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“Upside down tree” in Mendenhall Gardens, Juneau, Alaska, — a tree that has been uprooted and planted upside down.

*Photo by Ann Soo, MD.*
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On the Cover
Guilin, Li River.
Fisherman at sunset.
Photo by Jeffrey Lava, MD.

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Well the United States Congress did it. Like it or not, after a long and sometimes ugly legislative process, the House and Senate passed the health system reform bills that, with the president’s ink on March 30, are now law of the land.

Physicians anxiously followed the progression of this legislation since the presidential elections in 2008 as it morphed through our painful political process. Inevitably, with one party controlling both Houses of Congress and the White House itself, the stage was set for some type of reform.

In following the comments of my colleagues over the past 18 months, I realized that, just like our nation is divided 50-50 on most subjects, so were physicians in their opinions on the whole of the health system reform legislation. At the risk of oversimplifying a complicated divide, on the one hand were physicians who feared that radical change would be dangerous and risk throwing out the proverbial baby with the bathwater, and on the other were physicians who believed our system was so broken that only radical change could fix it.

To make consensus even more difficult, the transparency that was promised by elected leaders was unceremoniously deemed as trivial at their convenience and subsequently was a recipe for confusion, outrage, and finger pointing. This led physicians to lash out at their state and national medical associations for their handling of health reform efforts.

On each side of the issue, opinions seemed non-negotiable. Some felt that proposed programs were excessive and unaffordable, while others felt that our government wasn’t going far enough with reform. I heard from many physicians that we needed more thorough and thoughtful processes, not fast action; they resented the AMA’s tactical support of the evolving legislation. I heard from others that we needed major change now, not incremental tweaking; and they resented the TMA’s communication campaign and materials that suggested that the process should be slowed down.

So with all the division and intensely held opinions throughout the year-and-a-half national debate, it is hard not to take all this change very personally and with emotional flare. However, at this point, it’s no longer a debate; it’s the law and the devil will be in the details of regulation and implementation. If we as physicians seek to maximize the benefits of the new law for our patients while minimizing the harm to our profession, we will need to be pragmatic, not ideological, moving forward. We will need to think and work together as physicians, not as political partisans.

There is no perfect answer, but physicians need collaboration and consensus now more than ever, and education and dialogue is an absolute must.

On January 26, 2010, the Travis County Medical Society hosted a physician-only open house and forum for leaders to discuss the negotiations in Washington and to hear the concerns and opinions of local grassroots physicians. The auditorium was packed with doctors from a wide spectrum of medical practice and political viewpoints. The panel represented a purposeful diversity of medical organizations including Health Care for All Texans (HCFAT) and Physicians for Social Responsibility (PSR) along with the TCMS, TMA, and AMA.

Dialogue was spirited but collegial and respectful. Overall, there was much agreement and convergence of opinion on the major tenets of what AMA addressed as eight critical elements of reform and on the seventeen more expanded principles outlined by the TMA. While most were in agreement that these core principles should be a part of any health system reform, there were sharp differences of opinion about the means to achieve them in the broader political context.

My conclusion after seeing such agreement on core values and principles is that our American Medical Association was, after all, correct in its tactical approach. In Washington, it was important for physicians to be at the table and not on the menu. There would be no way for physicians to have any practical influence to protect patients and physicians should our AMA be picketing on the outside looking in. As nauseating as the legislative process can be, now that the bill has become law, it is the agencies of the executive branch of government, including the Department of Health and Human Services, that will need to convert that 3,000 page bill into

continued on page 8
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rules and regulations that will in all likelihood be 30,000 pages. This process will take years, maybe a decade, to complete. Understanding that reality, you can better appreciate that our physician-led AMA again needs to be at that table. If physicians are standing outside clamoring for repeal of the law instead of working to influence its implementation, we will miss a big opportunity.

We spent many years being educated and almost all our training has taught us collaboration in finding solutions/treatment plans to problems/diagnoses. We now need to work together to assure there is physician influence as the new health system laws are implemented. We need to continue to advocate for a permanent fix to the SGR in addition to educating lawmakers and advocating for patients on issues such as access to care or health information privacy protection which, for example, has been championed by the Patient Privacy Rights Foundation headed by Austin physician and TCMS member Deborah Peel, MD.

