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Photos top to bottom: Bruce McDonald, MD; Christopher Chenault, MD; Ann Son, MD; and Bruce McDonald, MD.

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Summer fun...hope yours is too!
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Citizen Physician

C. Mark Chassay, MD
President, Travis County Medical Society

I started learning about volunteerism on my father’s knee, literally.

At the end of my 1975 Little League season, our baseball fields were closed in order to build a Beltway through the Gulf Freeway in Houston. So, unexpectedly our community had to find and purchase a new location in addition to getting the field prepared in a short timeframe. My father was determined both his sons would be playing and, after our team was unceremoniously dumped from its previous location, I vividly recall his incessant work to get our new baseball fields ready for opening day. He would take my brother and me to the non-lighted facility to get in a few extra hours on the bulldozer flattening the field. The image of one little light to illuminate the dark on a 20 acre field, along with my brother and me sitting on my father’s knees, is priceless. Just as was my father’s pulling and pushing the large handles in concert to steer and manipulate this huge machine.

Dad was an engineer at the NASA Johnson Space Center but, to me, he was the Little League coach. He was the guy always volunteering to help out in the community – teaching by example.

Although the Beltway that displaced our team wasn’t finished until I was in medical residency almost 20 years later, that field was ready for the first pitch of our next season because of the kind of community commitment that my father exemplified as a “citizen rocket scientist.” So it isn’t surprising that one of my interests as president of the Society this year is to encourage positive community activism by our profession and its members.

The Travis County Medical Society has a long and illustrious history of community service – as the initial sponsor of residency training in Austin and activities such as Call a Doctor, the Community Internship Program, and Project Access which has served uninsured residents of Travis County since 2002.

My desire for TCMS this year is to create additional opportunities for members to engage in broader community service beyond health care – as “citizen physicians” lending a hand to the community.

The reason is simple... all relatively successful people, particularly we physicians, should give back to the community that made our success possible. Medicine continues to be one of the most respected professions, more esteemed than even rocket scientists!

Individually, we can (and many physicians do) use this earned trust on a broad palette of active involvement outside of medicine whether it be serving on local community boards or running for political office.

In politics, for example, there are currently 17 physicians serving in the US House and Senate, 5 in the Texas House andSenate, and 41 running for national office this year. This could result in one of the biggest shifts in diversity among officials elected to office. As most physicians balance compassion with financial implications every day, unlike those that traditionally comprise the political houses, we could see an historic change in thinking. This diversity would be good for our nation. Many people would like to see a reduction in the lawyer/corporate mix of our public officials and would welcome a broader cross-section from farmers to pharmacists to physicians representing us in our legislative bodies. It could result in more open-minded and thoughtful processes and debate.

As important as state and national politics is, deep in our hearts we all know that true progress always begins locally. Thus running for school board and home owners’ association positions are equally important activities for instigating progress.

Personally, I prefer just getting out in the community with neighbors in a common cause that transcends political thought, whether it be building a baseball field or feeding the hungry. As an organization, the Society can organize opportunities that allow physicians to participate in such activities while minimizing the burden on their time which, for all of us, is a precious commodity.

With this in mind, I have asked our TCMS Public Relations Committee to identify just such an opportunity to kick off this “campaign” and they selected the Capital Area Food Bank which has a very well organized volunteer program for groups and associations. TCMS has committed to cover one volunteer day at the Food Bank on Saturday, August 14, 2010. The morning shift is from 9:00 am to Noon, and the afternoon shift is from 1:00 pm to 4:00 pm.

Besides giving back to the community, volunteering can enrich our own lives by affording us the opportunity to meet others and, sometimes, to guide

continued on page 8
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Capital Area Food Bank
Volunteer Opportunity

The TCMS Public Relations Committee invites physicians and their families to participate in a volunteer opportunity at the Capital Area Food Bank.

