our Circle of Friends, please contact Cindy Barnard at 355-6854 or e-mail prcms@suddenlinkmail.com.

Do You Have:

- *Pain when walking?*
- *Swollen, aching or discolored legs?*
- *Pain in toes at night while at rest?*
- *Non-healing wounds on feet, toes or legs?*

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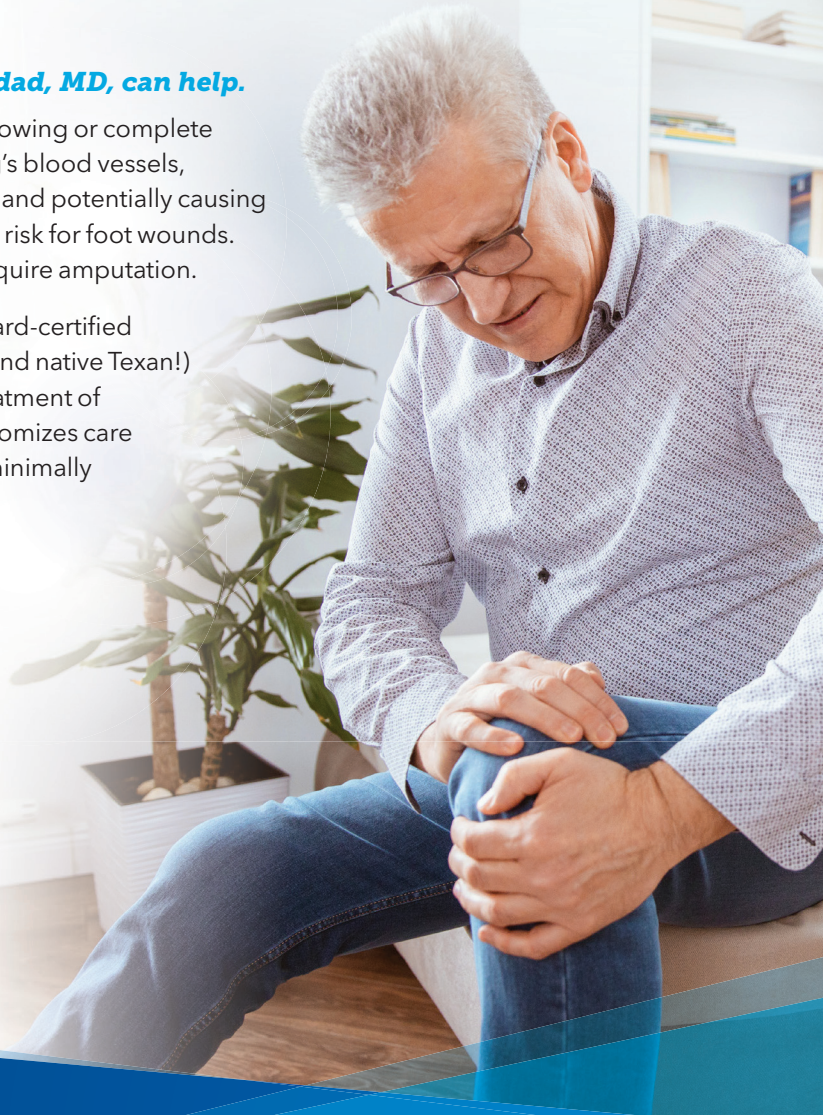

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Dr. Charles Wike

Interviewed by Scott Milton, MD

Dr. Charles Champion Wike is a retired general surgeon who practiced in Amarillo from 1973 until 1998. Dr. Wike, a native Georgian, practiced for a few years in his native state until ultimately retiring in 2002 and returning to Amarillo. Dr. Wike's story of how he found the Texas Panhandle as a place where he could live and practice is an interesting one and one that is intermingled with that of my own family.

EDUCATION AND EXPERIENCE IN VIETNAM

Charles Wike was born and raised in Eatonton, Georgia. He attended college at Georgia Tech and the University of Georgia, then graduated from the Medical College of Georgia in 1965. Dr. Wike interned at Parkland Hospital for one year. After this experience, he returned to Augusta, Georgia for further surgery residency. During this time, with the escalation of the Vietnam War, Dr. Wike became aware of an opportunity for surgery residents to volunteer for service in Vietnam. The Da Nang Hospital was established in Da Nang by the US public health service to serve the Vietnamese community that was in dire need of healthcare during the conflict. Dr. Wike volunteered at this facility, which consisted of 10 volunteer nurses with minimal laboratory resources and no microbiology laboratory capabilities. He and his tiny staff saw all comers, including local civilians, injured South Vietnamese army personnel, and occasionally members of the North Vietnamese Army. Dr. Wike volunteered for a total of two months at the Da Nang hospital and, while there, kept a detailed diary of his experiences. The diary was a fascinating read, not only for descriptions of the terrible injuries suffered by citizens, many of whom were children, but also for comments about Vietnamese culture and deep reflection about the war itself. One long passage questioned the involvement of the United States in Vietnam. There was a harrowing side trip to Hue, a community actually in the war zone, that involved a wild transport on a helicopter back to Da Nang that was arranged by a U.S. Special Forces officer. Other interesting facts listed by Dr. Wike in his diary were that 20% of the population had tuberculosis, 25% had syphilis, and all citizens had been infected with some form of hepatitis and intestinal parasite. He could watch artillery fire from the hospital roof. Charles left Vietnam in September 1967 with an incredible surgical and cultural experience. He finished his surgery residency in Augusta in 1970 and later served in the United States Navy in the Philippines, where he finished his service in late 1972.

I mentioned earlier that my family history is intermingled with Dr. Wike's. My father, Dr. John Milton, served in the United States Navy from 1960 to 1965 and spent part of his tour of duty serving as a flight surgeon in Marietta, GA. While there with my father, my mother became friends with Dr. Wike's stepmother through the officer's wives social club; our families quickly became friends. As a matter of fact, I was born in Marietta. My mother would take my sister and me to see Charles's stepmom and dad, and we met Charles, who was in medical school at the time. So, Dr. Wike and I have known each other my entire life! When Dr. Wike began looking for a place to practice, my dad a suggested that he look at Amarillo, and the rest is history.

Charles was introduced to Dr. E.B. Lokey, the first fully trained Ob-Gyn physician in the Panhandle, and the two physicians became friends and office partners. This arrangement continued until a new office building was built across the street from St. Anthony's Hospital, when Dr. Wike started leasing his own office space. Dr. Wike enjoyed working with many other physicians but mentions Dr. Walter Watkins, Dr. Bob Buford, Dr. Tom Easley and Dr. Buck Dravin as a few of his favorites.