In closing, it is important that physicians weed out the politics, understand the law, and again be at the table with the agencies responsible for writing the day-to-day operational interpretations of the law. The new rules and regulations ultimately will be how the legislation will be judged. With our experience in the trenches of health care delivery, we can influence the process to make it more congruent with the mutual principles the vast majority of physicians feel important and at the same time fulfill our ethical obligation to look out for and protect our patients.

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The Texas Medical Association's House of Delegates (see side bar) convened in Fort Worth recently during TexMed 2010.

The rhetoric was spirited as members testified in reference committees and delegates debated in the House over policies and the path that our organization will take in the future. Our profession is navigating uncharted waters with changes brought by the health system reform law. A major theme throughout the conference was the need for physicians to work together to implement the new law in a way that maximizes the benefit for our patients, and minimizes the harm to our beloved profession.

Emotions were strong and opinions mixed as evidenced by testimony at the reference committees and at a special forum on health system reform. One resolution debated in the House called for TMA to seek to partner with medical organizations other than the AMA for political and legislative advocacy, a proposal seen by some as a call to secede from the AMA. During floor debate, Travis County delegate Sarah Smiley rose to speak along with her mother, an alternate delegate from the West Texas caucus. Noting that the number of delegates in the AMA House from each state is proportional to that state’s AMA membership, they argued that – although it may seem counterintuitive – rather than pulling out of the AMA, Texas should leverage and increase its influence in the AMA House by maintaining or increasing its numbers during these difficult times when other states are falling in AMA membership. Thus we could work from the inside to make the AMA more like the TMA. Dr. Smiley’s remarks received a round of applause from the House.

In the annual elections process, Travis County was successful with all three of its candidates. Bruce Malone, MD (see side bar) was chosen as president-elect and will lead the TMA in 2011-2012. We are proud to be the home county of the next TMA president and congratulate Dr. Malone on his well deserved election. Clifford Moy, MD was re-elected for his third term as vice-speaker of the House of Delegates and David Fleeger, MD was re-elected to the Texas Delegation to the AMA. We are fortunate to have such fine members of TCMS in key leadership positions at the TMA.

Outside of Travis County, Tomas Garcia, MD of Houston was re-elected to the TMA Board of Trustees and two new members, David Teuscher, MD of Beaumont and Doug Curran, MD of Athens joined the board. The newly elected officers of the Board of Trustees were Dr. Carolyn Evans, chair; Dr. Tomas Garcia, vice chair; and Dr. Doug Curran, secretary. Drs. Carlos Cardenas and Lewis Foxhall were elected as executive committee members. Fort Worth orthopedic surgeon, Stephen Brotherton, MD was re-elected as speaker of the House of Delegates and Brad Butler, MD and Michael Ragin, MD won seats as the newest members of the Texas Delegation to the AMA. Finally, Sue Bailey, MD, a Fort Worth allergist, took the reins of leadership as the 145th president of the TMA in 2010-2011. All these chosen officials need our support for the coming challenging year as they help steer the TMA through what will undoubtedly be choppy waters.

TexMed 2010 was a weekend of stimulating work and good fellowship, and I encourage you to get involved. The best way to influence or change TMA policy is at the grassroots level as any Society member can present a policy idea or change. Ask your TCMS staff or leadership and we will help you get started. Medicine is going through a sea change and all physicians can make a contribution to our future.
The Texas Medical Association House of Delegates is the representative policy making body that meets to receive reports of the officers, boards, councils, committees, and sections of the Texas Medical Association (TMA) as well as resolutions from county medical societies or individual members. All these items, information reports, as well as proposals for action, become the business of the House of Delegates.

All business of the House is assigned by the Speakers, according to subject matter, to one of four reference committees. Any member of the TMA (not just delegates) may appear before reference committees to speak for or against any proposal or issue under consideration.

After reviewing (and sometimes consolidating) the reports and resolutions relative to each issue, and after hearing all testimony given by members, the reference committees summarize the information, discussions, and testimony. The reference committees then report their recommendations (which may include approval, amendment, disapproval, or referral) to the House for action.

C. Bruce Malone, MD was unanimously elected by the TMA House of Delegates as president-elect. Dr. Malone will be installed as TMA president at TexMed 2011.

Dr. Malone is an orthopedic surgeon and a past president of the Travis County Medical Society.

“I am honored that my colleagues have elected me,” said Dr. Malone. “My focus will be to protect the patient-physician relationship and strengthen the viability of Texas physicians’ practices in this era of health care reform.”