Saturday, August 14
Two Shifts Available
9:00 am to noon
1:00 pm to 4:00 pm

- Participants must arrive on time and stay for the entire shift.
- Volunteers will work in the “product recovery” area determining if donations are safe, edible, and usable.
- “Recovered” items are then sorted and packed for distribution.
- Minimum age for volunteers is 8-years-old.
- Volunteer orientation and training will take place at the beginning of each shift.

To volunteer, contact the Society at 206-1249
or tcms@tcms.com.

Capital Area Food Bank of Texas
8201 S Congress

and to mentor young people as an example of a “citizen physician.” The minimum age for Food Bank volunteers is 8, so this is a great opportunity for families to participate together.

Finally, I will leave you with the kind words that Dr. Homer Goehrs, a former TCMS president who we so sadly lost in March, penned to me back in January: “I like your interest in establishing better relationships with community organizations.”

Let’s rally around that and see you August 14!
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The influence your role as a physician carries in helping tobacco users quit cannot be overstated. Evidence by the U.S. Public Health Service in 2000 shows that a clinician's advice to quit improves a patient’s success in maintaining abstinence. With the addition of a few minutes of counseling, this success rate doubles.

One-third of the 3,306,700 adults in Texas who smoke will try to quit this year. Only 1 in 20 will be able to stay tobacco-free. Tobacco claims the lives of approximately 24,200 Texans every year, and every year, about 32,200 young Texans under age 18 become new, daily smokers. Of all Texas youth alive now, nearly 503,000 will ultimately die from tobacco-related diseases.

Adding to the challenge is the $884.7 million spent annually on marketing tobacco in Texas. As daunting as the task of smoking intervention may seem, current data underscores this fact: the coordinated efforts of health care administrators, insurers, purchasers, and practitioners can boost cessation success.

The Yes You Can: A Clinical Toolkit for Treating Tobacco Dependence for teens, pregnant women and adult population was designed to support your clinic’s own tobacco intervention efforts. It offers flexibility to meet the needs of different office practices and diverse patients, with Quick Guides that can accommodate the busiest practitioner. It includes materials in English and Spanish.

Contact Megan Cermak of the Austin Tobacco Prevention & Control Coalition (ATPCC) to order your Yes You Can: A Clinical Toolkit at megan.cermak@ci.austin.tx.us or (512) 972-6763. The ATPCC offers free resources for tobacco prevention & cessation, conducts presentations on tobacco for diverse audiences, and offers technical assistance to medical practices to implement the Yes You Can toolkit.

Tobacco Cessation CME
The United States Preventative Task Force has determined that even a three minute intervention by physicians is effective in instigating a patient's tobacco quit attempt. The Texas Medical Association's Physician Oncology Education Program now offers two versions of tobacco cessation education to assist doctors with motivational counseling techniques and the latest information in pharmacotherapies. Both the podcast and the online module for Tobacco Intervention and the Health Care Provider have been accredited for 1.0 hours of AMA PRA Category 1 Credits™, including ethics.

Both are available free of charge at www.poep.org. In addition, home studies focusing on pain management, late effects of cancer treatment, and ovarian cancer are also available.

Tobacco Cessation Testimonial
“I smoked for more than 40 years and never, even once, considered stopping. But I quit!”

I didn’t quit due to the potential for chronic bronchitis, emphysema, or lung cancer. I didn’t try to quit when my father passed away in 1983 due to complications from lung cancer. Even my husband’s chronic COPD and ultimate lung cancer diagnosis wasn’t enough motivation to quit.

What did make a difference for me was the Seton Family of Hospital’s smoke-free campus policy. It was while I was spending an average of 8-10 hours per day caring for my husband at the hospital, during multiple hospitalizations, and that the inconvenience of having to walk so far to be off the hospital campus and across the street to smoke that motivated me to use the benefits available from my employer, the City of Austin, and set a quit date.

After discussion with my personal physician, a free 1.5 hour smoking cessation class through my employer, and a prescription for a drug to help the effort, I quit smoking on April 23, 2008. I have now been tobacco-free for more than two years; no relapse and no desire to smoke. I’ve lost track of the money I’ve saved. How I wish I had quit years ago.

