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On the cover: TCMS medical missions on page 16.

features

7 tcms/tcma installation of officers
8 2017 tcms/aisd athletic physicals
   J. Diane West, MD
10 student athletes and sudden cardiac arrest
   Arnold Fenrich, MD and Ken Shaffer, MD
12 have we been properly introduced?
   Lisa Savage, MD
13 tcms auto show and family social
14 these two things cause more than
   1/3 of deaths in travis county
   Kristin Tommey
16 tcms physicians give the gift of medicine
   around the world
   Leanne DuPay
22 public health
   Philip Huang, MD, MPH
24 in memoriam
30 report of the constitution and bylaws committee
   Adam Schneider, MD

in every issue

6 from the president
   Sara G. Austin, MD
20 in the news
26 tcm alliance
   Kelly Hyde

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Membership: 3,858
Herd Immunity...

It’s a concept I’ve been thinking about recently for several reasons. Also known as “community immunity,” it’s the principle that, when a critical portion of a community is immunized against a contagious disease, most members of the community (even those who are not, or cannot be immunized) are protected because there is little opportunity for an outbreak.

In May, I again went to TMA’s First Tuesday at the Capitol. We had a good turn out and Stephanie Triggs, TCMS senior director of physician services and community relations, had arranged for lots of meetings, sometimes with our representatives or senators, and sometimes with their staff. One of the bills for which TMA is advocating is the “Parent’s Right to Know” bill—it’s related to herd immunity. It calls for disclosure of immunization rates at the school level (not just the district level as is currently required) so that parents who have a child that is unable to be vaccinated for medical reasons could tell if the herd immunity at the school is high enough to protect their child from an outbreak of an infectious disease. Did you know that one private school in Austin has a 41 percent vaccination exemption rate? The exemption rate of the Austin Independent School District is 2.02 percent and statewide, the average rate is 0.84 percent. Vaccines can prevent outbreaks of disease and save lives. From medicine’s perspective, the “Parent’s Right to Know” bill is good policy.

It’s late in the session and many other bills are also moving (or not). So at this point, policy is important but so is the process—where is the bill in calendars? Has it passed out of one chamber and been referred to the other? This First Tuesday reminded me, as it always does, that there are a lot of bills going through every session that directly affect both public health and the business of medicine and that politics are just as important as policy or process in determining the fate of these bills. Did you ever wonder who would pay attention to those bills for us physicians if the TMA or TCMS was not around?

For example, another bill working its way through on “surprise medical bills” was negotiated between TMA and Senator Kelly Hancock and has passed both the Senate and House in a form that is agreeable to doctors. It’s now been sent to the Governor. Another example is a bill that would have granted independent practice authority to nurse practitioners. That bill, thanks to the work of TMA, never passed out of committee. If you are like me, you use APPs all the time to help care for your patients, but don’t feel that independent practice authority would be good medicine or good policy.

The legislative session is what reminds me most that the House of Medicine needs to stick together, that we have work to do. And we need TCMS and TMA’s help to do it. Many in the legislature would like nothing better than to be able to write bills affecting the practice of medicine unfettered by any pesky doctors looking over their shoulder. Did you know that of the 7000 bills filed this session, more than 1400 of them had something to do with the practice of medicine? Did you know that approximately 30 percent of the state budget applies to health care? How can we not be involved?

So back to the herd immunity concept, and I realize that I’m speaking to the herd here because you are all TCMS members. John and I could have relied on herd immunity and chosen not to vaccinate our kids when they were babies. Assuming that everyone else’s child was vaccinated, our kids would have been relatively protected without having to have any shots. But we didn’t do that, we chose to vaccinate.

I feel the same way about my membership and participation in TCMS/TMA. I could have chosen not to join, and I would still have received the protections that those who do join make possible. But I remember when I first moved to Texas my older partners told me, in no uncertain terms, that we were all expected to be members of our county and state medical societies—(they also told me that we volunteer our time to take care of unfunded patients, but that’s another article). I didn’t fully understand the reason then, but it was good advice that I’ve followed over the years.

Sure, there are tangible things we get from membership, like meetings and information and networking. But there are intangibles as well, things that strengthen the practice of medicine and protect our patients. Every two years when the legislature is in session, there is this protection for us and for our practices that is intangible—almost invisible—to us, but really quite valuable. It may be one of those things that is most noticeable only when it’s gone, just like herd immunity. I hope we never find out.

Sara Austin, MD
TCMS President
2017 TCMS/TCMA Installation of Officers

Sara Austin, MD, accepted the TCMS presidential gavel from Immediate Past President Robert Cowan, MD and Berenice Craig stepped down as TCMA president, installing Kelly Hyde as 2017-2018 TCMA president.
TCMS physicians volunteered to provide free student athletic physicals over four nights in April. These necessary exams were given to middle school and high school students who want to play a sport, march in band or cheer. These students are uninsured or have other barriers to health care.

Over 1,060 exams were completed by more than 100 TCMS physicians. While a number of physicians volunteered for multiple shifts and/or days, some stalwarts worked both shifts on all four evenings.

Thank you to all who contributed their time and effort to once again make this 19-year-old community program a success.
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The Travis County Medical Society works annually with the Austin Independent School District to mobilize volunteers who perform physical exams on student athletes prior to participating in extracurricular activities such as sports and band. In late April and May, many students are evaluated prior to participating in these activities. The University Interscholastic League (UIL) provides a format for this evaluation with the “Pre-Participation Evaluation” form (PPE). Over 600,000 student athletes across the state of Texas participate in sports activities each year. The PPE evaluates the athletes for multiple different medical issues that may increase their risk during participation in activities.

Sudden cardiac arrest is a rare event in student athletes, but the UIL PPE includes medical history and physical exam findings aimed at screening for potential underlying cardiac concerns utilizing all 14 components recommended by the American Heart Association (AHA). A sudden cardiac arrest occurs by definition without warning; however, a history of prior symptoms is not uncommon in those who have a sudden event. Sudden cardiac arrest has numerous etiologies with an endpoint of electrical malfunction or pump malfunction causing an athlete to lose consciousness or have no pulse. There is no oxygen delivery to vital tissues and death can occur within minutes if not treated aggressively. The first line of prevention is to identify the likelihood of potential underlying cardiac concerns.

The UIL PPE, with respect to cardiac evaluation, is aimed at evaluating for two main groups of cardiac concern: (1) inherited conditions affecting the heart pump function, function of the cardiovascular system or function of the electrical system and (2) non-inherited conditions, some present at birth and others acquired later in life. The UIL also provides information on causes of sudden cardiac arrest in the “Sudden Cardiac Arrest Awareness” form. This form describes the inherited and acquired cardiac abnormalities that may place the student at risk. Additional information contained in this resource for providers and families can be found on the UIL website at http://bit.ly/2qazmZw.