REFLECTIONS ON LIFE AND MEDICAL PRACTICE

Dr. Wike has witnessed many events and advancements during his life and career. He was a junior medical student in 1963 when President Kennedy was assassinated; he believes this may have been the single most tragic event that occurred to the United States during his lifetime. Rapid improvements in medical technology such as the development of computer tomography, magnetic resonance imaging and laparoscopic surgery were among some of the advancements Dr. Wike mentioned. The increased pres-

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ence of the legal system in the practice of medicine, as well as the increased presence of insurance companies and their control over the practice of medicine, are probably the worst influences on medicine he has witnessed. He also mentioned the spiraling costs of the medical system to the public--especially the cost of hospitalization. Dr. Wike also learned several lessons from the colleagues he worked with over the years. He remembers that Dr. Bob Stafford would always dress his wounds carefully in the operating room after completing a case and would not allow anyone to remove the dressing unless the dressing became saturated or soiled. By reducing the chance of bacteria being introduced in to the wound bed, this practice facilitated faster healing.

When I asked him why he chose medicine as a career and then surgery as a specialty, Dr. Wike stated that his great uncle, the first urologist in his part of Georgia, was an important influence. Charles was initially enrolled at Georgia Tech in the engineering program but awoke one morning and realized that he was in the wrong school and had chosen the wrong career path. He then transferred to the University of Georgia and changed to pre-medicine. Charles has always enjoyed working with his hands; this is readily apparent in his home, where he has on display many of his hand-made creations. His first endeavor was woodworking, something he began at an early age. However, the pieces he created were not large items of furniture, but smaller pieces that are more akin to artwork, as they appear to be carved with artful detail. More prominently displayed in his home are his exquisite cross-stich and needlepoint works. All of the pieces on display are masterfully done, with beautiful colors that are stitched into each form. The stitchwork is tiny, displaying incredible attention to detail.

Dr.Wike was diagnosed with Type 1 diabetes upon his discharge physical from the Navy at age 32. He has always been very open about his diabetes, and I think it's important to mention here, as I was always amazed how Charles could manage this disease so well while also having a successful surgery practice, without the benefit of the modern technologies used today to manage type 1 diabetes. It's an inspirational story for others who might develop a disease early in their productive years. Dr. Wike, even with Type 1 diabetes, had a long and successful career in his chosen profession--a remarkable achievement by a remarkable person.

(Editor's note: Dr. Charles Wike grew up in Eatonton, Georgia. His undergraduate degree was from the University of Georgia and his MD from the Medical College of Georgia. He took his surgical training at Parkland Memorial Hospital in Dallas and then back at the Meical College of Georgia. Dr. Wike came to the Panhandle to start his surgical practice in 1973 and continued to practice general surgery until his retirement in 2002.)

Spotlight on New Members

The following were approved for membership on January 17, 2023:

NEW MEMBERSHIP:

Caga-Anan, Maria, M.D. - IM -

1215 S. Coulter, Amarillo, TX 79106

Graduated from CEBU Inst of Medicine, CEBU City, Philippines. Residency at New York Methodist Hospital, Brooklyn, NY.

Clark, Summer, M.D. - D -

1611 Wallace, Amarillo, TX 79106

Residency from Univ of Oklahoma College of Medicine, OKC, OK. Fellowship at Vanderbilt Univ., Nashville, TN.

TRANSFER MEMBERSHIP:

Huseman, Christina Min, M.D. - OBG -

Women's Healthcare Assoc., 1301 Coulter #300, 79106

Enos, Tyler H., M.D. - D -

4302 Wolflin, Amarillo, TX 79106

Arismendez, Shyla, M.D. - FM -

2001 S. Coulter, Ste. 2001, Amarillo, TX 79106

Henchcliffe, Blake E., M.D. - P -

PO Box 51090, Amarillo, TX 79159-1090

Residency from Univ of Texas, Houston, TX.

RETIRED MEMBERSHIP:

Merki, Daniel, M.D. - FM

The following were approved for membership on March 21, 2023:

RETIRED MEMBERSHIP:

Cesar, J. Arias, M.D. – END

Ragjjavemdra Saralaya, M.D. – IM

Shilpa Saralaya, M.D. – IM

Kimberly A. Waugh M.D. DR

LIFE MEMBERSHIP:

James D. Hale, M.D. – FM

Margaret Thurmond-Anderle, M.D. – IM

The following were approved for membership on May 16, 2023:

NEW MEMBERSHIP:

Jenna Lane, M.D. – AN –

Raphael J. Mattamal, M.D. – PD – *Graduated from TTUHSC, 2017*

Natasha Nawaz, M.D. -Hosp./IM – *Graduated from Univ. of Pittsburgh Medical Ctr. 2015*

Nibras Talib Mamury, M.D. – IM – *Graduated from TTUHSC, 2021*

TRANSFER MEMBERSHIP:

Tanay Patel, M.D. – OBG – *Graduated from Ross Univ. SOM, 2008*

David Stevener, M.D. IM – *Graduated from Univ. Of Texas Southwestern, 2013*

RETIRED MEMBERSHIP:

Alfred Chu, M.D. – IC

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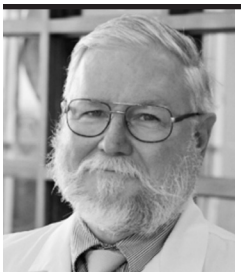
| *Spotlight On New Members continued on page 43*



45 Years of Delivering Babies and Performing Surgery In Dallas, Mississippi, and finally in academic practice at Texas Tech School of Medicine in Amarillo

by Paul Tullar, M.D

I was born in Houston, Texas, and grew up in a family with a father who was a Professor of Pharmacology at U.T. Dental Branch in Houston, but who had attended medical school in Nebraska. He had to leave medical school in his third year due to inability to make enough income working 3 jobs to keep up with tuition and pay his bills (during the Great Depression in the early 1930s). He moved through pharmacy jobs in Nebraska, worked for a pharmaceutical company in New York as a pharmaceutical researcher, then worked for the F.D.A. in Washington, D.C. While in Washington, he attended Georgetown University to earn his Ph.D. in Pharmacology. I was inspired by his story, and, by age 12, I realized I wanted to become a physician. My plan then was to become a Family Practice physician.

