PANHANDLE HEALTH

A QUARTERLY PUBLICATION OF THE POTTER-RANDALL COUNTY MEDICAL SOCIETY

Fall 2016 | VOL 26 | NO. 4

Celebrating 25 Years of Success in Our Medical Community

History of Medicine in the Panhandle:

Seasoned Physicians – Looking Back, Looking Forward

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PHOTOCOMPOSITION AND PRINTING BY CENVEO.

President's Message:
Medical Superheroes

by L. Edwin Dodson, M.D.

In this issue of the PRMC Journal dedicated to the history of medicine in the Panhandle several current practitioners give testimony to their own contributions to local medical history. I feel this is a fitting and important project for our local medical journal. I myself claim the title of first Endocrinologist to make a career of practicing in the Texas Panhandle, my proudest contribution to Medical History.

The History of Medicine has been of great interest to physicians thru the ages, perhaps as a means of seeking precedence for current treatments, especially in the days when medicine was less evidence-based, and perhaps because of something akin to the current popularity of Super Heroes. One of my favorite books that I keep to read for relaxation is *Classic Descriptions of Disease*[1] by Ralph Major M.D., a Professor Emeritus at my Alma Mater. I was privileged to meet Dr. Major when I was in training and have enjoyed his work immensely.

One of my all-time favorite Medical Super Heroes is Girolamo Fracastoro (Hieronymus Frascatorious in Latin) of Verona. Born in the 15th century, he is said to have survived a lightning strike which killed his mother while she was nursing him[2]. He was educated at Padua and became a philosopher, mathematician, physicist, astronomer, geologist, and poet, but Medicine was his passion. Needless to say, this was in the days before specialization.

Frascatorious was best known popularly for a long poem he wrote about "The French Disease"[3] and was the first to give it the name Syphilis. A portrait of Frascatorious in The National Gallery is attributed to Titian; recent art historians have suggested that the portrait was done in exchange for treatment for Syphilis[4]. He is most noted academically for his work Treatise on Contagion in which he set forth a very modern theory of the spread of disease by particulate and fomite agents and labeled smallpox, measles, tuberculosis, rabies, and syphilis as contagious diseases. He also made the first clear clinical description of Typhus Fever.

While we cannot all name new diseases we can feel the sense of belonging to the tradition of Medicine by considering the work of others, and gain a better feeling about the direction of Medicine in the future from our understanding of where our traditions began.

1 Classic Descriptions of Disease with Biographical Sketches of the Authors, Major, Ralph H, M.D. 1945. Charles C. Thomas, Publisher, Springfield, Illinois.
2 Ibid. P. 37.
3 Ibid. P 3.9-42.
4 Jones, Jonathan (January 7, 2013). "Titian painting rediscovered in depths of National Gallery." The Guardian.

Alliance News

by Irene Jones, Co-President

The Potter-Randall County Medical Society, Alliance and Circle of Friends are hosting a Fall Couples Social on Thursday September 15th. The Social will be held at the beautiful home of Dr. Shane & Melissa Holloway.

The Alliance has been steadily busy planning for our first New Year Eve fundraiser benefiting the Alliance and "Our Children's Blessing". If your practice is interested in sponsoring, we have several opportunities listed below. Table sales will start in mid-September. Please contact potterrandallalliance@yahoo.com or Kristen Atkins at 361-649-4551. This event is limited to two hundred people and will sell out. Get your tables today!

Al Capone- $7500
- Presenting Sponsor
- Reserved Table for 8 with preferred seating
- Ad space in Panhandle Health Magazine
- Recognition at Event
- Banner Displayed at Event
- Bottle Service & VIP reception
- $600 in chips per person at table for casino

Golden Age- $5000
- Reserved Table for 8 with preferred seating
- Ad space in Panhandle Health Magazine
- Recognition at Event
- Banner Displayed at Event
- Bottle Service & VIP reception
- $600 in chips per person at table for casino

Great Gatsby- $2500
- Reserved Table for 8
- Recognition in Panhandle Health Magazine
- Recognition at Event
- Banner Displayed at Event
- VIP reception
- $300 in chips per person at table for casino

Bootleg- $1500
- Reserved Table for 8
- VIP Reception
- $300 in chips per person

New Years Eve Gala will be held at the Amarillo Botanical Gardens. The event will be catered by OHMS and entertainment by Velvet Funk.

Fall Events:
September 15th @ 7pm: Fall Couples Social home of Dr. & Mrs. Shane Holloway

October 18th: Snack Pak 4Kids 5:45-6:45

November: Ladies Shopping Night @ Top Notch
More details to come!

December 31st: NYE GALA
Amarillo Botanical Gardens benefiting Potter-Randall County Medical Alliance and "Our Children's Blessing"

Best,
Irene Jones (Co-President)

Ongoing Volunteer Opportunities:
Ronald McDonald House:
Contact: Jamie
jbwilliams364@gmail.com

Northwest Pediatric Unit:
Contact: Kristen
kristenatkins@hotmail.com

Snack Pak 4 Kids:
Contact: Christine
lanechriscox@suddenlink.net

Hygiene Closet:
Contact: Irene
irene.jones83@gmail.com

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

Executive Director's Message

by Cindy Barnard, Executive Director

In 2013, *Panhandle Health, Vol. 23, No. 4* featured articles about the pioneer practitioners of the Panhandle's outlying communities from 1950 through the 80's—in essence, a sort of history of our small town "country doctors". In this issue, the authors are culled from our Retired Physicians, each telling his personal history as a practitioner. The autobiographies of these seasoned physicians are colorful, often humorous, sometimes poignant and personal, but above all, they are all truly interesting. These doctors' stories are as varied as their personalities and their individual specialties.

ON THE COVER:

The cover of the magazine, "Panhandle Pheasants" is by David McMurry. David is a painter of the outdoors searching for a better understanding of the natural world. He believes every piece he does should be better than the last, so the responsibility becomes greater as the consumer deserves quality work. David is an invited guest member of the Northwest Rendezvous Group, the Oil Painters of America and the Amarillo Fine Art Association. He has studied with Carolyn Stallwitz, Emilio Caballero, Scottsdale art school and Jackson Art Institute, just to name a few. His work can be seen at The Colony in Wolflin Square.

In Memory

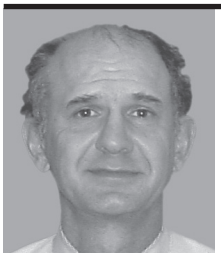
Dr. Coleman Taylor,
Ophthalmologist,
died Tuesday, March 22, 2016
at the age of 88.
He was a member of the
Potter-Randall County Medical
Society for 40 years.

Our Next Issue Of

Panhandle Health

Features:

Case Studies from Texas Tech



Guest Editor's Message

Seasoned Physicians—Looking Back, Looking Forward

by Steve Urban, M.D.

When I finished my residency at UT Southwestern in Dallas, I thought I was ready to practice internal medicine. Whereas most of my fellow residents had chosen subspecialty training and the academic track, I wanted to return to the Panhandle and be the best "LMD" (Local Medical Doctor) I could be. I thought I was well prepared; after all, I had worked in a high-pressure program, with plenty of ICU and CCU time. I knew all about thrombotic thrombocytopenic purpura and membranoproliferative glomerulonephritis. I was ready to take on the world.

Was I ever wrong!

In my first year of practice, I learned on the fly how to approach chronic fatigue, tension headache, surreptitious alcoholism, anxiety, chronic back pain, medication non-compliance—all the common problems that you actually see in practice, but that had been relegated to the back pages of *Harrison's Textbook*. Fortunately, I was blessed to join a group of intelligent, committed, and highly ethical physicians—Drs. Ted Nicklaus, Tom Nichols, and Barton Grooms—who took me under their collective wings and taught me how to be an internist.

My point is this: we all learn an immense amount of medicine by experience. I was a better internist after 10 years than I was to start with, and better after 20 years than I was after 10. Although part of this improvement was due to refinements in medical knowledge gained through scientific advances, most was due to paying attention to my patients, reflecting about my practice (including my mistakes), discussing problems with respected colleagues—i.e. experience. You don't learn how to counsel a patient whose marriage is falling apart, or deal with a patient who is distrustful of standard medical practice, or get a patient to accept her psychogenic symptoms—just by poring over the *New England Journal of Medicine*.

So, when it came time to do an issue of *Panhandle Health* dedicated to a non-technical topic, I decided to mine the experience of respected, seasoned clinicians. I wanted to give them an opportunity to communicate what they have learned by long experience to their younger colleagues. Hence, the genesis of this issue.

Between these covers you will read lessons that skilled practitioners have learned on reflection after 30 to 50 years of practice. Mitch Jones remembers physicians he admired and what characteristics set them apart. Walter Allison tells how he learned both from triumphs and from disappointments, and how he interacted with disparate colleagues over the years. Nick Goldstein recounts experience gained from three phases of his career—academia, private practice, and finally administrative medicine. Randal Posey muses on the interactions between mind and body that he observed in 46 years in the practice of dermatology. Phil Periman looks back at the changes he has witnessed in 50 years of the practice of medicine and makes suggestions to students and residents on how to keep up with medicine's ever-accelerating changes. Dick McKay focuses on his impressive involvement with the political branch of organized medicine—all the way from the county medical society to the American Medical Association.

Lowell Chaffin and Chuck Rimmer focus not on the past but on the challenges of successful retirement. Emily Archer's article is a heartfelt account of how she combined an incredibly busy solo practice with the challenges of being a wife, mother, and dedicated family member. Finally, I thought it would be heartless to ask 92-year-old Bill Price to document his exemplary career, so I interviewed him instead. You will be astounded at the breadth of his medical experiences—from a MASH hospital in the Korean war to the first MRI scanner to Amarillo—but equally so at how Bill combined a busy practice with world-spanning expertise in the collection of Asian art.

You have before you accounts by many of Amarillo's most respected physicians—what they learned, how they learned it, what changes they have seen, how they kept up, how they earned the respect of their colleagues, how they managed to infuse meaning into retirement. I have profited from reading their accounts; so will you.

How I got into Medicine Advocacy.

by Richard McKay, M.D.

Dr. Urban asked me to tell my story on how I got involved in advocacy for medicine in general, and for orthopedics in particular. It started when I was a senior orthopedic resident in Galveston in 1975 and Dr. Bob Hyde (my mentor in life) was president of Texas Orthopedic Association (TOA). The annual meeting that year was in Houston, and Dr. Hyde "invited me" (told me I would go) to the meeting. I have made every annual meeting since.

In the early 80s, one of my professors from Galveston called me and asked me to be chairman of the Physical Therapy sub-committee of the Legislative Affairs Committee of TOA. He said nothing was going on, but the current chair was not even attending the meetings and he knew I attended them all, so I said okay.

Two weeks later, the Physical Therapists filed a bill for independent practice where they could see and treat patients without a referral or diagnosis. We did not think this was in the patients' best interest, so I went to Austin to negotiate with them. We offered a compromise that would allow them to see a patient who had been referred in the last year with a recurrence of the same symptoms without a new referral. They turned us down, so I made two more trips to Austin to testify before the House and Senate Committees of Jurisdiction opposing their bill. The bill passed out of committee, but I learned it is easier to kill a bill than to pass one when we were able to keep the bill from ever reaching the legislative floors.

During the next session two years later, the therapists accepted our compromise and I testified in favor of their bill. It passed, and I went from being hated by every therapist in the state, to being loved by them.

I was chair of the PT Subcommittee until the chair of the Legislative Affairs Committee became President, then I became Legislative Chair. It took me ten years to figure out the only way out of that job was to become President; so I served as President of the Texas Orthopedic Association in 1998. During those years, we hired a lobbyist and formed our own Political Action Committee (of which I was treasurer for years).

While I was serving the TOA, I also became involved in the American Academy of Orthopedic Surgeons (AAOS). I was elected to the Board of Councilors, and appointed to the Council on Advocacy, both taking me to Washington D. C. several times a year to lobby Congress. I began my involvement with the AMA by serving as a delegate representing orthopedics, and I became involved with the TMA on the board of TEXPAC.

Of course, it is easier to be involved in the political process when we have such good representatives in Austin and Washington. I always enjoyed visiting Congressman Mac Thornberry in D.C. and even took our first-grade granddaughter to see him one year. I have always felt that Mac is one of the best informed congressmen on medical issues. Having Sylvia Nugent (wife of pathologist, Rod Nugent) as his first chief of staff in Washington didn't hurt. In Austin, State Representative John Smithee has always been accessible and willing to listen to our side of any issue, as has Senator Kel Seliger. When Four Price was elected to the House of Representatives, it just put another friend in the House.

I feel it is very important for physicians to become involved in the political process at all levels. No one else is going to protect our patients' best interests, and work to maintain the private practice of medicine. As you can see from my story the best way to do this is to become involved with TMA and your specialty organization, at both the state and national levels. I have made great friends from all over the country in my involvement with the national organizations. Even though one year I realized I was scheduled to be out of town 54 days for these activities, I felt it was all rewarding for me and well worth doing.

While not everyone can get as involved as I was, there is one thing every physician can and should do. Write a check today to your specialty political action committee, and to TEXPAC. Fewer than 20% of doctors do that now. If we could improve that number, then medicine could do so much more.

Looking Back Over 50 Years in Medicine

by Walter Allison, M.D.

My life began in a small town of 2,200 people in West Tennessee. My high school senior class had 34 members, the largest on record. This class produced one PhD in nuclear physics, one in political science, one DDS and one MD. This is mentioned to just show small towns can produce graduates who rise to significance in academic achievement.

I then enrolled in a small liberal arts Southern Baptist college. I went in with a small conservative and religious world view. I came out with a much broader "liberal" view (and, by the way, a supporter of J.F.K. in the 1960 U.S. Presidential race. I did eventually recover).

I then was fortunate to be accepted by the University of Tennessee medical school. I worked hard while in school and was so lucky to be in a study group of 3 or 4 that included a graduate of MIT who was very smart and also a good and sharing teacher. During medical school I was elected to A.O.A., which was thrilling to an ordinary guy like me.

I began my internship at the same institution, followed by 2 additional years of internal medicine residency, then a year of fellowship in cardiology, all at Tennessee. That was not a good year for me. I was caught between a conservative old division chief and a young whippersnapper who was up-to-date in invasive cardiology. The tension was so uncomfortable that I left the program and finished my cardiology training later at St. Paul's Hospital in Dallas, where my mentor Dr. Bill Krause provided a much more supportive environment for learning.

The following comments are directed to residents and younger physicians.

After residency, I took my board exam. It then hit, one of my life's great disappointments. I failed my board exam. That was the first test I had ever failed. How did I deal with that? I internalized it and avoided facing that head on and taking definitive action. I *should* have made an appointment with my former chief to seek his advice about how to remedy my predicament and set out to rectify it. I did not do that. Later on through the years, I came to realize that I had not been a good resident. I did not study intensely. At the time there was no MKSAP and most of all there was no "Dr. Urban"; so I thoroughly encourage residents to study, "work hard," and never miss a discussion with Dr. Urban on MKSAP sections.

My practice began in Amarillo with a cardiologist by the name of Bob Gulde. Dr. Gulde was a man before his time. He was innovative in some ways, but was dogmatic in a way that offended many fellow physicians. During practice years when you deal with and care for patients for long times, there are highs and lows. I have had times when I was delighted with patient outcomes (so upbeat). On one occasion a patient's wife told me while standing in his room on 4B at High Plain Baptist Hospital: "You are a great doctor." Think about that! How are you to respond? My response was, "That is probably not the case but it is sure good to hear." There will also be disappointments and frustrations that arise from a patient's own actions.

I have been through the maze of hospital and large practice medical staff positions (from Chief of Staff to Quality Assurance to Credentials Committee and several others). These committee assignments sometimes present issues that are very difficult, such as addressing physician privileges. From all this I have learned that there are at least two sides to every situation. You should listen to all sides, then gather together all the information available, and then make a definitive decision. It is a responsibility that many of us would like to avoid, but is essential if we physicians want to continue to police ourselves.