Linda Terry, Policy Aide
CPPW – Medical Director Division Austin/Travis County Health and Human Services Department
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“We didn’t get into this business to run a business; we got into it to take care of people. Choosing a company like API for medical liability makes it easier to do that.”

Orthopaedic Surgeon
Q: What is the legal status of the physician-patient relationship?
A: Many human relationships are characterized in law: husband-wife, parent-child, employer-employee, landlord-tenant, and so on. The physician-patient relationship is “contractual”; a voluntary contract is formed when a person requests that a physician become responsible for his care, and the physician agrees to do so. However, it does not require the formalities of a written contract so specific “consent to treatment” forms are not required.

Q: Isn’t it true that no physician-patient relationship is formed if money doesn’t change hands?
A: No. The physician-patient relationship does not depend on whether the physician gets paid for care. This is because contracts do not always require the payment of money to be valid, benefits of some type — even “in kind” — must be given to the other party. This is logical: if payment were required, then no person seen on a charity basis would ever be a “patient.”

Q: What is a physician’s duty to a patient?
A: A physician’s legal duty is sometimes expressed as the duty to do what an “ordinarily prudent physician” would do, or to “treat the patient with proper professional skill.” For liability purposes, a physician’s duties (whatever they may be in a particular case) do not begin until the relationship is determined to have been formed.

Q: Suppose would-be patient Jones comes to a physician’s office wanting medical attention. The physician is informed but decides not to see Jones, and gives instructions for him to go to a hospital. Is a physician-patient relationship created?
A: No. On these facts, a Texas Court of Appeals held that no physician-patient relationship existed where: (1) the physician did not talk to the patient, (2) the physician had not previously treated the patient or anyone in the family, and (3) the physician did not agree to see the person as a patient. Salas v. Gamboa, 760 SW2d 838 (Tex. App. - 1988).

Q: Jones has a new patient appointment at 1:00 pm. The physician instructs Jones to obtain an echocardiogram at 11:00 am before coming in. Jones dies the night before. Has a physician-patient relationship been established prior to his having actually met, examined, and treated Jones?
A: No. On these facts, a Texas Court of Appeals held that the agreement to see a new patient does not, by itself, establish a physician-patient relationship. The court concluded “If a person calls a new physician to schedule a physical exam and the physician’s office schedules that potential patient for an EKG and blood tests, there has been no affirmative act to treat the patient by the mere fact that the physician’s office has scheduled the appointment and the tests.” Jackson v. Issac, 76 S.W.3d 177 (Tex. App. - 2002).

Q: Jones applies for a job and must have a pre-employment physical examination. The employer sends him to a physician Jones previously saw for a skin ailment. Jones has a chest x-ray and is told it was normal, and has no health conditions that limit his ability to accept employment. Unfortunately, Jones later sees an oncologist who diagnoses him with Stage IV Hodgkins Lymphoma. The oncologist obtained the earlier chest x-ray and determined that is was “patently abnormal.” Was there a physician-patient relationship during the pre-employment physical?
A: No. On these facts, a Texas Court of Appeals held the patient waived the right to argue a pre-existing physician-patient relationship. The court noted that the patient did not select the physician for the pre-employment physical, the examination was arranged solely for employment purposes and that this alone did not elevate the encounter to a physician-patient relationship. Merely providing the patient with results of tests in a pre-employment medical examination arranged on behalf of the employer was insufficient to raise a fact issue on the existence of the physician-patient relationship. Dubose v. Workers Medical, P.A., 117 SW 3d 916 (Tex. App. - 2003). This case is remarkable because the parties had a pre-existing relationship.

Q: Can a physician terminate his services to a patient any time and for any reason?
A: A physician can terminate services to a patient but must avoid “abandonment.” Abandonment is a lawsuit alleging “the unilateral severance of the professional relationship . . . without reasonable notice at a time when there is still the necessity of continuing medical attention.” Proof requires a showing that

continued on page 14
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the physician failed to provide “an adequate medical attendant” and also failed to give “adequate notice.” Finally, the plaintiff must prove he suffered injuries or damages caused by wrongful conduct. A physician should send a letter to the patient, return receipt requested, to ensure that the patient is aware of the physician’s decision. A copy of the letter and the return receipt should be retained in the chart as well. While not necessary to state reasons for the decision to terminate, it might be advisable in some cases.

