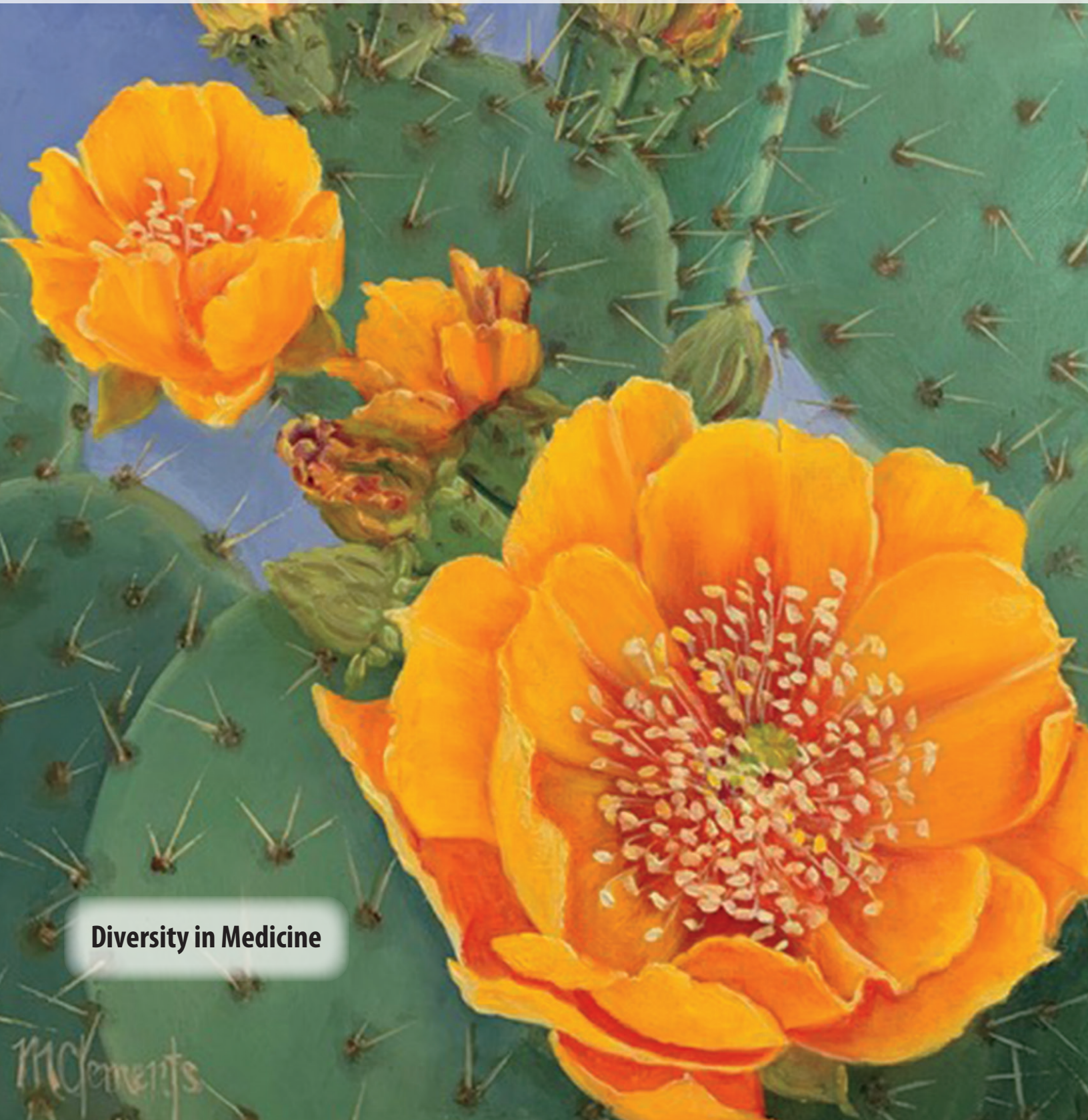
PANHANDLE HEALTH

A QUARTERLY PUBLICATION OF THE POTTER-RANDALL COUNTY MEDICAL SOCIETY

SPRING 2021 | VOL 31 | NO. 2



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Medical Education: University of the West Indies Mona Campus

Residency: State University of New York Health Sciences Center at Brooklyn

Fellowship in Internal Medicine: Mayo Graduate School of Medicine

Haq Nawaz, MD
Gastroenterology and Advanced Endoscopy

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Residency: University of Pittsburgh Medical Center

Fellowship in Gastroenterology, Hepatology and Nutrition: University of Pittsburgh Medical Center

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President's Message

by Neil Veggeberg, MD

Another 3 months has gone by, and the COVID numbers are starting to get a little better. A significant number of people have received their second vaccination. It is my opinion that the fierce debate by the Amarillo City Council that was live-broadcasted helped to convince a large percentage of the local population the threat was real. Having an opposing opinion on the city council compelled the pro-mask members to strengthen their arguments and, in my opinion, made the discussion fairer and more interesting. A recent article in the New Yorker described a similar meeting where the city council in Minot, ND was proposing mask requirements. Their population is about one fifth of ours. According to the article, one of the city councilmen contacted a friend of his who is a physician in Amarillo, TX. The Amarillo physician is reported to have said that you only need to wear your masks in crowded places and on planes. After reading the article, I sent off a letter to the New Yorker that it was the unanimous opinion of the Potter-Randall Medical Society board to support the Mayor's proposed ordinance and provided a link to the ordinance:

Whether it was fated to be or related to the ordinance, the Amarillo Public Health Department COVID-19 Report card (dated 2/11/21) shows that active case curve peaked at or around 12/8/21 and has declined steadily since that time. Our vaccination program has been going well. As of mid February, Potter County has had 7% fully vaccinated and Randall has had 10%. Since there is still no consistently good treatment for COVID, prevention is the best option. This virus appears to be with us for the foreseeable furture, but at least we are making some progress.

ORDINANCE NO. 7893 AN ORDINANCE OF THE CITY COUNCIL OF THE CITY OF AMARILLO, TEXAS: SETTING STANDARDS DESIGNED TO PREVENT THE TRANSMISSION OF COVID-19 AS A PUBLIC NUSIANCE; AUTHORIZING CIVIL AND CRIMINAL ENFORCEMENT; AND DECLARING AN EMERGENCY MEASURE; PROVIDING FOR SEVERABILITY; PROVIDING FOR REPEALER; PROVIDING PENALTY; PROVIDING FOR PUBLICATION AND EFFECTIVE DATE.

Editor's Message

by Steve Urban, MD

In the fall of 2020, *Panhandle Health* published an issue containing interviews with several "seasoned" physicians regarding their experiences in practice and in retirement. The issue was a success as far as it went. Unfortunately, as Dr. Margaret Thurmond-Anderle pointed out, what this issue did NOT include was anything about any doctor who was not an old white man. In this, she was spot on. This was chiefly my fault, but in part it also reflected a reality—that, in the early days of Panhandle medicine, almost every doctor in every specialty was a Caucasian male.

When we look back a hundred years, we are shocked at what America and the Panhandle missed by not opening our arms to under-represented groups. Where would we be in American medicine without cardiologist Dr. Helen Taussig, neurosurgeon Dr. Ben Carson, or public health leader Dr. Helen Rodriguez-Trias? Where would we in the Panhandle be without Dr. Leora Andrew or Dr. Gayle Bickers, without Dr. Hagos Tekeste or Dr. Joaquin Martinez de Arraras? The answer is: our medical community would be poorer, and our patients less healthy. So, in this issue, we want to lift up and to honor diversity in our physician community. We could recognize many more, but we are limited to fifteen articles. The Editorial Board hopes that you enjoy reading these stories and that you recognize the obstacles that many have had to overcome – and, in some cases, are still overcoming – to bring the best of modern medicine to our Panhandle communities.

Our Next Issue Of *Panhandle Health*

Features:

Looking Back: Covid Pandemic One Year Later

Executive Director's Message

by Cindy Barnard, Executive Director

Our topic in this issue is entitled "Diversity in Medicine". Articles deal with the many different physician ethnic groups as well as diverse physician sexual identifications. Diversity among medical school applicants and graduates continues to grow. For example, five years ago, Texas Health Professions Resource Center reported that the national physician population was 60% white, 8% Hispanic, 6% African-American, and 24% Asian and other groups. At that time, Texas physicians were 42% white, 40% Hispanic, 12% African-American, and 6% Asian and other groups. Obviously, Texas was not keeping up with national demographic changes. While Texas is becoming a "majority-minority state", we still are lacking physicians and other health care professionals representative of national demographics.

It is often the case that minority physicians tend to practice in minority neighborhoods. It is no surprise that patients tend to rate appointments with doctors of the same ethnic groups as more satisfying. However, Texas has a problem with reaching a truly diverse workforce, possibly because medical schools have to work against powerful forces outside of medicine (i.e. problems in lower income public schools, low family expectations, poverty and prejudice). There is also a shortage of minority physicians nationwide, along with a shortage of all physicians. We must be "willing to employ the same kind of rigor we apply to studies of science and medicine to efforts designed to eliminate bias and racism and promote diversity and inclusion" (Stanford University, Dr. Jonathon Lassiter). An interesting statistic is that women in medical school have now surpassed men, but the growth of African-American applicants still lags behind other groups. Although we now live in a diverse modern age, we still struggle to achieve "cultural competence. In non-medical professions, diversity is simply a social concern, but in the medical field it is a matter of health and well-being". Sadly, despite improvements, sex and ethnic disparities continue to persist, but the good news is that progress does continue, albeit slowly but surely.

Due to the dreaded virus, we cancelled our 118th Annual Meeting of the Potter Randall County Medical Society, traditionally held in January or February. Our 2020 and 2021 President will remain Dr. Neil Veggeberg. President-Elect is Evelyn Sbar, M.D., and Secretary-Treasurer is Nicole Lopez, M.D.

On March 30th, we will celebrate Doctors Day which was first observed in Winder, Georgia, in 1930. According to Wikipedia, Eudora Brown Almond, a physician's wife, decided to declare a day in honor of doctors. The red carnation was chosen as the symbolic flower for National Doctors Day. In 1958, a resolution commemorating Doctors Day was adopted by the U.S. House of Representatives, and in 1990, legislation was introduced both in the House and Senate to establish a National Doctors Day.

In 1991, President George Bush signed S. J. RES #336 which became public law 101-473, forever designating March 30th as National Doctors Day. President Bush wrote in the Proclamation, "In addition to the doctors whose names we easily recognize, there are countless others who carry on the quiet work of healing each day in communities throughout the United States—indeed throughout the world. Common to the experience of each of them, from the research specialist to the general practitioner, are hard work, stress, and sacrifice. All those who serve as licensed physicians have engaged in years of study and training, often at great financial cost. Most endure long and unpredictable hours, and many must cope with the conflicting demands of work and family life." President Bush urged that all Americans "observe this day with appropriate programs and activities".

On a different note, I have inadvertently neglected to thank Dave Autry of Swifty Communigraphics and Steve Trafton, Trafton Printing (now Cenveo) for their efforts in publishing *Panhandle Health*. We could not have gotten our magazine to you without them!

And finally, we continue to monitor and follow the guidelines recommended by the CDC and our state and local health departments. The well-being of our friends and families is our top priority. Despite the excellent efforts in vaccinating our residents, our Health Department needs us to continue to WEAR YOUR MASKS and practice social distancing. These small steps are not that difficult, and you may be saving not only your own life, but that of your neighbors. PLEASE BE SAFE!

The 2020-2021
Panhandle Area Physician Rosters
are on sale for $10.00
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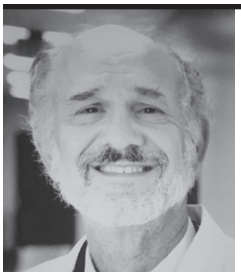

Hagos Tekeste: Pioneer African Physician

by Steve Urban, MD

Hagos Tekeste has been a vital member of the Panhandle medical community since he and his family moved here in 1983; he was the first African physician to establish a long-term practice in our area. Hagos came first as a faculty member in the internal medicine department at Texas Tech and, after his 3-year contract was up, went into solo practice of gastroenterology. When I was still taking call and needed a gastroenterologist, I was always relieved to hear Hagos's voice on the line; I knew to expect expert assistance, promptly provided, with a word of thanks for the consultation. Hagos's life story is a fascinating one, starting in Ethiopia, proceeding through some of the great educational institutions in the world, leading finally to our area. His journey to Amarillo and the excellence of his care for 38 years attest to the importance of drawing the best minds from across the world in building a strong Panhandle medical community.

Hagos Tekeste's story begins in Asmara, which at that time was in northern Ethiopia but is now the capital of the nation of Eritrea. Hagos's parents were educators and instilled a love of learning in each of their five children, all of whom are now professionals (i.e., nurses, engineers) in the United States. While Ethiopia is famous for its mixture of faiths – Coptic Orthodox, Jewish, and Muslim coexisting throughout much of its history – Hagos's parents were practicing Seventh Day Adventists and as such represented a minority of the Christian population. Hagos's paternal grandfather had been converted from Coptic Orthodoxy to the Seventh Day Adventist faith by a Swedish missionary in the early 20th century. With the help of the Adventist church, grandfather Tekeste started an elementary school in his home village, where Hagos attended as a child. For those who forget, Ethiopia has been a Christian nation for longer than any nation except for Armenia – longer, even, than the Roman empire of Constantine the Great. Since Adventists eschew not only alcohol but also caffeine, Hagos remembers with a shudder the barley-based tea served at family meals!

Hagos' professional life was transformed by two institutions. The first was a British boarding school in Addis Ababa – the General Orde Wingate Secondary School (I know Wingate as the leader of the Chindit forces in Burma during World War II, but he is famous in Ethiopia and Eritrea for helping expel the brutal Italian colonial regime in the 1930's.). Admission to the Wingate School was based on nation-wide competition; Hagos remembers the three-day bus trip to Addis Ababa for the examination and interview, when he was 14 years old. For most interviews, you wear your best suit, but financial need was a criterion; so Hagos's parents dressed him in his shabbiest attire. When he got there, he found a whole cadre of scruffy interviewees – news had gotten around! Another complicating factor was language; Hagos's home language wasn't Amharic (the official language of Ethiopia) but was instead Tigrinya, the language of the north (eventually, of Eritrea). Fortunately, the exam was in English, and Hagos had spent hours studying English and math with his father, who had been a math teacher for many years. Hagos aced the exam and was accepted into the prestigious academy, receiving the Haile Selassie Prize Trust scholarship to help defray costs. A constant theme, reiterated by our various interviewees – the power of education to transform a life.

The second important institution was the U.S. Foreign Service, which sponsored the African Scholarship Program of American Universities (ASPAU) from 1961 to 1970, to help many of the emerging and newly independent African nations. In this program, top-scoring high school graduates were selected to take a standardized test and to interview for a scholarship that would allow them to enroll in U.S. colleges. Applicants to the program did not apply to a particular university, but to the scholarship itself. Hagos relates an interesting anecdote from this time. A few weeks after submitting his application, he was summoned to the Ministry of Education and was handed an acceptance letter. Hagos soon ran into a friend, an American Peace Corps volunteer, who asked, "What school did you get?" Hagos related the name of a school that he had never heard of. The volunteer reached for the letter. "Holy cow, you're going to Yale!" he exclaimed.

The early 1970's represented a time of considerable racial tension in America. Yale president Kingman Brewster had famously irritated Vice-president Spiro Agnew by maintaining that a black man (in this case, Bobby Seale of the Black Panther Party) could not get a fair trial in the United States. This took place a few months before Hagos arrived at Yale, and, although he remembers a kind of de facto segregation in the campus cafeteria, Hagos's most pressing concerns at the time were: (1) dealing with culture shock and homesickness and (2) learning the demanding curriculum

Hagos' four years at Yale provided a wonderful experience and many life-long friends, but the culture shock was tremendous. Hagos recalls his first experience with snow; he was perplexed and a little worried when the crystalline flakes began to fill the New Haven sky one fall afternoon. His dormmates, on this as on

many other occasions, were helpful and supportive. They guided him through this strange American climate and culture – for instance, inviting him to their parents' homes for the holidays. Hagos regularly attends reunions and keeps up with many of his Yale friends.

