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Rob Roy on the Creek
This home is a unique blend of traditional exterior style with a modern, contemporary interior. The updated chef's kitchen has all the bells and whistles including granite countertops and stainless appliances! Hardwood flooring on first and second levels. Five spacious bedrooms plus a separate office/study provides perfect space for any size family. Multi-level decks with a pool & spa offer outdoor living space for those who want to relax or entertain. Located on 3.75 acres with stunning hill country views.

512 Beardsley Lane
$874,500

River Place
A beautiful new interior paint scheme plus a newly landscaped backyard give this home a whole new look and sparkle! See the stunning kitchen with updated cabinets that coordinate perfectly with the granite countertops and backsplash. The home can be purchased fully furnished if desired. The fourth bedroom on the main level is great for guests or for use as an office. Huge master suite upstairs has fireplace, adjoining exercise/office and reading/sitting area with built-in shelves. Backyard backs to a greenbelt.

3901 Michael Neill Drive
$549,000

Northwest Hills
Located on a wooded lot overlooking Bull Creek, this 2010 remodel has fantastic, unobstructed hill country views. The kitchen has been completely updated with lovely granite countertops, custom cabinetry & stainless appliances. Main level master suite has hardwood flooring and the master bath has a Jacuzzi tub, granite countertops plus a huge walk-in closet. Within easy walking distance of the community park and pool.

4421 Stony Meadow
$579,000

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Like ethics, collegiality – that special bond among all who have earned the right to call themselves physician – sets medicine apart from other vocations. The collegial environment fosters our growth, invigorates our work, and nourishes our society; it’s the connective tissue of our profession.

While we all cherish it, it has become increasingly difficult to foster collegiality among physicians in today’s complex and specialized practice environment, a reality made even more challenging by the economic fault lines that have evolved in modern health care.

Fourteen years ago, as a new physician in Austin, I really didn’t know the medical community as I had spent the previous seven years in Houston in medical school and residency. Sure, I had friends from my undergraduate days on the UT campus who were moving their families here to begin their medical careers, but I really did not know many experienced local physicians. In addition, I started my medical career at the UT Student Health Center (now known as University Health Services) where there was no need to be on staff at any hospital. Despite the fine physicians there and their friendships, we as a group were somewhat isolated.

It was around the late 1990s when the relatively new practice of hospitalists was becoming firmly established, essentially freeing office-based primary care physicians from having to juggle rounds at multiple hospitals with a busy office practice. For physicians, a downside by-product of this efficiency was more separation from colleagues, a further retreat into our respective silos.

In this environment, the Travis County Medical Society helps us reclaim and foster the collegiality we value as physicians. As doctors associated with a particular group, specialty, political party, or hospital system, we may be competitors; we may not even know each other. But as TCMS members, we are physicians, friends, and colleagues. The Society is the common ground where this is still possible.

When Harold Skaggs, MD appointed me to the Membership Committee in 1999, I looked around the room and didn’t recognize anyone at the meeting except Patrick Pevoto, MD the chair. Greg Roberts, MD, DDS was also new in the community and feeling the same way. As he and I attended all the meetings, we naturally migrated toward a friendship and spoke often about what we each desired from the Medical Society.

We were new kids on the block, young turks brash enough to ask questions about how or why the Medical Society did certain things. For one, we didn’t feel that the traditional Society “business meetings” were conducive for meeting new people in today’s medical environment. We wanted more. Dr. Pevoto was open to change, the Executive Board was supportive, and in 2005, I was even asked to chair the committee. Over time, more young physicians would come onto the Membership Committee such as Drs. Todd Shepler (current Membership chair), Daniel Leeman (immediate past chair), Ashwin Gowda, Earl Kilbride and others. All brought fresh ideas for new programs, more social activities, and different venues—all with the objective of fostering collegiality, of engaging and connecting more physicians in our growing medical community.

Eventually, the New Member Welcome reception, traditionally held at the TMA building, moved to different venues (Stubb’s, Threadgill’s, the Oasis, etc.) and became events that our experienced physicians and new members alike looked forward to for its networking value. It was successful! The TCMS membership calendar expanded to include a full year of networking socials and educational programs in addition to the traditional TCMS/Alliance installation dinner and the annual business meeting.

All of this was made possible in large part by the financial support of the Friends of the Society Program, another innovative idea that came out of this burst of creative activity within the Membership Committee.

While collegiality clearly is a primary objective of the Membership Committee, the role played by other TCMS committees in fostering a collegial environment is equally important, even if less obvious.