Q: If a patient has an outstanding balance for services rendered, and refuses to pay, does that mean the relationship has been terminated?
A: No, just as the relationship is not formed when the physician is paid, it is not terminated when the physician is not paid. However, if the patient’s refusal to pay interferes with the physician’s ability to render appropriate medical care, he may be justified in terminating the relationship so long as the other steps outlined above are followed.

Q: A patient leaves the hospital against medical advice (“AMA”) and later wants an office appointment. Is the physician obliged to treat the patient?
A: Did the patient, simply by leaving “AMA” intend to discharge his physician? Leaving the hospital might have been unrelated to the medical treatment provided. Such a patient should be asked about his intentions. Otherwise, if the physician-patient relationship has not been terminated by either party, the physician still has some obligation to the patient.

Q: A physician treated Jones, but lost touch with him some time ago. When Jones calls for an appointment now, is the physician still obligated to see him?
A: Beyond the obvious question of why he would not want to see the patient, if no formal termination of the physician-patient relationship has ever occurred, then the patient may have a reasonable expectation of continued care. There is no automatic rule that a patient not seen in a set period of time is regarded as having severed the relationship unilaterally.

Donald Patrick, MD, JD, is the new medical advisor at the Texas Department of Insurance Division of Workers’ Compensation.

The medical advisor’s duties include making recommendations regarding the adoption of rules and policies on issues such as reimbursement, review guidelines, impairment ratings, and sanctions or removal of physicians from the list of approved doctors.

Dr. Patrick retired from TMB in August 2008 after seven years. He also practiced neurosurgery in Austin from 1969 to 2001.

Edward L. Seade, MD, of Orthopaedic Specialists of Austin, has been elected President of the Texas Orthopaedic Association.

“In light of the current health care debate, this leadership role takes on an entirely new significance.” Dr. Seade said.

Dr. Seade is specially-trained in sports medicine and adult reconstructive surgery of the shoulder. Because of his insight into these issues, he has also been selected to be an Associate Clinical Professor for The University of Texas Medical Branch in Austin.

Michelle Berger, MD presents a TEXPAC contribution to Representative Donna Howard of House District 48.

Drs. Dawn Buckingham and David Fleeger present Representative Valinda Bolton of House District 47 with a TEXPAC contribution.

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TCMS Journal is now eco-friendly. The paper stock used to print the Journal is a product from well-managed forests and other controlled sources. This is part of the Society’s continued efforts to become environmentally responsible. The paper used is from commercially grown and managed forests as well as other recycled paper products.

The logo displayed below and on page 5 acknowledges TCMS’s support of sound environmental stewardship policies.

Michelle Berger, MD presents a TEXPAC contribution to Representative Donna Howard of House District 48.

Drs. Dawn Buckingham and David Fleeger present Representative Valinda Bolton of House District 47 with a TEXPAC contribution.

In the News
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Back in 2004, Travis County voters rallied behind a simple but effective message – “Save Money. Save Lives.” – and approved the creation of a healthcare district. When Central Health, formerly Travis County Healthcare District, officially began its work the following year, it focused its funds and strategies on ways to deliver on that promise. Today, looking back on the organization’s first five years, Central Health has helped Travis County make significant strides toward becoming a model healthy community.

The Travis County medical community was instrumental in defining the need, building the support, and securing the creation of Central Health. “Physicians know all too well the challenges the healthcare system faces in ensuring access to care,” says Thomas Coopwood, MD, FACS, chairperson of the Central Health Board of Managers, past chief of staff at University Medical Center Brackenridge, and former president of Travis County Medical Society. “A healthcare district serving Travis County was urgently needed not just to sustain, but also to enhance the network that meets the primary health care needs of so many in this community.”