Medicine was not initially on Hagos's radar, but, growing up in Eritrea, he had heard stories from his older sister about her experiences as a nurse. Once at Yale, Hagos majored in Molecular Biophysics and Biochemistry, not really planning to be a doctor. He was re-introduced to the idea of medicine by his classmates with the same major. Since he had already taken the necessary pre-med courses, the idea of being a doctor became more appealing. When it came time to take the MCATs, Hagos again excelled, gaining admission to medical school at the prestigious University of Pennsylvania.

Hagos spent 9 years in Philadelphia – medical school, internal medicine residency and G.I. fellowship. Medical school at Penn was challenging. Like most of us, Hagos remembers it mostly as a time of unending study. About 10% of his classmates were Black, but he was the only one with Ethiopian/Eritrean heritage. He remembers making student rounds at the Pennsylvania Hospital – the oldest hospital in the United States, established in 1751 by Benjamin Franklin and others. Hagos fell for gastroenterology when, on a 4th year elective; he got to look through one of the new fiberoptic endoscopes – primitive by today's standards, but providing a fascinating new view into the human body. Internship, residency and fellowship in Philadelphia's Presbyterian Hospital followed. One bright light in this time of constant work and study occurred when Hagos met his wife-to-be, Abrehet, an undergraduate student at a nearby Philadelphia college. Although they both grew up in Asmara, they had never crossed paths there. They married in 1979, and four wonderful and successful children have proceeded from their union.

In 1983, Hagos read about an academic opportunity in Amarillo as an assistant professor at the Texas Tech University School of Medicine. He and Abrehet brought their infant daughter to Amarillo for the interview. The trip did not start auspiciously; on the taxicab ride to the Philadelphia airport, their cabbie warned them to hold on tight to their baby, as she was at risk of being blown away by the Amarillo gale! Hagos was recruited by department chair Dr. John Higgins, but he especially remembers internist Dr. Rush Pierce as an important factor in choosing Amarillo. Rush befriended the Tekestes, helped them move in to their first house, and invited them to Polk Street United Methodist Church. Again, Hagos worked at Texas Tech for 3 years before venturing into the world of private practice.

Today, Hagos practices modern medicine without abandoning the old-style virtue of personal care for the patient. He takes his time, pays attention to the history, and knows his patients on an individual basis. He calls his patients personally to give them their post-endoscopy pathology results. To provide one example, Hagos recently saw a patient with dysphagia. Remembering seeing the patient's father – over 20 years before – with the same symptoms, he pulled the old chart (he keeps ALL his old records!). The chart confirmed that their symptoms were identical and that the father had had esophageal cancer; fortunately, the son had treatable but pre-malignant Barrett's esophagus.

Although Hagos has had wonderful experiences with his patients throughout his career, he has also encountered some instances of racism. While on-call at the hospitals, he recalls a few patients who did not want to be seen by a Black physician. Another instance occurred when Hagos first started his private practice. A new patient once arrived and asked the receptionist whether Dr. Tekeste was Polish! When she informed him that the doctor was from Africa, the patient said, "I'll be right back." He never returned.

Today, Hagos Tekeste looks back on his 38 years in Amarillo with satisfaction and a sense of accomplishment. He and Abrehet value Amarillo as a stable and prosperous community and a great place to raise their four children. They are delighted with the quality of education their children received at St. Andrew's Episcopal School, Amarillo High School and the Amarillo College Suzuki String Program. All four children have since received their undergraduate and graduate degrees, with one currently in medical school.

Hagos is an individual physician who takes care of the individual patient – he doesn't have an assembly-line practice. But, like all of us, he is part of a larger society. To me, Hagos' story embodies a simple but important truth – that a diverse physician practice enriches us all. Hagos has been my physician for almost 20 years (ever since I turned 50 – enough said!). I value our friendship, and I value having him as my doctor. I value the richness of being able to draw expertise from all over the world – from India, from the Middle East, from Africa – to bring skilled and caring physicians like Hagos Tekeste to Amarillo and to the Panhandle.

Update on the COVID 19 Pandemic

by Scott Milton, MD

As everyone is painfully aware, the pandemic continues not only in our community but across this country and the rest of the world. This historic event has affected every facet of our lives and, in my opinion, will likely continue to impact our lives well into the future. I'm often asked when our lives will return to normal; I usually answer this with the question "what is normal?". In other words, I believe this historic pandemic will forever alter our lives in some fashion. I would imagine that, at this point, most of us know of someone who has died or has become severely ill from COVID 19. Let's review some of the data regarding this pandemic over the last year.

At the time of this writing, there are well over 640 deaths caused by COVID 19 in this community. While the number of deaths has slowed somewhat over the last several weeks, this number continues to systematically rise and will continue to do so for the near future, as we know that there's continued community spread and hospitalizations. Our community has gone through two separate waves thus far. The first wave occurred in spring 2020 and peaked in early May. This initial wave heavily impacted two groups: workers in large enclosed spaces such as packing plants, and frail elderly individuals confined to nursing homes or similar facilities. Hospitalizations from COVID 19 peaked during the first week of May with just over 100 individuals hospitalized between BSA and Northwest Texas hospital. Hospitalizations began to fall at that point and reached a nadir in early September with only 20 to 25 patients hospitalized between the two facilities. From that point forward, the pandemic surged and peaked in our community in late November with 200 patients admitted to BSA and around 130 patients admitted to Northwest Texas hospital. Active cases in the community peaked around this time as well, at more than 8000 cases. Fortunately, there has been a slow and steady decline in these numbers since then; currently there are approximately 39 patients at Northwest Texas Hospital with COVID 19 and around 40 patients at BSA. The health department continues to follow around 2600 active cases in our community.

PANHANDLE HEALTH

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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.

Conflict of Interest Authors must disclose any conflict of interest that may exist in relation to their submissions.

Journal Articles Manuscripts should be double-spaced with ample margins. Text should be narrative with complete sentences and logical subheadings. The word count accepted is generally 1200 to 1500 words. Review articles and original contributions should be accompanied by an abstract of no more than 150 words.

References References to scientific publications should be listed in numerical order at the end of the article with reference numbers placed in parentheses at appropriate points in text. The minimum acceptable data include:

Journals: Authors, article title, journal, year volume, issue number, inclusive pages.

Books: Author, title, place of publication, publisher, year.

Web sites: URL of the site and the date the information was accessed.

Other sources: Enough information must be included so that the source can be identified and retrieved. If not possible, the information for source should be included parenthetically in the text.

Illustrations Illustrations should be black and white only with complete-sentence legend.

Previously Published Material Short verbatim quotations in the text may be used without permission but should be quoted exactly with source credited. Otherwise, permission should be obtained in writing from the publishers and authors for publishing extensive textual material that was previously published.

Editing Accepted manuscripts are edited in accordance with the *American Medical Association Manual of Style*.

Letters Letters will be published at the discretion of the editor and editorial board. The length should be within 400 words. References should not exceed five. All letters are subject to editing and abridgment.

News News should be e-mailed prcms@suddenlinkmail.com or mailed to Cindy Barnard, PRCMS, 1721 Hagy, Amarillo, TX 79106.

Obituaries Listings of deceased members of PRCMS with highlights of their contributions are published when adequate information is available.

Point of View Opinions published in any article, statement, or advertisement are the responsibility of the author and shall not be construed by any means to represent those of the editors or the medical society.

We have learned a lot about treatment of this infection, which differs radically based on the disease phase. During the initial viremic phase, antiviral therapy, as with remdesivir or monoclonal antibody, is most effective. The immune dysfunction phase (sometimes called the cytokine storm) is the second phase and usually occurs in severely ill individuals. Dexamethasone is appropriate for the treatment of these individuals. Remdesivir can only be administered intravenously and usually given in five-day increments. It is reserved exclusively for hospitalized patients. Monoclonal antibody therapy should be utilized in patients recently diagnosed with COVID 19 who have a high risk of disease progression. These individuals should not be requiring oxygen, and this treatment should be given within 10 days of diagnosis. Monoclonal antibody therapy is reserved for those individuals in an outpatient setting only. Those considered at high risk of the disease progression include those older than 65, immunocompromised persons, obese patients with a BMI greater than 35, or patients with conditions such as diabetes, chronic kidney disease, chronic lung disease, heart disease, or hypertension. The use of systemic steroid therapy in the first 7 to 10 days of symptoms will prolong the viremic phase and likely worsens clinical outcomes. To be clear, there is no conclusive data supporting the use of hydroxychloroquine, ivermectin, vitamin supplements or zinc.

The old saying "an ounce of prevention is worth a pound of cure" could never be more true than when discussing the current pandemic. The medications listed above for the treatment of COVID 19 are not particularly effective when treating severely ill patients. Therefore, the standard mitigation tools that have been mentioned many times by me and other healthcare professionals remain the most important method in reducing the burden of this pandemic on our community and health care resources. Wearing a mask, especially those specifically manufactured for healthcare workers, is most important in reducing the spread of the SARS CoV-2 virus. Social distancing and avoiding crowds, especially indoor crowds, is also extremely important in mitigating the spread of this virus. Our own experiences throughout this pandemic continue to support the use of these mitigation tools. For example, wearing a facemask was universally adopted by all of those individuals in the hospital from early on in the pandemic. Thereafter, exposures requiring quarantine of employees most commonly occurred from community rather than in the hospital exposure, with rare exception. And those exceptions only occurred when facemasks were removed against protocol.

Clearly the most important development in the battle against this pandemic has been the introduction of vaccines. In this country, there are currently two vaccines available for the prevention of COVID-19. The Pfizer-BioNTech vaccine was the first one approved and became available in this community on December 15, 2020. Shortly thereafter, the Moderna COVID 19 vaccine (mRNA-1273) became available. They are both lipid nanoparticle(LNP)-encapsulated mRNA vaccines; both are highly efficacious in preventing symptomatic disease and efficacious in individuals over age 65. The Pfizer vaccine is approved for individuals aged 16 and older in two doses 21 days apart. This vaccine must be stored at -70°C, which hampers widespread distribution in my opinion. The Moderna vaccine is approved for those 18 and older in two doses 28 days apart. It boasts similar efficacy but is easier to store at -20°C and is currently the vaccine in use through our health department. Contraindications include anaphylaxis or immediate allergic reaction to a previous dose or a vaccine constituent, including polyethylene glycol or polysorbate. Vaccination should be deferred for recipients of monoclonal antibody or plasma therapy for 90 days after administration. Adverse effects include pain at the injection site, fatigue, headache, muscle pain, chills, joint pain, fever, injection site swelling/redness, nausea, malaise, and lymphadenopathy. For pregnancy, the risk of contracting the disease while pregnant is greater than any known vaccine risk, and there are no preliminary reproductive or development concerns. For immunocompromised individuals or HIV patients, I endorse the use of either the Pfizer or the Moderna vaccine, understanding fully that there may be reduced immune response in these individuals and therefore safety and efficacy profiles are unknown. To date our health department has vaccinated more than 40,000 individuals, apparently leading the nation when considering the percent of individuals in our area who have received at least one dose of the vaccine. This is been accomplished by using our civic center as a large walk-in vaccination clinic. Our city has been designated a distribution hub by the state of Texas and has been receiving 5000 doses weekly. From my understanding, we will continue to receive similar amounts of the vaccine heading into the spring.

Finally, a word about variants. The CDC currently discusses three separate variants on their website. The United Kingdom (UK) variant was reported in the United States at the end of December 2020. It appears to be at least 70% more contagious and may confer an increased risk of death. In South Africa, another variant has emerged independently. This was reported in the US at the end of January 2021. There is some evidence that this variant may be less susceptible to monoclonal antibody treatment. A Brazilian variant has also been detected; it appears that some of the mutations of this variant may affect its transmissibility and antigenic profile, which may affect the ability of antibodies generated through a previous infection or vaccination to recognize and neutralize the virus. This variant was identified in the United States at the end of January 2021. The emergence of these variants stresses the importance not only of strain surveillance but of rapidly deploying the vaccine to halt reproduction of the virus. From my understanding, the mRNA vaccine technology is highly adaptable and could be quickly altered in order to address these variants. This is reassuring, but the lack of surveillance in this country is disturbing. Let us all hope that widespread vaccination in this country will lessen the impact of these variants.

Stay safe!

Rouzbeh K Kordestani, MD, MPH

by Rouzbeh Kordestani, MD, MPH

Tell us about your background – Your family, your upbringing.

I am Kurdish/Iranian by birth. I was born in Iran and lived my early years there. I completed my early schooling in Tehran where I was enrolled in the British Academy.

My father was a well-known construction engineer there. My mother was dedicated to the home, raising myself and my younger sister. My mother's family was well known in Iran since many of them were generals and part of the Shah's regime.

We lived there until the Iranian Revolution in 1979 at which time we escaped to the United States. We settled in the West Coast like so many Iranian immigrants. I completed my schooling through high school in the San Francisco Bay Area.

How did you become interested in medicine? Were there particular events or experiences that impelled you towards medicine?

I was actually not that interested in medicine, not specifically. I was interested in tinkering with things – engineering. I always wanted to understand how things worked. I also liked working with my hands. My schooling was in engineering, specifically genetic engineering. At UC Berkeley, the field of genetic engineering was just starting. Many of my early teachers soon left UC Berkeley and started the company Genentech. I went a different direction. After much soul-searching and shadowing a few family members who were physicians, I decided to follow a career path in medicine.

Tell us about your medical training – premedical, medical school, and/or post graduate (residency/fellowship). Describe obstacles you had to overcome to become a doctor. If you started your education outside the United States, what particular challenges did you face in getting a residency?

I started my medical school journey at Tulane School of Medicine in New Orleans. I decided to go there since I reasoned that the craziest and most dangerous place I could go to school would probably be the place that would teach me the most. After looking at Charity Hospital and their ER and the amount of trauma they were seeing on a daily basis, I was in love. I had to go there. Thankfully, Charity and Tulane proved to be the best place for me. I loved medical school and learned how to care for people and to understand medicine and my part in it.

Early in medical school, I decided that I would be a neurosurgeon. I soon focused all of my energy in that direction. Towards the end of medical school when I did my away rotations, I found out that there is some snobiness in the hierarchy of schools. When I finished my rotation at Johns Hopkins on the Cushing Service, I was told that I had done a great job, but that Johns Hopkins would never pick someone from Tulane. I was a bit disappointed but learned to adjust to the reality.

I did not initially match into neurosurgery but was given a position out of the match at UCLA. I was overjoyed. I had to start my time in neurosurgery with a research year. I moved to Los Angeles and joined the department and was quickly impressed by the sheer intellectual power at institutions like UCLA – WOW!!! The centers of knowledge. I completed my research year and was supposed to start my residency there. Unfortunately, I found out that, because of a power struggle between the different chairs, two individuals – myself included – would not be put into the rotations. I would have to find my own way. I switched out of neurosurgery and started my general surgery training at UCLA. I continued my general surgery in San Francisco, transferring to the University of California at San Francisco. At the end of my career at UCSF, I chose to continue my education by going into plastic and reconstructive surgery.

Where did you go after residency? What was your motivation to go to fellowship? Any particular challenges there?

Again, after residency in general surgery, I chose plastic and reconstructive surgery. I was initially supposed to be in Miami, but the match had different ideas. I was chosen by the University of Oklahoma. In Oklahoma, I truly found myself a fish out of water. Being from the west coast, much more progressive in thought and also being of middle eastern heritage, I was definitely out of my element. I did my best to move forward and learn. It was tough. I knew I was going to have to mind my step right from the start. In my Oklahoma Board of Medicine hearing, the first question that I was asked was "If I had ever been a member of Al-Qaida?" The answer was no, of course. But when I looked around the Boardroom and noted that the only persons in the room were other members of Middle Eastern descent – doctors who were going to get asked the same non-sense questions – I realized that the environment would be challenging. I tried to move on from my early experience. I found that the patients in Oklahoma City were like any other group of patients – normal people with normal problems trying to go through their lives. At times, though, the comments from the patients would leave you awestruck. I recall one instance when a patient was trying to compliment my care by saying: "Dr. Kordestani…We like you…You're one of the good terrorists!" Comments like that would leave you a bit shocked. In all fairness, I reasoned that they simply did not know what they were saying. All in all, though, the education at OU was wonderful and I learned a great deal.

Describe how you came to Amarillo to practice medicine. Who recruited you? What aspects of medical practice in the Panhandle were attractive to you?

