24% policyholder dividend
1% rate reduction

Effective January 2010

The Governing Board of Texas Medical Liability Trust has approved a 24% policyholder dividend for renewing TMLT policyholders and a 1% rate reduction for TMLT policyholders effective January 1, 2010. It is not too late to become eligible for this 2010 policyholder dividend. Become a TMLT policyholder by December 31, 2009, and you will be able to participate in the savings when you renew in 2010.

This is the fifth time TMLT has declared a policyholder dividend. The 24% dividend will amount to approximately $36 million in 2010 premium savings for TMLT insured physicians. This is the seventh consecutive rate reduction since the passage of House Bill 4 by the Texas legislature and Governor Rick Perry in 2003.

According to Dave W. Kittrell, MD, Governing Board Chairman of TMLT, once these rate cuts and dividends are implemented in 2010, TMLT insured physicians will have saved approximately $519.6 million since the passage of medical liability reform.

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Sacred Valley Natives. See accompanying article page 12. Photo by Robert Schlechter, MD.
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30 TAKE 5: MECHANICAL VENTILATION
It's almost axiomatic in the good old USA that competition brings out the best in people, although some might argue that it brings out the worst (think cheerleader mom, hockey dad, and Tanya Harding).

My real intent here is to explore friendly competition (or self-competition) in combination with executive coaching as tools of empowerment we might use to improve and change the quality and operations of our practice, which can easily translate to our personal life. You see, having just completed my health care MBA in December, I feel like I have to justify all my time and expense with some knowledge transfer.

So with that, please let me set the stage with an observation: Change is difficult. When you talk to an employee or a colleague about making a needed change in the practice setting, their first reaction can be to put up a mental wall. They are subconsciously thinking that their own methods are being challenged and thus the little guy in that brain of theirs is whispering, “Change is bad!” Thus the seeds are sown for continuing the same inefficient routines. Albert Einstein defined insanity as doing the same thing over and over again and expecting different results. You know these folks.

They may appear as obstructionists but, borrowing from academics, Situational Leadership models would identify them as S1 types. I guess that sounds better. People in this group tend to have needs for high task behavior but low relationship or support behavior. They are the least ready for change and are typically so busy with tasks that they can’t see the forest for the trees. Now if you or your partners are S1 types with this characteristic resistance to change, when the need arises to make significant changes or improvements in the practice, this will be a major challenge.

Situational Leadership models go on to define three additional characteristic types: S2, S3, and S4, with each successive number more indicative of a readiness for change. I find that most physicians seem to fall into the S2 group.

S2 group members are again occupied with their tasks, but they also understand and value improvement processes to some positive degree as to harbor some readiness for change. S2s can also be characterized as “Diagnose and Develop.” This sounds like a physician to me! Situational Leadership models describe them with needs for high task behavior and high relationship or support behavior. Again, sounds like a physician to me. In order to assess readiness for change, this group needs to focus discussion with direct questions and define performance gaps. Wait a minute, this sounds just like peer review! Well just maybe that is a first step, but please don’t let that put you off just yet.

Occasionally we will independently open up just a little bit to change on our own. The little guy in our brain is finally asking for help or direction. Maybe he can’t get home in time for other life activities; maybe he wants more face-to-face time with patients; or maybe his practice is just not as profitable as he would like. There is a break in the psyche. Good news is that it’s an opening for transformational change! The bad news is that we’re usually tempted to settle for transactional change. Transactional change is usually incremental while transformational change refers to fundamental behavior change that requires a great deal of fortitude if not leaps of faith.

Physicians will typically address the need for change in the office by hiring a consultant. The familiar story goes like this. The consultant will help you go through a checklist and evaluate tasks and operations. Hence, a list of deficiencies and planned responses will be submitted. The next step is to pay said consultant (not usually cheap in any physician’s mind). The final step is implementation. This is the phase where we get stuck (with more than just the bill) and where reports wind up collecting dust. The ultimate result is no change or, at best, superficial transactional change.

