

PANHANDLE HEALTH

A QUARTERLY PUBLICATION OF THE POTTER-RANDALL COUNTY MEDICAL SOCIETY

FALL 2015 | VOL 25 | NO. 4

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CONTENTS

25 Year Anniversary

- 6 President's Message: *In the Pursuit of Wisdom***
by Tarek Naguib, M.D., M.B.A., F.A.C.P.
- 7 Alliance News**
by Irene Jones, President
- 8 Executive Director's Message**
by Cindy Barnard
- 9 Editor's Message: The 25th Year**
by Rouzbeh Kordestani, M.D.
- 10 A History of Potter-Randall County Medical Society:
The First Hundred Years**
by Cindy Barnard, Executive Director
- 14 Guest Editorial: Early Medical History of the
Texas Panhandle**
by Steve Urban, M.D.
- 18 Marita Angleton Sheehan, M.D., M.P.H.**
by E.F. Luckstead, M.D.
- 20 The Story of a West Texas Girl: Leora Andrew**
by John Andrew, M.D. and Rachel Andrew
- 23 Pioneers of Medicine**
Potter Randall County Medical Society pays tribute
to the memory of the pioneer physicians
- 26 Pediatrician, Dean and Hospice Pioneer:
Gerald Holman**
by Steve Urban, M.D.
- 30 Heal the City Clinic**
by Alan Keister, M.D.
- 31 Mercy Ships**
An Interview with J. Brian Sims, M.D.
- 38 The Patient-Centered Medical Home**
by Rodney Young, M.D., John Slaton, D.O.
- 40 Affordable Care Act: Dr. William Biggs Interview**
by Steve Urban, M.D., Jaime Zusman, M.D.
- 47 A Stranger at the Bedside**
by Todd Bell, M.D.
- 49 Once upon a time ...**
by Glenn Friesen, M.D.
- 52 Bioterrorism - An Overview**
by Andrew C. Stenhouse, M.D., F.A.C.P., F.R.A.C.P.,
M.R.C.P. (London)
- 56 Large Animal Injuries**
by Dennis B. Dove, M.D., F.A.C.S.
- 61 The Bioenergetics of Sex, or Come on Baby
Light My Fire**
by Steve Urban, M.D.
- 63 Treating the Breastfeeding Mother: Choosing
an Appropriate Drug**
by Thomas W. Hale, R.Ph., Ph.D.

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On The Cover: "Copper Pot and Pampas Grass" by Kirk Richards

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President's Message: *In the Pursuit of Wisdom*

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

I shall pass this way but once. Therefore, any good that I can do or any kindness that I can show let me do it now! For I shall not pass this way again!

These wise words on my office wall give me a daily dose of wisdom. They remind me that the essence of a successful physician is in the timing of the intervention, rather than the nature of it, while they also emphasize the humble and temporary nature of our existence. In fact, the pursuit of wisdom is in the core of all physicians' goals as they grow wiser over the years to ultimately become wise! In the old Arab culture the physician is called "al-hakeem" which means the wise one; whereas, the same word is used often to describe the Deity - as the ultimate wise one! Only the context would distinguish among the two uses of the word. Therefore, those who have the wisdom probably have a whole lot of good bestowed upon them!

When I reviewed the Supreme Court of the United States (SCOTUS) ruling on the case of King vs Burwell I was reminded that the wisdom of the society grows over time, just like that of the physician. In my mind, it is not the issue whether we support the Affordable Care Act (ACA) or not, nor it is whether we support the federal nature of the subsidies offered by the ACA to the enrollees or not. It is clear that the language of the law gives the states the power of

offering subsidies, and it is also clear that the federal fallback option upholds the original intent of the Congress for the citizens in the states that offer no subsidies. One thing is clearer though: none of the two viewpoints will convince the other!

In a broader look, however, we would be remiss if we ignore the fact that the Chief Justice, a conservative judge by history, has opined twice in favor of saving the ACA. The previous opinion was when SCOTUS considered the penalty levied by the Congress against the uninsured to have a nature of tax, and therefore is constitutional. With these two rulings, a predominantly-conservative SCOTUS has affirmed ACA as the law of the land in 2015, just as a republican-dominated Congress enacted the Medicare law that covers 50 million Americans today, exactly 50 years earlier! It seems that landmark legislations always need some consensus between the liberal and conservative partners, and when the window of opportunity exists, conservatives and liberals collectively may not differ much in the ultimate outcome, despite the apparent bickering! There is no better comment in this respect than that of a cynical dissenting judge who described the ACA as the "SCOTUScare"!

In the heat of the debate and healthy cynicism, I find myself compelled to highlight the paramount role of SCOTUS

in advancing our civilization. Naturally, there will be differing opinions within the court as the issues at stake, by definition, have no easy answers. But the collective wisdom, and the civility of the court, despite occasionally harsh criticism, is truly admirable, making both the founding fathers and the following generations proud! Over the years, SCOTUS has ruled and reversed itself repeatedly on many crucial issues, collectively and incrementally injecting vision and insight into the proverbial blind justice.

It is interesting to note that the human civilization has, over time, coded the commendable activities as "right", "righteous", or "dexterous", and the non-commendable ones as being "left field" or "sinister"; whereas, our Latin tells us that words "dexterous" and "sinistrous" simply mean right and left sided, respectively, unrelated to correctness! I respectfully submit to the reader that SCOTUS has taught us that life cannot be reduced to simple right or left answers; rather, it is whatever it takes to preserve the common good and welfare for our people.

In the end, I submit to the reader that whether we agree with it or not, SCOTUS has always found itself, willingly or not, at the forefront whenever our nation was ready for change. This court has truly shared in making our society much wiser!

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Physicians Caring for Texans

Alliance News

by Irene Jones, President

First and foremost, we would like to thank Kiki Brabham for her commitment to the Potter-Randall Medical County Alliance as President over the last two years. In addition, Kim Artho, Christine Cox, Kasey Daniel, Kyla Hashmi, Anna Holland, Kenzie Jewell, Stacia Lusby, Heather Manderson, Kat McNeil, Erika North, Tammy Risko, Amy Slaton and Kensie Wolcott have committed their time, talents and efforts in organizing and planning events for our members and community. Listed are our new and returning officers for the 2015-2016 year and our upcoming events:

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Community Grants/Scholarships:

Kensie Wolcott

Medical Liaison/Community Outreach:

Courtney Wagner & Elisia Miller

Members at Large:

Kasey Daniels and Anna Holland

Upcoming Events

October 6: Family Community Service Project: Snack Pak for Kids
5:45-6:45 pm. Kids 5 and older are welcomed and encouraged to participate

November 17: Family Community Service Project: Snack Pak for Kids

December 17: Christmas Party
7:00-9:00 pm
Home of Sloan and Susan Teeple

We are in the works of planning an exciting year. If you are an Alliance member new or returning and have any new ideas on how we can better serve our community, we would love to have your input. Please email us at potterrandallalliance@yahoo.com.

Irene Jones

President

Potter-Randall Medical Alliance

Medicare Posts 2016 Proposed Fee Schedule

Medicare posted its 2016 proposed fee schedule in the 07/15/2015 Federal Register. Stay tuned for TMA's analysis of the proposal in a future edition of Action, TMA's bimonthly newsletter.

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Executive Director's Message

by *Cindy Barnard, Executive Director*

Twenty-five years ago, the first Editor of Panhandle Health, Edward J. Sherwood, M.D., wrote this mission statement in our magazine: "The mission of *Panhandle Health* is to promote the health of the citizens of the Texas Panhandle through education. With the help of physicians in the Panhandle, this magazine can be more than a journal. It can be an instrument of change through which the Potter Randall County Medical Society has a positive impact on the health and welfare of the public at large." Two and a half decades later, our mission remains the same. We owe a huge debt of gratitude to our original founders listed below:

The first *Panhandle Health* Editorial Board included:

Gerald H. Holman, M.D.,

Assistant Editor

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

Ralph Leone, Photographer

The first *Panhandle Health* Publications Board included:

Jack D. Waller, M.D., Chairman

Randal E. Posey, M.D.

William R. East, M.D.

Cindy Barnard, Managing Editor

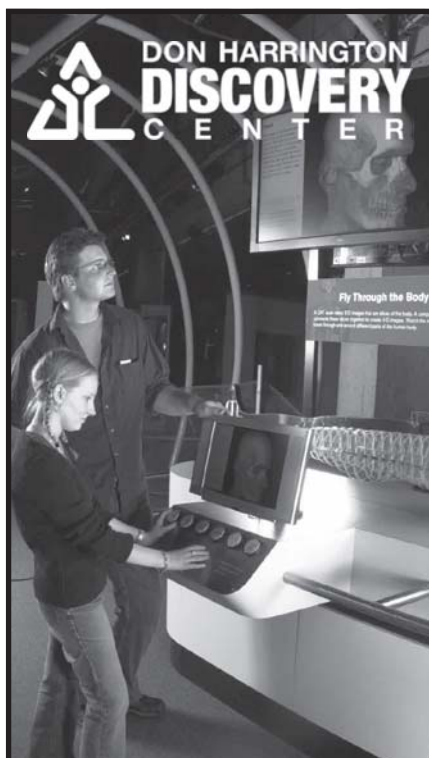
De De Vinson, Executive Director

In this 25th anniversary issue, our Editorial Board collaborated to assemble a subjective list of some of our finest articles ever. This issue is jam-packed with "the best" articles, covering a variety of medical topics. Obviously, the Board had a huge job: what are "the best" articles from the last 25 years? What does "best" actually mean? Clearly, selecting "the best" was more than difficult. We hope that the articles chosen here will act as a starting point for discussion and dialogue

and, possibly, further exploration.

Without the assistance of area artists, our magazine would not be nearly as attractive--a genuine thanks to each artist who has graced the cover of *Panhandle Health*. Our magazine has drawn accolades from around the state. The cover of this issue is entitled "Copper Pot and Pampas Grass" by Kirk Richards. It is an oil on linen canvas. Kirk lives in Amarillo. He received his training from Richard Lack, Minneapolis MN, after graduating with BFA and MA degrees from West Texas State University. He has won many awards and has received important portrait commissions as well as commissions to paint American historical paintings. This painting can be seen at "Town Square Frame & Art", Canyon TX.

We, at the Medical Society, feel our mission has been accomplished but remains unfinished as we continue our positive impact on the welfare of the public at large. One thing is certain: each of the articles will be a great read, so please enjoy!



New traveling exhibitions opening at the Don Harrington Discovery Center on October 3rd will offer even more discoveries!

Take a look inside with the *Beyond the X-Ray* exhibit that explores the world of medical imaging, spanning the ways doctors look inside the human body without surgery, and highlighting the latest advances in the field. This hands-on exhibit allows guests to travel through the brain, heart, and other organs through graphics and multimedia and try their hand at diagnosing ailments from x-rays, and attempt to identify hidden objects.

Once guests have discovered what is *Beyond the X-Ray*, they can then head over to the other exhibit wing at the Discovery Center and face their fears-- in the *Goosebumps: The Science of Fear* exhibit. Guests will explore and understand why some people are afraid of germs, worms, and even school terms within a safe, fun, and sometimes scary environment.

Both traveling exhibits open to the public on October 3rd and will be on display at the Discovery Center until early January. The Don Harrington Discovery Center is located at 1200 Streit Drive in Amarillo. More information about these new exhibits can be found at dhdc.org <<http://dhdc.org>> or on the Don Harrington Discovery Center's Facebook page, or by calling 806-355-9547.



Editor's Message: The 25th Year

by Rouzbeh K. Kordestani, MD, MPH

The Panhandle of Texas is a unique place. It is home to a wide variety of people and cultures. It is a part of Texas, and yet, it is not. Its people still relish in their simple and quiet life and do much to keep it that way.

Located within the heart of this geographically diverse region is Amarillo. Like the Panhandle, the Potter Randall County Medical Society has had a similarly long and rich history. Since *Panhandle Health's* inception 25 years ago, the members of the Society have tried to reflect not only current advancements in medicine but also the history of the medical community. The journal has done its best to keep up with the times in an effort to educate the people of the Panhandle and its physicians about the newest medical techniques and innovations.

Panhandle Health has made a concerted effort to move forward without losing the history of the area and its population. The editors and

staff of the journal have made every effort to highlight the achievements of individual physicians firmly rooted in the Panhandle. In each and every one of these physicians' achievements, the members of the Society and the members of the medical community can find accomplishments worthy of celebration. These include such examples as Dr. J.O. Wyatt who started the indigent service that so many patients use in the Panhandle and contributions like those of Dr. Werner who helped create and advance the medical community here in Amarillo. Another example was our own medical society editorial board member, Dr. Gene Luckstead.

I remember Dr. Gene Luckstead. He was one of the first members to welcome me into the Medical Society and the Editorial Board. With his smile, he seemed to say, "You have no idea what you have just gotten yourself into!!" Over the next few years, we helped one another compile the many needed articles for

Panhandle Health. That same friendly smile was the one smile he gave me in his hospital bed a few days before he died. Like other colleagues, Dr. Luckstead's dedication to the journal helped advance the subsequent success of *Panhandle Health*. In appreciation, we have included in this issue one of Dr. Luckstead's last contributions as a final thank you and a final goodbye.

There are many physicians like Dr. Luckstead here in the Panhandle, and we are proud to call them friends and colleagues. Each member of the Society has contributed in some way to our community, and they are the reason why *Panhandle Health* has become an excellent multi-faceted teaching tool.

Again, I thank all who have contributed to make this 25-year old magazine a rich and valued accomplishment. I thank them from us, the medical editors, and from all of the young physicians yet to come in years ahead.

Happy 25th!!! Here's to 25 more!!!!

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to the forms you can use to apply yourself or nominate a qualified leader or colleague.

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Important Deadlines

If you are applying yourself, the 2015 application cycle runs from Sept. 1, through Dec. 7, 2015. If you are nominating someone else, nominations are accepted year-round but nominees are bound by the annual application cycle deadlines.

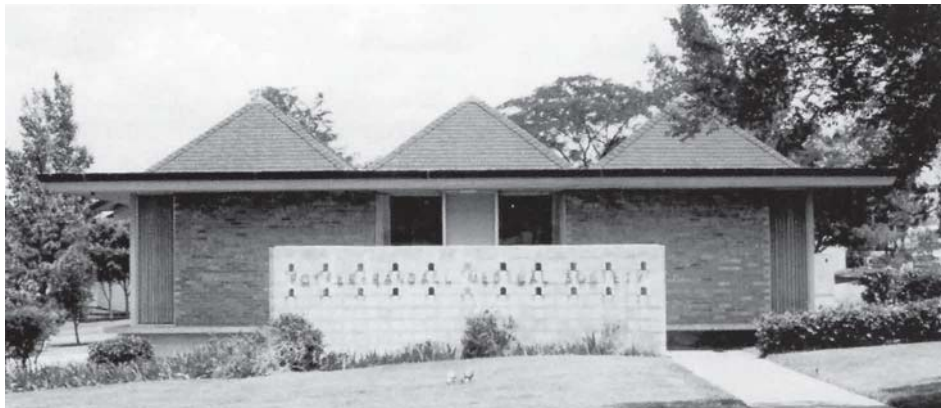
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A History of Potter-Randall County Medical Society: The First Hundred Years

Reprinted from *Panhandle Health*, Fall 2003

by *Cindy Barnard, Executive Director*



We live in a time of rapid change and progress. It is easy for all of us to define ourselves in terms of where we are going (the future), and not from where we have come (the past). However, it has been said that he who knows the past controls the future. Hopefully, the following will provide you with an historical overview of the history of the Potter-Randall County Medical Society as well as the direction in which the Society is headed.

This year, 2003, the Potter-Randall County Medical Society is celebrating its Centennial Anniversary—100 years of existence—quite an achievement! After all, this year, the Texas Medical Association, a state-wide organization, is only 50 years older than our regional Society.

The following history of PRCMS has been constructed from many sources, and, hopefully, will depict an accurate picture of the origin and development of the Society. It is a colorful history, and like a history of your health, essential to understanding the present condition of the Society and Panhandle medicine, in general.

It is not certain who was the first physician in Amarillo. A "Globe News" article lists Dr. E. A. Jones as first, followed by Dr. J.W. Cartwright, both around 1890. In 1891, Dr. J. W. Pierson came to Amarillo, and shortly thereafter, Drs. Patton, F. F. Magee, J. J. Hanna,

W.A. Lockett, and C. R. Randall settled here, too. However, it is certain that in 1903, nineteen physicians from Amarillo, Dalhart, Groom and Miami formed the Potter-Randall County Medical Society.

Two historical Amarillo physicians, Dr. David Fly and Dr. William Lockett, were well-known, not only regionally, but also within the state. Dr. Lockett was the Society's first President, arriving in Amarillo in 1900 from Alabama at the age of 61. Considering his age, Dr. Lockett must have been exceedingly scrappy. The West Texas frontier was brutal, with no roads and/or bridges. He repeatedly risked the dangerous quicksands of the Canadian River to treat his patients from his saddlebags of drugs and to impart his medical expertise to remote ranch families and their ranch hands. Dr. Lockett was not able to practice that long, due to his age and impaired health, but he was a beloved mentor to the younger area doctors. When he was 70, the Society presented him with a gold-headed cane as a token of their love and devotion.

Before he died, he asked the Society to pass on the cane to his successor, Dr. George Vinyard, and each succeeding President thereafter, and thus, an historical tradition was born. The Cane continues to be passed on from each retiring Society President to the incoming President, a visual reminder of our past and of our heritage. As for Dr. Fly, he was elected President of TMA in 1911, an

enormous honor, but sadly, he contracted tuberculosis and died before his term began.

Another early practitioner was the "Doc Holliday" of Amarillo, a Dr. Ashby. His application for membership in the Society was initially rejected, and his reaction was interesting, to say the least. The story is that he came to the next meeting, put a Colt 45 on the desk, and demanded a new vote. His action met with great success as, not surprisingly, he was unanimously elected to membership!

On May 9, 1911, the Texas Medical Association House of Delegates was called to order at the Grand Opera House in Amarillo. The Potter County Medical Society, now numbering 32 physicians, hosted the State meeting that year—the one and only time Amarillo has been the site of a TMA meeting. John T. Moore, M.D. of Houston called it a gathering "long to be remembered". The barbeque in beautiful Palo Duro Canyon may have prompted his words of praise. There were no paved roads into the Canyon—simply rough trails—and ladders were constructed to enter the Canyon over a thousand feet below. Few doctors had ever seen a live buffalo, and the state was "dry as a bone." However, all ate and drank, and ate and drank, and it took some a long time to climb out of the Canyon and return in their cars to Amarillo! For many years thereafter, doctors at state meetings reminisced about this occasion. Picture of that event are included in this issue, and one can only imagine the effort of not only the physicians in attendance, but also the "chief cooks and bottle-washers"... could they have been the local physicians' wives?

Progress came steadily—sometimes, quickly, often haltingly, and wars, the Depression, and drought took their toll on all aspects of Panhandle development. The only gaps in the Medical Society's list of officers appear in 1918 and in

1944 (war years). During World War II, Society membership was sparse as twelve of the Society's 48 were in the military, one dying in a Japanese prison camp (Dr. Hugh Lumpkin).

The Society's membership of general practitioners has slowly but consistently developed into a diverse group of generalists, specialists, and subspecialists, encompassing a four-state area surrounding Amarillo. As Amarillo grew in size and stature, so, too, did the medical



community. It has now developed into a group of almost 400 active and retired physicians in our two-county area. The Potter-Randall County Medical Society has officially been using this name since 1958 when Randall County physicians joined the doctors of Potter County.

Finally, in 1966, the Medical Society had a permanent home! Our headquarters were built at a cost of \$36,000, the second building to be finished in the Harrington Regional Medical Center (VAMC was the first). Previously, the office had been located in the garage apartment of Mary Tom Rasco-Crain.

PRCMS is the parent organization of two significant entities—the Goldston Tumor Registry and the Coffee Memorial Blood Center. The Tumor Registry was founded in 1960, named after A. B. Goldston, M.D. It maintains records of cancer incidence, treatment, and followups from the area hospitals. The Registry then codes this detailed data and sends it to the Texas State Department of Health and the American Cancer Society. The Director of the Registry is Joyce Ritter.

The Coffee Memorial Blood Center was founded in 1949, named for James

Robert Coffee, M.D. The facility is now located on the grounds of the Harrington Regional Medical Center, and the ceremonial ribbon was cut in 1985 by Mrs. Joe Coffee, the mother of James Coffee, M.D. The Center is accredited by the American Association of Blood Banks and is a charter member of the South Central Association of Blood Banks. Jim Rutledge and Mary Townsend, M.D. are the Center's current Director and Medical Director, respectively.

Since 1999, the Potter Randall County Medical Society and the Alliance have sponsored the Community Internship Program. This annual program invites leaders to obtain a closer look at medical care in our community by participating in the everyday life of physicians.

The Society's purpose is multi-fold. It is a professional association,

organized to nurture continued advancement of scientific knowledge and to maintain unity and harmony among all members of the profession. The Society provides representation, advocacy, and service to Panhandle physician members and functions as a liaison to Texas Medical Association and the American Medical Association. In addition, PRCMS acts as a referral service, sometimes fielding up to fifty calls per day from physicians, their staff, and the general public. Educational information on members is available as well as the hospitals in which the physician has privileges, office hours, and Medicare/Medicaid information. Other Society services include public and fee grievances, workshops on current medical issues for physicians and their office staff, and General Meetings for the membership. All services are free to the public.

The Society's members have influenced medical growth in all phases

of care, and the Society has encouraged and taken part in the development of our superb Medical Center and in the furtherance of medical education, health planning and peer review. The Society currently is staffed by the Executive Director, Cindy Barnard, Financial Assistant, Carol McKinney, and two Executive Assistants, Marty Schantz and Susan Hellberg. The current President of PRCMS is Dennis B. Dove, M.D., and the 2003/04 Alliance President is Jenny Alzeerah (Mrs. Masoud).

From 1946 until 1979, the Society published *The Bulletin*, a magazine for its members, but in 1990, *Panhandle Health*, a quarterly journal, was initiated, edited from its inception by Cindy Barnard. *Panhandle Health* is distributed to physicians, health care professionals, and many Panhandle businesses and residents. It features the work of local and/or area artists on its covers, and articles are written by local doctors and health care professionals. The magazine enjoys a state-wide reputation as an outstanding medical publication.

The one unchanging factor in all of mankind's history is that the nature of man does not change. His surroundings change; his technological achievements change; his economic circumstances change; but the nature of man, in general, has not changed in some six thousand years of recorded history. In spirit, the goals of today's physicians are most similar to those of our Society's founding members, thanks to their dedication and perseverance. The Society has come a long way in the last one hundred years, and it is certain that our doctors of today will be counted among the explorers in tomorrow's history as they continue to strive for the highest medical standards for our area.



Happy 100th Birthday and Congratulations to the Potter-Randall County Medical Society! Listed below are the physicians who have served as President.

1903-06 W.A. Lockett, M.D.
 1907 G.T. Vinyard, M.D.
 1908 T.F. McGee, M.D.
 1909 I. Rasco, M.D.
 1910 R.D. Gist, M.D.
 1911 E.A. Johnston, M.D.
 1912 G.T. Thomas, M.D.
 1913 J.J. Crume, M.D.
 1914 R.S. Killough, M.D.
 1915 S.P. Vineyard, M.D.
 1916 A.F. Lumpkin, M.D.
 1917 J.R. Wrather, M.D.
 1918
 1919 G.T. Thomas, M.D.
 1919 R.L. McMeans, M.D.
 1920 J.J. Crume, M.D.
 1922 E.A. Johnston, M.D.
 1923 H.H. Latson, M.D.
 1924 G.T. Vinyard, M.D.
 1925 A.J. Caldwell, M.D.
 1926 Richard Keys, M.D.
 1927 A.F. Lumpkin, M.D.
 1928 R.A. Duncan, M.D.
 1929 J.R. Wrather, M.D.
 1930 A.H. Lindsey, M.D.
 1931 Willis H. Flamm, M.D.
 1932 J.J. Crume, M.D.
 1933 Amos E. Winsett, M.D.
 1934 Nan L. Gilkerson, M.D.
 1935 Issac Rasco, M.D.

