

# PANHANDLE HEALTH

A QUARTERLY PUBLICATION OF THE POTTER-RANDALL COUNTY MEDICAL SOCIETY

Fall 2020 | VOL 30 | NO. 4



*30th Anniversary  
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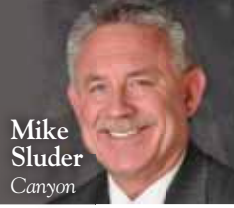




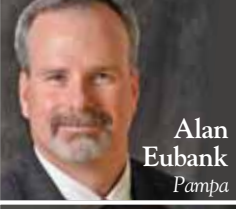



















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# PANHANDLE HEALTH

A Publication of the Potter-Randall County Medical Society

FALL 2020 | VOL 30 | NO. 4

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

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# A Note from the President

by Neil Veggeberg, MD

I would have thought by now we would have significantly reduced the COVID restrictions, and the numbers would be dropping dramatically. Apparently, that's not happening. Without a useful vaccine and or a mutation to a benign form, it looks like we're in it for the long haul. I had made a comment on the last letter that I hoped they were keeping and reporting accurate records and data so that effective treatments could be identified. I like to think that presently we are more scientific and creative about solutions. It's a good time for new ideas to be put out and then challenged.

While socially distancing at home, I was able to watch *The Great Courses* series of the Black Death. In 1348 as the Black Death entered Avignon in France, most of the physicians fled. Guy de Chauliac stayed and studied the disease. It is tricky to study a disease that has an 80% chance of killing you. He claims to have gotten the plague and survived. Through meticulous work, he established that the condition was a contagion. The disease did not strike the Jewish quadrant as aggressively. When accusations were made that wells were being contaminated, he emphatically declared that that was untrue. The most likely reason for the sparing of the Jewish population was that the plague arrived in the time of Passover. The quadrant was so clean the rats did not enter in as large of numbers. From an epidemiological standpoint, the information was there, but they drew the wrong conclusions.

A reported quote from Aristotle: "Seeing things which cannot be explained, even by the most gifted intellects, initially stirs the human mind to amazement; but after marveling, the prudent soul next yields to its desire for understanding and, anxious for its own perfection, strives with all its might to discover the causes of the amazing events. For there is within the human mind an innate desire to seize on goodness and truth."

The King of France Philip VI in 1348 ordered the *Report of the Paris Medical Faculty*. Some of the brightest minds studied the disease and came up with some conclusions. They concluded that the plague was due to the alignment of the planets. Mars, especially, is a very hostile planet. Somehow it wasn't getting along with Jupiter. I always thought after listening to popular music during the late '60s that it was good for Mars to align with Jupiter. Peace will guide the planets and love will steer the stars. Apparently, this didn't happen.

They also felt the air was corrupt, and that the four seasons had run awry. This conclusion, after living in Amarillo, I would probably not argue with. It is a shame the cause of the plague could not be determined until almost 500 years later. They had microscopes going back as far as 1590. Hans Janssen was thought to have described one of the first microscopes. He reported it to William Boreel, a diplomat who passed this onto the French King. Once again, a French King is involved. Galileo improved upon it but seemed to spend his time looking into the skies. Robert Hooke spent a great deal of time with his microscope. He wrote about it extensively in *Micrographia*. It probably would have been hard to understand.

One of the first sentences on how to stain I felt was a little difficult to read: "Having in the former Difcource from the Fundamental carife of Colour, made it probable, that there are but two Colours, and fhewn the the Phantolm of Colour is cas'd by the fenfation of the oblique of uneven pulfe of Light which is capable of no more varieties that two that arife from the two fides of the oblique pulfe, though each of the rhofe be capable of infinite gradations or degrees." It would have been a challenge to follow his instructions.

Antoine van Leeuwenhoek in the 17th century was capable of looking at bacteria with his microscope. Maybe this would have been a good time to find the cause of the disease.

Alexandre Yersin was the first to positively identify the plague bacterium in 1894. He was in close competition with Shibasaburo Kitasato. Yersin noted, while studying the plague in Hong Kong, that there were an inordinate number of dead rats. He found the same bacteria in the rats. His conclusion was the bacteria came from the soil. It wasn't until later that Paul-Louis Simond in 1898 put uninfected rats next to cages with infected rats. He determined that there was a blood-sucking vector. He found the bacilli in the stomach of the fleas. So, from the plague of 1347 to 1351 that devastated the population, it took over 500 years to determine its cause. I just hope it doesn't take another 500 years for us to treat the Coronavirus.

From the Potter-Randall Medical Society standpoint, it has been pretty quiet. We can't have much in the way of meetings. Most of the physicians are getting isolated. We tend to mention being quarantined, but thankfully, that's only 10 to 14 days. The original term refers to 40 days. The term social distancing for many of us is really social isolation.

This issue discusses the history of medicine in this area. Thirty years ago, doctors seemed to have gotten together more often. Most of us are now off in our own offices, apart from each other. Many physicians would have at least one or two patients in the hospital and while seeing them could interact with others. Radiology suites seemed to be a big collecting area for physicians to meet and discuss issues. Drug representatives used to invite speakers, which also gave physicians a chance to interact. Hopefully, next year will be better.



## Editor's Message: **COVID-19 Update**

by Scott Milton, MD, FACP

At the time of our last edition, Amarillo and the surrounding community were receiving national attention for the outbreak in local meatpacking plants. A strike force consisting of experts from the CDC, as well as state epidemiologists and local public health experts, toured many of these facilities and offered suggestions to mitigate the spread of COVID-19. Shortly thereafter the governor began opening up the Texas economy. This occurred in early June, and unfortunately it was clear within several weeks that this act was premature, as there was a dramatic rise in cases originating from areas where people were congregating such as restaurants and bars. By early July the governor had retracted his order and closed down the restaurants and bars. The remainder of the summer has shown persistent and widespread community spread of COVID-19, especially in certain areas of Texas (such as the Houston metropolitan area and the Rio Grande Valley), causing severe stress on numerous hospital systems.

In the Amarillo area, we peaked around the first week of May with slightly more than 100 patients with COVID admitted to BSA and Northwest Texas Hospitals. We reached a nadir 4 to 5 weeks later in early to mid-June with fewer than 25 patients between the two hospitals. There are currently around 50 to 55 patients admitted between the two hospitals, and our ventilator capacity has remained adequate with the current use. As of September 10, a total of 56,653 tests had been conducted and reported to the health department. We have seen a total of 6,527 cases of COVID-19, with 5,895 recoveries and 89 deaths. We currently have 593 active cases, evenly distributed between Potter and Randall County.

Our knowledge regarding effective treatment for COVID-19 continues to be refined and expanded. Currently, two drugs on the market, dexamethasone and remdesivir, have been shown to be effective

in treating COVID-19 in hospitalized patients. Remdesivir is dosed daily, usually in either five or 10 day courses. More and more evidence suggests that this drug is most effective when used relatively early in hospitalized patients. When initiated after patients have developed respiratory failure and are intubated, this drug appears to show no significant improvement in mortality. Therefore, recent strategy has focused on administering this drug to hospitalized patients who show progression in their oxygen requirements within a relatively short time-frame from diagnosis.

Guidelines for testing for COVID-19 continue to evolve as more is learned about this virus. The CDC now suggests a strategy for ending self-isolation based more on time than on test results. Persons who tested positive and were symptomatic can now discontinue isolation 10 days after symptom onset and 24 hours after fever resolution. For persons who are asymptomatic after a positive RT-PCR, isolation can be discontinued 10 days after the date of the positive test in most cases. For those who have previously tested positive and have recovered, guidelines suggest there is no need to retest that individual for at least 90 days. This is based on recent data suggesting that immunity lasts at least three months (and likely more) following infection. On many occasions, individuals may repeatedly test positive within this time frame. Most studies suggest that they are likely not contagious within 2 to 3 weeks following the initial infection even though the RT-PCR remains positive. These guidelines are much improved in reducing the burden on testing and also reducing the confusion that can occur with repeatedly positive tests. These guidelines are updated frequently on the CDC website, and I would encourage all readers to review this periodically.

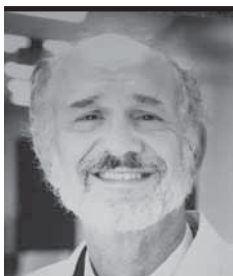
This week and next will mark the opening of our schools. Much thought

and discussion has occurred between our school districts and the health authorities. Online learning has been enhanced in most school districts and, I believe, offers the safest approach at this time. Wearing masks and practicing social distancing while at school should remain a top priority. If possible, conducting classes outdoors should be encouraged, as the risk of transmission of COVID-19 is markedly less. We all hope and pray for a safe and successful school opening.

In summary, this pandemic continues to interrupt our lives on a daily basis and continues to cause significant illness and death in our community. Our hospitals and healthcare professionals have risen to the challenge in an heroic manner. Our public health professionals have worked long and hard hours since the beginning of the pandemic in order to keep our community as safe as possible. The current guidelines for testing and treatment for COVID-19 continue to evolve and improve. Multiple companies are testing vaccines, although it appears these would likely be available several months from now at the earliest.

Stay safe!

**Our Next Issue Of**  
***Panhandle***  
***Health***  
**Features:**  
**Telemedicine**



## Guest Editor's Message: *Amarillo Icons*

by Steve Urban, MD

The Fall 2020 issue of *Panhandle Health* continues our tradition of periodically devoting one issue to the history of medicine in the Panhandle. In this issue, you can read about Amarillo icons like orthopedic surgeon Dr. Dick McKay, anesthesiologist Dr. Tom Easley, neonatologist Dr. Mubariz Naqvi, hematologist/oncologist Dr. Phillip Periman, pediatrician Dr. Holley Reed, internist Dr. Rush Pierce, and family physician Dr. Richard Bechtol. You can read about how Dr. John Milton and Dr. Wayne Smith help establish the Amarillo Diagnostic Clinic. And, since history is being made in 2020, you read about the COVID pandemic, including three articles from doctors on the front lines. You will also find our usual features—a case report from Texas Tech, a history of American medicine, and a patient information article, among others.

*Panhandle Health* has been publishing local history issues for over 20 years. Those of you who are interested in any of these articles can access it through our PRCMS website (<https://www.prcms.com>, click “Menu,” then click “Magazine”). Here follows a list of previous publications on the history of Panhandle medicine.

In the winter of 1998, we published articles on this history of major healthcare institutions in Amarillo (authors in parentheses): Northwest Texas Hospital (Earley B. Lokey), Baptist-St. Anthony's Hospital

(Kenneth Johnston), TTUSOM (Gerald Holmes), Harrington Cancer Center (Charlotte Rhodes), Coffee Memorial Blood Center (Mary Townsend and John Guthrie), Amarillo subspecialists (Gene White)—plus articles about Harrington Regional Medical Center Incorporated, the Speech and Hearing Center, and the Children's Rehabilitation Center.

In PRCMS's centennial year, the Fall 2003 issue included articles on nursing in the Panhandle (Eunice King), the Amarillo VAMC (Barbara Moore), and the Texas Tech School of Pharmacy (David Sougstad). A few years later, the spring 2008 issue addressed the practice of medicine and included articles on family medicine doctor Dr. Garnett Bryan, as well as histories of vaccines (Walter Bridges) and pulmonary tuberculosis (Harvey Richey).

In the spring of 2012, we published “Pioneer Doctors of the Panhandle”, with articles about obstetrician Earley B. Lokey (Paul Tullar), developmental pediatrician Leora Andrew (John and Rachel Andrew), neonatologist Mubariz Naqvi (Joyce Chuachingo), surgeons William Klingensmith and Henry Martinez (Walter Dickinson), radiation oncologist Dan Epley (Don Pratt), psychiatrist Mitch Jones (Steve Urban) and pediatrician/hospice physician Gerald Holman (Steve Urban), as well as a History of Orthopedic Surgery in the Panhandle (Bob Stafford).

In the fall of 2013, we felt that doctors from the region deserved their own issue, and we published articles on Drs. Ray Hampton (from Pampa), Joe Knowles (from Borger), Rush Snyder Sr. (from Canadian), Roy Sanford (from Perryton), Jack Fox and Mike Henderson (from Childress), Jack Prendergast (from Panhandle) and Dudley Moore (from Canyon). This issue also included a moderately humorous article by myself on the history of medicine in Ochiltree County.

In the fall of 2014, women physicians' voices were heard, as we read about pioneer women physicians of the Panhandle (Nan Gilkerson, Evelyn Powers, Ernestine Smith), as well as reflections on their careers in medicine from Drs. Rachel Anderson, Sue Nadeson, Sheryl Williams, Joanna Wilson, and Reba Halloush. Finally, in the fall of 2016, we got the lowdown on retirement from Drs. Mitch Jones, Walter Allison, Lowell Chaffin, Nick Goldstein, Chuck Rimmer, Phil Periman, and Emily Archer—plus a biographical sketch on Dr. William Price and an account of his life in advocacy by Dr. Dick McKay.

There was a time when a sophisticated diagnostic tool was a stethoscope, when routine lab tests were a CBC and urinalysis, when “films” were really films—when there were no tests for lupus or myasthenia gravis, when there was no way to image the brain except via arteriography or pneumoencephalography, when Hodgkin disease, uremia, recurrent ventricular tachycardia, and HIV were untreatable fatal diseases. Family doctors made house calls, internists saw their patients in the hospital, psychiatrists counselled their patients, and pediatricians saw their asthmatics in the emergency room. Even though those days are gone—probably for good (in both meanings of the phrase)—we still seek to give honor to the accomplishments of those physicians—their memories and their legacies. To do so is the intent of this issue of *Panhandle Health*.

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# Executive Director's Message

by Cindy Barnard, Executive Director

Thirty years ago, in the fall of 1990, Potter-Randall County Medical Society published our first quarterly magazine called *Panhandle Health*. The cover was the same then as this issue—a photograph of the gold-headed cane, given to every President of the Society. We have so many people to thank for the birth of *Panhandle Health*. President of PRCMS at that time was J. Franklin Howell, M.D. The *Panhandle Health* Editorial Board was chaired by Edward J. Sherwood M.D., Editor, assisted by Gerald H. Holman, M.D. Other Board members included John J. Alpar, M.D., Frank J. Kelly, M.D., James K. Luce, M.D., Gerald L. Moriarty, M.D., Patricia E. Penovich, M.D., J. Rush Pierce, M.D., Barbara Brooks, M.P.A., Editorial Assistant, and Ralph Leone, Photographer. *Panhandle Health* Publications Board was chaired by Jack D. Waller, M.D. Other members of the Publications Board included Randal E. Posey, M.D., William R. East, M.D., De De Vinson, Executive Director, and yours truly as Managing Editor. I have retained that position for all these years and watched our subscriptions grow to a list of 3000! All of the above have much to be proud of for the continuing progress of *Panhandle Health*.

This is a difficult time for all of us dealing with COVID-19 personally or just in general. COVID-19 has asked much of us all. To those who have lost loved ones to the illness, we extend our heartfelt, deepest

sympathy. And, of course, we thank those medical professionals who have cared for others with compassion as well as those whose research will lead to a vaccine's discovery. We also admire those whose essential work has kept groceries stocked, our community safe, and made public services available.

Our top priority is certainly the health and safety of our families, friends, employees, our community. To help ensure that priority, we have Personal Protective Equipment (PPE) for our members available at Panhandle Regional Advisory Council (RAC). Please contact Scot Leatherwood to make arrangements for pick up.

**When:** Monday – Friday 11:00 a.m. to 4:00 p.m.

**Where:** PAC - Panhandle Regional Advisory Council -TSA-A, 169 – I-27. Canyon TX 79015. (When travelling to Canyon on IH 27, take Rockwell RD exit. Remain on Frontage Road and until ¼ mile past Rockwell RD. Your destination is on the West side of Frontage Road.

**Contact:** Scot Leatherwood, Scot. Leatherwood@panhandlerac.com  
806 322-1290 office;  
806-282-8106 mobile

As PPE is limited right now, we want to make certain you have information about how to make yours last longer. TMA has a lot of other great COVID-19 Resources available at [www.texmed.org/coronavirus](http://www.texmed.org/coronavirus). The RAC does not know when, what, or if they will receive supplies. If/when supplies arrive, RAC will allocate based on needs assessments submitted. TMA asks that you fill out the TMA PPE Portal Needs Assessment once per week per practice for as long as you are in need of PPE.

Currently, the Panhandle RAC has the following supplies:

- \*Face Mask (surgical mask)
- \*Face Shields
- \*N95 Mask, Small and Regular only
- \*Hand Sanitizer (only have liquid, no gel)
- \*Goggles
- \*KN95 (may be used as a face mask, not as an N95 mask)
- \*Gowns (one size fits all)
- \*Coveralls
- \*Gloves

Please know that the well-being of all our friends and families is our top priority as we continue to monitor and follow guidelines recommended by the CDC and our state and local health departments.

**PROUD TO  
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INDUSTRY IN  
THE TEXAS  
PANHANDLE**





# Dr. Richard Bechtol: *35 Years of Family Medicine*

by Paul Tullar, MD



Richard Bechtol was born in Amarillo and went to school here, first at Lamar Elementary, then Fannin Jr. High, then Amarillo High School. Not from a wealthy family, Richard and his three brothers grew up on South Ong St., near what is now I-27. Dr. Bechtol attended First Baptist Church in Amarillo from an early age. He continues to serve the church in many capacities, and identifies his faith in God as an integral part of who he is today. He feels that his faith is the foundation of his calling into a career in medicine.

Richard had an experience at age 12, when a terrible auto wreck occurred only 8 houses away from his home. He and some of his family ran to see what had happened; they were drawn to help but felt helpless to do so. He then recognized a “desire to take care of people” in his heart, but it would require a lot of academic preparation and training.

