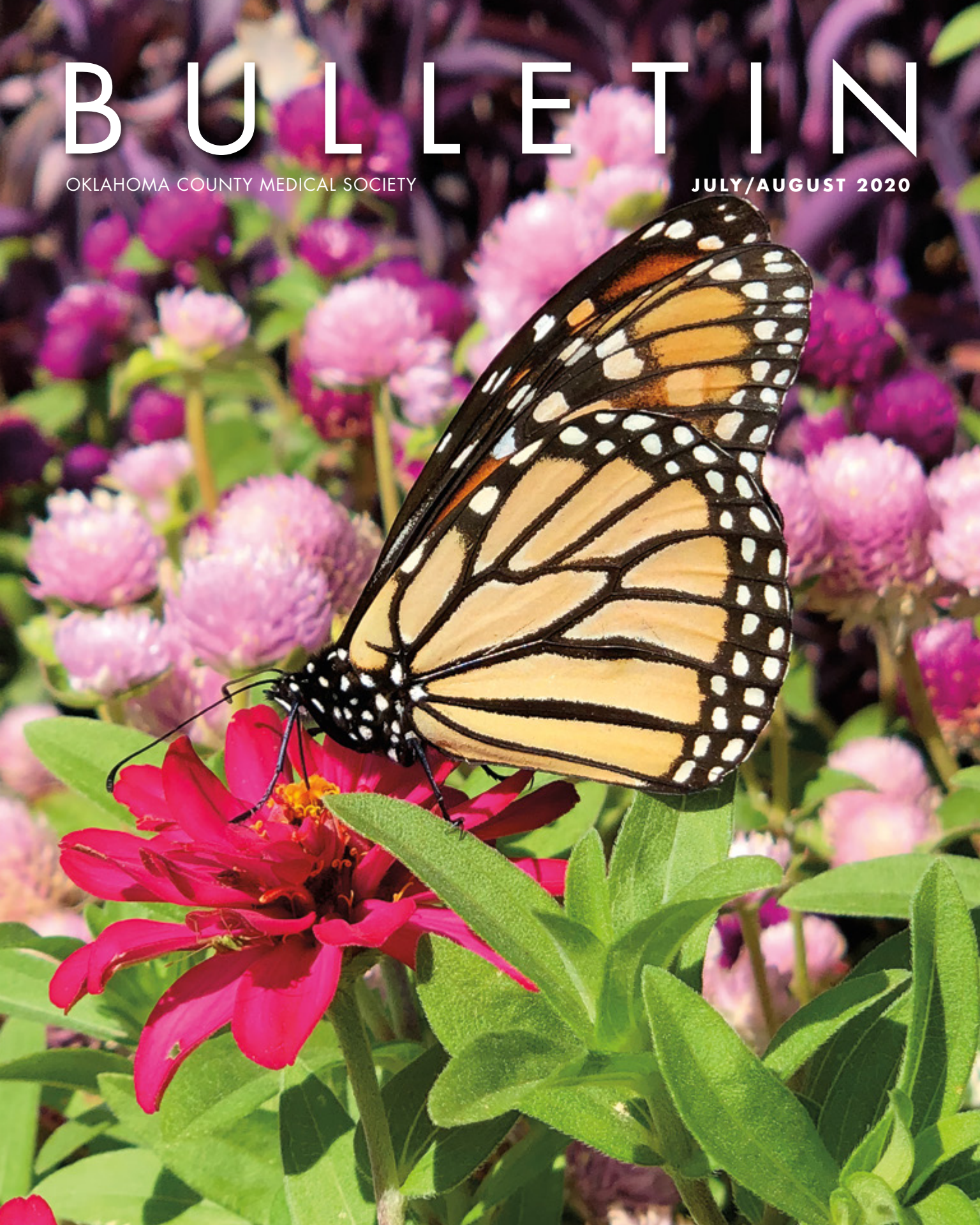
BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY

JULY/AUGUST 2020



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OKLAHOMA COUNTY MEDICAL SOCIETY

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THE BULLETIN

July/August Volume 93 Number 4
Six Annual Publications • Circulation 1500

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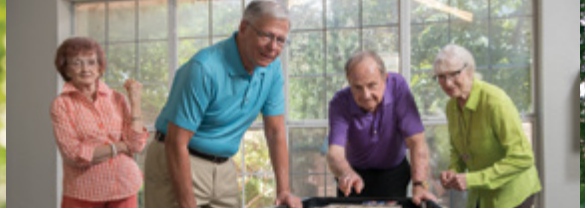


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ABOUT THE COVER

The cover photo was taken by OCMS member Ross Vanhooser, MD. The photo was taken outside of OU Edmond using his iPhone. As a radiologist, Dr. Vanhooser spends hours in darkened rooms, so on occasion a short break outside can be helpful.

"On this particular day, the monarchs were passing through town and pausing on a wonderful flowerbed. I caught this one posing," says Dr. Vanhooser.

If you have photos you would like to submit for the Bulletin, please contact Alison Fink.

In the previous issue of the Bulletin, we misstated the name of the reverend interviewed by Editor Bill Truels, MD. He is Reverend Norman Neaves, not Reaves. We deeply regret the error.

Q: What is concierge-style banking?

A: "5-Star" Banking

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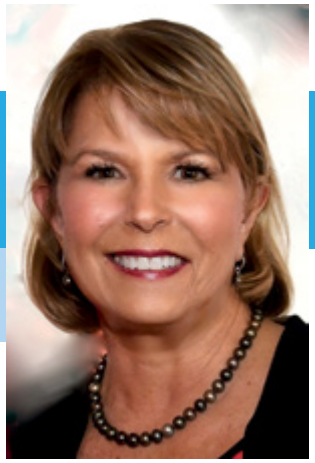
PRESIDENT'S PAGE

Lisa J. Wasemiller, MD



How do you describe what has been happening in the world? "Unprecedented" seems to be the word most used. Many other words apply. Unparalleled. Anomalous. Atypical. Horrific. There is actually no one word that can accurately describe the challenges that every person on this planet has experienced in the past several months.

I think Dickens intro into The Tale of Two Cities summed it up well: "It was the best of times. It was the worst of times. It was the age of foolishness. It was the epic of belief. It was the epic of incredulity. It was the season of light. It was the season of darkness. It was the spring of hope. It was the winter of despair.… We had nothing before us, we were all going direct to Heaven, we were all going direct the other way."

Intriguing that this wording so aptly describes the current dichotomy of chaos and conflict of the tumultuous environment of COVID-19 outbreak with the sanctity and unity provided by sheltering at home necessitated by social distancing. Certainly, the worst of times relates to the possibility of contracting and dying from the virus. However even if you are not infected with the virus, there is absolutely no doubt you will be significantly affected by the financial impact, as well as the physical, emotional, and psychological sequelae. I am not sure we will ever know exactly all the ramifications this pandemic has caused.

The coronavirus has disrupted life as we knew it.

Schools have been suspended. Essential businesses were allowed to remain open. Essential businesses were considered life-sustaining, providing supplies necessary for life both in the long and short term, Such as hospitals, banks, grocery stores, gas stations, pharmacies etc.

Nonessential businesses were closed. Nonessential businesses were considered as mostly for pleasure -such as restaurants, museums, movie theaters, sporting events, hair salons, etc.

Ironic that the ability to purchase liquor was deemed life-sustaining/essential; in contrast to going to the gym, where people actually go to improve their health. The controversy of "To mask? Or not to mask? That is the question." is still a subject of ongoing debate. But if the controversy is whether or not masks provide benefit for prevention- why are "traditional "surgical masks considered essential personal protective equipment in the operating room?

We are still in the ever-evolving process of defining the new normal.

As far as the best of times:

There has been an absolute explosion of research and development in the scientific community. Researchers throughout the entire world are working 24/7 to develop vaccines and treatments for COVID-19. Perhaps during this process additional discoveries will also be made.