1936 George M. Cultra, M.D.
 1937 Elmer A. Rowley, M.D.
 1938 W.J. Shudde, M.D.
 1939 Jason H. Robberson, M.D.
 1940 John H. Vaughn, M.D.
 1941 A.J. Streit, M.D.
 1942 J.B. White, M.D.
 1943 B.M. Puckett, MD.
 1944
 1945 W.R. Klingensmith, M.D.
 1946 R.R. Swindell, M.D.
 1947 Frank B. Duncan, M.D.
 1948 Kenneth Flamm, M.D.
 1949 Guy Owens, M.D.
 1950 George M. Waddill, M.D.
 1951 Howard E. Puckett, M.D.
 1952 Gaylord R. Chase, M.D.
 1953 Fred J. Crumley, M.D.
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 1956 Ralph Carroll, M.D.
 1957 J.R. Lemmon, M.D.
 1958 Capres S. Hatchett, M.D.
 1959 Ernestine Smith, M.D.
 1960 H. Fred Johnson, M.D.
 1961 J. Victor Ellis, M.D.
 1962 James L. Johnson, M.D.
 1963 Wilbur Q. Budd, M.D.
 1964 William E. Laur, M.D.
 1965 Charles B. Sadler, M.D.
 1966 E.K. Jones, M.D.
 1967 Charles R. Nester, M.D.
 1968 Tom W. Duke, M.D.
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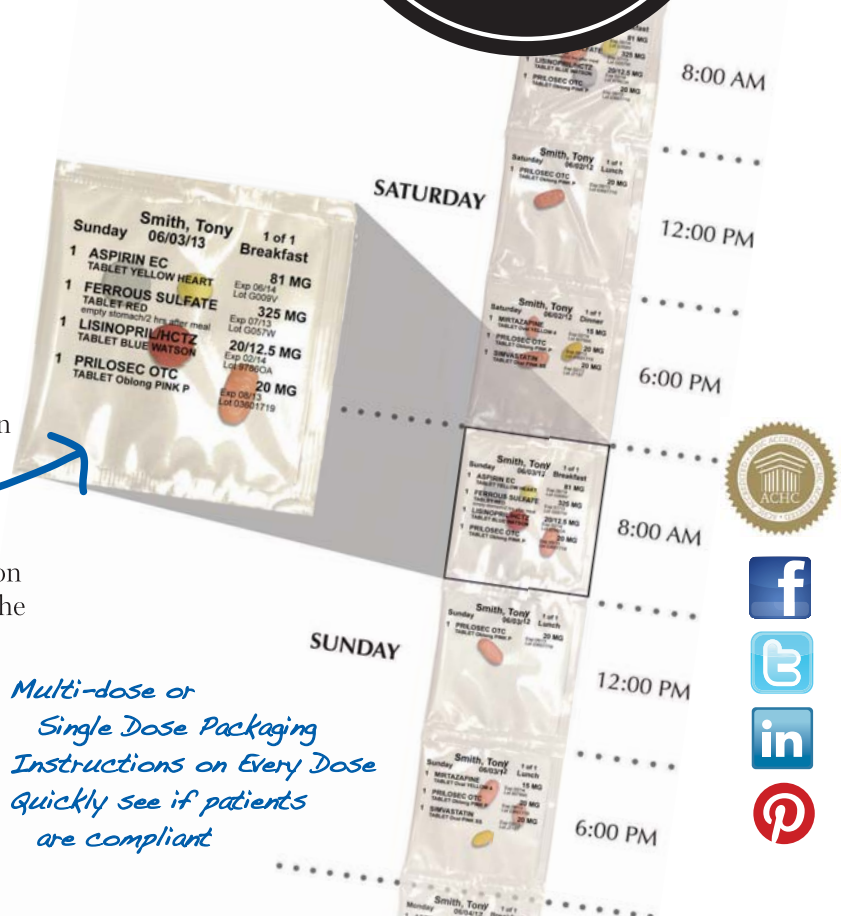
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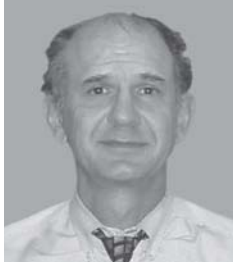
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Guest Editorial:

Early Medical History of the Texas Panhandle

Reprinted from *Panhandle Health*, Fall 2013

by Steve Urban, M.D.

Texas panhandle in the late 1800's

In 1874, the transcontinental railroad spanned America, Andrew Carnegie and J.D. Rockefeller were accumulating their first millions, and P.T. Barnum presented the "Greatest Show on Earth" for its second record-setting year. The world was reading *War and Peace*, and the impressionists shocked Paris with a new view of form and light. At this time the settled population of the panhandle of Texas was effectively zero.

If you look at maps of this era, our region is designated as "Comanche and Kiowa hunting grounds." Occasionally, a wagon train to Santa Fe, a band of Hispanic Comancheros, or a misguided trading party would pass through, but generally this area was a trackless prairie interrupted by a few creeks and rivers and ruled by the horse warriors. Within 10 years, everything would change.

The settlement of the Texas Panhandle depended on three factors: the "pacification" of the native Americans, the westward expansion of the railroads, and the development of the barbed wire fence (patented by Joseph Glidden in 1874). The rate-limiting step (then, as now) was finding enough water to make it all work.

In 1873, the Comanches still ruled this region (for a compelling account, read S.C. Gwynne's *Empire of the Summer Moon*) (1). Then Colonel Ranald MacKenzie wreaked final defeat on the Comanches, using the same approach that his boss, Gen William Tecumseh Sherman, had used to "pacify" Georgia. Whereas previous generals had captured Comanche ponies, only to have them liberated (usually that same night) by their "Indian" owners, MacKenzie had them all shot. He pursued the camps (i.e. women and children) mercilessly. In May of 1875 even the proud Quanah Parker surrendered and retired to the reservation at Ft. Sill, Oklahoma.

Soon after the victory of the 4th cavalry, cattlemen moved into our area—initially "free-range" owners like Charles Goodnight (1876), later settled landowners whose cattle were constrained by the new barbed wire. Right behind them snaked the railroads—the high plains first supplied by the Santa Fe (originally, the Atchison, Topeka, and Santa Fe) through southern Kansas. Its terminus at Dodge City in 1872 created the archetypical cowtown; subsequent extension to Pueblo in 1876, Albuquerque in 1880, and final linkage with the Southern Pacific at Deming, NM in 1881 connected wheat, cattle and buffalo lands in the central plains to markets on the east and west coast. Then came the Ft. Worth and Denver, whose progress across the panhandle in 1887 gave rise to Clarendon, Texline and (most importantly) Amarillo.

Finally: the water

First the few rivers and creeks, marked by rudimentary forts—e.g. Bent's Fort (also styled Fort Adobe, later Adobe Walls) and Fort Elliott on the Canadian. In their wake, villages such as Old Tascosa (1876) and Old Mobeetie (1878) struggled into being. Then came hand-dug wells on the flatland; finally machine dug wells with the necessary windmills. At last, settled civilization—mostly rural and scattered, to be sure—had arrived.

Early panhandle medicine

Of course, medical care in the late 1800s was rudimentary at best. Most doctors had no formal training and no scientific background at all. They learned via the apprenticeship method, much as did an artisan or tradesman. Many of the so-called "doctors" in the west were half-trained rascallions or alcoholics on the run. In newspapers of the time you will find "announcements" (advertising was prohibited by the AMA!) boasting of

local doctors' graduation from respected universities and medical schools, to distinguish them from practitioners with only "trade-school" diplomas.

The dearth of qualified doctors was a significant drawback to settlement of the Panhandle in the early days. Dr. Tom Hale has shared with me an account by his great-grandmother Mrs. W.B. Wright, who settled near "Fort" Bugbee on the Canadian River in 1877. Ms. Wright was the first Anglo woman to bear a child in Hutchinson County. When she became pregnant with her first child, the nearest doctor was in Dodge City; so the Wrights hired her brother, a physician from Missouri, to stay at their home through the lying-in. Later, the owner of a large cattle operation nearby offered the astounding retainer of \$100/week for Dr. Wright to stay until HIS baby had been safely delivered.

Ochiltree County: case in point

Much of the history that follows comes from Ochiltree County (county seat: Perryton), where my Urban-side forebears settled in 1888 and my maternal Hummer-side forebears settled in 1905. Every county has its own story—undoubtedly of more ancient provenance than ours—but I know Ochiltree County's story best and, after all, I AM the guest editor!

My great-grandfather William L. Coppock homesteaded in Ochiltree County in 1888 but returned to Tennessee with his family several years later. Having to dig a water well 200 feet deep with pick, shovel and windlass was only part of the problem. The family considered the lack of ready medical care an important factor. The nearest physician at this time was in Liberal, Kansas, 50 miles away by horseback across a wagon-trail through the prairie. An excerpt from the memoirs of Walter Stollings (related by marriage to

the Hummer clan) elucidates the problem:

“One evening, Walter was playing a game called dare base, and ran into the barbed wire guy line of a windmill; his face was ripped open from mouth to ear and he was in a bad way for a while. Soon a fine pioneer woman who knew how to meet the occasion came on the scene. Her name was Mrs. Beagle; she asked that the boy be held by force while she took an ordinary needle and silk thread and sewed a pretty stitch. Today the scar appears to be the work of a competent surgeon (2).

Early practitioners in Ochiltree County included Dr. Alfred Ahlman, who in 1906 opened a sanatorium; the doctor and his family lived downstairs and the patients occupied the second floor. Dr. William Pearson graduated from Vanderbilt in 1883 but came to the dry panhandle of Texas “for his health” (this usually meant that he had tuberculosis) and never practiced. Dr J.T. Guthrie was a well-loved practitioner but died in the 1918 influenza

pandemic while tending to his patients.

Perhaps the most colorful early practitioner in Ochiltree County was Dr W.J. Brewer, who was Dr. Guthrie’s brother-in-law. He came to Old Ochiltree in 1908 (11 years before Perryton was founded) and practiced in Ochiltree County for 30 years. His obituary proudly mentions his training at Barnes Medical College and his “post-graduate work” at Tulane and Chicago Polyclinic. A newspaper announcement from May 1916 bragged that Dr. Brewer, “one of our leading physicians and surgeons” was attending a refresher course in Chicago. The Ochiltree Herald commended him “for his progressiveness and desire to be at all times at the top of his profession.”(3)

That Dr. Brewer may have had other desires came out in October of 1916, when Dr. Brewer and County Judge Cap Correll shot it out in a duel in the “usually quiet little city of Ochiltree” over “difficulties of a delicate nature which have existed

between the two men for some time.”(4) Early 20th century journalistic diction must be quoted to be fully enjoyed:

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

No detail was omitted in the account; modern HIPAA compliance officials must shudder to read these facts:

“Dr. Brewer was leaning up against his car, writing a prescription for Bogus Wilbanks...when Judge Correll walked up on the sidewalk...and opened fire on Brewer, who immediately drew a gun and began shooting at Correll. About nine shots were exchanged, only two taking effect, one from each gun.”



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Certain details might seem excessive in today's *Globe News*. We learn that the Judge was struck "in the abdomen, the ball severing the intestines in two places and lodging in the hip" and that he was taken to Liberal Kansas "in Ed Forbes' Oldsmobile." Somewhat cryptically (but perhaps germane to the delicate matter), were are told that Dr. Brewer has "a wife and two daughters" and that "Judge Correll is 35 years old and was married to Miss Carrie Whippo only last June." Eat your heart out, Lance Lahnert!

Shooting a judge must not have been severely frowned upon in those days—or else they really needed a doctor!—since Dr. Brewer moved with the rest of the town in 1919. The town of Ochiltree hoisted up its skirts and moved 7 miles north to the side of the new Santa Fe spur. There Dr. Brewer continued to practice through the 1930's; he experienced a surprisingly peaceful demise in 1953.

Modern medicine

In 1930, a new hospital was built by Drs. Budd and May in the growing town of Perryton. The proud announcement mentions \$10,000 of equipment, 12 private rooms, one large public ward, and a fluoroscope! In those days serum chemistries were not widely available (just urinalyses and CBCs) and of course the radioimmunoassay had not been developed. The hospital was proud of its "Jones metabolic apparatus" for measuring basal metabolic rate for the diagnosis of hypothyroidism!

A lot has changed since those early days. The Flexner report (1910) transformed medical education. By the 1940s and 50s, doctors were trained at Baylor and UTMB (rather than in proprietary schools). Residencies were more likely accomplished in a hospital than in a saloon. Quantitative chemistries, then the radioimmunoassay, then CT and MRI scans moved us toward diagnostic certainty. Were doctors better diagnosticians in those days? Probably not. Were they more revered and respected? Probably. They carried the torch of healing to the bedside, even if their therapeutic armamentarium was weak. They brought care and empathy with them. Nowadays we're too busy

to sit and ponder—we've got to pay off those scanners and get the patient out of the hospital before the discharge planner comes around! When we read the old accounts, though, we sometimes wonder: how much has been gained and how much lost, in the advance toward our modern technological medicine?

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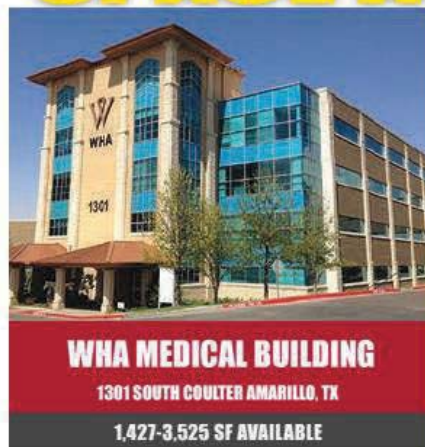
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- (2) Whippo SP, ed. *Wheatheart of the Plains: An Early History of Ochiltree County*. Ochiltree County Historical Survey Committee, 1969.
- (3) Ochiltree News. May 26, 1916. The Ochiltree News succeeded the earlier

Eagle-Investigator. Perhaps the querulous tone of the Eagle led to its demise. On May 18, 1910 it scolded: "The friends of the Investigator will please hand us in news items while they are fresh. We prefer not to publish a birth after a child is weaned, a marriage after the honeymoon, or the death of a man after his widow has married again!"

- (4) Ochiltree News. October 6, 1916.

Thanks to Odie Dear, Rena Gay Richardson, and Stacy Brown at the Museum of the Plains in Perryton TX for assisting my research of early Ochiltree County medicine.

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PROTECTION FOR A NEW ERA OF MEDICINE.



Marita Angleton Sheehan, M.D., M.P.H.

Reprinted from *Panhandle Health*, Summer 2013

by E.F. Luckstead, M.D.

Dr. Marita Sheehan grew up in a military family environment. Her father was career U.S. Navy and thus she and her family moved frequently with multiple home experiences for Marita. She was born at Ft. Scott, Kansas but lived in several locations in the United States including Hawaii. Dr. Sheehan spent her college and early medical years in California, graduating from her pre-med years at University of San Diego College for Women and attending the University of California at San Francisco (UCSF) medical school, graduating in 1968. Her pediatric internship was at Los Angeles County, (USC Medical Center) and residency years were spent in the San Francisco area at Mt Zion Hospital and Medical Center. Dr. Sheehan received her MPH in Maternal and Child Health from the University of California School of Public Health at Berkeley, California from May 1971- 1972.

Eventually, Dr. Sheehan moved to the state of Texas where she spent her early academic pediatric years at Baylor College of Medicine in Houston (1972-1975; 1980-1981), intertwined with a private pediatric practice in Kailua, Hawaii (1976-1979) and Houston, Texas (1980-1981). Marita joined the pediatric faculty in Austin as their Pediatric Residency Program Director from 1986 to 1991 before moving to TTUHSC in Amarillo, as the Regional Pediatric Chairperson, from May 1992 to October 1994 and Pediatric Residency Director from May 1992 to November 1997. Dr. Sheehan has always been very active in the administrative role needs of the medical school. She also served as Interim Regional Dean from February to October in 1999 and was the Assistant Academic Dean for Students from 1994 to 2011. Dr. Sheehan's concern and advocacy for medical students is evident from her long term leadership as the TTUHSC-Amarillo GME Committee Chairperson.

While working in Massachusetts in 1982-1983, Marita met a young future

lawyer, Tom Sheehan, who eventually became her spouse. Marita and Tom eventually adopted a 3-month old child, Christopher. This added a new dimension to her life. *"This has been the most fulfilling and exciting part of my life—watching and helping your child grow into an adult."* Marita and Tom's son Christopher was a recent graduate of West Texas A&M!

Since the time Dr. Sheehan joined to the TTUHSC Amarillo medical environment in 1983, she has been very active in the medical school with her supportive roles that have positively affected many medical students and residents. (Regional Chairperson, Pediatric program director, Interim Dean, Assistant Dean of Students are just some of her roles!) Her subspecialty care expertise and interest in adolescent medicine and the challenges of sexuality, drug use and abuse from such youth has made her serve as a medical pillar to address these teenage medical needs in the Amarillo area the past 30 years. Dr. Sheehan worked diligently to improve these adolescent care challenge areas. However, the most memorable patient that Dr. Sheehan still recalls with "emotion" was a severely neglected infant whom she cared for as a pediatric resident. The infant was initially non-reactive emotionally. During the ensuing hospital ward time under Dr. Sheehan's care and with her interaction, the infant progressively began emotionally to react with excitement when seeing Dr. Sheehan, like a normal child does when provided "loving care." Dr. Sheehan states that she saw "true love" occur with that particular infant!

Dr. Sheehan has been a mentor and teacher for many students and residents that have become successful physicians both in Amarillo, Texas and throughout other parts of the United States. (One she cites is Dr. Steve Urban, one of her former students, who is also now actively teaching medical students and residents

at the TTUHSC Amarillo medical school.)

"I had the pleasure of working with and being mentored by Marita for over 15 years before she retired from the Office of Medical Education. In her role as Assistant Dean, she impacted the lives of many residents and medical students. She took great care to nurture and encourage the development of humanistic physicians. She used her gentle, quiet strength to help them do the right thing and see the bigger picture. Marita instilled in them the great privilege it is to care for others and their loved ones." (Kristen Stutz- Assistant Dean of Students)

"I have known Dr. Marita Sheehan since 1982 when she joined the Department of Pediatrics at Texas Tech University Health Sciences Center – Amarillo Campus. She is a superb clinician and a great teacher of pediatrics. She has the finest clinical skills. According to my observations Marita has a very sharp diagnostic acumen. She is very compassionate towards her patients and, due to her vast clinical experience, she is very prompt in reaching an accurate clinical disposition. Her student and residents always tell me that Dr. Sheehan makes an accurate diagnosis after a very short interaction with her patients. She has a strong faith, which is a source of her inner strength and great sense of comfort even during difficult situations. Besides being a great and astute pediatrician, she is cloaked with humility; she has a peaceful smile and a non-judgmental demeanor. Marita is a rare example of a "real pediatrician" of the past several decades. I wish her many more years of clinical work and teaching." (M. Naqvi, M.D.)

"I guess the theme of my academic career is administration, patient care, student teaching. My bouncing between academics and private practice demonstrates my conflict between taking care of patients vs. teaching. To be able to do these two things together has been

the best of things for me as far as medicine goes!" (Marita Sheehan M.D. March 2013).

I have known Dr. Sheehan as a personal friend, a valuable peer and faculty member in our pediatric department over the past 13 years. She definitely represents a valuable role physician model for all medical students, residents in pediatrics and especially those women physicians now serving Amarillo and the surrounding communities.

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The Story of a West Texas Girl: Leora Andrew

Reprinted from *Panhandle Health*, Spring 2012
by John Andrew, M.D. and Rachel Andrew



The year 1971 was a year in which many important careers were launched:

1. Lance Armstrong, Amtrak, and Nasdaq were born.
2. Southwest Airlines, a low cost carrier, began its first flights between Houston, Dallas, and San Antonio.
3. Walt Disney World opened in Orlando, Florida.

Other great careers of the era ended:

1. Jim Morrison, lead singer for The Doors, died of a drug overdose in Paris.
2. The final episode of the Ed Sullivan show aired.
3. Three Soviet astronauts died during a Soyuz II accident.

Leora Andrew, M.D., wasn't paying attention. Her husband of 20 years had just kissed her goodbye and moved in with his nurse.

Leora Andrew was born in Scott City,

Kansas on February 8, 1926. Her father, C.C. Pate, was a general practitioner who attended Vanderbilt Medical School and then completed a residency in general practice in Kansas City. Her mother Leora Pate was a nurse. They moved to Paducah, Texas in 1928 and lived in the basement of the hospital for 5 years during the Great Depression before he could qualify for a loan to purchase a home.

Leora graduated from Paducah High School and then attended Texas Christian University in Fort Worth, Texas. After graduation, the little girl from Paducah, Texas refused to go quietly into the night or the kitchen, but chose instead to carve out her own niche in (what was then) a man's profession. She was accepted that year to the University of Texas Medical School in Galveston, Texas. Eleven females were accepted in a class of 120. Nine graduated. An internship in Augusta, Georgia

was followed by pediatric residency at Children's Hospital in Dallas, Texas.

Leora met John Gray Andrew during her senior year of medical school in Galveston. John was just starting his first year after serving as a naval officer in the Pacific during World War II. They dated during her last year of medical school, and after she finished her internship, they eloped to Oklahoma and were married. Leora says, "My daddy didn't mind one bit that I saved him some money." Leora and John Andrew lived in Houston, and she worked in Pasadena, Texas while John finished his residency. After completing their years of medical training, the couple moved to Pasadena, Texas in 1957. Pasadena was a hard-edged, blue-collar town on the outskirts of Houston. In the mornings, the dank humid air was so thick, you could taste the petroleum from the refineries along the ship channel.

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We are grateful for the support of these organizations and anticipate another great year of serving the needs of our members. The purpose for Circle of Friends is to provide a valuable base of

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

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

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

The stench arising from the paper mill prompted Houstonians to call it “Stinky Dena”. It was paradise for a young, energetic medical couple.

John Gray, the sole orthopedic surgeon in town, seldom left the hospital and when he retired in 1990, 15 orthopods practiced full time in Pasadena. Leora was a pediatrician at the height of the baby boom. She practiced for 12 years and then retired when her oldest child started grade school.

Leora enjoyed being a wife and a mother immensely, but by 1971, she and John had grown apart. So far apart, in fact, that she found herself a single mother. She was 45 years old, one of the only divorcees in Pasadena, unemployed for 12 years, with no credit rating, and 3 children to support. Where would she go? How would they live? What would she do? What would YOU do?

John, her oldest child, was struggling in his freshman year of college. James Edward, her misbehaving favorite, had miraculously finished middle school with no serious mishaps. Leora said she loved Jim best “because he needed me the most.”

At age 13, Jim was just starting his freshman year of high school. He would one day become a tall, handsome physician who would finish his pathology residency and dermatopathology fellowship at Columbia University in New York City. In 1971 he was a hyperactive and extremely eccentric child who sported thick horn-rimmed glasses with coke-bottle lenses and was impassioned by his work at a pet store. He would venture out on his miniature moped through back alleys and boggy fields to Pasadena Pets two miles away from their home. On one special occasion, he came home with a pet skunk named “Chanel”. The skunk had not sold at the store because her scent glands had been “incompletely removed.” Jim justified his purchase with, “Mother, she doesn’t smell thaaaaat bad.” In 1971, he was a handful.