Figure 1 is a portion of the UIL PPE focusing on excluding the possibility of these underlying cardiac concerns. This series of questions is meant to trigger more in-depth evaluation as the student athlete and their family answer “yes” or “no.” Each pertinent positive and negative is intended to aid the provider in determining whether there is risk of a significant underlying cardiac disorder. These medical history items are not meant to trigger restrictions or necessitate referral to cardiologists but are meant to trigger further evaluation for these potential illnesses. Clearly, pediatric subspecialists are available to

Arnold Fenrich, MD
Ken Shaffer, MD

Figure 1: Item 3 on the Pre-Participation Evaluation (PPE) Form. These items are intended to alert the evaluator of potential cardiac concerns in the student athlete.

Have you ever had prior testing for the heart ordered by a physician?
Have you ever passed out during or after exercise?
Have you ever had chest pain during or after exercise?
Do you get tired more quickly than your friends do during exercise?
Have you ever had racing of your heart or skipped heartbeats?
Have you had high blood pressure or high cholesterol?
Have you ever been told you have a heart murmur?
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?
Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc), Marfan’s syndrome, or abnormal heart rhythm?
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?
Has a physician ever denied or restricted your participation in sports for any heart problems?
investigate more subtle concerns, but there are a series of mechanisms to investigate the details of these medical history questionnaires.

The first item, “prior testing for the heart,” may indicate the potential for known heart disease or provide important information on “normal” findings. The evaluating provider should review any previous testing to assess for any previously diagnosed heart disease that may place the student at risk. In many cases, prior testing provides information confirming the student is “normal” and no restrictions are required.

In students who have “ever passed out during or after exercise,” there is concern that they may be manifesting symptoms of an arrhythmia. More in-depth questioning should include a detailed history of the events leading to the syncopal episode. The most common cause of non-cardiac syncope is related to heat exposure and fluid status—history should be focused on issues related to the environment and fluid intake during exercise. Additional questions about fast or strong heartbeats, symptoms prior to passing out and time to recovery/symptoms after passing out can aid the examining provider in deciding whether these symptoms may be related to potential underlying cardiac disease. Additional causes of syncope with exercise can include obstructive heart disease, and a careful examination should supplement careful medical history to complete the evaluation.

Chest pain is a relatively common non-cardiac symptom in children and adolescents. “Chest pain during or after exercise” may be a manifestation of respiratory muscle movement, musculoskeletal pain or even gastrointestinal pain. Associated symptoms of palpitations, dizziness, lack of respiratory symptoms, etc. may all add valuable information in deciding between chest pain which is potentially cardiac in etiology versus non-cardiac in etiology.

Many athletes compare themselves to peers. Student athletes who are poorly conditioned or have limitations related to excess body weight can “tire more quickly than [their] friends” but not have an underlying cardiac issue. An important point is to decide whether the student is having limitations in cardiac output/tiring from a cardiorespiratory standpoint versus fatigue/sleepiness related to numerous other causes. Students may also complain of “shortness of breath.” This difficulty with air movement can be related to respiratory causes, including environmental causes. Careful history for respiratory diseases as well as additional symptoms at rest, or with sleep, may aid the provider in distinguishing a respiratory risk from a cardiac risk.

Known medical issues such as a heart murmur, high blood pressure, high cholesterol or (as previously discussed) prior cardiac testing may require additional history to decide if a prior evaluation was conducted for any of these conditions. A positive response does not summarily dismiss the student from being able to participate in athletics. For example, isolated elevated blood pressure measurements that have not been followed with the appropriate renal evaluation or elevated cholesterol levels in the absence of significant family history or diet and exercise changes may actually be improved by participation in athletics with weight control as the goal. These students, however, may have some limitations on their athletic activities. Restriction from participation may not be necessary, but serial follow-up may help keep the student athlete on goal for minimizing general cardiac risk factors.

Many students will complain of fast or strong heartbeats during exercise. Key features like sudden onset and sudden termination, associated dizziness, associated fatigue during these episodes or other symptoms related to the cardiovascular system may aid the provider in separating sinus tachycardia from arrhythmia-related heart rate abnormalities.

Other potential causes of sudden cardiac arrest of an athlete may have a family history/genetic etiology. Hypertrophic cardiomyopathy, long QT syndrome, Brugada syndrome and Marfan syndrome may have a history in the family, although many student athletes and/or their parents may not be familiar with these abnormalities by name. A family history of early coronary artery disease can indicate lipid abnormalities in the family, but with respect to heart attacks and strokes in the family there is no clear indication that this puts the student athlete at risk as we extend beyond first-degree relatives. Opportunities to “capture” subtle historical findings can be optimized with statements like “has there been anybody in the family who has died suddenly for unexplained reasons” or “are there any cardiac abnormalities that seem to run in family members.” These questions should then be followed with requests for more details as to which family members—great grandparents and cousins are unlikely to be the family members of concern. Other subtle family history findings consistent with long QT syndrome include congenital deafness in immediate family members. There may also be a family history of things like “abnormal thickening of the heart.” All of these, however, require more detailed history taking than the simple history on the PPE form. This history can be obtained by any evaluator and is not solely the responsibility of subspecialists.

In summary, there are a number of underlying cardiac abnormalities placing a student athlete at risk for sudden cardiac arrest, but all of these are quite rare events. The intention of the “Pre-Participation Physical Evaluation” and “Medical History” form is to be used as a screening tool for a primary evaluator/provider to obtain more in-depth history and/or decide whether more specialized referral is necessary prior to participating in sports. A positive finding on the medical history questionnaire, however, does not necessitate restriction in and of itself and may not even necessitate specialist referral or expensive testing.
A t the risk of being thought hopelessly old-fashioned or stuffy, I will admit that I object to the immediate use of first names in medical and other professional situations. Let me just say straight away that I am not attached to any title for myself, such as “doctor” when I am the patient, although I would be aghast if my staff addressed someone known to have such a degree as anything other than that. I am quite happy with “Mrs.” or “Ms.” But, I am a stickler in my medical practice for the use of titles and surnames, unless the patient is quite young. Even then “Miss Jones” is always correct when calling an adolescent or young adult from the reception area. One rule of thumb I give my medical assistant and receptionist (both 30-something), is that if a patient appears younger than themselves, it might be appropriate to use the patient’s first name, but it is always appropriate not to, at least upon first meeting. While I may be more inclined to use a first name with a contemporary or someone younger, I would never address an older patient by her first name, I believe adults of every age appreciate this consideration.

Lisa Savage, MD

There is a certain degree of respect conveyed by using someone’s title and surname instead of the implied familiarity and casual nature of using first names. Since we are not in the business of something casual, I believe we should treat our patients with due regard and deference. My dad passed away in 2015 at the age of 81 and, for a few years before that, I was able to help him with medical visits, tests and procedures. It always startled both of us (he was a physician also) when a 20-something staff member called for “Charles.” I always thought “really?” and he would roll his eyes. He was also adamantly not attached to his physician’s title, but appreciated a respectful “Mr. LaPinta” instead of his first name. I believe adults of every age appreciate this consideration.