Throughout my 44 years of practice, I have been in several arrangements, in groups ranging from 2 to greater than 20. In seeking out group practice, it is important to find colleagues that have a practice pattern with which you agree. My best colleagues were hard-working and responsible; they were available and committed when on call. You don't have to agree in every matter, but you don't want someone who sloughs off. My worst colleagues didn't always show up (turned out to be an alcohol problem) or just couldn't make up their mind (just indecisive and lacking confidence). Once you find a congenial group, work very hard to get along with your associates.

I would suggest at the beginning of practice to select 5-6 journals and know when each of said journals is published. Then review the table of contents of each, and select what may be of interest or importance to you. "Stick with" this activity; make it a discipline. I would also seek membership as a fellow in one's specialty (i.e. FACP, FACC, FACS, and FACFP). Plan to attend a CME course at least once a year (go to the meetings to learn; stay off the golf course and out of the casinos). Attempt to maintain some relationship with an academic institution.

One other piece of advice: in mid-career I became depressed and disenchanted with cardiology. I interviewed for a residency in anesthesiology and also in physical medicine and rehabili-

tation. Then I realized the reason for this. I was a terrible record keeper and was always on every hospital's delinquent record list. I then did an about face. I attempted to never let a record go unfinished by the 10 pm hour of that day. My enjoyment returned and my depression disappeared. The last 25 years of my practice have been very enjoyable. In particular, I have had much pleasure in being identified with Texas Tech Internal Medicine department for the last 10 years.

In my 50 years of medicine, I have witnessed incredible changes for the good. Imaging techniques have advanced for the benefit of the patient. When I started, we had the EKG, the chest x-ray, and coronary arteriography. Echocardiography and nuclear studies now provide worlds of information in a non-invasive way. Cardiac biomarkers are much more sophisticated and better understood. But, as important as these technical innovations, our ways of interpreting information have advanced. The randomized clinical trial has replaced the anecdotal, historical study, and practice guidelines have enlisted the knowledge of hundreds of experts in helping us know what is best for our patients. The challenge for the doctor, however, is to decide whether his or her individual patient really fits in the study group. Knowing your patients well—which patient never complains, and which one notices every twitch and twinge—can be as important as knowing the guidelines by heart.

But not all the changes I have seen are for the good of the patient. Medicine has become less personal. Although computers are vital, the way the Electronic Medical Record is implemented has been a catastrophic failure. Doctors have now become masters of cut-and-paste, "clickologists" who may never make eye contact and rarely touch the patient. Collegiality has declined; physicians (or their assistants) would rather leave a note in the chart than talk to their consultants in person. Despite all the labor-saving devices, doctors are in a hurry to make money, in order to satisfy the businessmen who have taken over the control of medicine. In distant years, you could take time for the patient if you wanted to; now sympathetic listening is not "cost-effective" to our managers. But it's not just the managers. Doctors (myself included) are now accustomed to earning large incomes. This promotes activity that generates the most money (procedures), and the doctor-to-patient activity thus suffers (this happened to me too).

I tell the medical students that I have been an M.D. for 50 years now and somewhere along the way I hope I have earned the title "Doctor." To me, being a doctor means interacting with patients over time and developing an attitude of mutual respect. This is a two-edged sword; if you care about them as a person and if you discuss your ideas openly with them (rather than just telling them what to do), they will respect you in return. This will make your practice very enjoyable.

It has been great to be a "doctor" for many years. It still remains to be.

PANHANDLE HEALTH

A Publication of the Potter-Randall County Medical Society

Editorial Policy and Information for Authors

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

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

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

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.

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

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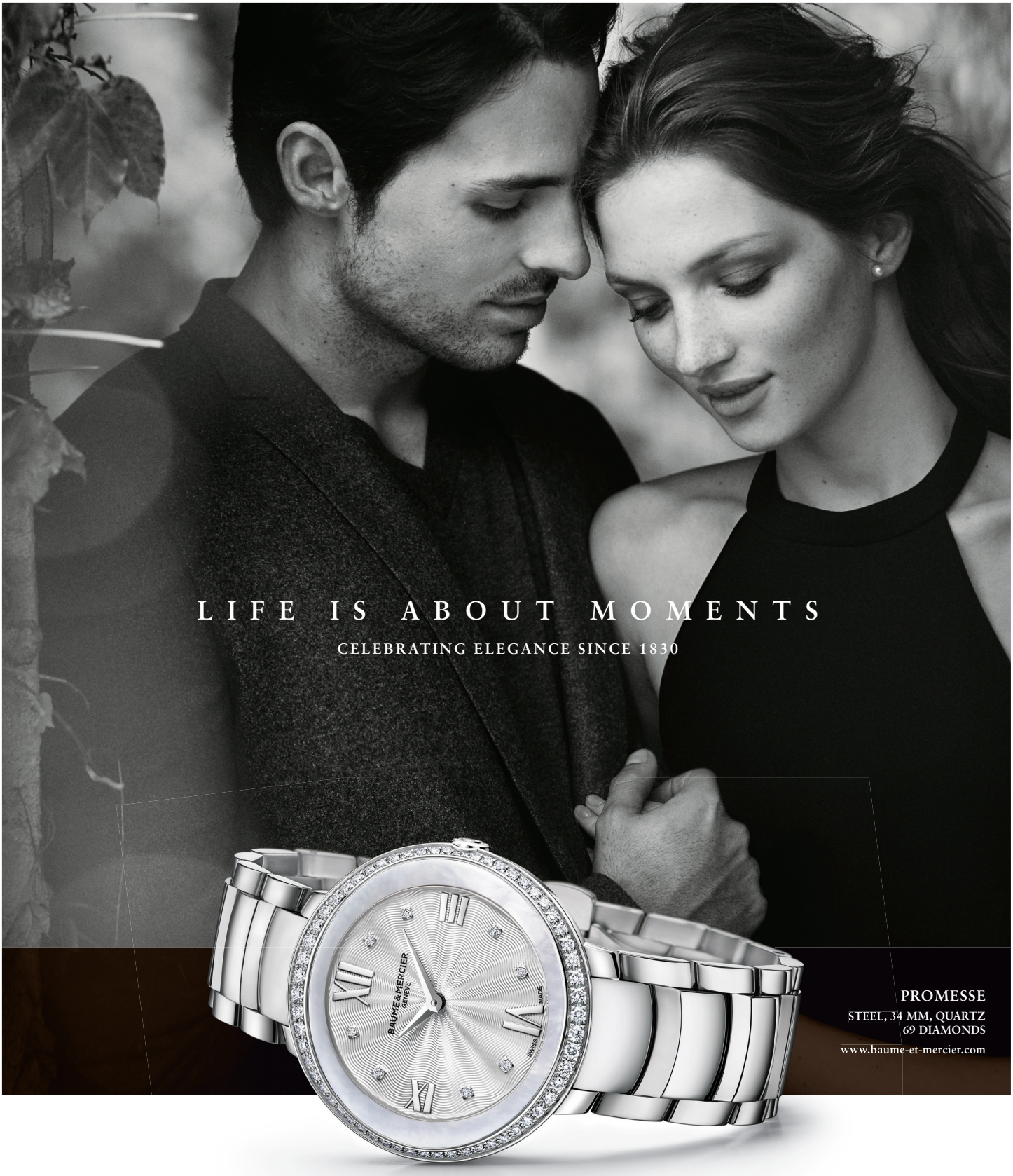

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My Retirement Mindset

by R. Lowell Chaffin, M.D.

For most retirement is coming. For others it is already here. For me it came last year. I had a great career. I feel fortunate for all the opportunities that medicine provided me and for the friends that I made along the way. But this past year has been as rewarding as any of my practice years. My transition to retirement has been smooth. I was mentally, emotionally, and physically ready. I do not know what triggered the exact timing, but I had been mulling the possibility for years. This gave me time to formulate a plan and generate excitement about tomorrow. Refining my retirement mindset was an important factor in my smooth transition.

When I started preparing for retirement, I attended a retirement planning seminar. It should have been retitled as a financial retirement planning seminar. It was not what I was looking for; I wanted one that explored the development of a retirement lifestyle. At first I was disappointed but later I was glad that I went. I came away with an appreciation for all the work that Jana and I had done. What seemed like sacrifice then seemed like wisdom today. Making adequate provision for financial security in retirement is a complex issue. It takes not only planning but time. I am glad that Jana and I had the self discipline to start early and to devise a prudent course. I am keenly aware that the decisions we made in the past have brought us successfully to this point. I am so grateful for the wise counsel we received and the wisdom to listen. I am so glad that, as we saved, we also quietly gave. I am convinced that when you give your first fruits you will be blessed many times over.

Just as financial planning underscores success, I needed to plan how I wanted my retirement life to unfold. We all spend a lot of time/effort in planning our career decisions, from selecting a college, to choosing an occupation, to years of training. For me, those good decisions carried me happily through the last 40 years and brought me to retirement. I felt remiss that I had not applied as much thought to the next 20 years. To catch up, I began applying daily effort. That planning started with an analysis of myself in order to know what I wanted out of the next decades. My career was not just about making money. My job was where I felt secure, respected, and trusted. It was a place where I grew personally and professionally. I valued the friendship of my colleagues, nurses, and patients. It was an occupation in which I could easily see the good I was doing for others. But now I needed to figure out how I was going to structure my days, weeks, and life in the future years. I knew that retirement could not be a substitute for the years before. I was most concerned with how my personal decision to retire would affect my wife Jana. I have been blessed with a good life and a good wife. I started dialoguing with her about the shaping of the next decades. My greatest failure would have been in neglecting her wants/needs in my plans. To do so would also have been the biggest impediment to my happiness. I am so glad that she was an ardent supporter of my retirement and had more insight into the future than I.

Influencing Factors

I loved my practice. I loved my time at work. I loved my nurses and associates. I loved it right up to the day I left. So why did I choose to leave? It was not that I felt a push out the door. The timing just felt right. Many factors generated that feeling.

First, I knew financially that I could retire. I had done the planning and work long before. Financially, I could have retired years ago but did not. So, while this was a critical factor, it was not a catalytic factor. However, I would not have considered retirement if I could not have afforded it.

Secondly, although I loved my work, I was no longer challenged by the call to grow better. Whether I were to practice 1 or 5 more years, the time horizon was too short to justify the time and effort it takes to acquire new skills and knowledge. I knew that I could not ride into tomorrow on the waves of today. If you don't grow, time itself diminishes you. I willingly left to the younger and more energetic that investment of time.

Thirdly, although I had had prostate cancer, I considered my health good, but I was mindful that health issues predominantly afflict the elderly. By survival tables, my life expectancy was 86; I had already lived 82% of my life span. For most, vitality rapidly declines in the last quarter of retirement, so I only had a few good years left. Working only shortens the good years and not the bad years. I wanted to retire while I still had the stamina and agility to take advantage of the good years. None of us know what tomorrow holds, and I did not want to wait too long.

Fourth, other life issues had become more important. In the past Jana and I had a family that needed our collective teamwork. Although we still have our granddaughter to shepherd, it was now time for us to move on. It was time for me to invest in Jana rather than us in them. It was time for us to assume the role of purveyors of insight rather than purveyors of support, while expanding our understanding of one another. God blessed me with a good wife. I wanted to explore that gift. I am reminded of Browning's sonnet: "Come grow old along with me, the best is yet to be, the last of life for which the first was made." Not where I breathe but where I love, I live. I wanted to concentrate these last few years on my wife, my family, and my friends.

Fifth, during my career all my efforts were concentrated on taking care of

my family or on being a better doctor. As a consequence, many interests were relegated to lesser importance. The constraints of time set the limits. Now I wanted the time to grow my heart and to explore who I was. I wanted to know my depth and breadth.

Sixth, I valued the freedom to shape my own day, the joy that comes from self expression. Heretofore, the day was governed by my schedule. It was not a reflection of me. I wanted the freedom and challenge to tailor each day so at the end of the day I could say: "I grew my way".

Seventh, I wanted time to explore the world around me from travel, to meetings, to classes, to people, to observations. I am a lifelong learner. The thrill of learning in many different subjects entices me and grows me.

Finally, I wanted the time to shape my heart, to mold it to be more Christ-like, so those who passed my way would know the source of my allegiance and strength. I had sorely neglected this as I undertook to deal with the pressures of life's vicissitudes. I firmly believe that the solutions to my problems lie within my heart and not in the circumstances that life sends me. I believe that people do not care how much I know until they understand how much I care. I wanted to cultivate friendships and activities that share and grow my heart and my relationships.

Keys to a Happy Retirement

Despite all the individual factors, I was most motivated by the desire to explore the next chapter of life and not the eagerness to exit the current chapter. Whether in retirement or in any other life circumstance, I believe that life is not determined by the events that happen to me but rather by how I react to those events, not by what life brings me but by the attitude/gratitude I bring to life. It will not be my position but my disposition that makes me happy in retirement. Retirement offered the opportunity to open another exciting door.

Many people dream of a happy retirement, but I believe that those who find happiness in retirement are those who work hard at it. Good luck is the lazy man's explanation for a worker's success. Determination is the key to success. Successful retirees are not those who dream about it but those who get up each morning and work hard at it. Clearly, transitioning from decades of a career to the unmolded future of retirement represents a major directional change in life's progression. At first, change seemed scary until I realized that I could not grow without changing. As I pondered retirement, I learned to embrace change. Things change for a reason. Once I learned to see boundaries as opportunities, then retirement life held no limits. Just as in my career, I know, as I explore uncharted waters, that I will sometimes fail. But sometimes my noble failures serve me better than my most distinguished successes. A smooth sea never made a skillful mariner. So I continue in retirement mode with confidence, knowing that others have gone before. I will not be different from those other successful retirees. They were ordinary workers like me. I am reminded that successful people are not those who do extraordinary things, but those who do ordinary things extraordinarily well. Retirement will be only as complex as I make it. So far I have kept it simple. My retirement will be as bright as my attitude about the future. I choose faith over doubt, hope over despair, and effort over luck.

I had been ambivalent about retirement for years but I felt that last year was the right time for me. I was reminded that there is never a wrong time to do the right thing. A decision was needed. The measure of a man's life is the courage to do the right thing, to choose right over wrong, ethics over convenience, and truth over popularity. Today I know that happiness will not be doing what I like but liking what I do. Similarly, contentment will be wanting what I have and not in coveting what I do not have. I have a grateful heart for the life and the wife God has given me. I had been blessed with a great career and supporting family and friends. It was now time to turn my heart towards them. I will be forever grateful for the road that had brought me to this stage of life.

I anticipate that the next road into retirement will hold as much joy as the road to my launch. It is my plan to live to become a happy centurion. After much reading and thinking, I have distilled 6 concepts as the keys to get me happily through retirement to the end of life. First I plan to be gratefully adaptable, peacefully adjusting to what life brings me and not wailing about what it did not bring. Secondly I plan on maintaining a forgiving spirit towards myself and others. Third I will continuously grow and cultivate social contacts outside my inner circle. Fourth I plan to incorporate physical activity and mental challenges to keep my aging mind and body well oiled and stimulated. Fifth I will always have a service project underway to make me feel worthwhile and to justify why God is keeping me on this earth. And last I will have an abiding faith in My Higher Power and where HE is leading me. I believe that if I can follow these steps, I will have a happy retirement to the end.

So far it must be working. My days are full and enjoyable. Life is good. The sun shines. I have no inkling to revisit my career. The decision to retire was a good one for me. If I have any regret, it is that I did not do it sooner.

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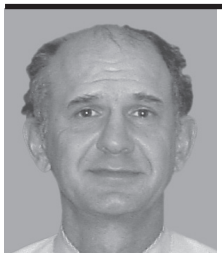

Dr. William Price

by Steve Urban, M.D.