Madeline the youngest was ten years old and just out of grade school. She would one day become an established forensic psychiatrist and the mother of three beautiful children, but at that time she was content to be everyone else’s favorite.

Leora did not spend long pondering how she would support her family. Nor did she have the luxury of time to mourn her lost marriage. She gathered her courage and went to the nearest medical

school. Leora left home at 4:45 am for the commute to Baylor Medical School, where she attempted to restore long-dormant skills following medical students and interns on morning rounds and presenting patients to residents and staff, who were ten years her junior. It was a humbling experience for a forty-five year old lady, but she persevered. After a year of honing her skills, the Pediatrics Department at Ben Taub Hospital offered Leora a job. She started immediately. Another obstacle was the national medical board exam, which had been perceived as unimportant during her first years of practice. Now in 1972, the test was mandatory. She passed her boards on the first attempt.

Leora’s pediatrics career restarted in Houston. She could never have realized the great impact she would have on her patients during her next 32 years of practicing medicine or the deep fulfillment she would find in her newly rediscovered vocation.

In 1972 Dr. Murdina Desmond offered her a position at Meyer Center in the new department of Developmental Pediatrics at Texas Children’s Hospital in Houston. The advent of neonatology and neonatal ICUs spawned an entirely new patient population with their own unique diseases including retinopathy of prematurity, bronchopulmonary dysplasia, necrotizing enterocolitis, and cerebral hemorrhage. Each of these conditions was treated in the acute phase by neonatologists. The toll for decreasing mortality was increased morbidity was a myriad of children who exhibited developmental delay. They showed failure to crawl, walk, and talk in a normal time frame. Other patients demonstrated their learning delay by performing poorly in school. These afflictions required categorization, specific diagnoses, and focused treatment plans. More than anything, these conditions required long-term follow-up. Leora worked for 10 years at the Meyer Center and was able to gain specialized skills with a specific population of patients that very few pediatricians had at that time.

After a decade in Houston, Leora was approached by a group of physicians in Amarillo where her specialized skills were needed. The process started in the summer of 1982, when Dr. Rolf Habersang, chief of pediatrics at Texas Tech University Health

Science Center (TTUHSC) in Amarillo, approved a search committee to seek out a developmental pediatrician to work with their Neonatology Department. Leora, as a member of Baylor’s developmental program, was asked to join Dr. Naqvi’s neonatology group to determine whether the patient outcomes from the Amarillo neonatal ICU were commensurate with nationwide standards. (The results proved to be excellent.)

Leora was the only staff member in Houston interested in Amarillo because her father was in poor health at his home in Paducah, Texas. Dr. Andrew chose to move closer to her parents and accepted the offer to join Texas Tech faculty. She arrived in Amarillo on January 1, 1983.

Amarillo offered its own challenges to Leora. The Panhandle had over 20 inches of snow that winter, compromising the logistics of scheduling and delaying her research. Another difficulty was the death of her father, Dr. C.C. Pate, who succumbed to radiation-induced cancer (acquired while treating a patient) within a year of her arrival.

Eventually, Leora was able to integrate her skills into the department of pediatrics at Texas Tech. The developmental pediatrics team saw a multitude of new patients with developmental delay. Referrals were usually nondescript, such as “not talking,” “not walking,” or “not toilet-trained.” The etiology behind the patients’ condition could be due to genetic factors, metabolic factors, low birth weight, hypoxia, exposure to toxins, infections, or trauma.

When patients were referred to the clinic, prenatal influences (such as maternal alcohol use, drug use, or genetic factors that could lead to chromosomal abnormalities in the patient) were assessed. Leora as the developmental pediatrician was prepared to deal with these conditions.

Children with perinatal insults such as Low Birth Weight (LBW) infants weighing less than 2500 grams and Very Low Birth Weight (VLBW) infants weighing less than 1500 grams needed periodic follow-up to determine delay and evolution of deficit. Children with postnatal accidents (gunshot wounds, automobile accidents, etc.) required regular periodic evaluations for delay or disability. Over time, those with delay had to be differentiated from those

with disability because of differences in treatment and outcome.

Leora's developmental team utilized social workers, psychologists, and physical, occupational, behavioral, and speech therapists. Interface with geneticists, neurologists, endocrinologists, and orthopedists was also necessary.

Eventually, Dr. Andrew and staff documented neonatal outcomes at TTUHSC. Outcomes for neonates in Amarillo were found to be commensurate with other centers treating Low Birth Weight and Very Low Birth Weight infants. Her extensive research, once published, earned her a Masters in Public Health from the University of Texas Health Science Center in Houston.

During the 20 years Dr. Andrew was at TTHSC (1983-2003), she evaluated hundreds of children with developmental disabilities through the Children's Rehabilitation Center as a part of the Texas Tech program. Great strides were made both in Amarillo and in the state of Texas toward better healthcare for young children, especially those with developmental delays.

Texas Public Laws 99-142 were passed, and health services were made available to all school-age children. Later those laws were expanded to include children ages 3-5. According to Leora: "The birth of a disabled child was still a family heartbreak, but these government policies provided aid and training for children with disabilities and their families."

Leora loved her profession, and therefore found her patients truly fascinating. Maybe she saw a little piece of her own son James Edward in each of these vulnerable children. Regardless of her reasons, she dedicated her life to their care. She recounts the story of one of her patients whom she found especially interesting with the chief complaint: "She's six years old and still can't drink out of a straw."

When Leora first saw the child, she noticed that she had a tented mouth with an upper lip shaped like an inverted "V," a type of facial diplegia with jaw weakness. The patient's mother was about forty years old and attractive. The mother reported that she had several other children who did not have the same difficulties as her daughter. The mother reported that this little girl seemed slower than her other

children and had struggled with feeding since infancy.

Leora was an astute physican and asked the mother for a handshake. Leora noted that the mother shook hands with a prolonged release. Then Leora took her percussion hammer and tapped the mother's thenar eminence, producing a prolonged contracture. At this point, the mother stood up, as though offended, and said, "Dr. Andrew, I am not the patient. I brought my daughter to you as the patient."

Dr. Andrew apologized for not explaining herself and then indicated that the little girl might have a condition which she could only inherit from her mother—myotonic dystrophy. Even though the mother's previous children had shown no delays, this condition is more profound with succeeding generations. At this point, the mother remembered that in the fall, before the first freeze, she had canned many pounds of okra, tomatoes, and other vegetables to keep them from freezing. By the end of the canning season, she had such strong contractures that she could hardly remove her hand from the vegetable jar lids. Leora referred her young patient for psychological testing, which revealed that she was in the mildly retarded range. The expected reaction was dealt with, and the family was referred for genetic and neurological evaluation. Genetic testing showed multiple cytosine, thymine, guanine (CTG) repeats of myotonic dystrophy.

When asked about her life, Dr. Andrew says, "I'm a little country girl from Paducah, Texas who grew up to be a doctor just like my Daddy." She raised three children to be doctors. She had a full and successful practice for several decades. She says, "Although I never did anything heroic or saved any lives, I did help make a few people's lives more tolerable and enjoyable." Those were children with developmental-behavioral disabilities and their families. According to Leora, "What's not to love about this job?"

Epilogue: What if I told you, that the end of a marriage could signal the beginning of a whole new life? What if I told you, Leora Andrew's new career would span 32 years, ending in a happy retirement from Texas Tech in 2003 at the age of 76? What if I told you, she was my hero? What if I told you, she was my mom?

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Pioneers of Medicine

Reprinted from *Panhandle Health*, Fall 2003

These courageous, dedicated physicians were willing to face hardships and to travel new roads. Potter Randall County Medical Society pays tribute to the memory of the pioneer physicians

MEDICAL MOVERS AND SHAKERS



Dr. William A. Lockett:

Dr. William A. Lockett was the first President of the Potter County Medical Society. One hundred years ago, 1903, Dr. Lockett met with a small group of doctors and organized the Society. We owe a great debt to this “grand old man of medicine.”

Dr. Lockett, born in Marion, Alabama, in 1839, arrived in Amarillo in 1900—before bridges crossed the Canadian River and before roads connected towns in the Panhandle. He came to Amarillo, an elderly physician, in poor health, and therefore, did not have a large practice. However, Dr. Lockett did his best to travel great distances on horseback to tend to sick ranch people. Due to his age and failing health, he mainly consulted with younger area doctors who were eager to learn his methods and techniques.

On Dr. Lockett’s 70th birthday, the Potter County Medical Society presented him with a goldheaded cane, a longstanding symbol of physicians and professional excellence, and a token of the Society’s love for and devotion to him. As his health continued to deteriorate, Dr. Lockett resigned as President and asked that the Goldheaded Cane be passed on to each future President of the Society. This request has been honored for 100 years, and, thus, a tradition was born. Each year,

the Goldheaded Cane is handed from retiring President to incoming President, and with this gesture, we are reminded of both our rich heritage and our exciting future.

Dr. Robert Austin Duncan:

Dr. Robert A. Duncan came to Amarillo to practice medicine in 1925 and was one of the first specialists in the area. He was born in Mulberry Creek, Arkansas, but his parents moved with his six siblings to Texas when he was an infant. His mother told him that, during the move, they were stopped by Indians, and the chief “picked me up and scared my mother half to death. However, after dangling me in his arms a bit, he laid me back down, mounted his horse...and rode away.”

Dr. Duncan’s childhood was spent on a farm in Wylie, and after his Baylor University graduation, he entered medical school at Tulane University, New Orleans. Dr. Duncan said that the last year one could practice before completing required courses was in 1907. After that, one had to pass a medical examination before he was given a license to practice.

Dr. Duncan was a third year med student, and took the exam, passed, and began practicing at Big Foot in Frio County. Dr. Duncan said he was promptly acclaimed “the best doctor in four counties. This was true. I was the only doctor!” His patients were treated mostly in their homes, and he rode 30-40 miles a day on horseback, carrying supplies in two old U.S. Cavalry bags, until he purchased a Model T. Ford in 1911.

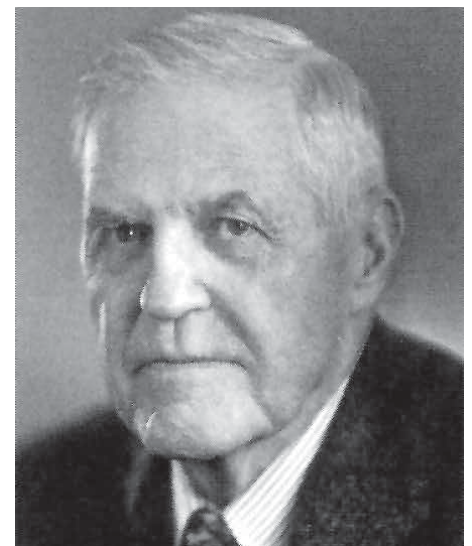
In 1907, Duncan married a teacher and decided to return to Tulane for his medical degree. After he received his M.D., he began his practice in Graham. Returning once again to Tulane in 1913, Duncan began a speciality in eye, ear, nose, and throat medicine. Duncan said that, at that time, doctors were either in general practice or ENT physicians, as

there were no other specialized medical fields.

Dr. Duncan did an ENT residency, returned to Graham, but in 1917, he enlisted in the Army Medical Corp and was sent to Camp Arthur, Waco, as an instructor. Following World War I, he once again returned to Graham. “I had always liked Western people and was always interested in the West and Amarillo appealed to me,” so in 1925, Dr. Duncan with his family came to Amarillo and opened a temporary office in the Johnson Building until the Amarillo Building was completed. At that time, there were three other ENT specialists in Amarillo.

“Although Amarillo had electricity, many of my patients, particularly those in rural areas, did not have it. Some of my worst experiences have been in trying to tie off a ruptured blood vessel to stop a nose bleed by the light of a coal-oillamp. Another mean chore, which frequently came my way, was extricating chicken bones by lamp light.” Because Dr. Duncan was a specialist, he did not have to make house calls, but he still covered many miles, mixed his own prescriptions, and sold and prescribed patent medicines.

He made a weekly trip to Hereford as well as Memphis and Childress and took



care of eye, ear, nose, and throat problems there and performed tonsillectomies. "I did wholesale tonsillectomies. I took along a couple of nurses and two sets of instruments and the Hereford general practitioners would have the patients prepared. One day, I did 32 tonsillectomies ...I used chloroform for the anesthetic. It was more dangerous than ether but it didn't make the patients as sick. Later, they improved ether and I used that."

When Dr. Duncan became ill in 1940, he bought a ranch near Skellytown. In 1966, he received a plaque for 25 years of membership in the Panhandle Hereford Breeders Association. He and his wife, Edna, had three children. Dr. Frank B. Duncan followed in his father's footsteps and practiced eye, ear, nose, and throat medicine here before his retirement. Dr. Robert Duncan died at the age of 82 in 1966.



Dr. Henry Martinez:

Henry Martinez was born in 1928 and raised in a tiny village, 40 miles north of Santa Fe, New Mexico. He attended a mission school, operated by the United Evangelical Brethren, and was the recipient of a scholarship to Indiana Central College, graduating cum laude in 1951. In 1952, he graduated from Butler University, and, in 1956, Martinez received his Medical Degree from Indiana School of Medicine. He went on to intern and do his residency in general surgery at the University of Texas, Galveston as well as complete a residency in thoracic and

cardiovascular surgery at the University of Texas Southwestern Medical School, Dallas. In 1963, he arrived in Amarillo.

Dr. Martinez was relentless in trying to bring modern heart treatments to Amarillo. Failing in his attempt to convince Amarillo hospitals to purchase a heart-lung machine, Martinez and his friend, Dr. W. R. Klingensmith, bought the machine themselves. Dr. Martinez's daughter, Dr. Robin Martinez, reported, "I remember it was in our garage at one time."

At last, St. Anthony's Hospital bought the machine, and Martinez's wife, Ann, a nurse, operated it in a lab, converted from a hospital storage room. Dr. Martinez performed the first successful operation using the heart-lung machine in Amarillo on October 14, 1964.

Dr. Martinez was known for his personality as well as his medical expertise. Liz Pepper, his former assistant, said he treated patients like friends. Dr. Roberto Estevez, a personal friend of Martinez's, said, "Henry was a rare combination—a great doctor and a great man. Quite often doctors are too busy in the practice of their profession... and don't have time to pay attention to people. Dr. Martinez was an outstanding human being."

Martinez was a member of the Society of Thoracic Surgeons, Southern Thoracic Surgical Association, American College of Cardiology, American College of Chest Physicians, Texas Medical Association, Potter-Randall County Medical Society, and the American College of Surgeons. He was also a clinical professor in the Department of Surgery at Texas Tech University School of Medicine, Lubbock, and served on the staff of all four Amarillo hospital boards.

He had a ranch near McLean and raised Beefmaster cattle. He was a member of the Texas and Southwestern Cattle Association, Texas Cattlefeeders Association, Panhandle and New Mexico Breeders Association, and participated in the Texas A & M Road to Rail. He died in 1999.

Dr. J. O. Wyatt:

J.O. Wyatt was born in 1906 in Victoria and received his Bachelor's Degree in 1926 from Samuel Houston College and his Medical Degree from



Meharry Medical College (Nashville). He did his residency in Kansas City, and then specialized in OB/GYN at the University of Southern California. He obtained his license to practice in Texas in 1932.

Wyatt practiced in San Angelo and Kerrville for seven years and then moved to Amarillo. Because he was black, Wyatt was denied privileges at both St. Anthony's and Northwest Texas Hospitals, so, with the help of his wife, he opened his own hospital at 901 North Hayden. Wyatt practiced at this location for 10 years until he was finally granted privileges at both hospitals.

In 1955, Wyatt became the first black man to seek public office in Amarillo. He ran for School Board, and a few days after announcing his candidacy, a cross was burned on his lawn. He called it a "cowardly stunt," "not worthy of notice." Previously, in 1952, a home that Wyatt was building was burned and ruled arson. The house was rebuilt, and no arrests were made.

Wyatt became Director of the Amarillo Community Chest, Director of the Amarillo Negro Chamber of Commerce, the Lobo Club and the Negro Elks Lodge. He was a member of the Masonic Lodge, the Knights of Pythias, the Phi Beta Sigma fraternity, and served as Chief Commander of the John W. McKinney Consistory.

He served on hospital committees for the Lone Star State Medical Association, was area Vice-President of the National Medical Association, and was listed in "Who's Who in Colored America".

Dr. J. O. Wyatt died in 1958, survived by his wife and five children.

In 1944, Dr. Wyatt was honored when the Amarillo Hospital District named a comprehensive health clinic, the J.O. Wyatt Sr. Community Health Center, for him. Dr. Wyatt was key to providing health-care needs to the black and Hispanic communities during the '40's and 50's.

The J. O. Wyatt Sr. Community Health is now a 45,000 square-foot clinic, housing a primary-care clinic, obstetrics and gynecology clinic, pharmacy, laboratory, x-ray facility, and ambulance station. The Center is located at 1411 East Amarillo Boulevard.

Dr. Jan Werner:

Viennese-born Jan Werner came to Amarillo in 1947. Although he was the city's first urology specialist, he was particularly interested in the care of the elderly and nursing education. Werner served on committees that established a Bachelor's Degree program in nursing at West Texas State University.

A nursing school director told

Werner of tearful studentnurses, crying after returning from training in various nursing homes. The facilities were apparently deplorable, and so Werner petitioned the hospital district to establish a concentrated program on geriatric care at Northwest Texas Hospital to train nurses and medical residents. Initially, Werner's proposal was rejected due to lack of funding, but the second petition received board support.

In 1978, the Amarillo Multiservice Center for the Aging Inc was chartered. The goal was to open a multi-service elderly day care center. The Veterans Administration Medical Center became one of two demonstration centers for adult day-care.

The Amarillo center was opened in 1978, and Werner officiated at the opening. Several days after the opening, Dr. Werner died. In honor of Jan Werner's tireless efforts to assist and provide dignity for the elderly, the Board of Directors dedicated the Center to his memory, and the name was changed to Adult Day Care at Jan Werner. Since then, the Center has moved to 3801 Fillmore St.



Today, the Center embodies Dr. Werner's philosophy, providing programs that foster independence and self-sufficiency for elderly citizens, relieving isolation and loneliness, and providing assistance to families who care for elderly relatives.

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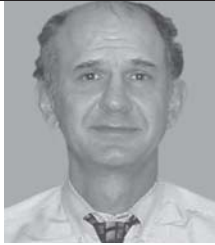


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Pediatrician, Dean and Hospice Pioneer: **Gerald Holman**

Reprinted from *Panhandle Health*, Spring 2012
by **Steve Urban, M.D.**



Gerry Holman came to Amarillo as regional dean for the Texas Tech School of Medicine (Amarillo campus) in 1979. He had an impressive academic record before his arrival—chief resident in pediatrics at Johns Hopkins, chair of pediatrics at the Medical College of Georgia at age 33, and dean at Eastern Virginia Medical School before being recruited to Amarillo. Building on the foundation of several dedicated community physicians, he is often credited as being the first “academic” dean at Texas Tech, Amarillo. After leaving the dean’s chair, he was instrumental in helping establish the hospice movement in America—indeed, the in-patient hospice unit at St. Anthony’s Hospital (now BSA) was the first one west of the Mississippi. After semi-retirement (I’m not sure that Gerry will ever fully retire), he has split time between his home in Amarillo and one in Florida, still passionately committed to medical education and the hospice model of end-of-life care.

Training and Early Career

Gerry Holman was raised in Winnipeg, Manitoba. He did a rotating internship at Johns Hopkins, initially considering a career in neurosurgery, but was convinced by an interested mentor to continue his training in pediatrics. He recalls the internationally renowned pediatric faculty at Hopkins, including pioneer pediatric cardiologist Helen Taussig and endocrinologist Lawson Wilkins, author of the first textbook on pediatric endocrinology. Gerry stayed on at Hopkins for a fellowship, where he studied the adrenogenital syndrome, and as chief resident in pediatrics.

After completing his training at Hopkins, Gerry ascended the academic ladder, working successively at the fledgling University of Saskatchewan, then at Kansas, the Medical College of

Georgia, the University of Alberta, and then at East Virginia. Within 6 months of joining the faculty in Norfolk, he was promoted to Dean of the EVU School of Medicine.

At the Medical College of Georgia, Gerry “inadvertently” desegregated the Eugene Talmadge Hospital. At this time, hospitals in the south were strictly segregated into “white” and “colored” wards. The colored wards were often poorly staffed and provisioned. When a seriously ill black child needed admission to an already-full “colored” ward, Gerry, looking past the mores of the deep South at that time, insisted that the child be placed in a semi-private room with a white child. Gerry went to the hospital administrator (whose name was Rufus Payne), and Payne backed his impetuous young academician. Gerry laughs that he “mistakenly” desegregated the hospital, but the policy stuck. He stayed at MCG for 5 years and was instrumental in gaining the first federal grants for Head Start programs in the south. He recalls testifying in Memphis, Tennessee the week before the assassination of Martin Luther King and remembers tanks rumbling down the street outside his hotel room!

Gerry’s first deanship at East Virginia helped prepare him for his pivotal role in Amarillo. EVU was envisioned as a community medical school. Gerry says that the legislature “wanted excellence but could afford mediocrity.” Fortunately, a strong cadre of community practitioners came to the aid of the medical school, and the innovative curriculum survived (despite sometimes negative scrutiny from the LCME, which seemed more interested in lab space than in student and resident teaching).

At this time Gerry met Dr. George Tyner, visionary dean of Texas Tech School of Medicine. Lubbock did not have the clinical resources to train its medical students, and Dr. Tyner was

interested in expanding Amarillo’s family medicine residency into a program that could train 3rd and 4th year students as well as residents in internal medicine, obstetrics and gynecology, and pediatrics. Gerry recalls receiving a call from Dr. Phillip Periman, then regional chair of internal medicine, who said “Holman, you ARE coming to Amarillo!” And the rest is Amarillo history.

Regional Dean, TTUHSC, Amarillo

Gerry arrived in Amarillo in December 1979 and had to provide for 6 new third year students by July. Gerry recalls strong community support from the Bivins family, Louise Evans Bruce, E. B. Williams, Carol Emeny, and Gene Edwards. He appreciates the local physicians who came to the aid of Texas Tech at that time, including internists Phillip Periman, Ted Nicklaus, Tom Nichols and Barton Grooms, gynecologist Roger Perry (who had already been recruited as chair of ob/gyn), pediatrician Rolf Habersang, and the surgeons at the Amarillo Surgical Group. The psychiatric community, headed by Jamie Quintanella and Mitch Jones, was eager to put the resources of the newly-built psychiatric pavilion to use. The 6 young men (more men than women in those days!) began their clinical rotations on time and graduated in June 1981. The first group of graduates included Dr. James Yearly, who still practices dermatology at the Amarillo VAMC. Since then almost 900 students have completed their 3rd and 4th medical school years in Amarillo and over 100 have taken up practice in the Panhandle area. It is difficult to envision recruiting these doctors to West Texas without the contribution of Texas Tech.

Gerry recalls his initial challenges as twofold: acceptance by the medical community (especially at Northwest Texas Hospital) and support from Lubbock. The most outspokenly skeptical members of the NWTH medical staff were

Early Lokey, John Jones, and John Denko, who questioned the quality of the faculty and the medical students. Medical staff members at High Plains Baptist Hospital were more welcoming, but Gerry believed that the cornerstone of the medical school had to be the county hospital. Dealing with Lubbock was equally difficult. In Gerry's first year, he had a budget of \$4,000,000. In the next biennium, the initial budget proposal for Amarillo medical education was zero! Funding was restored through the efforts of many of the community leaders mentioned above, as well as the intercession of U.S. representative Bill Sarpaulis. For several years thereafter, rumors continued to ooze out of Lubbock that the Amarillo campus would be "closed down." During this contentious climate, Gerry was fired as regional dean and went on to the next stage of his remarkable career.