Since beginning operations in 2005, Central Health’s efforts have helped more people get the care they need, when and where they need it – which has, in fact, saved money and saved lives. These accomplishments, improving the quality of life of thousands in Travis County, are evidenced by the service expansions that Central Health has been able to achieve while having the lowest tax rate of all urban hospital districts. Central Health’s success also demonstrates sound management and wise stewardship of limited public dollars available to support community health care.

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In addition to owning University Medical Center Brackenridge (operated by the Seton Family of Hospitals), Central Health administers the Medical Assistance Program that provides access to care for Travis County’s uninsured and underserved. Central Health works in partnership with CommUnityCare, its non-profit affiliate of federally qualified community health centers, and also contracts for care with a network of additional primary and specialty providers. The creation of the district integrated programs formerly housed within the City of Austin and Travis County, both of which transferred portions of their property tax rate to the new district.

This spring, Central Health released several of the milestones from the organization’s first five fiscal years and set the stage for more progress to come.

Highlights from the five-year report card include:

**Enhanced Emergency Care**
After nearly $6.5 million in new investments from Central Health and additional support from its partner, Seton Family of Hospitals, University Medical Center Brackenridge earned Level 1 Trauma Center status in 2009. This means Brackenridge is providing the widest range of emergency care services possible to the people of Central Texas.

**More People Covered**
More than 6,000 people in our community now have access to the care they need, as enrollment in the Central Health Medical Assistance Program has expanded by nearly 80 percent since 2004. Central Health has also supported other solutions to connect people to care. One example is TexHealth Central Texas, a non-profit corporation that offers low-cost health benefits programs to small businesses.
that otherwise can’t afford coverage for their employees.

**More Providers and Better Access**
Central Health has expanded the network of primary, specialty, and urgent care providers. These new providers, together with additional locations and expanded hours, have helped more people access the care they need when they need it. Total primary care visits in the Central Health network have increased by 25 percent since 2005.

**Expanded Mental Health Care**
Our community faced a crisis in 2004, as people in need of emergency mental health services were turned away from the overcrowded Austin State Hospital. Central Health led a collaborative effort that created more inpatient beds, intensive outpatient care, crisis respite care, mobile crisis outreach, and expanded emergency services. As part of that collaborative, Central Health now invests more than $5 million per year for mental health services.

**Simpler, Easier Enrollment**
Central Health has streamlined screening services so people can get to care quickly and easily. These services include “virtual enrollment,” financial screening at provider locations, re-enrollment by mail, and a new customer service call center that streamlines application appointment scheduling. The call center – launched last year – processed nearly 30,000 calls in its first six months.

These achievements set the stage for continued advances and better responses to the challenges we face – as individuals, as a community and region, and as a nation – to provide accessible health care for those who need it. “We will continue to need to innovate as our community grows and as medicine and our healthcare system grow more complex,” says Donald Patrick, MD, retired executive director of the Texas Medical Board and past chief of staff at University Medical Center Brackenridge, who along with Dr. Coopwood has served on the Central Health Board of Managers since its inception. “The impact of federal health care reform and other initiatives that affect the delivery and funding of care will be of great importance to us going forward.”

The community’s ability to meet these challenges will depend on sound and effective management of the healthcare system’s resources and of the taxes paid by businesses and individuals. The track record so far is a sign that Travis County residents and its medical community can have confidence in Central Health’s ability to help meet the community’s health care needs.

Central Health exists to respond to the needs of the people of Travis County. The organization has launched a new community planning initiative, *Central Health Connection*, to engage Central Texans in talking, imagining, and acting to create a model healthy community. The support of residents, businesses, health care professionals, and community leaders all working together helped create Central Health, and made these successes possible. As national health system reform rolls out, continued support of Central Health as a local resource to meet health care needs will make future successes just as possible. Please join in the healthy conversation at www.CentralHealthConnection.net.