After completing residency in plastics, I was contracted to start at one of the new affiliated hospitals at UCSF in San Francisco. This was going to be the culmination of my career. I would practice at home, close to my parents and get going. It was an ideal set-up. Unfortunately, the State of California ran out of money and the new governor (Mr. Arnold Schwarzenegger) put a hiring freeze on state positions. I did not realize it, but that applied to me and my contract as well. When I called, I was told that my contract was now null and void. I was heartbroken. In response, I did what any smart, overly trained unemployed person would do. I booked a one-way trip to Argentina and Brazil – I wanted to escape from this nonsense.

After my brief jaunt in South America, I was contacted by Dr. Mike Dixon (of Amarillo fame). Mike had trained at OU the year before me and was an Amarillo native. He told me that Amarillo and specifically Northwest Texas Hospital was looking for a dedicated reconstructive surgeon. He also noted that he would be open to helping me set up my practice. I was not interested at first. However, when there were not too many jobs open, I reasoned that I could not be too choosy. I soon arrived, interviewed and was given the position.

I started in Amarillo in November of 2004. I initially worked with Mike. The work was good and consistent, and the pathology was diverse. After about 18 months, though, I had parted ways with Mike and had started on my own. There were many reasons for that separation. Many who knew Dr. Dixon back then would understand (none of us had an idea of what would occur years later). I decided to stay in Amarillo because I found the medical community to be very supportive. I found the area quaint, and I found the living situation truly unique. I also had the chance to buy a very unique home here and I loved it very much.

What are some of the challenges that you have faced in moving to the Panhandle? What are the biggest "culture shocks" you have encountered? If you have children, what challenges did you face in raising them?

After living in a handful of larger cities, settling into Amarillo and the Panhandle was initially a shock. I was raised in very diverse backgrounds, in cities from Tehran, to Kuwait City, to Los Angeles, to New York. Transitioning to Amarillo was very rough at first. But I learned a lot of lessons from other doctors who had made the transition and soon learned to look at the big picture. When I would call my fellow classmates and listen to their frustrations about traffic and work conditions, I realized that many of those issues no longer applied to me. I learned that my job and my promise was to take care of people. I could take care of people in the Panhandle just as well as I could take care of people in Los Angeles. Instead, I focused on trying to be the best doctor and practicing surgeon I could become. I learned to focus less on the little things and focused more on the big picture.

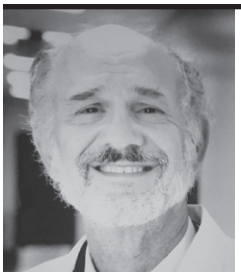
Unfortunately, I have no family and no children. The transition to the Panhandle though was tough for another reason. My nuclear family is very tightly-knit. I have several siblings. After deciding to live in the Panhandle, I was surprised that no one wanted to visit me! They found every excuse for me to come to them. In fact, my father visited once early on and then left in two days. When I asked him why, he answered, "your town is just boring." I am sad to say I think they missed out on many of the attributes of the small-town life. To each their own, I would say.

Any regrets you have had over the years?

No, not really. Regret is a harsh reality. There are many things that I would do differently in my life, especially with the knowledge I have now. But I believe everything happens for a reason. I am who I am because of all the experiences that I have had the fortune/ misfortune of going through. Each has been a learning experience. I am an amalgam of all the good and all the bad.

Any advice you wish to give to the young professional out there who are interested in going into medicine?

I would give the advice my father gave me. By training, he is a civil engineer. When I was a kid, I told him that I wanted to be rich, really rich. He looked at me with his ominous eyes and said that he hoped that he and my mother had raised me better than that. I asked him then what he would use as his motivation. He noted wisely, "be the best at what you love to do, the rest just comes." He was not wrong.



Ako D. Bradford, MD

by Steve Urban, MD

General internist Dr. Ako Bradford is one of the outstanding young doctors in the Panhandle. He is smart, diligent, and capable. Honors and accomplishments such as Physician of the Year at Northwest Texas Hospital and Fellowship in the American College of Physicians attest to his professional excellence. But it is his servant's heart—his willingness to engage with his patients, staff, and peers as human beings—that truly sets him apart from the crowd. Ako's experience grew out of the deep South, was nurtured in a historically black Southern college, and was enriched by professional training, first at the National Institutes of Health (NIH), then at the Medical College of Virginia, and finally at Texas Tech in Amarillo. In Amarillo, he has excelled in three worlds—residency training, work as a hospitalist, and now a career as an outpatient primary care general internist. Ako Bradford provides an inspiring example of how fortunate we are to have a diverse population of physicians to deliver care to our Panhandle patients.

Ako Bradford was raised in Tougaloo Mississippi, a suburb of Jackson. His parents grew up in the South at the peak of Jim Crow times, when black Americans were reminded of their imposed second-class status in every bus station and department store. Both of his parents graduated from Tougaloo College, a historically black school (in a sense, Mississippi's version of Morehouse or Fisk); both became career civil servants for the state and U.S. governments. But his parents were embroiled as well in the great social justice issue of the day—the civil rights movement. Indeed, Ako's father, James "Sammy" Bradford, was a member of the Tougaloo Nine (I am embarrassed to have to admit that, until I did research for this article, I didn't know about the powerful legacy of the Tougaloo Nine). Briefly, in 1961, this group of undergraduates helped desegregate the Jackson Public Library. They actually attempted to check out books from the "white's only" downtown 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 (he was murdered two years thereafter). Years later, when the mayor of Jackson offered to expunge the conviction, Sammy Bradford replied that he had done nothing wrong and was proud to let the record stand. The example of the Tougaloo Nine led directly a declaration by American Library Association that its libraries should be open to all patrons, regardless of race.

Ako's childhood was generally happy one; he felt supported by his family and community. Ako remembers one occasion, however, when, on the first day of middle school, his best childhood friend (a white child) turned his back on Ako and walked away, Understandably, he was hurt, but counsel from Ako's father brought home the lesson: "Never be afraid to be a crowd of one." Several year later, as a junior in high school, Ako was accepted into the prestigious Mississippi School for Math and Science in Columbus MS. As one of 14 black students in his class, Ako was challenged, then empowered, by the rigorous curriculum.

Despite offers from several universities, including Xavier in New Orleans, Ako decided to follow his parents' example and to matriculate at Tougaloo College. This was a good decision; Ako treasures the experience of attending a historically black college. For one thing, many of the role models in the black community—including Ob/gyn specialist Dr. Wesley Prater and 7th district court Judge Robert Gibbs—were graduates of Tougaloo. In addition, the college emphasized the sciences and encouraged its STEM students to seek out summer internships. As a result, Ako did summer research at Yale (after his freshman year), at Harvard (after his sophomore year) and, after graduation, at the NIH. Indeed, for two years after graduation, Ako stayed on at the NIH as a research assistant in the lab of nephrologist Dr. Mark Knepper. There, he participated in the isolation and characterization of the aquaporins and several other renal transport proteins. His name appears with that of Dr. Knepper and others in four peer-reviewed papers as a result.

Another happy outcome of Ako's time at Tougaloo involves persistence as well--but didn't start out so favorably. In 1992, a science seminar at Tougaloo College had attracted students from several universities. Science, it seems, was not Ako's sole pursuit. He tried to make friends with a couple of attractive young women, including one from Delta State University, but didn't make much headway. Three years later, Ako met one of the girls at the NIH. Not remembering her name, Ako's sauntered up with, as he says,"macho bravado." "Hey, girl" he began, trying to work his way around the sticky "name" issue. "Don't worry, Ako", the self-possessed young woman replied, "It doesn't bother me that you forgot my name." Ako was impressed: What a memory! What good taste in men! Ako was smitten by young Dawn Mitchell, and he was elated to discover that her laboratory was just one floor above his at the NIH. Amid micropipettes and Sprague-Dawley rats, they fell I love and maintained a long-distance relationship even after Dawn left to attend medical school at the University of Tennessee. They married seven years later, in 2002. Ako laughs, "I

haven't forgotten her name from then to now!"

After his 2 years at the NIH, Ako applied to and was accepted to medical school at the Medical College of Virginia in Richmond. Ako remembers being awed by the capabilities of his fellow students—ex-film producers, Army Rangers, nurses, Nave SEALs, and many more. Ako's previous experience at the NIH, as well as the intellectual challenge involved, attracted him to internal medicine. The work was hard, but he loved the sense of accomplishment of working through a difficult diagnosis.

Ako's time in Richmond was generally fulfilling, but he did meet with some instances of racial prejudice. One episode, in particular, is telling. Ako was on an infectious disease elective. The attending often taught using case studies and vignettes, but his cases betrayed racial bias. "A 57 year-old white banker with unexplained fever after a business trip to Asia" would often be followed by "A 27 year-old homeless black man with substance abuse and hepatitis C." Ako stayed after rounds and pointed out the obvious bias; the attending maintained that he'd never even thought about his own racial bias, but promised to do better. On another occasion, a white classmate referred to "colored people" in a discussion group. Afterwards, when approached by Ako, the student admitted that he'd never been in a class with an African-American student before!

Ako and Dawn came to Amarillo in 2002 for residencies—Ako in Internal Medicine and Dawn in Family Medicine. Ako excelled at TTUSOM, being chosen as chief resident and setting a shining example by his positive attitude, his clinical acumen, and his insistence on treating all patients with respect. In Ako's time at Texas Tech; several experiences stand out. He remembers being warned about stern and demanding attendings such as endocrinologist Dr. Hal Werner and consulting surgeon Dr. Dick Franklin. Ako learned, however, that these doctors simply expected residents to take their work seriously—to know their patients and to prepare their presentations ahead of time. For the prepared resident, these doctors were great sources of knowledge. Ako also remembers learning a life-lesson from nephrologist Dr. Steve Kelleher. As is the wont of enthusiastic residents, Ako was eager to present a "great case" from the night before. Dr. Kelleher listened carefully to the technical presentation, then brought the team back to the patient. "I want you never to forget that every 'great case' is a human tragedy."

Ako can recall very few instances where being African-American was an issue. On one occasion, a black woman saw him at the hospital in his white coat

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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.

and took him for an orderly. Ako introduced himself as Dr. Bradford and offered to help the woman. She was astonished; "I've never seen a black doctor before," she admitted. Ako uses this anecdote to point out how important it is for black patients to have access to a health provider who "looks like them." An abundant literature suggests that minority patients, often suspicious of a medical system that has mistreated or discriminated against people of color, display increased trust, better compliance and improved outcomes when cared for by physicians they identify with.

Ako and Dawn never expected to stay in Amarillo after their residencies, but they were won over by the warmth of our Panhandle community. Ako remembers being impressed when, driving to the hospital, he saw a police officer stopping to help a distraught motorist change her flat tire. He also appreciated the diversity of residents in the IM program. Finally, Ako and Dawn were looking for a stable the community as a place to raise their family. In other cities like New Haven or Richmond, the hospitals would be buffeted by a cacophony of sirens; Amarillo's medical center, Ako noted, is surrounded by churches, parks, and banks.

After residency, Ako stayed in academia for three years, attending at the Amarillo VAMC and working with IM residents. He then moved over the NWTH and helped set up the hospitalist program there. Ako excelled as a hospitalist. He knew that patients were often in crisis and that they would appreciate an attentive provider. Medical expertise, combined with kindness and humility, led to Ako's being chosen as NWTH's physician of the year in 2011. He recalls excellent colleagues such as Dr. Scott Dalston, Dr. Adeline Jou Tindou, and Dr. Chandana Yalamanchili. Despite hectic schedules, they worked seamlessly as a team.

When the NWTH hospitalist group moved en masse to BSA in 2014, however, Ako chose to go a separate way. He contacted Drs. Alan Keister and Reddy Biggs and was welcomed into Amarillo Medical Specialists, where he continues his private practice to today. Ako treasures having long -term relationships with patients. With Dawn's assistance, he has learned office management; he likes the fact that he gets to set the tone in the clinic. Ako knows that treating the patient with kindness at all levels—from the front office, through the nursing staff, to the phlebotomists—is crucial to making the patient feel cared for in his practice.

One cannot write about Dr. Ako Bradford without mentioning the role that religious faith and practice play in his daily life. I vividly remember taking Ako to breakfast on the first morning of his recruiting visit to TTUSOM. Very quietly, but firmly, he bowed his head in brief silent prayer before our interview began. It was clear to me then--and has become confirmed over the years--that Ako a man for whom compassion, humility, and servanthood are not just words but principles to live by. During our interview, Ako recounted an interesting story about his faith to me. In 2008, while trying to decide whether to leave the VA for the hospitalist group at NWTH, he prayed for guidance. In his heart he heard "It will not be easy." That wasn't the answer he was looking for! Again, he prayed—same response. Ako accepted these words as a call, decided to go with NWTH, and has never regretted the decision!

After living in Amarillo for almost 19 years now, Ako and Dawn feel at home. Dawn practiced medicine for four years after her FM residency, then decided to stay at home with daughter Eden. Ako often calls on Dawn's judgment and financial acumen to help with problems at the office. The Bradfords get back to Mississippi on occasion to visit their parents, although Eden seems to be the number one attraction. Ako and Dawn ponder about the plusses and minuses of encouraging Eden to attend a historically black college, as Ako and Ako's parents did, but he laughs and admits that Eden will probably have something to say about the issue.

Ako Bradford is an invaluable member of the Amarillo medical community. After my retirement, he has assumed the care of many of my former patients. I get feedback from these people at the grocery store, and they are as impressed as I am by his kindness, his willingness to listen, and the way he puts his higher principles into practice. Ako doesn't see himself as the representative of the African-American community (although, like Dr. Prater in Tougaloo, he undoubtedly serves as a role model for many young black students). He sees himself as an individual who, in his daily life and in his profession, continually strives to bring his medical practice into accord with his values and with his principles.

Biography: Dr. Teresa Baker

as told to Paul Tullar, MD

Dr. Teresa Baker was born in 1973 in Hereford Texas, and raised in a family of four children. Her mother passed away when she and her siblings were young, and her father raised the children while working as a golf professional and banker. She went to elementary, intermediate and high schools in Hereford. She attended Texas A & M in College Station, but came home each summer to see her family and to take college courses at West Texas A&M and Amarillo College. Today, she is a proudly enthusiastic about the value and benefits of community-based colleges.

As might be expected for a young person growing up in Hereford, her connections with the medical community were first through physicians in Hereford: Dr. Jan Swan (her family's pediatrician), Dr. Charles Allison (emergency room physician), and Dr. Howard Johnson (family practice physician in Hereford). Dr. Swan was the first female physician she knew and was Teresa's role model. Dr. Baker says that Dr. Allison and Dr. Johnson were always willing to offer their time as mentors and to answer questions; they were very encouraging when she was in undergraduate school, encouraging her to become a physician. When she applied to medical schools in 1995, she recalls Dr. Allison calling to visit and saying, "You need to go to the very best medical school you can get in to, and surround yourself with the very best people you can." After four years she received her medical degree from U.T. Southwestern Medical School in Dallas in 2000. She was considering both pediatrics and obstetrics as her life's work, asking again for her Hereford doctors' advice. Again, she was told, "You should go into the branch of medicine that makes you most happy to serve."

With that advice, she did her obstetrics & gynecology residency at Parkland Memorial Hospital in Dallas, also affiliated with U.T. Southwestern. Her residency was hard, with incredibly long hours. She experienced the same difficulties that any other resident, male or female, would experience and understood that every resident's social life and family life were "on hold" until residency was finished. She feels that she didn't experience discrimination as an OB resident, as she was just one of 18 doctors in her four-year-long OB-GYN residency at Parkland. Toward the end of her 4th year of her residency, she was in Hereford one weekend, visiting her dad, when she telephoned up to Texas Tech University in Amarillo and talked with Dr. David Barclay, then the OB-GYN Department Chair. On the spot, Dr. Barclay offered her a faculty position as Assistant Professor in the OB-GYN department in Amarillo.

Once she arrived in Amarillo, Teresa realized that the level of medical work was no less challenging than that in Dallas, and that she had a very good mentor in Dr. Barclay. He gave her good advice in surgery as well as good advice in work-life balance, and she feels that "work-life balance" has been the most difficult part of her career.