William T. Price, M.D.

Dr. Bill Price's medical career spanned 47 years in Amarillo—from his first surgeries in 1955 to his retirement in 2002. His surgical skills were developed in some of the best training programs in America, tempered and tested in a MASH hospital a few miles from the front in the Korean war, and honed in the ORs of all Amarillo's hospitals. He saw the development of modern imaging and stereotactic surgical techniques, removed hundreds of brain tumors and evacuated thousands of subdural hematomas, and helped lead the Amarillo medical community into the 21st century. But—both before retirement and after—Bill and wife Jimmie Dell have been leaders in another community—the artistic community. Bill Price is one of the most astute collectors of Japanese, middle Eastern, and Asian art in the United States. This paper hopes to give honor to both aspects of Bill Price's professional achievements.

Early years and medical education

Bill Price was born in Tuscaloosa, Alabama in 1923 and spent much of his childhood there, in the shadow of the University of Alabama. Although his parents were far from indigent, he grew up in the Great Depression; his first job was in a sawmill at age 12. Fortunately, an aunt who "married well" was able to pay for his tuition to the University of Alabama. An undergraduate course in neuroanatomy, and the charismatic teacher of that course, piqued his interest in the nervous system, and redirected his early interest from law to medicine.

Interestingly, the University of Alabama only sponsored a 2 year medical curriculum (in Tuscaloosa, not as today in Birmingham), and after the second year the students had to fend for themselves in finding a site for the 3rd and 4th years. Fortunately, Bill's academic prowess earned him a slot at Vanderbilt, where he graduated in 1947. Because of World War II, every student in his class was inducted into either the Army or the Navy. Bill selected the Army and was classified as a private, but he did not see combat since the war ended before graduation.

Bill was undecided between neurosurgery and Ob/gyn, but a surgery/ob-gyn internship at Grady Hospital in Atlanta decided the issue. Dr. Price says that this year and his year in Korea were the hardest of his life. Bill remembers his "worst night of the year" on the obstetric service at Grady, when he delivered 19 babies in one night; the rigors of neurosurgery seemed tame in comparison. Bill started with a two-year general surgical and neurosurgery residency at the Medical College of Virginia, followed by a neurosurgery fellowship at the Lahey Clinic in Boston and finally a neurology and neurosurgery residency at the University of Illinois at Chicago. In the early 1950's UI/Chicago, under the leadership of renowned neurosurgeons Eric Oldberg and Percival Bailey, was one of the best in the world. Bill completed his neurosurgery residency there in 1952.

Neurosurgery in Korea

All male medical students (there were few women at the time) had to enroll in the reserve corps, and Bill was called up into the army for the Korean War. He spent 7 weeks in Tokyo (buying his first Japanese prints at the time) before going to the front, as commanding officer of the 227th neurosurgery detachment of the 8th army. You can get an idea of the intensity of Bill's work in the trenches from Robert Altman's movie MASH. Bill was on call every night and day for a year; choppers would bring in 6-10 neurosurgery patients every 24 hours. Bill often operated on 5 or 6 brain cases in a day—never less than 2 or 3. On his first day in Korea, the departing neurosurgeon advised him that it was necessary to remove patients' eyes if they had been destroyed. Bill was horrified and informed him that he had never seen an enucleation. The departing surgeon pointed to a nearby copy of Callahan's Surgical Atlas and said there was nothing to it. Bill studied the atlas for 30 minutes before he went to bed. After midnight, he was called in to operate on a patient with a gunshot wound to the head and a destroyed eye. For seven consecutive nights after midnight, Bill had to remove one or two eyes.

At the start of the war, all American neurosurgical cases were referred to a hospital ship or to the hospital in Tokyo regardless of other injuries they might have sustained. The mortality was 78%. When neurosurgeons were deployed to the MASH units on the front, the mortality rate for American neurosurgical cases dropped to 12%.

When Bill arrived, all South Korean neurosurgical cases were referred to the South Korean MASHes where they did not have a properly trained neurosurgeon. Bill and his fellow neurosurgeon, Bernard Finneson, never referred a brain case to the Korean MASH. Instead, those cases were treated in the American MASH. There were 2 American divisions and 5 South Korean divisions in Bill's area, so there were numerous South Korean brain injuries. As the year progressed, South Korean ambulances and helicopters began to bring all South Korean casualties with brain injuries directly to his MASH. This greatly increased the workload for the unit's surgeons, anesthesiologists, etc. since these patients' had other injuries

that needed to be treated. Bill recalls that everyone was working very hard. Eventually, the medical staff formed a committee to complain to Lt. Colonel Hayes, the hospital commander at that time, in hopes of restraining Bill and his fellow neurosurgeon. The Lt. Colonel listened to their complaints and told them to get back to work as the neurosurgeons were doing a good job. Directly and indirectly, this policy resulted in better care for South Korean soldiers and saved many lives.

After his time in Korea ("One year and two days," Bill vividly recalls), Bill spent most of his second year in Tokyo, still occupied by American forces after the war. There he attended the American Embassy's language school for spoken Japanese and developed speaking proficiency in the language. This helped him to negotiate the art galleries and markets for Japanese woodblock prints. Bill admits that he knew almost nothing about fine art before this year in Tokyo, but when he left he had over 550 prints.

Neurosurgery in Amarillo

Bill received his honorable discharge from the Army in May 1955 and began looking for career opportunities. Bill investigated Baton Rouge LA and Austin TX, but neither state would accept the national board licensing exam; so Bill had to take the Texas state exam in Fort Worth. Afterwards, he was driving to California to look at a job opportunity when he stopped to spend the night in Amarillo. A few weeks earlier in Chicago, Dr. Percival Bailey advised him that there had been a great opportunity for a neurosurgeon in Amarillo, Texas, but Dr. Sam Scott had recently taken it. Dr. Scott seemed to be one step ahead of Bill; he found that in many cities he visited Dr. Scott had been there just prior to his arrival to look at the same opportunities! Still, Dr. Bailey told Bill that if he was ever in Amarillo, he should at least stop to talk to Dr. Clay Dine, who had been an associate of Dr. Bailey's at the University of Chicago.

Dr. Victor Ellis was the first residency-trained neurosurgeon in Amarillo, but he had been called away for duty in the US Navy. Then, a few days prior to Bill's arrival, Dr. Scott had passed away at age 31 from Streptococcal endocarditis. Amarillo practitioners were desperate. Drs. Clay Dine and Walter Watkins met him at his motel to try to convince him to stay in Amarillo. Various doctors entertained Bill over the next five days.

| *continued on page 21*

Spotlight on New Members

The following were approved for membership on January 12, 2016:

REGULAR MEMBERSHIP:

MARTINCHECK, DAVID L., M.D. - AN
Advanced Pain Care, 2001 Coulter, 79106. Graduated University of Texas Medical School, Houston, TX., 2006. Internship and Residency at TTUHSC, Lubbock, TX, 2012

WILKERSON, JAMIE L., M.D. - OB/GYN
Panhandle Obstetrics & Gynecology, 7620 Wallace Blvd., 79124 Graduated from TTUHSC, Lubbock, TX., 2011. Internship and Residency at TTUHSC, Lubbock, TX., 2015

KIRKLAND, JAMES PATRICK, M.D. - ER
ER Now, 2101 S. Coulter, 79106. Graduated University of Mississippi, 2007. PostGraduate work at University of Mississippi finishing in 2011

RETIRED MEMBERSHIP:

MASON, JAMES, M.D., -PD
7402 Parkridge Dr., Amarillo, TX, 79119

The following were approved for membership on March 8, 2016:

TRANSFER MEMBERSHIP:

TROUTMAN, GERAD A., M.D. EMERGENCY MEDICINE (EM)
Transfer from Lubbock-Crosby-Garza County Medical Society, Graduated from Texas Tech University Health Sciences Center, Lubbock TX 2007. Internship and Residency at University of Mississippi, Jackson, MS 2007-2011

RETIRED MEMBERSHIP:

RIKER, JOAN E., M.D., INTERNAL MEDICINE/GERIATRICS (IM/GER)
7910 London Court, Amarillo TX 79119

SETHI, USHA, M.D. - OBSTETRICS/GYNECOLOGY (OBG)
7402 Parkway Drive, Amarillo TX 79119

The following were approved for membership on March 8, 2016:

RETIRED MEMBERSHIP/LIFE:

HALE, WILLIAM P., M.D., OTOLARYNGOLOGY (OTO)
7210 Versailles, Amarillo TX 79121

WILLIAMS, MICHAEL D., OBSTETRICS/GYNECOLOGY (OBG)
6403 Palacio, Amarillo TX 79109

The following were approved for membership on May 10, 2016:

TRANSFER MEMBERSHIP:

MIMS, TIMOTHY, M.D., ANESTHESIOLOGY//PAIN MANAHGEMENT (AN/APM)
Transfer from Travis County Medical Society, Graduated from Ross University, Roseau, Dominica, 1999. Internship at Brookdale Hospital, Brooklyn NY, 2000-2001. Residency at Mount Sinai School of Medicine, New York NY, 2001-2004. Fellowship at Memorial Sloan-Kettering Cancer Center, New York NY, 2005-2006 (Pain Medicine)

The following were approved for membership on July 12, 2016:

REGULAR MEMBERSHIP:

ALAPATI, SRILATHA, M.D. - PEDIATRICS, CARDIOLOGY (PDC)
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On separate occasions, orthopedists Dr. Charles Sadler and Dr. Bob Hyde asked him to assist in spine cases. Bill didn't go down Route 66 to California; he knew that Amarillo was destined to be his home.

Bill's nearly 50 years of practice were intense. He worked at all 3 hospitals—St. Anthony's, Northwest Texas, and High Plains Baptist—often having to run across town to get the patients seen and the surgeries done. There were no medical neurologists in Amarillo until Dr. Joe Batson came to town in 1970, so neurosurgeons would see all neurological cases too. Bill would often see 25 patients a day—40 when on call on the weekends. He welcomed colorful Louis Finney and then well-trained youngsters Chuck Rimmer and Wayne Paullus Sr. to town. After retiring from the OR in 1998, Bill worked in Dr. Paullus' office, seeing patients with chronic neurological problems. He finally retired for good in 2002—55 years after graduating from Vanderbilt!

When asked about changes in his years of practice, Dr. Price emphasizes improvements in imaging and diagnostic techniques. During his first 15 years in Amarillo, CT scans were not available. The diagnosis of a brain tumor, for instance, was suggested by the clinical examination and supported by carotid and vertebral angiography and by "air studies"—i.e. pneumoencephalography, a painful and risky procedure. Anatomical definition of tumor margins was difficult in the absence of detailed imaging. Bill, along with Dr. Paullus and Dr. Jeff Cone, brought the first MRI scanner to Amarillo, before any of the hospitals had their own.

Bill Price and Asian art

Bill is known in the Panhandle community for his kindness, his expertise, and his dedication to his patients. In the world on international art, however, he has a separate reputation. His collection of Japanese wood block prints is among the finest in the Southwest. Bill began his collection in 1953, when an officer in Tokyo took him to shops where Edo period (1615-1868) art was available. Initially, he began with the Edo artist Eisen, but his collection of prints now includes works by Utamaro, Hiroshige, and Hokusai, the greatest proponents of this most Japanese of art forms.

In the 1950's Bill developed an interest in native American rugs and other textiles, which led into a fascination with middle eastern rugs. Bill started with Caucasian textiles, but his interest spread to rugs from Turkey, Iran, and Turkmenistan. He became a preeminent collector of Turkish rugs—especially those of the Ladik school. He served on the board of directors of the Textile Museum in Washington DC (probably the most prominent textile museum in the US) as an active member for 10 years and as an honorary member for 17 years. In 1978, he was invited by the Shah of Iran to participate in the grand opening of the Carpet Museum of Iran; he spent over 2 weeks in Tehran, being feted by the greatest patrons of this ancient art. Bill jokes that "I had more than he [the Shah] had"; before he started donating his textiles to museums, Bill had hundreds of antique oriental rugs!

By 1979 the Shah had been ousted, and Bill was invited to Delhi to view some Indian rugs. Because of political unrest at the time, Bill didn't have immediate access to the textiles, but began to look at Indian statuary. His collection is now replete with dancing Shivas, Buddhist monumental heads, and exquisite Gandharan art from Afghanistan and Pakistan. His Oriental artwork extends from a 1st century BC casting from North India to more contemporary works. He is particularly proud of his pieces from the Khmer culture (in modern Cambodia and the surrounding region) and extensive Buddhist and Hindu work from India. These works were purchased at auction at Sotheby's and Christie's, as well as from various dealers in the United States. You can go to the third floor of the Amarillo Museum of Art for a glimpse at some of his Asian collection. Bill has given extensively to the Amarillo Museum of Art as well as to the Birmingham Museum, but still his personal collection of Japanese prints, Caucasian and Turkish textiles and Asian statuary is outstanding. When asked about his method of choosing his collection, Bill says that he always bought what he liked (perhaps this accounts for the number of buxom goddesses). "I never bought a piece for investment," he says.

Today, at age 92, Bill doesn't move fast enough to round on 40 patients a day, but his mind still dances with alacrity. He keeps up with the art world and can tell you the provenance of each of his works by heart. Last year, he took a continuing education course in written Japanese at Amarillo College, 62 years after his first encounter with the language! According to his instructor (my daughter Catherine), he was her "star pupil". Bill Price learned compassion at his mother's knee, neurosurgery in medical school and residency, ophthalmology on the fly, and art appreciation by intuition and taste. He has enriched the lives of tens of thousands, both by his medical care and by generosity with his art collection, and at age 92, he's not done yet. Bring on intermediate Japanese!

In Memory

Dr. Daniel Jenkins,

Internist, died Thursday, September 8, 2016 at the age of 63. He was a member of the Potter Randall County Medical Society for 30 years.

Growing Up in a Medical Family

by Emily Archer, M.D.

It was 1962, and while all the other little girls were dressing up like their moms or Disney princesses, my sisters Elizabeth and Evelyn and I were dressing up in my father's clothes. [My father is Dr. Richard Archer.] It might have been foreshadowing for things to come, or it might have just been a funny thing for us to do, since we were always finding all sorts of creative and inventive activities to do on a tight budget. I come from a highly medical family. If you count all of the doctors in our extended family, add in all of the doctors we have married, then add in various 1st degree relatives, plus our offspring, aunts, uncles, grandfather, and so forth, I have counted 30 medical degrees in my extended family, almost exclusively from various Texas medical schools, plus I have 5 nieces/spouses-of-nieces/daughters currently in medical school, and one nephew matriculating in the fall. So patients in Texas haven't seen the last of the extended Archer/Andrew/Biggs/Schaeffer/McCarthy clan.

Growing up in a medical family was wonderful for me. I knew by the time I was 6 years old that I wanted to be a doctor, and I had my life planned out for the next 20 years. I knew I would attend Olsen Park, Crockett, Tascosa, Amarillo College, UT Austin, and finally UT Southwestern Medical School. I never questioned my plan, or how I would get there, and it never occurred to me that I might not be accepted. I had a level of hubris that is astonishing to me today; I realize now how oblivious I must have been in my simple assumption that I would be able to do everything that I planned with no interruptions or glitches along the way. Seeing the difference between my experience and this next generation's application process makes me realize how much harder getting into elite universities and medical schools has become.

I started my medical career extremely early. I can remember classmates as early as the 4th grade asking me for medical advice or questioning me about the medical problems of their family members. [In retrospect, this seems so ironic that other children would trust me in this way, but it happened, so I can only presume that I had a doctorly demeanor despite my youth. I was an introverted, serious student with a penchant for funny stories, and I guess this premature gravitas gained their early undeserved trust.] Even my own family consulted with me about medical matters. Somehow I had gotten hold of a first aid kit with a red cross on it. I always made sure that I had plenty of Band-Aids, ACE bandages, and that "magical" first aid cream. My sister Estelle still remembers that, when I would apply that cream (which was probably just hand lotion) to boo-boos, they always felt a lot better. With my "superior" medical knowledge, I knew that applying an ACE bandage around the head of a headache sufferer was a sure-fire cure for headache! In retrospect, I suspect that the ACE bandage drew attention to the sufferer in such a way as to make them pleased with the results of my medicinal ministrations. To this day, I still think sympathy and kindness go a long way towards curing the ills of many people.