---

**MAP ENROLLMENT**

![Chart showing increase in enrollment](chart.png)

Central Health increased enrollment in its Medical Assistance Program by nearly 80% between 2004 and 2009.

TCMS members can now download – for free – the DocBook app to their iPhone, iTouch, and iPad. Texas Medical Liability Trust, a loyal supporter of Texas physicians and organized medicine has partnered with TCMS and DocBook to provide this application at no cost to TCMS members.

A first-of-its-kind, DocBook was designed by physicians for physicians as a flexible, efficient, and easy-to-use communication tool that allows a TCMS member to search for another member and then text, call, or e-mail them with just one touch. You can see the physician's picture, get to a map by clicking the practice address, go directly to their web site, and even look up contact information for pharmacies. TCMS DocBook is secured through the highest levels of encryption and verification and may be activated only by TCMS members with a unique access number provided by the Society.

For your access number and download instructions, contact the Society at 206-1252 or shinojosa@tcms.com.

For a DocBook demonstration, visit: www.docbookmd.com.

Created in 1979, TMLT has grown to be the largest and most respected medical liability provider in the state, protecting more than 14,500 Texas physicians. TMLT is a unique, not-for-profit health care liability claim trust owned by its physician policyholders. TMLT is not an insurance company, but a self-insured trust established to provide coverage against health care liability claims to members of the Texas Medical Association – no matter what your specialty, practice type, or location.

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- Dr. David Baker
  Family Dentistry
- Dr. Betsy Reidy
  Schoolhouse Pediatrics
- Dr. Michou Shell / Dr. Jeff Shell
  Westlake Endodontics
- Dr. Mark Sanders / Dr. Derik Sanders
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Travis County Medical Alliance Wins State Award
The Texas Medical Association Alliance honored TCMA with The Durham Award for Membership at the 2010 annual meeting in Fort Worth. This award is given to the county alliance with the best overall membership campaign.

TCMA received this award due to its commitment to member recruitment and the creative ways the commitment is carried out. Throughout the year, there are numerous recruitment opportunities such as social functions and ten special interest groups (including such groups as Book Review, Lunch Bunch, Mah-jongg, For Parents’ Sake, and Austin Fun Runs). These opportunities are available to members and new recruits for support and fellowship.

Be-Wise Immunize and Hard Hats for Little Heads
August 14
The TCMA community outreach programs, Be-Wise Immunize and Hard Hats for Little Heads, will be assisting the UT Children’s Wellness Center in Del Valle again this summer with their “Back to School Immunization Day” on Saturday, August 14. The free immunizations are given predominately to low-income and medically underserved children served by the clinic.

TCMA will assist the shot clinic by providing publicity, volunteers, water bottles, lunch for the clinic staff, and goodie bags for the children. In addition, bike helmets will also be provided to the children at the clinic.

Last summer the clinic immunized 1,092 people and gave 2,881 vaccine doses. With immunization requirements changing once again this year, the TCMA looks forward to another record year!

TCMA Volunteer of the Year
The Alliance is proud to announce the 2010 Volunteer of the Year, Heather Fagin, DDS! Heather was the 2009-2010 Vice President of Community Service and has also held many other positions in the Alliance since joining in 2004. Heather’s first volunteer role came when she co-chaired the Gala’s Silent Auction and scheduled babysitting for our meetings. She has also been very active with Be-Wise Immunize, Holiday Luncheon, For Parents’ Sake, Austin Without Limits, and Spring Picnic.

Heather has worked diligently this year to change and improve the position of VP Community Service. Her willingness to adjust the timing and process for our grant awards positively impacted our ability to raise funds this year. She has spent tireless hours researching grant recipients and educating herself and the Board about the needs of the Austin community.

The Alliance thanks Heather for her stellar service!

Join the Alliance
Contact VP Membership, Mari Josey at mari.josey@gmail.com or visit www.traviscountymedicalalliance.com.

Shelly Ozdil presented Heather Fagin with the Volunteer of the Year award during the TCMA April general meeting.