I wonder if medical trainees (whether physician, nurse, medical assistant or technician) are taught about these things or if their employers or mentors even give it a second thought. Where I trained, both in medical school and especially in residency, it was unheard of to use a patient’s first name when introducing ourselves and also thereafter. I did my residency at a southern institution where manners really mattered and I will argue that they still do. For example, one never enters a lady’s exam or hospital room without knocking first. The chairman of my Ob/Gyn department was a gruff task master, but he did instill certain nice formalities which were required. One knocks, then slightly opens the door and asks “Mrs. Smith, may I come in?” I still knock on the door of every exam room, although I admit the “may I come in?” has fallen by the wayside of modernity and the more casual atmosphere that pervades our profession.

This “casualitis” is not unique to medical offices. I went to the bank I use for my business accounts recently, and at the end of the transaction the young teller said “Thanks, Miss Lisa.” I believe that a financial institution should instruct employees to address clients more formally, because not doing so makes the bank seem unprofessional. Many businesses, not just medical and
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These Two Things Cause More Than 1/3 of Deaths in Travis County ...

Find out what you need to know about health in the greater Austin area—and what Dell Med and its partners are doing to tackle cancer, heart disease and other critical health challenges head on.

Kristin Tommey

Of the more than 1.2 million people living in Travis County, 58 percent are overweight or obese. Fourteen percent smoke. Eight percent have diabetes.

On the other hand, fewer high-schoolers are using tobacco, and vaccines have reduced the number of people sick with hepatitis and mumps. Lung cancer mortality rates are declining.

The 2017 Critical Health Indicators Report, compiled by Austin Public Health, shows the successes—and reveals the challenges—impacting the health of those living in the greater Austin area.

Cancer and Heart Disease Cause 40 Percent of Deaths

Cancer is the leading cause of death in Travis County, killing 1,131 people in 2014 (the most recent year for which data is available). Together with heart disease, it is the cause of 40 percent of all deaths in the county.

Dell Medical School, alongside Seton Healthcare Family, Central Health and a range of other partners including Austin Public Health, is working to position primary care physicians to lead the fight against these and other debilitating illnesses. The departments of Internal Medicine and Population Health are developing a model for primary care that shifts the focus from treating sickness to helping patients stay healthy—from doctors’ offices to the community. By delivering robust preventive care; increasing access to vaccines and screenings and caring about the social, economic and environmental causes of health problems, Dell Med aims to reduce the onset of chronic illnesses, helping people to get and stay healthy.

Simultaneously, the LIVESTRONG Cancer Institute of the Dell Medical School, established by a $50 million pledge from the LIVESTRONG Foundation, are leveraging vast intellectual resources across The University of Texas at Austin to reinvent the full continuum of cancer care. The team includes experts in prevention, supportive care, survivorship and psychosocial sciences who are working to improve and save patient lives.

Too Many Mothers Don’t Get Prenatal Care

In 2012-14, 27 percent of mothers received late or no prenatal care—a significant risk factor for infant mortality. More than a third of all Hispanic babies were born to mothers with late or no care.

Dell Med’s Department of Women’s Health recently launched a new, redesigned system of perinatal care open to any Central Texas woman who needs it, regardless of her ability to pay. A collaboration of a number of community partners, the effort provides more coordinated care, helping to improve outcomes for both mothers and babies.

An Average of 125 People Die by Suicide Each Year

Depression, anxiety, addiction and many other psychiatric conditions can be fatal if left untreated. Demand for affordable and effective care far exceeds available resources in Travis County, and many patients go undiagnosed and untreated until their conditions worsen.

By integrating mental health care into primary care and other care pathways, the Department of Psychiatry seeks to help those suffering far before they reach crisis. But that’s just one aspect of the department’s plans for a large-scale redesign of the region’s outdated and inefficient public mental health care system.

Chair Steven Strakowski is helping lead a team of lawmakers, experts and health care leaders working to develop a comprehensive strategy to replace the 150-year-old Austin State Hospital with a modern campus that can serve as a national model for providing cost-effective, multidisciplinary mental health care—what State Senator Kirk Watson has labeled an “MD Anderson of the brain.”

Many Diseases Disproportionally Strike People of Lower Socioeconomic Status

As Austin continues to grow, so does the economic divide between rich and poor. Many historically underserved residents lack access to quality health care and education and are at higher risk for heart disease, cancer, diabetes, HIV and other illnesses. In fact, 13.4 percent of black adults in Travis County suffer from diabetes, compared to just 5.4 percent of Caucasians.

The Department of Population Health is leading Dell Med’s efforts to improve the overall health and well-being of Travis County residents. In collaboration with community partners, continued on page 29
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Dr. Lucia Diaz, a daktari wa ngozi (Swahili for dermatologist) headed to Kenya on her second medical mission trip in February through Heal Kenya, a collaboration between Dell Children’s Hospital and Ubuntu in Austin, TX. Kenya was 90 degrees F and dry when Diaz and a medical team flew to Nairobi to visit patients in surrounding communities, mostly Maai Mahiu. The team included a neurologist, a pediatrician, an emergency medicine physician, a nurse and a pediatric nurse practitioner.

Months before the team arrived, the Kenyan medical camp leaders recruited patients based on the specialties of the incoming medical team. The patients were triaged and scheduled before the clinics enabling the medical providers to see as many patients as possible during the two-week period. In addition to helping with communication, Kenyan translators and community health care workers helped the medical team better understand Kenyan customs and typical disease management. “Knowing about cultural beliefs and expectations helped the team provide better care,” says Diaz.

One notable case occurred during Dr. Diaz’s first mission trip—a young boy with a congenital skin disease that had been misdiagnosed for years. He was evaluated by Diaz and started treatment that made him get better. On the recent trip, Diaz was able to see the boy’s improvement and happiness. “He is a reminder of why I went into medicine,” she says passionately. “I will do all that I can for him to make sure he keeps getting better and stays out of the hospital.” With doctors at a premium, Diaz’s ability to see more than dermatology issues was invaluable. In addition to seeing skin issues, I also saw a variety of acute and chronic conditions in pediatric and adult patients.”

Dr. Diaz’s contributions continued with the treatment of two vulnerable groups. I saw local prisoners and a group with albinism who had various skin issues,” she explains. Albinism is a condition where people easily develop skin cancers due to the inability to repair skin damage from sun exposure.” Diaz conducted skin screenings, treated skin cancers and provided education for the albinism community.

The Heal Kenya medical team made sure to use medications that were readily available in Kenya so that the year-round community health care workers can continue treatments. The inclusion of Kenyan volunteers and health care workers who continue to follow up with those treated makes the medical interventions more sustainable. A medical team from Dell Children’s Hospital returns to these communities three times a year. “I intend to go every year, and I am recruiting other dermatologists to join us. I have started to work with the Kenyan albinism community to provide ongoing care and education.”

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Rift Valley, Kenya
Lucia Diaz, MD

“Clinic days are long, but the people we serve are so grateful for our care that it makes every minute worth it.”
“Haiti is the poorest country in the Western Hemisphere,” says Dr. Ric Bonnell. “Close to four million people live in the capital city of Port au Prince—conditions are bad and the air is thick with pollution.”

Bonnell, a pediatrician, travels to Port au Prince each December to work with Haiti’s only children’s hospital. The medical team has one goal: To continue to improve the country’s pediatric care. The children at this hospital frequently suffer from malnutrition, dehydration, malaria, tuberculosis and HIV. Sometimes there are cholera epidemics to deal with as well.