He played football in high school (quarterback and safety), but spent more time in sports than was good for his grades. He went on scholarship to Oklahoma State University, where he played football. He knew by graduation that he wanted to go on to medical school but, when he first applied in his senior year, did not get accepted to any American medical schools.

Upon graduation from OSU in 1971, Richard started studies at Texas Tech School of Business, working toward an MBA. He was accepted to the medical school in Guadalajara (the Autonomous University of Guadalajara School of Medicine), but deferred attending that year, due to the cost. He applied again in 1972 and, upon acceptance, discontinued his MBA studies and moved to Guadalajara in the summer of 1973.

Understanding that all his medical

school classes would be conducted in Spanish and wary of his limited Spanish, Richard enrolled in the Autonomous University of Guadalajara in the summer of 1973. There he took classes in geography, law and history (all classes and tests in Spanish), which did improve his understanding of spoken Spanish, his written Spanish, and his working and academic Spanish.

Richard began at the School of Medicine in Guadalajara in the academic year of 1973-1974, but, though he did well academically, he ran out of money, couldn't afford to pay the next year's tuition, and came home to Amarillo in the summer of 1974. His faith had always been an important part of his life, and he confided to his pastor, Dr. Winfred Moore of First Baptist Church, about his need for funds to continue his studies. Interest on bank loans was north of 11% at that time (on its way up to 19% prime interest rate), and borrowing the amount of money needed from a bank to complete medical school in a private university in Mexico was out of the question for the Bechtols.

Dr. Moore, his pastor, met weekly with businessmen as part of his community outreach at the Thursday meeting of the Amarillo Rotary Club. One Thursday, Dr. Moore couldn't go, so he went on a day he usually never attended (he wasn't fond of the menu scheduled on that day) – a Tuesday. There he met a man he would never otherwise have met, as this gentleman usually DID attend the Tuesday noon Rotary Club meeting. Dr. Moore happened to sit across the table from business leader, Mr. A. C. “Red” Walker, the owner of Royal Glass in Amarillo. Dr. Moore told Mr. Walker of this young man who had so much promise, who had already gone to such great lengths to become a doctor, who wanted to come back to Amarillo, and who had

a “desire to take care of people” here. The Amarillo businessman donated enough through the Church to help defray Richard's remaining three years of tuition and costs at Guadalajara, and Richard completed his medical degree in 1977. Dr. Bechtol relates that, even with 7% interest on the ‘handshake loan’ from the Church, he paid back the entire amount within 7 years of starting his private practice.

Many of our readers do not know that graduates from a foreign medical school cannot easily be licensed in the United States. For the American college graduate who completes medical school in a foreign country, there was, for a while, no easy way to qualify. Texas, chronically short of practicing physicians and recognizing a resource of American citizens who had gone to foreign medical schools, created another way to qualify to study in the state when other pathways were not available – a “Fifth Pathway”. American students who had completed an undergraduate degree in the U.S., and who had completed medical school in a W.H.O.-recognized foreign medical school, could attend a qualifying rigorous clinical program at an approved U.S. medical school to prepare for an American internship or residency. This Program ended in December, 2009.

Richard was accepted to begin his “Fifth Pathway” training through the College of Medicine and Dentistry of New Jersey, at Martland Hospital in Newark, NJ, in “a rough section of town.” The summer before starting (1974), however, he met a young woman in Amarillo. Susan was already a Registered Nurse with experience in Amarillo hospitals. They married June 19, 1977, in Amarillo, two weeks after Richard had graduated from medical school in Guadalajara. In August 1977 (the day Elvis died), they moved to New Jersey to begin his “Fifth Pathway/ Fifth Channel” training. As

Susan had established RN and hospital experience credentials, she was able to find work in St. Barnabas Hospital in Livingston, NJ. At the end of that year, Dr. Bechtol, who had benefitted from the leadership, clinical training, and mentorship of Dr. George Lordi, a Yale medical graduate, was asked to stay on in New Jersey. But the Bechtols wanted to return to Amarillo, Texas. He was accepted to begin his Texas Tech Family Practice residency in July, 1978.

Texas Tech University, opening in 1925, had founded a Health Sciences Center and School of Medicine in Lubbock in 1969. By 1977, Texas Tech had established a Family and Community Medicine residency in Amarillo. Dr. Bechtol, who had passed his FLEX exam to be licensed in Texas, came back to Amarillo with his wife. He entered only the second class of TTUHSC family medicine residents in Amarillo in July, 1978 and completed that residency in 1981 – but that doesn't give the flavor of that experience. In 1978, Amarillo had 5 hospitals: Northwest Texas Hospital, located on 6<sup>th</sup> Street (1924-mid 1980s), St. Anthony's Hospital (the first hospital in the Amarillo area, near downtown Amarillo, 1901-1996), High Plains Baptist Hospital, the Amarillo VA Hospital, and Amarillo Osteopathic Hospital (closed 1985). Northwest would move to its cur-

rent location in the mid-1980s. There were no Ob-gyn, pediatrics, or internal medicine residencies in Amarillo at the time. There were some private practice obstetricians, but many deliveries were done by family medicine doctors. Obstetrics was incorporated into family medicine residency training, as these physicians were expected to do "everything", including obstetrics, in rural medical practice. Dr. Bechtol's teachers in family medicine included Dr. George Patzkowski, Dr. Richard Rehm, and Dr. Peter Fagan. Obstetricians who helped out with complicated cases included Dr. Hollis Hands, Dr. Wendell Ashby, and Dr. Geoffrey Jubang. Family medicine residents had to run to wherever the deliveries were about to take place (St. Anthony's Hospital or Northwest Texas Hospital. High Plains Baptist, founded in 1968, didn't initially have obstetrics.) For complicated (especially premature) newborn care, Dr. Mubariz Naqvi was invaluable. Dr. Naqvi left an indelible impression on Dr. Bechtol and the other family medicine residents, saying, "See those parents waiting anxiously outside the window? Go talk to them; let them know more about their children. They are worried and you can help."

For patients in the newly-formed Potter-Randall County District Clinic, internist Dr. Horace Wolf was the attend-

ing, teaching the family medicine residents and helping take care of the clinic patients. Family medicine residents rotated with several other specialists who were willing to teach. Dr. Bechtol particularly remembers that oncologist Dr. Phillip Periman was an effective, if demanding, teacher. In pediatric intensive care, the young Dr. Rolf Habersang helped the family medicine residents learn to care for critically ill children. Like many residents in the 1980s, in addition to working over 80 hours per week in residency, Richard supplemented his income with "moonlighting," sometimes from Friday evening through Sunday at 6 pm, in Emergency Rooms in Hereford and Borger. He would see the usual gamut of ER cases—all the way from gunshot wounds and motor vehicle accidents to minor illnesses. He would stabilize the most serious cases and ship them by ambulance to hospitals in Amarillo. After working all night or weekend in the ER, he would go back to his residency and work in clinics and the hospitals the next morning. It helped pay the bills for his growing family.

Dr. Bechtol completed his residency in 1981 and moved into office space in MediPark for the first 2 years of solo practice. With prenatal care, deliveries, and newborn care, he soon found that

| *continued on page 12*

## UPCOMING EVENTS 2020-2021

### AMA House of Delegates Interim Meeting

Nov. 14-17  
Manchester Grand Hyatt  
San Diego, CA

### TMA Advocacy Retreat

Dec. 4-5  
Omni Barton Creek  
Austin, TX

### TMA 2021 Winter Conference

Jan. 29-30  
Hyatt Regency  
Austin Area, TX

### TexMed 2021

May 14-15  
JW Marriott Austin  
Austin, TX

he “could seldom get home to see the family.” By 1984, Dr. Bechtol’s family commitments, as well as rising malpractice premiums and dwindling OB reimbursement, led him to forego obstetrics. Furthermore, soon after Richard started private practice, busy general practitioners Dr. Jack Walker and Dr. Ernestine Smith both retired, providing Richard many new patients to care for. For the first time, he encountered old-time documentation. Dr. Bechtol was trained during his residency to dictate medical records in the “SOAP note” format. He found, when he reviewed the lifetime medical records from one of the older family practitioners, they would fit on 2 sides of a 5”X7” card, with only important details recorded. Sometimes the entry was just “patient is fine.” That was the prior standard of care for medical documentation.

Further help when he first started practice came from otolaryngologist Dr. William P. Hale, one of the first ENT graduates of the UT Southwestern/Parkland program. After work, Dr. Hale would come over to Dr. Bechtol’s office to advise and encourage him on best business practices. Both Dr. Hale and his wife, Sue, counseled Susan that a wife’s involvement was vital and essential in managing her husband’s office practice. They encouraged her to be involved in Richard’s office from the beginning. Dr. Bechtol is grateful for the Hales’ advice, all of which was correct and helpful.

During his first several years in private practice, Richard still helped out with teaching rounds for the Texas Tech FM residency, rounding with FM residents at

Northwest and St. Anthony’s Hospitals, going from hospital to hospital, in addition to his own practice. He said he did this to ‘give back’ to the residency that had given him so much and had allowed him to come back to Amarillo.

Dr. Bechtol had been interested in helping out in underserved areas of the developing world, volunteering first for a mission trip to a small clinic in Mulato, Chihuahua State, Mexico, across the Rio Grande from Presidio, TX. A nurse from nearby (by West Texas standards) Marfa helped see patients. Later, he and other Amarillo doctors would volunteer for medical mission trips, through First Baptist Church, to Africa, to Mexico, to Guatemala, and to the Dominican Republic, where they set up 2 teaching clinics in association with Dominican medical schools. Their medical mission trips were coordinated with Buckner International Charities and Amarillo First Baptist Church; they linked the faculty and students of the respective medical schools and helped to get medical care established in rural parts of the Dominican Republic, where it had not been available before. The Dominican Republic’s medical schools and medical students have taken those two clinics over permanently, improving teaching opportunities and medical care availability in that country.

Along the way, Dr. Bechtol, Dr. Alan Kiester, and several other Amarillo doctors who had gone on foreign mission trips recognized that there were a good many uninsured people in Amarillo who were underserved, who suffered the same

problems as his foreign medical mission patients, and who could use their help. Dr. Bechtol stated, “My desire was just to see that people who needed help, got it.” Upon retirement, Dr. Bechtol joined the volunteer medical staff at Heal the City, the clinic established by Dr. Keister which continues to provide medical care to the underserved and uninsured patients of Amarillo and the surrounding area.

Dr. Bechtol was in private practice for 35 years, from 1981 to September, 2016. Asked about memorable experiences in practice, he recalled several specific events. Once, early in his private practice years, he delivered a perfectly normal-appearing full-term baby, who took one gasp and died. The baby was born without a diaphragm. Later, after Dr. Bechtol had left obstetrics, the couple was able to have another baby, this one without birth defects. They were kind enough to bring the newborn by his office to share the joy and happiness of a healthy baby, as well as the remembered sadness of the first delivery. Another memorable experience involved a gentleman who came into his office with a ‘pulsating abdominal mass.’ Dr. Bechtol recognized immediately that the abdominal aortic aneurysm was about to rupture. He called a local surgeon, got the man to the ER, then promptly to the OR. Due to rapid recognition and intervention, the patient survived, when few with that problem did. Dr. Bechtol twice had patients come into his office with heart attacks, including one who arrested in the office. Immediate CPR, and continued CPR in the ambulance, got the man to a hospital cardiologist, who quickly saved his life.

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Asked about positive changes during his 35-year practice, Dr. Bechtol related that, from 1981 to the 1990s to the 2000s, diagnostic tools improved – from better, faster and more specific bacterial cultures, allowing more focused antibiotic usage, to better x-ray and ultrasound imaging machines, allowing for far more specific and rapid diagnoses. The diagnosis of pulmonary embolus went from “by guess” (when the V/Q scan report often read ‘indeterminate,’ leaving the provider to guess whether to anticoagulate or not) to the near certainty of today’s CT pulmonary angiography. Obstetrical ultrasound has become more available and more precise, revealing fetal developmental defects before birth, so that they might be better anticipated and managed. He related that cancer treatments became better, with far more survivors by the 2010s than would ever have been thought possible in early 1980s.

Asked about negative developments he witnessed during his 35 years

of practice, Dr. Bechtol stated that, in the mid-1980s and 90s, HMOs and the health insurance industry in general began to limit medical care by restraining trade and fixing prices. This has thrown many more difficulties into the daily practice of primary care doctors. Requirements to get “pre-certification” or “pre-authorization” (after the doctor and patient have discussed the issue and the doctor has ordered the test or treatment in good faith) have delayed and sometimes denied medical treatments for patients. Such hassles have made medical practice at times more frustrating than rewarding. Furthermore, since 2010, federal regulations have required the move from paper records to all-electronic medical records, have made additional hoops to jump through for sharing medical records, and have added additional work to maintain an office clinical laboratory – all additional burdens on the private practitioner. Retirement in 2016 made those hassles “not mine.”

When asked what he has done with his interests inside and outside of medicine in retirement, Dr. Bechtol points out that he has much more time to spend with Susan and his family—including his daughter, a veterinarian and mother of 3 children, and his son, a PhD in philosophy who teaches as a Professor in Houston. Richard and Susan enjoy traveling to see their 6 grandchildren (ages 2- 19). He owns ranch land in rural Kansas, and he enjoys training bird dogs (retrievers), as well as deer hunting, pheasant hunting and duck and quail hunting in Kansas. When in Amarillo Richard plays golf, continues to volunteer at Heal the City Clinic, and helps with fund raising for the Clinic, too. He is still quite active with First Baptist Church, serving as a deacon, teaching Sunday School, and enjoying fellowship before and after worship services. Reflecting upon his successful 35 years of family medicine practice, Dr. Bechtol avows that none of this would have been possible without the guidance of his foundational faith and the intervention of God.

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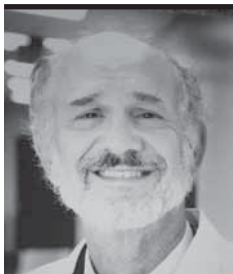
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resources to assist the physician in the business of medicine so their practice of medicine can improve.

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](mailto:prcms@suddenlinkmail.com).



# Dr. Dick McKay: 38 Years of Orthopedic Surgery and Community Involvement

by Steve Urban, MD



Dr. Richard (Dick) McKay was one of Amarillo's most skilled and respected orthopedic surgeons for the 38 years of his active clinical practice. Growing up in Texas (mostly in Amarillo), he returned to his home town in 1975 as a general orthopedist. While in practice, he devoted himself to his patients and to his family, but found time for community volunteerism as well as advocacy (see his article "How I got into medical advocacy", Panhandle Health, Fall 2016). In retirement, Dick continues his work with the American Academy of Orthopedic Surgery but now works in 9 holes of golf most days and, Covid permitting, visits with his extended family including four grandchildren. This essay is the product of a fascinating, hours-long interview with one of Amarillo's medical and community icons.

## Early career and training

Dick was born in Texarkana TX, spent several early years in Temple, but moved with his family to Amarillo in 1952. His father was EENT-trained (in the early days, the specialty combined "eye" with the "ear, nose, and throat" of today) but only practiced ophthalmology in Amarillo. Tragically, he was killed in a private airplane crash in 1963; so Dick's introduction to medicine came primarily from three summers' working as a scrub tech at old St. Anthony's Hospital. Orthopedist Dr. Bob Hyde, a family friend, took the young student "under his wing" and provided a foretaste of what orthopedic surgery in Amarillo could be like.

At Austin College in Sherman TX, Dick McKay's tried to study, but his attention was distracted by classmate Gerry Goleman, whose allure was enhanced by her cooking expertise (she had won a national Pillsbury competition with her killer chocolate sheet cookies in 1960). They dated in school and were married in 1963, as Dick was about to enter medical

school at the University of Texas Medical Branch (UTMB) in Galveston. He's proud that Gerry, with little scientific training but with an inquisitive mind and careful attention to detail, worked in the immunology lab at UTMB and helped write several papers. Dick's initial residency choice was pediatrics, but a fourth-year elective piqued his interest in orthopedics. Later, during a med-peds internship at the University of Virginia, he would slip into the OR during his ortho rotation. Dick had always been mechanically inclined, and his upper-level residents conveyed the excitement of seeing their young patients overcome great disabilities after surgery. Dick McKay realized that orthopedics, not pediatrics, was the career for him.

As was usual in the late 1960's, internship was followed by a 2-year military obligation, and the Navy sent young Dr. McKay to Marine Camp Lejeune in North Carolina. While working as a "general medical officer," Dick seized every opportunity to scrub in at the Naval Orthopedics Hospital at Camp Lejeune. By the time of his honorable discharge in 1971, he had a solid foundation for an orthopedics residency back at UTMB. This was a time of great excitement in the world of orthopedic surgery. Joint replacement was passing from a heroic intervention to a standard and very successful management strategy, initially for hips, then knees (and now, of course, for many damaged joints). A crucial development in joint replacement was the development of methyl methacrylate cement by Dr. John Charnley in England. One of Dick's fellow residents had worked with Dr. Charnley, so in Galveston they had access to methyl methacrylate before its general release in 1973. Dick was, therefore, well-schooled in joint replacement by 1975 when recruited back to Amarillo by Dr. Bob Hyde. Dick recalls moving to Amarillo two weeks early to provide coverage so that Dr. Hyde could embark on

one of his famous sailing vacations.

## Orthopedic practice in Amarillo

The founding four Amarillo orthopedists were Drs. Bob Hyde, Ralph Citron, Charles Sadler, and Ed Thomas (see Bob Stafford's article on "The history of orthopedic surgery in Amarillo", Panhandle Health, Fall 2013). These four paved the way for a very talented orthopedic community in the 1970's and 80's. In addition to the original four, Amarillo's orthopedists in 1975 included Joe Frank Robertson, Ira Livingston, Kenneth Johnston, Leon Fong, and Bob Stafford as well as the young Dick McKay. Within a few years they were joined by Johns Hopkins-trained Howard Berg and spine orthopedist Mike LaGrone. Dick remembers the collegiality and mutual respect that characterized their association. Saturday morning orthopedic rounds drew 90% attendance to a conference where the surgeons could put their heads together over troublesome cases. Dick recalls that, with over 100 years of orthopedics experience in the room, these rounds were a tremendous learning experience.