I’d like to suggest two additional tools that might help move us more toward transformational change. The first is Competition – either as friendly competition with some colleagues you trust or even competition with yourself. This involves each friendly competitor helping each other in four ways. First, helping each other let go of the past is paramount. Second, being supportive rather than cynical, sarcastic, or judgmental will lead to better outcomes. Next, telling the truth to each other is the rule. Finally, helping to identify in each other something you might improve. In the context of the mutual support of trusted colleagues, friendly competition to implement change will likely be much easier, whether it involves consultant recommendations or self-identified areas of improvement. Imagine that you were the laggard and had to watch as your colleagues left at 5pm and had full lunches because you weren’t implementing beneficial suggestions for operational effectiveness.

Then, to augment your friendly competition, consider hiring a Coach. And I don’t mean a Mack Brown; I’m talking about an executive coach. An executive

continued on page 8
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coach can help you develop your strengths and empower you to reach your potential through a collaborative, non-confrontational approach. Executive coaches can also challenge your perceptions and behavior patterns in a way that produces sustained positive change resulting in increased professional effectiveness and personal fulfillment. If your personality is such that you need an outside party to motivate you, this would help you immensely.

Just remember that only you can let the competition get the best of you! Healthy competition – whether within your medical community, the walls of your practice, or your own ability – provides an opportunity for excellence. Use the competition and coaching to challenge yourself and make a difference!

continued from page 6

Travis County Medical Society Membership Committee invites you to

A Networking Social

Friday, April 16
6:00 - 8:00pm

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For more information contact the Society at 206-1249 or tcms@tcms.com

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March • April 2010

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TCMS Journal  March • April 2010  9
Retired Membership is granted to those physicians who have retired from the active practice of medicine. Upon nomination from the Board of Ethics, the TCMS Executive Board elected the following to Retired Membership:

- Lawrence Stone, MD
- Ziga Tretjak, MD

Life Membership is granted to those physicians who have been a dues paying member of organized medicine for 35 years, of which 25 years must have been dues paying years in the Texas Medical Association and its component county medical societies, and who have reached a point of comparative inactivity in the practice of medicine, as determined by the Society. Upon nomination from the Board of Ethics, the TCMS Executive Board elected the following to Life Membership:

- Edwin R. Buster, III, MD
- Drew G. Sawyer, MD
- James C. Sharp, Jr., MD

Julia Allen died December 22, 2009. She was not a physician but was an extraordinary nurse who contributed enormously to the excellent Austin medical community. Julia served as the operating room supervisor at Seton Hospital for decades.

Was a unique personality who could combine charm with discipline, and was admired (loved) by generations of physicians and nurses.

Operating rooms were Julia’s territory. They were Julia’s domain for which she was dedicated and passionate. Her ability to combine efficiency with friendliness was respected by everyone. All surgeons were thankful for her competency.

Was a nurse’s nurse and a doctor’s nurse. A true professional. Julia Allen was a legend in “her own time.”

George Tipton, MD
(Retired TCMS Member)

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Dennis Factor, MD, and Joseph Abell, MD

TCMS Member Awarded Heart of Gold

Joseph M. Abell, Jr., MD, was recently recognized for exemplifying the “gold standard” of volunteerism by the Texas Medical Association Foundation. Dr. Abell was presented the TMAF Heart of Gold Award on Saturday, March 6 in a special presentation at the TMA building.

The Heart of Gold Award recognizes an exceptional individual who has made a measurable impact on the life of the Foundation, brought resources to it that would otherwise not have been attainable, and brought innovative ideas or contributions within a standard of excellence.

In the case of Dr. Abell, this translated into his chairing the Central Texas Campaign Committee for the Legacy of Caring Endowment Campaign – the effort that launched TMAF in 1989 and raised nearly $5 million dollars in immediate and deferred gifts. One of the original 11 TMAF Board of Trustees in 1994, he later chaired its Development Committee and served as TMAF president from 1997-1999.