Nine promising minority college students planning to enter a Texas medical school this fall each received a $5,000 scholarship from Texas Medical Association at TexMed 2010.

The Travis, Dallas, El Paso, Harris, and McLennan County Medical Societies joined to fund the $5000 scholarship that Amanda Little received from the TMA Foundation. Ms. Little already has a well-rounded, health-education background. She is an AmeriCorps member for the National AIDS Fund and spent a semester independently surveying public health issues among Amazonian cultures in Ecuador. She will receive her bachelor of arts from Washington University in St. Louis, MO, and will attend Baylor college of Medicine in the fall with hopes of becoming a primary care physician.

Amanda Little, scholarship recipient and TCMS President, Mark Chassay, MD.

For more information on the TMA House of Delegates visit www.texmed.org.
The TCMS Public Relations Committee recently sponsored a service project with the AISD Student Health Services to provide free athletic physicals to AISD students who do not have affordable access to health care.

With the assistance of 95 TCMS physician volunteers, over 800 middle school and high school students were screened over the course of four nights. Specialists from pediatric cardiology, otolaryngology, general surgery, pediatric surgery, and emergency medicine joined their pediatrician, internist, and family practitioner colleagues at Burger Activity Center and Delco Activity Center.

These physician volunteers were assisted by volunteer nurses, student nurses, and health educators from the AISD, UT School of Nursing, Texas Tech, and Dell Children’s Medical Center. Numerous volunteers from the Blood and Tissue Center’s Lend a Hand program helped with crowd control, serving snacks, and chaperoning duties.

We also received support from several members of our Friends of the Society Program: Austin Brokerage Company, Austin Radiological Association, and Physician’s Resource Services who made financial and in-kind donations to provide healthy snacks and water for students.

This year, as a pilot project, TCMS and the Travis County Medical Alliance Be Wise Immunize volunteers also partnered with AISD to provide immunizations to a number of these students in an effort to bring down the AISD vaccine delinquency rate.

The Medical Society could not continue to offer this program without the generosity of all those who volunteered their services and support.
A middle school student is now up-to-date on immunizations thanks to Crystal Garcia, MD and the AISD immunization team.

Thank You!!

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May 31 Deadline Is Looming...
Have You Signed the Stop the Medicare Meltdown Petition Yet?

The Travis County Medical Society, Texas Medical Association, and other Texas county medical societies have launched a petition drive to collect one million signatures by May 31. The petition simply asks Congress to stop the Medicare meltdown so that patients can choose their doctors and so their doctors can remain in the Medicare program.

The other 49 state medical associations, along with numerous national and state specialty societies have now joined the petition drive. Achieving the goal of one million signatures will set the stage for TMA to advocate at the national level in this and other matters of importance to patients and physicians.

As we go to press, Congress is again debating the fate of the faulty SGR payment formula Medicare uses to pay physicians. Tell members of Congress that you and your patients are watching their every action and care deeply about this issue. Congressmen keep telling us that physicians don’t care because they never hear from them. Prove to Congress that “physicians and patients do care.”

TCMS and TMA are asking every physician to sign the petition. After you sign it, please ask your family, friends, colleagues, and neighbors to sign it until you get 10 signatures or more. If you belong to civic groups, take the petition with you to meetings. We must get one million signatures by May 31. It’s imperative to your profession!

Make your voice heard to ensure Medicare patients have a doctor to care for them when they need one! Tell Congress to finish its work and permanently fix the Medicare SGR formula. Sign the petition at www.ipetitions.com/petition/meltdown today!

Note: Due to HIPAA regulations, TMA recommends that you not collect signatures directly from your patients nor use patient lists to disseminate this information without first having a HIPAA-compliant patient authorization to do so.

Don’t let the SGR fee cut take effect on June 1!
www.ipetitions.com/petition/meltdown

For printable flyers and petitions, visit www.tcms.com or contact Stephanie Triggs at (512) 206-1124 or striggs@tcms.com.
Ask Congress to Keep Doctors for Medicare Patients

Dear Patient,

For a Medicare patient, a doctor can mean everything: independence, hope, and security. Medicare makes it possible. For a doctor, treating our patients is everything. We have cared for many of you covered by Medicare for years. We know many of your children and grandchildren — our patients are family. The last thing we want to do is tell our patients that we can no longer care for them. I want to continue taking care of my Medicare patients — that’s why I became a doctor.