My father's approach to illness was quite different. He kept a syringe with a very long needle filled with Penicillin in the door of the refrigerator. If any of us complained of illness, he would tell us to "go get the Penicillin shot." It is simply AMAZING how many instant cures were declared! I can't remember him actually administering the shot to anyone. Even when my sister Evelyn got double pneumonia and went to the state finals swimming championship to swim the 500 yard freestyle event, she refused "The Penicillin Shot." (Of course, when it was discovered that she had pneumonia, she got appropriate treatment, but this just illustrates how scared we all were of that long-needled shot lurking in the refrigerator door.)

Medical school and residency were amazing, incredible, unbelievable, heart-breaking, soul-crushing, exhilarating, traumatic, hilarious, sad, exhausting, expletive-deleted experiences. In fact, I cannot think of a single adjective that in some way or another wouldn't describe those years. Medical school and residency taught me in no uncertain terms that I could *never* use my gender as an excuse for missing work. Pregnancy was a "gender-related" affliction, and when I was a resident in Boston, I was publicly humiliated by other residents for "taking away a man's position in medical school." I was punished in insidious ways for having the audacity to be pregnant while being a doctor. It was made very clear to me that I was on my own and couldn't count on anyone else to help me through that time. My internal dialog was, "Never let them see you cry. Never show weakness. Keep your head down, and your mouth shut. Just get through this. Your ancestors survived crossing the prairie, living in dugout houses, and fighting rattlesnakes, drought, and the dust bowl. You can do this. Never let them see you cry...."

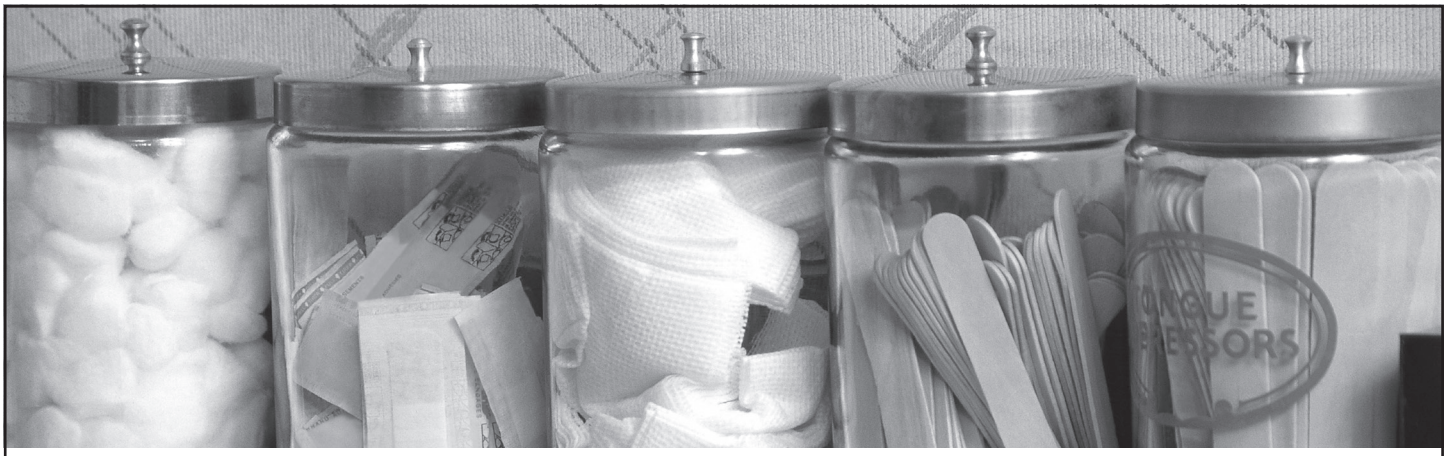
So, in 1986, I ended up back in Amarillo with a husband (my former anatomy partner Dr. Reddy Biggs), a son (Richard), and fortunately, part of my extended family. I practiced solo OB/GYN 365 days a year, by myself, with almost no breaks, not even for weekends or holidays, for 8 years. I only took 3 days off after my second son was born in 1987 before I was back at the hospital delivering someone else's baby. I didn't have any role models to tell me that this was insane, since I was the only female OB/GYN in private practice in the city at the time. I had a miscarriage on a Sunday which necessitated a D&C. The following day, on Monday morning, I performed a C-section for a patient. Having "learned my lesson" after second son William was born, I took a "full" 2 weeks off after the births of Sarah and Grace. When I finally needed an emergency hysterectomy for sepsis myself at three o'clock in the morning in 1993, it made a patient cry because it was going to delay her own surgery; so I was back in the office 7 days later and back in the operating room taking care of her needs 14 days later.

Medicine is unique in the overwhelming time commitment that is required of its practitioners, both in time required to take care of patients, as well as constantly studying and keeping up with continuing medical education, plus loads of after-hours paper work. Luckily for me, all 7 of my siblings ended up returning to Amarillo, 6 to practice medicine, and all to raise their own families. Everyone had some idea of what I was up against trying to rear 4 children while running a medical practice, delivering babies in the middle of the day or night, running a household, and trying to keep it "all together." When I was asked, not infrequently, how I "did it all," my usual response was that I felt like I was doing a crummy job at everything. The only way I was actually able to do it at all was with massive infusions of help, not just from family, but from a hired cadre of housekeepers, babysitters, nurses, and office help. Were it not for all of them, I wouldn't have lasted as long as I did.

The cracks in my life started to appear when my beloved sister Elizabeth (Dr. Elizabeth Archer, dermatologist, married to Dr. John Andrew, radiologist) was diagnosed with colon cancer. Not only was she my sister and best friend, but she was my moral compass and my patient. Her illness was horrible beyond anything I have ever seen before or since, partly due to medical errors that should never have happened. After Elizabeth was diagnosed with colon cancer, she lived 3 years in brutal agony, requiring multiple additional surgeries, chemotherapy, innumerable rounds of antibiotics and hospitalizations. It was awful. I was still practicing medicine, and I cannot count how many days I left work exhausted to go take care of Elizabeth because of yet another medical catastrophe, or to give her a foot massage, or to just to watch a show with her because she was so lonely at home. Once, I asked Elizabeth if she had the choice between being able to exercise again (she LOVED to exercise), or being able to practice medicine again, which would she choose? Without hesitation, she said she wished she could practice medicine. Elizabeth was a dermatologist, and dermatology was her absolute passion. She was really good at it, and she loved what she did. I think she would have done it for free.

Elizabeth's death was a crushing blow for many reasons. We already knew that Evelyn (Dr. Evelyn Archer, dermatologist) had a reoccurrence of her breast cancer, which had been in remission, and that Elizabeth had promised to be Evelyn's caretaker when the time came for her final battle with cancer. As the oldest sibling, Elizabeth had also promised to take care of our parents as age and infirmity set in. Her loss echoes painfully through my family to this very day. Her daughter Rachel is a surgical resident in Hershey, PA, with plans to specialize in colorectal surgery. I'm sure that losing her mother during her freshman year of medical school influenced her career choice. The tragedy of Elizabeth's untimely death also influenced Ruthie, Elizabeth's oldest daughter. Ruthie is a 4th year medical student at Texas Tech Health Science Center, and it saddens me that Elizabeth did not live to see Ruthie start medical school. I know in my heart that it would have made her enormously proud and happy to know that Ruthie finally chose the path that her mother had always dreamed for her.

During this traumatic period of my life, I began having my own health problem with an autoimmune disease coupled with adrenal failure. I couldn't believe that I was having health problems since I have never smoked, always exercised, and ate healthfully. Except for the extreme stress of trying to practice medicine while raising a family, I thought I had done a pretty good job of taking care of myself. I guess no one believes that these things are waiting in the future, and illness always seems to come as a big surprise.



My life plan had been to continue practicing medicine in some fashion until I was in my 80's, since that was what Dr. Early B. Lokey had done. If he could do it, I thought I could, too. But, as John Lennon famously said, "Life is what happens while you are busy making other plans."

Sick and hurting, I abruptly retired in January 2013, and the following month, my dear sister Evelyn, who was just a year younger than I, went into her final decline from breast cancer. The next few months, I dedicated my life, with the help my parents and siblings, as well as her many physicians and health care providers, to helping Evelyn through the devastating complications of her widely metastatic disease. Once again, I was not only taking care of my sister, but also my best friend, my confidante, my keeper of memories, and my patient. It was arguably the saddest year of my life, and yet I felt enormously grateful to the universe and to my husband for allowing me the privilege and time to devote to her needs. We all pulled together to give Evelyn the death with dignity and grace that was denied to my dear, sweet sister Elizabeth. The last thing I asked Evelyn was, "Are you in any pain." She replied, "No, I'm not in pain." She lapsed into a coma and died the next morning.

Tears stream down my face as I write these recollections. I recall the feeling of being utterly bereft when these losses occurred—far too soon, far before their time. In my own mind, I was thinking that I never, ever wanted to live alone. The four years of unbearable lonesomeness I endured in Dallas during medical school taught me that I was never meant to live all by myself. When I got married, I made a pledge to myself that I would do WHATEVER IT TOOK to make my marriage work, because I never, ever wanted to live alone again. Growing up with 7 siblings and more than a dozen cousins close by, I knew I was meant to live in a house filled to capacity with people! As time went on, I thought I would hedge my bet again by having 4 children, thinking that surely someone would always be there for me to live with.

But, despite all of my advance planning, after Evelyn died in 2013, I found myself alone in an empty house with nothing meaningful to do. After all of those crazy years when I didn't even have time to reach down and scratch the mosquito bites on my legs because my hands were occupied in sterile surgeries, or washing dishes, or changing diapers, or performing pelvic exams, or holding two children (one on each hip), with two little boys—one hanging onto each leg—after all of that, I had an empty, lonely home. My housekeeper of 25 years retired. The big house that had seemed like a train station with dozens of cars parked out front, and the front door left unlocked so that all of my children's friends could come and go unimpeded, became a mausoleum. The swimming pool was empty, and the water was green with scum and algae, since there was no longer any point in keeping the chemicals in balance. The trampoline was disassembled and given away.

Sadness glommed onto me like Oobleck from *Bartholomew and the Oobleck* (1949) by Dr. Seuss. I had wrongly assumed that with 4 children and a busy medical practice, and an active lifestyle, with swimming and reading and lots of crafts, I would never be bored. My husband was busy with the career that I thought I was going to have—working all hours of the day and night, rarely home, and gone to out-of-town meetings at least every other weekend, if not more. It was NOT what I had expected or planned. Based upon my own personal experience, I would advise physicians to *never* retire if you can possibly help it. Slow down. Work part-time. Do locum tenens, but never retire. You go from being super-important, the top of the pyramid, admired, respected, and needed, making life-and-death decisions to....nothing. Personally, I had hit "heartbreak hill," then a giant brick wall almost immediately afterwards. Retirement isn't nearly as fun or interesting as it sounds in theory....

But, I'm very happy to report that my story didn't end there. In March of 2015, my oldest son Richard and his wife Therese had their first child, a son, Everett. They live 7 minutes away from me. I'm so lucky!!! Everett is the absolute light of my life. Therese and Richard have been more than generous with Everett, and I can never be grateful enough for the love and joy that he has brought into my life—SO unexpected, and, for me, unplanned. I never thought I could love another human being as much as I loved my own children, but, again, happily, I was wrong. All of the years that I spent compromising between caring for my children and caring for my patients are a distant memory. With Everett, there is no need to compromise. I don't feel guilty when I am at work because I think I should be home, and guilty at home because I think I should be at work. With Everett, I am 100% with him, with no distractions. We are both pretty much on the same level but going in opposite directions. As he learns to walk, my steps slow down. We both sleep a lot, and take long cuddly naps together. I don't eat much, and neither does he. It's a symbiotic relationship. I know he'll outgrow me soon, but I'm just grateful for the opportunity to be in his life now.

After much distress and loss of identity and soul searching, I now realize that this next phase of my life can be just as important and meaningful as the last. It certainly doesn't pay as well...in fact, I am paying for the privilege of taking care of the people I love the most in the world, but, in a way, this is always what I wanted to do, that is, *to take care of people.* I count myself as unbelievably fortunate that I was allowed to get an education, to go to medical school when only 17% of my class was women, to practice medicine for 3 decades, and to have a life that has been full beyond my wildest expectations. Instead of being Dr. Emily Archer, I am now Mimi. I consider myself to be one of the most over-educated nannies around, but, I have lived so much more life than I ever imagined could be lived that I can only be incomparably grateful. I feel like I have packed 3 lifetimes into the time I have spent on this Earth!!

A final thought: Although I had to quit practicing medicine before I was ready, I want to pay it forward by helping this next generation get through medical school, residency, and beyond. With 2 daughters, 2 nieces, 2 nephews-in-law, and 2 nephews already starting, in, or finished with medical school, this new plan is working. They will be smarter, stronger, and better prepared for the medical future, and I look forward with love and awe to see what they will accomplish. I won't be doing the work myself, but, through them, the future will indubitably be a better place!

(Editor's note: this article is an abridgement of Dr. Archer's full paper. If you would like to read it in its entirety, contact her at emily@amarillomed.com)

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My Continuing Education

by Nathan Goldstein III, M.D., FAAP

I graduated from the University of Chicago Pritzker School of Medicine in 1970. I served two years as a pediatric resident at the University of Chicago hospitals and was chief resident of pediatrics at Indiana University School of Medicine. In 1973 I joined the faculty at Indiana University as an Assistant Professor in the Department of Pediatrics in the area of ambulatory pediatrics. After two and a half years I joined the faculty at Kansas University (KU) School of Medicine also as Assistant Professor in the Department of Pediatrics. My major role at KU, along with Dr. Rolf Habersang, who was also on the KU faculty, was as co-manager of a neighborhood pediatric health center.

In 1977, I joined three pediatricians in private practice in Amarillo, remaining in practice for fifteen years before becoming Chief Medical Officer at FIRSTCARE, the only HMO in the Panhandle. I worked from 1992 to the end of 1994 in that role. In December 1994 I became the Chief Medical Officer at Northwest Texas Healthcare System (NWTHS), the first person to serve in that position at that hospital. I remained CMO for the next 20 years, until retiring the end of January 2015. I experienced "on-the-job learning" in each practice experience: medical education, private practice and administration as a CMO.

Academic Medicine

As a member of a department of pediatrics at a major pediatric educational program, I learned a number of important lessons. I learned that most individuals have areas in which they are very knowledgeable, but that their medical expertise does not always include all aspects of interacting with others in a teaching environment. I learned that intellectual honesty is not always first and foremost in the minds of some individuals, even those who are very well-known and highly respected. I also learned that it is important to strive to undo an injustice, even when doing so may incur a personal risk to oneself, and especially when correcting that injustice is important for the future of a person in training.

While co-managing the neighborhood pediatric clinic I gained insight in areas not previously taught to me. Dr. Habersang and I had some things in common, but our individual strengths were different and very much complemented one another. We were able to work together to utilize both of our strengths to benefit the clinic and its teaching program. We hired a management consultant to teach our residents about contracting, billing, collecting, and liability issues. After working with the consultant, our clinic manager taught the course to the residents. And along with the residents, I gained knowledge that prepared me for my entry into private pediatric practice. From my experiences in academic medicine I also learned that it is important to find the right place to work or practice, in order to be comfortable and happy; it is critical to be able to look forward to going to work every day. I left both academic positions to find a practice situation in which I felt comfortable and fulfilled.