After graduating from Rice University in 1973, I was accepted to study medicine at the (then) U.T. School of Medicine at San Antonio. During my first and second years in medical school, I volunteered to work in free clinics in and around San Antonio and discovered that OB-GYN had a mix of medicine and surgery that I liked. OB-GYN doctors came to many of their diagnoses and management decisions by talking to the patient and by physical exam, and, like Family Medicine, the OB-GYN doctor took care of a variety of ages of patients. Like Pediatrics, it was necessary to know how to care for newborns in resuscitation (until the real pediatrician got there). I liked all these aspects of OB-GYN. During my third year in medical school, I discovered that, at least in San Antonio, Family Medicine trainees no longer performed surgeries and had to the leave most complicated pregnancy and delivery care to OB/GYN. Indeed, Family Medicine in San Antonio was being excused from all in-hospital care, leaving them with just outpatient, clinic/ office care. After my Obstetrics rotation in my third year, I realized that medical care of pregnancy and labor was an important part of how I saw my future in the practice of medicine.

From 1977-1981, I completed an OB-GYN Residency at Methodist Hospitals in Dallas and spent about half of that OB-GYN residency at U.T. Southwestern Medical School's OB-GYN Department at Parkland Memorial Hospital.

PRACTICE IN THE METROPLEX AND (BRIEFLY) IN MISSISSIPPI

After my four years of OB-GYN residency, I started private practice of OB-GYN in 1981 just down the street from Methodist Hospital in the downtown Oak Cliff neighborhood of Dallas. There I found that the economics of private practice were less successful in the inner city than in the suburbs. Insurance companies paid less for the same services depending on the zip code of the doctor. Managed care health insurance (which paid less for the same service) had made large inroads into lower socio-economic patients (who tended to live in the inner city) than upper socio-economic patients (who tended to live in the suburbs), again paying less for their care than more standard insurance companies. I was able to pay off my startup loans within 3 years, but I was working over 100 hours/week to do so.

After 3 years, I moved my practice to Charlton Methodist Hospital in southwest Dallas, and, with another physician, built a shared medical building just a few blocks from Charlton. I was able to share night call with younger, less busy OB physicians, and was able to scale my work week back to 90+ hours/week, leaving more time to spend with my growing family. I continued to work in southwest Dallas County from 1983 until 2005, when we relocated to Hattiesburg, Mississippi for 2 years. At the end of that time, I yearned to teach medicine and yearned to return to Texas. Fortunately, a couple of job openings appeared in the Texas Tech system in 2007, and I accepted an Assistant Professor of OB-GYN position in Amarillo.

ACADEMIC PRACTICE IN AMARILLO, 2007-2020

We sold our home in Mississippi and moved to Amarillo in 2007 to work in the OB-GYN Department of Texas Tech University Health Sciences Center, School of Medicine, where I begin teaching, delivering babies again, performing GYN surgery and caring for patients with pelvic floor disorders. I enjoyed teaching our medical students in their 3rd and 4th years of medical school. I also enjoyed training OB-GYN resident doctors and performing research. My weekly work hours increased to about 96 hours/ week, but my work more closely resembled what I felt I should be doing to serve our community.

During the next 13 years, I enjoyed teaching medical students and helping teach short courses for OB, Pediatrics, and Family Medicine Resident physicians. Indeed, I helped teach a Neonatal Resuscitation Course to OB, Family Medicine, and Pediatrics Resident physicians with Dr. Naqvi (the Medical Director of Northwest Texas Hospital's Neonatal Intensive Care unit) in late August 2007, the week before I officially started to work at Texas Tech! I taught medical students basic knot-tying and basic use of some of our surgical instruments. My OB and GYN lectures were aimed toward helping the students pass their national board exams in the OB part of medical licensure examinations. I helped establish and teach the Advanced Life Support in Obstetrics (ALSO)

national provider course in Amarillo, Lubbock, and Odessa. This nationally-recognized short course has continued in Amarillo for over 16 years, attracting providers from West Texas, the United States, US military doctors assigned to Caribbean bases, and Europe (as far away as Switzerland) to Amarillo to take this course.

After the first 2 years of teaching this ALSO Provider course to our resident doctors, I heard some critiques about the utility of this simulation-driven short course. I began research on student outcomes. The research demonstrated that even a 2-day hands-on course could give skills to OB and Family Medicine resident doctors that enabled them to resolve shoulder dystocia (a dangerous complication of childbirth) more safely after the instruction and 6 months later, compared to residents who did not have this nationally recognized, simulation-driven course.

In addition, in collaboration with our OB residents and our medical students, we published research on outcomes of patients evaluated 1 day after childbirth for developing post-partum depression. I helped School of Pharmacy researchers with cellular research on drug effects and metabolism of fetal cord blood cells. Several research articles involving cell biology, drug metabolism, and cell biochemistry pathways seen in cancer cells came from this collaborative research.

Practice in Amarillo included developing my skills in office female pelvic medicine and urogynecology and teaching these to my OB-GYN residents. From 2007, I had to learn to help and guide my residents in surgery, rather than doing the surgery all myself, as I had been used to in my private practice from 1981-2005. This took some getting used to on my part, allowing the residents to perform surgical procedures for which they had the skills yet helping when unexpected complications arose, in order to ensure patient safety and good outcomes. Our residents had their own patients, too, and I helped them care for women in childbirth, in gynecological surgery and in hospital and clinic care. All the while I was teaching them the medicine and surgery they would need when they were out on their own.

CHANGES IN THE BUSINESS AND PRACTICE OF OBSTETRICS/ GYNECOLOGY

During my years in my own private office in southwest Dallas, I would dedicate 10-15% of my private practice to caring for patients who had Medicaid. My office manager counseled against this, as the office was paid only about 30% of "Usual and Customary" payment for my work, but it was important to contribute to care for all our community patients. After closing my private office and mov-

Spotlight on New Members

The following were approved for membership on September 19, 2023:

NEW MEMBERSHIP:

1. Mak, Andrew W.C., M.D. – HO – (Hematology/ Oncology)

1751 Wallace Blvd., AMA, TX 79106.
Graduated from the Albany Medical College of Union University, Albany NY – 2015. Residency at NYU Long Island, NY – 2015-2018 (Internal Medicine), and Chief Residency of same 2018-2019. Fellowship at Roger Williams Medical Center/Boston University, Providence, RI – 2019-2022 (Hematology/Oncology)

2. Penniman, Joshua C., M.D. – HOSP/FM – (Hosp/Fmly MD)

1600 Wallace Blvd., AMA, TX 79106.
Graduated from Texas Tech University Paul L. Foster School of Medicine, El Paso, TX – 2018. Residency at Texas Tech Family Medicine Amarillo – Amarillo, TX – 2018-2021 (Family Medicine). Specialty Certification by American Board of Family Medicine – 2021.