The best of human nature is manifesting. Stories of compassion—taking time to draw chalk pictures on

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the sidewalk to express appreciation; shopping for a quarantined person, sewing masks, volunteering to hand out food at the food banks, and numerous other acts of self-sacrifice are rapidly spreading across the country.

The "shelter in place" lifestyle is fostering a litany of ingenious innovations Some of these inventions are producing unexpected efficiencies in business and in schools A new method of teaching with distance-learning is one example

Others are fostering surprisingly vibrant modes of social interaction. Telemedicine has made a remarkable impact in medical care.

Physicians are navigating one of the most major public health crisis. We are dealing with a highly contagious virus that significantly increases the risk of death, with very limited treatment options. Not only is the concern that we ourselves would contract the virus, but the fact that we could transmit to our friends or family. The way we practice medicine has been changing on an almost daily basis. The stresses of maintaining knowledge on management of the coronavirus, and the implications on how to manage patients in a safe fashion is uncharted waters. For most of us, the concerns about our financial stability for now and in the future are significant.

Physicians need to be able to recognize the likelihood of increased risk of depression, anxiety, insomnia, and an overall feeling of being overwhelmed.

Just a reminder to anyone reading this, that FREE and CONFIDENTIAL counseling is available through the OCMS and its Physicians Wellness program (www.okcountymed.org/pwp).

An extreme worst of times moment is exemplified by the needless loss of life of George Floyd through the use of excessive force. More training in de-escalation is warranted. In my opinion, we cannot do without our police force. However, looking into ADDING to not replacing the police, with other alternative forms of order could be an option - such as community care networks and justice structures based on a restoration process rather than punishment. There is still much more fundamental analysis necessary to determine how to arrange that the right person will respond with the right skills and tools to provide the protective action needed.

But follow that with a best of times moment as The Supreme Court ruled on Monday, June 8, 2020 on a landmark civil rights law that protects gay and transgender workplace discrimination. Until Monday's decision, it was legal in more than half of the states to fire workers for being gay, bisexual or transgender. This momentous decision has extended workplace protections to millions of people across the nation. This is a simple and profound victory for LGBTQ civil rights. Once the "crisis" is over, OCMS plans to resume our collegiality dinners. Besides our regularly scheduled membership meetings, OCMS has initiated new events designed to encourage and support the membership providing a venue for promoting the ability to meet and interact with our colleagues. Last year two dinner events were held. Both events – Women in Medicine and LGBTQ+ in Medicine were tremendous successes. OCMS plans to add a Physicians Under 40 dinner as soon as it's safe to do so and are considering virtual options while being considerate of "Zoom exhaustion."

The new normal is still being defined. If nothing else this year is shown to me there needs to be transformation. Transformation comes from within. We each must start with ourselves and then spread that outward. We need to think of ourselves as one big family all trying to fight this virus together. We all matter.

We need to go back to what we learned in kindergarten:

Share.

Play fair.

Don't hit people.

Put things back where you found them.

Clean up your own mess.

Don't take things that aren't yours.

Say you're sorry when you hurt somebody.

Wash your hands.

Live a balanced life – learn some and think some and draw and paint and sing and dance and play and work every day some.

Take naps.

Say please and thank you.

But most of all —When you go out into the world, watch out for traffic, hold hands, and stick together.

Ronald O. Gilcher, MD, FACP

in memoriam

Oklahoma Blood Institute honors the life and legacy of Ronald O. Gilcher, MD, FACP, who led our blood center as CEO, President and Medical Director from 1979 to 2006. Dr. Gilcher passed away following a lengthy illness.

Dr. Gilcher, an undisputed international leader in blood transfusion, helped grow Oklahoma Blood Institute into a self-sufficient blood center and a national leader in blood safety testing and donor recruitment.

We are thinking of and praying for Dr. Gilcher's family as we mourn his passing.

Thank you, Dr. Ronald O. Gilcher, for your momentous contributions that will forever improve the lives of transfused patients and strengthen our community spirit of neighbors helping neighbors.

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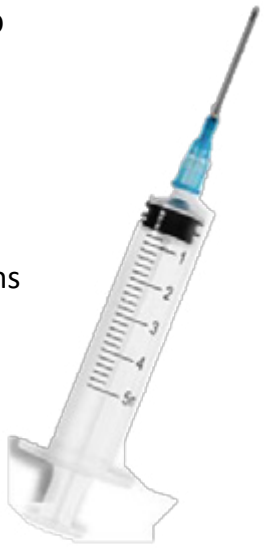

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John P. Zubialde, MD
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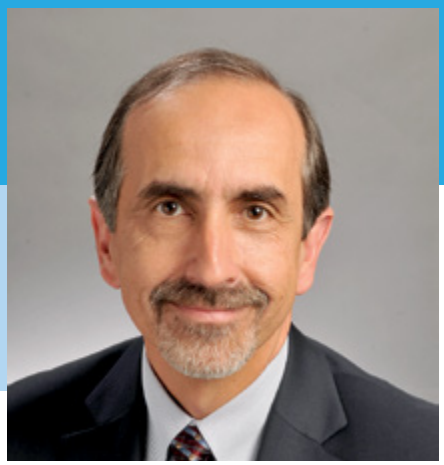

A core mission for the OU College of Medicine is to teach the next generation of physicians and conduct research that contributes to the foundation of medical knowledge. Our faculty members in the College of Medicine have chosen to practice in academic medicine because they are specifically drawn to that mission. Just as our faculty are dedicated to that mission, we are committed to supporting them from the moment they step on campus. One of my goals as Executive Dean is to increase our emphasis on faculty affairs and professional development. We support our faculty members in a variety of ways, but we want to seek new and better methods and to pull all initiatives under one umbrella.

This year, the college created a new role within the Dean's Office – Associate Dean for Faculty Affairs and Professional Development -- to focus solely on our faculty as they carry out their service in patient care, medical education and research. To lead that work, we welcomed Sheila Crow, Ph.D., who brings 30 years of experience across the continuum of medical education. Dr. Crow has spent the majority of her career with the College of Medicine, holding academic and administrative roles on both the Oklahoma City and Tulsa campuses.

Among her goals is to develop a longitudinal on-boarding process for our new faculty members. On-boarding shouldn't be a one-time offering -- what faculty need to know in their first week is quite different than what they need to understand in six months or years later. Dr. Crow will work with faculty throughout their careers, building organizational structures to support them as they enter different phases and helping them prepare for major objectives, such as promotion and tenure.

She will also engage with the Office of Diversity, Inclusion and Community Engagement to promote diversity among our faculty members. Our patients and students represent many ethnicities, cultures and backgrounds, and that diversity needs to be reflected in our faculty. Dr. Crow also will bring an emphasis on wellness and vitality among faculty members.

Formed in 2012, the Academy of Teaching Scholars continues to support our faculty by nurturing and recognizing teaching excellence and promoting educational research, among other priorities. Faculty engage with their colleagues

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to conduct research on various medical education topics, and they can receive peer assessment to improve their teaching ability, whether in the lecture hall or clinical setting. Ongoing lectures and grand rounds provide continuous opportunities for learning in the ever-changing landscape of medical education.

As they establish their careers, many of our junior research faculty are mentored and supported through a National Institutes of Health grant called CoBRE – Centers of Biomedical Research Excellence. The OU College of Medicine holds four CoBRE grants in the disciplines of cancer, diabetes, geroscience and, most recently, microbial pathogenesis and immunity. A major component of the CoBRE program is mentoring junior researchers -- more senior faculty members mentor early-career faculty selected for the grant, guiding them during their research projects and as they leverage their findings to attract new federal grants. This opportunity is invaluable as young researchers launch their careers and establish road maps to seek funding for sustaining their work.

I am grateful for our dedicated faculty and excited about how we can support them in new and meaningful ways. Faculty burnout is high in the academic medicine setting, and the COVID-19 pandemic has produced additional stress and anxiety. Medicine is always challenging, but by enhancing support of our faculty, throughout the span of their careers, I believe we can all maintain and even grow our passion for the tripartite mission that originally drew us to this setting.