Medical Society committees and processes provide a collegial environment for physicians to address serious issues that they might otherwise have to face in a judicial or regulatory setting. For example, the Physician Health and Rehabilitation Committee (PHRC) helps physicians impaired by addiction or other conditions to retain or reclaim their ability to practice medicine safely and it does so outside the traditional disciplinary environment. Similarly, the Mediation Committee gives patients and...
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physicians a forum to resolve their differences and, in some cases, avoid having to address them before the Texas Medical Board or in a lawsuit.

The ED/EMS Advisory Committee brings together the medical directors of emergency departments from the competing institutions in our community to discuss pre-hospital care and transport issues that affect the whole community and to advise the EMS medical director on the standard of care in the community. Again, in their respective hospitals, they are friendly competitors; in the Medical Society, they come together as friends and colleagues.

Finally, when issues arise such as the recent health system reform laws that profoundly affect medicine and its future, physicians may be divided along lines defined by their politics, economic situations, specialties, or types of practice. In such cases, it’s often hard to see through the divisions to the common ground we all share as physicians. In such times, the Medical Society cannot perform miracles and make all physicians adopt the same point of view; how boring would that be anyway? What it can do is facilitate dialogue in a collegial environment to help members better understand and tolerate each other in spite of their philosophical differences. In short, it can foster collegiality.

My membership and activity in the Travis County Medical Society has afforded me many meaningful relationships, for which, I am deeply grateful. I hope that, because of its programs, you have enjoyed not only the activities and events, but also the fellowship. For the veteran physicians in town I hope you will continue to lend your guidance to newer physicians at these events. For those newer to town, I sincerely hope that your attendance has begun friendships and referral bases that will last you a long time. I know mine has.
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The Texas Medical Association Political Action Committee (TEXPAC) is the Texas Medical Association’s (TMA) political arm. What exactly does that mean? Do you know what TEXPAC does?

Organized in 1962, TEXPAC provides financial support to candidates for state and federal offices. It’s really that simple. While TMA’s legislative staff works hard lobbying lawmakers in support of medicine’s agenda, TEXPAC is busy making sure a steady stream of medicine-friendly candidates is holding office in the first place.

TEXPAC raises funds to contribute to select candidates for office and protects that investment by helping educate each candidate about medicine’s issues and providing volunteers to help ensure the candidate's successful campaign. That’s what politics is all about.

While TMA’s dues dollars support the lobbying efforts of the TMA Legislative Affairs Department, by rule of law, your TMA dues dollars do not in any way support TEXPAC political activities. That’s where TEXPAC members come in. Those who wish to support TMA political action must contribute directly to TEXPAC in addition to paying their TMA/TCMS dues.

How Will Contributing to TEXPAC Help Protect Your Practice?

With national health system reform the hot issue in DC, the 82nd Texas Legislature convening in January 2011, the insurance industry biannually fighting patient-centered reforms, and tort reform perennially attacked, Texas physicians need to maintain their political vigilance. If you practice medicine in Texas, you can’t afford to not be engaged politically. Here’s how TEXPAC enables physicians to do just that:

**Political surveillance:** TEXPAC monitors more than 200 legislative and judicial races in which those decision makers could impact Texas physicians and their practice. The TEXPAC staff, along with Texas’s best political consultants, work tirelessly to give you the inside scoop on the current political landscape.

**On-the-ground action:** TEXPAC works to elect physician-friendly candidates at the state and federal level. By physician-friendly, TEXPAC means the best candidate for the job regardless of political party. And by work, we mean contribute, raise funds, staff phone banks, block-walk, and mail brochures and numerous letters. If it needs to be done, TEXPAC does it.

**Relationships that last:** TEXPAC facilitates relationships between physician and alliance members, and candidates and elected officials. These relationships are invaluable to TMA's lobby efforts. If you were a legislator, who would you trust when seeking advice on a bill? Someone who worked hard during campaign season to get you elected, of course.

**News you can use:** TEXPAC continually educates local physician and alliance members on key issues through e-mail and special TEXPAC-member-only seminars and events.

**The Power of Our Political Action**

Insurance companies, limited-license health providers, and trial lawyers all know the power of political action. They have put their money where their mouth is and made headway because of it. TEXPAC has a tradition of enormous success in staving off attacks on tort reform legislation, increasing Medicaid payments to physicians, and extending the Children’s Health Insurance Program.

The grassroots commitment is strong, and TEXPAC invests its endorsements and campaign contributions wisely and effectively.