In most cases, these patients and their families live in shacks or overcrowded buildings without running water, indoor plumbing or electricity. These circumstances breed illness and Haiti’s medical system is overwhelmed and understaffed. Equipment that will aid in accuracy and save diagnosis time is invaluable. “Our biggest triumph was teaching the Haitian pediatricians how to use the bedside ultrasound to diagnose patients with pneumonia, fractures, abdominal masses and more,” he says.

The training and confidence Haitian physicians gain from medical victories with the medical mission team is priceless. While the team was there, a mother ran into the emergency department at St. Damien Pediatric Hospital with her barely breathing one-year-old son. He had suffered from high fevers and a severe cough for several days, but she had waited to bring him to seek medical care because they were too poor to pay a physician. The Haitian team was hesitant to resuscitate the child and put him on one of the hospital’s few ventilators because all of the children that had previously arrived in such poor condition ended up dying.

“We had additional pediatric emergency physicians and critical care nurses on our team to assist and they intubated him and put him in one of their six ICU beds. He had severe pneumonia and likely sepsis, but over the course of the next two weeks slowly recovered on intravenous antibiotics, ventilator support and other critical care measures to eventually be discharged from the hospital completely healthy. It was the first child with severe pneumonia to have survived that long on a ventilator and the Haitian nurses gained confidence in their skills to apply to future patients,” Bonnell says.

Dell Children’s Medical Center and ten other North American children’s hospitals support the Haitian pediatric residency program. Dr. Bonnell believes the cure is with an investment in the future, “Our primary goal is teaching and equipping the residents to be the future pediatricians of Haiti.”
Honduras, Central America
Elliot Trester, MD

“It is a place that is somewhat forgotten by the more European central governments of the area.”

Dr. Trester is no stranger to medical mission trips. In fact, his list of mission trips is part of what earned him the 2016 TCMS Humanitarian of the Year award. “We’re all in this together, and if we don’t do some tikkun olam (healing of the world, an important Jewish precept), we won’t have any world to heal,” Trester says wisely.

While planning to attend a wedding in Central America, Dr. Trester decided to explore medical missions in that area. He contacted MEDICO, which had a trip to Honduras scheduled just before the wedding. Most of the population of this area is a mixture of ex-slaves and indigenous people who speak Spanish.

The medical/dental team was headed to Laka Tabila, a remote village without any electricity or mechanical vehicles. All the team’s gear had to be carried—from generators to potable water (enough for 10 people a week as well as for the dentists’ needs).

“The first experience I had on my trip to Laka Tabila was getting there by long boat,” Trester described. “We had a lot of medical and dental equipment, food, luggage and water, besides a couple of generators, and I wondered a bit, how we were going to unload all of this and walk half a mile. I should have realized that the town would join the effort and there were a good number of teenagers and young adults who helped to get our supplies expeditiously to the clinic where we worked and stayed. This was only the first of many demonstrations of support from the people of the town.”

The overall health of the population was good. “Mostly people were well nourished, though almost everyone had to be treated for parasites due to the lack of a clean water source,” he says. “The kids were playful and nurtured and most attended the community schools.”

The majority of the conditions treated included scabies, lice, parasite infections and urinary tract infections along with the need for many tooth extractions.

“I really feel like what I do is nothing special,” Trester says. “Treating people is what doctors do, no matter where they are located.”
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Mike Geeslin named President and CEO of Central Health

On Friday, April 21 the Central Health Board of Managers announced that Mike Geeslin has been selected as President and CEO of Central Health. Geeslin has more than 20 years of experience in legislative, executive and association leadership roles. He is currently serving as Executive Director for the Texas Dental Association and was the Commissioner of Insurance, Texas Department of Insurance for six years.

Philip Huang, MD, MPH Honored by People's Community Clinic

The many valuable services Dr. Philip Huang has provided throughout his career, especially here in Austin were recognized at a recent event hosted by People's Community Clinic. In his role as medical director and health authority for Austin Public Health, Dr. Huang is responsible for communicable disease control, emergency preparedness, epidemiology and surveillance, immunizations, environmental health and chronic disease prevention.

Soy medico. Donde le duele?

Jill Snyder, PhD is now an Assistant Professor at Dell Medical School teaching Spanish Meducation®. The program, which has been available to TCMS members and their office staff since 1994, is now offered as an elective for Dell medical students. Spanish Meducation is a practical medical Spanish program designed for all health care professionals. The classes develop conversational skills in general Spanish focusing on health care situations. Call 512-835-7612 for information on upcoming classes.

George P. Rodgers, MD receives Distinguished Fellowship Award

The American College of Cardiology (ACC) has awarded the 2017 Distinguished Fellowship Award to TCMS member, Dr. George P. Rodgers. This honor was given at the ACC’s 66th Annual Scientific Session in Washington.

The Kind Clinic

With a focus on care for Austin’s transgender community, The Kind Clinic opened on March 9 and is the first clinic of its type to open in Central Texas. The clinic offers sexual health and wellness services with emphasis on the treatment and prevention of sexually transmitted infections. Access to HIV prevention drugs PrEP and PEP is also provided. The Kind Clinic is located at Texas Health Action, 900 E 30th St, #302 in Austin.

www.austinprepaccessproject.org.

Late HIV DIAGNOSIS contributes to increased transmission of HIV.

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TMA INSURANCE TRUST
Exclusively endorsed by the Texas Medical Association
Human Papillomavirus and Immunization in Travis County
Part 1

Philip Huang, MD, MPH, Medical Director, Austin Public Health
Sarah Seidel, DrPH, Austin Public Health
Anna Klioueva, MPH, Austin Public Health

HPV
An estimated 280,000 Travis County residents are currently infected with mucosal human papillomavirus (HPV). Most people who are infected or who have been infected with the approximately 40 mucosal HPV types will never know, but persistent infections with high risk or oncogenic types (including HPV 16 and HPV 18) can result in cervical, anogenital and oropharyngeal cancers.

HPV-Associated Cancers in Travis County and Texas
In Travis County, an estimated 102 cancer cases per year are caused by HPV; approximately 60 of these cancer cases are diagnosed in women, with the remaining 42 in men (Table 1). HPV-associated cancers in women occur primarily in the cervix (55.7%), anus (15.6%), vulva (12.5%), and vagina (3.1% of all HPV-associated cancers), while men disproportionately share the burden of oropharyngeal cancers. Approximately 78% of HPV-associated cancers in men occur in the oropharynx, four times as many new cases each year as women.