Emergency call was shared equally, and nobody received compensation from the hospital for being on the call schedule. Each orthopedist was in solo practice and would round and operate on his own patients throughout the weekend. If one of their patients showed up in the Emergency Room on Saturday night, they went out to take care of them. The call schedule was just for unassigned patients (e.g. automobile accidents) and district clinic patients. Being on the call roster was felt to be part of their civic responsibility (young doctors unfamiliar with this term may want to Google it).

Dick practiced general orthopedics for 38 years in Amarillo, and liked every phase of orthopedic surgery practice. He enjoyed getting to know his patients, and

he developed strong bonds of friendship with many of them over the years. He gave up hand and disc cases when experts came along, but continued doing other bone and joint cases, including non-disc back surgeries. Dick and most other orthopedists were happy to help with the needs of children with cerebral palsy and muscular dystrophy at the Children's Rehabilitation Center. As a rule, only very complicated cases or probable malignant bone tumors were referred to Lubbock or Dallas.

Dick McKay saw tremendous advances in orthopedic surgery over his years of practice. He notes that technical advances have made total hips and knees easier and more successful. Original arthroscopic equipment was unwieldy, and knee scopes in the old days could take as long as 1 ½ to 2 hours (about twice as long as today). Anesthesiologists developed expertise with regional blocks, obviating some of the risk of general anesthesia, and intraoperative monitoring became much more sophisticated (e.g. pulse oximeters were unknown in 1975!). Surgical management of bone tumors

improved greatly, so that amputations for children with osteosarcoma, for instance, have become rare.

On advance not well recognized by non-surgeons (like myself) was the development of improved image intensifiers, which made intraoperative X-rays much clearer. CT and MRI, technologies unavailable in 1975, have clarified findings once hazy or obscure on plain films. Finally, specialization has changed orthopedics; now, almost all newly-trained orthopedists have done a fellowship in a particular technique or anatomical area.

#### **Changes in medicine in general: some good, some bad**

Dick McKay has been involved in organized medicine from an early day (for details, see his aforementioned article on advocacy). To summarize, he has been president not only of the Potter-Randall County Medical Society but also the Texas Orthopedic Association. Dick has been a delegate to the American Medical Association and has been a member of the Council on Advocacy for the American Academy of Orthopedic Surgeons. As a consequence, he has seen great changes

in business or administrative aspects of medicine. Dick has seen hospitals move from a patient-friendly mode, where physician input was valued, to a more distant corporate model, where the bottom line reigns supreme. He recalls (as does Dr. Periman in another article in this issue) how Sister Kathleen and the nuns at St. Anthony's worked hand in glove with the medical staff. Medical executive committees seemed more engaged in those days. Dick recalls that the executive committee members at St. Anthony's interviewed each new applicant personally; it was hard for a substandard practitioner to escape their scrutiny.

Dick McKay is not particularly enamored with physician-owned hospitals or with boutique hospitals that skim off the best-paying patients. Burdens of documentation have multiplied, as medical records (used now more for billing than for patient management) have ballooned into unreadable computer-generated monstrosities. It used to be that one office

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# **PANHANDLE HEALTH**

**A Publication of the Potter-Randall County Medical Society**

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**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](mailto: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.

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**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:

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manager would suffice for a solo practice. Now Medicare and insurance companies scrutinize every bill for technical glitches in order to deny payment, and every practice employs several clerks to resubmit paperwork that has been frivolously denied. Hospital choice is based not on patient preference or quality of facilities but on whichever hospital the insurance company will pay for. Government programs, beginning with Medicare and Medicaid in 1965, seem to require even more paperwork as they try to ratchet down reimbursement. Finally, private practices are giving way to ownership by large, for-profit entities. Now, over 50% of graduating orthopedic residents are entering corporate-owned, salaried practices. The solo-practice orthopedists of 1975 are a vanishing breed.

### Retirement

Again, Dick McKay retired from active practice in 2013. The long cases had become more arduous, and he fretted more over complications. Office expenses, such as new computer systems, had doubled overhead costs for the solo

practitioner. Finally, Dick believed it's important to "retire before you have to." He recommends TMA resources to help the retiring physician negotiate the complicated process of closing a practice.

In retirement, Dick has been able to devote more time to family and golf. Dick has always been a supporter of our excellent Amarillo Symphony. He had no choice; Gerry was President of the Board and even filled in as interim executive director on two occasions! Dick has also been involved in the Rotary Club, at one time taking student mentees into the OR with him, much as Dr. Hyde had done in the old days. One heartache of recent years has been Gerry's decline into the throes of Alzheimer disease. I remember with admiration how Dick would patiently chaperone Gerry to the Chamber Music and Symphony events that she loved, even as her illness progressed. He thinks that his training as a physician allowed her to stay at home for months longer than expected. Dick appreciates the insight he received from the Alzheimer Academy at Texas Tech

and the kind treatment she now receives at Ware.

In summary, Dick McKay is a repository of knowledge and insight into the history of medical care in Amarillo. He went from being a "doctor's kid," through jobs as a scrub tech and trainee, and into his own successful orthopedic practice. Dick has known almost all the orthopedists who have practiced in Amarillo—from the "Big Four" pioneers to recent residency graduates of today. Along the way, he took care of thousands of patients—would-be athletes with torn menisci, victims of automobile accidents and agricultural trauma, elderly women with osteoporotic hip fractures. Dick has always been calm, kind, and professional. If he ever lost his cool, neither I nor any of my fellow practitioners ever saw it. He ably served his patients, served his profession, and served his community for 38 years. Dick's commitment to excellence has always engendered admiration, and his legacy continues to set the standard for younger practitioners who are coming along today.

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**RYAN RUSH, M.D.**

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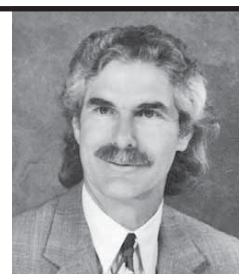
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# Dr. Tom Easley: 45 Years of Anesthesiology

by Scott Milton, MD, FACP



Dr. Tom Easley retired in 2018 after practicing anesthesiology in Amarillo for 45 years. Dr. Easley was born in San Francisco and lived the first few years of his life in Argentina as his father was likely involved in Army Intelligence during the second world war. After the war Tom's family lived in various locations as his dad was a meteorologist.

Eventually his family settled in Grand Prairie, Texas where he graduated from high school. After high school he enrolled at Texas A&M University. He chose Texas A&M because at the time it was much smaller than his other choice, the University of Texas. He also felt he would just fit in better at A&M.

Secondary to his love of the outdoors, Tom initially wanted to be a forest ranger but did not pursue this as he desired to make a better living. Tom had two relatives who were dentists who seemed to be doing well and initially thought he would pursue dentistry. Eventually, as his grades were good, Tom was encouraged to go to medical school by his advisor Dr. Gravitt at Texas A&M. Dr. Easley attended U.T. Southwestern medical school, graduating in 1967.

During this time of the Vietnam War, Dr. Easley and thousands of other

physicians in training were subject to the Berry Plan. This plan allowed physicians to defer obligatory military service until they had completed medical school and residency training. The Berry Plan offered draftees three choices: entry into the armed forces after completing a medical internship, after completing one year of residency (returning to their residencies after completion of service), or after completion of a full residency program. After completing a one-year medicine internship at the University of New Mexico in Albuquerque (chosen because the pay was 10x that of his second choice, Stanford), Dr. Easley went back to Southwestern in Dallas for a one-year surgery slot. During this year he traded for more anesthesia rotations. In 1969 he was scheduled to go to Vietnam but was allowed to enter the anesthesia residency program secondary to Berry Plan. He was influenced and guided by Dr. "Pepper" Jenkins, the chief of anesthesia at Parkland hospital and one of the leading scientists in the fields of shock and the development of Ringer's solution. Doctor Easley finished his anesthesia residency in 1971 and through Dr. Jenkins' contacts met Dr. Mendenhall, who was the Chief and director of anesthesia at Brooks Army Hospital. Luckily, he eventually was sent to Fort Carson in Colorado Springs, Colorado where he was the Medical Director and trained

nurse anesthetists for two years.

By 1973 Dr. Easley had finished his obligation with the service and began looking for places to practice his specialty. Dr. Easley has always loved the outdoors and the Rocky Mountains and looked extensively in this area. However, he was contacted by Dr. Clint Arthur whom he had known from his residency in Dallas and who was practicing in Amarillo. Tom moved to Amarillo as he felt Amarillo was a better place economically to practice medicine and he was still close enough to the mountains. Dr. Easley primarily practiced at St. Anthony's Hospital initially and later BSA after the merger in the mid 1990s. He described his time at St. Anthony's as his favorite and told me there was a special spirit that was present among the staff at that time in that hospital. This was primarily the result of the influence from the nuns working in and for St. Anthony's. The spirit was warm and collegial and focused on the care of the patient.

Dr. Easley has always felt he was extremely fortunate to be a physician. Whenever he was able to discuss with young people what they might do with their lives he was always quick to suggest the medical profession. Very few careers offer good pay as well as such a positive impact on other people's lives. Further, Dr. Easley believed that his role in anesthesia during the time of the surgical procedure was as a team player and a "copilot" with the surgeon. During the time of surgery he understood what pressure surgeons were under and they would commonly make bold and quick decisions. He knew that his role was to assist the surgeon to keep the patients stable during this critical time of the surgical procedure.

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**We wish to thank all Healthcare Workers, Law Enforcement, Firefighters and EMT's, for your tireless efforts in helping the people of the Texas Panhandle.**

While there have been many changes in medicine over Tom's career he knew that change was inevitable and always believed he was in a profession that had no equal. He eventually learned to avoid places (the doctor's lounge) where other colleagues may congregate and complain about the changes that were occurring in medicine. Tom always felt that the benefits of the practice of medicine, both financially and emotionally, vastly exceeded any negative event that occurred during his 45 years of practice.

Almost equal to his love of medicine is his love for outdoor activities. Over his lifetime Dr. Easley has become an accomplished golfer, fisherman, hunter and outdoorsman. As stated previously Tom chose Amarillo because it's close to the Rocky Mountains. Over the years he has become an accomplished fly fisherman and has hiked and backpacked extensively. In 1984 he hiked over 300 miles carrying a 100 lb. pack for 28 days while exploring the Wind River Range in Wyoming by himself. Dr. Easley has always been an avid hunter, and the

study in his house displays many of his trophy mounts.

Golf has also been a love of Tom's since an early age. In addition to his own love of golf, he has instilled the love of golf in his daughters and grandchildren. Three of his daughters played collegiate golf and his daughter Meredith has been the West Texas A&M women's golf head coach for many years. And not only has Dr. Easley taught his daughters and grandchildren the game, he has assumed the role of assistant coach under his daughter at West Texas A&M. As Dr. Easley explains, his role is "to keep my mouth shut and do what the head coach tells me." Many of the young women recruited to this talented team are from overseas and play golf at a very high-level. The atmosphere, that Coach Jameson and Coach "Dr. Tom" foster is a family atmosphere, and this obviously has been highly successful. He describes this team as highly competitive and boasts a First Team All-American from last year. I have no doubt that "Dr. Tom", as he is now called by the team, will con-

tribute much to the success that this program seems destined to accomplish.

Dr. Tom Easley practiced anesthesiology in Amarillo for 45 years, and he loved every minute of it. In addition, he was able to continue to pursue his love for the outdoors and specifically for golf, backpacking and hunting and fishing. I concluded my interview with him on a Saturday morning at his house on his back porch over-looking the beautiful La Paloma golf course. His tee time was just in five minutes and he was looking forward to the day playing with his friends and family. Tom told me many times on this morning that he knew he was lucky to have had such a great career. He's very grateful to have three of his daughters and many grandchildren close to him. He hopes to return at least once more to the Wind River Range to fish. He's very much looking forward to the resumption of play of the West Texas A&M women's golf team and helping his daughter, Coach Meredith Jameson, pursue a national title. I have no doubt that he will see all of this through.

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### Location

- Find a quiet and private space at your location – close doors and windows to high-traffic areas.
- Remove clutter from the area where you will sit. You want your doctor looking at you, not what's on your desk or wall.
- Make sure the area is well-lit. Keep lighting overhead and/or in front of you, rather than behind you. Close blinds and drapes to prevent glares and shadows.

### Technology

- Ensure your device has enough charge (or is plugged in).
- Check your internet signal strength. A connection speed of 384 Kbps is common.
- Adjust the angle of your camera so you fill as much of the screen as possible.
- Know how to use your equipment. Have the phone number for tech support close by – just in case.

### Audio

- Mute, turn off, or remove possible noisemakers such as your television, cell phone, alarms, or pets.
- Eliminate echoes.
- Check for air noises like a fan, AC unit, or open window that may affect the microphone.
- Make sure the microphone is not blocked.
- Speak normally – slowly and clearly – in the direction of the camera.

### Visual

- Avoid too much movement.
- Don't look at your picture on the screen.

### General

- Have your pharmacy name, location, and number handy.
- Explore the telemedicine app/platform to get comfortable with it.
- Don't be nervous or afraid to ask questions!

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# Dr. Mubbariz Naqvi: *A Medical Legacy in the Panhandle*

by Taru Bharadwaj



Dr. Mubbariz Naqvi is a neonatologist who has practiced in Amarillo, TX for the past forty-two years. He is the kind of physician to go above and beyond with patients, co-workers, and medical students, always aiming to better medicine with empathy and perseverance. He explains that it is true an effective doctor needs proper knowledge and practical experience to heal effectively. However, Dr. Naqvi reveals the most crucial assets a good doctor can have are something else entirely. He told me a doctor should be “cloaked with humility and empathy, and must always act without arrogance.” Not only was this statement vital advice to any student or doctor, but it also served as an ode to the spirit of Dr. Naqvi. His kind demeanor and quiet intelligence are summed up quite nicely in his advice. He kindly spoke to me about his life in medicine, outside of medicine, and how he has seen the medical field evolve throughout his career. His experiences are extraordinary reminders that medicine has greatly progressed in the last few decades, but has also remained the same in other ways.

Dr. Naqvi has always had the ability to calm people down; from a young age, he knew he wanted to work with people and help them through tough times. Thus, he found his calling and attended medical school in Pakistan at Dow Medical College at the University of Karachi. At the time, there were several doctors who were planning to further their medical training in the United States. These doctors mentored medical students, such as Dr. Naqvi, to help them begin a transition to the States. Dr. Naqvi was intrigued by the medical advances in the United States, and this interest is what eventually brought him over. After his internship at St. Vincent Hospital in Toledo, Ohio and his residency in pediatrics at the Children’s Hospital of Michigan in Detroit, he found the next steps of his journey in the panhandle of Texas. Northwest Hospital reached out to him because of a great need for neonatal doctors. Dr. Naqvi saw this need and recognized the opportunity to help people, so he made the big move to Amarillo, TX in 1978: “I followed my fate and came [to Amarillo]!” At the time, he was the only neonatologist in

town, a demanding challenge for any physician. However, Dr. Naqvi tackled the tough task with his penchant for empathy and unity.

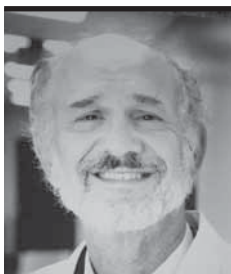
In addition to his own work as a physician, Dr. Naqvi trained people around him because of the lack of people specialized in neonatology at the time. He worked with the nurses, but he also trained them in specialized tasks, such as how to care for an infant with breathing problems. He worked with nurses, therapists, pharmacists, social workers, and many others to form the Perinatal Committee; this way, people from different medical backgrounds could come together every month to discuss how to tackle the perinatal problems that families were facing. The team followed a practical and effective methodology by discussing cases, analyzing difficulties, and implementing solutions. He cites this period in his life as one of the most striking and memorable in his career. The premature infants in Amarillo had a great need for care and medical attention, but there was a distinct lack in the very specialists that could help. This is why Dr. Naqvi’s and the Perinatal Committee’s work in this time was so impactful; it was a harmonious fusion of diverse medical backgrounds to directly provide solutions to a very imminent problem. This committee is still going strong to this day, as it has grown stronger with time and resources.

The formation of the Perinatal Committee shows the relentless drive of those involved, but it also shows a doctor’s devotion to patients. Dr. Naqvi was at the forefront of this team because of his empathy and care for his patients. He explains that medicine has come a very long way indeed, but the importance of the doctor-patient relationship has remained the same. The main part of healing society is the trust and care between a doctor and patient. This was important then, is important now, and will continue to be one of the most crucial parts of a doctor’s career.

Despite this consistency, Dr. Naqvi does point out some major changes he has observed in medicine. In his field, he has seen great improvement because of the preventative measures and better technical knowl-

edge when it comes to premature babies. Premature babies are able to survive now more than ever due to medical advancements and the close collaboration between neonatal and OB/GYN doctors. He does point out that technology can have a negative affect if not used properly. This is because online notes, dictations, and the technologically-induced fast pace of physicians can sometimes lead to detachment between doctors and patients. As he mentioned before, this relationship has retained its utmost importance throughout his entire career. Thus, he praises technology for the wonders and healing it has brought to the world of medicine, but reminds us refrain from getting carried away and forgetting the patient. He urges us to take our time with patients and their families, to give them our full attention.