3. Robertson, Donald J., M.D. – CSD/TX – (Cardiovascular Thoracic Surgery/Thoracic Surgery)

6611 W. Amarillo Blvd., AMA, TX 79106.
Graduated from Texas Tech University Health Science Center, Lubbock, TX – 1980. Residency at Baylor College Med. Affil. Hosp. – Houston, TX – 1980-1985 (General Surgery), 1985-1987 (Thoracic Surgery). Specialty Certification by American Board of Surgery – 1987, American Board of Thoracic Surgery – 1988.

LIFE MEMBERSHIP:

1. Habersang, Rolf, M.D.

2. Smith, Earl C., M.D.

The following were approved for membership on November 28, 2023:

NEW MEMBERSHIP:

1. McCollum, Deborah B., M.D. - CDS

6611 W. Amarillo Blvd., AMA TX 79106
Graduated from University of Oklahoma College of Medicine, OKC, OK – 1988. Residency at University of Oklahoma HSC – 1988-1993 (General Surgery), 1993-1995 (Cardiothoracic Surgery). Specialty Certification – American Board of Surgery/Surgical Critical Care – 1996, American Board of Thoracic Surgery – 1996. Hospital Privileges at BSA/NWTHS. Clinical Assistant Professor, Dept. of Surgery, TTUHSC, Amarillo, TX.

2. Mercado, Thomas M., M.D. – FM –

2105 S. Western St., AMA, TX 79109
Graduated from TTUHSC, Lubbock, TX – 2009. Internship at ISU Family Medicine, Pocatello, ID – 2009-2010. Fellowship at TTUHSC, Amarillo, TX – 2010-2012 (Family Medicine).

TRANSFER MEMBERSHIP:

1. DeJesus Morales, Reuben – R –

1901 MediPark St., Ste 2050, AMA, TX 79106
Graduated from University of Puerto Rico School of Medicine, San Juan, PR – 2015.

Residency at TTUHSC, El Paso, TX – 2017-2021 (Diagnostic Radiology). Fellowship at BCM, Houston, TX – 2021-2022 (Neuroradiology), UT-MD Anderson, Houston, TX – 2022-2023 (Oncological Neuroradiology and Head & Neck Imaging).

2. Huang, Genkai Jason – FM –

2701 S. Georgia St., AMA, TX 79109
Graduated from Texas Tech University Health Science Center, Lubbock, TX – 2020 (Family Medicine).

Holiday Vectors by Vecteezy

ing to Mississippi in 2005, I worked for a Federally Qualified Rural Health Clinic in southern Mississippi. There, all our patients were low-income Medicaid recipients or immigrants covered by a federally funded clinic care program. When I moved to Amarillo, I served a mixture of insured, uninsured, Medicaid, Medicare, and private pay patients. I tried to impress on our medical students and our resident doctors that we have a duty to serve all the members of our community. This lesson was well-received by the students with whom I worked. It was not always easy to find funding for all patients' medical care. Cancer patients, patients needing expensive care, or mothers with babies who needed super-specialized care not available in Amarillo were the hardest to get where they needed to be. Our residents, departmental specialists, and I "went to bat" for our patients, most often getting these people the care they needed.

In November 2017, at 66 years of age, I retired for the first time, but came back by February 2018 to work part-time 2 days a week in Labor and Delivery, intending to do this kind of work for "only 2 more years". When the COVID-19 pandemic began, I continued to work part-time, but, at my family's request, I put in my second request for resignation. I was asked to work until a replacement was hired, and, for the good of our patients and my Department, I continued to work (even though for my age the risks of COVID were greater than for some of my younger colleagues). My last day of part-time work (in semi-retirement for the second time!) was in October 2020, over 2 years from that February 2018 date when Social Security had first called me a member of the "working elderly".

How have things changed in medical practice since I began delivering babies in 1975? During the years in medical practice, the business office changed from using a paper accounting system to a computer-driven digital accounting system. Medical record charting gradually changed from all-paper to electronic medical records. These two changes were mostly urged on by both the health insurance industry and the federal government. The medical record changed from a narrative typed form to more "choose among the limited list of descriptors we give you" list-driven medical record, as the descriptor list record was easier for the health insurance company and the government to machine-analyze. I feel that this left the record incomplete, without documentation of what the patient had exactly said, and how things in their care had been tied together. The electronic medical record always promised "speedier completion, more availability and portability (for the patient), and greater ease in billing and speed of payment (by the insurance companies)." None of these things seem to have come to pass. Instead, it takes longer for physicians to complete these electronic medical records. They are portable only by printing out reams of paper and contain many things useful to billing departments, less useful to patients or their doctors.

Some parts of medical practice have improved. OB-GYN physicians are no longer expected to work 100+ hours/week, and patients seem to understand that they are safer if they are cared for by a colleague of their doctor who has slept better. Most spontaneous miscarriages can (or could, before recent states' changes in the law) be taken care of without surgery, making medical care safer for these unfortunately common complications (1 in 7) of early pregnancy. Better cancer care (more surgical specialists, more safe and effective surgeries, different and better anti-cancer medicines) has improved survivorship from what it was in 1980s. Better antibiotics and better use of them has drastically reduced post-operative infection following C-Section delivery. In the 1970s, it took over 10 years from when the measles immunization was first tested until it was approved and in common use, but it took only about 1 year from the time COVID-19 was first recognized as a rapidly fatal epidemic until the time the first vaccine was widely available. Not all vaccine technology is as rapid; HIV vaccines still seem stubbornly difficult and far off.

I still volunteer as Clinical Associate Professor Emeritus at Texas Tech University Health Sciences Center at Amarillo, teaching OB-GYN and Family Medicine residents hands-on skills in management of obstetric emergencies and continuing to work on scholarly activities in OB/GYN publications. I hope to help and serve in ways available and appropriate for a community physician who first delivered babies (as a medical student) in 1975.

(Editor's note: Dr. Paul Tullar grew up in Houston, Texas. He attended undergraduate school at Rice University and graduated from medical school at the University of Texas in San Antonio. He completed an obstetrics and gynecology residency at the Methodist Hospital in Dalla. Paul came to Amarillo as a faculty member at Texas Tech SOM in 2007. Dr. Tullar continued to take care of women, deliver babies, and teach medical students and residents until his most recent retirement in 2020.)