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Standing, left to right: Dr. Shannon D. Cox, Dr. John J. Costanzi, Dr. Stephen L. Brown, Dr. George R. Brown. Sitting, left to right: Dr. Douglas J. Rivera, Dr. Kirsten A. Warhoe, Dr. Brian J. Shimkus.
Are you old enough to remember the Weekly Reader from grade school? For me, this is where the journey began as I still remember the fascination of seeing pictures of Machu Picchu in that august publication in the third grade. I have since retained interest in these magical ruins high in the Andes and when the opportunity to make the trip arose, we snapped at the chance. It was frankly one of my “bucket list” events. My wife Marcia and I will travel with Bob and Beth Schlechter on this adventure. Hearing of the challenge day travail of 6,000 ft climb, culminating at 14,000 ft on Dead Woman’s Pass, we train for about 3 months with daily hikes and weighted packs. ‘Tis a good thing; without the preparation, the ascent for us might not have been possible, at least not before sunset.

It is the final morning on the trail and our only 5am wake up. I leave the tent before dawn and can feel the excitement in the air. It is a clear morning and the view of the Andes all around us is incredible, towering another 6 or 7,000 ft above our 12,000 ft camp. Porters are already packaging up some camp materials and talking excitedly as they prepare for departure. The work they do seems endless. As I approach the cook tent, one of our guides has his iPod on with portable speakers and I hear strains of Satisfaction and then Start Me Up, by the Rolling Stones, and it adds to the magic of the morning. It is almost all downhill today with a short climb up to Sun Gate, that will give us our first views of the ruins of Machu Picchu. Our porters will be leaving us this morning and taking a shorter route home, so there is a brief thank you and goodbye ceremony. They are good, hardworking men and have made our trip so much easier.

Our first stop is at the ruins of Runkurakay, what was once a rest stop for the “Inca Pony Express,” a service provided by runners called Chasquis. The Chasqui was usually a young male, between the ages of 18-25, who ran the trail with news from around the Inca Empire. From here to the Sun Gate we will hike along the original un-restored trail stepping on the same stones that existed in the 1400s when the trail was created, the same stone steps used by these runners of the past. The last two days we have hiked through the dense Forest of the Clouds, a rainforest that exists in the Andes between 11,000 and 13,000 ft, an odd ecosystem to find at this altitude where in most places nothing really grows for the most part. The lush section today is through the Bamboo Forest, a stark contrast to the more arid Andes we experienced the first days in Peru. We pass rock outcroppings that are so heavily covered with growth – a fascinating collection of lichen, moss, and microplants – that they appear just like the soft coral covered walls we have seen while diving in Bonaire. Amazing to even briefly stop and study this profusion of living things.
We see our first really large Andean butterflies here, colored indigo on one side and yellow on the other; with their 6-8 inch wingspans they seem to blink on and off as they flutter by. There is growing anticipation with each step of the climb as we approach the steep steps leading to the Sun Gate after about four hours of hiking. The steps are notoriously steep, like climbing a ladder, and our guide asks for a few moments of silence to reflect on what we have seen, what we will shortly see, and thankfulness for a safe journey. We all happily make the climb and then a brief walk to the gate itself. As you walk through you are greeted with the view we have been waiting for, the one I still remembered from third grade. It is a frequently seen view of the ruins of Machu Picchu from a 1,000 ft above. Fascinating they are, the ruins of this ancient city set before the smaller peak of Winapichu, and nestled in a small flat space against the larger Machu Picchu Mountain.

We stop for pictures, reflection, and just to enjoy the panorama before us. Bob, as usual, stands on the edge of the precipice gazing out, while the rest of us require at least a three foot safety margin as the drop is vertiginous to say the least. He hangs ten without a care and probably not even realizing it. Finally we complete our descent under threatening skies, and just as we reach the ruins it begins to thunderstorm. The descent from the ruins down to the paved road is a treacherous switchback dirt road just barely wide enough for the small buses that transport the sightseers who have not taken the trail route. It turns to mud rapidly, and I am certain that others’ thoughts are the same as mine, “I wish this guy would slow down!” Even though we are probably only going 15 mph it seems like 50. The road is perched on the hillside so steep the slightest error would mean a 1,000 ft tumble to the bottom. And then the scene goes from high anxiety to brief terror as, on one hairpin switchback, the bus begins to slide in the mud towards the edge. We slide until we just kiss the guardrail which stops us on the very edge of the cliff. The driver, unfazed, simply backs up and continues down as I swear I will never ride in a bus on this road again, though of course I do the next morning to tour the site in detail.