THE BULLETIN

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TO THE EDITOR

2020 continues to progress at a breakneck pace. Physicians have spent the last three months preparing for and working through the unprecedented challenges brought on by the COVID19 pandemic. Now our hearts break at the senseless and horrific deaths of George Floyd, Ahmaud Arbery, Breonna Taylor and many others before them. Their tragic and unnecessary deaths once again highlight the fact that racial discrimination has shaped every American institution, including health care.

Racism is undeniably a public health crisis. Simply stated, people of color receive less care, and worse care, than white Americans. Social determinants of health have important implications for health risk and the ability to attain health insurance. Among these factors are poverty, income inequality, wealth inequality, food insecurity, and the lack of safe and affordable housing. Another important social factor that leads to poor health outcomes and social disadvantage for people of color is racism. Studies have shown over and again that racism impacts social stratification and the ability of people of color to maintain physical and emotional wellness. This burden causes African Americans to experience chronic illnesses, mental health crises, and premature death at a rate higher than white Americans.

There is a growing field of research that indicates racial bias within health care contributes to poor health outcomes for African Americans and other patients of racial and ethnic minorities. There is evidence that physicians hold stereotypes based on race which may affect their interpretation of patient symptoms and ultimately their clinical decision making (Burgess, van Ryn, Dovidio, & Saha, 2007; Finucane & Carrese, 1990).[1,2] Another study found that physicians were more likely, after controlling for confounding variables, to rate their African Americans patients as less educated, less intelligent, more likely to abuse drugs and alcohol, and less likely to adhere to treatment regimens (van Ryn & Burke, 2000).[3] A study published as recently as 2016 showed that white medical trainees falsely believed that African American patients felt less pain and had thicker skin than white patients (Hoffman, Trawalter, Axt & Oliver, 2016).[4] Significant research shows that African Americans tend to receive lower quality of health care, including prenatal and preventive care, as well as HIV and cancer treatment. They are also less likely to receive cardiovascular procedures, and more likely to have unnecessary limb amputations.

Substantiating the realization that racial biases affect health care is a 2019 study[5] (Alsan, Garrick, Graziani, 2019) that found care for African American patients is better when they see African American physicians. Increased trust and communication led to a 34% increase in use of preventative services. Other studies have shown than nonwhite patients prefer racially concordant physicians and perceive them as better and more available communicators who provide more respectful care. However, it is unlikely that black patients could always see a black doctor. While African Americans account for 13% of the population of the United States, only 4% of current physicians are black. Additionally, researchers have found that resident physicians from racial and ethnic minorities face a daily barrage of microaggressions as well as overt prejudice that creates extra workplace burdens during a period already characterized by substantial stress (Osseo-Asare, Balasuryia & Huot, 2018).[6]

White Coats for Black Lives is a medical student run organization that was born out of the National White Coat Die-In demonstrations that took place on medical campuses across the nation on December 10, 2014, in reaction to the deaths of Michael Brown and Eric Garner at the hands of police in Ferguson,

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Missouri and New York. White Coats for Black Lives seeks to safeguard the lives and well-being of patients through the elimination of racism, and to dismantle racism in medicine and promote the health, well-being and self-determination of people of color. On Friday, June 5th, health care workers across the country gathered in their respective locations to offer peaceful support in the fight against racial injustice. Members of the Oklahoma Physician Moms Group organized the largest gathering of physicians on the south lawn of the capitol in Oklahoma City, with smaller events taking place at clinics and hospitals throughout the state. At noon in hundred-degree heat, an estimated 200-300 healthcare professionals and supporters listened to a compelling lineup of speakers that included Dr. Julie Krodel, Dr. Angela Hawkins, Dr. Noor Jihan Abdul-Haqq, Dr. Chris Harris and Oklahoma City Councilwoman Nikki Nice. We were reminded than gun violence is the number one killer of black children in America. We were encouraged to vote Yes on State Question 802 on June 30th so that our state can expand Medicaid and offer coverage to more low-income Oklahomans. We listened to stories of struggle and inspiration from our black colleagues. Councilwoman Nice reminded us that zip codes 73111, 73105, 73117 in northeast Oklahoma City have a life expectancy 18 years less than residents in predominantly white suburban Oklahoma county zip codes. Finally, we knelt in silence for 8 minutes and 46 seconds to mourn the death of George Floyd and other victims of police brutality.

Despite the data, many physicians doubt that racial bias can affect patient encounters and overall health outcomes. Many people have difficulty accepting the truth that their actions are influenced by unintended bias, but this is especially troubling for physicians who are trained to treat patients equally. It is time that we, as a profession, should listen, admit and acknowledge our biases and commit to change.

Savannah Stumph DO, FAAP

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IN MEMORIAM

Gordon H. Deckert, MD
1930-2020

A full remembrance of Dr. Deckert will be published in the September/October issue of The Bulletin.

OCMS BOARD NOMINEES

AS OF JUNE 1, 2020

Position 1

T. Craig Kupiec II, MD

Dr. Craig Kupiec is a board-certified Internist and Pediatrician in Edmond, OK with INTEGRIS Medical Group. He completed medical school at the University of Oklahoma and residency in Tulsa at the University of Oklahoma School of Community Medicine, where he served as Chief Resident. He also holds a Master of Science in Public Health and Tropical Medicine from Tulane University and a Diploma of Tropical Medicine and Hygiene from the Gorgas Memorial Institute at the Alexander Von Humboldt Institute of Tropical Medicine at Universidad Peruana Cayetano Heredia. He is active in Oklahoma County Medical Society (OCMS) and served on Oklahoma State Medical Association (OSMA) Board of Trustees from 2016-2018 and currently serves as an alternate trustee. Dr. Kupiec completed OCMS Leadership Academy in 2020.

Passionate about the health of Oklahomans, his focus is serving and advocating for patients and physicians while leading healthcare conversations in our community. Active in the American College of Physicians and the American Academy of Pediatrics, Dr. Kupiec's goal is to see OCMS represent the community well and model vibrant involvement, advocacy, and progress for Oklahoma County in partnership with other county medical societies across the state. He believes physicians have been trusted stalwarts in our communities for centuries, and bold leadership is important to maintain that status into the 21st Century.

Robert Glade, MD

Robert Glade, M.D. is a pediatric otolaryngologist in Oklahoma City whose practice treats children with general ENT issues as well as a special emphasis on care of cleft lip/palate and velopharyngeal insufficiency.

His undergraduate work was performed at Brigham Young University. He attended medical school at Texas A&M University Health Sciences Center College of Medicine. Following an internship University of Utah Affiliated Hospitals, Robert completed a residency at the George Washington University Hospital in Washington D.C. He attended fellowship training at Arkansas Children's Hospital in Little Rock, AR.

He was an attending physician for 6 years at Oklahoma Children's Hospital after which time he left as cofounder of Pediatric ENT of Oklahoma (PEO), a private practice group. PEO is a comprehensive pediatric ENT practice that offers not only ENT care, but audiology, speech therapy, and allergy.

Robert has a passion for mission trips to repair cleft lip and palates which he performs yearly, with most recent trips taking him to Guatemala, Ethiopia, the Philippines, China, and Nigeria.

Robert and his wife Melanie, reside in Edmond with their three young boys, TJ, Andy, and Micah.

Position 2

Bret Haymore, MD

Bret R. Haymore, M.D. attended Penn State Hershey College of Medicine where he was elected to the AOA honor society. He subsequently completed a residency in internal medicine and was chief medical resident. He has received numerous teaching and research awards and has published numerous articles in the medical literature. He served on the Board of Regents of the American College of Allergy, Asthma and Immunology from 2007-2008.

He served on active duty in the Army for nine years during which time he completed his residency in Internal Medicine and then an Allergy-Immunology fellowship at Walter Reed Army Medical Center in Washington D.C.