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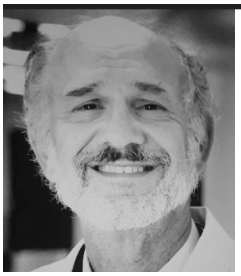

Panhandle Health: The County Medical Society Journal that Wouldn't Die

by Steve Urban, MD, MACP

In June of this year, I was asked by Dr. Alan Blum, professor and endowed chair in family medicine at the University of Alabama (Tuscaloosa), to speak at his "Art of Medicine" humanities series. A former editor of the Medical Journal of Australia and the New York State Journal of Medicine, Dr. Blum wanted me to tell the story of Panhandle Health. My first thought was, "I wonder why. We're pretty small potatoes." But he explained that has been an avid reader of our journal since 1992, after having been invited to speak at the Potter-Randall County Medical Society when he was a faculty member at Baylor College of Medicine. He added that he has admired the stick-to-it-iveness of our journal in a time when fewer and fewer medical society journals remain.

Of course, there's a certain weekly journal published by the Massachusetts Medical Society that still cuts a wide swath, but nearly all state medical society journals are gone. Texas Medicine has stopped publishing original medical articles. County society journals barely exist; Texas now just has four, us included. Uniquely, Panhandle Health has kept its emphasis on scientific articles, rather than on the political, economic, or practice-management aspects that the medical society addresses. While preparing my talk, I decided that the story may be more interesting than I had first thought. Maybe you will think so, too; the following article tells the story of Panhandle Health.

PANHANDLE HEALTH: FOUNDATION

Panhandle Health was the progeny of a May-December marriage. The older partner was the Potter-Randall County Medical Society (founded in 1903), and the young bride was the regional campus of the Texas Tech School of Medicine (SOM). TTUSOM was chartered in 1969; its first class graduated in 1974, and the first building on the Amarillo campus ("the Wallace building") was dedicated in 1978. Panhandle Health was the brainchild of a Tech faculty member—Boston-trained infectious disease specialist Dr. Ed Sherwood—and a former dean of the SOM, Dr. Gerry Holman. Ed was a fiery whippersnapper who believed in evidence-based medicine when almost no one used the term, and Gerry was (in my opinion) the first great regional dean in Amarillo, a highly-respected pediatric endocrinologist who went on to become one of the founding fathers of the hospice movement in the United States (if you don't believe me, read his bio in the spring 2012 issue of Panhandle Health).

I have reviewed founding documents from this time, and these men were emphatic that Panhandle Health should be an academically-focused journal. They established the quarterly format and a 6-8 person editorial board. Their focus on articles (usually review articles) of 1500-2000 words, directed to general practitioners and educated laypeople, still characterizes of our publication. The executive secretary of the PRCMS at that time, DeDe Baum, went along with this crazy idea but knew that she would need help to oversee the publication process and to drum up advertising support. Fortunately, she knew Cindy Barnard, who midwifed this product of the union of PRCMS and Texas Tech into squawling infancy as Panhandle Health (PH) in the fall of 1990. Now, 33 years later, Cindy is the executive director and guiding light of the PRCMS.

Table 1:
Original Editorial Board of Panhandle Health (1990)

Dr. Ed Sherwood, Editor
Dr. Gerald Holman, Assistant Editor
Dr. John Alpar
Dr. Frank Kelly
Dr. James Luce
Dr. Gerald Moriarty
Dr. Pat Penovich
Dr. Rush Pierce

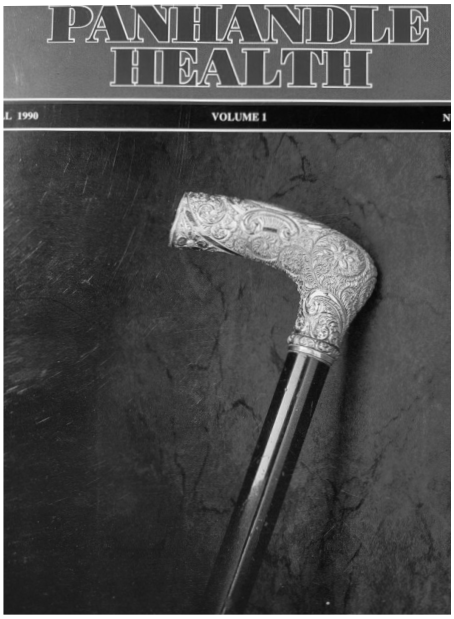

Figure 1: The First Cover (photograph by Frank Leone)

The first few issues of PH were a hodgepodge of articles (i.e., no overarching theme for each issue). Initial issues included reports from the county health department, the Coffee Memorial Blood Center, and other health-related organizations. The first themed issue (spring 1991) dealt with the most pressing public health issue of the day, the AIDS crisis--remember that this was a time when the cause of AIDS was unknown and the mode of transmission was uncertain (could I get it from casual contact with my patient?), when surgeons, hemophil-

iac children and transfusion recipients joined our gay patients in an inexorable march toward death. Soon, all issues were themed, and, before long, the practice of alternating "hard science" with social, behavioral and humanistic topics was established.

DISTRIBUTION & PUBLICATION

Our initial distribution efforts focused on medical society members. From the outset, Panhandle Health has been sent to county medical society members from the Oklahoma Panhandle all the way down to Lubbock. Over time, our subscription list has extended to other healthcare practitioners and to interested laypeople. Today you are likely to see Panhandle Health on the waiting room table of your lawyer, dentist or banker.

Each quarter, we print 3000 copies: 1500 copies for physicians, 700 for laypersons, and the remainder for dentists, other health-related providers, and private businesses. Our target audience has always been the general reader (not the subspecialist), and our style of expression is designed to match. We use jargon-free language if we can to explain sometimes-complicated concepts and procedures. Not always do we succeed, but we try!

From the financial standpoint, our journal was initially a profit center for the medical society; that is to say, our advertising revenue exceeded our production and mailing costs. Now, we just about break even. Printing costs are about $8000 per run. Mailing and other publication costs raise the total to about $10,000 per run. We are fortunate that our impressive cover art, painted (or sometimes photographed) by local artists, is donated in exchange for a wider display of the artists' skills. So far, none of our physician authors has hit us up for an honorarium.

"HARD SCIENCE" ISSUES

We try to dedicate about half of our issues to "hard science" topics that we think will be of general interest—recent issues on advances in oncology (spring 2022) and diabetes (fall 2022) are good examples. When we focus on a specific topic, we try to cover the waterfront—for example, in the recent issue on diabetes, we combined sharply-focused articles (e.g., "Intensive insulin treatment of Type 1 diabetics" and "Distinguishing Type 1 from Type 2 diabetes in children and adolescents") with articles on physical activity and the role of the dietitian/diabetes educator. We want the articles to be balanced and evidence-based; most include 3-5 (sometimes, way more) pertinent references.