Aguas Calientes is a quaint small town where we will spend the night in a real bed. It is for us the welcomed first opportunity for a hot shower and a meal at a real table.

Back at home we take our final Malarone tablets prescribed to prevent Malaria, and this must mark the official “end” of the trip. A trip of hard trail work, history, and the natural beauty of wonders all around us. A trip of thin air, black fly bites, living in tents, and sleeping on the ground was over. It was an unforgettable journey.

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After being installed as 2010 TCMS President, Dr. Mark Chassay presented Dr. Charlotte Smith with a past president's medallion, bound copy of the 2009 TCMS Journals, and a plaque recognizing her year as president.

(l-r) Jeffrey Johns, MD; Mrs. Cathy Powell; Hector Morales, MD; Mrs. Ann Morales; Joe Powell, MD; and Mrs. Connie Jobe.

(l-r) Mrs. Julie Cowan; Rob Cowan, MD; Dawn Buckingham, MD; and Andrea Pana, MD.

(l-r) Mrs. Ginger Uriquidez; Jose Uriquidez, MD; Jack Carsner, MD; and Mrs. Jennifer Carsner.
Dr. Mark and Mrs. Kimberly Chassay.

Dr. George and Mrs. Roberta Pazdral.

2010-2011 Travis County Medical Alliance Officers.

Roberta Pazdral  
President-Elect, Travis County Medical Alliance

**UT School of Nursing, Family Wellness Center**  
On February 4, Alliance members received a tour of the Family Wellness Center at the UT School of Nursing from Center Director, Lisa Doggett, MD and Development Director of the UT School of Nursing, Andria Brannon. Last year, the Alliance provided a grant to create an additional exam room for the Center located in the UT Development Building.

In addition to the normal features of the new pediatric exam room, a closet contains shelves of new and used books which are given to each child and their siblings provided by Bookspring – a beneficiary of both Alliance grants and volunteer time.

Dr. Doggett said that the Center was established as, “The School of Nursing wanted a place for students to see patients.” The Center is part of the safety net clinics of the City of Austin and provides medical care to low income and uninsured Austin adults and children.

---

**Member Spotlight: Amy White, MD**

Pediatrician Amy White grew up in Wausau, Wisconsin and attended the University of Wisconsin in Madison as an undergraduate and medical school student. It was during medical school that she met Eric, her husband who is now an anesthesiologist. They completed their residencies at University of North Carolina, Chapel Hill before moving to Austin in 2004. She and Eric have two children, Lucas and Emma.

Dr. White currently works at Dawson Ramirez Pediatrics, but is also an active community volunteer. A couple of years ago after talking to Wendy Kratzer, TCMA past president, Dr. White formed an Alliance committee to link TCMA volunteers to the clinic. The committee has improved the aesthetics of the clinic by displaying artwork painted by children of TCMA members, sponsored clinic families at Christmas, and has provided work days where TCMA families work on maintenance projects.

In her spare time, Dr. White enjoys traveling, reading, running, surfing, and practices Pekiti Tirsia Kali, a style specific to Filipino Martial Arts.

*Family photo: Amy, Eric, Lucas, and Emma.*

The 2010 Gala, “All About Austin” was held on Saturday, February 20 at the UT Golf Club. Over $80,000 was raised for the Volunteer Healthcare Clinic and other health related community agencies. TCMA extends a huge thank you to the following sponsors for their generous contributions to the success of the gala.

**Hole in One sponsors:** Austin Radiological Association, Clinical Pathology Associates, St. David’s Healthcare, and Travis County Medical Society.