Baker grew up with her husband TJ Head in Hereford. After returning to Amarillo, they married and have 4 children. "We are a good team. TJ has always been very understanding and helpful. The irregular hours and unpredictability of obstetrics make our family life challenging at times, but TJ has always been supportive of my career. We started our family 10-15 years later than many of our peers – which has been interesting – but we laugh a lot and, truthfully, he has been by my side through this whole journey. He knows what it took to get here and what it takes to sustain us. I couldn't ask for a better husband."

She denies ever having felt any discrimination in medicine, but does state that limiting work hours has helped medical education become more humane. She says that the "80 hour work week" came into effect just after she completed residency, and that very few of her colleagues in residency had children simply because "all we had time to do was work." Since the advent of the "80 hour work week" for residents, the adjustment for life outside the hospital "has been accepted and normalized" – thus acknowledging that work-life balance is critical for the mental health of physicians but also for patient safety. She feels that the doctor-patient relationship is still important and tries to attend the majority of her private patient's deliveries. Nevertheless, she feels that her patients understand that they may be better served by a fresh physician, if she has been "on task" for too long. She notes that the development of the role of hospitalist/ laborist has the potential to ease some of the lifestyle challenges that obstetricians face. "Many young physicians are discouraged from obstetrics because of the lifestyle. I think that is a shame. It is such a joyful field most of the time, and the rewards that come from helping a mother/child through childbirth produce a life affirming feeling. I just think we as a profession are going to have to come up with a way to allow our lifestyle to be more appealing to the younger generations of physicians."

Since finishing her residency training, she has progressed from Assistant Professor (2004) to Associate Professor (2010) and then to Professor (2019). She feels that she had the great fortune of being mentored by Dr. Barclay, Dr. James Van Hook, Dr. Usha Sethi, Dr. Bob Kauffman and countless other mentors. While working at Texas Tech, she began to work with Dr. Tom Hale in the Infant

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Risk Center at Texas Tech in Amarillo. They have partnered in research as well as clinical trials, and have built a service that is used around the world by breastfeeding women and the clinicians who take care of them. "It is such a unique service that the Infant Risk Center provides. To have the chance to work with a world-renowned researcher like Dr. Hale is something I never anticipated as I made the decision to join the faculty in Amarillo. This has been one of the most synergistic relationships of my professional life." She points out that, in university medicine, promotions come mostly with research and publications. For a busy obstetrician this can be very challenging. "The recruits that I visit with are surprised when I tell them I often go home for lunch or that I can walk out of the hospital and, 10 minutes later, be at one of the kids' functions – yet still be able to practice medicine and build a research portfolio. I think that is one of the truly exceptional perks of living and working in Amarillo, where you don't have to sit in traffic or drive 30 minutes to get home yet at the same time have a wonderful academic community and hospital."

When asked how she feels her upbringing and culture have affected the way she practices medicine, she quotes author Malcom Gladwell, in his book "The Tipping Point", that we succeed because of our upbringing and the examples set by our parents and community. She says that her father worked incredibly hard to care for, support and raise her and her siblings. She says that he woke up, took care of them, went to work every day, and that education was expected of them all. "We knew we were all going to get an education – it was the expectation. I am trying to emulate dad's example as TJ and I raise our children. Unconditional love was abundant and the value of education was understood. But my favorite thing he said every day when he let me out at school was 'kill 'em with kindness'. Those are the things I want to teach my kids too." She feels that her culture, summarized by faith, work ethic, community service and family, is the culture of the Texas Panhandle, and that it has been the focus of her professional and personal life. When asked if she has any regrets, she says that she regrets being "so one- dimensional." She notes that "over half of our job in the practice of medicine involves public relations – getting along with people", and states that "college and medical students who have some 'real life' experiences do a better job of communicating with patients. Plus, we as physicians spend the majority of our lives in the hospital. I think it would be good to have some other life experiences as well."

Dr. Baker, in addition to a busy obstetrical private practice, research portfolio, and raising four children with her husband T.J. Head, is interested in teen pregnancy, postpartum depression, and promoting preventive medicine for the women of the Texas Panhandle. Finally, as the Residency Program Director, she is interested in medical education and in the process of humanizing the training experience.. For more information, her Faculty Profile may be found at: https://www.ttuhsc.edu/medicine/amarillo/obstetrics-gynecology/faculty.aspx .

Dr. Paul Tullar is a Clinical Assistant Professor of OB-GYN at TTUHSC-Amarillo, and has had the privilege of working with Dr. Baker for 13 years. He has served on the Editorial Board of Panhandle Health for over 10 years.

POTTER RANDALL COUNTY MEDICAL SOCIETY (PRCMS) OFFERS HELP TO TROUBLED PHYSICIANS

If you, or a physician you know, are struggling with addiction, depression or burnout and are unsure what to do or whom to contact, the Potter-Randall County Medical Society is here to help. We offer face-to-face confidential sessions with the PRCMS Physician Health and Wellness Committee, made up of your physician peers who know and understand recovery. Please don't struggle alone when help is a phone call or an email away. Whether you are calling for yourself, your practice partner, or as a family member of a physician, contact Cindy Barnard, PRCMS Executive Director, at 806-355-6854 or prcms@suddenlinkmail.com. Membership in PRCMS is not required.

Dr. Griselda Camacho: A Medical Journey

by Taru Bharadwaj

With her bright personality and energy, Dr. Griselda Camacho spoke to me about her medical journey. Dr. Camacho practices internal medicine in Amarillo, TX, and she has made a positive impact on so many people. However, it was a long and sometimes challenging path for Dr. Camacho, and one she so graciously told me about. Born in Durango, Mexico where her family owned a ranch, Dr. Camacho and her family moved to Booker, Texas when she was just four. Because her whole young life was centered in Booker, Dr. Camacho visited cities like Amarillo with wide-eyed wonder; at the time, she did not know that she would be able to pursue a career in the city. She grew up loving to read and learn, but, due to the traditional environment she was raised in, she did not often see women with careers. There was a lack of educational guidance, and young Dr. Camacho had little understanding of what her future options were; at the time, the traditional route of marrying and raising children at home seemed like the only option. Despite not seeing many women in her community pursue careers, Dr. Camacho explains, "I knew early on that I wanted to get an education. I wanted to have a career."

In spite of the cultural hurdles, medicine still found a way into Dr. Camacho's life. Her exceptional English allowed her to translate for her family, especially in the Emergency Room. Much of her early interest in medicine stems from the fact that she came from a large family. According to Dr. Camacho, in a big family, "there are always going to be some illnesses, and I think that in itself played a big role," as she was able to serve as an interpreter when her brother was admitted for retinoblastoma or when her mom and her other brother struggled with asthma. She often observed the hospital atmosphere and noticed that there was confusion between her family and the healthcare providers. These experiences influenced her, and in college she

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finally decided that medicine was what she wanted to pursue. During her undergraduate years at West Texas A&M, Dr. Camacho met Dr. Mubariz Naqvi, another acclaimed panhandle physician; she accompanied him during his rounds and participated in his research. Dr. Camacho cites this period in her life as having a large influence over her interest in medicine.

After she decided medicine was the career for her, she realized that getting into medical school would be one of her biggest obstacles, but not for the reason that most people encounter – the hardest part was convincing her family. Initially, it was a challenge even to convince them into allowing her to go to college. She had made a deal with her mother that she would go to the same college as her brothers, so that she could cook and clean for them, and they could keep an eye on her. From her small town, it was uncommon for people to attend college, especially Hispanic girls. Then, applying to medical school came with its own tough demands. Dr. Camacho did not know many people who could guide her; her academic advisor did not provide much aid. Finally, she found a program at Quillen College of Medicine, where select students, including Dr. Camacho, could attend a summer program where they could study for the MCAT and learn about the application process; this program was a great help for her. Interestingly, many of her professors discouraged the students from applying to medical school, telling them to stick to paramedical programs. Of course, the ambitious Dr. Camacho overruled this advice, especially after her anatomy & physiology professor told her to apply to her dream schools. Because of this, she applied to, and was accepted, at UT Southwestern in Dallas, where she completed medical school as well as her internal medicine residency. When asked about facing discrimination, Dr. Camacho said, "there's always some discrimination" – sometimes from patients and sometimes from colleagues; she cites that this is a common experience as a woman within the medical world. Because she's gone through and overcome this type of discrimination her entire life, Dr. Camacho said that she is usually unfazed by any prejudice.

After practicing at UT Southwestern as a hospitalist for a short time, Dr. Camacho and her husband decided to move back to the Texas Panhandle. Both of their families live in the Panhandle, and she feels that this area of the country is her community. In the Panhandle are the people that she wants to help and to live alongside; she came back to her roots to serve the area out of a deep sense of connection. However, moving back into this area came with more hurdles.

She loved the academic setting at UT Southwestern, but moving first into private practice in Amarillo was an obstacle: "that was such an eye-opener... and it ultimately didn't make me happy." She found joy in an academic atmosphere rather than the business-like attitude that often accompanies private practice; working in an environment where she was surrounded by learning and teaching was important to her. Thus, after about a year, Dr. Camacho joined the internal medicine department at Texas Tech; so she could return to a place where she was constantly learning and working with medical students and residents.

Dr. Camacho also discussed the challenges of balancing her career with being a parent. At UT Southwester, she worked 12+ hour shifts, but also had seven days off. She then took three months off to spend time with her newborn daughter and her other children. Dr. Camacho firmly believes that one can be a fine doctor and a good parent at the same time – if they find the right balance. While it could be a challenge, she has no regrets about either her ambitions as a doctor or her life as a mother of three wonderful children. She has also been significantly affected by the COVID-19 pandemic. Dr. Camacho is busy as a physician during the day and tutors her son, who is in kindergarten, every evening for 3-5 hours at night, since she does not want the pandemic to hinder his education. This again shows the testing nature of balancing career life with family life.

One thing that has grounded her through her busy life is her Mexican heritage: "I love the Mexican culture." In Booker, the rich Mexican way of life always surrounded her through food and lifestyle. Every year there is a town-wide fiesta celebrating the Mexican culture. Because of this, she finds comfort in connecting with her culture. She says, "In Mexican culture, family is really important… people would be neighbors with their family." During Thanksgiving, her whole family packs into her home to celebrate. Through Mexican music, art, food, and lifestyle, Dr. Camacho finds comfort and peace. Her heritage also helps her in her medical practice. Dr. Camacho deals with many social issues and has noticed that her patients feel especially comfortable sharing their problems with her. Her background allows her to seamlessly communicate with many of her Spanish-speaking patients without experiencing a language or cultural barrier. For example, if a patient is diabetic, she can fully explain their condition to them and answer their questions without the need for a translator. This allows for a greater bond between herself and her patients, increasing the amount of trust between them. Dr. Camacho is also more understanding towards her patients; when she was younger, she saw her family leave the hospital in confusion because of the language and cultural barriers, so she ensures that none of her patients ever leave with the same feeling.

Despite her challenges with breaking the stigma in her small town, getting into medical school, balancing her life as a physician and a mother, and tackling the pandemic, Dr. Camacho deeply loves what she does. Her connection to her family and culture have largely grounded her during the most stressful times. Dr. Griselda Camacho encourages all medically-inclined students of all backgrounds to work hard. She says, "there's always a way."

Dr. Thien Vo

by Scott Milton, MD, FACP

Dr. Thien Vo is a pulmonologist and critical care specialist. He is an assistant professor of medicine in the department of internal medicine at the Texas Tech Health Sciences Center in Amarillo and has been on faculty since his hiring in 2016. His story is fascinating and is truly an American success story.

Doctor Vo was born in Vietnam in 1974, just one year before the fall of Saigon and the end of the Vietnam war. Dr. Vo's father, having worked for the Americans during the war, was imprisoned for six years thereafter in a concentration camp. During this time, Dr.Vo and his family were left destitute and struggling to survive. The struggle for survival continued after his father's release from the communist concentration camp. Dr. Vo describes living most of his childhood on a boat, having very little food or clothing, and moving in with relatives in order to receive an education. He was able to graduate from high school in Vietnam. He moved to America at age 20 and spoke no English. He was able to repeat high school after arriving to the twin cities region in Minnesota, his new home. He enrolled in the University of Minnesota and, while going to school full-time, worked three jobs in order to support his parents. He initially applied to pharmacy school but was encouraged by a professor to follow his dream of becoming a physician, and he was accepted to medical school at the University of Minnesota.

Dr. Vo remembers becoming ill as a child and being treated initially by traditional methods by his mother and village healers. This treatment included the use of various leaves and herbs obtained from the forest around his village. His family was only able to obtain access to western medication by selling their small rice farm and taking him to an urban hospital. He received modern care and medication and recovered. At that moment Thien became determined to pursue a medical career and a knowledge of western medicine.

Dr. Vo received all of his medical training in the University of Minnesota system. He received multiple awards for his academics during this time. He describes learning English and the

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American trait of talking as much as listening as the largest obstacles he had to overcome. His native culture had taught him to listen to superiors and not interact vocally. He learned, especially as a third-year medical student, to engage with residents and attending physicians verbally. Any previous perception that he lacked knowledge or was a poor student was changed quickly upon learning this new American skill.

Dr. Vo has experienced discrimination many times from patients who do not trust him because he is nonwhite. He has been able to overcome this by showing patience and respect and calmly discussing the patient's disease process and demonstrating his knowledge and skill in providing a cure.

Dr. Vo was recruited to Texas Tech by the Regional Dean, Dr. Rick Jordan, the Chairman of Medicine at the time Dr. Roger Smalligan, and his current partner Dr. Kishore Yalamanchili. He met Dr. Steve Urban and was so impressed to meet the author of the study guide "PreTest Internal Medicine" that he had used as a medical student. In addition to this, he describes Amarillo as a nice peaceful city with very friendly local residents. He realized that Amarillo was a perfect place for him to raise his family, he and his wife Dr. Lylla Ngo have always favored a smaller city.

The life of a Pulmonary/Critical Care specialist is a busy one. Caring for critically ill patients is a challenging task that requires long hours and dedication. In addition to this, Dr. Vo teaches residents and medical students while they are rotating through the intensive care units. As one can imagine, trying to balance patient care and teaching as a difficult task. Dr. Vo takes great pride in teaching these young physicians and is gratified by the fact that many of these young physicians choose to specialize in Pulmonary/Critical Care and have shown superior performance when compared to other residency programs.

Being raised in Vietnam, where the benefits of Western medicine were not available, has caused Dr. Vo to become truly dedicated to providing knowledge to his patients about their illnesses. He believes, and rightly so, that this is the most effective way to prevent their illnesses from worsening. Practicing medicine is an honor, a privilege, and a joy to Dr. Vo. He was raised under a communist regime, and he has seen firsthand the oppression and scarcity rendered by such a system. In our community he works hard to serve Amarillo and to show his appreciation to Texas Tech, this community, and the United States, the country that has provided him these opportunities.

One perplexing behavior that Dr. Vo has noticed while living in this country is the lack of understanding or appreciation of the health care available to the citizens of this country. One great example is the COVID 19 vaccine that our healthcare System produced in such a short period of time. Only the most advanced technology can accomplish such a feat, and many other countries are still waiting for a vaccine. Furthermore, coming from a country where many children become ill from infections that are preventable by vaccination, Dr. Vo has a hard time understanding why many US citizens refuse to take advantage of vaccinations for their children.

Another challenge that Dr. Vo faces is impressing upon his own child the privilege of living in America. A free education is available to every child in this country, unlike in Vietnam. Having a roof over his head and plentiful food was not always available to Dr. Vo during his childhood, and trying to teach his own young child to be grateful for these essentials is a challenge. I must say, as a parent, the teaching of gratitude to children is one of the most difficult tasks that any parent faces. Indeed, trying to understand the hardships endured by Dr. Vo as a child is difficult for me as an adult. I can only imagine the frustration felt by Dr. Vo when he wonders if his own child truly appreciates the privileges experienced every day by living in this country.

In closing, Doctor Vo wants everyone to understand how grateful he is to have the opportunity to live in this country and to practice medicine. He has never regretted choosing medicine as his career. He loves living in Amarillo and serving the people of this area. He takes great satisfaction in caring for critically ill patients and teaching young physicians the skills necessary to do the same. He would like all the readers of *Panhandle Health* not only to understand but to fully appreciate the privilege of living in this community and in this country.