Finally, Dr. Naqvi reminds doctors to take care of themselves as well. He recalled his early days, when he would spend most of his time at the hospital and get swept away by the demanding nature of the job. Though he adores teaching and small projects, he remembers to continue to learn as well. The role of a healthcare professional is treasured in our society, but the role of a doctor should also be humanized. Dr. Naqvi did just that when he talked about anxiety that a doctor can feel from the high intensity that stems from the job. We discussed the books he reads to learn about this anxiety and distress himself; as a pre-med student, I saw the human behind the doctor, and seeing the passion Dr. Naqvi had for self-care gave me hope for our future physicians. It is riveting to learn about how medicine has advanced and changed over the course of a single physician’s career: the juxtaposing nature of technology, the way people of diverse medical backgrounds can create tangible change, and the way the importance of a doctor’s relationship with a patient has remained important despite the major advancements show the complex nature of the medical field. Our insightful conversation came to an end when Dr. Naqvi told me why he has stayed in the Texas Panhandle even after the neonatal department improved. He had a simple, yet strong answer: “I stayed for the incredible people.”



# Dr. Holley Reed: *Pioneer Pediatrician*

by Steve Urban, MD

Despite his 97 years, retired pediatrician Dr. Holley Reed is still clear of mind and can recall his 39 years of pediatric practice in Amarillo with only minimal coaxing from wife Dorothy. Growing up in a medical family in the Hudson Valley of New York, then receiving his training in New York City and Philadelphia, Holley moved to Amarillo in 1951 and practiced general pediatrics until his retirement in 1990. Holley's recollection of epidemic diseases of the 1950s, before effective vaccinations had been discovered, can remind us that COVID is not the first communicable disease to be widely feared, and his account of therapeutic advances can show us how far we've come. Furthermore, the legacy of his practice and his 71-year (and counting) marriage can give us a picture of happiness both inside and outside the profession.

## Upbringing and training

Holley Reed was born in New York City in 1922 and was raised about 50 miles up the Hudson River, just north of West Point, in the city of Newburgh, NY. He was to become a third-generation doctor; his grandfather was a general practitioner and his father, after serving in World War I, completed training in radiology and returned to Newburgh. When asked about his choice to go into medicine, Holley speculates that "it was just in my genes." Then he laughs and says that his father said "It was a pretty good racket."

Holley attended Colgate University in Hamilton NY and then went to medical school at Hahnemann in Philadelphia. Medicine in those days was primarily a masculine pursuit—there were only three women in Holley's class. Because of World War II, the medical school curriculum was compressed into 3 years; Holley remembers being in a lecture hall when news of the attack on Pearl Harbor was announced on December 7, 1941.

As was usual in the 1940's, Holley completed a 1-year rotating internship in Stamford CN and then entered the Navy for a 2-year obligation. He was accepted into training as a Naval flight surgeon and was sent to Pensacola FL. All flight surgeons had to perform a solo flight; Holley's severe motion sickness made this a challenge, but he got by. The best part of Naval Flight School was meeting a young woman, Dorothy Lewis, who had come down from Rapid City, SD to work as a nanny for her brother (a Navy pilot) and his wife. Dorothy and Holley were married in 1948, a union which again has endured for 71 years.

After the Navy, Holley and Dorothy moved back to New York, where Holley took a residency in Pediatrics at the New York Medical College in Manhattan. When asked why he chose pediatrics, the 97-year old Holley laughs that he "couldn't stand to be around old folks."

Complaining all the time 'I'm going to die.'" Holley smiles, "Not on my watch, you're not!" In the late 1940's, penicillin had just become available; so previously fatal infections like bacterial meningitis and endocarditis were now manageable. Before the availability of corticosteroids and advanced surgical techniques, however, conditions like severe asthma and cyanotic heart disease still presented a challenge.

## Practice in Amarillo

While in New York City, Holley and Dorothy became friends with fellow pediatric resident Joe Lipscomb. Joe had come east for residency but planned to return to his home town, Amarillo TX, for practice. He made the place sound so good that Holley and Dorothy decided to move there, sight unseen—and have never regretted the decision. They appreciated the warm, dry climate and the collegial medical community. Holley recalls one winter when they returned to New York for a two-week vacation and didn't see the sun for the entire fortnight. Windy Amarillo looked pretty good in comparison.

In 1951, Holley and partner Joe Lipscomb set up an office on 6th street, not far from old Northwest Texas Hospital. When the Reeds came to town, Amarillo had 3 pediatricians: Bill Mullins, George Waddell, and John Pickett. The older pediatricians, especially George Waddell and his wife Esther, helped get the youngsters situated. A few years later, Dr. John Jones moved to Amarillo, and the pediatricians would cover for each other when one of them needed to leave town on vacation. Holley recalls that, about this time, acclaimed obstetrician Dr. Earley B. Lokey arrived in Amarillo. Drs. Lokey and Reed worked together frequently, especially at NPTH. Holley reminds me that referrals from obstetricians were and are important for a pediatrician just starting practice. Holley very

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often would provide care for these children from age 1 hour through 16 years. Holley recalls having to wait three years to be eligible to sit for the pediatric boards. He remembers going to Albuquerque for his written exam but all the way to Des Moines IA for the harrowing scrutiny of the oral exams.

In those days, antibiotics were the new “wonder drugs” (thus giving rise to unrealistic expectations of cure for many therapies to come). Penicillin G (injectable at first) and sulfadiazine were available initially. Cholormycetin™ (chloramphenicol) was popular in the 1950’s because it tasted so good, but Holley didn’t jump on the bandwagon. A few years later, the terrible side-effects (aplastic anemia, “grey-baby” syndrome) that have limited its use were recognized. As years went on, cephalosporins, streptomycin, and lincomycin were introduced to help treat increasingly resistant bacteria.

#### Changes in pediatrics over the years

Holley remembers summertime epidemics of poliomyelitis and recalls participating in the program of widespread vaccination when the Sabin vaccine (oral polio vaccine) came out. In New York he had seen patients die of tetanus. Chickenpox was ubiquitous and usually swept through whole families. Holley still recalls the brassy, emetic cough of pertussis echoing down the hall of the hospital. But the communicable disease that Holley most feared was measles. “It was a real killer,” he recounts. Holley remembers looking in the throat of one hospitalized febrile child and discovering that Koplik spots had developed overnight. He realized that the whole ward was at risk of coming down with the “red measles!” (If I were the ID god, I’d require those who discount the critical role of childhood vaccinations to endure one epidemic of polio, whooping cough, or the measles.)

In addition to the therapeutic advances alluded to above, Holley considers two local developments to be critically important. One was the arrival of skilled surgeons to deal with conditions like hernias and acute appendicitis. He especially valued the expertise of Dr. Walter Watkins and Dr. Pat Oles. Another tremendous advance occurred when Dr. Mubariz Naqvi came to town

and revolutionized neonatal care. Prior to his arrival, very premature or severely ill babies had to survive transfer to Lubbock, Dallas, or Ft. Worth. Holley remembers that Dr. Naqvi worked so collegially with local practitioners that nobody was threatened or alienated. Dr. Reed appreciated that Mubariz was always eager to care for any sick baby, regardless of time of day or the family’s socioeconomic status.

Holley and Dorothy raised their 3 girls in Amarillo (Marilyn Trook still lives here; the two others are in Littleton CO and the Houston area). Holley volunteered at the Presbyterian Children’s Home, while Dorothy dedicated time to the medical auxiliary. Holley continued to work in the office until the need

to purchase an expensive computer system led to his retirement in 1990. Now they live in an apartment at the Craig Retirement Center, where Holley still goes down to exercise classes. His mind is still sharp and his hearing pretty good, as I can attest since COVID forced me to conduct this interview by telephone. Holley still has the kindly pediatrician’s personality; I was unable to extract any controversial or critical comments from him, despite several leading questions. He looks back with satisfaction on his 39 years of practice in Amarillo, contented with the life in the medical field, proud of his accomplishments, and pleased with the thousands of children that he shepherded through to adolescence – where he then could turn them over to somebody meaner.

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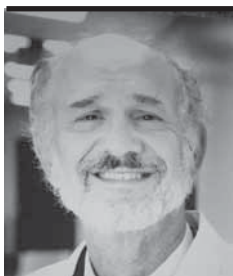
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# Dr. Phillip Periman: *Hematologist, Oncologist and Community Pioneer*

by Steve Urban, MD



Phillip Periman grew up in the Panhandle, was educated in some of the great institutions of our country, and then came back to Amarillo to help bring modern hematology and oncology to the Panhandle. Along the way he helped get Texas Tech University School of Medicine off the ground in Amarillo, founded the Harrington Cancer Center, taught (and terrified) generations of medical students, and practiced high-quality medicine in our community. As we say in the Panhandle, he cut a wide swath.

Now, having retired, Phillip devotes himself to golf, photography, poetry, and his friends and family. He is still sharp of mind and tongue. Having witnessed tremendous advances in technical medicine but also some regression in physicians' attitudes and practice in his 55 years of medicine, Dr. Periman is still articulate and opinionated. In this essay, I hope to do justice to the recollections and opinions of this remarkable physician.

## Upbringing and training

Young Phil Periman attended school not far from where his IC Gallery currently stands—at Bivins Elementary, Stephen F. Austin Junior High, and old downtown Amarillo High School. In those days, one of the AHS counselors, Effie Burkhalter, had an inside track to Yale University, and a string of Amarillo graduates—including internist Dr. Ted Nicklaus—were accepted at Yale. In Phillip's year (1957), five Amarillo seniors (4 from AHS, one from Palo Duro) matriculated in New Haven. Among these was Charles Deahl, who has been a close friend from 2nd grade, through Yale, and still today. It's hard to picture today's elder statesman, stylish with his bow ties and William B. Yeats specs, going off to New Haven with his Stetson hat and cowboy boots—probably as amazing to contemplate today as it was to the Yale preppers of 1957.

At Yale, 250 of the 1000 freshmen (all freshMEN in those days) were bound for medical school, but they were encouraged to pursue liberal arts majors. "They'll teach you science in medical school," was the message. "We want you to know humanity." Phillip majored in history, and the lessons learned there provided an important foundation for the future. "The cornerstone of medical care is history-taking," he muses. "Patients aren't always straightforward reporters. They withhold information, minimize some symptoms and exaggerate others." Phil believes that the probing, even skeptical, approach to information-gathering, learned under the tutelage of historians like John Morton Blum, gave him an important foundation for medical practice. Another formative event in his undergraduate years was a summer job in 1960 in the office of Senator Ralph Yarborough, an experience that produced a lifelong liberal Democrat (a phenomenon rarely encountered in the Amarillo medical community of his day or any other, for that matter).

From 1961-65, Phillip attended medical school at Washington University, one of the great heartland medical schools, to "get away from the East Coast." In St. Louis, he met Barton Grooms and Walter Dickinson, each a future practitioner in Amarillo – Barton an internist with what is now Amarillo Internal Medicine, and Walter a founding member of the Amarillo Surgical Group. At Wash U. Phil recalls the competitiveness of his classmates (Yale was low-key by comparison) and the paucity of women in his class—only about 10%.

Phillip pursued an internal medicine residency on the New York University (NYU) service at the famous Bellevue Hospital in Manhattan. He recalls 20-40 bed wards (arranged in the "Florence Nightingale" configuration to improve

ventilation while minimizing privacy), supervised by a single RN. Call was every other night, except for alternating weekends when you spent the entire weekend in the hospital. Interns were responsible for drawing blood, transporting patients to X-ray, plating cultures, and doing cut-downs for IV access. At the private hospital near NYU, on the other hand, the housestaff got to tag along behind full professors on rounds with their private patients. Phil's NYU professors included renowned innovators like Saul Farber and Lewis Thomas (of "Lives of a Cell" fame).

## Researcher, medical educator, pioneer

In the mid-60's, it was usual for residents to do an internship and then to be drafted, often destined for Vietnam. Almost all Phillip's male classmates were called into the uniformed services. Fortunately, the U.S. Public Health Servicemen were issued uniforms too, and Phil's academic record was good enough to procure a fellowship at the National Institutes of Health (where selected USPHS officers were assigned). While at the NIH, Phillip began to study multiple myeloma and to work on hybridizing myeloma cells with fibroblasts in order to simplify their analysis. For a year in the middle of his NIH training, Phil sojourned at Oxford University to work with famous cell biologist Dr. Henry Harris. A result of this labor was Phillip's paper on monoclonal antibody production, published in *Nature* (Periman P. IgG synthesis in hybrid cells from an antibody-producing mouse myeloma and an L-cell substrain. *Nature*. 228:1086-87; 1970). It is hard to overestimate the importance of the hybridoma technique; it underlies the mass production of monoclonal antibodies which has revolutionized rheumatology, heme/onc, gastroenterology and many other fields. Phil decided to turn his attention to clinical medicine, however, and to let

Milstein, Kohler, and Jerne win the 1984 Nobel prize for hybridomas.

In 1971, after 3 years at the NIH, Phillip accepted a faculty position at George Washington University School of Medicine, first as a general internist and then in the hematology/oncology division. He intended to pursue the academic track—tenure, research lab and all the rest. In 1976, however, the department was shaken by departures and academic unrest, and the young Associate Professor became restless. Opportunity called from an unexpected direction—the Texas Panhandle—and Phillip Periman decided to join the fledgling Texas Tech medical campus in Amarillo.

Dr. Periman joined TTUSOM (Amarillo) as regional chair of internal medicine (IM) in the fall of 1976. At that time, Tech (Amarillo) sponsored a Family Medicine residency but had no medical students on campus; the full-time IM faculty consisted of just 3 members. Phillip set about building a medicine department with early recruits including infectious diseases specialist Dr. Ed Sherwood and iconic Amarillo internist Dr. Rush Pierce. Over the next 5 years, Phillip helped lay the groundwork for full-time third year students (among the first 6 students of which was James Yeary, destined to become an outstanding dermatologist and medical educator at the Amarillo VA). By 1981 the department was preparing for an IM residency, and Phillip had recruited endocrinologist Dr. John Higgins from UT Southwestern to lead the department. Phil had identified another challenge, one that would engage most of his energies and would transform oncology care in the Panhandle.

#### **Founding the Harrington Cancer Center (HCC)**

In the late 1970's Amarillo had 3 hematologist/oncologists, but most local patients left the Panhandle—often for M.D. Anderson hospital in Houston—for cancer care. Radiation therapy was administered by general radiologists without benefit of a physicist, certified radiation technologist, or modern facilities. Almost all patients who needed chemotherapy were hospitalized.

In 1977 Dr. Periman had begun to think about updating cancer care in the Panhandle. He believed that Panhandle residents should have access to local care of equal quality to that offered in Houston or Dallas. With the help of community leaders Louise Evans Bruce and Katherine Wilson (our first woman city commissioner), he obtained a small grant from the Harrington Foundation to do a feasibility study for an outpatient cancer center. The consultant felt it could work, and fund-raising for the Harrington Cancer Center began. With help from Drs. Walter Dickinson and A.B. Goldston and community leaders Avery Rush Sr., Virgil Patterson, Tol Ware, David Culver and many others, Panhandle donors raised \$20 million in less than 2 years. By August 1981, Harrington Cancer Center was ready to open its doors. For his tireless efforts (all while running an IM department and submitting the arduous paperwork for a new IM residency), Dr. Periman was elected Amarillo's "Man of the Year"—the only practicing MD to be so honored.

It's hard to underestimate the transformation wrought by HCC. Modern radiation therapy machines—linear accelerators to replace the old cobalt machines—represented a quantum leap.

General radiologist Dr. Dan Epley—a meticulous and humane physician fondly remembered by all, including myself, who knew him—went off for formal training in radiation oncology, and Phillip hired Chief Radiation Technologist Allen Burns, pharmacist Cathy Coberly, and the many staff members necessary to bring hospital-level organization to the outpatient setting. Phillip recruited a talented practice group including gifted young oncologist Brian Pruitt from Wisconsin, and, later on, skilled doctors like Panpit Klug (from GWU), Jim Luce (from Adria pharmaceuticals) and Vance Esler (a converted general internist). Patients no longer had to go to Houston for state-of-the-art cancer care. Outpatient therapy—more convenient for the patient, with fewer complications and costs to the system—came to Amarillo. Phil turned over medical directorship to Dr. Luce but continued to bring his brand of high expectations and meticulous performance to HCC until 2005. In that year, he left HCC to join the Texas Oncology group, where he continued to work until his retirement in 2017.

#### **Words to set a medical student's heart aquiver: "Periman rounds"**

Despite his clinical and administra-

*| continued on page 26*

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tive roles, Dr. Periman remained a core participant in the educational mission of TTUSOM. Although he provided stimulating conferences on topics ranging from molecular biology to humanism in medicine, his most famous (and intimidating) role was as conductor of “Periman Rounds,” a rite of passage for generations of medical students on their IM rotation. In these weekly sessions, students were expected to obtain a complete history from the patient, to perform an extensive physical exam, and then to report their findings to Dr. Periman and the team at the bedside. Phillip encouraged students to ask the pertinent question, to delve for details—that is to say, to think diagnostically. You had to know if the elderly widow owned a pet that might be the source of her pneumonia, to delve into the diet of the patient with unexplained hypokalemia, to question the notorious “two drinks a day” evasion from the tremulous, disheveled loner. Students were expected to read at least two peer-reviewed papers about their patient’s condition and to lead a discussion of the topic before their fellows. Hundreds of students learned the importance of sitting at the patient’s bedside, of the sympathetic touch, of honesty in the face of uncertainty.