Even though the new health care bill promises to cover more patients, some big problems still exist. The health care bill did not fix Medicare — the government’s largest health care program.

Congress must fix Medicare now, so that you and other Medicare patients can have the doctors you need when you’re sick. You deserve to receive the care you’ve been promised. Congress MUST focus on this problem. Congress must finally fix a problem it has been putting off for more than 10 years.

A statewide effort now is underway to collect 1 million signatures. The petition drive is asking Congress to stop the Medicare meltdown so patients can choose their doctors and their doctors can stay in the program. However, due to government regulations, I cannot collect your signature on a petition. So instead, I’m sharing the information with you.

Please make your voice heard.

Go to [http://www.ipetitions.com/petition/meltdown/](http://www.ipetitions.com/petition/meltdown/). Tell Congress to continue its work. Tell Congress to fix the crumbling foundation of our health care system.

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Texas Medical Association
Physicians Caring for Texans

Me & My Doctor: We Know Best
Spring Picnic
Sunday, April 11
It was a cloudy day with drizzle threatening, but that didn’t stop toddlers, teens, and Alliance parents from gathering at the Mayfield Park and Preserve. Beneath the live oaks little ones ran around (avoiding the peacocks overhead and underfoot) attempting to snare bugs with pink, green, and yellow butterfly nets. Parents and grandparents tried to keep their offspring still as they sat for caricatures, while others sat for family photo portraits.

Stacy Jones and Sara Meigs did a wonderful job and the Alliance is so grateful to them for volunteering to organize this event next year.

Alliance Grant Awards
Tuesday, April 20
The last General Meeting of the 2009/2010 year was held on April 20 at the Barton Creek Country Club. During the meeting, Alliance members presented grant recipients with their awards.

The grant recipients included BookSpring (for bilingual books), Hospice Austin’s Camp Braveheart (for art therapy supplies), LifeWorks (for HIV, Hep C, and pregnancy testing kits), Shoes for Austin (for 250 pairs of running shoes for kids), VinCare Services of Austin (for medical exams and over-the-counter medications), Volunteer Healthcare Clinic (prescription medications and medical supplies for pediatric patients), Family Eldercare (for transportation to and from medical appointments for seniors), and the UT School of Nursing’s Children’s Wellness Center in Del Valle (for refurbishing the waiting area of the clinic).

The Alliance is thrilled to assist so many area agencies who benefit our community.

Member Spotlight: Heather Fagin, DDS
VP Community Service
Heather Fagin, DDS has a BS in biochemical pharmacology and an MS in molecular immunology. She is currently associate clinical professor at the UT Health Sciences Center, San Antonio School of Dental Medicine. She also works for the Austin Community College Department of Dental Hygiene as director of oral pathology.

She is married to urologist Randy Fagin, MD and has two children – Trevor and Sofia. In addition to taking care of her family and career, Heather somehow finds time to indulge in her hobbies of running, reading, sewing, and volunteering with the Alliance.

Heather has been a member of the Alliance for seven years and has brought her energy and focus to the Executive Board as the VP Community Service-Elect and as VP Community Service for the past two years. She streamlined the grant process and changed the system to enable potential donors to know which organizations would receive grants before committing their funds to the Alliance.

Heather’s work has not gone unnoticed as she was recently recognized as the Travis County Medical Alliance’s Volunteer of the Year. Heather says, “The Alliance has incredible, highly educated, and compassionate women who are an absolute pleasure to be around. I’ve met my best friends through the Alliance.”

The Alliance thanks Heather for her stellar service and hope she finds more down time in the coming year.
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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 L.E. Arnold, Jr., MD to Retired Membership.

Emeritus Membership is granted to a member who has rendered exceptional and distinguished service to scientific and/or organized medicine. Upon recommendation from the TCMS Executive Board, the TMA Board of Councilors holds the nomination for a period of one year before recommendation is made to the TMA House of Delegates where a two-thirds majority vote is required for election. The TMA House of Delegates granted Tom S. McHorse, MD Emeritus membership in the association.

Honorary Membership is granted to those physicians who have reached a point of comparative inactivity in the practice of medicine and who have rendered outstanding service to organized medicine or made noteworthy contributions to scientific medicine. Upon recommendation from the TCMS Executive Board and nomination from the TMA Board of Councilors, the TMA House of Delegates elected Hector E. Morales, MD to Honorary membership during TexMed 2010.