Olga Smirnova, MD

by Sheryl Williams, MD

I have had the great pleasure of knowing Dr. Olga Smirnova for the past twenty years. She is currently a hospitalist at Baptist St Anthony's Hospital. The story of how she chose medicine and her path to Amarillo began at age 17 when she enrolled in Ivanovo State Medical School in Russia. Medical school in Russia is more intense that here in the US – six days a week with strict discipline and you were "better off not to get pregnant in school". Olga was influenced by her mother to become a physician. Her father was an architect, but her mother was a cardiologist and later District Chief Medical Officer of all the clinics. Her mother told her the story of her grandfather, who was an engineer in a glass factory. He was drafted into the army during World War 2 and was captured by the Nazis as a prisoner of war. He was later rescued but, on returning to Russia, was imprisoned in the Gulag as a political prisoner, as Russian soldiers were not allowed to be captured. He survived his "rehabilitation" and went on to become a successful engineer in the glass industry; his technology was in use for decades in Russia. His advice to Olga's mother was "to go to medical school. I got through two prisons and I learned that medical doctors are respected and can survive even in prisons". Drastic advice, but certainly a valuable life lesson.

On graduating from medical school at age 23, Dr. Smirnova spent a year in Internship. She then entered a fellowship in Infectious Disease and practiced in Russia for 14 years before moving to the United States. Her first hurdle was learning English. "I learned very quickly the American way- you can't say 'you cannot' before you try! There I was listening to radio only in English, watching movies only in English, watching Fox News, etc. In one year, I applied for the ECFMG exams; I was reading medical textbooks daily starting in the morning and falling asleep with them at night. That was the most exciting studying time in my lifetime! I was practically craving to read medical textbooks. During medical school I was studying just to pass exams and graduate. With my 14 years of experience, reading about medicine opened my eyes to several difficult patient cases and gave me a better understanding of academic medicine. I was not sure if I could pass the ECFMG exam, but I was definitely enjoying reading and learning medicine with a more mature approach."

After passing the exams, Olga was accepted to an internship at Long Island College Hospital in Brooklyn, NY. She faced unexpected pitfalls such as medical abbreviations. "My Russian friends gave me a warning to beware about 'pidgin language' used by medical providers in the US. Learning from textbooks where they use full terms, it was very difficult to understand verbal directions such as "order treatment for A-fib" or "check for *C. diff*". I would look lost on rounds, and it took time to figure out what they were talking about – atrial fibrillation or *Clostridium difficile*. It's easier to understand an abbreviation when you see it than when you hear it. I did not experience any discrimination in my medical training. I am a strong believer that you have to prove yourself. Hard work, dedication, and responsibility build your good reputation. It's how you earn respect."

The big city of New York was not where Olga wanted to practice. She was raised in a small city and wanted to return to a smaller town. Amarillo's Texas Tech Health Science Center Internal Medicine Department had posted a second year opening for their residency program. On coming to interview, she was "immediately impressed with people from Texas. The first individual I asked for directions was a nurse from radiology at Northwest Texas Hospital. She dropped what she was doing and walked me through a long hallway to the place I was looking for and did it with a smile on her face. It definitely overcame my expectations. Dr Steve Urban interviewed me and offered me a position. I did not know it then, but with time realized it was a blessing for me to move to Amarillo. The main aspect of practicing here in the Panhandle area was and still is – the people. I was planning to continue my training at some fellowship. However, the more I listened to Dr. Urban, the more I was falling in love with Therapeutics (Internal Medicine) – the Queen of Medicine."

Finishing residency, Olga joined the Amarillo Diagnostic Clinic. "The best part was practicing in the 'clinic from the future' with everything under one roof, including access to any labs, any imaging studies, and multiple outstanding specialists. I loved it as much as my patients did. I stayed almost five years at ADC with no regrets – great memories and great experience. At that time, though, the hospitalist program was starting up at BSA and Dr. Bill Neilson made me an offer I could not turn down. The main reason for changing from outpatient to inpatient care was the attraction of a more dynamic, thrilling and exciting practice – my kind of personality!"

"I have been practicing medicine for almost 35 years. I have no regrets about choosing this career. I enjoy it! But there were certainly some culture shocks in changing practice from Russia to the US. I did not have access to much technology in the USSR. We had X-Rays, EKGs and stethoscopes. It was very challenging for me to learn multiple advanced imaging studies. It made medicine more exciting and adventurous combined with

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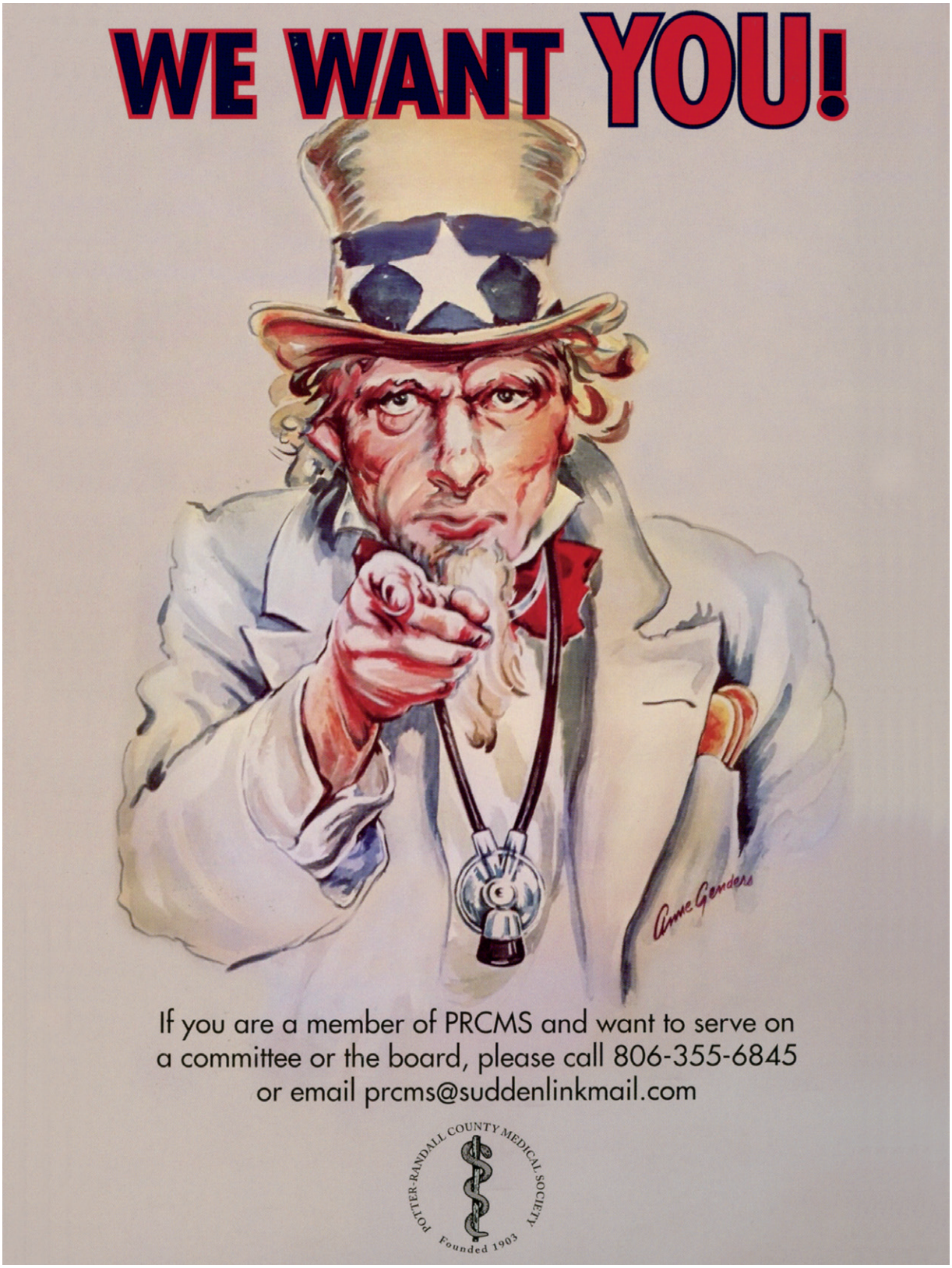
advanced treatment and surgical procedures. This is what makes American medicine one of the best in the world. Another difference was that, in the USSR, it was not allowed to tell patients if they had terminal conditions such as stage 4 cancer. We were trained to lie to patients even if they were directly asking if they had cancer. A doctor could be punished if they told a patient the truth about a terminal disease! It has changed now in Russia; however, when I first came to the US, I had to learn how to deliver bad news."

"My advice to young medical students is more than 100 years old. The truth remains that many medical conditions are beyond cure; so the sentiments of Dr. Edward Trudeau from the late 19th century remain the mainstay of practicing medicine: "To cure sometimes, to relieve often, to comfort always.'"



Srini Reddy, MD, Oncologist

by Rouzbeh K. Kordestani, MD, MPH

Tell us about your background – Your family, your upbringing.

I was born in India. I am the oldest of three children. My mother is a housewife and father was an elementary school teacher. From early on, both of my parents emphasized the importance of education in our lives. I started my schooling locally until the fourth grade. During the fourth grade, I was able to merit a national scholarship which allowed me to attend one of the best boarding schools in India.

How did you become interested in medicine? Were there any particular events or experiences that impelled you towards medicine?

During my early school years, I found the concept of the healing arts fascinating. I found the ability that physician seemed to have to address ailments and suffering to be extraordinary. This initially inspired me to pursue a career in medical field.

Tell us about your medical training—premedical, medical school, and/or post graduate (residency/fellowship). Describe obstacles you had to overcome to become a doctor. If you started your education outside the United States, what particular challenges did you face in getting a residency?

Getting into medical school is very competitive in India. To get into medical school, one has to place in the top 1% in the entrance exam nationally. I was fortunate enough to be accepted into medical school. While there, I was given the additional privilege of being awarded as the best incoming student into my medical school class. I was therefore elected to represent my class for the first 2 years. Through this honor, I was able to organize several medical education camps to help lay people understand preventive care.

After completing medical education in India, I had to go through several exams including the USMLE to be able to apply for a residency in the United States. I had to travel to Bangkok, Thailand to take the USMLE exams, as they were not offered in India at that time. Moreover, the exams were offered only twice a year. If one missed the deadline, he/she had to wait an entire year to take the next exam.

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After finishing medical school in India, I came to the United States and began my training in internal medicine at St. Francis Hospital in Evanston, Illinois. I completed my training there and then chose to work as an internist in Port Huron, Michigan. Later, I became a hospitalist in Austin, Texas.

My initial years in the United States were tough. During internship, we had to work long hours (7 AM to 5 PM the next day, when on call) and take call every fourth day. The current ACGME limitations in regards to residency hours did not exist back then. I can honestly say that my internship was the toughest year of my entire medical training.

What were some of the things that you found interesting during residency? What did you find difficult during these same years?

As an internist, I had the chance and the privilege to see complex hematological and oncological problems. Many of these cases were intellectually stimulating and challenging to diagnose. Even though these cases were interesting, when I had to convey the cancer diagnosis to the patients and their families, I was stricken by the sadness, despair and hopelessness. This gave me a new perspective. Thankfully, many of these same patients were able to be successfully treated by my oncological colleagues and made it to remission.

Where did you go after residency? What was your motivation to go to fellowship? Any particular challenges there?

After residency and my short time in Austin, I decided to follow my initial interests in oncology. I first joined MD Anderson Cancer Center as a research fellow for 1 year. Following this research stage, I was able to secure a fellowship in hematology/oncology at University of Kansas Medical Center.

After being in practice as an internist for almost 6 years, going back into fellowship in oncology was a difficult decision. At that time, my children were still very young. I had to give up my job and the job security that came with it to join the research group at MD Anderson. During my one-year research fellowship, I would work during the week from Monday to Friday in Houston; then I would quickly make my way to Austin over the weekend to work moonlighting hours as a hospitalist. I can truly say that it was hard. However, I can also say it was worth it, because I was able to pursue my interest in Oncology.

Describe how you came to Amarillo to practice medicine. Who recruited you? What aspects of medical practice in the Panhandle were attractive to you?

After completing oncology fellowship, I joined the Texas Oncology team in Amarillo. I had a strong desire to come back to Texas to practice oncology. At that time, the Texas Oncology team was looking for a physician through whom they could grow their breast cancer program. Fortunately, I have a special interest in breast cancer management, having sub-specialized in breast oncology while at Kansas Medical Center. It seemed like a perfect match and a worthwhile opportunity to start my career in Amarillo.

Texas Oncology has proven to be a wonderful place to work. The teams work and interact like an extended family, where everybody cares for each other's well-being and supports one another during both good times and bad.

What are some of the challenges that you have faced in moving to the Panhandle? What are the biggest "culture shocks" you have encountered? If you have children, what challenges did you face in raising them?

After living in much larger cities, I thought it would be difficult to transition our family to start over in Amarillo. Contrary to what we initially thought, we were able to quickly make friends and become a part of the community. Even though the Amarillo Indian community is small, it is vibrant and active. It conducts regular cultural activities that allow our children to participate and learn our true heritage. In doing so, we found that we had more quality time to spend with our family and friends.

What did you notice were advantages in living in the Panhandle?

People in the Texas Panhandle are warm and welcoming. More importantly, the medical community is very supportive. Along these lines, the amenities and the capabilities of the hospitals and the system allow for most of the needs of cancer patients to be addressed within the community. Only a few patients have to be routed to tertiary care centers.

I am thankful to be here in the Texas Panhandle community. I am able to comfortably raise my family and I am also able to provide the excellent cancer care, on par in most cases with any tertiary care center.

Any regrets you have had over the years?

The only regret I have is that I wished I had gone into my fellowship right after residency in internal medicine.

Any advice you wish to give to the young professional out there who are interested in going into medicine?

My advice to young students and residents is to follow your passion and do the right thing all the time. If you follow your passion, you will definitely succeed.

Diversity in Medicine: A Conversation with Jerry M. (Jay) Anderson, MD, Ob/Gyn, formerly of Amarillo

as told to Susan Hellberg

I am not a gay woman. Actually, I married three men (separately!), all now deceased, and I have two children and four grandchildren. However, from college to present day, I have continually enjoyed close relationships with gay men.

One of my most cherished relationships is with Jay Anderson, MD, ObGyn. Jay had *a* very successful practice in Amarillo; his patients truly loved him. However, after twelve years, Jay (with his partner) chose to move to Seattle. Upon his departure, the Medical Society received an unusually large number of calls from Jay's former patients, seeking new referrals, but all the while, bemoaning his departure. These women found a sympathetic ear in me as I answered their calls and commiserated with their sense of loss.

In Seattle, Jay was happy and successful from the beginning, both professionally and personally. He married his partner several years ago, and my then 13 year old granddaughter, Gaby, Jay's godchild, was the couple's only attendant. Her brother, Alex, then 10, also attended the elegant and intimate ceremony in Half Moon Bay, mostly orchestrated in secret by their mother, my San Francisco daughter, Liz. To the guests' amusement, Alex literally boogied down the aisle at the wedding's end. (I write this because I find it interesting to note that neither child, nor two of another guest's young children, gave a second thought to two men marrying. Diversity in medicine – diversity in life…how times have changed!)

As a testament to Jay's amazing observational skills, much earlier, at an Amarillo party, he was busy diagnosing my visiting, seven-months pregnant daughter, Liz, with severe growth restriction and low amniotic fluid. (My keen medical skills – ha! – had noted how small she was, but I wasn't worried. I thought she was just lucky!) After testing, Jay confirmed the frightening and unsettling diagnosis of fetal growth restriction with oligohydramnios. In California, Liz had somehow wrangled her way into the care of one of San Francisco's premier obstetricians, and she returned home to immediately discuss Jay's findings with her doctor. Coincidentally, this "expert" had authored a lengthy article for the *Wall Street Journal*, which appeared in the paper just days before Jay faxed his medical findings to her. That doctor haughtily dismissed "your little Amarillo doctor's opinion", upon which Liz fired her. In a fit of unbridled temper, Liz delivered a tirade to the packed and shocked waiting room that these women should immediately leave and find another doctor. Luckily, Liz was able to find a second Ob/gyn, not an easy task for a patient well into her pregnancy in a major city. This doctor totally concurred with Jay, and immediately Liz began to travel a much different route as a high-risk patient. That three-pound baby's life was likely saved by Jay's timely intervention. Thirteen years later, that same baby, Gaby, became the bridesmaid at Jay's wedding…thankfully, a happy ending!