Many current Texas Tech faculty members vividly recall their Periman rounds experience, despite the years. Pediatrician Rachel Anderson remembers her patient from 2012: “She was a 49-year-old woman, status post pulmonary valve replacement due to endocarditis from IV drug abuse. On the surface, it would be easy to judge her based on her illness. The day before my ‘Periman rounds’ presentation, I (somewhat begrudgingly) spent a few hours getting to know her. In addition to learning her favorite ice cream flavor (strawberry), I learned that she had turned her life around, and now worked at a church in downtown Amarillo that helped recovering addicts. This experience brought to light the importance of the human being behind the disease.” Rachel admits that a few, less dedicated classmates “would convince an agreeable patient to go along with any answer they made up to Dr. Periman’s questions. That, or a coma-

tose patient!” Pediatrician Dr. Johnnie Faircloth remembers Periman rounds from 2006: “He made sure we saw the humanity in what I was certainly treating as just a medical case...I was assigned to present a poem from Walt Whitman’s ‘Leaves of Grass.’ I would have never read that poem had it not been for Dr. Periman.”

Dr. Rodney Young, chair of Family Medicine at TTUSOM, remembers his “Periman patient” from 1995. Phillip insisted on careful documentation, but Rodney felt safe from his scrutiny: “When I mentioned [my patient’s] cholecystectomy, Dr. Periman stopped me to ask if I had reviewed the records. I answered (feeling pretty bulletproof) that the hospital had closed 20 years earlier, so they were unobtainable. He replied with incredulity, ‘Did you even call the county clerk’s office?’ which I did not even know was a thing. So, he threw me out of the room to go call the county clerk so we could get a decent history before proceeding! When I did, the clerk had no idea where any of those records might be. She told me I was the only person who had ever asked!”

#### **Changes in cancer care over 35 years**

Phillip Periman practiced state-of-the-art hematology and oncology for 35 years, until his retirement from active practice in 2017. When asked about changes he witnessed over those years, he first mentions advances in diagnostic imaging. In 1976, Amarillo had one CT scanner (brain only), which took almost an hour to acquire fuzzy pixilated images. The advent of fast and detailed CT scans, then MRI and finally PET scanning—a crucial tool in oncology—revealed much that had been hidden before. Films gave way to digital imaging. (Phillip recalls that, when the Hunt brothers tried to corner the silver market in the 1980’s, thieves targeted x-ray storage rooms for the silver iodide). Pathology became more sophisticated with immunochemical stains and flow cytometry. Outpatient infusion centers and subcutaneous ports for IV access enabled complex therapy to be administered to the outpatient. Cytotoxic chemotherapy has gotten better with the introduction of drugs with

novel and synergistic modes of action.

But a revolution in the understanding of cancer – as a series of acquired cellular mutations—has given rise to the greatest advances in cancer treatment: targeted therapy and immunotherapy. Elucidation of intracellular growth and intercellular signaling pathways has led to “targeted” therapy, directed against specific mutations. Initially, the fatal disease chronic myelogenous leukemia was brought under control. Now, targeted therapy has given us less toxic treatment even for common cancers like melanoma and colon cancer. As we have teased out the biology and structure of anti-tumor T-cells, effective immunotherapy has come out of the laboratory to the bedside, and melanoma, certain lung cancers and many other tumors now respond to PD1 checkpoint inhibitors and others.

#### **Reflections on medical practice in the Panhandle**

Dr. Periman has seen many changes in medical practice – some good and some bad. Phillip decries the loss of local control of hospitals. When he came to town in 1976, Amarillo had 5 hospitals, with only the VA being part of a national system. Now, the old Osteopathic Hospital has closed, St. Anthony’s and High Plains Baptist have merged, and all are now part of large, for-profit chains. He also laments the loss of a sense of community among physicians. Medical society meetings were once widely attended, and the education committee brought speakers of national renown to Amarillo. You had to attend a certain number of hospital staff and section meetings to maintain your privileges—so staff meeting thronged with colleagues full of ideas and referrals. Department meetings were often lively and sometimes controversial; now the controversy is kept behind closed doors. Phillip believes that the profit motive has contaminated the practice of medicine. He believes that everyone is entitled to medical care as much as clean water, a police department, or a public library. He speculates that treating the delivery of health care as a public utility would decrease the cost and improve the quality of health care.

On the good side of things, Phillip emphasizes the rise of hospice care, a movement led on a national level by former TTUSOM regional dean Gerald Holman. In 1976, nobody had even heard of a hospice, and palliative care was an afterthought. Inpatient, then home-based, hospice care has softened the once invariably horrific process of death from metastatic cancer. Phil also praises the expanding role of the Texas Tech School of Medicine, growing from a rudimentary facility in 1976 to a bustling enterprise that has educated and attracted hundreds of practitioners to our region. He is proud of his role in getting Tech's internal medicine program off the ground and in helping shape the student and residents who have completed their training there.

On a personal note, Phillip Periman has seen Panhandle medicine move from one dominated by general practitioners (in the early days, many had just one year of post-graduate training) to a community of specialists with advanced skills—electrophysiology, interven-

tional radiology, surgical oncology, etc. Of many great doctors, Phil singles out his Wash U. classmates, internist Dr. Barton Grooms and surgeon Dr. Walter Dickinson, for their independence and adherence to personal standards of excellence. Radiation oncologist Dr. Dan Epley was a careful doctor whose H&Ps were detailed and pertinent (back in the days when you were judged by the quality, not the quantity, of your documentation). Phillip valued the input of thoughtful neurologists Dr. Rush Snyder and Dr. Mike Ryan and pathologists Dr. Milan Kalus and Dr. Ralph Mennemeyer, who were not offended when you asked for slides to be sent off for a second opinion. Phil admired the expertise of Dr. Brian Pruitt in breast cancer, Dr. Richard Archer in interventional radiology and the late Dr. Bruce Baker in pulmonology. But Phil remembers his early mentor, Dr. Clay Dine, surrounded in his office by the writings of Osler and bound copies of the New England Journal, as the "smartest doctor in Amarillo."

In conclusion, Dr. Phillip Periman

grew up in the Panhandle, then trained at Wash U., Bellevue and the National Institutes of Health. Faculty appointment at George Washington preceded his return to the Panhandle for the rest of his medical career. Phil helped build the internal medicine department at Texas Tech from a three-man operation into the vigorous operation of today, then turned his attention to bringing modern outpatient cancer care to our area. Along the way, he rubbed shoulders with giants of American medicine, gifted local practitioners, and paragons of philanthropy and community service. He taught bedside medicine to a generation of medical students (many of whom tremble in recollection to this day) and delivered high-quality care to thousands of patients with cancer and blood diseases. And he's still moving on. In retirement, he supplements golf with poetry and photography, keeps up with a bevy of Yale classmates, and continues to propound cultural and political notions (usually of the liberal sort) to those who will listen. Phillip Periman, as thoughtful and opinionated as ever, continues to cut a wide swath.

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# Dr. Rush Pierce: *Internist Extrodinaire*

by Todd Bell, MD



John Rush Pierce, Jr. (“Rush”) grew up in Arlington, TX. His father was the first internist in the city, population 30,000 at the time, and Rush would occasionally go with him on house calls or to the hospital. Just as the Texas Ranger baseball team had not yet moved to Arlington, the separation of health care delivery among hospitalists and office-based physicians had not arrived to medicine. Dr. Pierce, Sr. was an “old-school” physician who tended the patient where and when he was needed. Rush notes that the phone was often ringing after-hours at the Pierce household. The obligation of physician to patient was modeled in his father’s practice and made an impact on the young man.

In spite of the medical influence of his father and uncle, also a physician, Pierce chose to pursue a degree in chemistry at nearby Southern Methodist University. He relates that long nights by himself in the qualitative analysis lab led him to the conclusion that, in spite of the enjoyable cognitive challenge, the life of a chemist might be fairly lonely. Perhaps his chemistry advisor, the late Harold Jesky, PhD, also identified Pierce’s other talents and suggested that he apply to medical school. He did so, applying primarily to Texas schools. Having never lived outside of Texas, and living 30 miles from his boyhood home, he likely would not have applied to his subsequent alma mater, University of California, San Francisco College of Medicine without some additional prompting from Dr. Jeskey. Jeskey told him there was an annual chemistry conference held in San Francisco, and if Rush attended medical school there, Jeskey would take him out to dinner when he traveled to San Francisco for the conference. With the well wishes of his advisor, and the promise of a free meal at least once per year, Rush matriculated at UCSF, graduating with honors four years later.

Internal Medicine residency found

the newly minted Dr. Pierce closer to home with his bride in Nashville, TN. In spite of every other night call as an intern, he and his wife, Diane, started their family during his residency at Vanderbilt. At the end of residency and a stint as Chief Resident, they decided to return to Texas. His parents still lived in Arlington, and Diane’s family lived in Albuquerque, so Amarillo was geographically a good fit. Enticingly, there was a new branch campus of the Texas Tech University Health Science Center in Amarillo, and his first job out of residency was a faculty appointment with the school. Dr. Pierce was on faculty with TTUHSC for three years before going into private practice with Ted Nicklaus, Tom Nichols, Barton Grooms, and Steve Urban, a friend from church. For the next 19 years, Dr. Pierce served the Amarillo community through his private practice.

In spite of his growing practice and reputation, Dr. Pierce found other ways to serve besides private health care delivery. He relates that, soon after entering private practice, he received a phone call from Peter Fagan, M.D., a Family Physician and the Local Health Authority. As recounted by Pierce, Dr. Fagan stated “With you being new in practice you are probably not that busy. Can you run our TB clinic? I can’t pay you anything.” Never one to turn down an unpaid opportunity, Dr. Pierce agreed. He started seeing TB patients in the evening at the clinic 2 nights per month. That initial involvement with the TB clinic led to additional roles at the Amarillo Health Department, and culminated in his appointment as Local Health Authority, a position he filled for 14 years. During that time, he precepted medical students and residents at the Health Department, negotiated and oversaw the sale of the County Hospital and became the first medical director of the J.O. Wyatt clinic. In 2003, Dr. Pierce left private practice to return to academics full-time at TTUHSC. He sub-

sequently served as regional chair of the department of Internal Medicine and Interim Regional Dean of the School of Medicine. In 2008, Dr. Pierce relocated to Albuquerque with his wife and joined the hospitalist practice at University of New Mexico, “retiring” in 2018. He now lives near grandchildren in Colorado and only does clinic 1 and ½ days per week, along with precepting medical students, reviewing journal manuscripts, and writing. In 2019, he was honored as a recipient of Mastership in the American College of Physicians, along with his friend and colleague, Dr. Steve Urban.

Dr. Pierce recounts multiple memorable aspects of his medical career. He recalls that negotiating the sale of the County Hospital to UHS was one of the most difficult projects of his career. He was subsequently asked to direct the new J.O. Wyatt clinic, in spite of the fact that he remained in private practice while managing the burgeoning clinic, which delivered care to the economically disadvantaged. He counts as an accomplishment the recruitment of other talented physicians to the Amarillo community during his time in Amarillo, specifically mentioning Dr. Hagos Tekeste and Dr. Joanna Wilson.

When asked what he has seen as some of the most positive changes in medicine over the course of his career, Dr. Pierce lists the primacy of evidence-based medicine in clinical practice and the advancement of imaging modalities for diagnostic purposes, though he laments the accompanying de-emphasis on physical examination skills for medical learners. He also appreciates the growing emphasis on communication skills in health care delivery. Dr. Pierce has a more jaded view of the national movement emphasizing “life balance” in medical practitioners. Although he recognizes the importance of physician wellness and family, at some point the well-being of the physician must be subject to the well-

being of the patient. The noblesse oblige modeled by his father many years ago in Arlington has become a rarity in a medical world of shift work and transactional patient interactions.

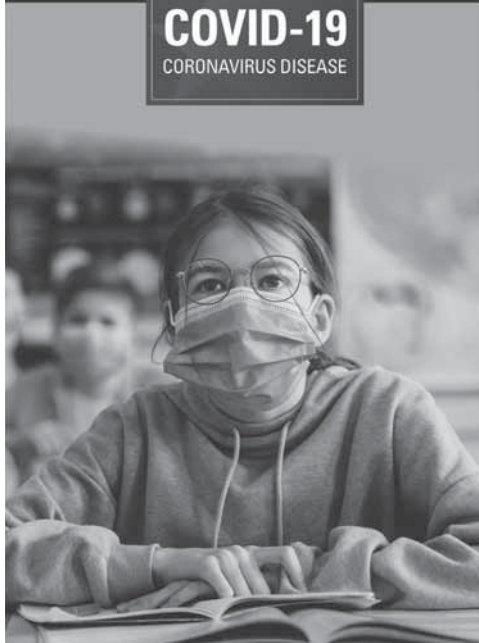
Dr. Pierce was a leader of and ser-

vant to the Amarillo community for more than thirty years. His mentorship has been cherished by many physicians, as his compassion has been cherished by countless patients. This author notes Dr. Pierce's steadfast concern for the community at large, and his perpetual humil-

ity. When Dr. Pierce retired from the role of Local Health Authority, he was honored with a small reception. Cake was served, decorated with a quotation from the Bible's book of Micah; "Act justly, love mercy, and walk humbly with your God." Dr. Pierce has lived that precept.

## DECISION TREE A TOOL FOR SCHOOL NURSES

**COVID-19**  
CORONAVIRUS DISEASE



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*This tool is largely adapted from the Centers for Disease Control and Prevention's (CDC's) [Screening K-12 Students for Symptoms of COVID-19: Limitations and Considerations](#). It does not replace local health guidance or state agency requirements and should complement sound clinical judgment.*

### COVID-19 Symptoms

- Mild illness is common in pediatric cases. Most present with symptoms of upper respiratory infection.
- Significant symptoms, which may affect students' ability to learn and put them at risk for spreading to others, might be, among others:
  - Fever (in absence of local guidance, defined as 100.4°F per CDC), taking into consideration physical exertion and outside temperature, which may affect temperature reading;
  - New uncontrolled cough that causes shortness of breath or difficulty breathing (for students with chronic allergies/asthmatic cough, a change in baseline uncharacteristic of underlying illness, especially after treatment is administered);
  - New onset of severe headache, especially with fever;
  - Nausea/vomiting, diarrhea, or abdominal pain; or
  - Sore throat.
- Other possible COVID-19 symptoms are:
  - New loss of taste or smell,
  - New onset of fatigue,
  - Congestion/runny nose, or
  - New onset of muscle or body aches.

### Exposure Definition

A student is considered to have been exposed if he or she:

- Had close contact<sup>‡</sup> with a person with confirmed COVID-19 within the last 14 days,
- Traveled to an area with high community transmission of COVID-19 identified by a federal, state, or local health authority (within the last 14 days), or
- Lives in areas of high community transmission as defined by the local health department or authority.

<sup>‡</sup> Per CDC, close contact is defined as being within 6 feet of a COVID-19 confirmed case for at least 15 minutes regardless if either was wearing a face covering.

Published Aug. 17, 2020



# Formation of the Amarillo Diagnostic Clinic

By Scott Milton, MD, FACP

The Amarillo Diagnostic Clinic was formed in 1968 by three founding physicians: Wayne Smith, John Milton, and Tom Duke. Dr. Duke had been in practice for quite some time prior to the formation of the clinic and retired shortly thereafter. Therefore, the initial success of the ADC can be attributed to Doctors Smith and Milton. They envisioned a clinic of internists and internal medicine subspecialists representing all subspecialties of internal medicine and helped bring this vision to reality. First, I will outline the history of each of these men.

Dr. Smith was raised in Munday, Texas, a small town of about 2000 about 70 miles from Abilene. His father was a pharmacist, but Wayne always envisioned being a physician. After graduating from high school, he attended McMurray University in Abilene. He was accepted to the University of Texas Southwestern Medical School and graduated in 1961. Dr. Donald Seldin and Dr. Jay Sanford at Southwestern were influential in his formative medical years. Dr. Smith was in medical school at the time of President Kennedy's assassination and remembers vividly the turmoil on that day. After an internal medicine residency at Parkland Hospital, he continued his training with one year of an infectious disease fellowship at the University of Colorado. Dr. Smith was interested in practicing in West Texas and felt that either Amarillo or Lubbock were the best cities with the best opportunities. His brother was practicing dentistry in Amarillo which further appealed to Dr. Smith. He also felt that Lubbock was too sandy and windy. He met and spoke with Dr. Duke at this time about the formation of a clinic, but Dr. Duke was not interested during this initial conversation. Wayne therefore took a job in Corsicana, Texas and shortly thereafter was drafted in the Air Force. He was told initially that he would have to go to the Philippines without his family, but fortunately arrangements were made for him to go to Shreveport, Louisiana

where he spent two years in the military. After completing his military service, he returned to Amarillo with Dr. Duke. This was in the spring of 1968. During this time Dr. John Milton was contacted and expressed interest in forming a clinic as well.

Dr. Milton was raised in Austin, Texas and attended the University of Texas. He was accepted to the University of Texas Medical Branch in Galveston, Texas after three years at the University of Texas. He graduated from the University of Texas Medical Branch in 1960. After graduation, he entered the Navy to fulfill his two years of public service. He spent four and a half years in the Navy and became a flight surgeon. He began his internal medicine residency in the summer 1965 through the Veterans Residency program that was affiliated with the U.T. Southwestern Medical School. Dr. Sanford was also influential to him. He met Dr. Bob Stafford when he was a resident and Bob was his medical student. They became friends and remained so after Bob decided to practice orthopedics in Amarillo in 1970. In the spring of 1968, Dr. Milton met Wayne Smith and Dr. Duke and agreed to move to Amarillo to form the Amarillo Diagnostic Clinic. Dr. Milton was an avid golfer and remembers visiting Amarillo in the late spring and witnessing golfers playing with snow still on the ground. He always enjoyed the weather in Amarillo much more than the intense heat of Central Texas.