Shelly Ozdil, Kylan Bunker, Roberta Pazdral and Pat Wallis accepted the Durham Award for Membership.
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* The ADC Podiatry section welcomes Thuy Ho, DPM to the practice July 15, 2010. New patients/appointments are welcome.
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The following 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.

Presentation
A 24-year-old patient came to the emergency department (ED) with left anterior thigh pain. She informed the triage nurse that her symptoms started two days earlier with no history of trauma, swelling, or redness in the leg. The patient's vital signs were: temperature 99.3 degrees; blood pressure 159/70 mm/Hg; pulse 113; and respirations 20. The patient's weight was recorded as 255 pounds.

The patient reported that she had been taking ibuprofen. Her medical history was unremarkable. The triage nurse's history stated the patient complained of anterior thigh pain involving the left leg.

Physician action
An emergency medicine physician noted that the pain was in the patient's buttocks, extending down the back of her leg. The pain was made worse by movement and was without relief. The physician documented complaints of back pain with radiation of the pain down the posterior portion of the left thigh. This documentation differs from the nurse's triage note.

The neurological exam and the patient's reflexes were reported as normal. There was no edema or calf tenderness. The patient had full range of motion to both legs. Her skin was warm and dry with no rashes or erythema. Both legs were described as normal, except for the pain in the left upper thigh and hip. The physician prescribed meperidine 50 mg IM, promethazine 25 mg IM, and dexamethasone 10 mg IM.

After two hours, the patient reported a decrease in her pain level and was walking. The patient was discharged with instructions to see her family physician in two or three days. Her vital signs at discharge were: normal temperature; pulse 96; and respirations 18. The discharge diagnosis was acute left sciatica.

Two days after the ED visit, the patient woke with difficulty breathing. While dressing to return to the ED, the patient became unresponsive. EMS was called, but the paramedics were unable to resuscitate the patient. An autopsy determined the cause of death to be a pulmonary embolism (PE) from deep venous thrombosis (DVT). Blood clots were discovered in the patient's right leg in both the calf and popliteal vasculature. No clot was found in the left leg.

Legal implications
The defendant stated that it is not his usual practice to conduct a physical exam unless the patient is in a gown. In this case, the patient was not asked to disrobe because the physician saw she was in a lot of pain, and he did not want to exacerbate her condition. The defendant also stated that a straight leg raise test was not done because of the patient's pain. The physician documented that the patient's pain was “moderate,” versus the patient's subjective complaint that the pain was ten on a scale of one to ten.

According to the defendant, the diagnosis of sciatica was made based on the patient's verbal complaints. The physician stated DVT was not high on the list of differential diagnoses because he had never seen a patient with lateral posterior thigh and back pain with a DVT; moreover, there is nothing in the literature to support this diagnosis.

The patient's mother, who was present with the patient in the ED, testified that the physician never performed a physical exam involving the left leg. Physicians who reviewed this case for the defense stated that if the pain was in the lateral posterior left thigh, she did not have a DVT when she came to the ED because there are no deep veins in her extremities. It was further alleged that based on anterior thigh pain and no straight leg testing, a diagnosis of sciatica was incorrect. Had a D-dimer test or ultrasound been performed, DVT would have been diagnosed and the patient would not have died.

Allegations
A lawsuit was filed against the emergency medicine physician, alleging that he never performed a physical exam of the patient and never asked her to disrobe in order to perform an adequate exam of the patient's extremities.

continued on page 26
Treating cancer by enhancing our care.

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.

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the lateral posterior thigh that would produce pain or cause a PE. The pathologist who conducted the autopsy testified that he could not totally rule out DVT in the left leg even though he did not find a clot because there was a possibility the clot was in a different portion of the leg.

The plaintiff’s expert stated the patient’s Well’s criteria placed her in a category in which DVT should have been ruled out before discharging the patient from the ED. It was also felt that the ED record did not support the diagnosis of sciatica. While the plaintiff’s expert could not rule out the possibility that the DVT formed after the patient left the ED, he stated it was within reasonable medical probability the DVT was present at the time of the ED visit because of the location of the pain, high respiration rate, elevated pulse rate, and the autopsy results.