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The Travis County Medical Society has a strong commitment to community – close to home and far away – especially when disaster strikes in the form of a hurricane or earthquake.

After a magnitude 7.0 earthquake hit Haiti on January 12, physicians, hospitals, and pharmacies donated needed medical supplies and made financial contributions to relief efforts.

Medical teams including TCMS physicians traveled to Haiti with various relief agencies to assist with the country’s medical needs. Below are excerpts from their experiences.

**Day 1 impressions.**

**J. Brannan Smoot, MD**
Texas Orthopedics
www.facebook.com/mohhaiti
February 15

We departed the Dominican Republic by bus and crossed into Haiti in the early morning hours, arriving in Port-au-Prince mid morning. The devastation, loss of human lives, and destroyed property was mind-numbing. United Nations’ cars and various aid groups and personnel were ubiquitous. Tent cities were everywhere.

In the following days, we held clinics in three different areas, serving more than 1,200 gracious and deserving Haitian patients. We were able to offer pain relief, sleep aid medication, vitamins, antibiotics, wound care, immunizations against tetanus, and piperazine, (a liquid medication taken by mouth for the treatment of intestinal parasites). In addition, we distributed food donations to each family.

**David Vander Straten, MD**
CommUnityCare
February 1

Team members stayed in tents outside the Guest House on the Mission of Hope compound. The building has a small kitchen, three bathrooms, and normally holds about 25 guests. On average, 75 people were using the facility at any one time.
Today our team members have been in town helping at the general clinic.

They saw over 100 patients in the clinic at MOH today; mostly general medical issues, several forearm fractures, distal radius fractures in kids. They are having some amputees coming back for evaluation.

More time for organization of long term medical care at MOH.

Goal to get patients where they need to be and the long term care that they will need to have.

Joel H. Hurt, MD
Texas Orthopedics
http://txortho.blogspot.com
January 28

By the time we hit the ground in Port-au-Prince we had a well-organized team of 16. There were 10 physicians, 2 surgical techs, 3 nurses, and 1 pastor/photographer. I took the approach that this is a military operation and I mentally put on a "suit of armor" to be able to do what I knew was ahead. I thought I had seen it all, and have been in a lot of situations over the years – in India, Africa, and even my residency in downtown Detroit couldn’t prepare me for the utter devastation I saw, inflicted on so many. It’s what I would imagine the aftermath of large-scale war would look like....

As the week ended, that bulletproof armor was soaked with tears and sweat – my tears and my sweat, mixed with those of patients and team members who would now become lifelong friends. There was no protection from the love and suffering of the Haitian people and both pierced my heart, changing it forever. The moment I arrived home, I started planning my return to Mission of Hope with my wife. We are in it for the long run!

Timothy C. Gueramy, MD
Medical Park Orthopaedic Clinic
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January 16
Donald Edward Pohl, MD passed away on January 23, 2010. Dr. Pohl was born in Council Bluffs, IA and graduated Phi Beta Kappa at the University of Iowa. He earned his medical degree at the University of Iowa School of Medicine. Dr. Pohl served during WWII as post surgeon in Battle Creek, MI. Following the war, he enrolled in the Pathology Residency Program at the University of Michigan at Grand Rapids. He initiated a Pathology Program at the University of North Dakota.

Dr. Pohl moved to Austin in 1952 and was the second internal medicine specialist in the city. He enjoyed life as an accomplished artist, a skilled pilot, and as a solo practitioner his entire career.

Stewart M. Ponder, MD passed away on February 18, 2010 at the age of 92. Dr. Ponder was a psychiatrist who received his medical degree from the Baylor College of Medicine at Dallas in 1942. Dr. Ponder served in the US Army during WWII and was assigned to the US Army Air Force Medical Corps in the European Theater of Operations. He was president of the Gonzales County Medical Society before moving to Austin.

Dr. Ponder moved to Austin in 1952 and was the second internal medicine specialist in the city. He enjoyed life as an accomplished artist, a skilled pilot, and as a solo practitioner his entire career.