In fact, TMA has been called the most effective medical organization in the country due to combined efforts on the campaign and legislative fronts. Just ask The New York Times, The Washington Post, The Wall Street Journal, Medical Economics, and Los Angeles Times.

Can you imagine the power TEXPAC would have to protect your practice and your patients if every physician joined? If you don't invest in your profession’s political viability, who will?

Take us one step closer to that ideal and join TEXPAC. Call (512) 370-1361, email paula.frey@texmed.org, or visit www.texpac.org today!

If you have any questions, observations or insights you’d like to share, contact TEXPAC Director of Political Education, David Reynolds at (512) 762-3730 or david.reynolds@texmed.org. Or, you can contact Dawn Buckingham, MD, the Austin/Travis County TEXPAC District Chair at (512) 583-2020.
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Your patients need YOU to be a lobbyist for a day! Come to Austin for First Tuesdays at the Capitol and make a difference for your patients and your practice.

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Recently, the *Austin Business Journal* recognized health care professionals for their dedication to medicine and the community during the annual Health Care Heroes Awards Breakfast. Several Travis County Medical Society members were recognized in four of the ten categories. (See page 17 for details on those honored.)

The reasons these physicians were recognized brought to mind another volunteer effort to assist the community at large – Project Access (PA) and its hundreds of TCMS physicians who dedicate their time to this endeavor.

Health system reform has dominated public discourse in our community, state, and nation for the last two years. However, the problems of access to care in a fragmented delivery system have been present for many years. That is why nine years ago the leadership of TCMS decided to launch Project Access, a coordinated system of health care for low-income, uninsured residents of Travis County. In July 2002, after several months of planning, the program began asking physicians to accept eligible PA patients into their practice. Within the first six weeks of the program’s recruitment campaign, 252 physicians made pledges and within 12 weeks a total of 471 physicians had signed up. Today, Project Access has grown to a network of over 1,000 physician volunteers, with a little more than half seeing patients in their private offices. There are the unsung health care heroes of our community.

Project Access demonstrates TCMS physicians’ commitment to patients and community, and continues to be a highly visible example of physician leadership in action. Because of their dedication, PA volunteers have treated over 2,800 individuals, resulting in 18,000 plus patient encounters; of which, 51% were private physician office visits, 11% were outpatient/inpatient physician procedures, 24% were outpatient diagnostic services, and 14% were hospital/surgery center services. PA physicians have also assisted their patients in receiving over $697,000 in free medications. To date, the program has provided $16.5 million in donated care to the Austin/Travis County community.

Through the volunteer efforts of Project Access physicians and the program’s community partners, Project Access demonstrates that quality health care can be delivered in a more cost-efficient way when all providers come together in a coordinated system of volunteer care. The keys to its success lie in the physician direction provided by the PA Executive committee and the dedicated work of the Patient Service Coordinators on the program staff.

Did you know that, if you are a Project Access volunteer physician, any patient in your practice that meets the eligibility criteria would be able to become part of this coordinated delivery system and be counted toward your pledge? The screening process is easy. Your staff or the patient can call the PA office (206-1164) or visit www.projectaccessaustin.com. Project Access staff can also provide patients information about other community services.

The program is currently in need of both primary care and subspecialists. To learn more about becoming involved with Project Access, visit www.projectaccessaustin.com or call (512) 206-1165.

---

**Project Access Physician Participation**

A physician participating in Project Access agrees to either see patients in their office or volunteer at a community clinic.

I will volunteer my time to Project Access as:

- **Primary Care Physician** (FM, GP, PD, IM)
  - Over a 12 month period I pledge to accept up to the following number of patients:
    - 10 Other ____________

- **Specialty Care Physician**
  - Over a 12 month period I pledge to accept up to the following number of patients:
    - 10 Other ____________

Or

- **I will volunteer at a Community Clinic**
  - Over a 12 month period I pledge to volunteer the following number of hours:
    - 24 hours Other ____________

- Please contact me. I have additional questions regarding my role in Project Access.

Office Contact Name (please print): __________________________________________

Physician name: ___________________________ Specialty: ________________

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For more information, contact Cliff Ames at 206-1165.
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Austin is a model city of environmental stewardship. Extending this environmental friendliness to health care, Austin’s Dell Children’s Medical Center of Central Texas became the first platinum Leadership in Energy and Environmental Design (LEED) hospital in the world, incorporating benign construction materials, a philosophy of sustainable design, and an aesthetic intended for easing the minds and hearts of its young patients.