Cervical Cancer
Over 90% of cervical cancers are caused by HPV, and 70% of cervical cancers are caused by high-risk types 16 and 18. Though cervical cancer incidence rates and mortality rates have decreased significantly due to the effectiveness of Pap test screening, in 2014 there were 31 cases of cervical cancer in Travis County. The number of cases of cervical cancer in Travis County has remained roughly the same since 2000 (Figure 1), but the incidence rate has decreased from 11.2 in 2000 to its lowest point in 2014 at 5.3 cases per 100,000 population. Yet, disparities among racial/ethnic groups remain (Figure 2). Hispanic women in Travis County have the highest incidence rate (11.9 cases per 100,000), compared to 9.2 in Travis County Non-Hispanic Blacks, 8.1 in Travis County Non-Hispanic Asians/Pacific Islanders, and 6.0 in Travis County Non-Hispanic Whites (2004-2014). Additionally, cervical cancer incidence rates are lower for Travis County than Texas for all racial/ethnic groups except Asian/Pacific Islander women (8.1 in Travis County vs. 5.2 in Texas).

Oropharyngeal Cancer
While the incidence of cervical cancer in the US has declined in recent years, the incidence of HPV-positive oropharyngeal cancer and anal cancer has been increasing. The number of HPV-positive non-cervical cancers in the United States is now similar to the number of cervical cancers. In addition, most HPV-positive non-cervical cancers arise in men.

In Travis County, incidence rates of oropharyngeal cancers among white males 50-59 and 60-69 have risen since 1999 (Figure 3), a trend that mirrors the trend in Texas males 50-59 and 60-69 but that has not been observed in any other age group of males or females.

Table 1. Estimated average annual percentage and estimated number of cancers attributable to human papillomavirus (HPV), by anatomic site and sex, Travis County, 2008-2012

<table>
<thead>
<tr>
<th>Cancer</th>
<th>% of all cancers for each gender</th>
<th>No. of cancers (Travis)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical</td>
<td>55.7%</td>
<td>33</td>
</tr>
<tr>
<td>Vaginal</td>
<td>3.1%</td>
<td>2</td>
</tr>
<tr>
<td>Vulvar</td>
<td>12.5%</td>
<td>8</td>
</tr>
<tr>
<td>Female</td>
<td>4.4%</td>
<td>2</td>
</tr>
<tr>
<td>Anal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>15.6%</td>
<td>9</td>
</tr>
<tr>
<td>Male</td>
<td>33.8%</td>
<td>6</td>
</tr>
<tr>
<td>Rectal</td>
<td>2.6%</td>
<td>2</td>
</tr>
<tr>
<td>Female</td>
<td>1.7%</td>
<td>1</td>
</tr>
<tr>
<td>Male</td>
<td>78.4%</td>
<td>33</td>
</tr>
<tr>
<td>Oropharyngeal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>10.4%</td>
<td>6</td>
</tr>
<tr>
<td>Male</td>
<td>57.4%</td>
<td>37</td>
</tr>
<tr>
<td>Total</td>
<td>102</td>
<td>60</td>
</tr>
</tbody>
</table>


Figure 1. Trend in number of cases and incidence rate of cervical cancer, Travis County 2000-2014

Figure 2. Incidence rates of cervical cancer by race/ethnicity, Travis County and Texas 2000-2014
in males of other races/ethnicities.iii In Travis County but not Texas, rates among white males 70-79 dropped from 1999 to 2013 (73.3 vs. 43.8 per 100,000; 4-year combined rates). Currently in Travis County, the rate of oral-pharyngeal cancer is highest among white males 60-69 (80.4 per 100,000; 4-year combined rate), whereas in Texas the rate of oral-pharyngeal cancer is highest among white males 70-79 (68.8 per 100,000; 4-year combined rate).

Because there is no screening for oropharyngeal cancer and other HPV-associated non-cervical cancers such as anal, vulvar, and penile cancers, HPV vaccination is the best and only prevention strategy.iv It is therefore concerning that the most recent data from the NHANES survey indicate that overall prevalence of genital HPV infections among US males (>40%) is now similar to that of previously estimated prevalence of cervicovaginal HPV infections in US women.vi,xi

Economic Costs of HPV

The annual direct medical costs associated with preventing and treating HPV-associated disease in Travis County is estimated to be $29.9 million, of which cervical cancer screening and follow-up account for roughly $25 million, cervical cancer treatment $1.7 million, and oropharyngeal cancer treatment $1.1 million (Table 3).xii

Follow-Up

As can be seen from this report, HPV presents a large burden on Travis County in terms of disease and economic cost. Part 2 of this article, which will report on the HPV vaccination, will be featured in the July/August TCMS Journal.

<table>
<thead>
<tr>
<th>Table 3. Annual direct medical costs associated with HPV-associated disease for Travis County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost component</td>
</tr>
<tr>
<td>Cervical screening: routine</td>
</tr>
<tr>
<td>Cervical screening: follow-up</td>
</tr>
<tr>
<td>Cervical cancer</td>
</tr>
<tr>
<td>Oropharyngeal cancer</td>
</tr>
<tr>
<td>Anal cancer</td>
</tr>
<tr>
<td>Vulvar cancer</td>
</tr>
<tr>
<td>Vaginal cancer</td>
</tr>
<tr>
<td>Penile cancer</td>
</tr>
<tr>
<td>Genital warts</td>
</tr>
<tr>
<td>RRP?</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Source: Adapted from Chesson et al., 2012
IN MEMORIAM

The Medical Society extends deepest sympathy to the family and friends of the following physician.

David Russell Woerner, MD, 67, died unexpectedly on March 28. He grew up in Houston and graduated with honors from UT Austin in 1971. After receiving his medical degree at the University of Guadalajara School of Medicine, he completed a family practice residency at Texas Tech University School of Medicine.

Dr. Woerner had a solo practice in Salina, Kansas for four years before moving to Austin in the mid-1980s, where he established a successful family practice clinic for a number of years, later joining Austin Regional Clinic for the last decade of his life. Dr. Asha Lall worked closely with Dr. Woerner for the past ten years and fondly recalls, “. . . he was the quiet and steady ‘dad’ of our unit, naturally mentoring many of us younger docs. He provided a steady and calm presence that made us feel connected as colleagues. Most of all, he was just a good person who cared about his colleagues, his patients and his family.”

He married his wife of 32 years, Alma, soon after his move to Austin and they had six children. Dr. Woerner was a man of many talents and interests. Pilot; self-taught banjo player; chicken farmer; gardener; teacher; mentor; beloved husband and father; traveler; collector of rocks, minerals and crazy socks; outdoorsman; animal lover and Basset hound wrangler were all ingredients of a full life.

Typical of the outpouring from many long-time patients after his death is this heartfelt observation, “He was always so warm and approachable and cared about the whole person. What I appreciated most was the fact that he truly listened . . . Godspeed, Dr. Woerner.”
Advancing the practice of good medicine.
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ANNOUNCING THE 2017 DIVIDEND FOR TEXAS MEMBERS
The Doctors Company has returned nearly $400 million to our members through our dividend program—and that includes approximately 10% to qualified Texas members. We’ve always been guided by the belief that the practice of good medicine should be advanced, protected, and rewarded. So when our insured physicians keep patients safe and claims low, we all win. That’s malpractice without the mal.