The formative years of the Amarillo Diagnostic Clinic were uncertain at best. Initially, they officed in a small, cramped space in downtown Amarillo. Within a couple of years, they realized that much more space would be necessary in order to grow their own practices and to recruit subspecialists. Therefore in 1971 both Doctors Smith and Milton assumed personal financial notes in order to build the initial building where the Amarillo Diagnostic Clinic is today in the Medical Center. At that time the only

other building in the Medical Center was Baptist Hospital. On more than one occasion the physicians and patients would "shoo" cattle away from the entrance of the building. Apparently, because of Dr. Duke's retirement and their an initial inability to recruit physicians, the financial entity providing financial backing called their notes. If they could not obtain immediate new financial backing, then they were through. Fortunately, they were contacted by Tol Ware, and the Amarillo National Bank assumed their notes. Bill Jackson was hired as a clinic director shortly thereafter, and recruitment of subspecialists became successful with the recruitment of several physicians. From this time in the mid 1970s until their retirements from the clinic by Dr. Milton in 1996 and by Dr. Smith in 2002, the clinic had grown from three to more than 25 physicians.

When looking back, both John and Wayne were most satisfied with the success of their idea, the Amarillo Diagnostic Clinic. They were respected and liked among their physician peers, which they strengthened by offering specialty services in the internal medicine related subspecialty fields. Equally important was fostering the relationships of their employees in the business office and medical staff at the clinic. Each physician made a point to interact daily with these employees.

The greatest positive change during their careers was the progress made in the ability to diagnose and treat disease. In order to stay abreast of these advances, both men relied on reviewing the medical literature and attending internal medicine conferences.

Dr. Smith believes that the current pandemic has delivered the greatest negative impact on the medical profession in his entire career. Until the pandemic, he could not envision a scenario where the livelihood of so many physicians could be

threatened. Dr. Milton agrees with this, although he believes that the loss of the physical exam in the care of the patient is worse.

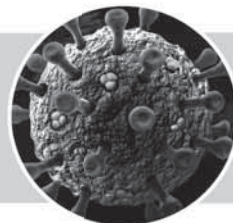
Following his retirement from the Amarillo Diagnostic Clinic, Dr. Smith became the medical director for First Care. He served in this capacity for 12 years and retired only five years ago. He describes this time as stimulating because he learned other aspects of the

medical field besides internal medicine. Dr. Milton continued to work in various capacities following his retirement from the Amarillo Diagnostic Clinic. This includes being medical director for a skilled nursing facility and various hospice programs. He also became interested in hyperbaric oxygen therapy and promoted its use in this community for many years. Both physicians have working careers of 50 years or more.

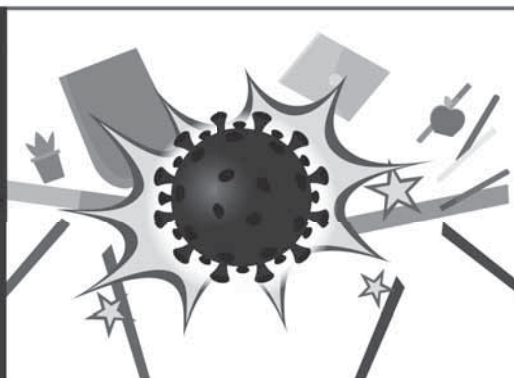
In summary, the Amarillo Diagnostic Clinic has been providing healthcare to the people of the Texas Panhandle since the late 1960s. The clinic grew from three internists to more than 20 physicians at its peak. The clinic continues to provide medical care through the BSA system. Both physicians discussed here witnessed many changes over their long careers. They're both proud of their successes and grateful to the people they cared for during this time.

# COVID-19 DOES YOUR SCHOOL'S INFECTION CONTROL PLAN STAND UP TO COVID-19?

**4 STURDY LEGS** stabilize a robust plan. Plans should closely follow Centers for Disease Control and Prevention guidance.



High community transmission of COVID-19, however, can overwhelm even well-crafted plans. COVID-19 cases and outbreaks may result in quarantines or campus closures.



## 1 ADOPT SAFE PROCEDURES

- Physical distancing of at least 6 feet
- Students grouped in "pods" to limit mixing with others
- Staggered attendance
- Limiting visitors

## 2 REQUIRE SAFE BEHAVIORS

- Wearing face coverings correctly
- Practicing hand hygiene
- Covering coughs and sneezes

## 3 CREATE A SAFE ENVIRONMENT

- Ventilation
- Disinfection
- Plexiglass barriers
- Contactless fixtures (like wastebaskets, paper towels)

## 4 MANAGE SICK STUDENTS AND STAFF

- Daily symptom checks at home
- Isolation of symptomatic students and staff
- Methods to communicate with caregivers of a sick child



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# Superstar on Facetime, Outcast within Six Feet

By Mary Elhardt, MD

It was early May, at the height of the COVID wave, and I was missing my family. Our gatherings had been limited to Facetime and Zoom. I wanted to see them, but I had been in close contact with several COVID positive patients at work as a physician. My step mother immediately thought it was a bad idea to meet in person. Alternatively, my father told me that he would risk dying to see me, and that life isn't worth living unless you can see loved ones. So, I went for a compromise.

"How about we sit six feet apart outside in the yard, and we can all wear masks," I offered. They agreed. I waited four days without any work before I saw them. I was completely asymptomatic, and I even took a COVID antibody test, which was negative. I was confident that our plan wouldn't result in any accidental exposures.

I came over, and my family had dinner ready on the outdoor furniture. I was separated from my parents by the length of the table, yielding more than six feet of the required social distance.

We ate, drank, and wondered when we would ever be able to hug again without the fear of deadly retribution. We

Facetimed with other family members, who all stated how proud they were of my dedication to medicine during the pandemic. Somehow the conversation switched to reports of physicians volunteering in NYC, and then flying back home on the same flights as non-medical flyers. My parents were repulsed and convinced that the flyers would get COVID. Then we launched into a discussion about how traveling healthcare workers must contribute to the spread of COVID.

The sun began to set, and I needed to use the restroom. I offered to go down the street to a gas station. Suddenly, my parents debated about whether or not I could use their house toilet. My dad offered to give me a bucket to use behind the shed, but my step-mother couldn't fathom having a human urinating in her yard. I felt like an outcast. I told them it would probably be best to end our gathering early. We could, of course, finish any discussions via Facetime.

Two days later, I heard that my step-mother hosted a book club party in her house with ten women in attendance, and it wasn't socially distanced in the backyard. They had even used the house toilet. My parents' perceived risk of infection

from the book club was extremely low. When I inquired about how this gathering was different from my visit, I learned that all of the attendees were not involved in health care. None had taken antibody tests at all. None had been COVID swabbed, but all had been to the grocery store and their jobs that week.

How was I different? My parent's fear of contracting COVID was legitimate, but at the same time inconsistent. I had been around people with diagnosed COVID. I had worn complete PPE. These women could have been around people with COVID, but just didn't know their status. I felt as if my risk of exposure was less than an indoor book club who hadn't been tested. I felt that my parents had a misconception of the science of antibody testing and a physician's interaction with patients when fully armed with PPE. Were my parents' concerns overexaggerated, or are health care workers supposed to remain completely ostracized from all family during a pandemic?

Colleagues of mine rented RVs or apartments to decrease the risk of exposure to their families at home. Seeing family helps maintain sanity during a pandemic, especially for health care workers. How much is too much? Helping and serving the sick alienated me from my family during the time of COVID, but I still felt honored to have taken care of these patients when they needed me. I felt that I had become a hero on Facetime, but an outcast at six feet. I felt like my parents socially discriminated against me because I am a health care worker. I still attempt to correct their misconceptions about COVID, but people will continue to think and do what they want to do even during a pandemic. I have simply told my family and patients to treat everyone as if they have COVID regardless of their occupation.

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# Thoughts from the “Frontline”

By Raphael J. Mattamal, MD, FAAP

“Science is more than a body of knowledge; it is a way of thinking. I have a foreboding of an America in my children’s or grandchildren’s time – when the United States is a service and information economy; when nearly all the key manufacturing industries have slipped away to other counties; when awesome technological powers are in the hands of a very few, and no one representing the public interest can even grasp the issues; when the people have lost the ability to set their own agendas or knowledgeably question those in authority; when, clutching our crystals and nervously consulting our horoscopes, our critical faculties in decline, unable to distinguish between what feels good and what’s true, we slide, almost without noticing, back into superstition and darkness.”

– Carl Sagan, *The Demon-Haunted World: Science as a Candle in the Dark*, written in 1995.

I have been asked to provide a perspective as a medical professional on the “frontlines” of the current COVID-19 pandemic. It is an odd term co-opted from military jargon that honestly raises my hackles, like calling healthcare workers “heroes” or declaring “war” on anything that cannot be defeated in battle, such as poverty or illicit drug usage. Just for fun, I will frame my thoughts on COVID-19 using these terms.

This is not to make light of the current situation, which will have killed more than 190,000 Americans (probably undercounted, but not significantly) and 900,000 people worldwide (definitely undercounted significantly, given the testing capability of many nations) by the time you read this. For those of you who think I should have used the word “overcounted” instead of

“undercounted” there, congratulations on being part of the problem, and please get rid of Facebook. Social media and 24/7 news channels cause nontraumatic brain injury.

I do not envy my colleagues in internal medicine or family practice; they and their staff are the ones bearing the brunt of this current crisis as they deal with adult patients with significant comorbidities and a much higher case

fatality rate than my pediatric team. Our job currently consists of screening children with COVID-19 for MIS-C, treating the occasional sicker child with comorbidities such as sickle cell disease or chronic lung disease, preventing any of our staff members (especially high risk individuals) from exposure, and giving anticipatory guidance to families on keeping high risk individuals in the

| continued on page 34

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household and the community from being infected by their child while they recover.

**My current thoughts regarding the COVID-19 situation are as follows:**

1.) The “Hero”: Beware anyone in power or leadership who uses this term to describe you or your coworkers on a regular basis. A true hero is someone who selflessly goes beyond what is expected of normal people, but the term has been appropriated as a feel-good moniker by many in power to excuse substandard treatment of staff.

“Heroes” are what we called NYC firefighters on 9/11, many of whom didn’t have to die if they had received the better radio equipment as requested earlier before the tragedy –like their police counterparts who would have warned them that the WTC buildings were becoming increasingly unstable. “Heroes” are what we called our troops, who were given substandard equipment and vehicles made by the lowest bidder and then assigned the unenviable task of peacekeeping in hostile territory and engaging in asymmetric warfare, which has been a recipe for disaster for pretty much every occupying force in history that has attempted it (did I describe Iraq or Vietnam there?). We then rewarded them with generally substandard medical care at home, unless you want to argue against that by finding me the occasional sycophant who thinks the VA does a fantastic job treating PTSD or occupational toxin exposures (did I describe Iraq or Vietnam there?). And “heroes” are what we called nurses and respiratory therapists and doctors in northern Italy and NYC and countless other areas who were given little to no adequate PPE and sent into a meat grinder by feckless hospital administration while hundreds of them died needlessly.

The groups I mentioned had plenty of true heroes among them, but we should be wary of broadly applying the term and using it as an excuse to expect people to overlook deficiencies

in how we take care of them, whether they be patients or our colleagues. We are not heroes and did not sign up to be heroes. We are just doing our job, and we expect our employers to protect us by providing us the resources we need to do this job safely.

2.) The “War”: This is what worries me the most in the long term, and why I started with the Sagan quote above. We have a novel coronavirus with primarily respiratory spread and an unclear case fatality rate that at its most conservative estimate is still deadlier than influenza (case fatality rate for influenza for 2018-2019 was less than 0.1%, or 1 per 1000 infections), and large swaths of the general public (and unfortunately the occasional colleague) don’t realize that. Case fatality rates for this virus are usually in the 1-2% range by most counts, though this will certainly be revised downward once we get a better handle on true numbers of asymptomatic carriers. For those who did the math in their head, 1% of the U.S. population is more than three million people, which is an unacceptable amount of fatalities.

For those who keep quoting herd immunity to me, studies on the general population in the worst-hit areas are still reporting only single digit percentages of people affected, not to mention multiple studies published already indicating that our antibodies and immune response to natural infection with SARS-CoV-2 may be waning or temporary. Natural herd immunity is likely impossible with this virus, so please do not make our job harder by adopting the “everybody go out and get this thing in batches” approach to a public health crisis. That reminds me – opening school to in-person instruction this fall will probably not go well, even though such in-person instruction will be very helpful for the mental wellbeing of most children. Without adequate precautions and protection for staff and students, your kids are not going to school this fall – given the response to this pandemic so far.

We have not even earned school, much less sports or crowded movie theaters or concerts. Because we have decided to go to war, and war is ugly. War is costly. War involves sacrifices by the general population, not just the “troops”. You do not want to go to war if you can help it. But we are currently struggling with a new virus that has been weaponized by political strife and has been provided the force multipliers of willful ignorance, mixed messaging, and poor leadership. Best case scenario is the development and deployment of a safe and effective vaccine against this thing. Worst case scenario is that it is a continual thorn in our side for years to come, and that you can get this illness more than once, like most other RNA viruses.

If the community really wants to help us out, beyond well wishes and keeping us in their thoughts, I recommend frequently washing your hands with warm soap and water, WEARING A MASK (WHY IS THIS SO HARD FOR YOU PEOPLE), physically distancing yourself from others where practically possible (whoever coined the term “social distancing” should be exiled to Russia), maintaining a healthy social life through safer outdoor activities / phone calls / videoconferencing, maintaining a healthy body through preventative healthcare measures (better control of your diabetes, taking your children to their well child checks and getting their immunizations, smoking cessation measures if you still engage in it), and minimizing higher risk activities such as coughing on my pregnant wife.

This is not to be alarmist or to imply the world is ending. We will survive this crisis and the world will continue functioning, albeit with some adjustments. But we will be in for a rough year or two in the meantime. I will leave you with an acronym from military jargon that will not be found in any official handbook: BOHICA. That sums up how I feel about the current situation, and I will let you Google that one for yourself. We will be here in the meantime to take care of you and your family in these trying times.

# COVID and Health Inequities

By Steven Cummings, MD

Coronavirus in Amarillo has been a dichotomous experience from the start. We watched in a placid calm before the storm as the pandemic raged its way across the world and the country. We had a complete change in patient composition as CHF, COPD, infections, and chronic conditions strangely disappeared and made way for COVID admissions. Some hospital services saw limited COVID cases and others more than their share. In Amarillo, the story of COVID will likely lie with the meat packing plants, where we saw the continuing effects of medical and social inequities. During this experience, it has shown us some of our best and worst sides and has given plenty of surprises along the way.

I did not think Coronavirus would hit Amarillo as hard as it did. Pre-impact was a time of questioning: through each other, news, and scientific articles. The old attending who had lived here most of his life said it would be focused on the meat packing plants and prisons. He became a soothsayer when he uttered those words. I avoid news, but you could not avoid this pandemic. It was too loud to go unnoticed. I called friends in hot spots like Detroit

and Albany, Georgia. How many people on the vent, I asked them? Dozens and dozens, with only a handful surviving. How many residents sick? 8 in one residency – all on the floor service, where precautions were lax and masks were not worn. There was an excruciating dribble of new information, followed by an explosion of it. Then we got hands on experience.

We saw the hot spots develop, especially in the plants. We've seen these people before, immigrant families who need the money and a job, with three generations in one apartment. They can't afford not to go to work and they can't afford to get sick; so they go into the mouth of the beast every day. And then some come in to see us. Most go to the floor wards and slowly get better, but some go a different way. I cannot help but think they have suffered only for corporate greed. When I was born, you could buy a share in one of the plants' corporate owners for 33 cents. It bounced just below \$100 last year. Explosive growth does not happen by shutting the plant down or cutting efficiency, especially when the labor force is silent. So the plant continues to run with workers side by side, whether

healthy or ill, and we treat the results of that decision.

Surprises happened inside the hospital frequently. A call from a nurse that the patient sat up on the edge of the bed to urinate and is now tanking from sitting up. Fifteen minutes later, they are one of the ones on a vent. Check-out on another night reveals an extra name on my list to cross out. She died that day after the list was printed, her name with a line through it a silent memorial in my mind. Realizing one morning just before handoff that the helicopter never arrived with our transfer, 20 year-old. He died en route. The unexpected became normal.

And life went on outside. I have nearly zero desire to go out. But most people didn't have our perspective. Should I be angry at the DPS trooper who had a full kids' birthday party during the lockdown? I stood slack-jawed watching it – screaming kids all over a bounce house and a street full of cars. Eventually, a reopening with speeches from politicians. But most of the people having that discussion were not at

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great risk. It was the immigrant family, the minority, the person on the sidelines who was at risk. They were the ones we saw in the middle of the night, having to loudly shout through the N95 and over the ER HEPA filter into some scratchy translator phone on speaker. Sometimes we had to call their family and have them translate. Take care of my mom - or dad - or brother - or son, they would say. We will, we said.

Going to medical school in Memphis opened my eyes to all the discrepancies in health care, exacerbated by racism, segregation, violence, generational poverty, offset by a growing awareness and discussion of the problems. These were the people with health inequities who we were failing as a system. These underserved communities exist everywhere, perhaps not as overtly as in Memphis. In Amarillo, it was the immigrants and refugees in the meat packing plants, the people who would show up no matter what the work to provide for their families. They live isolated, clustered, outside of the bubble of mainstream Amarillo, among others who share their language, food, and customs.

The majority of people in Amarillo feel safe because the pandemic raging here isn't in their backyard with the bounce houses and parties, but over there - out of sight and out of mind.

The only way to tackle the problem is head on. We have cared for these patients at their sickest. I am proud of all the doctors, residents, nurses, and staff who worked the ER, the ICU, the floor, and the COVID clinic. We have neglected travel to see our loved ones to keep everyone a little safer. I am proud of Texas Tech for opening its clinic doors to see the immigrant patients in good times and bad. I am proud of the hospitals for a long history of caring for these patients, long before this pandemic. As doctors here in Amarillo, I have seen us strive to eliminate health-care inequalities, and that should be one of our fundamental actions here in West Texas. I think about telling that voice on the phone in the ER that I will take care of their family member. My mind circles back to how we will keep working on breaking down those barriers to care here in Amarillo. I hope that is the legacy that Coronavirus leaves.