It is interesting to review the gamut of topics covered under the rubric of "hard science." We've published three issues on women's health and two dedicated to transplantation (even though only stem cell transplants have ever been done in Amarillo). We've had numerous issues related to "advances"—advances in surgery, in trauma care, in radiology, and in pediatric care, to name a few. Several publications have been devoted entirely to case reports from Texas Tech, in order to give our students and residents their first taste of publication and their first experience with the editor's red pen.

We've dedicated individual issues to topics as broad as the opioid crisis, obesity, and aging and as focused as prematurity and new medical subspecialties. Some articles have addressed basic science topics (you can't get much more basic than Allen Edmunsdson's article on X-ray crystallography in the fall 1992 issue) and some have touched on topics of more regional interest (rural health care, winter-related conditions, etc.).

SCIENTIFIC ARTICLES: OFF THE BEATEN PATH

We've printed several issues dealing with "hard" topics, but approached from a somewhat quirky angle. We've devoted two issues to complementary and alternative medicine (but viewed through an evidence-based lens). Hal Werner once served as the guest editor of an issue devoted to "Controversies in Medicine", where doctors wrote "pro" and "con" articles on topics such as PSA screening for prostate cancer and hormone therapy at the menopause (issues that, interestingly, still generate controversy 25 years later). We've published three issues edited and written by faculty members of Texas Tech's School of Pharmacy, including an issue in the winter of 2021 that detailed cutting-edge research from SOP faculty members. We have looked at cosmetic surgery and procedures ("Extreme Makeup", fall 2006), burnout, substance abuse and behavioral issues among professionals ("Physician, Heal Thyself", spring 2019), as well as dentistry, physical therapy and other allied health topics. Perhaps our most reprinted and requested issue—"Human Sexuality"--came out in the summer of 2011, addressing topics such as sexual dysfunction in women, "low T" in men, discrepant sexual desire in couples, and the bioenergetics of sex. For some reason, our readers seemed to be unusually interested in an issue promising "What's new in sex"!

LESS RIGOROUS TOPICS

Again, a general pattern for Panhandle Health has been to alternate issues dealing with "hard science" with those on the societal, political, and humanistic themes. We've devoted issues to "Cost Management in Medical Practice", "The Business of Medicine" and "Healthcare Reform" (published as the Affordable Care Act was being rolled out). In the winter of 2014, we published an inspiring issue about medical missions, with Alan Keister as guest editor; in this issue, doctors including Richard Bechtol, Roger Smalligan, and Ellen Hampsten told of mission trips that had proved life-changing for doctor and patients alike. I was proud of our Summer 2022 issue, guest-edited by Sheryl Williams, which dealt with "Social Determinants of Health"—i.e., issues such as poverty, homelessness, educational status, and geography (rural vs urban) that profoundly affect the health of our patients. These authors pointed out that the reason America lags far behind other developed nations in healthcare outcomes is not because of technology (in which we lead the world) but because of our failure to deliver this care to people—often disadvantaged people--who need it the most.

SOFTER TOPICS: MEDICAL ETHICS AND HUMANISM

Some of our most popular issues (judged in terms of requests for additional copies and calls to the PRCMS office) have been devoted to medical ethics and humanities. I think that patients just like to know that their doctors struggle over issues like values and quality of life, spirituality and meaning-- just like they do. Our first issue devoted to ethics and humanism came out in the fall of 1995, when Rush Pierce edited "Ethical issues in medicine." The furor surrounding tort reform gave rise to an issue on "Ethical and liability issues in medicine" (this issue came out in the winter of 2002; House Bill 4 was passed in 2003). This issue featured an article by Walter Bridges on the role of the ethics committee and a heartfelt article by Lisa Veggeberg on the care of the indigent patient, entitled "Thoughts from the Boulevard." Our winter 2006 issue on medical humanities included a wonderful reflection by Todd Bell entitled "Stranger at the Bedside"—an article about compassion and humility that I distributed to my medical ethics students at Texas Tech for years.

In the spring of 2000, under the editorship of iconoclastic Dr. Jack Long, we published the first of our "the physician looks at literature" issues, which have been very popular with our lay readership. Reviews in this initial issue ranged from Dr. Long's review of the *Odyssey of Homer* to Mike Ryan's analysis of Charles Dickens' 900-page *Bleak House* to Rush Snyder's critique of the modern classic *Remains of the Day* by Kazuo Ishiguro. Taylor Carlisle decided to stir things up by reviewing William Burrough's explicit and phantasmagoric novel *Naked Lunch*. This issue was followed by our summer 2014 issue, which included topics ranging from *Hamlet* (reviewed by Brian Pruitt) to Virginia Woolf's *Mrs. Dalloway* (reviewed by Jamie Zusman). Our most recent book review issue, from fall 2021, featured fascinating reviews of Grinker's *Nobody's Normal: How Culture Created the Stigma of Mental Illness* (reviewed by Mitch Jones), the Pulitzer-prize winning poetry collection *Twice Alive* by Forrest Gander (reviewed by Phil Periman) and a careful examination of racism in our society, *Caste* by Isabel Williamson (reviewed by Skye McLaurin-Jiang)

Why should doctors even care about literature, and why do patients seem to notice when their doctors write about it? I'll reprint a passage from an article I wrote in 2014: "These stories will help you understand how to elicit the history of present illness; they will help you to know what to pay attention to and what to ignore. They will help you to empathize with your patients, with their fears, with their loss, and with their persistence. That is to say, these stories will reinforce all the important attributes of a physician."

FINALLY, A FEW SELECTIONS FROM MEDICAL HISTORY OF THE PANHANDLE.

In my guest editorial for this issue, I discuss past publications that we have devoted to the history of medicine in the Panhandle, and I won't repeat that account here. But I want to cite passages from three of these articles, just to demonstrate how rich and surprising these accounts can be--especially, when doctors tell about their own lives and experiences. From wartime experiences in Vietnam (viz., Charlie Wike's story in this issue) to encounters with famous people, from involvement in important political and social movements to triumphs over poverty and oppression—these stories are interesting and often inspiring to read.

The first reprint, from the fall 2013 issue, relates to early Panhandle medical history. Librarians from the Museum of the Plains in Perryton helped me find this account from the Ochiltree News, May 26, 1916:

"[Ochiltree] was thrown onto a state of intense excitement last Saturday just as dusk was gathering, by the sound of several shots fired in quick succession in the region of the drug store, and a pall of sadness surrounded the scene where two of our prominent business men [Dr. W.J. Brewer and judge Cap Correll] had just engaged in a duel with automatic pistols, each one receiving a severe wound, but neither being fatally shot."