Join us at thedoctors.com
Member Spotlight: Lacey Jobe

Lacey Jobe joined TCMA a year ago and serves as VP-elect of Financial Development. In August 2015 her family moved from Charlottesville, Virginia when her husband, Taylor Jobe, started working for Greater Austin Orthopedics where he specializes in hand and elbow surgery. The couple has two children, Hutton (6) and Holland (5). Lacey is originally from Lockney, Texas, a very small farming town of 1,500 people. She graduated from Texas Tech University with a degree in Human Development Family Studies. She met her husband while at Tech. Lacey received her post-bachelor’s degree from TCU in education. She taught elementary school for nine years until she decided to stay home with the kids.

A few of Lacey’s other passions are being involved in the Austin community. She enjoys volunteering at her children’s school and at Saint Louise House where she co-chairs activities for the annual Mother and Me Tea. Since moving to Austin she and her sister-in-law started OVE handbags. The leather handbags are manufactured here in Texas with attention to using quality leather and unique design. Lacey is very excited to be part of TCMA and looks forward to working with the other board members.

The Alliance also enjoyed a joint TCMS/TCMA Installation dinner on March 23 at the Renaissance Hotel.

Many thanks are in order to all the volunteers that graciously gave their time over the past year and to those who have committed or recommitted to the 2017-2018 executive board and council.

Due to generous sponsors, over $97,000 has been raised this year. These sponsors have allowed the TCMA Foundation to fulfill grants to:

- Volunteer Healthcare Clinic
- Saint Louise House
- The SAFE Alliance
- Hospice Austin
- Partnerships for Children
- Casa Marianella
- Children’s Diabetes Camp of Central Texas
- Family Eldercare.

For more information
www.tcmalliance.org

Join the TCMA
vp-membership@tcmalliance.org
Have We Been Properly Introduced?

financial, should adhere to a more serious and respectful way of interacting with clients because doing so conveys professionalism. Patients, clients and customers appreciate a more elevated level of service and manners.

I do understand that in some more artistic or creative professions, calling your 60-something boss “Bill” and your clients by their first name, even when you are a college intern, is de rigueur. One size may not fit all, depending on the workplace and industry culture. I did make absolutely sure my daughter, a college senior, knows never to be so informal unless invited to do so; and that sometimes even then, maintaining a more formal interaction is most appropriate.

The same concept applies in social settings, although perhaps not to the same degree. My family was dining at an upscale restaurant for my mother-in-law’s birthday, an event for which my father-in-law made the reservation. After we were seated, the server came over to him, a 75 year old gentleman, and was gushing “Henry!! Welcome!!” We were all taken aback, especially my father-in-law, because we were momentarily confused…does she know him? Does she recognize him from somewhere else? What is going on? She addressed him in an effusive and too-familiar way that threw us all off. Then we realized she was just being really casual, despite his age and the setting. I actually called the manager a few days later to share my observations. White tablecloths and a dress code did not correspond with how they address their patrons. Perhaps this is a reflection of our overall culture, but the correct way to address customers in the workplace is certainly something that can be taught. I do not think we ought to start sounding like the cast of Downton Abbey, but common courtesy should be more common.

Older people are especially bothered by casual address, although most are too polite to mention it. Or they don’t want to go against the “young and hip” habit of using someone’s first name regardless of the situation. I cringe when I hear older patients being addressed informally by a member of a medical team young enough to be their grandchild. Let’s bring back some decorum. I submit that nobody is ever offended by the use of her surname in a professional setting, and many would prefer it…so why not use that as our default, especially in a medical office?

CDC recommendation:
Test everyone born from 1945-1965 for Hepatitis C

People born from 1945-1965 account for 3 out of every 4 people with Hepatitis C, and more are unaware of their infection.

- Testing only patients with elevated ALT’s may miss 50% of infection
- Hepatitis C is a leading cause of liver cancer and liver transplants
- Care and treatment can help prevent Hepatitis C-related disease and deaths
Saving Lives One Drop at a Time:
Mothers' Milk Bank at Austin

Very low birth weight (VLBW) infants represent only two percent of live births in the US (60,000 annually), yet they account for 55 percent of infant deaths and the majority of patients diagnosed with necrotizing enterocolitis (NEC). NEC, a debilitating inflammatory condition of intestinal tissues, requires lengthy hospitalization and often results in death. Although NEC is minimized when VLBW infants are fed human milk exclusively, many of their mothers are unable to provide for them. For these infants in need, the lifesaving alternative is donor human milk dispensed by milk banks.

For nearly two decades, Mothers’ Milk Bank at Austin (MMBA) has been a leader in the effort to save the lives of these at-risk infants. Dedication to the highest safety standards, development and success of a research program, an earned-revenue business model and a philanthropically-supported charitable care program earned MMBA international recognition in the milk banking industry. MMBA has safely dispensed nearly five million ounces of donor milk since 1999, with over 550,000 ounces in 2016 alone thanks to last year’s cohort of 1,068 volunteer milk donors. We currently serve more than 120 hospitals and 30 outpatients in Texas and 22 other states, and the demand for safe, healthy donor human milk continues to grow.

Xzavier was born at 29 weeks estimated gestational age, and weighed only 3.4 lbs. He spent his first 64 days in a neonatal intensive care unit (NICU) with only short visits from his mom permitted. His mom’s supply of breast milk was insufficient, so donor human milk feedings were started at 32 weeks, continuing to 37 weeks when he was stable and mature enough to tolerate formula. Today, Xzavier is a healthy, active and smart toddler, thanks to the precious gifts of donor milk.

Only 65 percent of Level 3 and 4 NICUs in the US use donor human milk when a mom’s own milk is unavailable. An unknown number of medically-fragile infants at home could benefit from donor milk but don’t know about this precious resource or cannot afford it. MMBA is committed to addressing these needs, and that’s where we need help from the community.

For the past two years we have operated at capacity, with milk production limited to 12,000 ounces per week, a supply well short of our medical orders and prescriptions. Freezers have taken over our filing room, conference room and offices. Former storage rooms have been converted to laboratories. Research and development has been halted, as we lack space for the advanced laboratory equipment required. We also lack space and facilities to provide training and support for parenting and breastfeeding.

Last spring the MMBA Board of Directors purchased a building in Central Austin that will quadruple our space for state-of-the-art processing, class and meeting rooms and offices. MMBA will be able to double milk production over the next two years, resume our currently-stymied research and development program and provide parenting and breastfeeding classes.

Can You Help?
Construction, equipment and furnishings for the building project will cost $2.9 million with project completion expected in June. Half of the needed funds have been raised, and here’s how you can help. Consider a donation or pledge today. The benefits of donor human milk are unparalleled, and we owe it to these children to provide every possible opportunity for them to grow and become thriving members of our society.

This is Nina. Born with a complex congenital heart defect, she had the first of three open-heart surgeries when she was just a week old. Nina was also diagnosed with NEC, requiring that she only receive breastmilk. “So much about Nina’s health was out of my control, but I was committed to pumping milk for her. It felt like that was the one thing I could do to help her—but my supply was very low,” said Lani, Nina’s mom. “Mothers’ Milk Bank at Austin helped save my daughter’s life.” Nina, now four years-old, is growing and thriving thanks to MMBA.