Dr. Haymore completed his active duty service in 2011 as a Major and Chief of Clinical Services for the Allergy and Immunology Department at WRAMC. He deployed in support of Operation Iraqi Freedom during his tenure in the military. He has been in private practice in Oklahoma since his departure from the military.

Dr. Haymore and his wife have 5 children and enjoy many activities together including sports, music and outdoor activities. They are active in their Church and the community.

Kevin Miller, MD

Kevin Miller, MD is a board-certified interventional cardiologist with the Oklahoma Heart Hospital. His interests include Interventional Cardiology, Carotid and Peripheral Vascular Disease, Women's Heart Disease and General Cardiology.

Dr. Miller is a member of the American College of Cardiology, Oklahoma City, American Clinical Society, Society of Echocardiography, Society for Cardiovascular Angiography and Interventions, and OCMS and OSMA.

He is the proud father of four children. He is an Eagle Scout and enjoys fishing and wood-working in his spare time.

Continues on page 14 …

Position 3

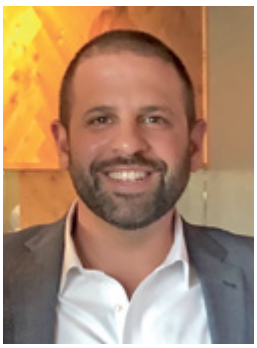
Latisha Heinlen, MD

Latisha Heinlen, MD, is a board-certified rheumatologist currently practicing in a private practice in Oklahoma City. An Oklahoma native, Dr. Heinlen completed medical school at University of Oklahoma College of Medicine and obtained her PhD from University of Oklahoma Department of Pathology. After completing internal medicine residency she worked as a hospitalist at Integris hospital for three years but then decided to return to OUHSC to complete rheumatology fellowship.

Dr. Heinlen founded Rheumatology Associates of Oklahoma (RAO), a private practice in Oklahoma City which includes in-house lab, x-ray, infusion services and ultrasound. In 2020 Dr. Heinlen was recognized as a graduate of the Oklahoma County Medical Society Leadership Academy. She is also an active member in the American College of Rheumatology and the Association of Women in Rheumatology.

In her spare time, Dr. Heinlen enjoys spending time with her husband, also a physician, and her three daughters. When she's not running her girls to a wide variety of activities, you could find her anywhere in the world as she is an avid traveler.

S. Christopher Shadid, MD



S. Christopher Shadid, MD, was born and raised in Oklahoma. He attended Putnam City North High School then the University of Oklahoma, followed by the Ross University School of Medicine. Dr. Shadid completed his residency at the University of Oklahoma Health Sciences Center.

He is a board-certified family medicine physician who spends the majority of his time at his Edmond outpatient practice. Dr. Shadid is also a hospitalist at INTEGRIS Baptist Medical Center and owns an IV infusion center, Infuse. He is an active member of OCMS and OSMA and a graduate of the OCMS Physicians Academy. Dr. Shadid is a two-time winner (2018, 2019) of the Oklahoman's Readers' Choice Award for Best Family Physician and was nominated as the 2020 Best Doctor by 405 Magazine.

Dr. Shadid spends his free time with his wife of 13 years, Katy, and three children Micah (10), Noelle (8) and Layla (6). He is very active in his church. Dr. Shadid is the former medical director of the church free medical clinic (Crossings Community Clinic) and currently serves on their board of directors.

Position 4

Alan W. Hawxby, MD

Dr. Alan Hawxby is currently Surgical Director of Kidney Transplantation at OU Medical Center and Children's Hospital.

A native of Perkins, Oklahoma; Dr. Hawxby has a degree in Biochemistry from OSU and graduated from OU College of Medicine in 1997. He completed General Surgery residency at UMKC in 2002, followed by Transplant fellowship at Johns Hopkins in 2004.

His career began at UAB, where he established the South's first kidney paired donation program in 2005. He was selected as Chief of Transplant Surgery at University of Mississippi in 2007, before being recruited back to OUHSC in 2011.

His research interests include biomedical engineering, and innovative methods to increase the number of livers and kidneys available for transplantation. He has recently developed a multidisciplinary transplant research workgroup on campus. He frequently engages with OU surgery residents and especially medical students - whom he meets with weekly for tutorial sessions throughout their surgery rotations.

Dr. Hawxby has spent nine years on the Medical Advisory Board of LifeShare, serving as Chairman from 2015-2017. He is a member of Leadership Oklahoma (Class 32) and participated in last years' OSMA Physician Leadership Academy. He has an interest in transplant advocacy, and has been involved with state and federal legislation to improve access to transplantation.

He is married to SICU nurse and Edmond native, Andrea Meunier Hawxby. They have three children – Ada, a Freshman at Crossings Christian School; Harrison, a Senior at Oklahoma School for Science and Mathematics; and Emma, a Sophomore at OBU. His outside interests are multiple, but include travel, reading, music, and hiking.

R. Matt Atkins, MD

Dr. Atkins practices general internal medicine with OU Physicians and is an Assistant Professor of Medicine in the Department of Medicine. He is also the Chief Medical Information Officer for OU Medicine and oversees the physician informatics and business intelligence missions in this role. He has specific research interests in predictive analytics and the pursuit of the Learning Health System.

Dr. Atkins received his medical degree from the University of Oklahoma Health Sciences Center. He completed his residency in internal medicine at Duke University Health System. He then served as the Chief Resident for Quality and Safety at Duke Health and the Durham VA Medical Center. He is board certified in Internal Medicine through the ABIM and Clinical Informatics through the ABPM.

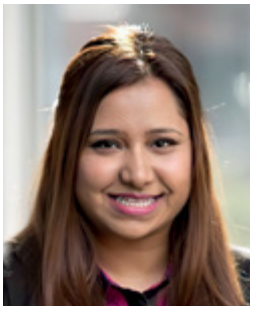
Position 5

Hakeem J. Shakir, MD

Dr. Hakeem Shakir was born and raised in Oklahoma City and attended Casady School. As a National Merit Scholar, he attended the University of Oklahoma graduating with a BA in Spanish in just under 3 years. He attended the University of Oklahoma College of Medicine graduating in 2011. Subsequently, Dr. Shakir completed Neurosurgery residency training, and Endovascular Neurosurgery Fellowship at the University at Buffalo in 2018. He has published over 35 peer-reviewed academic articles ranging from stroke care to physician burnout and has been featured in popular media for his work and advocacy in concussion and stroke prevention. Currently, he is the Director of Endovascular Neurosciences at SSM St. Anthony Hospital, serves on the Board of Visitors at the University of Oklahoma Honors College, and the Social Enterprise Committee of the OKC Homeless Alliance. He lives in Oklahoma City with his wife and newborn daughter.

Pooja Singhal, MD

Dr. Pooja Singhal, MD, FACG, DABOM is a board-certified Gastroenterologist and Director of Women's Digestive Health at SSM Health/St. Anthony Hospital. She completed her medical school training at the University of Oklahoma Health Sciences Center and an internal medicine residency at Georgetown University Hospital in Washington, DC. Dr. Singhal received her fellowship training in gastroenterology at Georgetown as well, where she also served as Chief Resident and Chief Fellow. Dr. Singhal has received several awards and honors including National SCOPY award consecutively from 2016 to 2019 for raising Colon cancer awareness in Oklahoma, ACG train the trainee scholarship, AGA young delegates membership, Caring Star Award, and numerous scholarships. Dr. Singhal's clinical training and interests include Esophageal disorders, Inflammatory bowel disease, Irritable bowel syndrome, liver diseases and women's gastrointestinal health. Dr. Singhal is a Diplomate of the American Board of Obesity Medicine as well. Dr. Singhal holds numerous national positions including ACG Young Scholar leader, ACG Women in Medicine committee chair, and Healio top 200 GI physicians. Dr. Singhal was a part of OCMS leadership academy Class VII, and has been active locally in medical community and Allied Arts community. Dr. Singhal and her husband were recently blessed with a baby boy, and they enjoy traveling and exploring the world together.