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# COVID: A Historical Review of What We Know (As of Right Now)

By Rouzbeh K. Kordestani, MD, MPH

## History of Pandemics

COVID (SARS-CoV2) is the fifth pandemic to have plagued the world in the last century. The Spanish Flu of 1918 (H1N1) was the first. It started in 1918 at the close of the first World War and led to the century's first world-wide pandemic. The Spanish Flu caused the death of more than 50 million people by 1919. It was followed by the Asian Flu of 1957 (H2N2), which eventually led to the death of 1.5 million people world-wide. Soon after, in 1968, the world witnessed its third pandemic. It surfaced in Hong Kong (H3N2) and caused a death toll of greater than 1 million people. The fourth pandemic, 2009 (H1N1), produced a total death count of over 300,000 people.

COVID (SARS-CoV2) derives its designation from its namesake, the Severe Acute Respiratory Syndrome (SARS) virus. In this grouping, it is the second coronavirus to cause similar symptoms, hence CoV2. It was detected as a new disease process (in Wuhan province, China) in 2019, giving it its official title. Even though it is a SARS virus, genome sequencing has shown that is a novel coronavirus that does not share any direct evolutionary lineage with any of its family.

## Shape and Description of COVID

The COVID virus is a spherical particle, 120 nm in size. It has a single-stranded RNA genome that shares some sequence homology with others in its group, especially the Middle East Respiratory Syndrome (MERS) virus. COVID was first detected in bats, using them as the initial host. This again is similar to its other viral family members. Bats are the documented initial hosts of both the SARS virus (2003) and the MERS virus (2012). Following infection in an initial host, most viruses need a steady intermediate host prior to their eventual transmission to humans. SARS/MERS have intermediate hosts. Unlike both of these viruses, though, COVID has no proven intermediate host.

Some of the initial data point to pangolins as the intermediate host for the disease transmission, but these data are sparse and inconclusive.

## Symptoms

Although no invariable series of symptoms develop in any viral process, some commonalities are noted. Fever usually comes first. Then, as a respiratory virus, dry cough and shortness of breath soon follow, often accompanied by malaise and flu-like symptoms such as arthralgias and body aches. In the case of COVID, there are some additional symptoms. Nausea, vomiting, and diarrhea may follow. This is uncommon in relation to the other SARS viruses. Other common symptom that are somewhat unique to COVID include anosmia, the loss of sense of smell, and ageusia, the loss of taste.

With COVID, a grouping of symptoms is often noted and may lead to a worrisome progression of the disease proceeds. As the flu-like symptoms get worse, patients often exhibit signs of early hypoxia and respiratory compromise. This may lead eventually to death from respiratory failure.

## Disease Transmission and Incubation Period

In general, viral diseases have clear transmission patterns. With COVID, three such transmission pathways have been demonstrated. COVID has been shown to transmit between human hosts by contact, respiratory droplets and by the fecal-oral pathway. With such a variable and common series of possible transmission pathways, the quick spread of COVID can be explained. A similar transmission pattern has been documented with MERS. A retrospective study of transmission from only one MERS patient demonstrated spread of the infection to 186 people in the course of one day. Such a tremendous, explosive infectivity accounts for the growth and the eventual spread of the viral pandemics.

Even though the transmission pattern is now well understood, the incubation period is not. The most common incubation period is 5 days. However, some individuals exposed to the disease have shown symptoms in as little as 24 hours. Others have taken the full 14 days to show any signs. Still others have been exposed and are known to possess the virus without showing any signs whatsoever. Why some patients are asymptomatic is still poorly understood.

## Risk Factors

There are many factors that may put a patient at risk for contracting the COVID virus. The most recent population analysis highlights the increased susceptibility of those who are elderly or immunocompromised. Along with these risk factors, patients with hypertension and diabetes, those who are morbidly obese, and those with a history of smoking or cancer (all types) have a much higher likelihood of contracting the infection. Chronic obstructive pulmonary disease, other respiratory conditions such as asthma, and underlying cardiovascular disease seem also to be strong predictors of intensive care unit admission and overall poor prognosis.

Analysis of the patients most affected by the virus seems to indicate a proclivity of the virus for certain types of cellular receptors, namely ACE receptors. These receptors are often upregulated in tobacco smokers and in patients with diabetes and hypertension. This finding seems to be fit the pattern of those at risk. This finding may or may not prove to be a vital factor. Unfortunately, it is too early to tell.

## Lessons Learned from the Other Pandemics

Medical and public health institutions often fail when faced with the staggering numbers seen in world-wide pandemics. Most often the failure in the public and medical arenas is one of policy. Others

fail due to poor execution. In 1900, during an outbreak of the bubonic plague in San Francisco, public health policies were disregarded. Instead, a simple rule was instituted and actively followed. A rope line was placed, closing off the ghetto area where the plague was known to exist. The rope line was to act as a barrier. Only a very few were allowed entry into the infected ghetto. Needless to say, this barrier failed and the bubonic plague spread unabated across the city.

An example of a failed execution of policy is evidenced by the efforts during the Second World War to halt the spread of syphilis. Even though the disease was well understood and its transmission pathway was clear (through sexual contact), it became obvious that a policy of abstinence or monogamy was unrealistic during the heyday of a world-wide conflict. With the advent of penicillin as a treatment drug, any hope of actually preventing syphilis was lost. It was too easy to cure—why bother to prevent it? The same failure in understanding and prevention has played out in the arena of the human immunodeficiency virus (HIV). Once the transmission patterns of HIV were discovered and well detailed, it became clear that prevention was possible. However, even with the best policy, the lack of compliance among the population at large showed that HIV would not be contained. Now, with the advent of retroviral cocktails, HIV has been reduced to a chronic disease. Most people do not fear the disease as much as they did or they should. They regard it much as the soldiers in the war did syphilis—as a fact of life. As a consequence of non-compliance and the failure of prevention, disease processes (i.e. syphilis, HIV) that could be eradicated are instead here to stay, throughout the populations of the world.

Another lesson learned from the study of previous pandemics is the failure of health systems to effectively communicate. This applies both to regional as well as to international health efforts. Looking through the historical content, China has been at the heart of at least two world-wide pandemics. China has grown by leaps and bounds over the last 40 years. It has become an industrial power and has moved millions of its poor from rural areas into a prosperous middle class liv-

ing in urban luxury. Even with these advances, however, China still suffers from the stigma of being thought of as backward. For this reason, when faced with a global pandemic, China failed to alert its neighbors to the possible calamity. In facing the outbreak, it understood that it was poorly equipped to handle such an infection, especially in its major urban centers. It initially hid its numbers of infected patients. It did not communicate the initial data with other regional health authorities. Only when a politically appropriate response had been formulated, showing China in a better light, were regional and international health authorities alerted to the gravity of the situation. By the time other groups were alerted, the disease had spread to Europe and the United States. Both regions suffered greatly for this lost time. The lack of communication and the submission of the public health voice to the political one cost thousands of lives.

A final lesson learned from a historical review of pandemics is that physicians and health care professionals often suffer asymmetrically in the death toll. In the Spanish Flu of 1918 as well as the COVID pandemic, the initial front line of casualties has been health care professionals. Some of this was simply due to ignorance. Many first-line healthcare workers were exposed and subsequently died due to lack of knowledge of what they faced and ways to prevent it. However, ignorance can be combated with knowledge. Pandemics unfortunately become even more problematic when knowledge and information are ignored. While a great many health care professionals died from the first wave of the disease, an equal number have suffered later in the disease process. While knowledge about the disease transmission has been made available, many governments (local as well as federal) have downplayed the severity of the threat. The reasoning for this is simply to control hysteria in the population. If the message is one of disaster, people may lose hope and confidence in their government. In this manner, both in the Spanish Flu of 1918 and in the current pandemic, misinformation has dulled the population to the severity of the disease process. Most Americans have trouble digesting or comprehending the images of thousands

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of fellow Americans fitted into body bags. If they could, they would simply change the channel.

In pandemics, the magnitude of death and mayhem can overwhelm public policy. In 1918, during the first World War, the Sedition Act made it treasonous even to speak of the Spanish Flu. Even though it was known that the disease process was wreaking havoc across the United States, speaking about it was deemed unpatriotic. In the current pandemic, initial governmental policies downplayed the gravity of the disease, letting people co-mingle, even though medical data had shown clearly that this policy would cost lives. The historical study of pandemics shows that disease and politics are a volatile combination.

### Conclusion

It is difficult to write about history as it happens. As of today (9/10/2020), the death toll in the United States of America is 190,909 (Johns Hopkins data/website;), with a global total of 904,485. There are now 6,365,000 detected cases in the United States, with a global number of 27,902,002.

Americans (myself included) live a life of luxury, thinking of themselves (ourselves) as separate from the ills and struggles of the world. Because of this pandemic, we now must face the simple fact that we are very much part of a bigger world. We share the good and the bad with the rest of the world. America and its citizens are great because of more than 200 years of hard work and involvement, not because of one president and one catchy slogan.

Because of what we are now having to endure with the pandemic, we have to accept our role as a responsible member of the world at large. Only with our full participation and an acceptance of our sincere responsibility to the world will we be able to effectively overcome this pandemic and the others that will surely follow.

### Bibliography

1. Brandt AM. No Magic Bullet: A Social History of Venereal Disease in the United States since 1880. New York: Oxford University Press, 1985.
2. Burnet M, White DO. Natural History of Infectious Disease, 4th Edition,

Cambridge, United Kingdom; Cambridge University Press, 1972.

3. Chan JF, To KK, Tse H, Jin DY, Yuen KY. Interspecies transmission and emergence of novel viruses: lessons from bats and birds. *Trends Microbiol.* 2013; 21: 544-555.
4. Fang L, et al. Are patients with hypertension and diabetes mellitus at increased risk for COVID-19 infection?" *Lancet Respir Med.* 2020. (DOI 10.1016/S2213-2600) 301:16-8.
5. Huang C, Wang Y, Li X, Ren J, Zhao J, Hu Y, et al. Clinical features of patients with 2019 novel coronavirus in Wuhan, China. *Lancet.* 395(2020):497-506.
6. Mehta P, et al, COVID-19: consider cytokine storm syndromes and immunosuppression. *Lancet.* 2020; 395 (10229): 1033-4.
7. Wu F, Zhao S, Yu B, Chen YM, Wang W, Song ZG, et al. A new coronavirus associated with human respiratory disease in China. *Nature*; 579 (2020); 265-269.

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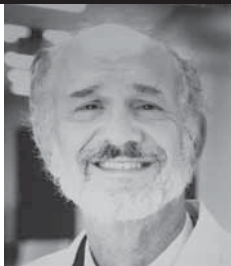
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# Respiratory (Ventilatory) Support

By Steve Urban, MD

The commonest serious complication of COVID-19 is viral pneumonia with respiratory failure. Low oxygen level (hypoxia) is the most frequent indication for hospital admission, and persistent hypoxia despite supplemental oxygen is the main reason for transfer to the ICU.

## Is the ventilator the only way to bring the oxygen level up?

No. The first step is simple oxygen administration, either via nasal cannula (the little prongs that go in your nose) or via face mask. Nasal cannulas are more convenient (talking, eating, and drinking are easier), and newer versions

can supply up to 40 L/min. Face masks commonly provide 28-40% oxygen and can go much higher if necessary. If supplemental oxygen fails, doctors may try non-invasive ventilation (often called BiPAP, or Bi-level Positive Airway Pressure). BiPAP employs a mask with secure seal around the face (it has to be strapped on tight). In addition, BiPAP requires a cooperative alert patient. In addition to these oxygen delivery methods, prone positioning (making the patient lie on their stomach) can be helpful.

## How does the ventilator help the patient to breathe?

When you breathe normally, you suck air into the lungs via negative pressure; the ventilator blows air into your lungs (hence we call it positive pressure ventilation). A plastic tube is introduced through the throat into the windpipe (trachea). To prevent the pressurized air from just blowing out around the tube, a cuff has to be inflated in the trachea. The ventilator controls the volume of air pushed into the lungs, the pressure that is generated, and the concentration of oxygen in the inhaled air. The ventilator controls your breathing; if your ventilator wants you to breathe in, and you want to breathe out, the ventilator wins. Most people find this state of affairs (i.e. tube in your throat, not being in charge of your own breathing) to be somewhere between unpleasant and horrific, and so most patients have to be sedated to tolerate the ventilator.

## So, how much pressure does it take to blow this amount of air into the lungs?

Well, as much as it takes – usually around 20-40 cm H<sub>2</sub>O. In patients with tight (constricted) airways, as seen with asthma, the pressure can be

much higher and there is risk of popping the little air sacs (alveoli) in your lungs. Doctors have ways of treating bronchial constriction and the pneumothorax that may result from alveolar rupture, but these can be very serious problems. In addition, providing extra pressure throughout the respiratory cycle (called Positive End-Expiratory Pressure or PEEP) can actually keep the air sacs from collapsing on themselves and can improve the oxygen level. The amount of PEEP administered is usually between 5 and 15 cm H<sub>2</sub>O (higher in special circumstances).

## What are common complications of being on the ventilator?

The patient is pretty helpless while on the ventilator, and management of their nutrition, fluid status, and personal hygiene is complicated. All patients lose considerable muscle strength while on the ventilator, and some never regain full strength. Blood clots can occur from immobilization (a particular problem in the COVID patient). The breathing tube provides a straight shot for germs to get into the already-compromised lungs; so ventilator-associated pneumonia is a constant worry. Turning the patient frequently is necessary to prevent pressure sores.

## How long is the patient kept on the ventilator?

The ventilator doesn't cure anything; it just keeps the patient alive while their body tries to fight off the underlying condition. So, the answer is: as long as it takes for the patient to get better. Patients with a readily treatable condition (such as drug overdose or fluid overload) may need the vent for a day or less. COVID patients commonly need ventilatory support for 1-3 weeks.

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## Why do some people get a tracheostomy while on the ventilator?

After the patient has been intubated (i.e. with the tube through the vocal cords into the windpipe) for a few weeks, inflammation from the tube can lead to a very serious complication called tracheal stenosis, which can permanently narrow the windpipe. This can be avoided by doing a tracheostomy, a surgical procedure where an incision is made in the neck and a short tube introduced directly into the trachea (bypassing the throat and vocal cords and sticking straight out from the neck). The tracheostomy tube can stay in place indefinitely and can be removed easily (i.e. without another operation) if the patient improves.

## How many patients are able to get off the ventilator?

This depends largely on the underlying disease process. Again, patients with a treatable drug overdose and no brain damage may come off the ventilator in

hours. Patients with untreatable underlying conditions (such as pulmonary fibrosis) almost never get off the machine; this is why we try not to put these patients on the vent in the first place. In COVID, between 30 and 70% of patients improve and are able to get off the machine. These numbers are so imprecise because other variables – like age, obesity, underlying diseases, and complications – play such an important role.

## What if the ventilated patient doesn't get better?

This is a very serious and usually fatal circumstance. Heroic measures such as ECMO (extracorporeal membrane oxygenation) are very occasionally tried. In ECMO, the patient is placed on a machine similar to the heart-lung bypass machine used for cardiac surgery, but this time for days or weeks. Usually, however, failure to improve gives rise to a discussion about stopping ventilatory support and letting the patient die. Few people want

to live out the rest of their lives on a ventilator.

## How do you make the decision to terminate care?

Only with input from the entire care team, the family, and, hopefully, from the patient. Many patients have a durable power of attorney for health care ("living will") that specifies what they want. Some patients are lucid enough to convey their wishes through writing or other forms of communication. Often, however, the family, speaking through the legally-designated "surrogate decision maker," makes this decision with the care team. If the ventilator is to be turned off, palliative care measures are employed to keep the patient comfortable until death. The cornerstone of this treatment is IV morphine, which allays air hunger, treats pain, and provides sedation until the patient stops breathing. Death in these circumstances usually takes from minutes to hours.

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THURSDAY, JANUARY 19, 2012

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Posted by Me and My Doctor at 12:38 PM

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# A Tale of Two Outbreaks: A Case of E-Cigarette or Vaping Product Use Associated Lung Injury Masquerading as COVID-19 Pneumonia

By James Tran MS4; Sheikh Islam, MD; Kerolos Abdelmalek, MD; Steven Urban, MD; Ravindra Bharadwaj, MD

## Introduction

In the current SARS-CoV-2 pandemic, respiratory symptoms raise reasonable suspicion and concern regarding the possibility of yet another COVID-19 infection. One must, however, consider other etiologies such as the consequences of widespread e-cigarette and vape usage and the occurrence of what the Center for Disease Control and Prevention (CDC) has termed “E-Cigarette-or-Vaping-Product-Use-Associated-Lung-Injury” (EVALI) (1). The CDC first released their recommendations regarding EVALI in August of 2019; to date, much remains to be learned about the causes, pathophysiology, and treatments for EVALI (2). Standardized criteria for confirmed EVALI or probable EVALI do not currently exist. Probable patterns have emerged, but EVALI remains a diagnosis of exclusion. Furthermore, the effective treatments for EVALI are still being studied. In this report, the authors present a case of worsening respiratory distress, dyspnea, and hypoxemia resembling COVID-19 infection but subsequently diagnosed as probable EVALI.