Private Pediatric Practice

In December 1977, I joined Doctors McCue, Dyer and Barry in Amarillo at the Pediatric Center, an expense-sharing, call-sharing group of pediatricians. During the first ten years of practice, we treated a large number of bacterial (H. flu, pneumococcal and meningococcal etiologies) meningitis patients. I learned how variable the outcome of the disease could be, even if diagnosed early. A child diagnosed in the first hours of illness could have unilateral deafness, while a child treated after days of illness and a seizure could recover virtually unscathed. I also learned that some parents were more concerned about how soon their child with meningitis could eat, rather than whether the child would have neurological damage, even after the potential complications had been explained.

I discovered that some physicians received the majority of their "continuing education" from pharmaceutical representatives. Such "education" resulted in a new cephalosporin being used for bacterial septicemia in a child, when there was good evidence that the new drug did NOT cross the blood brain barrier. Several days after a child had concluded a week of therapy for bacterial septicemia with the new cephalosporin prescribed by another physician, I diagnosed and treated the child for bacterial meningitis from the same bacterium. Fortunately the child suffered no complications from either episode.

In undergraduate abnormal psychology class my professor emphasized that *"one cannot deal rationally with an irrational person"*. I was reminded of the importance of that fact when dealing with an irrational father whose infant child had not recovered from severe RSV bronchiolitis 48 hours after admission. The father said, "You are fired and off the case." I explained that I would transfer his child to the care of another physician as soon as he found an accepting physician. I informed him that I was required to continue providing care for his child until the accepting physician was physically present to care for his child, who was on 100% oxygen per tent, and who would require mechanical ventilation if the child's condition worsened. The father replied, "Leave immediately and don't worry about my child." I again stated what I had stated multiple times, that I could not just leave the child with no treating physician. Again the father stated, "You are fired and I am taking my child home." I completely "lost it"; I became flushed and began to shake. Fortunately, the head nurse of the pediatric unit pulled me away, called security to escort the father off the floor, and took me to the treatment room to decompress. Since then, I've needed no further reminders of my psychology professor's sage advice.

Most parents were profoundly grateful for the effective diagnosis and treatment

of their children, and they expressed their appreciation freely. Interestingly, those few parents who seemed to focus on the cost of care, stating that we should "spare no cost in treating their child," rarely paid their bills. I taught my office staff to be forever mindful that parents who are worried about their children's health are not always polite and to be patient, ignoring the poor behavior. Disgruntled parents would invariably calm down when they became comfortable that their children were going to be okay and even apologized profusely about their poor behavior.

Another important lesson I learned in practice is to avoid being an alarmist. Even when a life-threatening diagnosis is a possibility, concern should be minimized until there is evidence that such a diagnosis is likely. For example, the finding of swollen cervical lymph nodes in a five year old is usually not serious. It is not appropriate to tell the parents you need to perform some tests to rule out leukemia. The diagnosis of leukemia is extremely remote with such an isolated finding in an otherwise healthy five year old, and mentioning a concern about leukemia in such an instance leads to unwarranted anxiety for the parents.

After six or seven years, the expense sharing aspect of my group's relationship ceased, but three of us continued to share call for the remainder of my fifteen years in practice. Dr. David Barry, Dr. Bill McCue and I had shared a similar approach to our patients. No matter who was on call, our respective patients received much the same care. I learned that one should share practice with individual physicians who approach patients in the same manner, and who are equally concerned about the patient's well-being.

In medical school and residency (and repeatedly confirmed in practice), my mentors' advice about the importance of a good history (H) and a complete physical examination (P) was repeatedly confirmed. I was trained before CAT scans and MRIs were available, and I was taught to perform laboratory and radiologic examinations to evaluate differential diagnoses reached following the H & P. I have all too frequently seen a barrage of non-indicated tests performed based on only the chief complaint, with inadequate H & Ps having been performed. My mentors ordered tests only to confirm their presumptive diagnosis. Even with all the testing available today, I continue to believe that my mentors were correct in their approach.

Administrative Medicine

When I began my tenure as Chief Medical Officer (CMO) of FIRSTCARE, Dr. E.B. Lokey advised that I would have to remind physicians that I was no longer a pediatrician rendering approval of a certain therapy, but that I was instead the Chief Medical Officer of the HMO; I quickly learned to follow his advice. I learned to speak with authority, based on sound principles and guidelines. I recall a request for authorization of a hysterectomy for the single indication that the patient's insurance about to lapse. I also remember being asked to approve a child's tonsillectomy, even though the child had never had a single throat culture positive for Group A Streptococci, and in fact the patient had never had a throat culture at all. The patient's mother had treated "sore throats" with one to two days of a single called-in prescription for amoxicillin suspension over a four month period, never having seen a physician. I was the only physician who had obtained that history from the mother; neither the referring pediatrician nor the requesting ENT specialist had obtained that history. At FIRSTCARE I learned that the majority of physicians are honest, ethical and care deeply about providing the best and most appropriate care for their patients. Of course as is often the case there are always exceptions, and those individuals are the reason for rules and guidelines and prior authorization. Those individuals exemplify the 90/10 rule; ten percent of the individuals require ninety percent of one's efforts.

It became obvious to me very early in my twenty years as CMO at NWTHS that hospitals could benefit greatly by having a physician as part of their administrative leadership team. I was rather stunned to hear a hospital administrator ask why emergency room (ER) call schedules were such a big deal for physicians. I suspect that no physician participating in an ER call schedule has ever asked that same question. If one has never taken ER call, one might well wonder why it's a big deal. As a CMO I was readily able to answer that question for my fellow administrators.

To the question, "Wouldn't you rather have me admitting patients to your hospital than completing delinquent medical records?" I learned to respond, "It doesn't matter what I want, since if you don't complete your records, you'll be suspended from the staff and won't be able to do anything at my hospital."

A number of physicians had their clinical privileges terminated at NWTHS during my career. I learned that those physicians tended to have one thing in common. They felt they had never done anything wrong, even though by the time the process of removing them from the staff had occurred, many of their peers had reviewed and concurred about their poor judgment. However, the majority of physicians were ethical and caring and were deeply contrite about any mistake identified by their peers. They often punished themselves more than any external peer review group could.

I worked under six CEOs at NWTHS, and during that time I learned the importance of withholding reaction about a newly surfacing fact until I learned, as Paul Harvey, the radio personality, used to say, the rest of the story. Additional facts and/or findings often greatly altered the initial facts. I fondly remember a surgeon asking for my help in finding his previously dictated pre-op H & P. He was not happy that it couldn't be found, was certain he had dictated it the evening before, and simply wanted me to assist in fixing the problem. He had already done a "short-form" H & P, so that his case could proceed. Imagine how grateful he was that he had not reacted, when he called an hour after completing his case to inform me that he had dictated the H & P at another hospital. He did ask me if he had made a fool of himself, and I was able to tell him that, although he had been upset, he was totally appropriate when he spoke to me.

Finally, I think that perhaps the most important fact my experiences confirmed was that, as a physician and as a CMO, honesty and integrity are absolutely essential to one's effectiveness. The absence of honesty and integrity in treating patients can have serious deleterious effects for the patients, and as a CMO, the absence of such traits would make it impossible to be effective in the role.

Retirement 3.5.02

by Charles Rimmer, M.D.

No more nights on call. No weekends on call. No late nights in the ER. No more medical records. No more meetings. You can sleep in if you choose. You can see a complete movie without interruptions. You can play golf or participate in whatever activity interests you. You can finally take that trip you've been wanting to do. You can go around the world if that interests you. Then when you come home, pay the bills and balance the checkbook. Now what are you going to do? Welcome to retirement.

Work has been the foundation and structure of your life. It's gone. You will need to create a new foundation and structure for your life. Today I use physical exercise, mental exercise, social exercise and spiritual exercise.

Exercise Physically

If you are one of those people who gets sweaty palms and cold feet merely at the thought of physical exercise, please skip this section and go to the next one. As a clinical physician you were busy. You were standing up and sitting down all the time. You were walking to exam rooms and back. You were examining the patients. You were on the computer and the phone. If you worked at the hospital you had to park your car and walk to the entrance. You walked the halls to get to the elevator. Then you walked to the patient's room and walked to the nursing station. You went to the doctors' lounge and back out again. If you were a surgeon you did all that and the work in the OR. You were physically very active. Now that's all gone.

The most important thing now is to keep moving. If you have some type of exercise activity, don't stop. Consider how you can add to it with things you will like and will keep doing. I have organized my exercise activities as balance, strength, range of motion and cardio. Yoga gives me the first three, and I add some free weights. Cardio can be anything to get your pulse up. Please use a pulse monitor, preferably one with a chest band which is more accurate than one on your wrist. The Polar brand synchs with many of the machines, and you can read your heart rate on the console. There are other brands that also do this. A newer approach to cardio is high-intensity interval training (HIIT). The newest one I have read about only involves one minute of intense exercise. Developed st McMaster University in Canada and reported in The New York Times, it is equivalent to 45 minutes of moderate exercise. You warm up for two minutes on a stationary bicycle, then pedal as hard as possible for 20 seconds, ride at a very slow pace for two minutes, sprint again for 20 seconds, recover with slow riding for another two minutes, sprint again for 20 seconds, and finally cool down at a slow pace for three minutes. In ten minutes you are done.

Exercise Mentally

What is wrong with this patient, and how do I treat their illness? Like your body your brain will need exercise to be at its best. CME will be needed to keep your license if you choose to keep it. Continue doing all the things you like to do. I thought I was doing well in this area until several years ago when one of my friends asked me to be a judge at The Science Bowl sponsored by the Department of Energy through PANTEX. I was humiliated to learn that I couldn't pass a middle school science exam. I looked at taking an online GED course. About that time MIT and Harvard created their own education site, edx.org. One of the first courses was Biochemistry—The Secret of Life, taught by Eric Lander. It was a freshman lecture course at MIT. The course work was the hardest and most satisfying I can remember taking. I passed. Now I could read and understand some of the articles in the New England Journal of Medicine (NEJM). I also found a two-semester course on immunology from Rice University. It was difficult, but after completing it more articles were comprehensible. Now I have some understanding of immunotherapy. Can I pass a middle school science exam? No, but now I can answer a lot more of the questions.

Exercise Socially

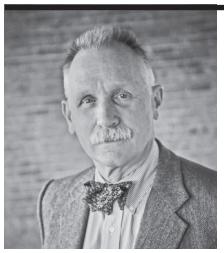
In your work you were surrounded by people and constantly interacting with them. In your practice you persuaded people to do things they didn't want to do for their own wellbeing. The team worked to help, and communication was ongoing. The team is still there, but you aren't. Now you can spend time with your friends without interruption. This is the opportunity to grow in old and new areas of interest to you and to make new friends in your areas of interest. Civic, charitable, religious and volunteer organizations may have wonderful projects where you can share your time and talents. People to people contact is very important and a new journey for you to embrace.

Exercise Spiritually

For most people this will sound like religion. It can be, or it also could be watching one of our beautiful sunsets, listening to special music, reading, playing the guitar or learning to make pottery. You could watch a baby sleep or watch your grandchildren grow. Spiritually is the biggest area where the options seem unlimited. Each individual will need to find his or her own spiritual growth.

3.5.02

In over ten years after my practice closed I have had four major surgeries and have been blessed with two daughters-in-law and four grandchildren. Things will happen and things will change. It is a new life journey. Enjoy it, and good luck.



My Last Grand Rounds Advice and Observations

by Phillip Periman, M.D., F.A.C.P.

In the fifty-five years I have been in the practice of medicine, I estimate I have given over one hundred different grand rounds. Initially, I viewed grand rounds as a chance for the presenters to show off their skills and knowledge. Recently, I have been concerned with the question of whether anyone learns anything from attending grand rounds. I know preparing a grand rounds presentation made me learn. I always discovered something new, relevant, and important.

At my last grand round on 11 May 2016, I not only announced my retirement in January 2017, I gave some unsolicited advice and made some observations based on my years in medicine. I hesitated doing so as medical students and doctors are not only smart, but also generally opinionated and not likely to take advice. Once I told my son not to expect my advice any more as he never took it. He replied, "You would be surprised Dad at how much of your advice I really do take." Remembering our exchange gave me courage to plunge ahead with some observations and advice.

Everyone needs heroes and cheerleaders. For me the founding fathers of the Johns Hopkins Medical School have always been inspirational. Welch, Halsted, Osler, and Kelly changed medical education. They demanded students have a college degree and required high standards of learning. The curriculum put in place in Baltimore and recognized in the Flexner report of 1910 caused a renaissance in medical education. My medical school in St. Louis changed its teaching program, raised an amazingly large endowment, recruited full time professors from the east coast, and since has routinely ranked in the top ten medical schools.

The "Big Four" at Hopkins posed for an impressive group portrait by John Singer Sargent. Each had a distinctive personality. On the weekends,Welch, the Dean and a pathologist, a bachelor given to carnival rides and five dessert meals, visited Atlantic City; Halsted, the father of American surgery, shy and severe with students, retreated to West Virginia and his life-long opiate addiction; Kelly, the gynecologist, preached to the prostitutes on the Baltimore harbor; Osler, the father of internal medicine, became an expert in contriving medical pranks such as getting his report about "penis captivus" published in the medical literature.

Medicine changed then and has continued changing at an accelerating pace. One characteristic of advances in medical science is the immediate widespread acceptance and use of new discoveries. Overnight the old ways of diagnosing and treating disappear. Here is a list of things done routinely when I was a 3rd year medical student in 1963.

1. 75% of doctors smoked; 90% or more of doctors were male.
2. Everyone who wanted to be up-to-date could be found in the library.
3. 67% of hospital deaths went to autopsy.
4. Pneumoencephalograms were the best way to image the brain.
5. Radiologists had stub fingers from radiation damage to their hands.
6. Choral hydrate was the best sleeping pill.
7. Paraldehyde was the best drug for alcoholic withdrawal.
8. Surgical cut-downs were routine for vascular access and i.v. therapy.
9. Hematocrits were actually done by hand.
10. Female nurses ran the wards because they were as capable as the doctors.
11. As there were no Xerox machines, we mailed postcards requesting journal reprints.
12. Every hospital and most private libraries had bound journals. Amarillo had a bookbinder with a shop on 7th Street.
13. A common treatment of peptic ulcer disease was surgery.

Fortunately, medicine changes constantly. Medicine in the good old days never really worked that well. Here is a partial list of things my patient receive routinely that were unavailable in 1963-1964.

1. CT, MRI, and PET scans
2. Quinolone antibiotics
3. Chemotherapy that cures cancer
4. Coronary artery surgery and stenting
5. Dialysis easily available for everyone
6. Medicare
7. Disposable needles
8. Platelet transfusion
9. Growth factors for white cells, red cells, and platelets.
10. Tyrosine kinase inhibitor therapy for chronic myelocytic leukemia
11. Monoclonal antibodies for diagnosis and treatment of disease
12. Subclavian central lines and ports
13. Hospice care

Of course, the above lists are incomplete. The take home lesson is that change in medicine is constant. The question is: how does a committed, caring, and compassionate doctor keep up? Here are some of my suggestions.

1. Read the medical literature related to your patients. Reading about diseases and procedures your patients don't have or need is probably a waste of time. If you read about the specific problems your patients present, that information tends to stick in your memory. Five and ten years later you will be able to recall specific information. It is what I call "useful memory."

2. Read regularly, daily, the best journals, such as the New England Journal of Medicine and the Medical Letter. Subscribe to several good journals. Throw away without opening them journals published by drug companies. These are not refereed and more importantly are not complete. They will not tell you about other companies therapies that might work as well and cost less.

3. Teach someone about your patients. When you can teach someone about the medical problems and solutions required for your patients, you know that you have learned the information.