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ENCLOTHED COGNITION

Bill Truels, MD

"When one of your patient's dies, do you ever think of yourself as a Pretender?" I asked Herb, as we sat in the Doctor's Lounge at Holy Christian Hospital, waiting for our cases to start.

"Not hardly," Herb replied. "It took me six years after medical school to become a plastic surgeon – I'm no Poser – I'm a real plastic surgeon!"

"Well, sure," I answered. "It took me six years after medical school to become a general surgeon. Then I had to pass a written exam, followed by an oral exam to get board certified."

"I'm not talking about credentials, Herb. What I mean is that sometimes I feel like I don't deserve all this credit and respect- I mean, I'm the same person I was in high school and college. Back then, I put on a white jacket and worked as a busboy in a sorority. People barely noticed me!"

"And for good reason," Herb joked. "You were just a Nerd back then, who studied hard and didn't know how to enjoy college life!"

"True enough," I said. "But, now people walk up to me and say, 'Doctor this' and 'Doctor that'– I mean, sometimes, when my patients aren't doing well, I think I don't deserve all this attention."

"O.K., I'll just call you Mr. Truewater, if it makes you feel any better!"

"I think back to my medical school days. "I was a second year medical student in Chicago, steeped in book learning, and short on social skills."

"I was assigned to do a patient history and physical. I put on my White Coat, told the patient that I was a student, and bravely proceeded to pretend like I was a doctor."

"Then I saw one of my colleagues – you know, the ones that are always one year ahead of you in school – you never catch up to them. Well, Jim had lost most of his hair in college, so he looked older. I saw him walking in the medical ward of Holy Christian, wearing his scrubs, with his white coat and stethoscope – patients thought he was a real doctor!"

"I mean, isn't that what we do – we pretend – we play the role of a doctor."

"True enough, Dr. Truewater, we all have a role to play. You can be humble like a pediatrician or obnoxious like a surgeon!" Herb quipped.

"We go through a solemn, almost mystical, White Coat ceremony," I continued. "They call it a Transformation Ceremony – sort of like an anointing. Then we have a Graduation Ceremony, and we put on a robe and a fancy hat that has a tail on it, and we get a paper certificate that puts an MD or DO after our embossed name – and we keep on playing the role – we keep on pretending that we're doctors! But do clothes really make the man – or are they costumes that we use to masquerade?"

"There's a professor at Northwestern, Dr. Hajo Adam, who uses the term 'Enclothed Cognition' to describe how the clothes we wear affect the way you think, feel and behave," Herb interjected. "Society gives us a white coat and bestows upon us the role of Healers."

"In a sense, we're all role players with Enclothed Cognition!" Herb added. "We are who we think we are – it becomes a self-fulfilling prophecy!"

"People put us on a pedestal, but we're all just ordinary people!" I concluded.

"Trying to do extraordinary things!" Herb replied.

"Besides, it's not like you're some Charlatan, or some Great Pretender," Herb added. "You worked hard to get where you are today – you deserve a little respect, and society gives it to you!"

"We're not movie actors on a stage, Dr. Truewater. Movie actors pretend to be someone who they're not – and they're good at it. But we're not pretending to be doctors – we really are doctors, for God's sake!"

"I saw an interview with a rock star on TV," I interjected. "He says he adopts a Persona on stage when he's performing. Isn't that what we all do? I mean, if you're a judge in front of the jury, you put on a black robe, and you learn to play the role."

"We adopt a very serious doctor Persona when we're doctoring. Then we go out and have a beer at the local pub to let off steam!"

"True enough," Herb replied. "But do you think it's any easier for other professions? Take the ministry – do you think that first time preachers have a few self-doubts when they give their first sermon, preaching hellfire and brimstone to a crowded congregation, and promising eternal life to the believer?"

"We each have a role to play, Dr. Truewater. The doctor's role is to keep the patient alive and healthy. The preacher's role is to marry them and bury them!"

"That's all well and good, Herb. But we're dealing with human lives here – we're claiming to cure people of their afflictions by performing surgery and writing prescriptions. I don't know if I can promise that!"

"I mean, when one of my patient's dies, I feel responsible. I remember one resident I trained with who didn't want anybody to die while he was on duty

Continues on page 18 …

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– like he would be blamed. Nobody wanted to follow him on duty!"

"For the first five years, I looked too young and had some self-doubts. Then, for the next thirty years, the doubts vanished and everything was fine. Now, in the last five years, with my patients becoming senior citizens, I'm beginning to realize my shortcomings. I'm busy extolling the wonders of modern science, but my patients are dying, for God's sake – I'm calling the preacher to help!"

"Most of the time we don't cure people, Dr. Truewater – we don't prevent death – as doctors our role is to delay death and improve the quality of life."

"Besides, it's been shown that if you honestly believe that you're a doctor and you convey that self-confidence to your patient, then your patient is more likely to be healed! It's important to believe in yourself, Dr. Truewater, so that your patients can believe in you!"

"Of course, you have to be honest with your patient," Herb added. "You can't promise pie in the sky – you have to be realistic with your patient and explain the downside."

"And as a physician, it's important to give back to the community – look at those eye doctors who travel to Africa every year – or those doctors at St. Jude who treat children with cancer for free. Look at those missionary doctors who travel to far-off lands to treat disease and heal the afflicted!"

"But, you're right in a sense, Dr. Truewater," Herb added after further introspection.

"We all have self-doubts from time to time. In that sense, we're all actors – we're all role playing. You put on a White Coat and a stethoscope and you go play 'Doctor'. Then you go home and you play, 'Mommy' or 'Daddy' and 'Husband' or 'Wife'."

"Perhaps the most important thing," I concluded, as I put on my cap and mask and headed back to surgery, "is to learn to play multiple roles – don't play 'Doctor' so hard that you forget to take off your White Coat, slip into something casual, and play 'Parent' or 'Spouse' when you get back home!"

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CONCERNS ABOUT DEATH IN LONG-TERM CARE FACILITIES

S. Sandy Sanbar, MD, PhD, JD, FCLM*

Long-term care facilities (LTCFs) is a collective term for nursing homes, skilled nursing facilities (SNF), and assisted living facilities, or *residential care homes* or *personal care homes*. There are about 15,600 nursing homes and 7,500 assisted living facilities in the U.S.[1] 2.1 million people live in LTCFs., of whom 1.3 million people live in nursing homes[2]; 80 percent are white. Every year, 1-3 million serious infections occur in LTCFs, including urinary tract infections, diarrheal diseases, antibiotic-resistant staph infections, upper respiratory infections and many more. In LTCFs, infections are a major cause of hospitalization and cause deaths of 380,000 people every year.

The COVID pandemic has obviated vulnerabilities and concerns pertaining to LTCFs.

- About 81,000 elderly Americans age 65 years or older have died from COVID-19 out of a total of 110,000 deaths as of June 6, 2020.
- LTCFs have accounted for 42% of the COVID-19 deaths in the U.S.
- Nursing homes with a significant number of African-American and Latino residents have been twice to three times as likely to be hit by COVID-19 as those where the population is overwhelmingly white.
- In May 2020, the Oklahoma State Health Department tested 35,800 at 265 LTCFs and found 3% (1,100) of the residents (714) and staff (428) were positive for COVID-19.

*Executive Director, Diplomate and Past Chairman, American Board of Legal Medicine; Vice President and Director of CME, Western Institute of Legal Medicine, California; Fellow and Past President, American College of Legal Medicine; and Adjunct Professor, Medical Education, OUHSC.

Concerns about LTCFs Building Structures:

- Nursing homes often have long hallways with 40 rooms and 80 or more residents.
- Residents mingle in large dining rooms and share resident rooms with mostly two occupants per room, but some have 3-4 occupants.
- Some nursing homes house hundreds of residents.
- This makes it easier to transmit from person-to-person a highly contagious disease such as COVID-19.