Pioneer in the hospice movement

While still dean, Gerry had developed an interest in the hospice movement, which had been initiated in England by the remarkable Dame Cicely Saunders. In 1983 Gerry started working with an early hospice program at the Amarillo VA Hospital. He became director of the hospice department at St. Anthony's Hospital and, by 1985, helped raised over 4 million dollars to build the first inpatient hospice facility west of the Mississippi. Gerry recalls the tremendous outpouring of community support for the project. He appreciates the early interest of Phillip Periman (again) and Sister Olivia, who started a hospice service based on the "scatterbed" model at Saints. Administrator Jack Buckley, architect Jim

Doche, and physicians Dan Epley and Gary Rose were other early movers and shakers. Interestingly, the first patient in this hospice founded by a pediatrician was a child with Menke's syndrome.

After this successful start, Gerry became active in the national hospice movement, in 1988 helping found the organization that today is the American Academy of Hospice and Palliative Care Physicians. He was the first president of this organization, now over 2500 strong. Gerry's lobbying efforts were critical in establishing the medicare hospice benefit, which (although sometimes abused) has provided the financial foundation for the hospice movement in America. Gerry has served in leadership positions in the National Hospice Organization and the Hospice Foundation of America. He recalls helping write the first certifying exam in hospice medicine in 1996. Subsequently the discipline has become recognized by the National Board of Medical Specialists, and the exam is given to over 500 applicants each year. Truly Gerry Holman was a founding figure in the hospice movement in America.

Gerry Holman reflects on his career

Given the integral role that Texas Tech and Tech-trained physicians now serve in the Panhandle medical community, it is interesting to look back on the halting steps the school was taking when Gerry Holman got off the airplane from Norfolk on that cold December day in 1979. Again, Gerry's major challenges were earning the acceptance of the administration and medical staff at NWTH and establishing credibility with Lubbock. The former was built up

haltingly and required many more years than Gerry's 4 and a half, not reaching the current level of symbiosis until the deanship of Steven Berk. Now, it would be difficult to envision how indigent care would be delivered (at NWTH, the Amarillo VAMC and at BSA) without Tech students, residents, and faculty members. Palpable evidence of the progress that these two deans made can be witnessed in the Texas Tech campus. Gerry recalls the project to add a second floor to the Wallace Street building. State funds were grudgingly relinquished, but private funding (Gerry recalls the efforts of Jim Matthews, Dick Palmer, and the Don and Sibyl Harrington Foundation) provided over \$800,000 in short order. Twenty years later, Steve Berk (this time with solid support from the state) helped oversee the \$25 million academic building on Coulter. Many observers consider Holman and Berk the strongest and most visionary of all Texas Tech (Amarillo) deans.

Gerry remembers a visit by the world-famous ethicist, Dr. Ed Pellegrino, to the campus in 1982. At that time the medical center contained 2 hospitals (the "new" NWTH was being constructed), the psychiatric Pavilion, the speech and hearing center, the Harrington Cancer Center, and facilities to support these institutions. Dr. Pellegrino was impressed that Amarillo could be a model of the "community medical center" and encouraged Gerry in his efforts to bring this about. Gerry says that he tried to emphasize the "Academic" in Regional Academic Health Center, even though in 1984 he himself was stretched out on this RAHC.

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When asked about his “best hires”, Gerry mentions Dr. Rush Pierce in internal medicine and Dr. Cathy Phillips in basic research. Although research was never the main focus of the Amarillo RAHC, Gerry felt that a program in bench research was necessary to gain legitimacy for the campus and to make sure that Lubbock and the state legislature “took the Amarillo campus seriously.” He views his deanship in Amarillo together with his foundational work in the U.S. hospice movement and his family as his most enduring achievements.

Again, Gerry Holman, a native of Canada, has continued to maintain his home in Amarillo, where he shares the summer and fall months with wife Audrey. When asked why he stays here, Gerry invokes a spiritual explanation. He says “God wanted us to be here.” Gerry praises the community spirit of

the founding fathers and mothers of the community, almost all of whom were strong supporters of the medical center and of Texas Tech. He enjoys the Amarillo Symphony, the Amarillo Little Theater (he describes Allen Shankles of the ALT as “a genius”), and the world-class Harrington String Quartet. He has enjoyed golf at Tascosa Country Club and is still involved with the hospice movement (although I won’t record what he has to say about the proliferation of “for-profit” entities in the world of hospice care). Like others who choose to stay and live in Amarillo, Gerry appreciates the people.

Perhaps we people give too little thought to the “giants” among us, including the little pediatrician with the bow tie and big ideas, who helped bring academic health care to Amarillo and compassionate end-of-life care to America.

Table 1

Regional Deans, Amarillo Campus, Texas Tech School of Medicine

- Maurice Dyer, M.D.
October 1973-May 1975
- Clarence Mast, M.D.
September 1975-August 1976
- Lawrence Patzkowski, M.D.
February 1977-December 1979
- Gerald Holman, M.D.
December 1979-July 1984
- Walter Dickinson, M.D.
November 1984-June 1989
- E. Lee Taylor, M.D.
November 1990-January 1999
- Steven Berk, M.D.
October 1999-July 2006
- Richard Jordan, M.D.
September 2007-present

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Heal the City Clinic

Reprinted from *Panhandle Health*, Winter 2014

by Alan Keister, M.D.

After leading several medical mission trips to Central America, I began wondering why we did not have a free clinic in Amarillo. A dream was born. I have shared this vision with a number of people over the last 5 years. On September 8, 2014, the dream was realized when Heal the City Free Clinic opened its doors.

Heal the City is a new medical mission providing free urgent medical care and referral services with compassion and dignity to the uninsured in Amarillo. Our vision is to provide for the medical needs of the uninsured while connecting them to the existing health community and to share Christ's love and hope with patients and volunteers alike.

For the last 8 years, I have been taking a group of Amarillo health care professionals to Honduras to provide medical and dental services to the poor. I remember the overwhelming joy after my first trip and the satisfaction of serving those in need. The clinic was not complicated by the bureaucracy and onerous paperwork of my American practice. I came back with a refreshed sense of purpose and a desire to go back. For a few years, I really considered moving to Central America for an extended period of time to serve. After much prayer and consideration, I sensed a peace about staying in Amarillo but the desire to serve did not go away.

I began to talk about a free clinic here in Amarillo with friends. A seed was planted and soon a group of volunteers was starting screening clinics in the local schools. The screening clinic started out rather simple: target a school and offer free blood pressure, cholesterol and glucose screenings. In addition we provided dental screenings and basic physician consultations. Soon the superintendent heard about the screening clinic, and I was invited to do this in the schools of AISD. I was overwhelmed by our response at San Jacinto Elementary School. We had 500 people show up for our health screening clinic in 3 hours.

During the fair, our team conducted

a survey about where the participants received their last health care encounter. The majority had last been in the Emergency Room. After talking to several of the patients, I had a clear understanding of the need for access in the San Jacinto community. The problem is both financial and cultural. Many are limited in the ability to pay for care and therefore use the ER as a free clinic. However the cost of emergency care is high and ultimately gets passed on to taxpayers. In addition, the cultural way that many have learned to receive care is that you head to the emergency room for anything from an earache to a gunshot wound. I began to wonder what could happen if we put a free clinic in a neighborhood that used the ER at a high rate for non-emergency things.

Within a few weeks, I was visiting with parents from the school and discussing the possibility of a clinic in their community. They were very excited but wanted some input. They suggested a place that was regarded as safe to house the clinic. They also suggested that Monday night would be the best time to do it because it is the night they most often seek health care. I approached Pastor Tommy Fulgham from Generation Next Church. He immediately joined in and soon Heal the City Clinic had a home. The problem of course was that we had no money. I am still amazed at the generosity of our community. The next thing I knew I was standing before the Harrington Cancer Foundation giving a presentation. We have been richly blessed through 2 generous grants from HCF and the Panhandle Women's and Children's Fund. Baptist Community Services provided a grant to Generation Next to renovate a small house and Pastor Tommy transformed it into a medical clinic.

Heal the City Clinic is blessed to have developed key collaboration relationships as well. Amarillo Area Foundation has graciously started a fund for our grant money and other donations. Texas Tech School of Medicine and School of Pharmacy

are providing staff and students to volunteer at the clinic. We are in the process of getting a Class D pharmacy license, and Maxor Pharmacy is assisting us with our formulary. We are also in close contact with the J O Wyatt clinic, Regence Health Network, Hillside Clinic, and Texas Tech as we seek to help patients navigate our local health care system.

Our goal is to meet the urgent care needs of the uninsured in Amarillo and to keep people out of the ER. We want to change the way they learn to receive care. We have local providers volunteering to see patients. We have social workers arranging follow up and getting them plugged in to appropriate clinics. We believe we have the opportunity to be a blessing to Amarillo. I also see this as a mission – a way to live out in my faith in my actions. In Matthew 25, Christ calls us to serve to the "least of these."

We will only be open on Monday nights to start. We wanted to start small so we can serve well. As the volunteer pool solidifies, the goal is to open on Thursday night and possibly Saturday. At this time, we have several volunteers in primary care, but my goal is to get subspecialists to join us as we seek to serve in Amarillo. We had our grand opening on Sept 8. One of the first patients came in with a complaint of jaundice. The pediatrician came to find me and ask for a liver specialist. Imagine her surprise when I introduced Dr. Tom Johnson, a hepatologist who was volunteering that night. I am so thankful for my incredible colleagues in this community. Please come join us at the clinic. We do have a website www.healthcityamarillo.com and you can easily fill out a volunteer form and sign up for a clinic night.

As an Amarillo native, I grew up with all the blessings this great Panhandle community provides. I was glad to come back home and to open an internal medicine practice here in 2000. Heal the City Clinic is really just an extension of my desire to serve the people of Amarillo—the place I call home.



Mercy Ships

Reprinted from *Panhandle Health*, Summer 2008

An Interview with J. Brian Sims, M.D.



Dr. Rouzbeh Kordestani graduated from Tulane University School of Medicine. He completed his internship at UCLA Medical Center and his residency at Harbor UCLA Medical Center. His specialty is Plastic and Reconstructive Surgery. Dr. Kordestani is a member of PRCMS and is currently in private practice.

Dr. Kordestani: Hi, this is Dr. Kordestani. I am here interviewing Dr. Brian Sims, one of the orthopedic surgeons here in the Panhandle. We are going to go ahead and discuss his most recent adventure over in Africa. I am going to go ahead and hand it over to Dr. Sims himself. Dr. Sims, why don't you go ahead and start by telling us about yourself and the newest project?

Dr. Sims: I've been in practice here for about 13, or going on, 13 years now. I practice orthopedic surgery here in the Panhandle, doing mostly upper extremity. But my actual subspecialty training is in pediatric orthopedics, for which I trained at Scottish Rite Hospital in Dallas. I became acquainted with Mercy Ships during my time in medical school through the organization there called the Christian Medical Society. I thought it was an interesting project. Later on, one of the residents that was several years ahead of me in my residency program at Texas Tech joined Mercy Ships and actually started the orthopedic program there. And that's kind of my first introduction into the orthopedic program there. After that, another orthopedist, James McDaniel, that I used to work with some in Abilene when I was moonlighting as a resident, later came on board Mercy Ships and has taken over their orthopedic program. He would contact me from time to time with different projects that they had coming up, and the need particularly for a pediatric orthopedist. In 2003, I believe it was, he called me and asked if I would be interested in

going to Togo, which is in West Africa, to serve as a pediatric orthopedist. So I went there to work for two weeks, doing pediatric orthopedics, correction of limb deformities and club feet mostly. Since then I have gone back on another mission with them to Honduras, where we would do just solely orthopedics, and worked in one of the inland government hospitals. We did a couple weeks; mainly neglected trauma was what we worked on there. And then this past summer of 2007, I went to Liberia for two weeks and worked on the new ship they have, called the Africa Mercy, and did two weeks of pediatric orthopedics as well.

Dr. Kordestani: Wonderful. So let's concentrate on the most recent trip over in Liberia. Can you tell us some more specifics about the trip?

Dr. Sims: It had been a number of years since Mercy Ships had been to Liberia. They moved to doing more longterm outreaches, between 6 and 9 months. They had been using a ship... the original ship I worked on in Togo was called the Anastasis. The Anastasis was a ship they bought nearly 30 years ago. It was an old Greek cruise liner and Anastasis is actually Greek for "resurrection." So this old ship was kind of resurrected as a hospital ship. But being a cruise liner, even though it had been refitted as a hospital ship, obviously it wasn't well built for a hospital ship. So approximately eight years ago they were given a train ferry from Norway that had a large empty bay, where obviously the train cars pulled into, and it made a perfect place to build and develop two floors of a true hospital in the ship. So last summer in Liberia was the maiden voyage of that new ship. About two weeks before I got there they actually moved all the hospital out of the old ship, the Anastasis, into the new ship. When they are in port, they do many different programs at once. As far as medical programs, they do maxillofacial surgery, cleft lips. They

Dr. Brian Sims attended medical school at Texas Tech University in Lubbock. He also completed his internship and residency at Texas Tech. Dr. Sims is board certified in Orthopaedic Surgery with special training in Pediatrics. He is a member of PRCMS and is currently in private practice.

do plastics as well, mostly scar and burn revisions and such. They do VVF surgery, which stands for vesicovaginal fistula surgery. In Africa it is a big problem with women having contracted labors that end up with them developing a fistula between the bladder and the vagina. Those women are kind of outcasts in their society until that can be fixed. So they provide that service. Lots of ophthalmology, cataracts are dealt with. Then there is the orthopedic program.

Dr. Kordestani: That sounds really interesting, Dr. Sims. How often do the teams actually make the journey to places like Liberia?

Dr. Sims: They usually will rotate between several different countries. Typically what they do is...now, they will spend 2 to 3 months restocking the ship and putting the ship in dry dock to do the maintenance and such. That's usually done during the winter months. So about February they then go to whichever country they are going to go to and they dock there. At this time they are usually going for a 9-month period. So the ship pulls into the dock. Of course, there is an advance team that goes ahead and tries to make contact with physicians in the area that will be able to help and assist with some of the on-going care after the ship leaves, and just getting the word out. So then the ship comes into dock. It usually takes about a week to get all the vehicles off-loaded and get things set up there. Then they will have a screening. Usually they will use one of the outdoor soccer arenas, where they

can have thousands of people come. So the word is out that the ship is here and all these people go to the soccer arena to be screened, for usually 2 to 3 days. At that time they screen most of the people that receive surgery through that nine month stay that they are going to be there. They are given cards to tell them when to return to the ship. Then, when those patients come, they are usually admitted the day before and have their surgery. They stay on the ship until they are ready, until their postoperative care is far enough along that they can go off the ship and go home. The follow up care is sometimes done by some of the local physicians, if there has been contact with some of those. But typically, say with the orthopedic...we have an orthopedic P.A.-C. that is there for three months after the last surgery is done typically. So we get these people well into their post-operative care before we release them on their own. They do as much as they can for these people to have on-going care. But always there is a big limitation and oftentimes...this year is a little bit of an anomaly because they were in Liberia

last year and they returned to Liberia this year. They were actually planning to go to Sierra Leone this year but because of some of the political changes and such there, that was not really possible. So they decided to go back to Liberia and spend another tour of duty there. I'm not sure where they are going the year after that. But typically to Gambia, Sierra Leone, Liberia, and Togo. Those are the main countries there in West Africa that they serve.

Dr. Kordestani: You mentioned the advance teams. There are screening teams and then there is actually a surgical team, and also post-surgical care. Just briefly, who else goes? Who comprises the teams?

Dr. Sims: There are actually even more teams than that. When Mercy Ships goes into an area, there are many different teams. There are some teams who are working in community development, so that may mean going into some more of the up-country villages and helping them with developing a safe water supply. There may be some building teams who go in and are helping an orphanage or a clinic. There are people going in

and helping them teach people to read. So, there are lots of different teams out there. I also forgot to mention that there is always a dental team, too. The dental teams go out into the community. They don't really do any of that on the ship. On the ship itself...the ship is very much like a small city. You really have to have people from every walk of life. You have to have people to cook, engineers, electricians, plumbers, welders, air conditioning, information technology, P.R., you name it. The unique thing about Mercy Ships is that everybody, from the CEO of the organization to the captain of the ship to the engineer in the engine room, everybody donates their time. So there are no paid positions. Actually, everyone pays to be there. Everybody pays their own crew fees and pays their own way there and back when they work on that ship. There is sort of a division between long-term people and short-term. Short-term is anywhere from two weeks to a year of service on the ship. If anyone wants to spend more than one year on the ship, then they have to do

| continued on page 34

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| continued from page 32

some formalized training with Mercy Ships, which is usually about a six month process before they can become long-term staff of the ship.

Dr. Kordestani: So just to clarify here, practically everybody who goes through this effort does it as a volunteer and does it through some sort of a group effort with the focus being this larger volunteer effort?

Dr. Sims: Right.

Dr. Kordestani: It's interesting, the things that you mentioned. Specifically, is there any group of patients that you treat? Or who do you treat?

Dr. Sims: I think the main thrust of the...of course, these countries being so poor, and they don't have any organized healthcare. Unless people have an ability to pay, they don't...they cannot receive healthcare in their own country. And say, just taking Liberia for an example, the population of Liberia is around 3.5 million people. We were only able to local two orthopedists in that entire country. And one of them had cancer and basically was retired since last year. So there is one orthopedic surgeon for a population of 3.5 million people. So the need is tremendous. So really, they treat whoever comes with a need.

Dr. Kordestani: So all comers.

Dr. Sims: All comers. But not everybody has a problem that we have the expertise or the people coming to treat. So that's where the screenings come in. But it's not...I mean, there are people from the city. In Liberia we went to Monrovia, which is the capital city there. There were a lot of people from Monrovia itself. But you have people traveling for days to reach there from up-country down into that area because they had heard that the ship was coming. So when I was there, we continued to do screening on the dock. Every day there would be people show up and we would go down and see if they had a problem we felt like we could help them with. So yeah, whoever has a need and we have the ability to help.

Dr. Kordestani: So after you go through and treat all these people, and from the sounds of it, you treat a significant portion of people that otherwise would never receive care, then

who does the follow up? Where do they go from there?

Dr. Sims: Some of those that have surgery will follow up with the P.A.-C. that's on board the ship and will be there typically for the duration of that outreach. That nine month outreach. Beyond that, if it's somebody that we know is going to need on-going care, we try to make contact with, in our care, an orthopedic surgeon there, so that if that patient has complications or has problems, that they would be able to have somebody that would agree to see them. Oftentimes, like in Togo, we found several orthopedists and we had some implants, some plates and screws, that we were able to offer them. Of course, that stuff's like gold because they actually do hardware removal so they can reuse the hardware on patients because it's very scarce.

Dr. Kordestani: So they actually remove hardware from patients who don't otherwise need it, sterilize it, then get it ready to be reused? Just because there is such a shortage?

Dr. Sims: Yes. Such a shortage. So we were able to say, "Would you be willing to take care of any of these kids if they have problems after we leave, and as a sign of appreciation, we'll give you some of these implants." We are able to work out a situation where the orthopedist will say, "I'll be happy to do that and thank you very much for those things." So we try to work that out. It doesn't always happen. I think that's the real argument about missionary medicine. By western standards, it's not the best. Because in the west we wouldn't think of leaving somebody without follow up care. I mean that would be patient abandonment in a sense. But when you have somebody who has absolutely no other option, it's the next best thing, if you're not able to arrange that.

Dr. Kordestani: Listening to you, it seems like it's been probably a life-altering experience in some ways. Going with that, what do you take away from this?

Dr. Sims: I think every time I go, I feel like God teaches me something different. I think on this last trip to Liberia, what I was really struck by was that you have people who have absolutely nothing, and yet they show contentment and joyfulness

in their lives. There are many Christians in Liberia. Going to church there and seeing those people, in spite of the just absolutely horrid conditions that some of them have to live in, they have true joy in their hearts. And I thought, you know, these people, there is no way that they can go and give money towards a mission or go and do mission work. They are struggling to survive every day, and here I am in the west, with untold riches by their comparison. I feel like I have no choice but to serve. I feel very much that that's part of my service back to my God, is to be able to help those people who can't help themselves. So that's what I take from it. It's a very deep sense of gratification that you make some kind of difference.

Dr. Kordestani: That's very admirable. Would you go back?

Dr. Sims: I was actually going to go to Sierra Leone but when they had to switch from Sierra Leone back to Liberia, their schedule was full because they didn't have as much of an orthopedic schedule as they were going to have in Sierra Leone. I'll wait and see if they are able to go next year. I've heard that they are going to be able to go back to Honduras in 2009. I'd very much like to do that because I really enjoyed working with the surgeons in Honduras. It was a different experience because it was just strictly an orthopedic outreach. We didn't have the whole ship and all the other outreaches going on. Each one is very different. But each is a very neat experience.

Dr. Kordestani: From your experience, or at least the knowledge that you have right now, what projects are pending?

Dr. Sims: I don't know of any. I'm not sure how to answer that. I know they are in Liberia right now and they are going to be there through the first part of the fall. I don't know what their plan is. I'm sure they already have where they're going to be next year already planned out. But I don't know what that is. I know from just the orthopedic department of the Mercy Ships, they are planning to go, I think in the late summer or fall of 2009. As far as new ships or anything, they used to have, I think, three ships. One of them was very small and didn't have any operating

facilities on it. They eventually sold that ship. They had another ship that had one small operating room, just big enough to do some ophthalmology.

That ship has been retired. So they are really down to just the one big ship that they have now. They have six O.R.s and about 75 hospital beds on it.

Dr. Kordestani: Right now, as you are aware, there are on-going efforts, it's just that it's something that we need to look into to get the specifics.

Dr. Sims: Right.

Dr. Kordestani: So it's a definite ongoing effort and it's year-round, the different projects both in Central America and in Africa.

Dr. Sims: Right.

Dr. Kordestani: The group has a commitment to do this from now on?

Dr. Sims: Yes. They've been going for over 30 years now.

Dr. Kordestani: So they've been going for 30 years? So that's a definite show that they have resilience.

Dr. Sims: Yes.

Dr. Kordestani: Okay. That's wonderful. That's wonderful. That being all said, and again it's been very admirable

to listen to you and your story, what about other physicians? Other health professionals who want to get involved? How should they proceed?

Dr. Sims: If they want to get involved, the international operation center for Mercy Ships is in Garden Valley, Texas. It's just outside of Tyler, about an hour east of Dallas. Their international operation center is there. If you are ever in that area, it would be a very easy thing to go and visit. But probably the best thing for most people would be just to go to mercyships.org and get on their website and go through there and fill out an application for medical service. Really, there are not too many subspecialties that could not be filled because even the head general medical officers on the ship go out and do immunizations and things like that that take care of the crew. I helped take care of a lady with schistosomiasis when I was there. For a few hours I thought that I might have to do a cholecystectomy, which I had not done in nearly 20 years. (laughter) I realized when they called me and said, "Are you the general surgeon on call?" I was like, I don't think so. They said, "Well, we're

all kind of getting together down here to look at this lady and try to figure out what is going on." So I went down there and I was like...I'm the only surgeon here. (laughter) The other guys are gone. So that was interesting.

Dr. Kordestani: That's actually pretty funny. Well, Dr. Sims, to be perfectly honest and fair, do you have any regrets?