During a public health nursing course at the University of Texas at Austin’s School of Nursing this summer, a project was chosen to continue in this vein of “greening” health care facilities. Working with Dr. Lisa Doggett, a family physician and Director of the UT Family Wellness Center (a CommUnityCare clinic), the goal was to find ways to reduce the “carbon footprint” of the clinic and develop strategies for other local health centers to follow suit.

Efforts to make health care facilities run more sustainably can produce economic benefits through lower overhead and a healthier environment for patients and staff (e.g., by using natural cleaning products). While we await stronger federal legislation and coordinated global efforts to combat climate change and reduce our exposure to environmental toxins, more can be done as individuals now to create a healthy environment for ourselves, our patients, and future generations.

To begin the process of greening your clinic it is important to assess the facility for unhealthy exposures for patients and staff, unintentional environmental waste, and opportunities for savings and conservation. Assessment provides a baseline from which to measure the impact of greening efforts and allows an opportunity for staff to contribute their ideas. Regular communication about initiating and continuing the program and involvement of all staff are essential. Developing a “Green Team” may encourage employees to work on enhancing the overall sustainability of the clinic or office setting. In addition, an energy audit can help pinpoint inefficiencies in energy usage and create a plan for improvements. See table: What you can do to help get started.

After assessing the Family Wellness Center, our team discovered that some employees carried home recyclable containers, because the clinic lacked a coordinated recycling program. It was recommended that the clinic institute aluminum and plastic container recycling, and were then connected with UT staff who could pick up the recycling bin when full. It was also recommended that staff turn off computers at night, use power strips to reduce phantom loads, designate a Green Team in the clinic, write Green Team tasks into job descriptions, and investigate an ironic increase in paper use after implementing an electronic medical records system. Finally, strategies to reduce energy use during an upcoming clinic remodel were suggested, such as adding solar shades

Continuum of Greening Projects: What can your clinic do?

- Start a clinic Green Team.
- Gain buy-in of staff to do greening efforts.
- Assess for unintentional waste.
- Arrange for an energy audit from your utility provider
- Set up clinic paper and plastic/aluminum recycling
- Check for proper refrigerator seals
- Check for water leaks in toilets
- Replace appliances with Energy Star appliances
- Use low-VOC paints
- Apply solar film to windows
- Employ reusable medical supplies when possible
- Create a pharmaceutical take-back program to responsibly dispose of unused medications
- See if biohazard wastes can be sterilized so that they can go out with other solid wastes instead of requiring incineration. Look into alternative waste disposal (consult with medical waste facility)
- Install solar panels
- Use contractors who know green building techniques for renovations and new buildings

Website resources:
- AustinEnergy: www.austinenergy.com
- Toilet leaks: www1.eere.energy.gov/consumer/tips
- VOC Paints: http://eartheasy.com/live_nontoxic_paints.htm
- Pharmaceutical take-back program: www.takebacknetwork.com/index.html
- Green Builders: www.usgbc-centraltexas.org
- Austin Recycles: www.austirecycles.com
- Energy Star: www.energystar.gov
- Solar Guard: http://solargard.com
- Pharmaceutical take-back program: www.takebacknetwork.com/index.html
- Green Builders: www.usgbc-centraltexas.org
- Solar Panels: www.boses.org/solar/content/solar-energy-resources
Barriers encountered included a lack of resources to carry out greening efforts, a lack of enthusiasm and (possibly) understanding of the benefits of “greening” among some staff, and a lack of infrastructure to measure energy consumption. In an ideal world there would be unlimited funding for greening efforts, but since resources are limited, it is more feasible for clinics to consider larger-scale green projects when funding becomes available.

The Family Wellness Center is striving to become a more sustainable facility with the ultimate goal of increasing the health of clients, staff, and the environment. They are an example of how a small office takes charge to become more environmentally responsible. Throughout the duration of the project, it was discovered that in order to have a successful green project, support is required. Look for these resources in your setting: strong involvement and enthusiasm of decision-makers; local models for green efforts; and City of Austin resources (there are many!).

As health care practitioners, we invest tremendous time and energy into improving the health of our individual patients. However, decisions about energy use on a personal level can have a broad influence on the health of future generations. We encourage local physicians to follow the example of the Family Wellness Center by finding ways to reduce your environmental impact.

Interested in serving on a TCMS Committee?

Brian Sayers, MD, TCMS President Elect, will soon make appointments to Medical Society committees for 2011. Mark any committees below in which you have an interest. If an opening is not available on your committee of interest, your name will be kept for future consideration. For additional information on a particular committee, contact Belinda Clare at (512) 206-1250 or bclare@tcms.com.