LTCFs Workers:

- The LTCFs workers might be inadvertently carriers of COVID-19.
- They have had shortages of safety gear.
- They have had difficulty securing coronavirus test kits.
- Some of the nursing home workers fell ill, alongside their patients.
- Some nursing homes have been short-staffed, disorganized facilities that lack adequate protective gear amid the pandemic.
- Restricting visitor access, screening for symptoms anyone who enters, and following federal guidelines for personal protective equipment and patient isolation were delayed partly because of delayed response to COVID-19 by the government.
- There have been delays in receiving proper supplies, including face shields, medical-grade eye protection, masks and gowns.

LTCFs Residents

Nursing home and assisted living facility residents are generally older people with underlying health conditions. Infections, such as COVID-19, prey on such people. The diagnosis and treatment of COVID-19 infections has been difficult because it is a novel virus, a lack of timely testing and lack of specialists and proper equipment in LTCFs, such as ventilators.

Future of LTCFs

- Large nursing home populations should be divided into small, self-sufficient units with kitchens, private rooms and a dedicated staff.
- "Smaller-is-better" approach arose before COVID-19 out of concern for residents' privacy and dignity. COVID-19 infections and deaths in large nursing homes indicate that the smaller-is-better approach helps with infection control as well.
- Private rooms can make a big difference in controlling COVID-19 and keeping it at bay. A private room or even an entire 'household' can be closed off more easily, keeping out or confining viruses.

- Staff members who are focused on a small number of residents may be more likely to pick up on warning signs that someone is sick.
- The preparation of food and laundry in a household instead of a central facility eliminates some of the way diseases can infiltrate.
- Disease control should include scrutiny of air circulation and filtration when heating, ventilation and air conditioning systems are planned. Use of high-efficiency particulate air filters, commonly called HEPA filters, can trap bacteria and other particles.
- Adding ultraviolet light filters are effective in killing airborne viruses.
- Other considerations include easy-to-clean, nonporous surfaces; use of antimicrobial materials, like copper, for "high touch" areas like hand railings; voice - or sensor-activated controls for doors, lighting, curtains, faucets and toilets; solar and/or wind energy; battery back-up equipment; audio and video communications between residents and nursing staff; and telemedicine/telehealth equipment and trained presenters.
- Some nursing home designers may install modular walls so that resident rooms can quickly be reconfigured in a crisis. During a pandemic, the virus infected patient may not be moved to an isolation area, but the room may be changed into an isolation area.

Examples

- Private rooms have made a significant difference in the ability to control the virus at *Jewish Senior Services*, a four-story building for skilled nursing and assisted living in Bridgeport, Conn.[3] There are 330 residents divided into 'households' of 14 residents each. When somebody is diagnosed with COVID-19, their door is closed. Signs are posted and safety gear is placed outside the door so that staff know to suit up before entering. Eight of the 23 'households' had COVID-19 infections and 15 residents died.
- The *Green House Project*[4] is a nonprofit organization that oversees 266 small-house nursing homes. Of the 243 projects that supplied data in early May 2020, eight reported having cases of Covid-19, and there were no deaths.
- The *Department of Veterans Affairs* began embracing a small-house model[5] in 2011; now, 13 of its 134 nursing homes are organized around communities of 10 to 14 residents. In these settings, only a single veteran has tested positive for COVID-19.

The Centers for Medicare & Medicaid Services (CMS)[6] and *the Centers for Disease Control and Prevention (CDC) issued Nursing Homes Guidance*[7] on April 2, 2020 new recommendations to State and local governments and long-term care facilities to help mitigate the spread of COVID-19. These include,

- Addressing nursing homes in different phases of COVID-19 response;
- Assigning an individual to manage the facility's infection control program;
- New requirements for nursing homes to report to the National Healthcare Safety Network (NHSN);
- Creating a plan for frequent testing of residents and healthcare personnel for COVID-19;
- Providing clinical staff Information;
- Provide resident information;

I • mplement prevention tools; and

- Workers infection prevention training.

Finally, the *Facility Guidelines Institute*[8] writes planning and design standards that are adopted in most states and by federal agencies. In May 2020, the Institute set up a task force to make recommendations for how health care facilities can cope during emergencies. A report is expected in January 2022.

1. https://www.cdc.gov/nchs/fastats/nursing-home-care.htm
2. https://www.kff.org/other/state-indicator/number-of-nursing-facility-residents/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
3. https://www.jseniors.org/?utm_source=google&utm_medium=organic&utm_campaign=gmb
4. https://www.thegreenhouseproject.org/
5. https://www.cfm.va.gov/til/dGuide/dgSHModel.pdf
6. https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf
7. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html
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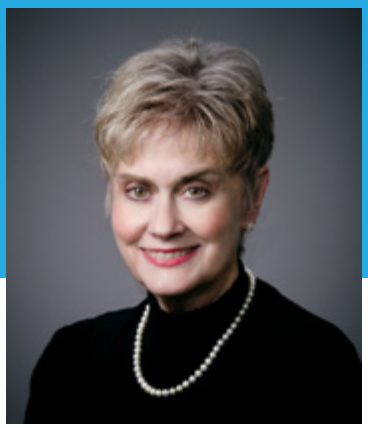

By Jana Timberlake, Executive Director

Every time we turn our heads the other way when we see the law flouted, when we tolerate what we know to be wrong, when we close our eye and ears to the corrupt because we are too busy or too frightened, when we fail to speak up and speak out, we strike a blow against freedom and decency and justice. **~ Robert F. Kennedy**

Did you participate in, or happen to see the media coverage of, the White Coats for Black Lives event at the Capitol on Friday, June 5th? My heart swelled when I saw the many physicians and medical staff members taking a knee against the lack of social justice for people of color. And they did so in 100 degree temperatures.

Being born in 1953, it allowed me a glimpse into the quiet racism that I would not truly understand until I became much older. But I saw the symbols – colored and white only drinking fountains and restrooms, segregation of schools, and the lack of opportunities afforded to people of color. My mother worked part-time during the summer months and an African American woman, Beatrice Peters, stayed with me and cooked lunch each day for my father and brothers as they took a noon-time break from plowing fields, chopping cotton, baling hay and working with the cattle. You see, Beatrice was my best friend, and I loved her with all my heart. She was filled with kindness, with never a harsh word spoken.

My family's social life revolved around visiting friends in the evenings, where the adults engaged in a game of bridge and the kids played with each other. One day, I asked my mother why we never visited Beatrice and her husband, Lem. Beatrice was my friend, and I wanted to go to her home that we passed with each trip to town. My mother's reply has never been forgotten, "It's just not done." My parents were not prejudiced or racist and believed each human being deserved respect and kindness. But what I just mentioned was the norm in the mid to late 1950s where everyone "knew their place."

Then desegregation occurred. While our small school was not segregated, other larger schools in southwestern Oklahoma were. I remember the Civil Rights Movement and watching Americans march in protest much like what is occurring at this moment. Memories of the Watts Riots in 1965 caused me to fear that our civilization was unraveling. I will never forget the feeling of despair when Martin Luther King, Jr. and Robert F. Kennedy were both assassinated in 1968. It felt as if this country was insane and at the same time sending young men to the Vietnam conflict, with many returning in body bags. And I feel the same way at this very moment while dealing with the COVID-19 pandemic and the social injustice that pervades our society.

Continues on page 24 …

While my family was not wealthy, and many in our farming community were not, I was still born into privilege because of my skin color. You know, the kind of privilege that money cannot buy. And even today I still do not have to contend with the type of social injustices experienced by people of color and can never truly understand the anger that is derived from it because it has not happened to me.

Our church continues to conduct services via Zoom. Last Sunday's sermon was by the Rev. Dr. William J. Barber, II that was originally preached on Pentecost Sunday and was brought to us by Repairers of the Breach. He spoke about the systemic oppression built into our society, i.e. lack of education opportunities, judicial injustices, inadequate access to health care, etc. We can no longer turn away if these issues are to be solved.