## Case Presentation

A 33 year-old male was transferred from an outside facility due to worsening respiratory distress, dyspnea, and hypoxemia. The patient had a history of vape usage, and he reported that, approximately 3 months prior to this event, he switched from his usual vape liquid to what he described as “off-brand” vape liquids (labeled “Smart Cart” and “Alpine Premium”) containing THC and CBD. After using this new liquid for 2 months, the patient developed nightly fevers, which gradually progressed to all-day fevers. After 10 days, the patient reported severe dyspnea, called for an ambulance, and was taken to the outside facility. He spent approximately 6 days in

the intensive care unit (ICU) with possible COVID-19 pneumonia and acute hypoxic respiratory failure. During this admission, the patient received respiratory support, corticosteroids, 5 days of remdesivir, and empiric linezolid and piperacillin-tazobactam to treat infectious pathologies. Further deterioration necessitated intubation, and the patient was transferred to our facility.

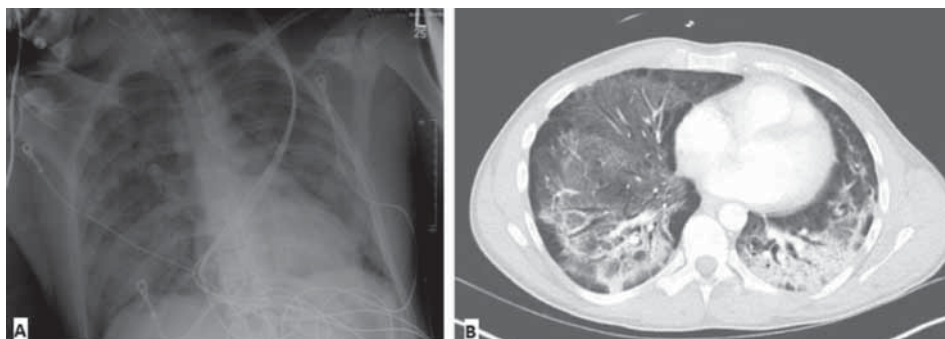
His vital signs on hospital day (HD#) 1 included normal blood pressure, heart rate of 140 beats per minute (bpm), oxygen saturation (SPO<sub>2</sub>) of 92% on 100% FiO<sub>2</sub>, and positive end-expiratory pressure (PEEP) of 12 cm H<sub>2</sub>O. Physical examination was notable for bilateral coarse breath sounds and tachycardia. Chest X-Ray (CXR) revealed diffuse bilateral infiltrates as seen in Image 1A. Labs showed leukocytosis at 20,000 white blood cells (WBCs)/ $\mu$ L, hypokalemia at 3.1 mmol/L, elevated C-Reactive Protein (CRP) at greater than 190 mg/L (normal: 0-2.99 mg/L), elevated ferritin at 1,573 ng/mL (normal: 8-388 ng/mL), elevated D-Dimer at 8.41 mg/L (normal 0.19-0.50 mg/L), and elevated procalcitonin at 1.860 ng/mL (normal: 0-0.15 ng/mL). An arterial blood gas (ABG) study

showed a low PO<sub>2</sub> of 68 mmHg and a high PCO<sub>2</sub> of 60 mmHg, with a pH of 7.39 (within normal limits). The patient’s past medical history was only significant for rib fractures and acromioclavicular separation with no surgical intervention, alcohol use, and methamphetamine abuse. COVID-19 PCR, blood cultures, sputum culture, QuantiFERON-TB Gold (QFT-TB), and Interleukin-6 (IL-6) plasma levels were ordered.

## Differential Diagnosis

Given the patient’s transfer from a Texas county which had a relatively high burden of COVID-19 cases, plus respiratory symptoms, physical exam findings of bilateral coarse breath sounds and tachycardia, elevated WBC count, and elevated inflammatory markers (CRP, procalcitonin, ferritin), and elevated D-dimer, this patient’s condition was highly suspicious for COVID-19 infection.

In the same vein, infectious etiologies, such as community acquired pneumonia, would be relatively common causes of this patient’s respiratory symptoms, bilateral coarse breath sounds, hypoxemia, and lab findings. Non-infectious



**Image 1:** (A) CXR obtained on HD#1 revealing diffuse bilateral infiltrates. (B) Computed tomography image obtained on HD#6 demonstrating extensive ground glass opacities and dense, patchy consolidations in the lung bases bilaterally.

| continued on page 46

Hospital Day	Ferritin (ng/mL)	IL-6 (pg/mL)	CRP High Sensitivity (mg/L)	Procalcitonin (ng/mL)
2	1484.6	166.7	190	1.83
10	895.8		0.59	0.16
14	1052.2		84	0.15
20	515.2		2.28	0.075
23	343.9		1.49	0.075

**Table 1:** This table displays the patient's serum ferritin, IL-6, CRP, and Procalcitonin on selected days of his hospitalization at this facility.

etiologies causing respiratory symptoms such as heart failure were considered, given the patient's afebrile status at presentation, although systemic markers of inflammation discounted this possibility. Given the timing of the patient's onset with his switching from his usual vaping product to an "off-brand" product containing both THC and CBD, in addition to his extensive e-cigarette and vaping related product usage, EVALI was also considered.

### Hospital Course

The patient's remdesivir and corticosteroids were continued. Vancomycin, piperacillin-tazobactam, azithromycin, and tocilizumab were added, while continuing ventilator support. The IL-6 plasma concentration of 166.7 pg/mL (normal: 0-12.2 pg/mL) suggested cytokine storm. SARS-CoV-2 PCR tests from both the outside facility and our hospital, however, came back negative. Blood and sputum cultures were negative as well, and QFT-TB revealed an indeterminate result. Multiple CXRs demonstrated bilateral airspace disease.

The subsequent hospital course was marked by pulmonary emboli, *Haemophilus* and *Staphylococcus epidermidis* superinfection, right ventricular thrombus, and recurrent episodes of respiratory failure requiring reintubation.

On HD#16, CXR revealed slightly improved appearance of the diffuse bilateral airspace disease, and the patient was extubated. Of interest, he maintained a temperature within normal limits for most of the hospital stay. Inflammatory

markers are depicted in Table 1. This patient gradually improved on face mask, and, later on, nasal cannula oxygen. In the final days of his admission, oxygen requirement was weaned down to 2L oxygen via nasal cannula. Despite oxygen desaturation with minimal exertion, the patient appeared clinically stable with improving functional status. He was discharged from this facility on HD#25 and placed in rehabilitation in his home county.

### Discussion

Although this patient was admitted due to severe respiratory symptoms with corresponding physical exam findings, imaging findings, elevated inflammatory markers, and signs of cytokine storm, all SARS-CoV-2 tests returned negative. This called attention to his history of vape usage with a switch from his usual product to a different "off brand" product containing THC and CBD 3 months prior to onset of symptoms. A current case definition of EVALI consists of: use of an e-cigarette or vaping related product within 90 days of onset, lung opacities on chest imaging studies, exclusion of lung infection, and an absence of a more likely alternate diagnosis (3). Given the symptoms, timing, lack of fever, bilateral pulmonary infiltrates on imaging, and decreasing probability of COVID-19 and other infections, this appeared to represent a case of EVALI.

EVALI generally affects younger men, with a median age ranging from 19 to 27 (4). It presents with a constellation of findings including constitutional (fevers, chills), respiratory (dyspnea, cough, pleuritic pain), and gastrointesti-

nal (nausea, abdominal pain) symptoms as well as tachypnea, tachycardia, and occasional progression to hypoxemic respiratory failure (4). Chest imaging findings vary, but bilateral lower-lobe ground glass opacities and consolidations predominate (4). While not pursued in this patient, bronchiolar lavage and lung biopsy typically reveal acute lung injury, fibrinous pneumonitis, foamy macrophages, and pneumocyte vacuolization (4).

Due to the global SARS-CoV-2 crisis, valuable time and effort had to be poured into evaluating whether this was a case of COVID-19, and the patient had to be treated as though he were COVID-19 positive until proven otherwise. This highlights the need for increased capabilities of diagnosing etiologies such as EVALI. As a possible diagnostic aid, Singh et al. in 2019 showed that IL-6, among other interleukins, is elevated in vaping-associated lung injuries (5). Our patient had an elevated IL-6 level. Another unique facet of this patient's presentation was the persistently elevated ferritin level. The highest measured ferritin level occurred on HD#3. While the overall ferritin trend was a gradual decrease towards normal, the ferritin level only reached normal limits by HD# 23. Thus, this case supports the finding of elevated IL-6 as a biomarker for vaping pulmonary injury (as previously reported) and suggests that ferritin be evaluated further as another readily-measured biomarker for EVALI.

This patient's treatments for possible COVID-19 infection and pneumonia overlapped with the treatment for

EVALI in that empiric antibiotics for community acquired pneumonia, remdesivir, corticosteroids, and supportive measures were all employed early on during this patient's admission. The patient's condition eventually improved, perhaps due to the use of corticosteroids and supportive measures (4).

The patient reported the specific products he used were labeled "Smart Cart" and "Alpine Premium"; both contained THC and CBD. THC and CBD containing vape products have previously come under scrutiny for their correlation with EVALI, and this case further reinforces the possibility that THC or CBD containing products may significantly contribute to EVALI (4)(6).

#### Future Directions

While a diagnosis of EVALI seemed likely, the fact that EVALI remains a diagnosis of exclusion increases the possibility of delayed diagnosis and treatment – in this case, the presence of the SARS-CoV-2 pandemic may have brought on superfluous medical treatments. To address this, further studies are warranted to evaluate the use of biomarkers such as IL-6, other interleukins, and especially ferritin levels in

patients with suspicion of EVALI. This case emphasizes the importance of e-cigarette constituents (such as THC, CBD, and vitamin E acetate) and evaluation of the chemical changes that occur with the rapid heating process used in various e-cigarettes.

#### Conclusion

This patient presented with respiratory symptoms, physical exam findings, labs values, and imaging suggestive of an inflammatory response to an infectious etiology in the setting of a global SARS-CoV-2 pandemic – specifically, COVID-19 infection. However, SARS-CoV-2 PCR testing, blood cultures, sputum cultures, and QFT-TB failed to reveal an infectious etiology as the cause of this patient's presentation. Given the patient's history of e-cigarette usage and change to an "off brand" product containing THC and CBD within 90 days of presentation, as well as the pulmonary image findings and lack of evidence for another diagnosis, EVALI rose to the top of the differential diagnoses. In an endeavor to elucidate further nuances and patterns in EVALI presentation, IL-6 and other interleukins as well as ferritin levels may serve as potential biomarkers in the diagnosis of EVALI.

#### References

1. Centers for Disease Control and Prevention. Outbreak of lung injury associated with E-cigarette use, or vaping. 2020; [https://www.cdc.gov/tobacco/basic\\_information/e-cigarettes/severe-lung-disease.html](https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html)
2. Siegel DA et al. Update: interim guidance for health care providers evaluating and caring for patients with suspected E-cigarette, or Vaping, Product Use Associated Lung Injury – United States, October 2019. *MMWR Morb Mortal Wkly Rep.* 2019; 68(41): 919-927.
3. Layden JE et al. Pulmonary illness related to E-Cigarette use in Illinois and Wisconsin – final report. *N Engl J Med.* 2020; 382: 903-916.
4. Cherian S et al. E-Cigarette or Vaping Product-Associated Lung Injury: a review. *Am J Med Sci.* 2020; 133(6): 657-663.
5. Singh KP et al. Systemic biomarkers in electronic cigarette users: implications for noninvasive assessment of vaping-associated pulmonary injuries. *ERJ Open Res.* 2019; 5(4): 00182-2019.
6. Christiani DC. Vaping-induced acute lung injury. *N Engl J Med.* 2020; 382: 960-962.

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- » E-cigarettes are not safe for youth, young adults, pregnant women, or adults who do not currently use tobacco products.
- » While e-cigarettes have the potential to benefit some people and harm others, scientists still have a lot to learn about whether e-cigarettes are effective for quitting smoking.
- » If you've never smoked or used other tobacco products or e-cigarettes, don't start.

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# The Flexner Report

By Susan Hellberg

The Flexner Report was one of the most significant publications in the history of American and Canadian medical education. It was a commentary on the condition of medical education in the early 1900's which defined the standards of modern medical education. Because of the Flexner Report, today's medical schools have high admission and graduation requirements. Today's medical schools require four years for completion as a result of the Report. Today's medical schools accept Flexner's suggestion (for the most part) to "strictly adhere to the protocols of mainstream science in both teaching and research". And finally, today's medical schools follow Flexner's suggestion that said schools be regulated by states, resulting in more precise and uniform standards in medical education.

Who authored this influential Report? The 346-page Report was written by Abraham Flexner (1866- 1959), a secondary school teacher and principal of 19 years from Louisville, Kentucky. Although Flexner was not a physician, he was known as one of the great educators of the 20th century, and American modern medical educators owe him a huge debt. Flexner did his graduate work at Harvard and the University of Berlin and then joined the research staff of the Carnegie Foundation for the Advancement of Teaching. For the Foundation, Flexner researched, wrote and, in 1910, published a report entitled "Medical Education in the United States and Canada", which became known as the Flexner Report. His research was commissioned by AMA's Committee on Medical Education and was almost completely funded by the Carnegie Foundation. Before Flexner authored his paper, he visited and objectively evaluated 156 graduate and 12 postgraduate medical schools in the U.S. and Canada, collecting an enormous amount of infor-

mation and observations. Although he said his methods of collection were "objective", it is difficult to see how that was possible during that era. Regardless, the Flexner Report was far more "scientific" than any previous scholarly papers on comparable subjects. The Flexner Report triggered much-needed reforms in the standards, organization and curricula of North American medical schools.

At the time of the Report, many American medical schools were proprietary schools, meaning that they were operated more for profit than for education. Flexner criticized this concept as a "loose, lax apprenticeship system, lacking defined standards of goals beyond financial gain". Instead, the Report proposed that medical schools base their policies on the Teutonic (German) tradition of strong biomedical sciences together with hands-on clinical training. Specifically, Flexner criticized the use of bloodletting, leeches and purging as he found these "treatments" to be experimental, little known and never "statistically assessed". Certainly, these "treatments" did not meet the "gold standard of medical education in biomedicine", i.e. "the lab-based and bedside-oriented Johns Hopkins' model of medical research". In proprietary medical schools, Flexner noted the lack of experimental laboratories, calling the labs "filthy and unhygienic". He wrote that several schools were "weak and uneven", owning only one mannequin. Six were designated as "filthy and neglected", and in Louisiana, he noted that no branch was properly equipped. He called one school "dirty and tattered", and in another, he wrote that "a single guinea pig awaits his fate in a cage". Intensely critical of homeopathic medical schools, Flexner concluded that "pure science will conquer the whole". The Report recommended that, at the least, a medical school should

require a high school diploma and two years of college science. Flexner actually believed that medical students should study for four years and their medical school should ideally be connected to a larger research university (as compared to a stand-alone medical school). His academic emphasis was unquestionably based on factual analytic reasoning. And lastly, Flexner's vision was that of active clinical teaching in academically-oriented hospitals.

In general, the Report triggered much-needed changes in the standards, curriculum, and organization of North American medical schools. Later, Flexner's standards led to the closure of hospital and college programs in which "unconscionable quacks" were working--"a disgrace to the State". By 1920, almost half of American medical schools had closed due to Flexner's stricter admission standards. "Quality as opposed to quantity" became the new norm. The remaining schools underwent an almost total reformation and transformation in order to conform to the Flexnerian model. It is interesting to note that the Flexner Report, written over 100 years ago, is, even today, considered to be revolutionary, a "seminal document that subsequently raised the standards for medical education". It most definitely caused the closure of commercial medical schools and strengthened university-affiliated institutions' adaptations of more scientific approaches. Almost total reform in American medical education was a direct result of the Flexner Report, and, of course, the Report influenced American medical professionals as well. It is extraordinary that Flexner's paper, published in the early 1900's—over a century ago—established the basis for today's medical curriculum and medical education standards.

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**Q: What equipment do I need?**

**A:** At the very least, you need a mobile device or computer that has a camera and microphone. You also need an internet connection that allows you to stream video.

**Q: Can I use a Wi-Fi connection?**

**A:** Yes, as long as your connection is strong enough. It is recommended that you have an internet speed of at least 15Mbps for upload and 5Mbps for download. Don't know your internet speed? In your browser, type 'internet speed test' and test your internet speed for free.

**Q: Can my problem be treated?**

**A:** Your doctor can diagnose many illnesses during a telemedicine visit, such as [list common diagnoses for your specialty (e.g. rashes, sinus infections, and acne)]. You can receive mental health counseling, Substance abuse counseling, post-operative check-ins, lab result reviews, contraceptive counseling, prescription refills, and more.

**Q: How can my doctor diagnose me without an exam?**

**A:** Physicians think about a lot of information to make a diagnosis, like the signs and symptoms you've experienced, your medical history, and so on. So, how you feel may be just as important as a visual exam.

**Q: Whom will I see – my doctor or someone I don't know?**

**A:** If you are an existing patient of this practice, most likely you will see your own doctor. But your doctor may not be available all the time. When scheduling your telemedicine appointment, be sure to tell staff if this is important to you so they can schedule your appointment accordingly.

**Q: How long will the visit take?**

**A:** Just as long as if you were being seen in the office – less the wait and travel time.

**Q: Can my doctor prescribe a medication during this visit?**

**A:** In most cases, yes. If your doctor decides you need a medication, he or she can send the prescription electronically directly to the pharmacy you choose.

**Q: Will insurance cover this service?**

**A:** Most insurance companies recognize and cover telemedicine services, but payment varies. Before you schedule an appointment, call the number on the back of your insurance card to find out if your specific policy covers telemedicine service.

**Q: If I have insurance, do I still have to pay the \$XX convenience fee?**

**A:** Yes. There is a fee for the convenience of a telemedicine visit, which will be collected through the app before your visit. After your visit, this practice will [submit a claim to your insurance company just as we do when you visit the office.] or [print and mail to you a claim form for you to submit to your insurer, and payment will be mailed to you.]

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