Disposition
This case was settled of behalf of the emergency medicine physician.

Risk management considerations
Patients are often not the most reliable historians and may explain their injury or illness differently to different caregivers. Physicians and nurses may also put different emphasis on patient care based on their authority or responsibility to act on a specific complaint. While you may have two different perceptions of the history, physical examination, or response to care, acknowledgement of the differences should be documented.

In this case, physician documentation could have reflected the discrepancy in what the patient reported to the nurses with what was reported to the physician. Additionally, while patient-reported histories are valuable, they are not a substitute for a physical examination. It is the physician’s responsibility to conduct an adequate exam.

Documentation of this exam should include: the presenting issue, if different from the triage nurse’s description; assessment, including any labs or diagnostic test results; diagnosis; plan for care. It is imperative that the rationale for treatment is supported by the physical examination, and results of diagnostic and other ancillary services. When a patient comes to the ED, physical examination is important and should not be deferred in an attempt to keep the patient more comfortable.

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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The study will last 5 months and will include 6-7 visits to the study site. You and/or your child may receive compensation for your time and travel. Eligible participants may receive, at no cost, the following supplies and/or procedures:

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For more information, or to see if your child may be eligible, please contact us at:

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POSTOPERATIVE INFECTIONS

Infections after surgical procedures (operations) can cause pain, poor wound healing, need for further treatment including antibiotics, longer hospital stays, and increased health care costs. Postoperative infections may cause severe problems, including failure of the surgical procedure, other surgical complications, sepsis, organ failure, and even death. Some persons are at higher risk of developing postoperative infections than others. Ways to try to prevent these types of infections include giving antibiotics before a procedure, when appropriate; making sure the patient is in the best condition possible before elective surgery; using an antiseptic solution to “prep” the area around a surgical incision; maintaining sterility (no bacteria or other organisms, such as viruses or parasites) of the surgical area (also called the “surgical field”) and operating tools; and having operating room staff wear clean scrub clothes, hats, and masks.

RISK FACTORS FOR POSTOPERATIVE INFECTION

- Diabetes
- Obesity
- Older age
- Emergency operations
- Obvious contamination (with debris, pus, stool, or other substances) of the injury or the surgical area.

TREATMENT

- Antibiotics are given, sometimes by mouth but often through an intravenous line (an IV) for serious infections. In many cases, cultures of the affected area are taken to see if resistant bacteria (which do not respond to the usual antibiotic treatment) are involved.
- Reexploration of a surgical incision may be necessary to drain pus, an abscess (a collection of infected fluid), or a hematoma (an area of blood and blood clot that can also become infected).
- If hardware is involved (such as plates, screws, or total joint replacements), and the infection is serious, the metal parts may need to be removed.
- Supportive care, including fluids, medications to lower a fever, and pain medication, is often needed. If the infection is severe, a person may require staying in the hospital or even in the intensive care unit (ICU) for treatment.

PREVENTING POSTOPERATIVE INFECTION

A national effort to reduce postoperative infections, sponsored by many organizations involved in surgical patient care and health care quality, the Surgical Care Improvement Program (SCIP) was launched in July 2006. Several steps were recommended, and some extra steps were added later, to help prevent surgically related infections. These include appropriate choice of preoperative antibiotics, proper timing and duration of antibiotic dosing, clipping of hair (instead of shaving) around a surgical incision site, keeping appropriate blood sugar levels for persons with diabetes (especially for individuals having heart surgery), and keeping patients having colon surgery at a normal body temperature.

For More Information

- Surgical Care Improvement Project (SCIP) http://www.qualitynet.org
- http://www.jointcommission.org/performancemeasurement/performancemeasurement/scip+core+measure+set.htm
- World Health Organization http://www.who.int
- Agency for Healthcare Research and Quality http://www.ahrq.gov
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- All of ARA's imaging centers are accredited by the American College of Radiology (ACR).
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