VC Smart, Jr., MD passed away on February 2, 2010. Dr. Smart grew up in Spur, TX. He received his medical degree from the University of Texas at Galveston in 1956. Dr. Smart moved to Austin to establish his medical practice as a general practitioner and later as an allergist.

He enjoyed flying, dancing, roses, hunting, and nature. Dr. Smart served in various capacities on medical boards, associations, and societies including as president of TCMS in 1979. He supported the Austin Symphony, missionaries, and other organizations.

Milton Turner, MD passed away on March 3, 2010. Dr. Turner was born in Brooklyn, NY. He earned a BS degree and medical degree from Tulane University. Dr. Turner volunteered in the US Army during WWII and was assigned to the US Army Air Force Medical Corps in the European Theater of Operations.

Dr. Turner completed his obstetrics-gynecology training and opened his medical practice in Austin. He served as chairman of the department of Ob-Gyn at Brackenridge, Holy Cross, and St. David's hospitals. He resumed military service with the active reserves and was commissioned as Major in the Air Force Reserves. Dr. Turner is credited for starting the first Ob-Gyn section at Bergstrom Air Force Base.
MICHAEL J. KHOURI
ATTORNEY AT LAW

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Presentation
A 6-year-old girl began vomiting on a Saturday. The child’s mother called her pediatrician, the defendant in this case. The pediatrician prescribed Phenergan suppositories, and told the mother if the girl did not improve over the weekend, to let him know and he would meet them at the clinic or the emergency department (ED).

Physician action
The pediatrician did not hear from the mother again until Monday when he saw the child at the office. The pediatrician indicated that the patient “looks pretty sick, not toxic.” She was mildly dehydrated, and her abdomen was soft and slightly bloated. Bowel sounds were normal with no rebound or guarding. A blood count completed at 9:49 am revealed a normal white blood count of 8.2 with a normal machine differential. Results from a urinalysis were abnormal with positive red and white blood cells, protein, ketones, and nitrate.

The pediatrician’s assessment was gastroenteritis and dehydration. He admitted the patient to a children’s hospital in stable condition. He ordered IV fluids, a CBC, blood cultures and electrolytes, and nothing by mouth except acetaminophen and ibuprofen.

The patient was admitted, and the IV fluids were started at 11:30 am. She was complaining of nausea and abdominal pain, but was unable to pinpoint the location. The patient described the pain as throbbing, and the nurse documented that her abdomen was slightly firm and flat and that she had hyperactive bowel sounds. The patient was weak and needed help walking. She had no fever.

Upon admission, the patient’s white blood count was 11.3, but she had 31% bands. Her electrolytes were reported as normal, but fibrin formation was noted by the lab. (The blood culture grew Fusobacterium varium six days later.) No record was found that these results were reported to any physician or nurse.

At 2 pm, the patient stated that her abdomen hurt, but was better when her mom came in the room. Between 2 and 3:15 pm, a nurse’s assessment revealed “no distress condition noted at this time.” The next nurse’s notes were timed from 3 to 11 pm, and the patient’s abdomen was slightly “extended,” tender to touch with bowel sounds present in all quadrants. The patient was weak and had difficulty walking due to abdominal pain.

The patient complained of abdominal pain at 3:15 pm, and was given Tylenol. At 4:15 pm, the nurse noted that Tylenol was “effective” and that the patient was sleeping. At 6 pm, the nurse documented that she notified the pediatrician that the patient’s abdomen was hard and more “extended” compared to an hour earlier. The pediatrician ordered a surgical consult at 5:45 pm He also ordered a CBC, sodium, and potassium.

The record revealed that by 6:30 pm. The postoperative diagnosis was perforated appendix with generalized peritonitis. Following the surgery, the patient had a very complicated hospital stay that lasted more than one month. She was taken back to surgery several times for abscess drainage, necrotizing fasciitis, and skin grafting.