All of this is just a smattering of background on my friend, Dr. Jay Anderson. When "Diversity in Medicine" was chosen as the subject for our journal, I was asked to interview Jay. He was more than willing to help me write this article. I find him to be an excellent writer with both a sharp sense of perception and an outstanding sense of humor. It was both an honor and a pleasure to chat with Jay about his views on Diversity in Medicine. What follows below is mostly his writing, not mine.

Jay begins, "I am a native Texan, born and raised in Sherman, near the Oklahoma border. I am the son of two 'Shermanites' and the youngest of four, with three older sisters. My father was a dentist, and my mother assumed the expected role of housewife and mom. Both of my parents were devout Southern Baptists: my father served as a deacon at the First Baptist Church of Sherman, and my mother sang in the choir. Both taught Sunday School. Most certainly, I grew up with white privilege, which meant my college and medical school were totally paid for by my parents. (For this, I am truly grateful.) In grade school, I was enrolled in a private Catholic elementary school which made for interesting dinner conversations! My sisters, however, attended public schools. This is telling."

Jay became interested in medicine during his teenage years. "At 16, I was invited by a vascular surgeon to observe him perform a carotid endarterectomy, which was mind-blowing. This was in the 80's when there were few, if any, obstacles or regulations preventing a teenager from accompanying a surgeon into the operating room if 'he said so'. I was two feet away from a neck dissection which was surprisingly bloodless. That was it; I knew for certain what I wanted to do! At Austin College, I felt extremely lucky, knowing exactly what I wanted to get out of it, while many of my friends floundered around, wandering from major to major, without ever finding a true passion." After Jay graduated, he went on to medical school at Texas Tech University School of Medicine, followed by residency training in Fort Worth at John Peter Smith Hospital.

Jay continues, "My childhood was very scripted: 'play these sports, hang out with these friends, attend church services on Sunday morning, Sunday night, and occasionally, Wednesday night.' Once at college, things were also expected: 'make

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the grades to go on to medical school, meet the right girl, preferably a Baptist, marry, have a family, carry on the family name' – in essence, achieve the life that my parents were already living. 'Think this; do that'. But then, once at Austin College, for the first time, I experienced the notion of how to think, not what to think. This was pivotal. I am so thankful for the eye-opening experiences of a liberal arts education. Skepticism is a virtue in my book. This started the crack in the shell that I had worn my whole life. After college, I started realizing the gay was not going away, and I was on a road that would take me far from the world in which I grew up. Luckily, however, I was succeeding in school, which gave me the confidence that I could navigate this world and continue to thrive."

Of course, even with the many changes in today's world, Jay has experienced challenges. "Specifically, in Seattle, that challenge is in being a male Ob/gyn. Seattle women want to see female providers. Women in Texas are more open to seeing male Ob/gyn physicians. In Amarillo, being gay was both a blessing and a curse: patients certainly felt safe with me and never had to worry about me being a creep. However, on the other side, there were patients who would never go to a gay obgyn because they disapproved of the 'lifestyle'. But overall, I had a wonderful and successful practice in Amarillo for almost 12 years."

As Jay pursued medicine, he was part of a medical school minority – a gay minority. "But the pursuit of medicine was actually life-saving for me." He adds, "I was able to focus on my career and could compartmentalize the struggles of accepting my identity as a gay man. Then, I was able to come out to my family on my terms, when I could stand on my own and tolerate the backlash without being derailed."

Jay weathered these challenges with "therapy, therapy, therapy. I learned in the early years of medical school lectures that I had depression which had never been treated…not surprising, really, in retrospect – a closeted gay man from a fundamentalist Baptist family who had just not found 'the right woman'. I would sit in a neuroscience or a behavioral health class and listen to a professor describe all of the symptoms that I had walked around with for years, never knowing that this was not normal. It was interesting to have the physiology explained in the same lecture. It normalized my depression such that I was neither afraid nor ashamed of it. I began medication while in medical school which was a game changer. I started the process of self-acceptance and coming out around this time (but only locally, not back home.) Ultimately, I benefited the most from psychotherapy. I rarely meet someone who cannot benefit from a good dose of introspection and self-evaluation."

"If I had to advise any LGBT aspiring physicians, I would say, 'Think big; embrace self-awareness and individuation (1). Take the leaps, and welcome the unknown. When someone has continually been told how to live his/her life, I would encourage them to: 'Question everything. Discover your own answers, and find your own path.'"

I asked Jay if he had any regrets about choosing medicine. He replied, "It was and is the perfect fit for me, then and now. I cannot imagine what I would be doing if my life path had diverged away from medicine."

In typical Jay style, he ended our conversation with "That's all I got! I don't have much to hide." He told me to "feel free to add things." I would add only that my friendship with Jay has enriched my life. Jay has selflessly helped me with some of my personal issues. I miss his often-acerbic sense of humor, his wit, his sympathetic ear and excellent advice, his brilliance, and his never-ending support of my family and me. Alas, Seattle's gain is truly Amarillo's loss! Every person would be lucky to have a Dr. Jay in his life. And that's all I've got!

(Well, not quite! Before Christmas, I received a text from Jay, wishing me a wonderful holiday. An example of his sense of humor is as follows: "Be careful on your ill-advised trip to the biggest hotspot in the U.S [Florida]. I mean, you'd be safer going to Vegas and licking the floor of Caesar's Palace! Wear a mask and carry hand sanitizer. (Scotch does not count!)" And now, that's really all I've got!

References:

1. Individuation is a new word to me: a process through which a person achieves a sense of individuality separate from the identities of others and begins consciously to exist as a human in the world. It is often a part of Jungian psychology.

Dr. Joy Obokhare, Otolaryngologist

as told to Paul Tullar, MD

Dr. Joy Obokhare was born the oldest of five children in Benin City, capitol of Edo state in southern Nigeria. Her family belonged to one of the larger linguistic-cultural groups in her country, the Yoruba. Her father had an opportunity to come to America to study in seminary and brought his family here when Joy was 2 years old. The family emigrated and her mother, having completed her medical training in Nigeria, had to study to take examinations for international doctors to practice medicine in the United states. Watching her mother study for those examinations, while raising her children, was an inspiration to her young children. This was done while her father, having completed his seminary training, began leading a congregation in Irving, Texas. Both her father and mother were involved in the ministry. She states that, growing up in the U.S. as a daughter of Nigerian immigrants, she was nurtured in the close-knit Nigerian-American church culture and family. She attended elementary through 4th grade in southern California, but her family moved to Irving, Texas when she began 5th grade.

When Joy was in the seventh grade, her mother began and subsequently completed a Family Medicine residency. At this time, Joy already knew she wanted to become a physician, having been inspired by a Reader's Digest article on a pediatric neurosurgeon. The story about his successful surgical separation of conjoint twins inspired her when she was just 8 years old. Joy Obokhare became a naturalized U.S. citizen at the age of 16 years old and completed high school in Flower Mound, Texas, a suburb in the DFW area, in 1998.

Joy then attended undergraduate college at Xavier University in New Orleans, LA (1998-2002), completing her pre-medical requirements there, while earning her major in Biology and minor in Chemistry, cum laude. After graduation, she was accepted to U. T. Southwestern Medical School in Dallas, completing her medical school training in 2006. She says that, though the studies were hard, she felt supported at the U.T. Southwestern by the Dean of Minority Affairs, the medical school faculty, and the members of the Student National Medical Association. Her physician mother and pastor father were her counselors, advisers, and comforters during this time.

She was accepted to do a residency as the first minority female resident on the Otolaryngology-Head and Neck Surgery service at University Hospital of Cleveland, part of Case Western Reserve University in Cleveland, OH (2006-2011). After residency, she was accepted to and completed a fellowship in Facial Plastic and Reconstructive Surgery at Louisiana State University Health Science Center in Shreveport, LA (2011-2012). She met Dr. Izi Obokhare the weekend before residency orientation while they were in Cleveland, Ohio, and they were married during their second year of residency. They were then recruited to Port Arthur, TX where she accepted her first job at The Medical Center of Southeast Texas and worked to establish a new otolaryngology practice from 2012 to 2014. After 2 years, she and husband Izi were looking for job opportunities in larger cities, in order to be able perform the wider variety of cases that they had trained for. Often job offers would come for one, but not both of them in a given town's recruitment efforts. Amarillo was different, as "everything aligned just right"; there were attractive job offers for each of them. Dr. Joy Obokhare has worked in a multispecialty practice owned by the Northwest Texas Physician Group from 2015 to the present.

When asked about challenges, Dr. Joy says that balancing her medical and surgical practice with the needs of her family is particularly challenging. She says that there may be times that one cannot give 100% to each, but one must learn to prioritize and keep prioritizing.

When asked about positive aspects of medical practice in the Panhandle, she states that the ease of travel in and around Amarillo, as well as the larger patient population for referral, are both helpful. She feels that her current practice situation provides better balance between work and family life than other places she has worked. She feels that respect for families in an important part of West Texas culture and that this is a good place to raise her children in the long term. Here in Amarillo, her church community has also given her encouragement.

When asked how her Nigerian culture affects the way she practices medicine, Dr.

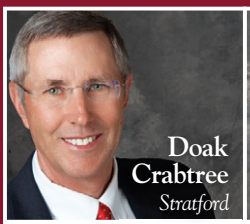
| *continued on page 30*

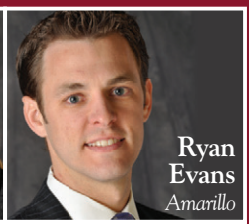
Obokhare says her parents, as teachers of her culture, impressed on her that everyone, certainly every patient, needs to feel heard and needs to feel respected. She says that, because of her culture, she takes the extra effort to make that happen.

Dr. Joy and her husband have three children who are a source of joy and inspiration to both of them. She says they work to build their children up and to teach them to appreciate their differences. When asked if she has any regrets about choosing her career, she emphatically says, "No! I love ENT!" and that she looks forward to building and sustaining her practice, while allowing for intentional care for her family and her marriage.

Dr. Joy Obokhare is board certified in Otolaryngology-Head and Neck Surgery, has completed a Facial Plastic Reconstructive Surgery fellowship, and is affiliated with Northwest Texas Hospital. She is a member of American College of Otolaryngology Head and Neck Surgery, the American Academy of Facial Plastic and Reconstructive Surgery, and the American College of Surgeons. Her NWTH web page may be found at: https://www.nwtpg.com/find-a-doctor/joy-obokhare

Dr. Paul Tullar is an Assistant Professor Emeritus of OB-GYN at TTUHSC-Amarillo, and enjoyed interviewing the Obokhares for Panhandle Health. He has served on the Editorial Board of Panhandle Health for over 10 years.





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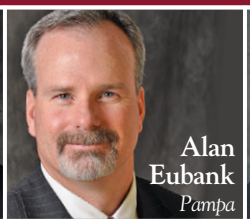
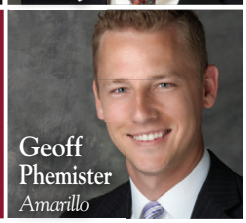


are so



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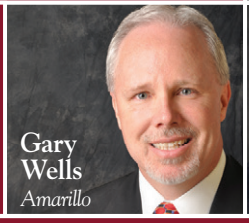

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Urologist: Dr. Natalie Gaines

by Rouzbeh K. Kordestani, MD, MPH

Tell us about your background – your family, your upbringing.

I grew up in Nederland, Texas, a blue-collar community in Southeast Texas where most jobs are tangentially related to the oil refineries. My parents had a small industrial waste business, so I guess messing with human waste is really genetic at this point!

How did you become interested in medicine? Were there any particular events or experiences that impelled you towards medicine?

Like lots of other doctors, I knew I wanted to be a physician in high school – I really wanted to help people and make a difference and, quite frankly, that's what smart people did! I went to undergrad at Baylor, where after three degree-changes and a lot of soul searching, I finally graduated with a Bachelor of Science degree in Biochemistry and a minor in Biology. As a first-generation college graduate, one thing that I can see in retrospect is that a lot of smart kids struggle (as I did) because they don't know how the system WORKS (you aren't annoying your professor when you ask questions during office hours, and the teaching assistants really are there to help you learn the material) and how to use the college system to their advantage. It isn't about money, desire, or intellect (although those can all be limitations) – it's about the more subtle nuances that really help you to succeed.

Tell us about your medical training – premedical, medical school, and/or post graduate residency/fellowship.

I went to medical school and did my urology residency at Texas Tech and really fell in love with West Texas after spending nine years here. I also married a Lubbock boy whose parents still live on 96th Street; so I developed much stronger and more official roots in 2010! After residency, we moved to metro Detroit, where I did a Female Pelvic Medicine and Reconstructive (FPMRS) fellowship at Beaumont Hospital in Royal Oak, Michigan.

Describe how you came to Amarillo to practice medicine. Who recruited you? What aspects of medical practice in the Panhandle were attractive to you?

After practicing elsewhere, I returned to Amarillo, where I did my third and fourth years of medical school at Texas Tech, because, quite frankly – I liked it here. I like the patient population, the short commute and easy lifestyle, and the great community support. My medical school classmate, Dr. Jas Lemert, was already at Amarillo Urology, so I was able to find out a lot about the group before interviewing.

Since finishing your training, what obstacles have you faced? How have you overcome them?

Being a woman in the field of urology can be tough! Women in urology are still very much outnumbered by male urologists. By the most recent national statistics, only about 8% of practicing urologists are women. There are some inherent differences in our practices because of that simple fact. Even though I am a fellowship-trained FPMRS urologist (meaning my practice focuses on complex voiding dysfunction, neuro-urology, prolapse, and pelvic reconstruction), many of my NON-fellowship trained urologist colleagues who happen to be women also see these same very complex patients. This can be due to a number of reasons. One of the biggest reasons is the actual demand by female patients to see another woman for their urological issues. Regardless of whether a urological trainee is a male or a female, however, they have the exact same training during residency and have met the same standards – that is, female urologists are just as competent to see surgical and oncologic patients (like prostate or renal cancer) as male urologists, and male urologists are just as competent at managing non-surgical issues, like recurrent urinary tract infections. Many of my female colleagues are at times frustrated that their clinics

UPCOMING EVENTS 2021

TexMed
May 14-15
JW Marriott Austin • Austin, TX

AMA House of Delegates
Annual Meeting
June 12-16
Hyatt Regency
Chicago, IL

AMA House of Delegates
Interim Meeting
Nov. 13-16
Walt Disney World Swan and Dolphin Resort
Orlando, FL

TMA Advocacy Retreat
Dec. 3-4
Omni Barton Creek • Austin, TX

are filled with non-surgical referrals, while their male partners seem to be seeing all of the operative candidates. I have even had friends tell me that they received a referral for a patient's recurrent urinary infections while the patient's adrenal adenoma was simultaneously referred to a male colleague! This can be understandably frustrating for a lot of women practicing urology. I don't know of a solution, except to shout from the rooftops – women in urology are surgeons too!

What would you like the readers of the Panhandle Health Journal to know about your specialty? What is so special about what you now offer to us and the patient population of Amarillo and the surrounding areas?

One of the most important things that I want to highlight is the creation of an entirely new subspecialty, Female Pelvic Medicine and Reconstructive Surgery or FPMRS. This new subspecialty was created as a cooperative effort between the American College of Obstetrics and Gynecology and the American Board of Urology. Basically, the different fields that were previously known as urogynecology and female urology (confusing nomenclature, because female urology does not imply that the urologist is a woman!) sat down and realized that working together would be to the advantage of all players, physicians and patients alike. In 2011, the American Board of Medical Specialties (ABMS) finally recognized FPMRS as a new subspecialty. Then, in 2013, FPMRS fellowships became ACGME accredited and subspecialty boarded, making them more widely accepted. Because of this collaborative effort, the study of women's pelvic health has been revolutionized in the last decade – what we have learned in the last 10 years truly eclipses what was known and accepted in the previous 90 years. For instance, many women come to me and say they were told that "nothing works for incontinence", or they are suspicious when I discuss the nationally-recognized/FDA-approved/insurance-covered management for medication-refractory overactive bladder – having heard that it is "experimental." A large part of my practice now deals with chemo-denervation (or Botox) for bladder hyperactivity or sacral neuro-modulation. Not only are these interventions not experimental, but they are also truly game-changers when it comes to improvements in the quality of life seen by patients.