The Texas Medical Association elected Lawrence A. Stone, MD, as president of its 50-Year Club, a group of physician leaders who graduated from medical school at least 50 years ago but remain dedicated to the mission of continuing to advance medicine.

TCMS Foundation Scholarships available for Texas medical school students. Austin area high school graduates attending or accepted into a Texas medical school are invited to apply for the Travis County Medical Society Foundation/Evans Swann Scholarship which was established by the Evans Swann Memorial Trust. Applicants are judged on character and ability, financial need is considered, but not mandatory, and scholarships are renewable annually if students demonstrate progress and ability in their medical studies.

Download an application from the TCMS Web site: www.tcms.com/member/evansswann.html

For more information contact the Medical Society office at (512) 206-1270.

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**June**
- 10 – Business over Breakfast
  TCMS Boardroom
- 22 – Networking Social

**July**
- 15 – Business of Medicine Dinner
  TMA Thompson Auditorium
- 20 – Networking Social

**August**
- 12 – Networking Social
- 19 – Business over Breakfast
  TCMS Boardroom

**September**
- 2 – Business of Medicine Dinner
  TMA Thompson Auditorium
- 24 – New Member Welcome

**October**
- 5 – Business over Breakfast
  TCMS Boardroom
- 21 – Networking Social

**November**
- 4 – Business of Medicine Dinner
  Cedar Park Regional Medical Center
- 16 – End of Year Networking Social

**December**
- Annual Meeting

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William Earl Barnes Jr., MD passed away on February 21, 2010. Dr. Barnes was born in Augusta, TX and graduated from Portales High School in Portales, NM. He graduated with honors from Hardin-Simmons University in Abilene and received his medical training at Baylor College of Medicine in Houston. Dr. Barnes completed his internship in San Antonio and six years of plastic surgery residency at Duke University in Durham, NC. Known as Bill to family and friends, he was the second plastic and reconstructive surgeon in Austin. A man of many interests, he was a sculptor, painter, photographer, outdoorsman, and a lover of animals.

Georgia Routh Felter Legett, MD passed away on March 16, 2010. Dr. Legett was born in Austin and graduated from Austin High as salutatorian. She graduated from the University of Texas at age nineteen. She then graduated from the University of Texas Medical Branch, Galveston and completed an internship at Jefferson Davis Hospital in Houston.

While her husband Carey Legett, Jr., MD served as a flight surgeon during WWII, Georgia moved to Jersey City, NJ to complete specialty training in obstetrics and gynecology at the Jersey City Medical Center and Margaret Hague Maternity Hospital. After completing their residency training in 1948, the Legett's moved to Austin and began their medical practice together. Georgia brought the “Pap” smear, a lab test she learned from Dr. George Papanicolaou, to Austin and donated many hours of service to those who could not pay.

Throughout her life and professional career Dr. Legett was recognized for her leadership abilities and was active in community service endeavors, especially those affecting women and the family unit.

A member of the Medical Society for over 60 years, Dr. Legett was a strong supporter of the Blood and Tissue Center.

Otto Brandt Jr., MD passed away on March 21, 2010. Dr. Brandt was born in Brenham, TX and graduated Valedictorian from Brenham High School. He graduated from UTMB, Galveston in 1942 and moved to Dallas for a residency at St. Paul’s Hospital. His medical training continued when he was appointed to the US Army, eventually serving in a MASH unit in the Philippines.

Moving to Austin to finish his residency training at Brackenridge Hospital, Dr. Brandt joined the Medical Society in 1949 and was a regular attendee of the TCMS Retired Physicians’ Organization luncheons.

Dr. Brandt enjoyed tennis, hunting, and was a passionate Longhorn fan. He was one of the original members of BEVO Medico and a member of the Forum Club, Journal Club, Westwood Country Club, and life member of the Texas Exes Association.

Francis Elliott ‘Mac’ McIntyre, MD passed away on April 3, 2010. Dr. McIntyre was born in Marshall, IN and attended the University of Texas Southwestern Medical School in Dallas.

Dr. McIntyre joined the US Army Air Corps in 1943 and was a navigator in World War II. In 1952, during the Korean War, he navigated a B-36 airplane that simulated the dropping of the hydrogen bomb in the Pacific as part of Operation Ivy – which he was not allowed to talk about for many years. Mac and his crew escaped the bomb’s cloud of radioactive smoke and heat and he was awarded the Army Commendation Medal for his participation.