No detail was omitted from the account: "Dr. Brewer was leaning up against his car, writing a prescription for Bogus Wilbanks…when Judge Correll walked up on the sidewalk…and opened fire on Brewer, who immediately drew a gun and began shooting at Correll. About nine shots were exchanged, only two taking effect, one from each gun."

Shooting a judge must not have been severely frowned upon in those days—or else they really needed a doctor!—since Dr. Brewer moved north with the rest of the town in 1919…There Dr. Brewe continued his practice through the 1930's;

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he experienced a surprisingly peaceful demise in 1953.

My second story comes from the "Physician Diversity" issue (spring 2021),where internist Ako Bradford recounted an anecdote that connects his family with one of the most important social movements of the 20th century:

Ako's father, James "Sam" Bradford was a member of the Tougaloo Nine… in 1961, this group of undergraduates helped desegregate the Jackson (MS) Public Library. They actually attempted to check out books from the "whites only" library! Ako's father and the other participants were arrested, while reading quietly, for "disturbing the peace." At a rally in their support the next day, protesters were bludgeoned and set upon by police dogs; the legendary civil rights martyr Medgar Evers was present at the rally, two years before his murder.

Years later, when the mayor of Jackson offered to expunge the conviction, Sam Bradford replied that he had done nothing wrong and was proud to let the record stand. The example of the Tougaloo Nine led directly to a declaration by the American Library Association that its libraries should be open to all patrons, regardless of race.

Sam Bradford recently passed away at the age of 81. As you can see from the accompanying picture, he and the other members of the Tougaloo Nine have been honored by the now-more- enlightened civic leaders of Jackson. I might never have known about the Tougaloo Nine and its important role in American history if not for my visit with Ako!

Finally, here is a story told by psychiatrist Dr. Mitch Jones. Early in his career (actually when he was a resident, moonlighting the Kansas State Hospital for the Criminally Insane), Mitch was assigned to provide psychiatric testimony for a legal case in Garden City, Kansas. The trial turned out to be the famous "In Cold Blood" murder trial, immortalized by Truman Capote in his nonfiction novel of the same name. Mitch recounted this harrowing anecdote:

Mitch recalls the initial interviews. He was locked in a cell first with Richard Hickock, whom he interviewed for two hours, and then with Perry Smith. After the two-hour examination with Smith, Mitch called out for the jailer. No response. Smith produced an old broom handle (!!!) and raked it across the bars. Again, nothing. 'They must have gone to lunch," said Smith. Mitch was locked in an isolated cell, face-to-face with the man who, a few months before, had pitilessly shotgunned a family of four! To Mitch's relief, Smith then proceeded to sit down and calmly to recount another hour of his story to the young psychiatrist.

Stories of Panhandle medical history, certainly--but with regional and even national resonance. These are the kind of stories you will encounter in the pages of Panhandle Health when we devote an issue to social, historical, or humanistic topics.

CONCLUSION

After my remote presentation to faculty and students in Tuscaloosa, Dr. Blum wrote a kind note: "I'm even more impressed by Panhandle Health and the commitment of the Potter-Randall County Medical Society after hearing the behind-the-scenes story. And I loved how you wove in those stories of great West Texas physicians…Each issue is readable and interesting…You're helping authors to share their knowledge with an appreciative audience as well as to inspire them to submit to national journals if they so choose."

The Potter Randall Medical Society, our friends at Texas Tech, and the editorial board hope to continue providing an up-to-date, scientifically-focused journal to our readers—to our physician readers and our lay readers alike. We are always looking for topics that are both interesting and relevant to current medical practice. Even though we sometimes look back to our local medical history and sometimes forward to new technological advances, we hope never to lose sight of the ethical principles that shore up medical practice: that medical care should be relational, not transactional; that the primary focus should always be on the welfare—physical, emotional, and spiritual—of the patient; that even when we can't cure, we can still care. Although many current trends seem to be pulling us away from our patients, we at Panhandle Health hope to maintain focus on these high principles, principles that have motivated practitioners of the healing arts since our histories were first recorded.

Figure 2. Members of the Tougaloo Nine, at the dedication of a historical marker in their honor. Sam Bradford is just beneath and slightly to the viewer's left of the marker.

History of the Potter-Randall County Medical Society

by Rouzbeh K Kordestani, MD, MPH

How it all started

The Potter-Randall County Medical Society began in 1958 when the physicians of Potter County joined the physicians of Randall County to form the entity we now know. However, the societies have rather illustrious histories mixed with interesting characters and events to note.

Early on, the communities of the Panhandle were sparsely populated. Records show that Amarillo had a population of around 1500 in 1900. The community grew, but slowly, until the oil and gas boom of 1926. With that oil boom, the population grew at a much faster pace, reaching around 15,000. This growth was only further accelerated by industry needs and technological advances of the times. As the population grew, so did the need for physicians. Initially, most of the physicians in the Panhandle were generalists. However, as the population grew, there was a greater need for specialists and sub-specialists. This need was further motivated by Amarillo's location, and the need to service the population of the surroundings five states with access to its more advanced medical services.

Like many areas around the United States, two time periods provided a dampening effect to the general population growth of the Panhandle and in turn of the medical societies. These were in 1918 and in 1944, World Wars I and II, respectively. As many members of the Panhandle community enlisted in the military, so did the physicians. Historical records show that approximately 25% of the physicians of the society were enrolled in the military, serving and being deployed abroad. Unfortunately, many of them did not return, having paid the heaviest of prices for their service.

The first group of physicians and their stories

Looking back at the records available, it appears that Dr. E.A. Jones was the first doctor to set up practice in Amarillo, in and or around the year 1890. He was soon followed by the likes of general physicians Drs. J.W. Cartwright and D.W. Pierson. By 1903, all in all, a total of 19 physicians had moved to Amarillo or to the smaller towns surrounding Amarillo. As it would happen, one night, in a get-together in mid-1903, these same 19 physicians formed the Potter County Medical Society.

Even though the Panhandle seems small and less consequential than larger cities such as Dallas or Houston, some of these early physicians of Amarillo proved to be of significant consequence. One of the first physicians to move to Amarillo was Dr. David Fly. Dr. Fly was very involved in the medical issues of the times and in medical politics throughout Texas. Even though he lived in Amarillo, he was elected President of the Texas Medical Association (TMA) in 1911. Unfortunately, he soon contracted tuberculosis and was unable to finish out his duties and had to relinquish his role as the head of TMA.