Dr. Sims: No. Not at all. I think my only regret is that I haven't been able to take my family with me yet. That's something that's really just from a space...you know, there's not enough space on the ship to house everybody. That's something that I do have a goal in the future, is to take some of my family members as I go. But as far as regrets, I plan to continue to go whenever I can.

Dr. Kordestani: Again, thank you for sitting with us for this interview. I think the people and the readers of Panhandle Health will find this not only enjoyable but also educational for the most part. Hopefully we can get more people to contribute. Brian, thank you again for your help.

Dr. Sims: You bet.

Dr. Kordestani: Good day, sir.



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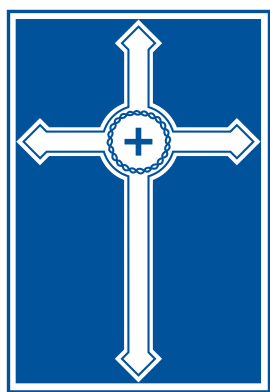
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The Patient-Centered Medical Home

Reprinted from *Panhandle Health*, Spring 2013

Rodney Young, M.D.

Like it or not, the Patient Protection and Affordable Care Act (ACA) is the law of the land, and since the President has been re-elected and the Supreme Court has already ruled, its provisions will continue to be implemented in the coming years. Its nearly 1000 pages contain dozens of provisions penned with a goal of increasing coverage, improving quality, and containing costs, though obviously we remain sharply divided as a nation with regard to how effective or ineffective those provisions will be in achieving their goals. A key concept in the planned reforms is the creation and cultivation of a robust primary care infrastructure, an ideal supported by both data and experience from healthcare systems around the world. The Patient Centered Medical Home (PCMH) is one way that primary care can help accomplish these goals, but what is a PCMH? Where did this term come from, and what is the role of a PCMH in the future of health care? As we enter a new era in American healthcare, it is important to understand what the PCMH is and how practices may adopt this model.

The term, "medical home" was first coined by the American Academy of Pediatrics in 1967 to describe comprehensive medical care. In 1978, the World Health Organization began to define what constitutes a medical home. In the 1990s, medical home models began to be cited in the medical literature as a potential solution to the rising costs in healthcare. In 2006, as a result of the joint efforts of the four major primary care physician associations -- the American Osteopathic Association, the American Academy of Family Physicians, the American College of Physicians, and the American Academy of Pediatrics -- the Patient Centered Primary Care Collaborative (PCPCC) was founded. One year later, the PCPCC released the "Joint Principles of the Patient Centered

Medical Home", which outlines the basic tenets and ideas behind the medical home model. Since that time, many medical home accreditation programs have been developed. Now, with the Affordable Care Act, there are incentives in place for practices to reach a "medical home" designation. But what does that actually mean?

The joint principles that were established by the PCPCC characterize a primary care setting in which comprehensive medical care is provided for all individuals. These principles include:

1. A personal physician
2. Physician directed medical practice
3. Whole person orientation
4. Integrated/coordinated care
5. Healthcare quality and patient safety
6. Enhanced access to care

In order for a place to feel like home, it needs to be comfortable and familiar, and a medical home should be no exception. In a medical home, each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care. Ideally, the patient should be able to see the same physician on each visit to promote the development of a physician-patient partnership, and to increase comfort and efficiency of the visit. Enduring doctor-patient relationships not only decrease the need for redundant history taking, but also allow the doctor to better understand their patient's informed values and preferences, and may lead to reduced use of ancillary testing as well.

An office visit is a complex web of interactions for a patient and almost all of them are with someone other than the physician. Despite a physician's desire to give the patient optimal care, ultimately the product is a result of how the office and staff functions as a whole. Every part of the office has an important function and role to play in patient care. Medical



John Slaton, D.O.

homes emphasize physician directed, but team-based, medical practice where the primary physician guides and directs staff members, so that each member of the PCMH team feels a collective responsibility for the ongoing care of the patient. When all parts of the office are functioning smoothly, patient care becomes more efficient, creating happier patients, and happier staff members.

The whole person orientation of the medical home refers to the responsibility of the personal physician and primary care team to provide care for all of the patient's needs. The PCMH cares for the patient at all stages of life, from preventive care, to treating acute illness, to chronic disease management, to end-of-life care. The PCMH physician should be able to provide care in any of those circumstances, and to recognize, refer, and coordinate their specialty care when appropriate. This contrasts with the gatekeeper concept of the 90's, which focused more on restricting referrals to control costs. The whole person orientation of the PCMH recognizes that complex illnesses frequently require care from many different specialties, each of which views the patient through a different lens, in a system where communication is often difficult or inadequate. The PCMH offers first contact care for any problem, which further enhances the physician-patient partnership and establishes trust in that relationship.

The concept of whole person orientation also necessitates the next major principle of the medical home: care coordination and integration across the healthcare spectrum. The PCMH physicians and staff share responsibility for coordinating care to provide the best outcome for the patient possible in light of their multiple different healthcare needs. When care occurs in silos, ordered by many different providers in many different settings, it introduces more and

often redundant testing, and adds expense and sometimes risk to the patient and the system. When the PCMH is functioning optimally, care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it, in a culturally and linguistically appropriate manner.

Healthcare quality and patient safety are essential to the PCMH model, but what defines healthcare quality, particularly in a patient-centered system? Stronger patient-physician partnerships promote better communication, giving patients the opportunity to make informed decisions about their healthcare, and are associated with higher patient ratings of care quality. In the PCMH, evidence-based medicine and clinical decision-support tools guide decision making, and information technology is used to support optimal patient care, performance measurement, patient education, and enhanced communication. The medical home model also suggests that patients be polled about the quality of their visits and their overall satisfaction with their care, and that physicians engage in benchmarking and continuous quality improvement initiatives to keep the focus on patient-oriented outcomes that improve health. The PCMH model also suggests that physicians continually look for quality improvement ideas. The PCPCC recommends that offices be evaluated for recognition by one of the many available

entities (e.g. National Committee for Quality Assurance) to demonstrate that the office can provide services on a level that is consistent with the standards of a PCMH. Through the Affordable Care Act, there are now incentives for PCMH recognition. Ultimately, more medical homes will lead to lower healthcare costs, better quality of care, and greater patient satisfaction.

Finally, enhanced access to care refers to the ability of a patient to communicate with his/her doctor. The medical home model suggests that clinics begin to use open-access scheduling, a system in which a fraction of appointment times are set aside for scheduling within 24 hours. The model also suggests extending clinic hours for access during the evening as well as improving communication afterhours between physicians and patients. The use of an EMR system could be one potential way to improve communication between patients and physicians. Giving patients a "portal" to the EMR (so that they may access their records and labs as well as make appointments and refill requests) would greatly reduce the number of phone calls taken by clinic staff, giving them an opportunity to focus more on the patients in the clinic. It also gives patients a sense of control and encourages them to take ownership of their medical care.

Positive results have already been shown from practices who have achieved PCMH recognition. The PCPCC has released a report in 2012 entitled "Benefits of Implementing the Primary

Care Patient Centered Medical Home: A Review of Cost and Quality Results". The data reviewed clearly shows practices that have transitioned to the PCMH model have had better patient outcomes and increased satisfaction both on the part of the patient and provider. This report also shows that this model decreased hospital visits and emergency department expenses, thus helping to lower medical costs as a whole.

A strong and efficient primary care infrastructure will be a critical, central piece in solving the nation's healthcare puzzle. The transformation from the practices of yesterday into the patient-centered medical homes of tomorrow won't take place overnight, but primary care will become a focal point of healthcare under the new reform laws. As more and more practices transition to the PCMH model, we will be able to care for our patients better than ever before. With hard work and effort, we can achieve the "Triple Aim" of the PCPCC: improving the patient experience, improving the patient outcome, and lowering overall cost of care.

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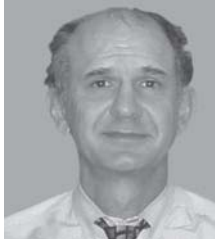
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Steve Urban, M.D.



Jaime Zusman, M.D.

Affordable Care Act: Dr. William Biggs Interview

Reprinted from *Panhandle Health*, Spring 2014

Dr. Biggs is a highly respected endocrinologist and diabetologist; he is affiliated with Amarillo Medical Specialists. He has been a driving force for years in improving the quality of diabetes care in Amarillo. Recently, his group has been instrumental in establishing the first Accountable Care Organization in Amarillo. He was kind enough to devote a noon hour to this interview.

Dr. Zusman: What, in your opinion, are the most notable reforms of the Affordable Care Act?

Dr. Biggs: Well, there are actually some good things hidden within the Affordable Care Act. One of those was the legislation enabling the formation of the Accountable Care Organizations, which if properly implemented can lead to improvements in patient care and reduced cost, and also allow physicians to work collaboratively to improve their practice. It allows the physicians, for instance, to negotiate collaboratively with insurance companies on items that need negotiation, such as: how do you manage your patients, what pre-authorizations do you need, what kind of formularies do you have, and what kind of fee schedule do you get from the insurance companies. So, we felt that this legislation enabled us to work more directly with insurance companies and more positively with insurance companies as far as both fee schedule issues and also patient care issues.

Dr. Zusman: So you think it will give physicians more negotiating power?

Dr. Biggs: It absolutely does.

Dr. Urban: To follow up on the question, what are the differences between what is in the Affordable Care Act and what we had before?

Dr. Biggs: Well, previously physicians could not work together because of

antitrust concerns, Stark concerns, kickback concerns. There is a substantial protection as far as Stark and antitrust risk for physicians that work together in an Accountable Care Organization. This was introduced in the Affordable Care Act.

Dr. Urban: Are there any other differences that you can tell between the old system is and the Affordable Care Act?

Dr. Biggs: Well, I think there are other parts of the Affordable Care Act that are improvements, such as: getting rid of pre-existing conditions, having mandates for consistent vaccination policies, improving access to insurance. I think one bad thing about the Affordable Care Act is that it has given cover to the insurance companies for a lot of bad behavior.

Dr. Zusman: Such as?

Dr. Biggs: For just about every bad behavior you see from an insurance company lately, they have blamed it on the Affordable Care Act, and that is not always the case. Termination of plans and rate increases have all been blamed on the Affordable Care Act. But, the insurance companies are now limited in terms of how much they can charge in administrative fees. They have to refund any excess, so many of the Blue Cross plans have been overcharging their patients and then refunding the difference at the end of the year to those patients. So, it is that kind of bad behavior that they blame on the ACA.

Dr. Zusman: Has the ACA really gone in to effect?

Dr. Biggs: Unfortunately I think this has been so heavily politicized that everybody makes the assumption: well, if it is included in the Affordable Care Act, it has got to be bad. The whole concept of the Accountable Care Organizations, for instance, came out during the Bush

administration; so, the Republicans were actually heavily involved in the creation of these organizations. It is not a Democrat-Republican issue or a Tea Party issue. This is more of a common sense approach to how doctors should work together and not provide care that is as fragmented as we have had the last couple of decades.

Dr. Zusman: Let's go on to the second question. What, in your opinion, are the benefits of this legislation, first for patients.

Dr. Biggs: Well, we had, in my own practice for instance, a large number of patients who simply could not get insurance because they had diabetes or adrenal insufficiency or something that insurance companies just did not want to insure. If they could find a plan it would cost \$1500.00 a month. Now they can get insurance that is affordable. We did have the Texas high-risk plan under Governor Perry but, due to changes that were made by the State of Texas, the cost of that plan went from about \$400.00 a month to \$900.00 a month. So even that became unaffordable. Now, a patient with diabetes or any chronic illness can get an affordable plan anywhere from, depending on their age, \$250.00 to \$450.00 a month, and they often qualify for a subsidy to help with that as well. That's actually a very positive thing for patients. They have to be very careful in shopping for a plan, though, because some of the plans are simply horrible.

Dr. Urban: Too high a deductible or just not good coverage?

Dr. Biggs: Either they have a physician panel that is next to nonexistent or they have an enormous deductible, making it more of a catastrophic plan. But if you actually have a chronic illness, you need something better than that.

| continued on page 42



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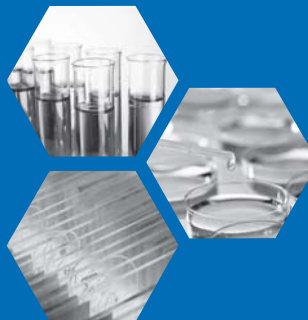


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Dr. Urban: So a patient who is shopping around needs to double check to make sure that their physician is on the panel?

Dr. Biggs: Right. Or, at least they need to know that somebody on the plan can take care of their issues. I recently looked at one low cost exchange plan, for instance, and the only pulmonary doctor was somebody who only works inside a hospital. There was no endocrinologist; in fact almost no specialties--either surgical or medical--were included in the plan. So, unless you are a relatively healthy person, you probably wouldn't want to touch that plan.

Dr. Urban: So the buyer has to beware on those kinds of plans.

Dr. Biggs: Yes, and, unfortunately, since all of this is so new, there is nobody to really guide you to look for these problems. The State of Texas abdicated on its role in that they are not going to help because they frankly are in opposition to the whole concept. I think it was a mistake for Governor Perry not to implement a Texas-based exchange. If you consider that healthcare is about 1/6th of the economy, to give control to Washington DC rather than keeping it in Austin, I think was a big mistake. They have philosophical problem with the whole concept, but it is here, it is real, I don't think it is going to go anywhere, and unfortunately now Washington is calling the shots instead of Austin. I think strategically that was a misfire.

Dr. Zusman: Very interesting. Next question. What, in your opinion, are the benefits of the legislation specifically for doctors?

Dr. Biggs: Again the part that enabled Accountable Care Organizations was a huge plus for doctors whether you belong to an ACO or not. That is going to empower the doctors to have more control vs. the insurance companies. Also, if we consider that Texas is one of the worst states in the union as far as the number of uninsured patients, the fact that more of our patients will have some coverage to take care of their serious healthcare needs--that is going to

improve the economics for physicians. There will be less unreimbursed care.

Dr. Zusman: What, in your opinion, are the benefits of this legislation for hospitals?

Dr. Biggs: Well, similarly, the unreimbursed care. As more people are insured, we will have fewer write-offs for patients that are totally uninsured. Hospitals under the ACA have a bit more risk--in that, to whatever extent improvements in care delivery reduce hospital utilization and hospital admissions, that could affect the hospital bottom line as well. Cost reductions are going to happen primarily with people who have insurance rather than people who don't have insurance. So, for instance, in our Medicare ACO, we reduced our admission rate by 12%; our CHF admissions are down 16%. To whatever extent that gets disseminated into the general community, you are going to see fewer hospital admissions, and that could adversely affect the hospital's bottom line.

Dr. Zusman: So, it's good for patients and good for healthcare in general, but may put a strain on the economics of the hospital.

Dr. Biggs: It could. And that could also more seriously impact rural or outlying hospitals that don't have access to a more organized care system. Time will tell how that plays out.

Dr. Zusman: And, what are the benefits of this legislation for the country?

Dr. Biggs: Well, to whatever extent it reduces our overall healthcare cost, that will be a huge benefit.

Dr. Zusman: Do you think that will happen?

Dr. Biggs: We are already benefiting today here in Amarillo with our ACO. You know, health care costs are a huge burden for our competitiveness level vs. other countries. Why are jobs going overseas? Twenty percent of the cost of your Chevrolet is healthcare for the guys who put it together, whereas the cost of healthcare in Japan or Mexico is less. That makes us less competitive as a country.

It makes Amarillo less competitive as a city for a company to relocate here if we have a higher than average medical cost in Amarillo compared to other cities. It is not just us as a country. Think locally; if Amarillo had a lower healthcare cost base, that would make us more attractive to the Bell Helicopters and other large companies that may want to locate a facility here. I recently attended a session given by the medical director for IBM. One of the first things that they look at, when looking for a new regional center, are local healthcare costs. If you are above average, you are not even included in the first cut.

Dr. Urban: And you think the major thing that is going to bend the curve is the ACO?

Dr. Biggs: ACOs are one mechanism. The insurance companies have tried everything within their power to lower costs. Some of them obviously are maladaptive--they sometimes have these crazy formularies that require a lot of effort on the primary care physicians to comply with them. Basically, they are asking physicians to do all this extra work for relatively small benefit. But, what if we could just work smarter? What if we had a system where we didn't have to wait a couple of weeks to get each other's records, for instance?

We implemented the first Health Information Exchange in Amarillo to get around that problem. We can see hospital records quickly; we don't have to duplicate tests because we see that somebody else has already done them last week and here are the results. Another example: our ACO found that home health care costs were higher in Amarillo than average. So, we identified the home health care agencies that provided the best quality and lowest cost. We told the hospitals: for our patients we want you to use these three agencies over all the others because we think they do a better job and we think that they are more cost effective.

Dr. Urban: Before ACOs, who cared, right? As a physician, it wouldn't matter to me how much they charged, but with ACOs it begins to matter.

Dr. Biggs: It does matter and it makes the physician somewhat accountable for the total cost. But physicians have always wanted to have more cost effective treatment for their patients, it is just that they never had access to that information.

Dr. Urban: Cost information?

Dr. Biggs: We had no access to information either on quality or cost. Now our doctors do have that information and they are using it. And they are using it to the benefit of the patients. You know, yesterday I had a call from one of the home health agencies that wasn't in our top three. He was extremely disappointed, but he was also almost the highest-cost home health agency out there, and his quality was not any different than the rest. So I said we really can't work with you unless you can demonstrate to us either that you have superior quality or that you cost significantly less. How you do that is up to you, but that is what we are looking for! He had never in his life had such a conversation with a doctor. Again, that is physician empowerment. Now doctors who are referring to home health agencies have information like Consumer Reports that they have never had before. Patients will benefit and they should appreciate that, but it also returns control for the total responsibility for the patient's care to that primary care physician. That is the way it used to be, and we have gotten away from that. Now we are getting back to the physician being more of the executive director position for the benefit of his patients' health.

Dr. Zusman: Let me get on to the other side of the coin about some of the disadvantages of this legislation. What disadvantages do you see for patients?

Dr. Biggs: Well, it has been a very disruptive thing as far as the insurance market. It has caused charges to go up for people who are already insured. It has resulted in some availability problems, such as people getting dropped from their insurance plans, especially insurance plan that do not fully comply with ACA. How big a problem, I guess time will tell. So far, for my patient base, since I have so many people with diabetes, it has actually been more of a positive than a negative--

just due to improved access to affordable insurance.

Dr. Zusman: What disadvantages do you see for doctors?

Dr. Biggs: Due to the psychological makeup of doctors, some have trouble dealing with change even though it is a constructive change. I think that we are going to see changes in payment that some doctors may not be comfortable with. We may evolve from pure fee-for-service to a system with more performance or quality measures as part of their payment mix. This may be difficult for some folks to adapt to. Inherent in some of this legislation is a push towards more information technology approach that some people will have difficulty with. We have to understand that and be prepared for that.

Dr. Urban: Let me ask you a question related to that. Some subspecialty groups are really worried about the ACA as cutting their income or decreasing the number of procedures that they can do. Do you think that is a legitimate concern?

Dr. Biggs: It is a legitimate concern. I have been asked to speak to the American Association of Clinical Endocrinology at their annual meeting this year on how the Affordable Care Act will impact an endocrine practice for instance, and I think it does have the potential to decrease reimbursement. However, particularly in Texas, we have to balance against that the fact that we should have more insured patients. I think there is going to be plenty of work for everyone. I am actually more concerned with there being an insufficiency of physician supply, rather than having specialties that are going to be underutilized. There could be some procedures that will become less popular, but these procedures may be over-utilized today under our current system. Some of these changes are more related to evidence based medicine, rather than the Affordable Care Act. But if there is not good evidence for doing a particular test, procedure or type of treatment, as we see physician collaborative groups grow and thrive and as we become more evidence based in our approach, specific types of treatment or procedures may fall

into disfavor. But, that has always been the case; it is just going to happen a bit more rapidly now.

Dr. Zusman: We talked a little bit about some of the disadvantages this legislation would have for hospitals. Would you like to add anything at this point?

Dr. Biggs: Yes, again I think that the net effect for hospitals is going to be positive, just due to having more people with insurance coverage, rather than having a huge roster of unreimbursed care. I think it will be net positive for the hospital. Hospitals that are the most innovative are going to seize the opportunity as they see that payment models shifting away from fee for service; so they are going to try to set up care systems that include them in some way. Either they have their own in-house roster of physicians and have their own healthcare system, or they are strongly allied with larger physician groups. Either way, we will have a more collaborative approach.

Dr. Zusman: What are the disadvantages of the Affordable Care Act for the country in general?

Dr. Biggs: I think the worst thing about the ACA is that it has been so divisive. People have drawn the line between Republican vs. Democrat, and really healthcare should supersede all of that. We don't seem to be pulling the rope in the same direction now. It has been such a bitter battle on both sides; I don't think that has been good for the country.

Dr. Zusman: What aspects of this legislation would you change?

Dr. Biggs: Wow. Nobody has asked me that before!

Dr. Zusman: Imagine you were running for president!

Dr. Biggs: Well, the first thing is, the whole way the exchanges were organized, the way they were created and regulated, such as how insurance companies can enter their products into the exchanges, I think has been a real mess--and not just the website implementation. Just getting into the exchange is a mess and so is

the fact that in our marketplace we only have two companies participating in the exchange.

Dr. Zusman: What are those companies?

Dr. Biggs: Blue Cross and Firstcare. We need to have a really robust market in order to have the level of competition necessary to really contain costs. It evolved this way because the legislation had a whole set of complex rules. Then we let employers out of the mandate for an extra year but continued it on people, and still people aren't signing up. Legislation written in such a complicated way is almost impossible to properly implement.

Dr. Urban: This leads to a related question, which is: do you think that the problems that you've alluded to are simply a matter of fixing an information technology computer glitch, or are these problems inherent to the plan? Is the plan just so complex that the regular American citizen will never be able to

understand it?

Dr. Biggs: Well, I guess they can fix the website, but that is really not the biggest part of the problem. We have a government run exchange; perhaps we would have been better off with an exchange system that is run by the private sector. The private sector may have done a better job. Again, because of philosophical reasons, the State of Texas lost the opportunity to operate the exchange themselves, whereas if they had been more practical about it, the state could probably have done a better job. You know, if we had hired Amazon to run this, things would have turned out a lot differently. But there is still the problem of how insurance companies get their products into the exchange plan. For instance, we had an exchange plan in development with Coventry that was going to be a super plan. It had a lot of elements that were excellent for patients and excellent for physicians, but it was knocked out of the exchange because Coventry merged with Aetna and, due

to technical reasons, could not get it into the exchange. The whole process was so burdensome that it eliminated a lot of potentially good plans from participating, and the more plans that we have the better job that they do for providing high quality healthcare at a reasonable cost, just because of the competitive nature of things.

Dr. Zusman: Do you think that the Affordable Care Act is affordable?

Dr. Biggs: I think that the Affordable Care Act was inevitable, in that there is no way that we can continue as a country to have these huge increases in healthcare costs and stay alive. You know, our deficits have been higher than ever, and an enormous amount of that goes to pay for healthcare costs. This is a tax on the American people that we shouldn't have to pay. No other country on the face of the earth has healthcare costs like the United States; this is not a sustainable situation. So in some ways the Affordable Care Act was a maladaptive response to

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a problem that needed to be addressed, and nobody had the guts to really address it like it needed to be done. There were political interests that came out pretty well in the Affordable Care Act; for instance, the pharmaceutical companies continue to maintain their profit structure under this whole algorithm. That was an entity you didn't ask about, but they are coming out pretty well in the Affordable Care Act at very little cost to them. They account for a very large percentage of our excess cost compared to other countries, and yet the Affordable Care Act really didn't address that issue. I don't think physician pay is a reason for excess costs, as physician income today in the USA is not much different from other industrialized countries. There are some utilization issues and waste issues built into the American system compared to other countries but, you know, if we are going to preserve a free marketplace and have freedom of choice we have to understand that we are going to pay more than other countries for our healthcare. At the same time, we are paying way too much as citizens than we need to, and a lot of it is because of the inefficiencies and fragmentation built into our system that the other countries just don't have.