You’ll Never Regret Saving a Life
Donations to the MMBA’s Capital Campaign can be made online or by check. To donate online, visit www.milkbank.org. Or mail checks to Mothers’ Milk Bank at Austin, 2911 Medical Arts St, Ste 12, Austin, TX 78705.

For more information or to schedule a Milk Bank tour, contact Development Director Tedrah Robertson at 512-494-0800 or Tedrah@milkbank.org.

Kim Updegrove
Executive Director
Simultaneously, a number of other groups across Dell Med are working in tandem with the department to improve access to health care:

- The Health Disparities team, working alongside Huston-Tillotson University, has forged partnerships to identify and resolve inequities in the community. One outcome is the Sandra Joy Anderson Community Health and Wellness Center, which offers health care services in a primary care setting to residents in East Austin and across Travis County.
- The Design Institute for Health is working with an underserved community in Austin and a real estate developer to plan thinkEAST, a new neighborhood where broad health interventions become an embedded and mostly unnoticeable component of daily life.
- A pilot project led by the Department of Surgery and Perioperative Care has increased access to specialty care among low-income and uninsured Travis County patients, trimmed a waiting list of referrals for musculoskeletal care, and initiated a new approach, designed around patients, to diagnosing and treating bone, joint and muscle-related pain and illness.
Proposed Amendments

Medical Student Membership Category. With the advent of the Dell Medical School, the following amendments are proposed to add a medical student membership category to the TCMS Constitution and Bylaws:

Constitution: Article III Composition
The Society shall consist of eligible doctors of medicine and osteopathy, Doctors of Medicine or Doctors of Osteopathy, and full-time students who are pursuing a course of study in a medical school approved by the Liaison Committee on Medical Education leading to the degree of Doctor of Medicine or Doctor of Osteopathy, who subscribe to the Principles of Medical Ethics of the American Medical Association, and who have been duly elected to membership in accordance with

Bylaws: Chapter 1 Membership
1.10 Admission
1.11 Eligibility. Physicians who are doctors of medicine and osteopathy, Doctors of Medicine or Doctors of Osteopathy, and full-time students who are pursuing a course of study in a medical school approved by the Liaison Committee on Medical Education leading to the degree of Doctor of Medicine or Doctor of Osteopathy, who subscribe to the Principles of Medical Ethics of the American Medical Association, and, except as provided by these Bylaws, who are licensed to practice medicine in Texas are eligible for membership.

1.20 Membership Classifications
1.28 Student members. Full-time students who are pursuing a course of study in a medical school approved by the Liaison Committee on Medical Education leading to the degree of Doctor of Medicine or Doctor of Osteopathy shall be eligible for Student membership. Student membership terminates upon termination of Student status.

Student members shall have all the privileges of membership except the right to vote, hold office or other elective position, or serve as a Delegate or Alternate Delegate to the Texas Medical Association.

However, in accordance with TMA Bylaws, student members may serve as voting Medical Student Section delegates or alternate delegates, may be elected to the designated student position on the AMA delegation, may serve as special appointees to the TMA Board of Trustees with the right to vote, may be appointed to the designated member position on the Committee on Membership, and may serve as special appointees to councils and committees. Voting privileges on committees of the Travis County Medical Society may be granted to student members at the society’s discretion.

Student members shall not be counted in determining the number of TCMS Delegates to the Texas Medical Association.
Membership Applications. The following proposed amendment will update language to reflect current processes.

1.13 Application for Membership.
1.131 General. A physician applying for membership shall fill out the appropriate application form as promulgated by the Association. The application form shall be submitted to the membership office of the Society, which shall retain the original application and forward a copy along with the dues to the TMA Membership Department. Any person who desires to become a member of the Society must make application in writing on the forms prescribed by the Texas Medical Association and by the Travis County Medical Society.

Retired membership. The following proposed amendment would allow physicians who retire to Austin from out of state to join as a retired member.

1.22 Retired members.

A physician member who has fully retired from the active practice of medicine, upon recommendation of the Board of Ethics, may be elected by the Society as a retired member.

When a physician, who in the preceding year was in good fiscal standing, is nominated for retired membership, payment of dues will not be required for the year in which the physician's name is presented to the society, provided the name of the nominee is received by the TMA prior to March 1. Thereafter, retired members are exempt from payment of dues.

A physician member of another state medical society, who has established residence in Texas and is fully retired from medical practice, may apply for retired membership. Dues shall not be required of a physician elected to retired membership, who at the time of retirement was a member in good standing of another state medical society.

TCMS/We are Blood Board Representation. The Central Texas Regional Blood and Tissue Center has changed its corporate name to We Are Blood (WrB), and the Bylaws of We Are Blood provide that all four TCMS officers serve as voting members of the Board of Trustees of WrB. The following amendments are proposed to update TCMS bylaws to reflect those changes:

Chapter 4 Executive Board
4.10 Composition

There shall be an Executive Board composed of the president, president-elect, secretary-treasurer, immediate past president, chair of the Board of Ethics, one (1) representative of the Delegation to the TMA such representative having been elected annually by the Delegation, one (1) representative of the Central Texas Regional Blood and Tissue Center, such representative having been elected annually by its board, and six (6) members of the Society elected at large for three (3) year terms staggered so that two (2) at-large-members are elected each year. The tenure of consecutive service of an at-large-member shall not exceed one term except when appointed to fill the unexpired term of a vacant position, in which case the tenure of consecutive service shall not exceed the remainder of the unexpired term plus one three-year elected term.

4.20 Duties

(h) appoint annually a representative of the Society to serve on the Board of Trustees of the Central Texas Regional Blood and Tissue Center; The president, president-elect, secretary-treasurer and immediate past-president shall represent the Society as voting members of the Board of Trustees of We Are Blood (formerly the Central Texas Regional Blood and Tissue Center).

TCMS Foundation. The proposed amendment to section 4.20 updates TCMS bylaws consistent with TCMS Foundation bylaws.

(i) Serve as the Board of Trustees of the Travis County Medical Society Foundation;
Standing Committee Term Limits. The Committee recommends that Section 6.10 be amended for clarification and that 6.14 be amended to provide continuity as follows:

6.10 Standing (Triennial) Committees

There shall be standing committees as follows: Medical Legislation, Public Relations, Physician Health and Rehabilitation and Constitution and Bylaws. Unless otherwise specified in the Bylaws: the president shall appoint the members and chairs of all standing committees. Committee members shall be appointed for three-year terms staggered so that one-third of such terms expire annually. The tenure of consecutive service shall not exceed one term except when appointed to fill the unexpired term of a vacant position, in which case the tenure of consecutive service shall not exceed the remainder of the unexpired term plus one full three-year term.

6.14 Constitution and Bylaws Committee. This committee shall consist of six members appointed for three-year terms with two members appointed each year. The committee shall study and report on all proposed amendments to the Constitution as provided for in Article IX or to the Bylaws as provided for in Chapter 14. The members of the Constitution and Bylaws Committee shall be appointed for three-year staggered terms as provided in 6.10 of these Bylaws. The tenure of consecutive service shall not exceed two terms except when appointed to fill the unexpired term of a vacant position, in which case the tenure of consecutive service shall not exceed the remainder of the unexpired term plus two full three-year terms.