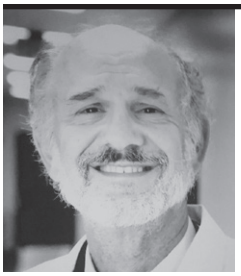
I am the first and only FPMRS urologist in the Panhandle. In a similar vein, my colleague, Dr. Melissa Sanford, is the first and only FPMRS urologist in Lubbock.

If you have children, what challenges have you faced in raising them – either just as a physician, or as a member of an under-represented group?

Being a parent and an urologist is an interesting balance. My kids know the correct words to call their body parts, which is really fun in the grocery store when they use their outside voices to discuss them.

Do you have any regrets about choosing this career? Any advice to give to a young student who might be following in your footsteps?

Awkward moments aside, I have no regrets about my career choice. The intimate issues that I help patients sort through can be really life changing, and that in itself is truly rewarding.



Dr. Hena Tewari: Obstetrician, Gynecologist, and Medical Educator

by Steve Urban, MD

Physicians from India and Pakistan have played an important role in the Panhandle medical community since the 1970s. The first Indian physician was anesthesiologist Dr. Mahindra Patel, who arrived in 1976. Pakistani oncologist Dr. Karim Nawaz also came to Amarillo in 1976, followed 2 years later by iconic neonatologist Dr. Mubariz Naqvi. The first Bangladeshi practitioner was Dr. Nazre Mawla, who started his surgical practice in 1981. In the 1980's, oncologist Dr. Narian Pilai and colorectal surgeon Dr. Sam Maripudi strengthened their foundation, a foundation that has endured until today. Just to give one example, our medical oncology community today would be impoverished without gifted practitioners such as Praveen Tumula, Anita Ravipati, Srini Reddy, and Javed Shinwari. Some of the best internal medicine residents we have ever trained at Texas Tech – including renowned gastroenterologists Zaid Saeed and Arun Sanyal – have had roots in the subcontinent.

It was clear, therefore, that our issue of *Panhandle Health* on physician diversity would be incomplete without an interview with an Indian or Pakistani physician. We chose Dr. Hena Tewari because, as a woman physician and a medical educator, she provides a multi-faceted glimpse into several aspects of physicians' lives. This promise was certainly fulfilled, as my interview with her proved enlightening and inspiring. The following article summarizes our wide-ranging conversation.

Hena Tewari grew up in Lucknow, India, a city of over three million whose importance started with the Islamic Delhi sultanates of the 1200's and extended through the great Mughul empire (in the middle ages, the Mughal empire – along with the Ottoman and Ming Chinese empires – was among the richest in the world). Lucknow was an important entrepôt during the British raj and is still a bustling city today, known for its cuisine as well as its medical facilities. As a girl, Hena was encouraged in her studies by her parents; she remembers a maxim from her father, a professor of sociology: "Educate women, educate the nation." In her early years, thirty years after partition of 1947, there was still a considerable Islamic population in the city. Hena recalls that her best childhood friend was a Muslim – although that would be less common today. She attended high school at Mount Carmel High School, a Catholic school with strong roots in the British educational system. She recalls that the nuns, although stern, were not dogmatic; they valued spirituality in all its manifestations – Hindu, Jain, Muslim, as well as Christian.

As is common in countries of the former British empire, high school was designed to prepare students for nationwide examinations to determine their educational future. Not surprisingly, Hena scored very well and matriculated into medical school at King George's College, one of the top ten medical schools in this nation of 1 billion. Her 4 ½ year medical curriculum led to a year-long rotating internship. Hena has always been gifted with good hand skills and was initially interested in surgery, but it was then difficult for women to be accepted into general surgery (a situation also prevalent in American surgical residencies of the time). She decided that obstetrics/gynecology, with its combination of procedures plus primary care and long-lasting relationships, was best for her.

While in medical school, Hena met her husband-to-be, Dr. Ravi Bharadwaj, two years her senior at King George's. As was the custom, their first meeting was arranged by her father, but he was very non-directive. "Just see if you like him," he said. Hena tells me that it was love at first sight; it would be no surprise to anyone who knows Dr. Ravi that he was thoughtful, kind, and engaging. What MIGHT surprise us was that Ravi's beautiful curly hair was an additional attraction (sic transit gloria mundi). Our American culture sometimes bridles at the idea of an arranged marriage, but, after all, where are you most likely to find a responsible and compatible mate – at a dinner arranged by your parents, or in a bar? (Most arranged marriages that I know of have endured in loving companionship.)

Ravi and Hena completed their residencies (Hena in 1997) in India and practiced there for several years, before making the momentous choice to move together to the United States. When asked why they wanted to move, Hena says that U.S. medical facilities are the best In the world, that the culture is exciting and appealing, and that the freedom to follow your dreams is unparalleled. Also, having started their family, they wanted a strong educational system for their children. It was a big decision, but their families were supportive; so, with a 5 month-old daughter in their arms, the couple came to New York City. At first, Hena stayed at home while Ravi pursued his second IM residency. Then, after working for 2 years in a reproductive endocrinology laboratory, she landed an Ob/gyn residency in the New York area, transferring later to Mt. Sinai Hospital to be with the family in Chicago. By this time, Ravi had taken a private practice job in Marion IN as a general internist and geriatrician. With a split family, the last years of residency were stressful – but finally they were reunited in Indiana. The family enjoyed their 4 years in Marion (a town like a smaller version of Amarillo) but in 2012 chose to return to academic practice in Amarillo--Ravi as associate professor and head of the geriatrics division in the Department of Internal Medicine at Texas Tech, and Hena as a faculty member in the Ob/gyn department.

Hena's role in the Ob/gyn department grown steadily. By 2016, she had become

student clerkship coordinator, supervising the medical students' clinical rotations. She has garnered many teaching awards (including both the Regional Dean's and the President's Teaching Awards) and 2 clinical service awards (also from the Regional Dean). In 2017 Dr. Tewari earned promotion to associate professorship. She volunteers for overseas mission trips and at Heal the City; she is active in Tech's global health initiative through St. George's in Lucknow. Most recently, in 2020 she was elected to Alpha Omega Alpha as a faculty inductee from the Amarillo campus – a high honor indeed.

As a medical educator, Hena fulfills a role that is both demanding and rewarding. One challenge has been ensuring that the students get frequent and honest feedback on their performance – a difficult obstacle for medical educators over the decades. She emphasizes "formative" feedback (i.e. ongoing feedback during the clerkship), so the students can improve on their weaknesses in real time. Dr. Tewari favors the "sandwich method" of providing positive reinforcement, then discussing areas that need improvement, and finally concluding with positive encouragement for the student. Providing the students with experience in doing the pelvic exam has been another challenge. Traditionally, students have gained much experience by examining patients during surgery. Now, as surely seems ethical, specific informed consent must be obtained from the woman before surgery. Learning the pelvic exam is now accomplished primarily in two ways: by using simulation (e.g. TTUSOM's excellent SiMCentral with its high-fidelity mannequins), and by employing standardized patients, who are paid to allow medical students to perform pelvic exams under supervision.

The COVID pandemic has added another level of difficulty to Ob/gyn education. As Dr. Tewari notes, "You can't socially distance while delivering a baby!" Abstract discussions in a Zoom meeting can't replace bedside experience. Dr. Tewari points out that, for the most part, Ob/gyn is a joyful specialty, and the warmth of seeing new parents with their healthy baby simply cannot be replicated in the classroom. Early in the pandemic, parents weren't allowed to have skin-to-skin contact with their babies, a restriction that fortunately has been lifted as we learn more about the low risk of transmission from mother to baby. Hena has grown as a physician during her years at Texas Tech. Dr. Bob Kaufman, her chair, has been supportive, and she has learned the administrative details with the help of her staff and colleagues. As have so many medical educators before her, Dr. Tewari points out that teachers learn as much as they teach. "Teachers teach themselves, " she says.

Coming to America required adjustment to medical and cultural differences. Medical differences abound. In India, patients would often present with advanced cancer or infectious diseases. Oftentimes, the patient's family would have to sell off assets (i.e. a farm animal, or sometimes even the farm) just to be able to afford care – so care was often delayed. Advanced surgical equipment and modern medicines were too expensive to be easily available; social support services (i.e. social workers) were nonexistent. On the other hand, illicit drug abuse by pregnant women (a common problem in Texas Tech's patient population) was almost unheard of. Cultural shocks accompanied the medical ones. For instance, Dr. Tewari, a vegetarian, soon found that a cheeseburger was not what she expected! She has encountered some gender bias in Ob/gyn, especially when gynecological surgery is involved. "Who is going to do my surgery?" is an occasional question. Almost all patients are reassured, however, when Dr. Tewari recounts her training, qualifications, and experience.

Drs Ravi and Hena have loved their time in the Amarillo medical community. They feel valued and accepted. Their two daughters have received excellent educations in the Amarillo public school systems--Dr. Tewari particularly values the International Baccalaureate program. Indeed, their oldest daughter Taru, a BA/MD student at Texas Tech, will be entering TTUSOM this fall, and their youngest daughter Ananya will be entering college with an impressive academic resume. Hena and Ravi enjoy the weather, the sunsets, and the lack of traffic snarls. Their transplant from India to Amarillo has taken!

Dr. Tewari's religious faith has also provided support for her and for the family. She reveres the concepts of dharma and karma as espoused in Hinduism. She believes that the world is a family with children of all faiths and beliefs; she strives to treat all these children with equal respect. She feels a sense of stability in the welter of modern world and modern medicine. "A stable mind wins any war" she quotes. Something is working for Dr. Tewari. Her kindness allows her to be firm when the situation calls for it. Her concern for her students allows her to provide them honest feedback. She is competent, confident and centered. Her numerous awards and the universal love that her students feel for her are markers of this stable foundation. Amarillo and the Panhandle community are indeed fortunate that Drs. Tewari and Bhradwaj have chosen to build on the legacy in our community of their predecessors from India, Pakistan, and Bangladesh.

Iziokhai (Izi) Obokhare, MD

by Paul Tullar, MD

Dr. Iziokhai (Izi) Obokhare was born in Benin City, regional capital of Edo state in southern Nigeria. When asked, he notes that there are three large linguistic-cultural groups in Nigeria (Yoruba, Igbo and Hausa), but there are over 240 other smaller ethnicities. His family is from one of the smaller linguistic groups – the Ora. His first name translated in his dialect means "I choose from the best" and his last name means "Good hands." He and his family did not know the family of his wife-to-be, even though they came from the same town and were both born in the same hospital. There is a saying in his home country, "one can walk five kilometers and leave one's own language, and find another entirely different language and culture." He grew up as the middle child of 5 siblings. He attended elementary, middle and high school as well as 1 year of college in his home town, just a little larger than Amarillo, but never travelled outside of that town.

Izi's maternal uncle, Dr. Emmanuel Eguare, was a huge influence in his career choice. Dr. Eguare was the first one in his extended family to travel outside Nigeria for his medical education. His uncle became a colorectal surgeon and immigrated to Ireland to work; he was a huge source of encouragement and support. Izi wanted to study outside the country, but had only an American SAT brochure and a few sample questions to study in preparation. Nevertheless, he took the American SAT and scored very well. His father's close friend, Professor Joshua Aisiku, who had successfully emigrated from Nigeria to teach college in Worcester, Massachusetts, asked if he could help. Izi's parents were initially reluctant to allow him to leave. Besides, when they heard how much college in America would cost, it seemed out of the question. Izi applied for a scholarship, but not being an American citizen, he could not qualify for financial help.

After "much prayer, persuasion, help from Professor Aisiku (in the way of family encouragement and an offer of room and board in his home for one year) in Massachusetts", and the financial assistance of his maternal uncle, the Obokhares were persuaded to help their son with the transportation (1 way) to the USA and gave their permission to go. Izi realizes that, though he worked hard, he "would not be where I am today, without the help of a lot of people. My success today is built on the shoulders of angels and giants who came before me." He left his native land in 1999; it would be over 7 years before he would see his family again.

Izi was impressed with the quality of education available in America. He said that "no textbook I had studied in Nigeria was less than 10 years old – some older than that. When I got to college in Massachusetts, my first class was Biology 101 and the textbook was still in shrink wrap. I was the first one to see it or use it. When I opened it, it had been published the same year I was taking the course! No textbook in college in Nigeria would be so up-to-date. At this point, I realized I have no reason to fail any class."

Izi was accepted to Worcester State University in Worcester, Massachusetts and received part-time work-study jobs to help with the tuition, in addition to support received from his parents. His mother had to sell some of her clothes to keep him in school! Izi discovered that the college charged by the credit hour up to 18 hours/ semester, but did not charge any more tuition for credit hours beyond that if the student could just keep up. Thus, in addition to working in the audio-visual lab and running cross-country on the college varsity team, he carried up to 30 hours per semester. In 2002, Izi graduated after only 3 years with a Master of Science degree with double majors in Natural Sciences and Chemistry and minors in Mathematics and Biology, graduating magna cum laude. He applied to medical school and was accepted at Howard University Medical School in Washington, DC.

He studied hard at Howard University College of Medicine, earning fellowships (hospital scholarships) in 2003 and 2004 and graduating in 2006 with his M. D. Dr. Obokhare was accepted into a general surgery residency at University Hospitals of Cleveland-Case Western Reserve University in Cleveland, OH during 2006-2011. During this time, he applied for naturalization and became an American citizen. While in Cleveland, he met his wife-to be, Dr. Joy Falola. They married and both were able to continue their post-doctoral education together in New Orleans, LA. Izi had long had an interest in colorectal surgery and obtained a fellowship in Colon and Rectal Surgery at The Ochsner Clinic Foundation in New Orleans 2011-2012. After fellowship, he was recruited to St. Elizabeth Hospital in Port Arthur, Texas and CHRISTUS Hospital in Beaumont, TX, where he worked from 2012-2014. In 2015, he came to Amarillo to join the Texas Tech University Health Sciences Center (TTUHSC) School of Medicine Department of Surgery (also in Colon and Rectal Surgery), and has been here ever since. He has received numerous awards in research, teaching, service (including the Gold Humanism honor society award); he was elected to the Alpha Omega Alpha honor medical society in 2019.

When asked about challenges overcome during his college and medical education, Dr. Izi stated that, as a person of color and as an immigrant, he represents

all people like him and tries to perform with excellence to put all people of color and all immigrants in the "best possible light, and to treat everyone the way you would like to be treated". When he began his general surgery residency, he would get there extra early, prepare more than most residents for hospital rounds, thinking "if I messed this up, I would mess it up not only for myself, but for everyone else who would come after me." He felt that, even though some residents could have an off day, he always had to be on his A game, every single day. He was impressed by his mentors at Howard University, Dr. Charles Drew and Dr Lasalle Lefall, who stated, "Excellence in performance (of all one's duties) will transcend all barriers set by man."

When asked how his upbringing and culture affect his practice of medicine, Izi pointed out that one difference between the culture in Nigeria and that practiced in the US involves a particular respect and honor of elders, recognizing their many years of wisdom and experience, especially in address, regardless of gender. Dr. Obokhare feels that this leads him to treat all patients as he would treat an extension of his own family. He feels that the culture of the Texas Panhandle unites many other cultures and that these disparate cultures together unite us in riches, as we learn from each other.

When asked about his children, he feels that "they have felt some pressure, because they're different; however, kids are resilient." He says that his youngsters don't see children as "black or white", but rather speak to the differences in skin color as "chocolate and peach". In addition to his busy clinical practice, research and teaching, he coaches his kids' soccer team. He calls on his experience playing soccer when growing up in Benin City, as this was the national sport. In addition, he sees this as an opportunity to help his and other children. He recommends the book "Battle Hymn of the Tiger Mother" about how children of Asian (and Nigerian) parents raise their children differently than many American parents. The premise is that Asian children raised this way are taught that they are "better than no one and that no one is better than them." He notes that Asian parents will make many sacrifices, both in time and in money, for their children's education, if necessary taking out loans to afford extra tutoring and encouraging their children to take on extra curricula if it would help them get ahead. He feels that this is a good model and that it improves the kids' performance. When asked if he has any regrets about his career, he says, "We get paid to do what we love (medicine, surgery and patient care) every day. I think about that every time I approach a patient's room." He feels that medical practice involves "a lot of sacrifice (of time) and risks to one's mental health" but that medical practice still provides "a great career choice".