Dr. Zusman: Do you think that the Affordable Care Act will be inflationary?

Dr. Biggs: I don't think it is going to be inflationary; our old system actually was quite inflationary.

Dr. Zusman: It seems to me that you have very positive view of the Affordable Care Act. What do you think should be done to encourage other physicians to see perhaps the positive sides that you have alluded to?

Dr. Biggs: Well, lost in all the rhetoric is that physicians have not been made aware of the aspects that can be positive for their practice, in that more of their patients will have insurance and that, particularly in primary care, they will have power in dealing with insurance companies and hospitals that they didn't have before. I think that physicians will realize that, but now it is getting drowned out in all of shouting. Doctors will discover that, but it may not be for a year or two.

Dr. Zusman: That is all the questions I have. Dr. Urban, do you have any other questions?

Dr. Urban: Yes, I have a couple. Regarding the implications of Texas "opting out": we opted out of the exchanges but we also opted out of the Medicaid expansion. So, Reddy, could you help our readers understand the implications of Governor Perry's approach, besides its effect on the exchanges.

Dr. Biggs: So the Medicaid expansion would have funded the majority of the cost for expanding Medicaid to higher income levels.

Dr. Urban: That is to say that funds would have come from the federal government to defray those expenses?

Dr. Biggs: Correct. And that would have been a huge boost to the healthcare industry in Texas, and so that is something that the healthcare industry in Texas has lost. Again, the concern was a philosophical one--that this would become a permanent mandate from the federal government to fund Medicaid for a number of years and, as the federal subsidies become less robust, then the state would have to pick up the tab. I have never seen a good economic analysis to help us make a decision on whether that was a good idea or not, but, at least for the short term, it was not a good idea because, as Texans, we are now sending our federal tax dollars to Washington DC to fund Medicaid patients in other states but not our own. So, we are not getting any of our money back on this.

Dr. Urban: Were there any other implications of the state of Texas opting out of the ACA?

Dr. Biggs: Some of the concern was whether government agencies, such as Medicaid, would be involved in a larger share of the healthcare market. You know, all of us have some experience with Medicaid and it has generally not been favorable, so that is a scary thought. However, since a large percentage of those patients who are currently uncovered by anything would have been picked up by Medicaid, I think it would be better for them to have something rather than a completely disorganized non-system,

which they have now. Showing up at the emergency room quite sick without getting their problems addressed is, at the end of the day, going to be a very expensive option. As a society, that is a very inefficient way to deliver healthcare and costs us more in the long run.

Dr. Urban: Some of our readers may not understand what an Accountable Care Organization is, and how it functions.

Dr. Biggs: An Accountable Care Organization is a group of practitioners or practices that have joined together to try to have a common way of taking care of their patients so that they are accountable for the quality of their care and the cost of their care.

Dr. Urban: So it is not just a cost saving system like capitation was? Quality is as important as cost savings?

Dr. Biggs: Our ACO has no capitation contracts at all. The things that were bad about capitation obviously were that it was run and implemented by an insurance company that had no way of adapting care to an individual patient and no way of assessing different types of medical practices. For instance, one doctor's practice may have more high risk patients than another, but they would all get the same rates. This is not capitation. One of the things that is unique about our ACO is that we will have quality measures that look at the immunization rates, mammography rates, colonoscopy rates, etc.

Dr. Urban: So you are encouraging care rather than discouraging care if it is appropriate?

Dr. Biggs: Absolutely. We actually provide more care rather than less care. We try to make sure that the patients and the doctors choose wisely on the care that they are getting. So, we don't tell a doctor, "Hey, you are not giving enough flu shots." What we do is we provide to them data about how many flu shots we are giving. Here is how many all of your peers in the ACO are giving and here is how you stand. We have shown our doctors their hemoglobin A1C data on their diabetes patients. We have them all in the same room, and it is unblinded.

You see the graph where you stand and you get to look at each other and have them look at you with your results up on the screen. Those are very interesting meetings! One doctor may be blowing away the national average, and compared to the State of Texas, his numbers look fabulous. But compared to his peers in the ACO he is the worst. He is sitting there thinking, gosh what can I do to just do a little bit better. Do I need to work harder on getting my patients to come back more frequently or do I need to establish more contact with them or do I need to convert them to insulin a little earlier? We are not telling him how to do his practice; we are just giving him data on how he looks compared to everybody else. That is a positive thing.

You know, when you were in school you got a grade, and you got into medical school because you made good grades. Everybody continues to want to make good grades. But the reason you got into medical school is that somebody gave you feedback on how you were doing in elementary, high school and college. And there is no reason why that feedback shouldn't continue. So, we'll again be able to help doctors know how their practices are doing in comparison to others and, by having that measurement to strive for improvement. This is basically part of a process change.

In addition, we can identify which consultants are high-quality, cost-efficient consultants. We have analytic claims data from Medicare. I have a printout that shows me all the hospital costs that we have incurred at the ACO level; the size of the graph shows me how much money is spent at each hospital—BSA, Northwest, Urgent Care Center, Surgi-hospitals, etc. We can go in and see which hospital does

the most efficient job and the highest quality job.

Dr. Urban: You can drill down to specific data about back surgery or heart failure, for instance?

Dr. Biggs: Exactly. Just like we do with the home health agencies. That can lead to some very interesting conversations with the hospitals. For instance, we have found that for one particular line of DRG's one hospital was 15% higher than the other. So, we are going to work on that. The enablement of an ACO to get claims data and to have these type of conversations, that is a sea change. Whoever thought that you would have access to this kind of information and could use it for the benefit of our patients and the benefit of our practices?

Dr. Urban: And that is where Information Technology is so important to making an ACO work properly?

Dr. Biggs: Right. All the physicians in our ACO were already on electronic health records, and we have been able to knit them together into our health information exchange; so if somebody sees me today and then they go to their family physician in the ACO next week, they can see my labs, they can see my notes, they can see what the medicine list is. It makes their job easier to have that information readily available, and vice versa. You know, they can see if the patient has already had a pneumonia shot or if they had a steroid shot last week and that is why their sugars are so high this week. Having that information is a huge plus for patient care.

Dr. Zusman—Dr. Biggs that concludes our interview. Thank you very much.

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A Stranger at the Bedside

Reprinted from *Panhandle Health*, Winter 2006

by Todd Bell, M.D.

Mrs. L expected a miracle. Chronic steroid use secondary to emphysema and hematological disease had weakened her 80 year old bones so that the most mundane maneuvers threatened the stability of her spine. The inevitable occurred. Sitting down sharply one morning resulted in a compression fracture of a vertebra in her thoracic spine. Within twenty-four hours she had gone from an active vibrant woman who “refused to act her age” to a debilitated, pain filled woman who was unable to ambulate to the bathroom without assistance. A friend had recently had a procedure to reduce and stabilize a similar spinal fracture and described the results as “miraculous”. After a sharp escalation of her pain medications by her physician, and some pre-procedure studies to ensure she was a good candidate, she was admitted to my service prior to the procedure. As I listened, Mrs. L gave a dynamic account of the events leading to her hospitalization, and a summation of how she expected her pain medications to be managed. I received the distinct impression that she had decided I was not too bright, and only meticulous instructions would ensure she received adequate care.

Already labeled by her referring physician as taxing, the patient lived up to her billing with the nursing staff. Her fingers upon the call button mimicked the speed of a skilled typist. The afternoon following her procedure, I stepped into her room expecting the speedy resolution of pain that I had witnessed in other patients. Surprisingly, she seemed to be in more pain than when I had seen her earlier that day. An unfortunate and unavoidable complication had occurred with the procedure. Her pain had changed position, but had not improved. In fact, she was in more pain now than when she had entered the hospital. Out of ideas for “fixing” her problem, I sat on the edge of her bed and listened.

Veatch describes 4 models of the physician-patient relationship.¹ Of these, the collegial model is frequently held as ideal, if not perhaps realistic. This model, however, even more than others is dependent on a foundation of trust. Can the patient trust the physician’s knowledge and skills? Can she trust that the physician’s goals and objectives are fully aligned with hers? Can the patient trust the physician’s discretion? Is the physician “worthy” of the life, the limb, or loved one they have been entrusted with?

Experience would teach that trust is most frequently based on shared experiences. I have angst about letting the waiter take my credit card to the back of a restaurant to pay for dinner, yet I trust my wife to make end of life decisions in my stead. Why the difference? My wife and I have shared years of experiences, the mundane and the profound. The waiter has a nose ring, and I only met him 45 minutes ago when I came into the café.

I am a hospitalist. Every patient admitted is new. I have no prior shared experiences with the patient. I have not managed her diabetes for the past 7 years. I have never called her with the reassuring result of a negative mammogram. At our introduction, I have no knowledge of her past achievements or current passions. I am a blank page to her, and her to me. How then, do we achieve a level of trust that allows us to both feel comfortable with the diagnostic plan, therapy, and outcome? It often seems that the “art of medicine,” as it pertains to hospitalists, is in the development of therapeutic relationships in “fast forward.” When a patient is so steeped in illness that an inpatient admission is necessary, we must try to establish trust in a single meeting. The same tools that we learn as medical students to achieve rapport with our patients are vital to being a hospitalist.

- Listen (a lot). My residents would agree that any discussion in which my voice was the only one heard was “good air

wasted.” How could I hope to establish a therapeutic relationship with a patient if I do not allow her to teach me about herself? The patient has decades of experiences that have molded her. The only way to understand who she is and what she expects is to listen to those excerpts of her life she chooses to reveal. Some excerpts will deal directly with the reason for her admission. Some excerpts may only tangentially relate. Neither of us has time for a recounting of her entire life, but I am willing to devote some time to the tangential threads of the story so as to better understand the immediate.

- Talk (a little). too many patients leave a patient-physician encounter with little understanding of what their ailment is and how it is going to be remedied. Lectures regarding pathophysiology and pharmacokinetics are useful to only a few patients. Likewise, one word descriptors of complex processes also do not fulfill a patient’s need for understanding. Finding the right level of communication, the right analogies, and the right amount of detail is vital. It is impossible to achieve that communication without having first listened.
- Empathize. One of the saddest byproducts of our medical system is that we often accentuate the pathology at the expense of the person. Our medical education focuses on organs and disease processes, yet a patient is more than the sum of his diabetes, hypertension, and chest pain. I think most people know when we lose sight of the individual behind the saline bags and PCAs. Knowing the patient (by listening) helps place the disease in context of the person. Touching a knee, holding a hand, sitting instead of standing all convince the patient they are more than a medical record number. The concept of touch is, I think, beautifully illustrated by a story

in the Bible. In the book of Mark, Jesus is confronted by a leper seeking healing. "Filled with compassion, Jesus reached out and touched him, and healed him." Would the therapy or outcome have been different if the man had been healed from a distance? Unlikely. The human touch conveyed the compassion which motivated the healing. Our nursing colleagues often do a better job at sharing compassion than we do as physicians. A patient who is only touched for the delivery of medications, intubation, or chest compressions would be as well served by a machine.

- Never make promises you can not, or will not, keep. There are no 100% guarantees in medicine. It does the patient a disservice if you "guarantee" the outcome of a therapy or procedure. I had a patient in residency who asked me upon admission who his wife's doctor was going to be. With the confidence of youth, I told him my name. He told me that he needed someone to be there if anything untoward occurred to his wife. Again, I responded affirmatively. Over

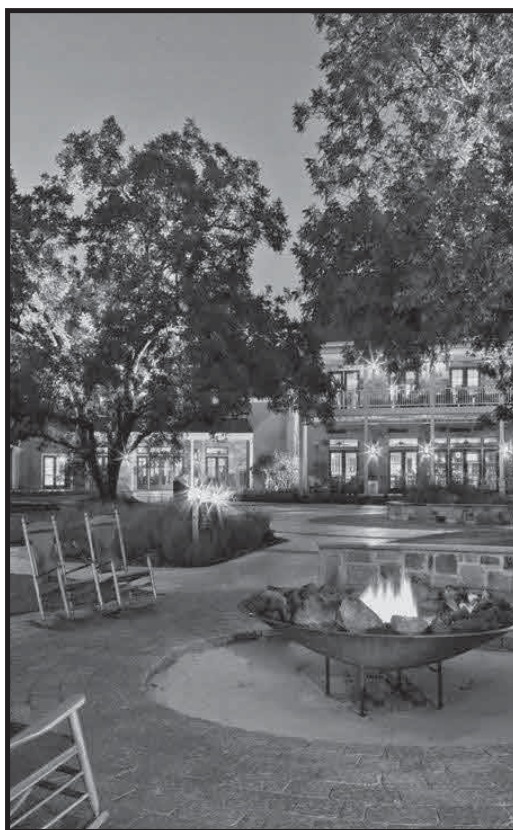
the subsequent week, the patient's diagnosis shifted from a simple retained biliary stone to a diagnosis of metastatic cancer. During my one weekend, the patient's husband admonished me. Quoting my own words, he asked me where I had been when his wife took a turn for the worst. Over time, I have come to realize that gentleman's anger did not stem from his unreasonable expectation that I work every day for four weeks straight. Rather, it was my glib confirmation of his unreasonable expectation that was the culprit.

- Be yourself. In physically and emotionally stressful times, a patient needs a doctor without a mask. In a well worded essay on patient trust, Toni Gitle states "Authenticity... is one of the few things that inspire people to action." Playing a stage role during patient interactions tends to be disconcerting to the patients, confusing to the nursing staff (who always know the "real" you), and tiring to the physician. I am not accomplished enough of an actor to make it through a 10 hour day with a persona in place. My patients are

therefore stuck with the real me, and most forgive me the inadequacy. As we talked, Ms. L recounted fears and concerns that she had. I alleviated those fears as I was able, and validated her concerns of the others. Over the subsequent few days, we negotiated a pain regimen that worked and started physical therapy. She left the hospital with 2-3 weeks of physical therapy in a rehab facility planned and the hope of returning to independent living. Not exactly the "miracle" she had planned when she was first admitted. In spite of her upsets and my own apparent inadequacy in preventing her poor outcome, when she left she asked me if I would "be her doctor." With only small regret, I explained that, "no, I am a hospitalist."

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Once upon a time ...

Reprinted from *Panhandle Health*, Summer 2009

by *Glenn Friesen, M.D.*

Dr. Glenn Friesen attended medical school at the University of British Columbia in Vancouver. He completed his internship at Detroit Memorial and his residency at the University of Oregon. Dr. Friesen is board certified in Cardiology and Internal Medicine. He is a member of PRCMS and is currently associated with the Amarillo Cardiovascular Center.

This article was written in 1988 by an anonymous Canadian physician for *British Columbia Medical Association News*. We are reprinting it in 2009 under the author's name as well as a reprint of his more recent article from *Panhandle Health*.

Once upon a time in Paradise, the physicians here eagerly attended committee meetings. Priorities were defined and generally acted upon by the administration who seemed to be keenly interested in medical advances and quality care. The Medical Director was always available for critical incidents. The Executive Director had his door open to the physicians. The staff meetings were attended by the majority and lively debates were the rule. There was a feeling that we had some input into the system. There was an emphasis on patient care and individualization of treatment. The nurses were the advocates of the patient. Overall, there was a good spirit in the five Paradise hospitals. While there were budgetary restraints, high priority items were not restricted. Expensive low priority areas were canceled. Unfortunately, as care improved and population increased, hospital expenses went up, and the global budget set by the government was overrun.

After several years of the hospital budgets being exceeded, a man was sent by the government carrying a proclamation. He had a paper which was signed by the Premier and the

Lieutenant-Governor, giving him total executive power over the five hospitals in Paradise. This man, a chartered accountant who never smiled, told our medical executive committee how terrible things were in Paradise. The spending by the administration was unforgivably flagrant, and the inventory was excessive. There was incompetence at every level. Within weeks, the executive officers were dismissed. Compliant people were chosen. Opponents were discredited. There was total insecurity felt by those who were salaried. There would be only one materials manager, one finance office, one person in charge of patient care, etc., for the whole of Paradise. There was one common newspaper for the staff. All the rules and regulations were listed, and all the changes in the administration were listed.

Three years have passed. The corporation is in control. Every few months, there continues to be a shift in lines of authority as key positions are changed from one site to another, and committee structures are constantly being changed. The bag of gold (global budget) is being distributed through department heads and division chiefs who will now be paid by the corporation for their work. It seems to the other doctors that their allegiance is with the corporation. The doctors looking after patients do not see the President or the Vice-President.

The Medical Advisory Committee in its wisdom decides all things for the hospitals. The individual doctor has no more input. Because of this, the medical staff meetings are poorly attended, and there is no quorum. Because there is no quorum, no issues can be raised from the floor, and there can be no criticism of the corporation. The corporation seems to be quite content that they have created this **division, disorientation, and distancing**. After all, contact with doctors usually means that they want changes, and changes cost money! We are told that the waiting list for procedures is becoming longer because we are booking too many cases! We now are allowed to do mostly just emergency cases in a number of areas. It is the doctors' fault if costs are exceeded. No one wants to look at the statistics of the number of emergency visits. In any case, too many people come to the emergency room because of lack of user fees. It has become "fashionable" for people to have bypass surgery! No one wants to look at the demographics. It is our estimate that at least one-third are against and make it a federal problem because retired people bring their money to Paradise, and the tradeoff has to be considered.

The government rewards the corporation by giving them presents—a five-million dollar MRI, for example, and a 14



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million dollar rehabilitation unit. In the meantime, critical care is at a low priority.

The works in Paradise hospitals, as well as the majority of physicians, feel a great loss. They have very little input and now are tending to just punch the clock and put in time as there is no longer any consideration of their contribution. It will take many months to get new techniques through this multilayered, insulated administration. Their prime goal is to balance the budget, as they bow and scrape to government demands. The government will reward them but will use the example of the corporation's economy in establishing other corporations across the province.

"Don't call us, we'll call you" - but after three years, we know that the call is not coming. The Pentagon is in place, and the troops are fending for themselves, but there is very little communication. The administrators come and go. We, who are on the front lines, know that the cycle will eventually change and that we will outlive the corporate leaders!

Has patient care improved? No. Waiting lists for procedures are longer than before.

Has the corporation saved the taxpayer money? There is no evidence that it has.

Is the hospital staff happy to work in this system? No. Experience and dedication are not rewarded anymore. No one is trusted. Morale is low.

Why are they (the corporation) in power? We, as doctors, are now in a cage, totally controlled, and ready to be squeezed into any mold the government wants. Accountants will legislate your hospital practice from now on.

*The following is Dr. Friesen's
more recent article*

I graduated from the University of British Columbia in Vancouver, Canada and interned at the Detroit Memorial Hospital affiliated with Wayne State University and the Detroit Receiving Hospital. It was a general rotating internship. I did two years of general practice in a city 25 miles from Vancouver. I then moved to Portland, Oregon—the University of Oregon Medical School Hospitals—in 1964, and spent five years there. Two

years were in internal medicine and two years cardiology fellowship and one year of cardiology research. I was there on an exchange visitors program and had to return to Canada. I accepted a position at the University of Alberta in Edmonton, Alberta, as Assistant Professor of Medicine in the Department of Cardiology. I was there three years and did half of their cardiac catheterizations, directed the CCU, and did clinical research on acute myocardial infarction. Research funds dwindled about that time and it was apparent that in order to survive, I would have to go into private practice. I was fortunate to go back to British Columbia and a very lovely city, Victoria, B.C. After being there one year, we established an open heart surgery program, which was very successful. We started with three cardiologists and one heart surgeon, and worked up over the next 10 years to 4 heart surgeons and 12 cardiologists. We looked after Vancouver Island heart services and were the tertiary care center. I was Chief of Cardiology at the Victoria General Hospital for approximately 16 years.

In 1985, there was an economic crisis in Canada and health care dollars had to be cut. Doctors were to be blamed for these excesses in cost. A public administrator (a CPA) was appointed to amalgamate five hospitals within a 20 mile region. There would be one administration, one hospital responsible for cardiology and cardiac surgery, one pediatric and obstetrics area, one respiratory area, etc. This logic seemed to appeal to the politicians and a massive reorganization was undertaken and completed. Each department was allotted so much money for a year from the global budget, which was provided by the provincial government. In order for cardiology to survive and to meet the needs of the heart patients presented to us, we had to make a lot of cost-saving changes. We began to reuse catheters two to four times, we went back to older contrast agents, which were cheaper (renografin), and began a bloc system of catheterization "to make things more efficient." You would have to spend one day out of seven in the

cath lab and work from 7:00 a.m. to 6:00 p.m., and do all of the cases. This might be three or four angioplasties, three or four cardiac catheterizations, a valvuloplasty, diagnostic cardiac catheterizations, etc. The benefit was that you could do more cases in one day with one cardiologist, as there would be no delay between cases. The disadvantage, of course, was that you were catheterizing patients who you did not know and just had the available history, and that you would not follow up. The cath reports would go to the patient's cardiologist.

The average wait list for a cardiac catheterization was at least three months. After diagnosing the problem, it would be another three months to do the angioplasty. If surgery was required, that would take another three or four months unless the patient was having symptoms at rest. I recall the weekend prior to my leaving that a coroner called me. A patient had died suddenly. I reviewed my records with the coroner. The patient was catheterized at the end of June. He had a 70% main left stenosis and 80% main right stenosis, and was advised to have surgery within several weeks—a letter had been written to the surgeons regarding this matter. The patient was scheduled for surgery on September 5th. He died at the end of August. This type of story occurred fairly frequently. Even inpatients had to wait 7 to 10 days for a slot. The heart surgeons were only allowed to do two cases per day. We were serving a population of 600,000 people! You were constantly on the telephone trying to get service for your patient.

Another frustrating situation occurred at the hospital level. The new QI and QA personnel had come from other states or provinces. They did not know the history of the individual cardiologist. They questioned everything including indications for admission, why wasn't the patient being discharged promptly, and even questioned treatment! They were using cookbook medicine to judge the physicians. A patient with very severe pulmonary hypertension and marked anasarca was admitted. I was asked to write a letter to the Medical Director as to why the patient was admitted when the chest x-ray was normal! I tried to explain to the QI nurse that the severest

form of pulmonary hypertension has a normalized chest x-ray. In any case, a two page justification for admission was sent to the Medical Administrator. These kinds of situations occurred practically weekly, making the experience very confrontational and disgusting. It was interesting that one of the government's finance ministers had a wife with angina. He could not tolerate the three month wait and had his wife go to Seattle for the angiography. Some of the other ministers went to San Diego— Scripps Institute— for their health care and those who could afford it would go to the Mayo Clinic, for example, to get more rapid health care. A nurse in my office, only 25 years of age, had a baseball injury and tore a knee ligament. It took her three months to get an MRI and another three months to get arthroscopic surgery. She hobbled around the office for six months with a swollen knee! I could cite numerous other examples of delayed care under the Canadian Medicare system. Believe me, you would not want to have this system here.

I have never had a waiting list here in Amarillo. When I see a patient who needs a procedure, I sometimes say "Let's do it in about a week's time," and they say, "How about today?" We usually end up doing it today!

At the present time, we see the gathering storm of HMO restrictions coming on us. I sincerely hope that they will not lead to the kind of restricted care that I have experienced.