Allegations
A lawsuit was filed against the pediatrician, alleging:
• failure to complete a history and physical exam on the patient when contacted on Saturday;
• failure to hospitalize the patient when she had symptoms of appendicitis and abdominal pain;
• failure to order testing to rule out appendicitis; and
• failure to include appendicitis in the differential diagnosis.

Legal implications
The plaintiff’s expert was critical of the defendant for prescribing Phenergan over the phone without eliciting a more complete history of the patient’s condition. When the patient was seen on Monday, this expert believed that she had an acute abdomen and should have been admitted and a surgical consult requested immediately.

During his deposition, the plaintiff’s expert admitted that diagnosing appendicitis in a young child is difficult, and that there are circumstances in which a pediatrician may miss a
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diagnosis of appendicitis and not violate the standard of care. He further stated he did not believe the defendant violated the standard of care in failing to diagnose appendicitis. However, the defendant did violate the standard of care by not including appendicitis in the differential diagnosis.

Defense consultants were mostly supportive of the defendant’s actions. One expert pointed out that it was within the standard of care to prescribe Phenergan and to advise the parent to have the child treated in the ED if she did not improve. Based on the defendant’s examination of the child on Monday morning—specifically the lack of rebound, guarding, or significant tenderness—the diagnosis of appendicitis at that time was unlikely.

Defense consultants did express concern about why it took the pediatrician so long to obtain a surgical consult once the child was admitted to the hospital. There were several blood counts taken, with the latter one indicating that the white count was 11.3 with 31% bands. While there was no record in the chart that the pediatrician was given that information, consultants questioned why the pediatrician did not more closely follow up on these lab results. An obstacle for the defense of this case involved a difference of opinion about the Saturday phone conversation between the pediatrician and the patient’s mother. What the mother recalled about the conversation was in direct conflict with what the pediatrician recalled about the conversation. The record did not include complete documentation regarding this conversation.

Disposition
This case was settled on behalf of the pediatrician. Though there was expert support for his care of the patient, it was felt that documentation issues compromised the defense of this case.

Risk management considerations
The medical record should be a complete chronological diary of patient encounters including phone calls during and after hours. To accurately record concerns reported by a patient or parent and the physician’s response and recommendations assures a reliable record of events and leaves no room for conjecture. Physicians are encouraged to develop and implement a system to document phone calls to assure a complete medical record. Options may include a dictated note, direct entry in an electronic medical record, dial back to an answering machine or voice mail at the practice, or a note written on paper and affixed permanently in a paper medical record. When an accurate chronology of events is not included in the record, answers relying on memory long after the fact will likely influence a jury.

This closed claim study is based on an actual malpractice claim from TMLT. This case illustrates how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician’s defensibility. An attempt has been made to make the material less easy to identify. If you recognize your own claim, please be assured it is presented solely to emphasize the issues of the case. ©TMLT 2010
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RISKS OF MECHANICAL VENTILATION

- Infection, including pneumonia, sinus infection, and sepsis (bloodstream infection), can occur anytime the body’s natural barriers are broken. Steps are taken to protect patients who have to remain intubated and on ventilators, to reduce their chances of infection, especially ventilator-associated pneumonia.
- Prolonged intubation can cause damage to the trachea, lips, tongue, teeth, and vocal cords. Careful measures taken by intensive care providers help to reduce this risk. In some cases, tracheostomy (a surgically placed breathing tube through an incision in the neck) may be offered to improve a person’s care when intubation is required for a longer time period.
- Ventilators, like all other mechanical devices, can malfunction. Sophisticated alarms and system checks are built into the machines to prevent harm.

COMMON REASONS FOR MECHANICAL VENTILATION

- Routine, short-term use during general anesthesia for surgical procedures
- Respiratory failure from pneumonia, chronic obstructive pulmonary disease (COPD – chronic bronchitis, emphysema), acute asthma attack, acute respiratory distress syndrome, or severe viral infections (such as West Nile virus or influenza)
- Severe heart disease
- Neurological diseases that prevent normal breathing
- Sepsis and multiorgan system failure

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