Even though I continue to be cognizant of the virus by wearing my mask and proper social distancing, my heart is with the protesters. One of my favorite quotes by Martin Luther King, Jr., A Testament of Hope: The Essential Writings and Speeches, is below:

"Darkness cannot drive out darkness: only light can do that.

Hate cannot drive out hate: only love can do that."

I beg each of you to continue to shine your lights and love one another, EVERY SINGLE OTHER.

JanaTimberlake, Executive Director

Hanna A. Saadah, MD

The repeating conflicts that continue to splinter humanity have spurred me to wonder why Homo sapiens (Latin for wise man) after more than 200,000 years of cohabitation on this little bubble of a planet, have not yet learned to get along. Perhaps, as many have already suggested, we should change our race's nomenclature from Homo sapiens to Homo conflictus because violent conflict is what really defines our historic behavior.

The title of the sonnet was inspired by the corona virus because it wears a crown of spikes.

Crown of Thorns Sonnet 113

Life is at war with life and grief, with joy
And frowns, with smiles and violence, with peace
And lies, with truth. 'Tis Mother Nature's ploy
To see that human conflicts never cease.

With brains selected not to get along
We group and splinter, group and splinter more
Nor let the meek think wisely for the strong
Nor learn that peace is glorious, more than war.

Perhaps fear will unite us when the air
Becomes less clear and trees become less fair
And the one choice that unto us remains
Is to unite, succor, and share our pains.

Oh, crown of thorns that everyone must wear
Like once He did who saved us from despair.

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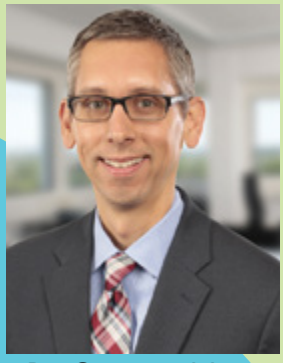
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RAGING STORM

Oklahoma City VA Hospital, 2019

HIS FACE QUIVERED. **His eyes simmered.**

His wife hid behind dark glasses.

The examination room was angular and sterile.

I WAS PRE-WARNED BY THE CLINIC NURSE:

"BEWARE, DOCTOR. HE'S A RAGING STORM."

"Good morning, Mr. Tinnier," I began, cracking the stiff, dry silence.

"Where're you from?" He snapped.

"Lebanon."

"What brings you here?"

"I came fifty years ago to specialize."

"And why didn't you go back to your own country?"

"A civil war broke out and I couldn't return."

"Are you legal?"

*

Mr. Ira Tinnier's long, lean legs shook as he sat behind his bushy, white mustache and glared into my eyes. Cautiously, I inched my rolling stool closer and closer until his wife clasped his right arm and held it down. Then, with a tremulous voice, she whispered, "Honey. He's here to help you."

"No one can help me," he snapped back.

"We've come all this way for a second opinion. Might as well give the doctor a chance?"

Then, while still clasping Mr. Tinnier's sinewy, right arm, she explained. "We drove three hours to this appointment because his doctor wanted to see if the VA had anything new to offer. He's 100% service connected for his PTSD"

"Mr. Tinnier," I said with a calming voice. "I can tell that you don't feel like talking. But, using just one, simple word could you please help me by telling me what bothers you the most."

"Anger."

His wife nodded approvingly and let go of his arm. Then, seeing my confused aspect, added, "He's angry all the time and snaps at everyone and everything at least once a day. He's never been able to keep a job. He's been fired more than thirty times because of his temper. He snaps at the dog, at the TV, at the weather, at the furniture, but mostly at me. I love him dearly, but I'm afraid of him. He gave me a black eye just the other day."

Mrs. Tinnier took off her dark glasses. It was her left eye. Mr. Tinnier seemed unconcerned as if this had nothing to do with him or her.

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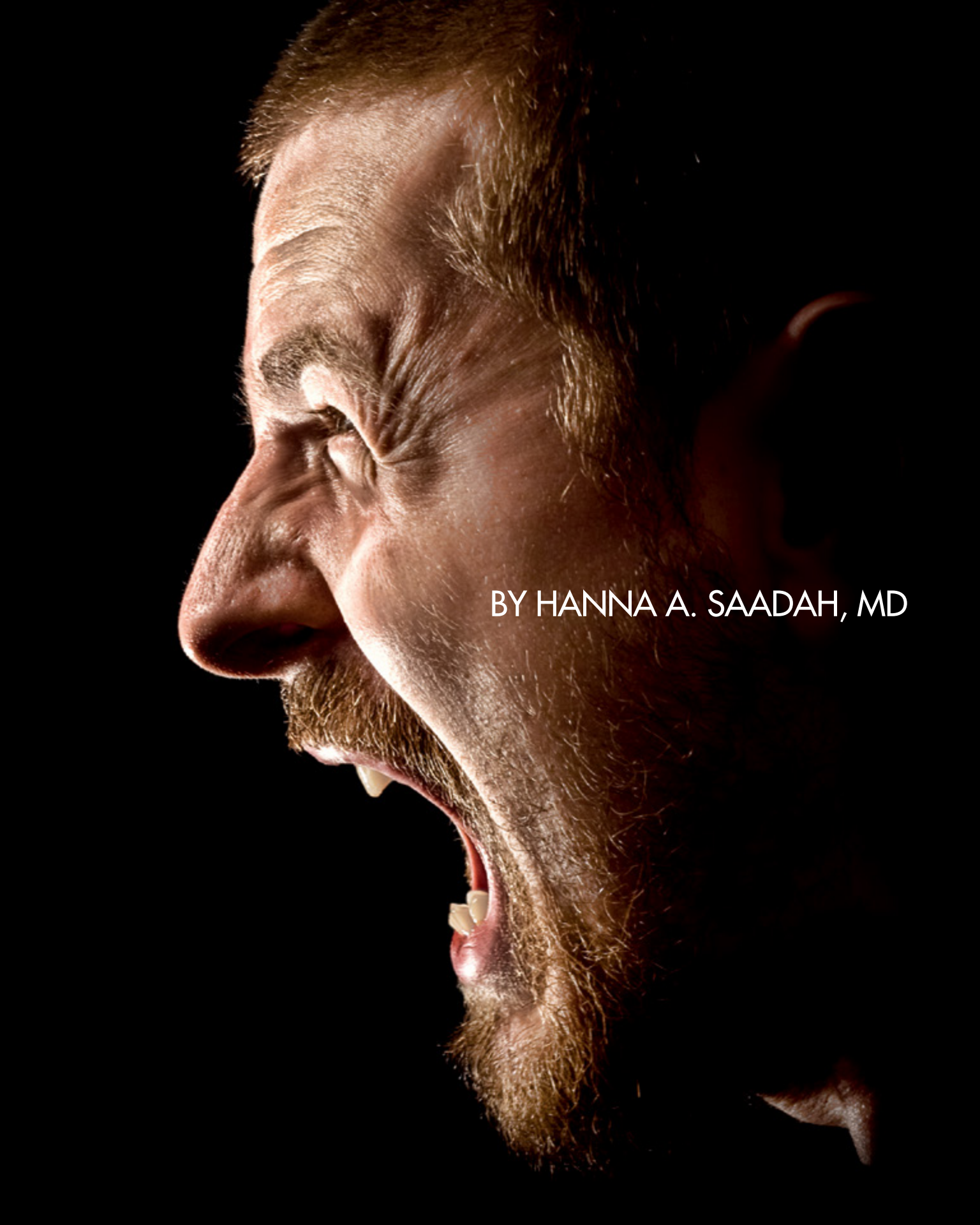

BY HANNA A. SAADAH, MD

"He's a good man," added Mrs. Tinnier, putting her dark glasses back on. "It was his anger that did it, not him. He doesn't know what he's doing when he snaps."

Mr. Tinnier, as if uninvolved, somberly stared at his elaborately embroidered cowboy boots.

*

"Mr. Tinnier," I asked after a polite pause. "What makes you snap?"

"Questions, like what you're doing to me right now."