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Bioterrorism - An Overview

Reprinted from *Panhandle Health*, Summer 2010

by **Andrew C. Stenhouse, M.D., F.A.C.P., F.R.A.C.P., M.R.C.P. (London)**

Among the weapons of mass destruction, biological weapons are more destructive and generally less expensive than chemical weapons, and under certain circumstances, they may be as devastating as nuclear devices. In 1993 it was estimated that the release of aerosolized 100 kg of anthrax spores upwind of Washington D.C. could result in 130,000 to 3,000,000 deaths which matches the effects of the Hydrogen Bomb.

Over the past decade, concerns have increased due to the 2001 incidents in which the letters containing B, anthracis spores were released on the employees of the U.S. Postal Service. Most experts in Bioterrorism have concluded that the release of one or more biological agents is inevitable. The remarkable ring containment method employed by the W.H.O. eliminated Smallpox in the early 1970s, but has left a large immunologically unprotected population worldwide. The release of large scale quantities of non-transmissible anthrax or Botulinum toxin, and, within the last 20 years, the use of genetically modified agents makes it clear that there are increasing challenges to us as Physicians.

Historically, the attempts to induce infectious disease date back to Roman times when the Roman armies used the bodies of humans and animals to contaminate water supplies. In the 14th century, cadavers were slung into Kaffa by the Mongol besiegers who had carried plague with them from Asia. The subsequent flight of the defenders and, coincidentally, with this, the Black Death began to spread across Europe, killing about one-third of the population. However, it is likely that the natural spread of the disease through the rodent population impacted this also.

Smallpox, following its introduction to the Americas, was deliberately introduced to the Native American Indians who accepted infected blankets as gifts. During the American Revolutionary War, smallpox was again employed by British forces.

The 20th century, with the advent of World Wars I and II, showed a marked increase in intensity and sophistication, and these were coincided with the development of modern microbiology. In World War I, the emphasis was on the use of chemical agents, while biological agents were not a factor. The horrors of the chemical agents were instigational in the banning of an entire class of weapons with the signing of "The Geneva Protocol for the Prohibition of the use in War of Asphyxiating, Poisonousness, or other gasses and of Bacteriological methods of Warfare" in 1925. This was signed by 108 countries; the United States later signed in 1972.

The United States commenced its own biological weapon program at Camp Detrick in 1942 due to its growing concern about these weapons. The main activity in World War II was Japan, which had a major center in Manchuria, employing more than 3000 scientists. Japan attacked 11 cities in China, employing a wide variety of bacterial agents. In Europe, very little bacteriological warfare was encountered.

Following World War II, numerous countries, including the United States, had active programs weaponizing seven human disease organisms, which were stockpiled. During the Cold War Era, most of the world's attention was focused on the growing nuclear agents. In 1969, President Nixon declared the end of the United States offensive biological program. This was soon followed by the agreement of 1972 Biological and Toxin Weapons Convention to remove the threat of biological warfare, which was signed by 140 countries. The Soviet Union however, continued to expand its BIOPREPARAT Program in approximately 10 laboratories. This was confirmed when an accidental release of aerosolized anthrax spores from the Soviet weapons plant in Sverdlovsk resulted in at least 68 deaths from inhalational anthrax.

Up to seventeen other nations, including Iraq, were known to have developed offensive biological warfare

programs. Additionally, there is an ongoing threat that terrorists groups without any obvious state support continue to be a problem. The same is true for various cults or individuals with numerous arrests in the United States for possession of vaccine strain anthrax, as well as botulism and ricin toxins.

This brief historical outline brings us into the 21st century, where the CDC is developing a Table of Bioterrorism agents and diseases by category and priority.

Primary Health Care providers (PCP), Emergency Departments' Physicians (ER), Infectious Control Practitioners, Internists, and Infectious Disease specialists should be prepared to recognize disease caused by a variety of biological agents infrequently seen here in the United States.

Category A high priority agents are easily disseminated person to person, cause a huge mortality, would contribute to panic and source concern, and would require special actions for public health preparedness. Category B is the second highest priority group and includes agents that are moderately easy to disseminate, cause generally moderate morbidity and low mortality, and require specific enhancement of diagnostic capacity and enhanced disease surveillance. The third and highest priority agents are diagnosed as Category C agents and include emerging pathogens that could be engineered for mass dissemination in the future, and have the potential for high morbidity, mortality, and a major health impact.

Biological attacks may be "overt" when a warning is given, and the response includes containments, confirmation, clean-up, directed prophylaxis and directed therapy as necessary. In this event, clinicians are warned through media and law enforcement personnel problem and secure communication channels. A "covert" dissemination, however, will not have an immediate impact because of the delay between exposure and the onset of



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the illness. This is where we, as physicians, in particular PCP, ER, Intensivist and Infectious Disease specialists, need to be vigilant and excellent in our day to day work. Early detection of a potential bioterrorism event is the key to minimizing morbidity and mortality. Clinical suspect cases require prompt laboratory confirmation which is an essential step for any emergency response. It is important to report to public health officials and also have access available to laboratories that are prepared to provide rapid disease diagnosis.

The United States Department of Health and Human Services has designated the CDC to command and lead the overall planning effort to upgrade natural public health capabilities at the Local, National and Federal levels to respond to bioterrorism. In conjunction with the Association for Professionals in Infection control and Epidemiology (APIC) the Bioterrorism Rediness Plan: A template for Health Facilities, which is to serve as a reference document and initial template for diverse health care facilities.

Potter/Randall Counties have an excellent Emergency Response Group with a most effective multidisciplinary integrative approach. As physicians, our role is critical in terms of early diagnosis and laboratory confirmation. We should be aware of unusually high rates of illness, but also unnatural diseases would signal a warning. In bioterrorism response, the FBI has overall jurisdiction. The local emergency response system should be activated by dialing 911, or if this is unavailable, notifying local law enforcement authorities should be done. During 2010, the entire emergency operations plan locally, will be revised. The bioterrorism response appendix will be revised to include a biological response appendix, which then will detail the various guidelines. Supplies and response capabilities have been augmented from various grants, not only on the local level, but also at the regional, state and federal levels.

Following the detection of an event, the next step is the confirmation of the etiologic agent. A network of laboratories that communicate directly with the public health infrastructure had been developed to analyze clinical and environmental samples potentially containing biological

agents. Obtaining proper specimens is important for the correct functioning of this network.

The CDC does not encourage the use of external patient decontamination for aerosol exposure. One study showed hand washing regularly with soap and water as effective as two percent chlorhexidine. Ethyl alcohol waterless rub was not active against the spores of *B. subtilis* (a surrogate for *B. anthracis*). For incidents involving contaminated letters, the environment in direct contact with the letter or its contents should be decontaminated with .5% hypochlorite solution (i.e. one part of house hold bleach to 10 parts of water). The latter is not recommended for the decontamination of human skin.

In the event of an "overt" attack when the agent is unknown, symptomatic and supportive care should follow established principles. If the organism is known, then all efforts should be directed at the organism. Chemoprophylaxis should be given to all exposed persons based on a rapid and complete epidemiological study. The CDC has a national stockpile program. Terrorists have a tendency, if possible, to release multiple organisms, and this should be borne in mind by all clinicians.

Infectious control, following standard precautions, are the most important part of the guidelines for both inpatient and outpatient cases. Individual organisms require specialized care and, in particular, not only contact, but aerosol precautions are critical for smallpox.

One report of care that is sometimes given a low priority is the psychological care of not only first responders but also the community in general. It is critical to allay panic. This is more effective when the cause of the illness is known, the course of the disease is described, and the outcome can be predicted with reasonable accuracy. In general, public health officials should prepare educational materials that inform and reassure the public during and after an attack.

Modern biology continues to accrue knowledge in the areas of immune systems and host restriction evasion. Additionally it is now possible to synthesize and manipulate genomes. The areas of greatest future concern are the ability to transfer antibiotic resistance, modify antigenic properties, modification of the stability

in the environment, and the transfer of pathogenic properties.

Several scientists have reported in the medical literature on the development of an antibiotic resistant strain of anthrax. Researches in Australia found that after adding a single gene to the mousepox virus, to their surprise, it shut down the immunological response even of vaccinated mice. The question of whether adding this gene added, to the smallpox virus, a closely related virus, would shut down the immune defenses, cannot be definitely answered.

It is becoming increasingly important to impose appropriate controls on work in laboratories, by balancing security and freedom for enquiry, will not be easy. A Russian defector reported in the mid 1990s that the Soviet Union had regularly stockpiled thirty metric tons of dried Anthrax spores and twenty tons each of smallpox, plague and tularemia, all of which had been modified for use as weapons.

Two Acts have been passed by Congress and both may be problematic. First, the Patriot Act (which was enacted in 2001 and reauthorized in 2006). The second is the Public Health Security and Bioterrorism and Response Act (2002). More vexing is that other nations have not implemented measures that are in any way comparable.

Discussions are taking place in the United States and international forums with the hopes that some rational and effective systems can be agreed upon to decrease the likelihood of biological agents being developed and used for sinister purposes. As one writer has said, the need is real and urgent.

On a personal note, I would like to emphasize that we have an excellent leadership group and with the wonderful quality of the medical community in our counties, we will manage any bioterrorism event. I have available some Power Point presentations on the clinical aspects of the major and minor agents and will be glad to e-mail or forward these to anyone interested. My email address is astenhause@suddenlink.net.

Let us pray that future research, for the benefit of our patients, will be encouraged and that any subversive activity will be exposed quickly. Blessings to each of you as we go forward together.

CDC Bioterrorism Agents and Disease Categories			
Category	A	B	A
Priority	1	2	1
Characteristics	Easily disseminated or spread person to person, highly lethal, serious public health effects, may cause great panic or social disruption	Moderately easy to disseminate, moderate morbidity, less lethal than category A agents, requires fewer special public health preparations	Includes emerging infectious diseases, potential for wide dissemination in the future, could result in high morbidity, lethality, and major public health effects
Disease (agents)	Anthrax (<i>Bacillus anthracis</i>), Botulism (<i>Clostridium botulinum</i> toxin), Plague (<i>Yersinia pestis</i>), Smallpox (<i>Variola</i>), Tularemia (<i>Francisella tularensis</i>), Hemorrhagic fever viruses	Brucellosis (<i>Brucella</i> species), Epsilon toxin of <i>Clostridium perfringens</i> , food safety threats (eg. <i>Salmonella</i>), Glanders (<i>Burkholderia mallei</i>), Melioidosis (<i>Burkholderia pseudomallei</i>), Psittacosis (<i>Chlamydia psittaci</i>), Q fever (<i>Coxiella burnetii</i>), Ricin toxin from <i>Ricinus communis</i> (Castor beans), Staphylococcal enterotoxin B, Typhus fever (<i>Rickettsia prowazekii</i>), Viral encephalitis (eg. <i>Venezuelan equine encephalitis</i>), Water safety threats (eg. <i>Vibrio cholerae</i>)	Emerging infectious disease threats such as Nipah virus and Hanta virus

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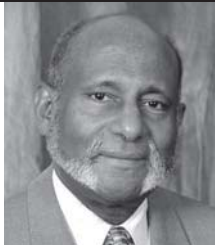
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Large Animal Injuries

Reprinted from *Panhandle Health*, Summer 2006

Dennis B. Dove, M.D., F.A.C.S.

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Human-animal interaction has been recorded as having occurred since the dawn of our species. Humans, as the dominant species, then selected certain other animal species to remain in our food chain, and others to be domesticated and become participants in those activities which have provided us with sustenance. Livestock—the large, domesticated animals found on ranches and farms, at racetracks, and in feed lots and stables—exist in abundance in the urban, rural and agricultural areas of our vast country, with millions of persons interacting with these creatures on a regular basis. As a result of these human-animal interactions, trauma or injury to the significantly out-sized human inevitably occurs. This trauma which results from the transference of significant kinetic energy is not unlike the trauma which results from gunshot wounds and motor vehicle collisions. However, unlike these more common mechanisms of injury, readily accessible databases for the assessment of incidence and outcome of trauma resulting from human-animal interaction are not available. The National Trauma Data Bank of the American College of Surgeons (NTDB) collects the data but does not include analysis in its annual report presentation.

The State of Texas designated Lead Trauma facility at Northwest Texas Hospital (NETH) provides service to a catchment area which includes the 26 counties of the Texas Panhandle [Texas Trauma Service Area - A], eastern New Mexico, southeastern Colorado, a portion of the Kansas high plains and the western

portion of Oklahoma bordering the I-40 corridor to Altus, Okla. These regions, to this date, remain true to their founding ancestry in which the cattle industry continues to dominate the industry of the region. Equine activity remains intimately associated with the animal husbandry of the cattle industry and continues to provide a livelihood for many in this region. Horseback riding and rodeo related sports remain popular recreational activities in this region.

We recently sought to review our experience with trauma which resulted from human-large animal contact in this region. The preliminary evaluation of this data and a review of the literature on this subject represent the basis for this report to our community. Large animals are here defined as equine (horse, donkey, mule), bull, cow (including bull and heifer calves), or large wild animals (deer, exotic animals). Patients injured by vehicular collisions with large animals were not included in the review, nor were animal related scene deaths.

The Trauma Registry maintained by the NETH Trauma Center entered a total of 5442 persons with a trauma related diagnosis and requiring admission to the hospital for the period January 1999 through December 2005; [744 average annual Trauma admissions]. Analysis of this database would indicate that trauma which resulted from contact with large animals included 211 persons (3.8% of total) which have remained constant for each year of the reporting period. Equine – horse related injuries predominated, and, unlike the published data from the neighboring states of Oklahoma, Colorado and New Mexico, injured patients from our region were involved in work related activities more often than recreational activities. Equine – horse related injuries were also dominant in Rodeo related injuries, surpassing the incidence of those injuries which resulted from being thrown from, trampled and or gored by a bull

during the Bull Riding portion of these Rodeo activities. Falls from, or having been thrown, from a horse or bull remained the most frequently presenting mechanism of injury. Being kicked by the animal (horse, cow or bull), stepped on/or trampled, crushed by the full weight of the animal, or having an extremity only (lower extremity in horse mounted cowboy) crushed remain as other mechanisms of injuries following these human-large animal contact. In this review, all body regions were represented in the areas of injury, and included brain and cranio-facial structures, vertebral column and spinal cord, chest, abdomen, pelvic girdle and pelvic contents, upper and lower extremities. Multi system injuries were frequently present, with single injuries – upper extremity and pelvic fractures serving as the sentinel marker for the presence of other injuries. A detailed analysis of these injuries is forthcoming and will be presented as a separate paper.

Injuries which result from Human – Cattle (cow) Contact:

Several researchers have previously examined agriculture related livestock injuries—those associated with the routine activities of running a working ranch, farm, feed lot, or dairy. Studies from diverse locations have consistently documented the fact that animal-related injuries remain a leading cause of agricultural trauma; yet, the true overall incidence of this trauma continues to remain undocumented. This trauma occurs in the course of regular farm or ranch activities such as roundups, branding, vaccinations, and any routine animal care. In studies of Wisconsin and Minnesota dairy farms, it was found that the greatest numbers of livestock related injuries were associated with milking charging bulls constituted the most serious trauma threat. In these studies, being kicked by the animal was presented as having the highest incidence of occurrence. Ranchers continue to recognize that “breeding” times in particular can be even more dangerous

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because animals may become more difficult to manage.

Most reported injuries in the literature regarding human-cattle contact, while considered a required occupational hazard, are indeed accidental. However, deliberate attacks by livestock are reported as being associated with more significant trauma. One study consisting of 225 farmers injured by animals reported that 36% (N = 81) were wounded in assaults by charging or uncontrolled horses or cattle. Twenty-five of these assaults resulted in serious multisystem trauma.

Northwest Texas Hospital (NTH) data would indicate that non deliberate attacks were more common; crushing injuries occurred most often; and would occur during the process of herding these beasts through the feed lots onto and off transportation, prior to and at the meat processing facilities themselves. Given the sheer volume of cattle herded, transported and processed within this region, the reported low incidence of injury remains a testament to the continued utilization of proven techniques of handling these large animals during these occupational encounters. In one prior study from East Texas, 38% of all cow-related injuries occurred in males who were significantly older than injured bull and horse riders (elderly ranchers). This was not substantiated by our data.

Human – Equine Contact and resultant injuries:

National advertising for pickup trucks notwithstanding, equestrian activities continue to remain an integral part of the livestock industry, while at the same time recreational equestrian activities continue to gain in popularity. These recreational equestrian activities include a variety of forms such as racing, dressage, cross-country, fox-hunting, stadium jumping, polo, and trail-riding. Thirty million Americans participate in these activities annually, and presumably accept the unique risks of equine-related trauma. “The grave yawns for the horseman” is an old Arab proverb that is particularly apt, considering the unpredictable power of the horse.

This single recreational activity results in more than 50,000 emergency room visits annually. When injuries do occur

in equestrian events and require hospital admissions, they are often serious; a finding reflected in the high incidence of closed head injuries, spinal column fractures with associated para-vertebral muscular derangements, blunt intra-abdominal and thoracic injuries and long bone and pelvic girdle injuries. Horseback riding accidents alone are estimated to account for over 2,300 admissions per year nationwide in persons less than 25 years of age. The risk of injury or death from equestrian activities is considered higher than the risks associated with football, motorcycle sports, and even automobile racing and remains a significant health problem because of the large number of participants at risk and the potential severity of injury. Earlier studies have documented that horseback riding was the leading cause of recreational neurological injury in Oklahoma, New Mexico and Colorado.

Horseback riding entails a unique combination of risk factors that predispose the participant to severe neurological injury. Few activities require the participant to be so completely dependent on an animal at all times, making the rider vulnerable to the “unpredictability” of these large, powerful creatures. Horses can weigh up to 1,500 pounds and reach speeds up to 40 mph. These animals can kick with up to 1.8 times their own body weight, which can correspond to approximately 1 ton of force delivered with a single hoof. The force of a horse’s kick can easily fracture bones of the skull or spine. The rider’s head remains elevated approximately 9 feet above the ground; the head-forward stance and lack of restraining devices also predispose to ejection or falls. These elements allow horses to impart tremendous kinetic energy to their riders, with potentially devastating results. It is accepted that approximately 80g of acceleration is required to shear or disrupt cerebral parenchyma at a cellular/fiber-tract level; a fall from a galloping horse can deliver 100-300g of acceleration to the rider’s cranium or spine.

Ejection/being thrown from the horse is the most common mechanism of injury related to equestrian activities as reported in the literature. Kicking or crushing of a pedestrian horse-handler or bystander is the next most common mechanism of injury, and, in one series reporting on equine related injuries in the pediatric

population, nearly half of the injured patients were non riders. In our NTH series, several patients were crushed under the animal, representing the third most common means of injury. In two published studies from Kentucky and Colorado, no correlation was identified between level of experience and the occurrence of injury, leading the authors to conclude that “experience is certainly not protective”.

As in motorcycle related activities, helmets have clearly proven a benefit as demonstrated by the marked decrease in the incidence and severity of head injuries with the adoption of compulsory headgear by the U.S. Pony Club and by the decreased injury rate of helmeted riders in numerous other studies. In these studies, no fatalities were reported in sponsored recreational horse-related injuries if the rider was wearing a properly fitting, approved helmet. Patients with these head injuries tended to have excellent recoveries, in keeping with their initial Glasgow Coma Scale scores. In these events, the importance of wearing a helmet even when not mounted, and in being in close proximity to the animal was considered to be protective.

Based on the preliminary review of our data from this Trauma Center and our review of the literature, we make several conclusions: the power, size, speed, and unpredictability of horses can cause serious injuries to both those mounted on the horse and those individuals in proximity to the horse. Head injuries predominate and can be fatal. Spinal injuries are less common but can be very serious. Multi-system injuries are frequent, should be suspected based on the mechanism of injury, and require complete evaluation by the Trauma Surgeon. Helmet use remains recommended in sponsored recreational equine activities.

Rodeo-related Livestock Trauma:

Although very few studies have explored the impact of rodeo-related livestock trauma, the injury rate appears to be as high as 20% to 30% in professional competition. Although some rodeo events are similar to routine ranching activities, the regimented, timed, and competitive nature of rodeos adds a much different but significant degree of intensity to these activities. But because riders are expected to remain mounted in the barrel racing and

team roping events, far fewer injuries are sustained in these events.

In bronco and bull-riding events, however, the rider is tossed back and forth with tremendous force as the animal tries to dislodge the contestant. The rider then falls, in whichever direction he or she is currently headed, landing on whatever body part is closest to the ground. A horse will usually avoid stepping on a downed cowboy, but bulls will deliberately try to kick, stomp, butt, gore, or crush a dislodged rider.

The speed, power, and sheer orneriness of a 2000-pound Brahma bull make bullriding the most dangerous of rodeo activities, and it is responsible for twice as many injuries as any other event. The Sportswriters of America have voted bull riding (one of the five standard events in rodeos sanctioned by the Professional Rodeo Cowboys Association) as the most dangerous sports contest in the United States. Bull riders are at an obviously overwhelming size disadvantage to their adversary and are, therefore, highly

vulnerable to injury when riding animals weighing 2,000 to 2,500 pounds. It is also reasonable to assume that the level of experience in this sport is inversely proportional to risk and severity of injury. The job of rodeo clowns, also known as "bullfighters," is to distract the bull from a fallen rider. Consequently, these clowns are reported to have a rodeo injury rate second only to that of bull riders.

Amateur bull riding events are a fixture of weekend rodeo activities in many communities throughout the five states included in the catchment area utilized in our review, and we witness a steep increase in Emergency Department visits and subsequent hospital admissions in association with these events. The incidence of injuries experienced by amateur bull riders is not readily available because of the informal nature of many of these events, and the only published data concerning types of injuries are from collegiate and professional rodeo competition.

The available data would indicate that approximately 12,000 professional cowboys

compete in over 850 rodeos yearly in the United States and Canada and their injury rate is estimated at 2.3 to 19.7 injuries per 100 animal events, with injuries during rough stock competition (bull riding, bareback horse riding, and saddle-bronco riding) being three to four times higher than that occurring during other rodeo related events. As with any professional sport, a high degree of skill is required. The amount of skill required in rough stock events to oppose the tremendous power generated by these animals is substantial, and there is an ever-present potential for debilitating injury. Skill and the risk for injury at the collegiate level are now considered similar to that of the professional rodeo. A study of 10 collegiate rodeos over a 7-month time period identified a 4% (1 of 24) injury rate for all 24 events.

Professional rodeo participants had a similarly low incidence of serious injury. This data would suggest that the potential for injury remains greater for amateur bull riding participants when compared

PANHANDLE HEALTH

A Publication of the Potter-Randall County Medical Society

Editorial Policy and Information for Authors

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

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

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with their collegiate and professional counterparts. This finding is due to their generally younger age, their lower level of experience with a sport that has a steep learning curve, and the fact that many of the injuries for which the neophyte bull rider is treated become career-ending (thus, eliminating the less agile and talented riders from the pool of riders at the higher levels of rodeo competition).

Patients who are injured during large animal encounters can present with both blunt and penetrating high-energy transfer injuries to multiple body regions. A review of the available studies would identify a significant difference in the incidence of head/craniofacial and torso trauma when patients with upper extremity injuries were compared with those with lower extremity injuries. Given that the most common mechanism of injury from horses is a fall, it is reasonable to speculate that falling on an upper extremity is more likely to be associated with a head or torso injury than striking the ground with a lower extremity. In fact, the lower extremity is more likely to be crushed in the chute. These same scenarios occur with bull riding, with the added danger of being trampled in the region of the upper extremity, torso, and head after the fall. Because extremity injuries are generally easier to diagnose clinically than injuries to other body regions, these studies would suggest that upper extremity injuries may serve as an accurate marker for possible injury to the brain/craniofacial and torso regions during both the pre-hospital and emergency department setting.