4. Participate in laboratory and clinical research. This will keep you on the cutting edge and will also make you

aware of the strengths and weaknesses in new medical evidence.
5. Learn more science. Learn more about human beings. Listen and look all the time.

Not only has the science of medicine changed, but also the culture. Once fiercely independent small businessmen, doctors have become employees of hospitals and insurance groups. The Potter-Randall County Medical Society used to have a committee that evaluated the "advertising" done by its members. If the lettering on the sign outside the office was deemed too large, it had to be changed! No doctor had a billboard or TV ad, and even the yellow pages had only a listing of specialties, names and addresses. Medicine has been dragged into the business world. The consequences are still being uncovered. The training of doctors for shift work as compared to training them for 24/7 commitment to their patients may be moving medicine from a profession to a trade.

There is too much money in medicine! The average medical student in 2014 graduated with $183,000 in debt. Since the number of women in medicine now essentially equals the number of men, doctors are marrying doctors. Many couples at age 26 already have children and debt of almost $400,000. Consequently, the doctors coming into practice in 2016 are under tremendous pressure to put financial interests ahead of their patients' interest. This will not change until the cost of medical education decreases.

Hospital administration positions have grown tremendously and their salaries exponentially (see "Medicine's Top Earners Are Not M.D.s" in NY Times, 17 May 2014). According to our local newspaper, one year the CEO of the BSA Hospital took home $2.3 million in compensation. Even not-for-profit hospitals are raking in the bucks. US News & World Report (5/2/2016) carried an article on $150 million profit by such institutions.

My friends at MD Anderson joke that the going price for any new drug is $10,000 per month. Four doses of ipilimumab, which can cure a small percentage of patients with metastatic melanoma, has a wholesale price of $120,000! According to the Wall Street Journal a few years ago, big pharma spent $30 billion on research and $60 billion on marketing. Patients come to my office demanding expensive treatments that are not always the best for their disease. Advertising works.

The Texas Medical Association published data showing that 25% of Texans do not have health insurance. These patients show up in the emergency room with advanced disease that is expensive to treat. The cost of modern medical care is fast becoming unaffordable. What should we as a profession and a society do about the delivery of health care? Perhaps, medical care should be treated as a public utility. I would like to see a single payer system covering basic medical needs including preventive medicine. I think the data show this would have a lower administrative cost. Everyone could be covered. What if medical education were free, but each doctor had to do two years of public service?

My advice to the young doctor is to put your patient's interest first. Always ask if what you are doing is really what will give your patient the best chance to be healed. To care for the patient you must also care for yourself. Become a student for life. Hug and kiss those you love. Never miss a day of vacation. Remember that, regardless of the solutions or lack of them, medicine remains a noble profession, not a business. As Paul Kalanithi wrote in his memoir, "When Breath Becomes Air", medicine should be a "calling" not just a job.

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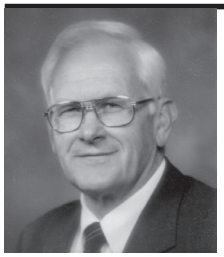
Be a part of the circle. In 2006, Potter Randall County Medical Society introduced the Circle of Friends, a program designed with the business of medicine in mind. Members of the Circle of Friends are companies that pay an annual fee to participate in Medical Society events. Their financial commitment 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.



Medical Practice in the Panhandle– Fifty Years and Counting

by Mitch Jones, M.D.

I grew up in Canyon Texas and majored in Chemistry at West Texas State University. When it became clear I wasn't cut out to be a chemist, one of my first mentors, a kindly chemistry professor, suggested that I might make it in medical school. It is clear that my career has been marked by simply falling into things rather than by careful planning, by considerable luck rather than any notable talent, and by unending dependence on kindness and help from others.

Following medical school [UTMB], internship [Detroit Receiving Hospital] and residency [Menninger Foundation in Kansas], I fell into a job as Medical Director of a Mennonite sponsored psychiatric hospital and clinic in Newton Kansas. I had little administrative experience but learned from that job that the secret to building a good program is to hire the brightest, most competent, creative people you can get [the smarter they are than you are the better]; make good friends with them and give them room to develop their own ideas and style of working. We did well together; I loved the job and the people but felt drawn back to the Panhandle and came with my family to Amarillo in the fall of 1969.

In Amarillo I started a solo private practice in Psychiatry. I shared an office with Jaime Quintanilla and we became close friends. Jaimie was the only board certified child psychiatrist in town. He was a marvelous, gentle clinician and was socially charming and outgoing. [He also had a fiery side which served him surprisingly well on occasion.] With the help of a group of influential citizens, Jamie had established the Kilgore Children's Psychiatric Hospital which he ran as Medical Director for several years. Because of my working relationship with Jaimie I began doing child as well as adult psychiatry and began to put serious study and effort into that field.

In Amarillo in 1969, many, maybe most, physicians were in solo private practice; the specialty groups which existed were relatively small compared to now. There were no subspecialty groups—there were still at least a couple of "double ENT"-[Eye, Ear, Nose and Throat] Docs here. There were less than 200 physicians in town and we almost all knew each other. Essentially every Doctor in town belonged to the Potter Randall Medical Society and the entire membership of the Society met for dinner once a month. In the meetings whatever medical/political issues were current were brought up and debated [sometimes heatedly]. In those days the Medical Society was the primary forum for open expression of ideas and opinions of physicians and had strong influence on outcomes in community projects affecting them. I remember, for example, a long night's discussion about the proposed move of Northwest Texas Hospital from Sixth Street to the medical center on Coulter, and another about bringing full time Emergency Physicians to staff the Emergency room at Northwest Texas Hospital [to replace the system of coverage by private physicians]. Strong feelings were expressed on all sides of these questions, as in many other situations over the years. Usually the problems were settled by agreement or workable compromise.

At every Medical Society meeting, after the meeting and the program, Doctors moved about the room discussing mutually held patients, possible referrals, requests for call coverage and other clinical concerns. This way of interacting and communicating changed with increased numbers of physicians in practice, large and somewhat self-contained groups, importance of Hospital Staff membership and meetings, increase in specialty and super-sub specialty groups, establishment of the medical school and increase in salaried positions for physicians.

I was greatly influenced and helped by physicians and office personnel in the medical community in ways ranging from learning to manage a private practice to use of new or different medications [much help from fellow psychiatrists], to adapting a practice style or even copying mannerisms of certain Docs. I have noted below a few of these local physicians who set standards of accomplishment and service that were exemplary and stand as larger than life examples of good practice.

The psychiatrists in Amarillo were all independent practitioners but worked closely together. Hugh Pennal was unofficial "Dean." Hugh was an expert clinician, a prodigious worker and was direct and outspoken. [Never had to wonder what Hugh was thinking; he told you]. Hugh was tough and funny. He had been a fighter pilot in World War II and was fearless. He was instrumental in the development and building of the Psychiatric Pavilion and was a leader in all other aspects of organized psychiatric care in the Panhandle. He, through sheer force of personality, held the rest of the psychiatrists in town feet to the fire to take our fair share of call for each other and the emergency room and to take care of all patients regardless of circumstances.

Dewey Britain was another close colleague. He was informed and disciplined in clinical practice. He was the best dressed of the psychiatrists in town, which with his thoughtful and measured speech, his pleasant voice and his unlit pipe made him come on as professorial. He had a knack for clear precise writing and was assigned to produce any official document we needed.

Buster McCoy was my greatest support, the best psychiatrist I ever knew. He was always available and never fazed by anything. He was a superbly competent physician who was as calm in the face of crisis as anyone I have ever worked with. He was personally kind and gentle. He sometimes sang snatches of gospel hymns in the nursing station with a sweet voiced nurse's aide. ["Swing Low Sweet Chariot" was their favorite and could be heard

drifting down the hall often on days she was on duty.] Buster was not only unhurried in dealing with tough situations but seemed to relish them and his calmness and control steadied the nerves of everyone around him. Buster and I were in the Nurses' station one morning working on charts. I had some worrisome problem and I mumbled aloud, "O Lord." Buster looked over and said, "Yes my Child?" I still laugh when I think of Buster.

Henry Martinez was an early cardiovascular surgeon who, according to the surgeons who operated with him, was unbelievably technically skilled and innovative in surgery. Henry was an amiable, friendly man, self-assured, unassuming and unflappable. When asked for help he never turned down a colleague or a patient.

Bill Klingensmith was co-founder of an early surgical group. He was a highly trained general Surgeon who pushed for front edge technologies and procedures to be included in local surgical practice. He and Henry Martinez bought a heart lung machine and when the local hospitals wanted nothing to do with it, set it up in Bill's garage where Bill, Henry and his wife Ann, a nurse, practiced with it until St. Anthony's brought it to their facility. Dr. Klingensmith held himself and those he worked with to exacting standards of practice. He was personally engaging, an accomplished raconteur and host and, with his wife, a major player in the arts and cultural activities of the city.

Dr. Early B. Lokey not only was a leading specialist in O.B. Gynecology, but also saw to it that organizations and facilities existed to care for the medical needs of poor and uninsured women.

In those days there was a group of independently practicing pediatricians who were closely allied to each other in providing service to patients and backup for each other. They were all seasoned clinicians and committed to taking good care of kids. It was not uncommon for any one of them to stay close by the bedside of a sick patient night and day until the child got better. Among those good people were John Pickett, George Waddell, Joe Lipscomb, Bill McCue, Mo Dyer, John Jones, and Holley Reid.

Dr. Vic Ellis and Dr. Bill Price arrived about the same time to be the first Neurosurgeons in Amarillo. Both were excellent surgeons and strong, influential personalities and, in the early years, worked literally day and night to meet the demand for their services.

As different in outlook, tastes and personality [some genuine characters] as these physicians were, the best of them shared traits I admired and tried to emulate. They were excellent clinicians; they were sharply aware of advancements in medical science; they cheerfully made themselves available to talk to colleagues and patients; they were cool under pressure; they listened with respect to patients and anyone with information about a patient; they turned no patient down and they all had a sense of humor [optional, but really helpful in medical practice].

Sometimes observing other physicians has taught me what not to do. In my internship I remember a resident who was smart and capable but was so rude and unpleasant when he was on call at night for interns managing patients on his service that we avoided calling him when at all possible. This may have made us more self-reliant in the long run but could be detrimental to the best care of the patient as well as to the resident, who missed out on information regarding the patient he was responsible for. This attitude has similar effect with regard to nurses and other staff. Any Doc should instinctively know that for a patient, in the hospital or out, "boots on the ground" people, those with the patient literally 24 hours a day, including nurses and family, know many things otherwise not apparent about the patient, and should be listened to carefully.

Some physicians are "naturals" at relating to patients and some gradually learn with experience. Seeing the patient as partner, particularly in the care of chronic disease, listening to his or her input and being sure that he or she completely understands the medical condition and the options for treatment is fundamental. The importance of the physician to the patient can't be overemphasized [I learned that by being a patient] For the Doctor the ten or fifteen minute appointment or contact is one of dozens in a busy day, for the patient it is of major importance and has often been looked forward to for days or weeks. The physician's friendliness, competency and caring attitude light the fire of hope in the patient. The faith that the patient has in the Doctor and his or her treatment may be a powerful force in the healing. Medicine is both art and science. The science changes and explodes exponentially but the art of practice doesn't change. The first part of the art is the building of lasting trust and mutual respect with the patient. The second is the weaving of facts of the medical case into a credible narrative. This "story" takes into consideration every detail of history of the illness, every physical and labora-

| *continued on page 37*

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tory and imaging finding, considers all possible causes and explanations for symptoms and findings and narrows the account to a diagnosis that covers all the bases. The building of this narrative may take five minutes in the case of an ingrown toenail or hours or days in a complex case; once formed it is shared in a clear way with the patient and family so that all involved, the professionals and the lay folks, are on board and committed to a plan of treatment.

In the early seventies Dr. Quintanilla and I and other private practice physicians, on voluntary or contract basis, began serving as preceptors for students from the newly formed medical school. For me and the other doctors this was extremely rewarding. The eagerness and enthusiasm of the students was stimulating and we were motivated to not only study and keep up with our specialty more intensely but also to develop clear and interesting teaching styles to try to be of help to the students. Establishing friendly respectful rapport with the student is crucial to a good learning experience. This is another place in which there is benefit in dealing with people smarter than you are—the student often opens new insights and ideas for the attending.

In the late eighties I joined the medical school faculty full time. I continued my inpatient and outpatient practice and my cooperation in the call schedule with private practice psychiatrists and was more heavily involved with supervising clinical work by medical students. I retired from the Medical School and fulltime practice at age 65 in 1996.

From 1996 to 2015 I worked part time at the state prison outside Amarillo. As usual, I "fell into" that job and once there continued to learn a lot. The contact with inmate/patients showed me that the same illnesses and needs existed for them as for patients on the outside and that they were just as grateful for kindness and help. I apparently didn't do much to change their ethics. When an inmate found I didn't have a smart phone he said, "Don't worry Doc, when I get out I will steal you one."

I feel privileged to have practiced medicine. There is a lot to be said for a job which is never the same on any day, with new problems, new challenges and the chance to meet people who are always a little different from anyone you have ever met before. There are problems also; the possibility of not solving the problem, failing to be of help, missing a clue or an opportunity and then, in my case anyway, being left to worry or even have lasting regret. "Letting go" of unhappy times or adverse circumstances has been hard for me to do.

If I had it all to do over I would plan ahead better, I would try to be more patient and open minded, I would study more, I would try to worry less and I would take more time to be with my wife and family.

I am 85 now [officially "old-old"] and recently quit practice. When I get one part of my body fixed these days another goes out. I see several physicians for myself and they are, without exception, highly competent, friendly, and caring, and in the face of demanding schedules, take time to talk. I think these are not exceptional attitudes but are the norm for most practicing physicians today and I am convinced that medicine is in good hands for what will be an interesting and maybe difficult future.

Leukocytoclastic Vascuilitis secondary to IV Ceftriaxone

by Kamel Azhar, M.D., Nasser Aljehani, M.D., Qassim Aljabr, M.D., Evelyn Sbar, M.D.

Introduction:

Vasculitis is defined as inflammation of the blood vessel that may lead to tissue or organ injury. It's classification has been a controversial topic for decades due to the unknown nature of the disease[1]. Leukocytoclastic vasculitis (LCV), previously known as hypersensitivity angiitis on Zeek's classification of vasculitis[2], is a histopathologic term commonly used to denote a small-vessel vasculitis. It is a very common form of skin vasculitis results from immune complex deposition in the small vessels[3]. Histologically, LCV is characterized by leukocytoclasis, which refers to vascular damage caused by nuclear debris from infiltrating neutrophils. It may be secondary to drugs, underlying infection, collagen-vascular disorders, or malignancy. However, 44.1% of the cases are idiopathic. It may present as a focal inflammation of the skin and may have systemic involvement. Organs that might be involved in the process include the joints, gastrointestinal (GI) tract, and kidneys. Confirming the diagnosis by skin biopsy is necessary to determine the best management plan and outcome[4]. The prognosis varies and has 2% mortality rate in the absence of internal involvement with the majority of cases resolving within weeks to months. Fever and paresthesia are the main factors for organ involvement[5]. It may be acute or chronic with approximately 10% of patients having a chronic or recurrent disease.

Ceftriaxone is a third generation cephalosporin and is commonly used as an IV antibiotic for many infections. Local phlebitis, fever, rash, neutropenia, drug-induced thrombocytopenia are among the rare side effects. The prevalence of developing LCV from IV ceftriaxone is unknown. Understanding the disease process and its association to ceftriaxone will help prevent future incidences and establish management guidelines.

Case presentation:

A 64-year-old Iranian male was presented complaining of skin rash. Four days prior to presentation, he received IV Ceftriaxone for treatment of staphylococcus bacteremia. On the day of presentation, he developed a petechial skin rash on both upper and lower extremities which was bright red, pruritic in nature. It began distally and gradually was spreading proximally. He was also complaining of mild and generalized joint pain. His past medical history included type 2 diabetes mellitus, congestive heart failure, atrial fibrillation, chronic kidney disease and coronary artery disease.