"Doctor," interjected his wife. "He hates to be questioned, but he also explodes for no reason. Scares the heck out of me."

"Mr. Tinnier. Do you have any warning signs before your anger snaps?"

"No. It just explodes like a dynamite stick."

"How long does it take you to get over it?"

"It lasts a minute, but then I stay shaken for twenty more minutes. Then a real mild headache follows and lasts about an hour or so."

"Where does the headache hurt?"

"All over but it isn't bad enough to take anything for it."

"Have they tried you on anti-seizure medicines?"

"I'm taking two. They do no good."

"How about antidepressants?"

"I've taken so many. Same thing. This last one helps me sleep, but it [sic] don't help the spells."

At this point, Mrs. Tinnier took over the conversation. "He was a wonderful man before he went to the service. I never gave up on him, though, because I love him. We've been married fifty years."

"Was he in combat?"

"I never saw combat," interjected, Mr. Tinnier. "I was trained in Morse Code and was a Morse Code operator on a ship in Vietnam's South China Sea from 1960 to 1964, 12 hours on, 12 hours off, seven days a week without breaks."

"He sometimes worked 18-hour shifts," added Mrs. Tinnier.

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"Them headphones drove me crazy," he snapped again. "I can still hear that dud-da-daa in my head. Can you help me without giving me more medicines? I'm already taking nineteen."

His wife handed me his bulging bag of pills.

*

I examined Mr. Tinnier's medicines, moving them one-by-one out of the bag. He was taking pills for high blood pressure, atrial fibrillation, diabetes, anxiety, depression, insomnia, seizures, arthritis, osteoporosis, allergies, and cholesterol.

"I see that you're not taking any vitamins."

"He took bunches of vitamins for a long time, but then he got mad because they were expensive and did him no good," interjected Mrs. Tinnier.

"Nothing has ever done me any good except them weekly group sessions," affirmed Mr. Tinnier. "I'm seventy-seven. My ears ring constantly as if an endless train is passing through my head. I can't control my temper; it controls me. I've hurt everyone's feelings. I force myself to eat because I continue to lose weight. I am just waiting to die and am as ready for relief as is everyone else around me."

Having fumed out his frustration, Mr. Tinnier sighed and fell into a deep well of silence. His attitude, almost suicidal, worried me. He clearly disliked being questioned, but I felt compelled to further probe his desperate soul. After a cautious pause, I whispered, "Tell me about them weekly sessions."

"A psychologist holds group therapy for a bunch of us guys with PTSD. I've been going for twenty years and I never miss. I always feel calm when I leave. They're the only thing keeping me alive," he confessed, and then, after a moment's reflection, added, "that, and reading my Bible."

*

His last statement relieved my anguish. Men of faith do not commit suicide, I surmised. But, something about his anguished despair still worried me. As I composed my next question, Mr. Ira Tinnier stared at his boots and nervously shook his knees.

"Mr. Tinnier. Are you thinking of death as a solution?"

"What's wrong with death?" he retorted.

"You may think that death ends your problems, but it leaves all kinds of problems behind."

"No, it won't. No one will miss me. Everyone will be relieved when I die. My life has so much wrong with it. It can't be fixed." Then, with a softer tone, he pleaded, "I know you understand what I'm saying. Why can't you help me get it over with?"

When he said that, his wife seemed unconcerned, which surprised me. I needed her to hold his arm,

Continues on page 30 …

to admonish him, to remind him of his daily Bible readings, but she behaved as if she were a spectator, watching a show.

"I do understand what you mean, Mr. Tinnier, but as a doctor, my mission is to save your life, not to help you end it."

"Save my life from what?"

"Save it from death."

"But, what's wrong with death?" He retorted again. "It solves all the wrongs of life and there's never anything wrong with it. Death cleans life's dung and makes room for others who need a place to live. I went to college on the GI Bill and majored in philosophy and religion. I know all about death. There's nothing wrong with death; there's everything wrong with life."

"But it is selfish to choose death, leaving those who love you with problems that have no solutions."

"We are born in bondage, Doctor. You are ruled by your profession, I am ruled by my infirmity, we are both ruled by life, and only death can free us from our captivity. All our so-called freedoms are illusions. No one is really free while alive."

"He reads philosophy every day," added his wife. "No one can win an argument against him."

*

"Do you believe in God, Mr. Tinnier?" I asked with a firm voice.

"Our beliefs are myths to others as the beliefs of others are myths to us. We don't only live on earth, Doctor. We live equally hard in our fantasies, which are just as real as the earth upon which we walk."

I knew at that point that I was dealing with a desperate man who still reads his Bible every day even though he had lost his faith in God. His wife and I exchanged knowing glances, which he noticed but did not seem to mind. Nevertheless, my options were limited. I could tell him that I had nothing to offer and apologize for wasting his long day of travel. Or I could keep the conversation alive, hoping that by verbalizing his thoughts he would feel improved, as he does after his group therapy sessions. Even though I was un-steeped in philosophy, my best idea was to challenge his notion that no one is free while alive.

"Surely, Mr. Tinnier, you must at least agree that our imagination is free."

"Imagination is not free," he sneered. "No one can imagine anything totally unknown to the mind. Imagination merely extrapolates from what we know, but all its images and scenes must remain tethered to our experiences. Try to imagine what God looks like and you will not be able to go beyond the collective images that are already in your brain."

"Mr. Tinnier. Can you imagine that I may be able to help you?"

A long pause followed without a response. Saying that he could not imagine that I can help him, would be hard to defend because my next question would challenge him with, 'Why did you bother to come to the VA then?' As I waited for an answer, he sighed, fidgeted, roamed his eyes around the room, and then replied, "I have hope, and that's what keeps me going. But I don't want more medicines."

"Are you talking about prescription medicines?"

"Yes. No more prescriptions for me. I already feel overmedicated."

*

Despair conjures desperate ideas. The Tinniers and I were desperate. Mr. Tinnier was desperate for relief, Mrs. Tinnier was desperate for peace, and I was desperate for an alternative solution. I agonized under the gaze of Mr. and Mrs. Tinnier's expectant eyes. Silence hissed and grew louder and louder the longer I theorized: "What if his 20-minute spells were violent migraine auras followed by very mild headaches? What if his PTSD anxieties were his migraine triggers?"

*

"Mr. Tinnier. I have a theory."

I explained my idea to the Tinniers avoiding medical jargon.

"Vitamin B2 is a good migraine preventer. Fish oil is a good anxiety calmer. You can get them both without a prescription. Would you be willing to try them?"

"Sure. I've taken vitamins before. They don't bother me."

Diligently, I inscribed on a blank sheet of paper:

Riboflavin 400 mg daily at bedtime.

Fish Oil 900 (EPA 653 mg / DHA 247 mg) daily at bedtime.

*

When I called Mr. Tinnier a week later, he felt much improved and reported no anger spells. Two weeks later, his wife was happy with his progress and they were doing better as a couple. Three weeks later, he was taking care of his wife, going to the store, getting her medicines, and going with her to her doctors' appointments. Three months later, he still reported no anger spells, was eating better, and had gained much of his lost weight. After 54 years of turmoil, Mrs. Tinnier had her wonderful husband back.

*

I had always believed that complex problems couldn't have simple solutions. Mr. Tinnier proved me wrong. I was also a strong believer in traditional medicine and, were it not for Mr. Tinnier's refusal to take more prescription medications, I would not have stumbled on the ideas of Vitamin B2 and Fish Oil. This humbling experience served to remind me that, in comparison with what I think I know, what I do not know is as vast as the universe.

Alfred North Whitehead, a British philosopher put it best when he said: "The Universe is vast. Nothing is more curious than the self-satisfied dogmatism with which mankind at each period of its history cherishes the delusion of the finality of its existing modes of knowledge. Skeptics and believers are all alike. At this moment scientists and skeptics are the leading dogmatists. Advance in detail is admitted; fundamental novelty is barred. This dogmatic common sense is the death of philosophical adventure. The Universe is vast."

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