Dr. Izi Obokhare is an Assistant Professor in the Division of Minimally Invasive Laparoscopic and Robotic Surgery at TTUHSC in Amarillo. He is board certified by the American Board of Surgery and is a Fellow of the American College of Surgeons and Fellow of the International College of Surgeons. He brings significant expertise and experience in providing minimally invasive surgical care and provides general and acute care along with colorectal care using advanced laparoscopic techniques and the Da Vinci robotic platform. More than 70% of his practice involves patients with colon and rectal disorders, specifically benign and neoplastic disease. He has a strong focus on screening and prevention of colon and rectal cancer in the Texas Panhandle as evidenced by his involvement in community outreach and education targeting the underserved population. He is currently the Principal Investigator of the Get Fit to Stay Fit: Reducing Colorectal Cancer in the Texas Panhandle grant. This multimillion-dollar grant is focused on providing cost-effective screening for the under- and uninsured populations in the Texas Panhandle. He is affiliated with medical facilities Baptist Saint Anthony's Hospital and Northwest Texas Healthcare System. To view his TTUHSC Faculty Profile, please see: https://www.ttuhsc.edu/medicine/amarillo/surgery/faculty.aspx

Dr. Paul Tullar is an Assistant Professor Emeritus of OB-GYN at TTUHSC-Amarillo, and has had the privilege of working with Dr. Izi Obokhare for the last 5 years. Dr. Tullar very much enjoyed interviewing both of the Obokhares. Dr. Tullar has served on the Editorial Board of Panhandle Health for over 10 years.

Cardiologist Dr. Gus Cabrera

by Rouzbeh K. Kordestani, MD, MPH

Tell us about your background – your family and your upbringing. How did you become interested in medicine? Were there any particular events that spurred your interest in a career in medicine?

My interest in medicine started at an early age in Puerto Rico, where I grew up. My father was a pediatrician, and I was the only of four boys who seemed to take an interest in his career. I would take time to go on rounds with him during the weekend and, by the time I was 12, I was pretty adept at basic things like checking a pharynx or looking at a tympanic membrane. While learning the basics of medicine was always interesting, listening to my father visit with his patients' parents when medical situations turned dire taught me more about medicine than I could have ever learned in school. It was his empathy for the human condition and the care with which he approached each and every patient that sparked in me a passion that would last a lifetime.

Tell us about your medical training – premedical, medical school, and/or post graduate (residency and fellowship). Describe obstacles you had to overcome to become a doctor. If you started your education outside America, what particular challenges did you face in getting a residency?

Eventually, as we all need to do, I grew up. I headed to college in Pennsylvania, just outside of Pittsburg, where I studied biology. After graduation, I returned to Puerto Rico for medical school and remained on the island for my residency and fellowship at the VA Medical Center in San Juan. Working at the VA, a particularly vulnerable population, exposed me early in my career to the inequalities in healthcare. It was yet another experience where I learned more in practice than in the classroom, and I continue to educate myself on the inequalities in care and the challenges in policy that create them.

Describe how you came to Amarillo to practice medicine. Who recruited you? What aspects of medical practice in the Panhandle were attractive to you? What were the early years like?

I first learned of job opportunities in the Texas Panhandle from a recruiter who helped me apply to the position and to schedule an interview. I met and interviewed with Doctors Fortner and Desai at the Amarillo Heart Group, and the three of us hit it off from the get-go. I could tell that their organization was genuine in their intention of being a catalyst for change here in the Texas Panhandle – a continued theme in my career.

I began my career in Pampa, where the community embraced my family and me with open arms. My wife of 30 years, Gloria, placed her psychology career on hold and helped me raise 3 wonder kids who went to school locally and who are currently pursuing their own professional endeavors. We soon moved to Amarillo, but I continued to practice in Pampa with an outreach clinic for 23 years until recently. Being Hispanic, I was able to use my language to immediately make a difference in the community – something that I continue to do to this day here in Amarillo.

If you have children, what challenges have you faced in raising them – either just as a physician, or as a member of an underrepresented group? What are the biggest "culture shocks" you have encountered?

When we moved to Texas, I came reassured that I was more than ready for any challenges to come. I knew that my background and education had prepared me to play a unique and vital role in providing healthcare in the Panhandle. However, I don't think I could have been prepared to grapple with the complicated questions of identity and race that would accompany bringing my family to Texas. My family and I were blessed with a welcoming environment and didn't experience active racism on a personal level at any given time, a blessing many in this country sadly do not receive. I quickly learned, though, that, while my heritage was a source of pride for me, it slowly began to become a source of confusion for my children. On the island, we didn't need to think much about our identity as Puerto Ricans. However, now we were Puerto Ricans in Texas. My children grew up with many questions about the color of their skin, comments other kids made about their names, and why they needed to speak Spanish. Nothing could have prepared me to address any of these questions, and it broke my heart to see the three of them grapple with such heavy topics at such a young age. The three of them felt different and, to some of the kids, they were – for the mere fact that they had darker skin.

I asked my son about his own experience, having spent most of his life in Texas. He told me that he was a child of two cultures, belonging to none. He felt that he would never be Puerto Rican enough for Puerto Ricans, nor would he be "American" enough for the people he encounters on the mainland. This, he said, brought many questions and a desire to not feel so different. He said he would constantly ask himself "why can't I be like the white kids?"

My son and I saw our identity so differently, and it was painful to see that my pride was, at one point in his young life, his shame. He tells me that now, he wouldn't have it any other way. He says that living in between two cultures provided him a desire to learn about other cultures and identities and the challenges that they face in America. It also allowed him to take the best parts of Puerto Rico and America and create find an empowerment in his own, unique

identity. He would go on to study and work in politics, where he hopes someday to help address the challenges that many in America face solely because of their race or identity.

What do you see as continued challenges here in the community?

The challenges that my son wishes to address, unfortunately, also reach into my own field; the health disparities that I learned of early in my career continue to plague us. Now that we are in the midst of a pandemic, Black and Latino/a patients are dying of COVID-19 at higher rates than that of white Americans. (I'd remind people here to please wear your masks, keep your distance, and wash your hands!) Over the years, I've noticed improvements in patients' compliance with therapies and outcomes which has been encouraging to see. However, inequalities in healthcare access are still a great issue for some if they don't have insurance or access to government assistance – another problem that affects many across our country, and here in the Texas Panhandle.

As my years of practicing here in Amarillo went on, the city continued to grow and change. I was glad to see people from diverse backgrounds come to our community and bring their stories, cultures, and beliefs with them. The beauty of healthcare is that I am able to provide my skills to any human on the planet. However, I did begin to run into some language and cultural barriers that I needed to find out how to overcome to continue to provide the best care. It was daunting seeing patients come in with a 10 year-old child to serve as a translator. In times like these I remembered my father and the empathy and professional care he extended to every person who walked into his office. I learned to adjust to a shifting reality. While many of us healthcare professionals are ready for this challenge, there are still questions about healthcare inequality and outcomes that must be addressed.

Any closing thoughts?

Having experienced first-hand what representation in medicine means to my own Hispanic community, having had the honor of coming to Amarillo with my own background and language to share; I know that it is vital that we reach out to community leaders and ensure that young children from all backgrounds are getting involved in science programs. I would love to see young students in shadowing programs, getting to learn about medical care like I did following my father all those years ago. The healthcare profession can and must look like the population of our community in order to provide the best care and to create the conditions for better healthcare outcomes.

With that in mind, I would like to thank the writers and editors of *Panhandle Health* for allowing me the opportunity to be involved in this project of telling our stories. The sounds of our voices are so important, and I hope that my own story can serve as an inspiration to the next generation of Panhandle medical professionals. Although I miss my island, I thoroughly enjoy serving the people of Texas. The community has always had a unique kindness of heart and a warm inclusiveness that has genuinely made a difference in my life and allowed me to thrive in Amarillo.

Dr. Adeline Jou Tindo

by Sheryl Williams, MD

BSA Hospital was extremely fortunate to have Dr. Adeline Jou Tindo join our team a few years ago. I spoke with her about how she ended up in Amarillo after growing up in West Africa and facing obstacles in becoming an American physician. Adeline grew up in Dschang, a small city in Cameroon. She had a large family by American standards, with one sister and five brothers. Her mother was a teacher and, for lack of a babysitter, brought her to school every day from a young age. This passive education allowed Adeline to skip several grades and graduate from high school at age 15. From there, she was off to university and later medical school in Belgium. "Compared to the US, the educational system is completely different – a seven-year full-time program, of which the first three are general education and the last four are concentrated on clinical training."

Adeline initially moved to Los Angeles after medical school. "As long as I can remember, I always wanted to be in the medical field. When I was a kid, I used to love babies. I used to go to my neighbors, from house to house, to carry their babies. I always dreamed to be the person who helped a human being come into the world and become an OBGYN. I went to Europe to study to become a medical doctor, but, over there and at that time, some specialties were reserved for Belgian citizens or for whites. I did my thesis in OBGYN. Since I was not able to specialize in OBGYN in Belgium, I decided to come to the US where opportunities for anyone ambitious and determined are open. When I moved here, I changed my mind as to what specialty to get into when I realized that you must take exams in order to be considered for a residency program in the US."

Her first hurdle was to study English, as all her training had been in French. Then she had to pass the STEP Exams, no easy task, especially under pressure to score high enough to impress prospective residency programs. "As a foreign medical graduate, there were many challenges getting into residency that I did not anticipate. Those challenges included but were not limited to the process (educational standards and evaluation methods being different) and the expense (exam fees, papers, transcripts). In the meantime, I was not getting any younger and decided to start a family while preparing for the exams. Prior to starting residency, I had my first two children – already a full-time job! I was advised that going into an OB residency would not be wise because the schedule was really demanding. I decided to pursue Internal Medicine as my first choice of residency, although I still applied to OB. I will never know if I matched in OB as my first choice was Internal Medicine. I still loved OB, but cannot even compare the reward that I get from medicine. I love waking up every day knowing that I will make someone feel better, regain a smile, or walk out of the hospital as a new person." She was accepted as a resident at Texas Tech Health Science Center here in Amarillo. Having children in residency "was the hardest part, but my husband made some sacrifices to help me cruise through the program. As a physician, it is hard because of schedule; as a member of an underrepresented group, the most difficult issue is that people do not take you seriously just because you have an accent and you are a foreign medical graduate."

"At the end of residency, I was offered a position as a hospitalist by Dr. Lee at Northwest Texas Hospital. I came here from Los Angeles for my residency, and my plan was to return. I did not know much about the Panhandle when I was offered the job. I grew up in a small city, went to school in Brussels which is big city, moved to Los Angeles which was an even bigger city – but not the right place to raise my children. Amarillo offered the small city experience with no traffic (at the time), so I accepted the offer. The main obstacles that I faced after finishing my training were mostly related to cultural and language differences, not enough knowledge of the medical healthcare system, pharmaceutical, hospital, and ethical challenges. For instance, it is important in the American culture to adapt your conversational style to include eye contact, which, out of respect, we do not do where I grew up. You must also remember the importance of patient autonomy in your interaction. I came from a different educational system with different clinical experiences, populations, and epidemiology. I overcame those issues with my strong work ethic, commitment to medicine, appreciation of opportunities, and respect for authority."

"I cannot really say that I experienced discrimination in my medical training in Belgium because not only did I not have a clue what discrimination WAS at the time, but I was so happy to be in medical school, and I was not the only woman or black in the school. A faculty member would sometimes try to embarrass or humiliate you or say something about your country of origin, but I never took it personally, as I was raised to be respectful and was prepared in advance to know what to do. I came to America to practice because of my love of medicine. At the beginning it was a lot of years of adjustments, and my main priority was to find balance. I was not trying to stress out about learning everything; I just wanted to be happy. Coming from LA, I experienced culture shock and had to adjust, especially in an area that was primarily white and conservative. I met a lot of people who had never left the state of Texas, let alone the USA. But I always wanted to be a physician since I was born and I made it! No regrets at all so far. God has been my guardian, and I would not have done it without his blessings. I also would not have done it without the help and love of my dear husband Calvin and my four children: Javin, Jessica, Jayden, and Jayson (the JT's). My advice to young people contemplating a career in medicine is to have their heart there, have a passion about medicine, keep their goal in mind and always remember that medicine is extremely rewarding and actually becomes enjoyable with time."

Adeline is truly a remarkable person and physician. We are so lucky to have kept her here in the Panhandle and as a hospitalist at BSA. It is a long way from Cameroon to Amarillo, but Adeline has survived – and thrived! – with her strength of character, determination, and commitment to medicine.

Falling: What You Need to Know

by Taru Bharadwaj and Ravi Bharadwaj, MD

Who is most prone to injury by falling?

Falls are most common in Americans who are 65 years of age or older (5). Although millions of older people fall each year, fewer than half of them go to the doctor or tell their healthcare providers about it. This is dangerous because one fall doubles the chances of falling again (1). Furthermore, one out of every five falls causes a major injury, such as head injury or broken bones (5). Among the elderly population, women are more likely to fall; in fact, women "account for three-quarters of all hip fractures" (1). This is why each person will require a slightly different approach to fall prevention; each will have a unique regime based on how and why they are most likely to fall. Contrary to popular belief, falling is not a natural part of aging and can be prevented.

Why is falling dangerous?

While a simple fall may not seem serious, the statistics speak for themselves. According to the CDC, around 36 million older people fall each year; of this number, 32,000 patients die due to the fall (5). In fact, "falls are the leading cause of injury-related deaths among persons aged 65 years or older;" every 19 minutes, an older adult will pass away from a fall (4). Deaths due to unintentional injuries are the seventh leading cause of death among older adults and, according to the CDC, falls account for a large percentage of that. Unfortunately, this number only continues to grow each year. In 2018, 36 million elderly patients fell, a 30% increase in the number of falls compared to a decade before. This number is predicted to grow to 52 million people falling in 2030; this dramatic increase is due to the steadily growing population of the elderly (3). In older people, even short falls can lead to severe injury. According to the University of Rochester, "elderly people are three times as likely to die following a ground-level fall" when compared to younger people (2).

What is the healthcare provider's role in preventing falls?

While older people and their caregivers have a major role in working to prevent falls, the healthcare provider should help strategize a unique plan for each patient. According to the University of Rochester, one of the most important steps is to recognize falls as an important issue (2). As the number of older people who have fallen increases, emergency departments should alter their approach to handling fall injuries. The risk of the current fall leading to death can be quickly assessed by using two simple numbers: age and the Glasgow Coma Scale (2). It is recommended, however, that trauma centers asses the patient for "less dramatic" injuries due to falling, since these types of injuries too can have significant impact on a person's long-term health (3). Furthermore, healthcare providers should also observe the small details in a patient that show their likelihood of falling. For example, something as simple getting one's feet checked or stopping certain herbal supplements could be all it takes to improve balance (5).

How do older adults prevent falls?

To prevent dangerous falls, older adults and their caregivers can work together to ensure safety when walking and traveling. Elderly people can perform light exercises to improve leg strength and build balance (3). They can also customize their homes by ridding them of hazards such as loose carpeting and excess clutter and by adding grab bars, handrails, and improved lighting (3). These preventative measures can allow a person to stay independent for a longer period of time, while protecting themselves from accidental falls. Also, patients should openly communicate with their healthcare providers by keeping them up-to-date on mobility issues, quality of eyesight, and health conditions that could increase the risk of falls (5). This is because small health issues that may not seem serious often contribute to a major risk of falling. Feeling a slight pain in one's right ankle or having slightly blurry vision could be all it takes to initiate a trip and fall. Talking to their doctor about previous falls, or their feeling of unsteadiness when walking, is also essential when drawing up a carefully crafted plan for better mobility. Caregivers should remain attentive and start the important conversations about the risk of falling and how to prevent it (3). Encouraging the elderly to practice better safety and lifestyle can make a huge difference in the risk of falling (3). Thus, openly communicating with a healthcare provider, improving lifestyle, having regular eye and foot check-ups, and adjusting one's home to make it a safer environment are major steps that any elderly person can take to prevent falling (5).

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