On physical exam, his vitals were: BP 133/96, HR 77, RR 19, Temp 98.2F. The skin exam showed a scattered, non-palpable purpuric rash that was non-blanching and non-tender in both lower extremities, extending to the buttocks and scattered over the abdomen. There was a coalescence of the rash in the upper extremities. The face, back and chest were spared. He was diagnosed with infective endocarditis based on an echocardiogram demonstrating vegetations on the mitral valve and a blood culture that was positive for staphylococcus bacteremia.

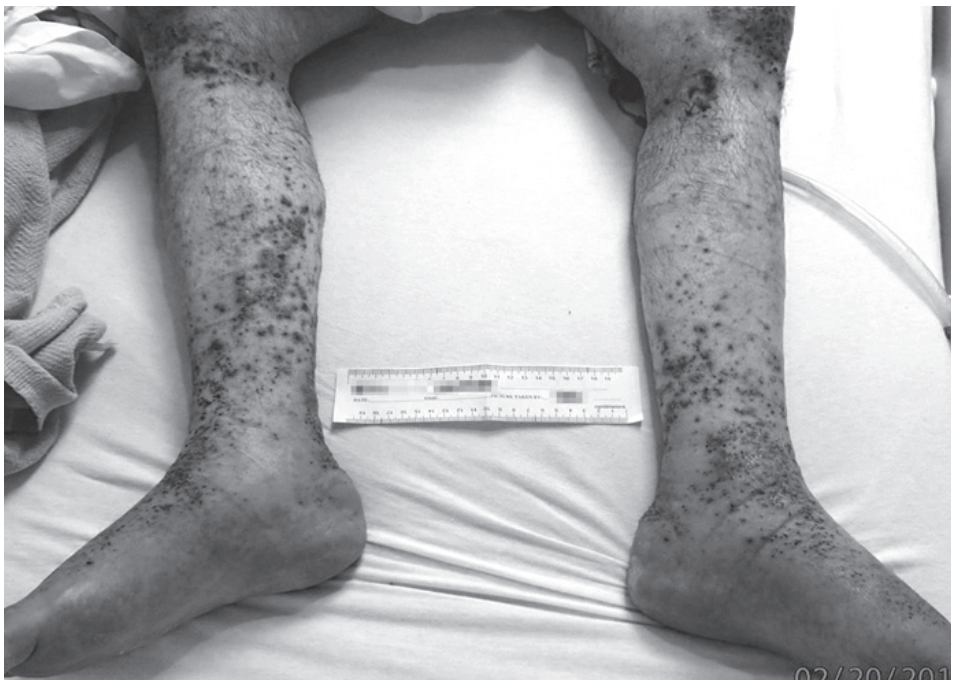

Figure 1: Purpuric rash involving both lower limbs

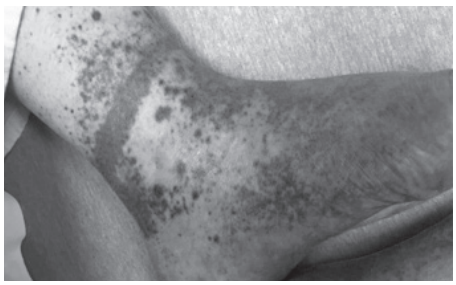

Figure 2: Rash covering the medial aspect of the leg

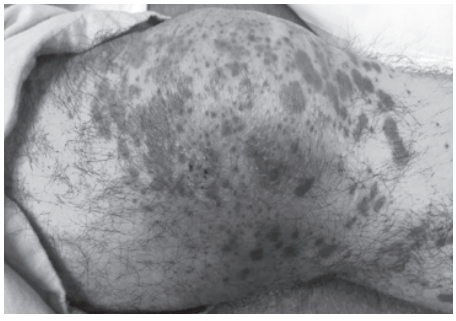

Figure 3: The same rash extends to the knees

Laboratory findings demonstrated the following: see tables below.

Chemistry	
Na	138
K	4.4
Cl	100
CO_2	28
BUN	30
Cr	1.41
Glucose	150

CBC	
WBC	10.6
Hgb	10
Hct	32
Plt	348
MCV	73.8
MCH	23.1

Urinalysis	
Occult bld	Large
Lk Est	Small
RBC	155
WBC	9

Hep Panel	
Hep A	Neg
Hep B	Neg
Hep C	Neg

LFTs	
T. Bili	1.5
T. Protein	8
Alk Phos	81
AST	11
ALT	7
Albumin	2.4

Imm markers	
ANA	0.59
ANCA	<1:20
Procalc	0.1

Other Labs	
Magnesium	2.4
Phosphate	4
Calcium	8.9
ESR	130
CRP	4.91
PT	21.2
INR	1.78
PTT	91
BNP	3594

Skin biopsy showed inflammatory infiltrate of lymphocytes, neutrophils, some eosinophils, and nuclear dust with extravasation of erythrocytes and fibrin in the walls of small blood vessels. (Figure 4)

After confirming the diagnosis, IV ceftriaxone was stopped. He was put on prednisone 60 mg PO daily. Diphenhydramine (Benadryl) was used to control his pruritus. We also used moisturizing cream on affected areas.

The rash started to subside after initiating treatment. Some papules evolved into pustules and erupted, requiring wound care. Four weeks later and after being discharged from the hospital, he was evaluated in the outpatient setting and the rash was improved by 50% in both surface area and severity.

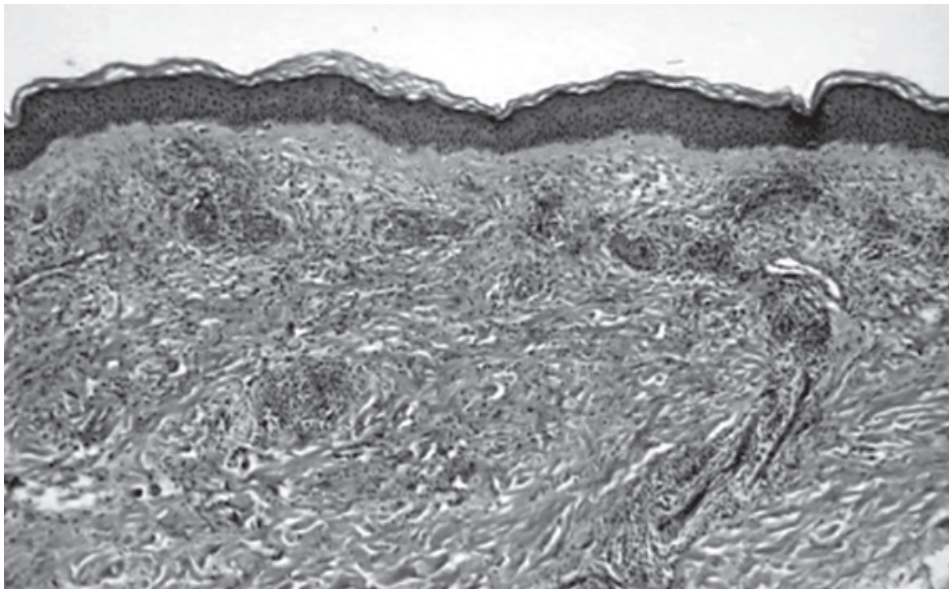

Figure 4

Final Diagnosis:

Leukocytoclastic Vascuilitis secondary to administration of Ceftriaxone.

Discussion:

Ceftriaxone is a commonly used antibiotic in the inpatient setting. It is often used to treat infections caused by aerobic gram-negative bacilli, Strep. Pneumoniae, N.Meningitidis and MSSA. It inhibits cell-wall synthesis by binding penicillin binding proteins making the organism prone to cell-wall autolytic enzymes[6]. In this article, we are reporting one of the rare cases of ceftriaxone-induce LCV.

LCV is a necrotizing inflammation of the small vessels manifests as segmental areas of transmural infiltration and disruption of the vessel architecture by neutrophils with fibrinoid necrosis. It can be isolated (cutaneous) or widespread (systemic). Causes of LCV erup-

| *continued on page 41*

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tion are unknown in (45-55%) of the cases. Other identifiable causes are infection (15-20%), inflammatory conditions (15-20%), drug-induced (10-15%) and malignancy (<5%). Classifying and diagnosing LVC has been controversial for decades as other vasculitides. Factors were used to classify a vasculitic disease are vessel size, organs involved, clinical findings, histopathological findings, cause of the disease. The American College of Rheumatology (ACR) criteria for LCV are 1) Age > 16 years at onset, 2) Medication that may have precipitated event, 3) Palpable purpura, 4) cutaneous eruption, and 5) positive biopsy. Having three of the five criteria is required to classify LCV with 71.0%, 83.9% sensitivity and specificity, respectively[7, 8].

Antibiotics, anticoagulants, antipsychotic, and anti-hyperthyroidism medications are among the known drugs to cause LCV[9-12]. However, almost all drugs are a potential cause. Infections include upper respiratory tract infections, bacterial endocarditis (most frequently with gram-positive cocci), hepatitis C[13-15].

It starts as cutaneous eruption that affects mainly the lower extremities. It presents in many forms but commonly presents as purpura, necrosis, pruritus, ulcers, urticaria, bullae or vesicles, nodules and pustules. Involvement of upper extremities, abdomen and chest were observed in other cases. It can present with systemic symptoms that are nonspecific including fever, weight changes, musculoskeletal, renal, gastrointestinal, neurological, respiratory and ENT symptoms. Tests that help establishing the diagnosis include: ESR, fibrinogen, CRP, urinalysis, monoclonal and polyclonal gammopathy, IgA, ANA, ANCA. Skin biopsy is the gold standard to confirm the diagnosis as it will show neutrophilic leukocytoclastic vasculitis of the small vessels. Biopsy cannot determine if the disease will be confined to the skin or will have a systemic involvement [16].

Discontinuing the suspected causative drug will be the first step in management. Systemic involvement can be treated with corticosteroid with or without an immunosuppressive therapy. Treatment of skin lesions should be directed to the presentation. Antihistamines can be used as an initial therapy for pruritus and urticaria. Few cases reported benefit from NSAIDs, Dapsone and colchicine. More severe lesions like ulcers, necrosis or bullae may be treated with systemic corticosteroid[16]. Inpatient care is needed in patients who have severe systemic vasculitic syndromes and severe organ dysfunction. Most patients with cutaneous LCV are treated in the outpatient setting.

Conclusion:

Leukocytoclastic vasculitis, also known as hypersensitivity vasculitis, is a small vessel inflammatory disease of the dermal capillaries and post capillary venules. The gold standard for diagnosis is via a skin biopsy of the affected area. Diagnosis is made histologically and is based on the presence of a neutrophilic perivascular infiltrate, fibrinoid deposits in and around the vessel wall, endothelial swelling, extravasation of erythrocytes, and leukocytoclasis.

The most commonly affected organ is the skin. The onset of LCV has classically been linked to various drugs, especially beta-lactam group antibiotics. However, systemic infections, intravenous drug abuse, malignancy, and connective tissue disorders have also been described to precipitate LCV. LCV can be managed by removal of the suspected offending agent and systemic steroids to decrease inflammation during an acute episode.

Consent:

The patient agreed to report his case including all the images by signing an informed written consent. A copy of the consent can be provided for review upon request.

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Depression Related Skin Disorders
An Anecdotal Clinical Adventure

by Randal Earl Posey, M.D.

After 46 years of private practice in dermatology, I can look back with immense gratification that, early on, I was made aware of a unique association between conditions of the skin and the status of the mind, especially by the ability of depression to manifest itself through the skin (or other body organ), so that the patient did not appear depressed in many cases. I often refer to somatization as the mind-body connection. Once I had a Russian medical student rotate through our office, and when he observed my clinical approach, he let me know that Russia is far ahead of America in routinely addressing this connection.

Comorbid somatized major depressive disorder is ubiquitous among common skin diseases seen daily in the practice of dermatology, if one only takes the time to expose it. Managing the depression yields remarkable results in helping persons with these skin disorders, both medically and economically.

In medical school I became interested in psychiatry through the excellent teaching of Dr. Titus Harris in Galveston, Texas at UTMB. I was also a registered pharmacist upon entering medical school, which brings me to a mandate by the Potter Randall County Medical Society staff to recount the following true story.

I was a senior medical student shadowing a psychiatry resident on a Friday afternoon at the psychiatry clinic. I was dressed in a black tie and white coat and stood motionless while the resident prescribed treatment and told the patient to return to the clinic for followup in one week. On Friday evenings I moonlighted at Texas Drug Store across from the clinic, and in she came seeing me wearing a different white pharmacy coat. We were out of the medication, and rather than let me send out for it and deliver it, she chose to shop elsewhere.

On Saturday mornings I moonlighted at Walgreen Drug Store in downtown Galveston, and again, in she came seeing me in yet another white coat. I filled her prescription. She returned to psychiatry clinic as scheduled, and there I was as on her first visit in my black tie and white coat. The resident asked her how she was doing, to which she answered, "I'm resting better, but I'm really worried—(pointing at me) everyone in a white coat looks just like him!" I replied that I truly was a pharmacist working part-time in both of those drug stores! Aside from the hilarity of the situation for a psychiatry clinic, to see the sudden smile and relaxation in her facial expression made my day!

Later as a resident, I was trying to manage a patient with treatment-resistant pustular psoriasis. Based upon my psychiatry elective rotation, the history suggested depression; a psychiatry resident was summoned and agreed with my diagnosis and initiated antidepressant treatment. Suddenly the pustular psoriasis dramatically improved in spite of receiving essentially the same dermatological treatment she had for months before the referral.

In my second or third year of practice in Amarillo, a patient presented with recalcitrant rosacea. In a routine history depression was discovered, and after two or three weeks on antidepressant therapy she cleared. Suddenly my index of suspicion for the co-existence of depression began to skyrocket. Over the next many years I began to screen patients with other skin disorders for depression. See the Table for my findings during a given 4 year period of time.

My favorite screening question was, "How do you feel when you wake up in the mornings—good, bad or tired?" Most patients with depression felt tired. To add credence to the diagnosis, I then used a modified Zung scale, followed later with a Mood Disorder Questionnaire (from Galveston) for bipolar disorder. I routinely screened such patients, calling it a "stress questionnaire," avoiding the word "depression" until the diagnosis was substantiated in writing. One must keep in mind that questionnaires are only as effective as the patient's willingness or ability to be honest with themselves. With proper training, ancillary personnel can administer and score the questionnaires. Five hundred ten patients with depression were identified from 1998 to 2001; one asks, "If one dermatologist can diagnose this many depressions in such a time period, think of how many depressions thousands of dermatologists or other practitioners can diagnose in the same time period."

Why go to all the trouble? Treating depression usually expedites improvement in the skin disorder. It cuts down on expenses and proves to be a lot safer than many alternative medications. Besides, it holistically improves overall quality of life. Depression can spill over into other specialties: for example, gastroenterological disorders such as irritable bowel syndrome consistently improved as I treated depression related to a skin disorder.

Next, one has to admit there could be a degree of placebo effect when treating skin disorders with antidepressants, but at least the diagnosis of depression (or bipolar disorder) had been substantiated with questionnaires, although ours were relatively elementary but adequate for our purposes. I regret not having had the time for evidence-based studies. My work remained primarily anecdotal and based upon accumulated experience.

One of the fathers of dermatology in the United States was the late Albert Kligman, M.D., Ph. D. He once wrote to me: "Double blind studies are not the only path to new insights. Nothing supplants acute

clinical observations. To this day physicians treat the disease and not the person. They rarely enquire about stress, depression and anxiety."

One still has to use standard topical dermatological therapy, such as proper bathing (for one's geographical residence), anti-inflammatories, anti-pruritics, preparations and procedures specifically indicated for the given diagnosis and avoidance of known precipitating or aggravating factors. Actually there have been countless articles describing depression as a form of inflammation, and this could easily explain skin disorder involved. Some say, "Well, if I had eczema, I would be depressed too." However, I discovered through careful history taking that the depression often antedated the appearance of the skin disorder.