These injury patterns beg the question

for individual participant protection while engaged in these activities. Indeed, many solutions have been proposed and are available but have not gained widespread acceptance in these sports. Bull riding helmets are available and are indeed utilized at the collegiate level, as are Kevlar vests worn under the statement shirts. Limited data is available regarding the utility of these additions in affecting injury. Injuries to the hand wrist, elbow, and shoulder girdle continue to present with alarming frequency with the continued practice of many participants of tying one hand to the saddle of the animal prior to the ride, thus, prohibiting rapid disengagement and leading to the individual being dragged for considerable distances. The same phenomenon of being dragged occurs when a boot is not promptly disengaged from the stirrup.

Concluding Observations...

Human – large animal interactions remain an ongoing phenomenon in our present society. In the region of the Texas Panhandle and its surrounding four states, these interactions remain an essential part of the occupational activities necessitated by the cattle industry. Rodeo related, amateur and professional, human-large animal interactions predominate as the recreation activity cluster involving these encounters. Beyond the area of the bordering states, horse back riding predominates as the recreational activity which produces significant injuries from these human-large animal interactions.

The available data demonstrates that large animal encounters can result

in significant injuries to multiple body regions. The mechanism of injury remains species-specific as related to the activity type; occupational versus recreational. Because of the tremendous size and speed of these animals, direct blunt impact and falls from these animals can produce forces of mass and velocity similar to motor vehicle collisions with a similar resultant disruption of physiologic and anatomic functions. Thus, those individuals who choose to become willing participants in these human-large animal encounters should pay heed to our updated version of the old Arab proverb which was previously cited... "The Trauma Center awaits the unprepared, non skilled horseman/woman and bull rider".

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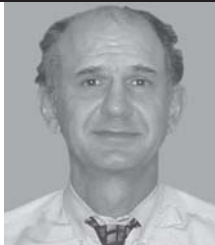
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Our Next Issue Of
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Features:
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The Bioenergetics of Sex, or Come on Baby Light My Fire

Reprinted from *Panhandle Health*, Summer of Love, 2011
by **Steve Urban, M.D.**

Dr. Steve Urban received his medical degree from Baylor College of Medicine in Houston, Texas. He completed his internship and residency at the University of Southwestern. Dr. Urban is board certified in Internal Medicine. He is a member of PRCMS and currently is associated with Texas Tech University Health Sciences Center.

Within 10 years of the discovery of oxygen by Priestly, the brilliant scientist Lavoisier realized that respiration, which consumed oxygen and produced carbon dioxide, was analogous to combustion. Two hundred years later, Jim Morrison, during his only minutes of lucidity between 1966 and 1971, referred back to the seminal work of Lavoisier when he pled “Try to set the night on fire” to one of his 3000 lovers. Since then, modern physiology has expanded on Lavoisier and Morrison with numerous clinical studies. In this essay, I will review what we know about the metabolic cost of sexual activity—especially as it relates to cardiovascular disease.

Phases of the sexual response

Despite eons of uncontrolled preclinical studies, Masters and Johnson were the first to conduct scientific studies of coition, one of the most fundamental of human activities (Human Sexual Response, 1966). On a conceptual basis (conception occasionally being the intended outcome), they defined four phases of human sexual response:

1. excitement (signaled by penile erection in the male, vaginal lubrication in the female)
2. plateau (beginning with penile/vaginal intromission in the paradigm case)
3. orgasm (no definition required)
4. resolution.

Other pundits have added phases, not

generally accepted, including anticipation (a phase often lasting years in the adolescent male), the refractory period (in males), and regret (sometimes lasting a lifetime, especially in the female).

Masters and Johnson found dramatic cardiovascular changes with intercourse. For instance, they documented a dramatic increase in heart rate (peak HR men 100-180, women 110-180), and a blood pressure rise of 40-100 mm Hg in men, 30-80 mm Hg women, especially with orgasm. Others documented peak heart rates of 170 and peak systolic blood pressures over 200, particularly in previously hypertensive patients. In retrospect, some of these dramatic perturbations may have been related to the conditions in which the readings were obtained. For instance, in the Masters and Johnson studies, the “volunteers” were studied in a clinical laboratory, often with direct visual observation. The subjects underwent careful physiological monitoring, including vaginal and anal electromyography to detect the clonic muscular contractions associated with orgasm. Yeow.

After Masters and Johnson

In the 1970s and 1980s, physiological studies were conducted in more natural settings (i.e. in married subjects’ homes, with remote heart rate and BP monitoring). Among the best of these were studies by Hellerstein et al, which demonstrated more modest increments in HR and BP. These studies were conducted almost exclusively in men. Hellerstein documented a mean maximum HR with orgasm of 117 (range 90-144), with an estimated energy expenditure of 2-3 METs after intromission and 3-4 METs with orgasm. These investigators first suggested that the energy expenditure of sexual intercourse was the equivalent of climbing 2 flights of stairs. Millions of adolescent boys began looking for those stairs.

An important study was carried out by Bohlen et al, published in the *Annals of Internal Medicine* in 1984. This is one of my favorite papers of all time, the other contender being the British Medical Journal classic, “Penile Vacuum Cleaner Injuries.” Bohlen studied 10 married couples aged 24-43 years in a more naturalistic setting (although the male subjects wore face masks in order to determine O₂ consumption, in the words of the paper precluding “some physical expressions” of intimacy such as “kissing or talking”). Nonetheless, this study confirmed that the energy requirements of intercourse were more modest; they showed an increased heart rate of 4-6 with foreplay (phase 1), 15-30 with intromission (phase 2), and 30-45 with orgasm (phase 3). In terms of energy expenditure, they showed that the usual energy expenditure with sexual intercourse ranged from 1.7 METs (masturbation) to 3.3 (man-on-top intercourse). The maximum expenditure for ANY patient in this study was 6 METs (the equivalent of walking 5 mph). These investigators also showed that masturbation (either by self or by partner) required less energy than intercourse, and that woman-on-top intercourse required less work than man-on-top intercourse. Jogging appeared to be a riskier pastime than sex, as I have long suspected.

What is a MET?

A MET (metabolic equivalent) is a measure of oxygen consumption and energy expenditure. One MET is the energy expenditure in the resting state (3.5 ml of O₂ consumed per Kg per minute). In clinical studies, energy expenditure in METs is often estimated by the “double product” (heart rate multiplied by systolic blood pressure). The following table summarizes the energy cost of various activities:

1 MET — resting, thinking about sex
2-3 METs — walking 2-3 mph on a flat

surface, usual sexual activity in a non-stressful setting

4-6 METs — walking 4-5 mph, strenuous sexual activity

9 METs — running 6-7 mph

13+ METs — maximum symptom-limited stress test

More recent refinements

Since the original studies of Hellerstein and Bohlen, metabolic studies have been expanded to include women and older subjects. As a general rule, sexual intercourse appears to require less metabolic energy in women than in men. For instance, one study showed mean maximum heart rate in women of 121 (vs 141 in men) and mean maximum systolic BP in women of 136 (vs 152 in men). Since peak heart rate decreases with age, the energy cost of sexual activity tends to decrease in older patients. Palmeri et al studied patients aged 40-75 and found the maximum heart rate to be 105 in women and 113 in men (i.e. 15-30 beats/minute less than in younger patients). Interestingly, at all ages, the energy expenditure of sex is about 60-70 % of the age-expected maximum (i.e. slightly less than the anaerobic threshold); this is less than the energy use at 3 minutes of the standard treadmill test. Palmeri estimated that intercourse in women was the equivalent of late stage 1 on the standard Bruce protocol exercise test and that intercourse in men corresponded to stage 2.

Coital death: will our love become a funeral pyre?

Fear of coital MI or death is an often-unstated worry in the cardiac (especially post-MI) patient, but actual events are exceedingly rare. Four autopsy studies have addressed the risk of sudden death during sex. Natural deaths during sexual activity comprise between 0.2 to 1.7% of all autopsied deaths. As expected, most of the decedents had coronary artery disease and, since CAD manifests at younger age in men than women, most were men. In one German study, 30 of 1722 autopsied natural deaths were classified as coital deaths. 28 of the 30 were in men and 23 occurred during extramarital liaisons. Five of the deaths occurred during foreplay, 9 between intromission and orgasm, and 16

after orgasm. One expects that the recall of exact timing by the surviving partner might be clouded by circumstance. It was estimated that the relative risk of coronary event during intercourse is approximately twice normal, and that the duration of risk lasts just 1-2 hours. This risk is felt to be less than anger or unaccustomed physical exercise. Most experts feel that the risk of coital death, especially in a customary setting with a usual partner, is extremely small.

Sexual activity and longevity (Jim Morrison notwithstanding)

Several observational studies have shown a slight association between continuation of sexual activity throughout the life cycle and longevity. For instance, in a longitudinal study of Duke University graduates, self-reported frequency of sexual activity was positively correlated with longevity in men. Another study (again in men, average age 70) showed that early cessation of sexual activity was associated with premature death. A study from Wales showed that the risk of cardiac death was 50 % less in those with frequent intercourse (2 or more times per week) when compared with those sad and lonely subjects having intercourse once a month or less. The true magnitude of risk, however, may be more modest. One study of priests and nuns showed no major difference in cardiovascular mortality when compared with an age matched population (relative risk in priests of 1.04).

Conclusions

Several conclusions can be drawn from the current literature:

1. The metabolic cost of sexual activity is modest. Hellerstein's "two flight of stairs" analogy may be an oversimplification; one hopes, for your spouse's sake, that sex takes longer than this. Most patients who can walk 3-4 miles per hour on level ground, however, should be able to engage in sexual activity in a comfortable and usual setting.
2. The main determinant of sexual energy expenditure is the activity of large muscles involved in pelvic thrusting, with a slight contribution from the smaller

muscles (e.g. pubococcygeus) involved in orgasm. This accounts for the lesser METs involved in masturbation and (possibly) in the woman-on-top sexual position.

3. The risk of sexual activity is very small. In a 50 year old nonsmoking male, the risk of MI is 1% per year. This corresponds to a risk of 1 per million per hour. This risk increases to 2 per million for 1-2 hours during and after a sexual encounter. Stable coronary patients have a similar risk.

4. If a patient does not have ischemia on a standard symptom-limited Bruce treadmill test, they will not have ischemia during sexual intercourse. It is generally recommended that patients with severe heart disease (unstable angina, poorly controlled hypertension, malignant arrhythmias, severe valvular disease) be treated before they resume sexual activity, and that other high risk groups (MI within 2 weeks, NYHA class 3 or 4 CHF) be assessed by a cardiologist or internist before resuming sex. A stress test will answer any questions about these patients' ability to have intercourse. Regular aerobic exercise will improve a patient's ability to engage in sexual activity.

5. Anecdotal study of this topic, by professionals and nonprofessionals alike, will likely continue unabated.

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Treating the Breastfeeding Mother: Choosing an Appropriate Drug

Reprinted from *Panhandle Health*, Summer 2013

by Thomas W. Hale, R.Ph., Ph.D.

INTRODUCTION:

The interest in breastfeeding is at an all time high, with approximately 77% of women leaving the hospital breastfeeding. This is clearly due to the enormous benefits to health that have been documented in the last decade. Infants fed human milk experience significantly reduced rates of acute and chronic diseases. Infants who do not receive human milk cost the health care system over \$13 billion each year and result in over 900 unnecessary infant deaths annually.

Compared with the breastfed infant, formula-fed infants face much higher risks of infectious morbidity. In the first year alone, the risk of otitis media in formula-fed infants is doubled compared to breastfed infants. An extensive literature supports higher risks of lower respiratory tract infections (66%), gastrointestinal infections (2.8 fold, meta analysis of 14 studies), necrotizing enterocolitis (>2.4-8 fold), and a higher death rate (1.3 fold) if infants are fed formula.

The mother benefits from breastfeeding as well, including an enhanced weight loss and a major reduction in the risk of breast cancer. Numerous studies now confirm that the longer a mother breast feeds, the greater the reduction in risk of breast cancer (up to 36%).

While recent studies have clearly suggested that the number of women who choose to breastfeed is rising, the number of women who discontinue breastfeeding to take a medication is simply too high.

Surveys in other countries indicated that 90-99% of women will receive some medication during the first week postpartum, and virtually all will consume medications throughout the breastfeeding period. In Scandinavian women who discontinue breastfeeding prematurely, the use of medications is a major reason. While the drugs used early postnatally primarily include analgesics, methylergonovine, antihypertensives,

and sedatives, many other mothers are now consuming antidepressants, antipsychotics, anti-epileptics, antibiotics, steroids, and many other medication classes. Hence, the relative number of medications that an infant is exposed to seems to be rising.

Because so many women ingest medications during the early neonatal period, one of the most common questions encountered concerns the use of various drugs in breastfeeding mothers. Almost invariably, most physicians and pharmacists [without having done a thorough study of the literature] simply review the package insert and advise the mother not to breastfeed. Most often, advice to discontinue breastfeeding is inaccurate and unnecessary. Most mothers could easily continue to breastfeed their infants and take the medication without a major risk to the infant.

In the past 20 years, we have developed a proficient understanding of the kinetics of drug transfer into human milk. Most of the physiochemical properties that facilitate transfer into milk (molecular weight, pKa, lipophilicity, oral bioavailability) are known and understood. The following review will describe in some detail the transfer of medications into human milk and the implications of this transfer on the infant.

The Milk Compartment:

During gestation the milk ducts migrate backwards from the nipple via the breast fat pads, terminating into extensive lobulo-alveolar clusters (grape-like) (Figure1).¹ Each alveolus is lined with a single layer of polarized secretory epithelial cells (called lactocytes) which synthesize human milk. Human milk consists of hundreds of unique proteins

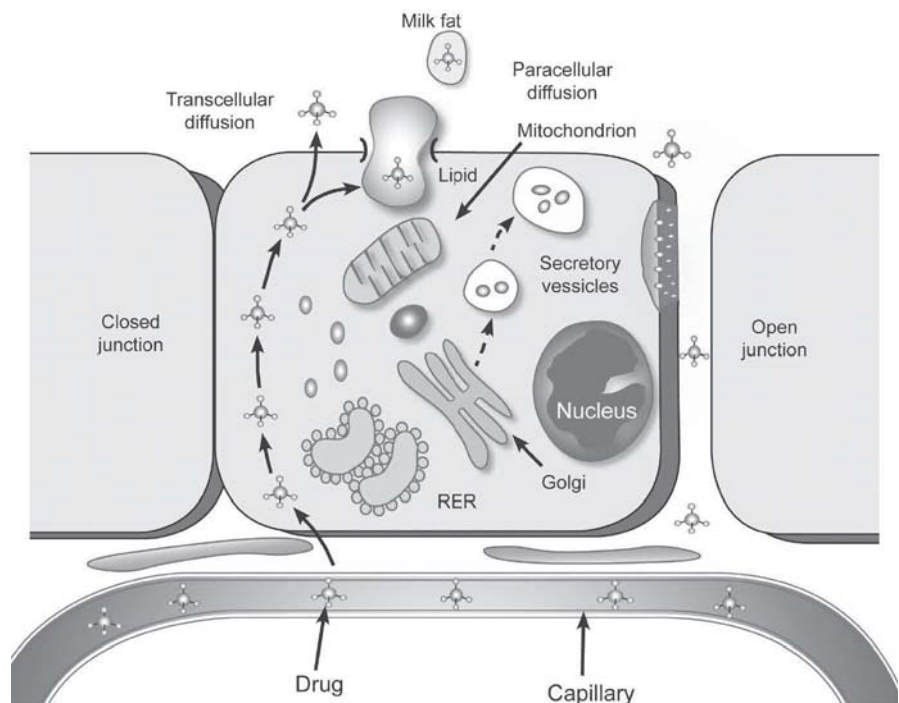


Figure 1. Transport of medications through the alveolar epithelial cell

* Adapted from Hale TW, Hartmann PE. *Textbook of Human Lactation*. Amarillo: Hale Publishing; 2007.

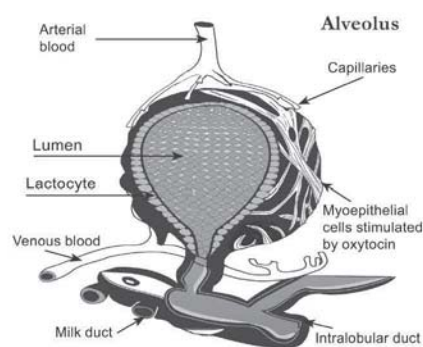


Figure 2. Structure of the alveolar subunit with blood supply and other structures

** Adapted from Hale TW, Hartmann PE. Textbook of Human Lactation. Amarillo: Hale Publishing; 2007.*

and peptides, lipopolysaccharides, secretory IgA, insulin growth factor-1, and other components designed to protect the infant from infection, and provide ideal nutrition and growth.

After delivery of the placenta, estrogen and progesterone levels drop to baseline levels. This generally occurs by approximately 40 hours postpartum. At this point, prolactin dramatically stimulates the lactocytes to produce milk. During this terminal growth phase, lactocytes connect to one another via an apical junctional complex that functions to inhibit direct paracellular exchange of substances from the maternal to the milk compartment during lactation.

One week postpartum, the milk compartment is almost completely isolated from the maternal compartment and is virtually closed to the entry of substances from the maternal plasma. At this time, it is almost identical to the blood-brain barrier. Because of this tight compartmentalization, most drugs are excluded from the milk compartment. But this exclusion is a function of maternal plasma levels, the physicochemistry of the drug, and other chemical properties. Drugs that are large in molecular weight (> 800 daltons), highly water soluble (polar), and highly protein bound (> 80%), are virtually excluded from the milk compartment. On average, less than 1% of the maternal dose of most drugs enter the milk compartment.

The age of the infant is also a major concern. Newborn infants during the

first 4 days are of minimal concern, as the volume of colostrum is minimal (30-160 cc/day), hence the dose of the drug delivered is minimal. Infants 1 week to 6 months are at higher risk, due to higher volume of milk ingestion. Infants > 1 year of age are at minimal risk, due to declining milk volume, and increased clearance in older infants. Thus, be more careful with young infants, and don't worry so much about older infants.

Selected Drug Classes

Analgesics

Analgesics compose the most commonly used agents in breastfeeding mothers and are used most commonly early postpartum. These include the non-steroidal anti-inflammatory drugs (ibuprofen, naproxen, celecoxib), hydrocodone, oxycodone, morphine, and fentanyl. All are considered relatively safe when used in moderate to low doses in breastfeeding mothers.² Always observe the infant for somnolence and respiratory rate.

Antibiotics

With exception of three antibiotics (erythromycin, nitrofurantoin, and sulfonamides), all other antibiotics are considered safe to use in breastfeeding mothers (Table 1). Erythromycin, used the first month of life, may increase the risk of pyloric stenosis, and should be avoided in breastfeeding mothers. Nitrofurantoin and sulfonamides may displace bilirubin from its albumin-binding sites, and should be avoided in infants with hyperbilirubinemia. Of the tetracyclines, doxycycline is relatively safe to use in breastfeeding mothers, but for no longer than 3 weeks. Levels in milk are exceedingly low, and it is the least likely to produce dental staining. All the cephalosporins, penicillins, and new macrolides (azithromycin) are quite safe to use.³

Antidepressants/Antipsychotics

Interestingly, the most commonly studied drugs in breastfeeding mothers are the antidepressants. Almost 15% of breastfeeding mothers consume an antidepressant for the treatment of depression, anxiety, or other disorders. More than 100 mother-infant pairs have been studied with fluoxetine, and more than 60 have been studied with sertraline.

All these studies confirm that the level of transmission of these drugs to the infant is relatively low (Table 2). Using the Relative Infant Dose estimation (% of mom's dose that is transferred to the infant via milk), most are less than 9% of the maternal dose.⁴

Most importantly, prior concerns concerning exposure to these drugs during gestation or breastfeeding have been answered. It is all but certain that these drugs do not alter the neurobehavioral outcome in exposed infants. The most dangerous complication is "untreated" depression or psychosis. This we know seriously alters neurobehavioral outcome in infants. It is now the standard of care to opt for treatment of depression and anxiety disorders in pregnant and breastfeeding mothers. Postpartum psychosis can be safely treated with atypical antipsychotics while mothers are pregnant or breastfeeding. Levels in breastmilk are very low.

Anticonvulsants

Most of the anticonvulsants have been studied in breastfeeding mothers and most are safe. Lamotrigine produces relatively high plasma levels in infants for about 3 weeks; the levels fall significantly thereafter, probably due to increased renal output. It is extremely popular for the treatment of mania, and can safely be used in breastfeeding mothers. Valproic acid, while producing low levels in milk, should be avoided today. New data clearly show that valproic acid interrupts brain development and lowers IQ, particularly in the third trimester of pregnancy, and probably during the first year of life. It should also be avoided in women early postpartum, because of the relatively high risk of pregnancy and its classic teratogenicity.

Other Safe Agents

Hundreds of other drugs are quite safe in breastfeeding mothers. These include the proton pump inhibitors, all of the antiasthmatic preparations (budesonide, fluticasone, albuterol, levalbuterol, etc.), heparin, low molecular weight heparins, infliximab, interferons, and many others.

Summary

All medications transfer into human milk to some degree. However, few

actually produce clinically relevant levels in infants. The most important information about a drug is its Relative Infant Dose. This estimate of the infant's exposure gives the prescriber a relatively accurate estimate of just how much medication the infant will receive daily.

If the RID is low, then the medication is probably safe to use. As a general rule, when the Relative Infant Dose rises above 10%, we become more concerned, and clinicians should be more cautious concerning breastfeeding of the infant.

Each mother/infant pair must however be individually evaluated to determine a risk-benefit analysis of this infant. Infant factors that must be included are: prematurity, apnea, weakness, renal or liver failure, or other factors that would reduce the infant's ability to adapt and tolerate the medication.

While the infant has nothing to gain from exposure to most medications, in most instances, the level of exposure is far subclinical. Then the most important factor to consider, is maintaining the breastfeeding relationship. Formula-fed infants are known to have higher rates of GI syndromes, upper respiratory tract infections, and numerous other syndromes. Thus, it is sometimes far riskier to use formula than a mother's own milk.

In most situations, there are numerous medications that can be safely used for specific syndromes. Further, you always have multiple choices for most conditions, and choosing a medication that enters milk poorly should be your goal. Physicians and other health care providers are advised to carefully choose those medications with lower Relative Infant Doses and fewer side effects in infants.

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Table 1. Relative Infant Dose and Clinical Significance of Antibiotics⁴

Drug	Relative Infant Dose (%)	Lactation Risk Category
Amoxicillin	1	Safest
Ampicillin	0.3	Safest
Ampicillin + Sulbactam	0.5	Safest
Gentamicin	2.1	Safer
Tobramycin	0-2.6	Probably Safe
Cefazolin	0.8	Safest
Cephalexin	0.5	Safest
Cefuroxime	0.6	Safer
Ceftriaxone	4.1	Safest
Erythromycin	1.4	Safest
Clarithromycin	2.1	Safest
Azithromycin	5.9	Safer
Clindamycin	1.6	Safer

Table 2. Relative Infant Dose and Clinical Significance of Psychotropic Drugs⁴

Antidepressant	Relative Infant Dose (%)	Lactation Risk Category
Citalopram	3.6	Safer
Escitalopram	5.3	Safer
Fluoxetine	5-9	Safer
Sertraline	0.54	Safer
Paroxetine	1.4	Safer
Venlafaxine	8.1	Probably Safe
Olanzapine	1.6	Probably Safe
Quetiapine	0.09	Safer
Risperidone	4.3	Probably Safe
Valproic Acid (VPA)	1.4-1.7	Probably Safe
Carbamazepine	5.9	Safer
Lithium	30.1	Probably Safe with close observation
Lamotrigine	9.2%	Probably Safe

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