TCMS records indicate he joined the Medical Society in June, 1958, when he moved to Austin for his internship at Brackenridge Hospital and was a dues paying member until his retirement in 2006.

Dr. McIntyre was a founding member of both the English Speaking Union and the Austin Yacht Club, and was a member of the Rotary Club. He also served 25 years as medical director and a clinician for Planned Parenthood.

In 2006, Dr. McIntyre retired from his 48-year medical practice. Five generations of the families he treated attended his retirement party.
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Presentation and physician action
On a Thursday evening at approximately 5 pm, a 44-year-old man came to a private imaging center for an MRI. The patient was referred by his family physician for a short-term history of chronic back pain that had not responded to conservative measures including physical therapy. The radiological technicians conducted an MRI of the lumbar spine after both of the radiologists had left for the day.

The next day, a radiologist interpreted the MRI as showing three potential diagnoses involving the area extending from the mid L4 vertebral body to the lower S1 segment: 1) tumor, 2) osteomyelitis, or 3) hematoma. In order to help confirm his impression, the radiologist ordered additional views and a Gadolinium study to be completed within 72 hours. He did not dictate a preliminary report. The radiologist did not contact the patient or the referring physician, and asked the imaging center’s staff to contact the patient for additional studies as was typical. The physician left early that day due to illness, and did not return to the center over the weekend.

After the physician left, a staff member attempted to call the patient using the phone number the referring physician provided. The attempt to call the patient at this phone number failed. The employee called the family physician’s office to find the patient’s correct phone number. The family physician’s office confirmed that the number being used for the patient was the “correct” number. Unfortunately, the radiology center staff did not review the patient’s demographic information sheet that he completed at check-in, which contained the patient’s current working phone numbers. The patient was never contacted.

On Saturday morning, the patient came to the emergency department complaining of back pain with radiation down his legs. He informed the staff that he had a previous MRI on Thursday but had not received the results. The ED staff contacted the imaging center and asked for a written, preliminary report. Finding no films or report, an imaging center employee contacted the radiologist at home to determine the film’s location. The radiologist indicated the location of the films and asked the radiologist on duty at the imaging center to review the films.

This radiologist reviewed the films. He then allegedly hand wrote a preliminary report with findings of heterogeneous cystic mass located from L4 to S1 and that a Gadolinium study was needed, agreeing with the initial read. The report was then allegedly faxed to the ED by an imaging center employee. The ED physician and personnel denied receiving a faxed report and alleged that they only received an oral report that included findings of degenerative disease and a mild diffuse posterior disc bulge, along with foraminal stenosis and a compression fracture. Based on his evaluation and the oral MRI report, the ED physician diagnosed back pain and herniated disc. He discharged the patient. The faxed report was never found at the imaging center or in the hospital records.

Sunday morning the patient returned to the ED after falling the previous night. He was now complaining of not being able to move or feel his legs. A new MRI was completed and was read as showing a spinal epidural hematoma.

A neurosurgeon was consulted and he took the patient to surgery for decompression of the epidural space. The patient was ultimately diagnosed with cauda equina syndrome and secondary incomplete paraplegia. Despite inpatient and outpatient rehabilitation, he continues to have limited lower extremity motor function and nocturnal incontinence.

Allegations
The patient filed a lawsuit against the radiologist, the radiologist’s practice partner, the imaging center, the ED physician, and the hospital. Allegations against the radiologist include failure to contact the patient with the findings, failure to notify the referring physician to facilitate adequate follow up, and failure to contact the emergency department directly.

Legal implications
The issue of what constitutes proper, accurate, and effective communication is the main focus of this lawsuit. The American College of Radiology guidelines at the time of this case stated that, when a radiologist sees an unexpected and/or significant finding on a radiological study, he or she must immediately communicate directly to the referring physician.1 In this case the radiologist did not “immediately” communicate the findings, believing that the report would not be complete without the Gadolinium study and further films. As of the initial reading of the films on Friday, the radiologist felt that the case was urgent and not emergent.

The physician reviewers of this case agreed with the radiologist’s interpretation of the films. Most agreed with his choice not to communicate results to the patient continued on page 26
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or referring physician prior to completing the Gadolinium study. However, there was some question regarding the differential diagnosis including hematoma and the radiologist not considering this an emergent finding requiring prompt follow-up.