Compliance Amendments

In accordance with section 14.20, the Committee approved the following amendments to bring TCMS bylaws into compliance with current TMA bylaws as required by the Society’s charter. Implementation of these amendments is automatic and is being reported to the Executive Board and to the membership for information.

Chapter 1 Membership

1.10 Admission

1.11 Eligibility

House staff physicians who, in Travis County, are serving in training programs approved by the Accreditation Council for Graduate Medical Education and who are licensed by or who hold institutional permits from the Texas Medical Board Texas State Board of Medical Examiners shall be eligible for resident membership.

1.13 Application for Membership.

1.132 Board of Ethics examination. Within 120 days from the date an application is completed, the Board of Ethics shall assure itself that the applicant is duly licensed as a Doctor of Medicine or Osteopathy according to Texas law, and eligible for membership. The Board’s investigation shall include an examination of the merits of any written objections received as provided in 1.132, complete its examination of the applicant’s qualifications, approve or disapprove the application, and provide to the executive board its report on the applicant’s qualifications and on the Board of Ethics’ decision to approve or disapprove membership. After investigation, the Board of Ethics shall provide to the Executive Board its report on the applicant’s qualifications along with a recommendation for approval or disapproval of membership.

Upon good cause shown, the Executive Board may grant the Board of Ethics an extension of time not to exceed 90 days to complete its examination.

1.133 Procedure on recommendation for approval of application. If the report of the Board of Ethics recommends approval of membership, the Executive Board shall declare the applicant a member within 90 days following receipt of such report, or at the next regularly scheduled meeting, whichever comes first.

1.134 Procedure on recommendation for disapproval of application. If the report of the Board of Ethics recommends disapproval of membership, the Executive Board may vote to either accept or deny the applicant for membership within 90 days following receipt of such report or at the next regularly scheduled meeting, whichever comes first. If the application for membership is denied, the Executive Board shall deliver a notice of denial of membership to the applicant in conformity with the TMA Hearings Procedures Manual.
1.22 Retired members.
Retired members shall not be counted in determining the number of delegates or alternate delegates to the TMA. Retired members shall be included in the Annual Report of the Society.

1.26 Resident members.
Resident members shall pay annual dues as required in the Bylaws, and must be reported in the Annual Report of the Society. Resident membership terminates automatically upon completion of the internship, residency, or fellowship program.

On completion of postgraduate training, a physician who has been a resident member of the Society may apply for active membership.

1.27 Military members.
Military members shall pay dues as provided in these Bylaws, and shall not be counted in determining the number of delegates or alternate delegates to the TMA. Military members shall be included in the Annual Report of the Society.

1.32 Resident of Travis County.
Any applicant residing in Travis County refused membership in the Society under section 1.13 of the bylaws shall have the right to request the Society for permission to apply for membership in a contiguous component county medical society. A physician living within the jurisdiction of this society may request permission to apply for membership in another contiguous county medical society.

1.60 Out of State Members.
Physicians accorded out of state membership shall be included in the Annual Report of the Society.

Chapter 6 Committees
6.13 Physician Health and Rehabilitation Committee.
This committee shall operate as a medical peer review committee as that term is defined in the Texas Medical Practice Act. The committee shall identify and strongly urge treatment and rehabilitation, where appropriate, to physicians of Travis County and Central Texas. The committee shall aid physicians whose ability to practice medicine is impaired, or reasonably believed to be impaired, by drug or alcohol abuse or mental or physical illness. It shall pursue all ethical means available to identify and offer assistance to physicians who are impaired. It will coordinate its activities with and abide by the guidelines issued by the TMA Committee on Physician Health and Wellness Rehabilitation. The members of the Physician Health and Rehabilitation Committee shall serve terms of three years as provided in 6.10 of these Bylaws but shall not, however, be subject to the limitation on the tenure of consecutive service.

Chapter 12 Disciplinary Process
12.30 Disciplinary Reports
12.32 Information to be reported to the Texas Medical Board Texas State Board of Medical Examiners.
Information concerning the final resolution of all disciplinary actions by the Society resulting in expulsion or probation shall be communicated by the secretary-treasurer of the Society to the Texas Medical Board Texas State Board of Medical Examiners. Such information shall consist of the respondent member’s name, the charges or complaints, and the final resolution, and the results and circumstances of such disciplinary action, including disciplinary action taken and appropriate dates.
**Classifieds**

Call 512-206-1245.

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**OFFICE SPACE**

**Cedar Park Medical Clinics:** No finish out needed 1.) Move in ready, 1720 RSF available now 2.) Another is 4800 RSF (formerly ARC clinic) available Jan 1. Rate is $18/sq ft. Both are conveniently located between 183A and 183 near regional hospital. Drive-up parking, 24/7 HVAC. Email for floor plans: lesley_ann2000@hotmail.com. Call Lesley Heaton 512-921-2960, agent or Tom Heaton, broker 512-219-7732.

**Office for Lease:** Excellent medical office for lease, perfect for 1-2 doctors, next to outpatient surgery facility, across street from South Austin Hospital; approx. 1500 sq. ft., very little renovation needed. Call for appointment 512-940-8392.

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**EQUIPMENT**

**For Sale - Medical equipment**

- X-RAY unit Amrad DX 57B
- X-RAY file metal 30 inches five tier
- Hope Processor Micro-Max
- Cast Separators
- Wallach Zoomscope Colposcope
- Colposcope curette, Tischler cervical biopsy forceps, etc.
- 4 Pneumatic adjustable MD height chairs
- 2 Tycos Sphygmomanometer wall
- 2 Baum Sphygmomanometer wall
- Time clock Pyramid PTR 400
- Artwork

See photos on Craigslist Medical Equipment. Contact Dorisrobitaille@att.net.

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**HOME FOR LEASE**

**For Lease:** Country living in Cedar Creek, TX. 2200 sq/ft 3 BR house nestled in a 16 acre working cattle and horse ranch 15 miles east of ABIA off Hwy 71E. Contact Lisa at 512-423-8639 or lisarepowell@gmail.com.

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**FOR SALE - LAKEWAY MEDICAL BUILDING**

Located across from The Oaks at Lakeway and 1 mile from LRMC.

- **.5 acre lot w/ 2400 sq/ ft building**
- 6 fully equipped exam rooms • 2 physician offices
- X-ray and lab • fully furnished
- Great visibility w/signage on RR 620
- 1411 RR 620 South, Lakeway

View the building at [http://bit.ly/1YKGtBq](http://bit.ly/1YKGtBq)

Contact: dorisrobitaille@att.net
512-413-1903

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For more information contact Ron Mize at rmize@tcms.com or 512-206-1245.

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**FOR SALE**

**SITE FOR SURGI-CENTER & MEDICAL OFFICE BLDG**

“COMPLETELY PHYSICIAN OWNED”

9 acre parcel in central Leander, Texas with ramp access to Hwy 183A

Email: Alex Tynberg atynberg@tynberg.com
512-496-5373

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