The mere presence of one of the depression-related dermatoses should be reason enough to screen for depression and to rule out many other medical conditions which might mimic depression. My management in the low-risk (i.e. non-suicidal) patient was often more effective and expeditious than referral to mental health professionals, since they were reluctant to prescribe the dosages required to affect skin improvement. The mental symptoms were usually alleviated before the cutaneous ones. Many times an increase of one dosage level, above that necessary for psychological stabilization, was all that was needed to clear the skin. In comorbid cases, the skin is a reliable indicator of the most effective dose. I often said to patients, "I may lie to you, and you may lie to me, but the skin won't lie to either of us!"

I often referred my patients to mental health professionals to complete the overall evaluation and possibly to take over all psychopharmacologic management. Patients were more receptive to such a referral once the depression-related skin disorder came under control, thus proving, to some extent, the mind-body connection. They got in touch with their feelings and developed cognitive skills which helped with psychotherapy. It is important that all patients with suspected depression under 18 years of age be immediately sent to mental health professionals.

Atopic dermatitis and rosacea are the two most common diagnoses to respond to anti-depressants. Many cases can be controlled and maintained with antidepressants alone, especially facial and ocular rosacea, once the acute stages are minimized with combined standard therapy.

Obvious prudent and wise questions arise and need yet to be answered:

a. "Wouldn't the patient feel less depressed once their skin symptoms are alleviated by the usual drugs and methods?" Undoubtedly, but they come off such drugs much sooner if treated for depression.
b. "Aren't your enthusiastic approach and the possible placebo effect of the medication responsible for the patient's improvement?" Probably to some extent, but if we are dealing primarily with a positive placebo effect, it's extremely effective and safer than more toxic approaches.
c. "Do the antidepressant drugs have multiple pharmacologic actions?" On that first pustular psoriasis case mentioned earlier, I entertained this possibility.
d. "What happens if you treat a non-depressed patient with antidepressants?" I never did so, but it needs to be tried and tested.
e. "How many patients with each diagnosis were not depressed?" This is my greatest regret; I should have tabulated both groups of patients. When I first started screening and listing them, I was doing so out of simple curiosity, and then the numbers of depressed patients suddenly overwhelmed me.
f. "What about medication risks and medico-legal liability." Know your limitations if you prescribe; otherwise refer for treatment. (The same caveat applies to all prescription drugs.) The side effects of antidepressants are far less significant than some of the stronger dermatological systemic treatment regimens, such as biologicals, methotrexate, cyclosporine and systemic steroids to name just a few.

In my opinion, based upon the referrals to me from other physicians, the average dermatologist does not have enough experience or knowledge about depression management, and subsequently has a lack of interest in investigating or treating depression. In order to change the status quo, a grassroots approach may be needed, starting with curriculum committees and deans of the medical schools. Dr. John Wolf at Baylor College of Medicine was on record in *Dialogues in Dermatology* stating that more psychiatry needs to be taught in medical schools. With this I heartily concur. Once my findings are scientifically documented and reproduced, I encourage that an effort be made to institute wider undergraduate training and clinical exposure to psychiatry.

I encourage and challenge all dermatologists, family physicians and other physicians to look for depression when dealing with the depression-related dermatoses, and quite possibly for other somatized medical disorders yet to be identified.

The Life and Times of Joseph Murray: Nobel Prize Winner, 1990

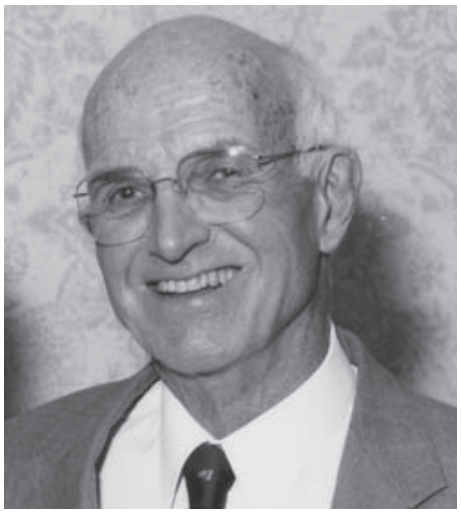
by Rouzbeh K. Kordestani, M.D., MPH

"We have been blessed in our lives beyond my wildest dreams. My only wish would be to have ten more lives to live on this planet. If that were possible, I'd spend one lifetime each in embryology, genetics, physics, astronomy and geology. The other lifetimes would be as a pianist, backwoodsman, tennis player, or writer for the National Geographic. If anyone has bothered to read this far, you would note that I still have one future lifetime unaccounted for. That is because I'd like to keep open the option for another lifetime as a surgeon-scientist," wrote Joseph Murray in his speech when he accepted the Nobel Prize in 1990. He received the Nobel Prize for his work in transplantation and immunology and for completing the first successful organ (kidney) transplant in 1954. He was a plastic surgeon.

Joseph Murray was always thought to be an amalgam of his past. He was born in Massachusetts to a schoolteacher mother and a judge/lawyer father. He and his siblings were taught early on to have a sense of responsibility and to do whatever was necessary to make a difference. Joe's interest in medicine was spurred by his respect for his family practitioner. He chose to pursue his dreams by advancing his studies. He first attended the College of the Holy Cross and then matriculated at Harvard Medical School. He found Harvard of particular interest since he wished to pursue a career in surgery. However, the Second World War cut this interest short. Although many of his friends were quickly assigned and sent overseas, Lieutenant Joseph Murray was kept stateside because his more senior officers were impressed by his interest in surgery and learning. They kept him at the Valley Forge General Hospital, a tertiary center for injured GIs. Of particular note was Murray's interest in burn surgery and reconstruction. He had observed early on that patients' skin grafts often tended to deteriorate over a short period of time. He intensified his research on skin grafts and immunology at Valley Forge. Interestingly, it was here that Joseph Murray served under Colonel James Barrett Brown, who had performed an interesting experiment in 1937; Dr. Brown had cross-grafted skin in a pair of identical twins and documented permanent success and graft survival in both twins. Dr. Murray confessed that this successful experaiment and the graft survival spurred on his interest in organ transplantation and beyond. From this particular success, it was postulated that the closer the genetic relationship between skin donor and recipient, the slower dissolution of the graft. Dr. Murray continued his work at Valley Forge until 1947.

After completing his surgical residency at Peter Bent Brigham Hospital, Dr. Murray went off to New York to study plastic and reconstructive surgery. He returned to Harvard in 1951 as an instructor in surgery. He stayed there for the better part of the next 35 years, finishing his tenure as the Chief of Plastic Surgery in 1985. While at Harvard, his work on transplantation led the field. He and fellow researchers used the immunosuppressive drug Imuran in transplantation patients and developed many of the protocols used today for unrelated donors/recipients. Along the way, many of his fellows became experts in the field of immunology and applied their expertise to surgery of other organs. Jean Michel Duberand, the surgeon who performed the first facial transplant, was a student of Dr. Murray's.

When asked about his success and his achievements, Dr. Murray replied: "The whole field of transplantation continues to expand far beyond the simple replacement of skin or kidney.... It's been a glorious experience to be a part of. (You have to understand) that each person is intrinsically valuable. Whether you're repairing a small blemish of the cheek or a major facial reconstruction, for the patient, it's 100 percent. You're (simply) putting them back into the mainstream—improving the quality of their life."



The Nobel Prize Committee cited Dr. Murray's work in 1990. They noted: "He (Murray) has given the gift of life to hundreds of thousands of people destined to die young. His success did not come easily. How many people do we know try to achieve something that no one has ever before even attempted, because it was judged to be impossible? He kept trying; he kept failing, but still kept trying for a decade! His attempts were severely criticized by his peers. But he did not give up."

Joseph Murray, M.D., died at the end of a wonderful journey at the age of 93 in 2012. He was full of life, life experiences and achievements. He started life simply and used his simple appreciation of life to understand some of the most complex problems in human biology. His successes are seen in the countless lives he saved and in the thousands of operations he performed. But most importantly, Dr. Joseph Murray will be remembered because he lived a full life. He made a difference; he mattered.

The disciplines of medicine and surgery and many of the subspecialties exist because of the likes of Dr. Joseph Murray. Physicians and scientists like Dr. Joseph Murray will never be forgotten.

(In 2001, Dr. Murray published his autobiography and aptly named it Surgery of the *Soul: Reflections on a Curious Career.*)

End-Of-Life Care

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

What is End-of-Life Care
End-of–life care is the attention to the care of a person who is close to dying.

Why End-of-Life Care?
When a person is approaching end of life and the death is seen as inevitable, an open understanding about the process of dying and the expectations of medical care provision versus withholding it is important. This makes the dying person choose what is best for the remaining period of life. Due to the advances of medicine, without this discussion, the death process could be prolonged.

How Do I Suspect the Need for End-of-Life care?
When the discussion with your physician indicates that the life is severely shortened and/or the options of therapy are severely limited, a discussion of expectations and options is clearly warranted.

How Do Doctors Diagnose End-of-Life?
A diagnosis of terminal condition rests with your physician. However, examples include end-stage kidney disease, end-stage liver disease, end-stage heart disease, advanced cancers, and advanced dementia.

What is the Plan to Manage End-of-Life?
There are few terms to recognize when discussing end-of-life. These include: Do not resuscitate (DNR), comfort care, and hospice care.

What is DNR?
DNR means withholding resuscitation from a person who has already stopped his heart beating or breathing or both. Resuscitation is defined as CPR (cardiopulmonary resuscitation) using chest compressions, connecting person to ventilator via a tube through the mouth to the wind pipe, or both. A DNR status means that neither CPR nor respirators will be used.

What is Comfort (Palliative) Care?
Comfort care is an important part of end-of-life care and it refers to the process of choosing what makes that dying person comfortable rather than what makes him merely live longer. At the heart of the decision here is the choosing of what makes the life better in quality than just quantity. For instance, if a treatment will prolong life for a few weeks while causing unacceptable side effects like severe vomiting and nausea, the patient may forgo this treatment in order to live an enjoyable span albeit shorter. Comfort care avoids hospitalizations and medical procedures like blood work and injections.

What is Hospice Care?
Hospice care is an arrangement where a person on comfort care receives multidisciplinary care at home (or a nursing home) with the focus being on comfort, pain control, and social support. A hospice care team includes a physician, a nurse, and non-skilled care for personal care like bathing. The hospice nurse has ways to provide medications for efficient pain control at home. Also, other treatments for problems like nausea and vomiting and shortness of breath can be provided at home with similar efficacy to those treatments provided in the hospitals.

How is Comfort Care Provided?
Comfort care is provided at home (or nursing home) with the collaboration of hospice team and the family while utilizing spiritual community services as appropriate for the patient.

What is the Difference between DNR and Comfort Care?
While comfort care is described above, a DNR means only the withholding of resuscitation if a person dies, but short of dying, the rest of medical care continues as usual. Persons on DNR status can go to surgery after rescinding (withholding) DNR status for the duration of surgery and resuming it later after they recover. A discussion with your physician is imperative to clarify your understanding of particulars of your care as every person is different.

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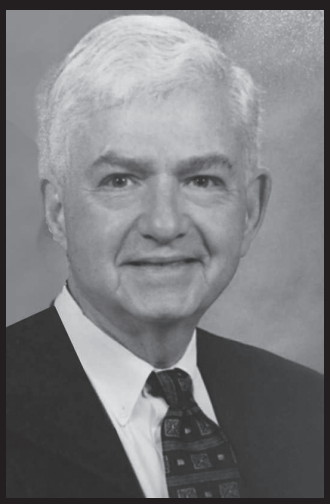
As this page is provided for educational purposes only it shall not be construed by any means to replace actual physician's management.

Sources reviewed: National Institute on Aging.
http://www.nia.nih.gov/health/publication/end-life-helping-comfort-and-care/introduction

In Memory



Dr. James Dunn,

Otolaryngologist, died Friday, August 5, 2016 at the age of 80. He was a member of the Potter Randall County Medical Society for 10 years.

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

Resident-to-Resident Mistreatment in Nursing Homes Annals Intern Med (Aug 2016) - Resident to resident elder mistreatment in nursing homes is a highly prevalent problem in the range of 20% of the residents in a month duration according to a study in the Annals of Internal Medicine. Verbal mistreatment is 9%, physical 5%, invasion of privacy 5%, and sexual is 0.6%. The problem is higher whenever the staffing ratio is low and in dementia units.

Aspirin Reduces Cancer Colon Annals Intern Med (Aug 2016) – In patients at average risk of colorectal cancer, aspirin reduces long-term risk of incidence and mortality of the disease. However, it does not provide protection in persons eligible for primary cardiovascular prevention.

Aspirin May Cause Bleeding Annals Intern Med (Aug 2016) – In an analysis of several studies regarding the effect of aspirin on the potential of bleeding complications when used to prevent cardiovascular events in persons who had no prior events (primary prevention), aspirin was associated with bleeding increase 30-60% in terms of hemorrhagic stroke and gastrointestinal hemorrhage.

FDA Extends its Authority to e-Cigarettes JAMA (Aug 2016) – In a new ruling, the FDA has extended its authority this August to all tobacco products including e-cigarettes, and requires manufacturers to report products ingredients and undergo premarket review to receive authorization.

Suicide-Prone Occupations JAMA (Aug 2016) – CDC researchers analyzed suicide rates among different occupations. The highest rates were 85 in 100,000 population among farming, fishing, and forestry workers, followed by 53 among construction and extraction workers, and 47% among installation, maintenance and repair workers. The lowest rates were 7.5% among education, training, and library workers.

Funding to Combat Superbugs JAMA (Aug 2016) – CDC's Prevention Epicenter Program provides for $26 million boost for combating superbugs including research work on healthcare associated infections, antibiotic resistance, and microbiome.

Screening for Cholesterol not Recommended for the Young JAMA (Aug 2016) – The US Preventive Services Task Force concluded that the current evidence is insufficient to assess the balance of benefits and harms of screening for lipid disorder in children and adolescents 20 years or younger.

Trend of Kidney failure with Diabetes in US JAMA (Aug 2016) – Among US adults with diabetes from 1988 to 2014, the overall prevalence of diabetic kidney disease did not change significantly, whereas the prevalence of albuminuria declined while reduced eGFR increased.

EKG Screening for Athletes Deferred to Colleges JAMA (Jul 2016) – The Inter-association Task Force has deferred the EKG decision to athletic administrators, trainers, and physicians to whether require the test for all athletes or only the high risk ones.

Food Label will be Modified JAMA (Jul 2016) – The Nutrition Facts label on packaged foods will be modified. It will include the number of grams and the daily value percentage for added sugars as well as total sugar. Also, vitamin D and potassium content will be added and the requirement to include vitamin A and C will be lifted. Calcium and iron contents will continue. The design also will reflect the serving size and calorie content in bold type.

Tai Chi Versus Physical Therapy JAMA (Jul 2016) – Tai Chi produced beneficial effectgs similar to those of a standard course of physical therapy in the treatment of knee osteoarthritis.

Drain your Stomach after Overeating! JAMA (Jul 2016) – FDA has approved a device that is a surgically placed tube to connect the stomach content to the outside. Morbidly obese persons who fail to lose weight can have the device that is placed via an outpatient surgery procedure. After the meal by 20-30 minutes, the person can drain 30% of his stomach content into the toilet through the tube. Persons with eating disorders are not candidates for the procedure.

Social Behavior of Offspring of Obese Mothers JAMA (Jul 2016) – An experiment done in mice revealed that a maternal high-fat resulted in impaired social behavior in the offspring. The altered gut bacteria was associated with aloof behavior of the offspring that improved by mingling with other offspring that had non-obese mothers!

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