The radiologist had two opportunities to inform the patient of the results and possibly prevent the adverse outcome. The first missed opportunity occurred after the first reading when the radiologist chose not to contact the family physician or patient with the results. The family physician later testified that if he had known the results of the MRI, he would have sought further care for the patient. The second opportunity occurred when the radiologist was contacted by his staff indicating that the ED needed a report on the patient. At this point the radiologist could have called the ED directly indicating the results of the patient’s study and the need for further films.

Disposition
Due to the possibility of a sympathetic jury verdict and disagreements among the codefendants as to when the patient should have been contacted, this case was settled on behalf of the radiologist. The radiologist’s partner, the imaging center, and the hospital also settled.

Risk management considerations
Communication errors occurred in several instances: physician to physician, physician to patient, physician to staff, and staff to outside physician. Unfortunately communication problems are not rare events. Communication breakdowns are now a factor in 80% of all malpractice suits. Allegations of failure or delay in communication is now the fourth most prevalent malpractice claim against radiologists.²

Physicians should develop methods to help prevent these communication errors. First, develop a policy on communication methods, when to report results, and who to report them to. Second, ensure that the policy indicates that all communications are documented, including after-hours calls.

Physicians are well served by being aware of specialty society guidelines and the medical literature, since a plaintiff’s attorney will produce these documents when alleging the physician practiced below the standard of care. The American College of Radiology recently updated the Practice Guideline for Communication of Diagnostic Imaging Findings. It is available at www.acr.org.

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. The ultimate goal in presenting this case is to help physicians practice safe medicine. 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.

Sources

The information and opinions in this article should not be used or referred to as primary legal sources nor construed as establishing medical standards of care for the purposes of litigation, including expert testimony. The standard of care is dependent upon the particular facts and circumstances of each individual case and no generalization can be made that would apply to all cases. The information presented should be used as a resource, selected and adapted with the advice of your attorney. It is distributed with the understanding that neither Texas Medical Liability Trust nor Texas Medical Insurance Company is engaged in rendering legal services.

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PERIPHERAL NEUROPATHY

Peripheral nerves carry messages from the brain and spinal cord to muscles, organs, and other body tissues. Damage or disease of these nerves is called peripheral neuropathy. Sometimes one nerve, or a group of related nerves, is involved in neuropathy; in polyneuropathy, multiple nerves are affected in different areas of the body. Because nerves are made up of several different types of nerve fibers affecting sensation, movement, pain transmission, or balance, symptoms and signs are based on the involved type of nerve fiber.

TYPES AND CAUSES OF NEUROPATHY

- Diabetic neuropathy
- Trigeminal neuralgia involves a nerve that brings sensation to the face, jaw, and eye area
- Inherited neuropathy (present from birth)
- Autonomic neuropathy (involving involuntary body functions, such as breathing, intestinal function, and regulation of blood pressure)
- Vitamin deficiency
- Medication effects
- Traumatic injury
- Excessive alcohol use
- Infections, including human immunodeficiency virus (HIV)
- Immune system diseases

Diabetic neuropathy is the most common type of neuropathy and affects up to two-thirds of patients with type 1 and type 2 diabetes. Diabetic neuropathy often involves the feet and legs and is responsible for lack of sensation, foot ulcers, and infections.

SIGNS AND SYMPTOMS

- Pain
- Numbness
- Burning sensation
- Tingling
- Lancingat (shooting) pain
- Hypersensitive areas of the skin
- Hair loss on the affected part
- Shiny skin
- Weakness
- Muscle atrophy (loss of muscle tissue)

DIAGNOSIS AND TESTING

A detailed medical history and physical examination can identify causes of neuropathy. Blood testing, measurement of glucose levels, an electromyogram (EMG, an electrical test of muscle function), nerve conduction studies, and lumbar puncture may all be part of the evaluation of neuropathy.

TREATMENT

Most neuropathies are not curable but can be improved with treatment. Vitamin deficiencies, often present in patients with alcoholism, can be corrected with a healthy diet and vitamin supplementation. Treatment for alcohol-related neuropathy also includes stopping alcohol consumption. Control of blood glucose levels can slow progression of diabetic neuropathy, in addition to other benefits for individuals with diabetes. Medications may be prescribed, including some medications originally developed for treating seizures or depression, that may improve pain and other sensory symptoms in persons with neuropathies.

For More Information

National Institute of Neurological Disorders and Stroke
http://www.ninds.nih.gov
Neuropathy Association
http://www.neuropathy.org
American Diabetes Association
http://www.diabetes.org
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