Another early physician of note from Amarillo was Dr. William Lockett. Dr. Lockett was the Potter County Medical Society's first President. He had originally moved to Amarillo in 1900 at the spry age of 61. He had perceived a need for physicians and so had moved here to treat the patients of the Panhandle. It is said that Dr. Lockett often found himself daring the terrain to get to his many patients in the canyons and pastures of the Panhandle. He too, like Dr. Fly, found himself dealing with medical issues. Unfortunately falling ill, he was hampered with poor health throughout the rest of his years, but he never relented in his medical duties. Later, he was able to continue to advise the younger generations of physicians moving to Amarillo. He served as a senior physician consultant for many years. For his devotion to the society and to medical education, he was awarded a Gold-headed Cane by a group of the younger members. At the age of 70, as his health was further fading, he asked that his responsibilities to the Society and his cane be transferred to the incoming President. In this manner, he founded a tradition that is still respected today in the medical society in the passing of the golden cane from the outgoing president to the new president.

Like Drs. Lockett and Fly, another physician often remembered in the records was Dr. Charles Ashby. Although he too was a generalist, he was more akin to a "Doc Holliday" character seen from the Western movies. Dr. Ashby was known to be involved in many scrapes and more than his share of gunfights. Because of these shenanigans, it is said that initially he was not allowed into the medical society. After his admittance was blocked, he made a personal appearance at a board meeting and placed a Colt .45 on the desk awaiting the tally of votes. For obvious reasons, it seems that he was elected soon thereafter by a unanimous vote of the other physicians in attendance.

AMARILLO AND THE SOCIETY NOW

As the Panhandle has grown in population, so have the community's needs increased in complexity. Our population has grown from that paltry 1500; now, around 350,000 people call the Amarillo area home. Lubbock has burgeoned to reach a number closer to 450,000. Amarillo and Lubbock are now home to two campuses of the School of Medicine for Texas Tech, and the main campus of the School of Pharmacy is here in Amarillo. Each city boasts multiple healthcare complexes; Amarillo has two large hospital systems (Baptist St. Anthony's and Northwest Texas Health), with one of them acting as the regional trauma center (NTWH). These two healthcare systems are home to hundreds of physicians and medical professionals, and a myriad of medical specialists and sub-specialists. Moreover, Amarillo has two well-established cancer care systems that allow tertiary cancer care as part of much larger national networks. Our hospitals also sponsor multiple residencies including internal medicine, family practice, pediatrics, and obstetrics and gynecology. All in all, the medical system in Amarillo has grown to serve and provide tens of thousands of people with their medical and health care needs.

Amarillo and the Panhandle may have started small, but they have grown tremendously and continue to flourish. As for the medical societies, they continue to prosper and to show that great things can still come from humble beginnings.

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A Publication of the Potter-Randall County Medical Society

Editorial Policy and Information for Authors

Purpose *Panhandle Health* strives to promote the health and welfare of the residents of Amarillo and the Texas Panhandle through the publication of practical informative papers on topics of general interest to most physicians while maintaining editorial integrity and newsworthiness.

Spectrum *The Journal* seeks a wide range of review articles and original observations addressing clinical and non-clinical, social and public health, aspects as they relate to the advancement of the state of health in the Texas Panhandle. Pertinent letters to the editor, news submissions, and obituaries listings are accepted pending editorial review. The Editorial Board accepts or rejects submissions based on merit, appropriateness, and space availability.

Submission process Material should be e-mailed to the editor at prcms@suddenlinkmail.com or mail a hard copy to Cindy Barnard, PRCMS, 1721 Hagy, Amarillo, TX 79106. A recent photograph of the author (optional) and a curriculum vitae or a biographical summary are also to be submitted.

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Enhancing Access to Rare Disease Clinical Trials for Underserved Patient Populations: A Strategy for Equitable Participation

by Adaugo Opiegbe, MD, Karen Cutts, MD, Lewis Kelly, MS, Elizabeth Tilley, PhD, Tetyana L. Vasylyeva, MD, PhD

Background: Access to clinical trials for rare diseases is a pervasive challenge, particularly for patients residing in suburban and rural areas. This issue is acutely evident in the Panhandle region of Texas, prompting the initiation of this project. Its primary objective is to develop a comprehensive strategy that would bridge the access gap for these underserved patients.

Methods: The study's methodology encompassed interviews with both physicians and patients within the target region. It additionally involved the use of pre- and post-participation surveys, designed to extract valuable insights. Data gathered from these surveys were meticulously collected, transcribed into Excel, and subsequently subjected to detailed analysis using SPSS.

Results: Within the Panhandle region, physicians were discovered to be treating a substantial number of patients diagnosed with rare diseases. However, the participation of these patients in clinical trials was disappointingly low. Notably, the primary obstacles encountered by physicians included their limited availability of time during clinical visits and a lack of knowledge about clinical trials. An intriguing revelation was the prevalent reliance on specialists for trial referrals, even though patients expressed a strong preference for referrals from primary care physicians.

The patients participating in the study exhibited a significant interest in engaging in clinical trials. Nevertheless, they confronted substantial barriers, including concerns about potential side effects and the financial burden of travel expenses. There was a prevailing desire among patients for more comprehensive information about trial details, with electronic enrollment and signature processes garnering notable support. Feedback from post-survey patients indicated that the information they received proved to be invaluable.

Conclusion: The study's findings underscore the evident challenges related to referral and participation in clinical trials for patients in suburban and rural areas, particularly in the Panhandle region of Texas. These challenges stem from constraints faced by both physicians and patients. While physicians possessed adequate knowledge about accessing trial information, the inherent time constraints during clinical visits impeded their ability to inform patients effectively. Consequently, patients remained largely uninformed about relevant clinical trials for their specific medical conditions.

The study emphasized a distinct preference among patients for referrals from primary care physicians in contrast to the prevalent reliance on specialists. Despite these barriers, patients demonstrated a resounding interest in participating in clinical trials. Their persistence in the face of these hurdles underscores the immense potential for equitable participation in rare disease clinical trials within underserved areas. This project highlights the pivotal importance of bridging information gaps and improving accessibility to fulfill this potential.

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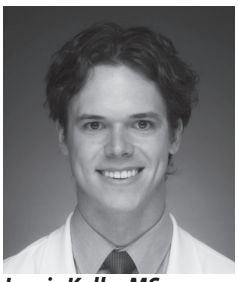

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