[ ] Mediation — Mediates complaints from the general public against members of the Society in accordance with the principles of fair process.

[ ] Medical Legislation — Works in cooperation with the TMA Council on Legislation to promote the enactment of appropriate medical and health care legislation. Also works in cooperation with TEXPAC to evaluate political candidates’ positions on medical or health care related issues.

[ ] Public Relations — Oversees and promotes community service and other activities that enhance public understanding and appreciation of the medical profession.

[ ] Physician Health and Rehabilitation — Assists physicians whose ability to practice medicine is impaired, or reasonably believed to be impaired, by drug or alcohol abuse or mental or physical illness. (It coordinates its activities with and abides by the guidelines issued by the TMA Committee on Physician Health and Rehabilitation.)

[ ] Constitution and Bylaws

[ ] Communications — Provides oversight of TCMS publications including editorial and advertising policy for the Journal, pictorial directory, newsletter and website.

[ ] Public Health — Works to foster communication and cooperation on current public health issues between the health department and practicing physicians.

[ ] Membership — Organizes, develops, and executes strategies for the recruitment and retention of members in the Society. Plan activities for the members of TCMS.

Name: ____________________________________ Specialty: _________________________________ (PLEASE print)

Phone:___________________________________ Email: _________________________________

Return to: TCMS, PO Box 4679, Austin, Texas 78765 or Fax to: 450-1326
Happenings

Take advantage of Travis County Medical Society events – whether it be an educational opportunity, networking social, or volunteer project. Each event offers the opportunity to renew acquaintances and meet new colleagues. If you have any suggestions for future events, contact the Society at 206-1221 or tcms@tcms.com.

Community Volunteer Project
Many thanks to the TCMS members and their families who volunteered at the Capital Area Food Bank on August 14. TCMS volunteers processed 7,020 lbs. of food and 5,990 lbs. of non-food items.

Networking Social
TCMS members enjoyed an evening with colleagues as they cruised Lady Bird Lake.
The Austin Business Journal recently recognized several TCMS members as Health Care Heroes. Physicians were nominated by ABJ readers and finalists were recognized at a special ceremony. Congratulations to Tom Coopwood, MD who received the “Volunteer” award – while no longer practicing, he’s far from retired as chairperson of Central Health; Tim Gueramy, MD received the “Community Outreach” award for assisting with the establishment of Austin Medical Relief for Haiti; and John “Chip” Oswalt, MD who received the “Physician” award for dedicating himself to saving children all over the world with the HeartGiftFoundation.

In addition, Tom McHorse, MD received the Health Care Heroes’ “Special Achievement” award. Dr. McHorse was recognized not only for his service as a physician, but also for his service as a volunteer outside of medicine.

Photos clockwise from top left: Paul Carrozza, 2009 Special Achievement recipient, Dr. Tom McHorse, and Clarke Heidrick, Graves Dougherty Hearon & Moody, PA; Diane Carter, Brown McCarroll LLP and Dr. Tom Coopwood; Diane Carter and Dr. Tim Gueramy; and Dr. “Chip” Oswalt and Mark Clayton, St. David’s HealthCare.

TCMS all member social honoring new members.
Bring your family and join your colleagues at

18300 FM 1826 in Driftwood
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Friday, September 24
6:30 - 9:00 pm
RSVP (512) 206-1146 or tcms@tcms.com

This event sponsored in part by these Friends of the Society: Medical Service Bureau; Texas Medical Association Insurance Trust; Texas Medical Liability Trust; Austin Radiological Association; Cedar Park Regional Medical Center; Austin Brokerage Company; Independent Bank; Laura M. Stephens and Associates; On-Air Development; and Physician’s Resource Services.
The Top Ten Things To Know About Consent For Treatment Of Adults

By Hugh M. Barton, JD
Health Attorney

Q: Do I have to get written consent to treat in an office setting?
A: No. Recall that the physician/patient relationship is a contract formed when a person requests that a physician become responsible for his care, and the physician agrees to do so. Thus, consent for treatment is bound up in the patient’s request to receive care. Case law from other states tends to verify this. Thus, if a competent adult has been informed of proposed treatment, knowing that it can be refused or accepted, and then cooperates with the physician, then he has given implied consent to treatment. LaCaze v. Collier, 434 So.2d 1039 (La. 1983). Implied consent is what is usually obtained in routine office practice. Seals v. Pittman, 499 So.2d 114 (La. App. I Cir. 1986).

Q: Are any specific forms necessary?
A: No. Though no written consent is generally required for routine office practice, if a printed form is used, it should, at a minimum, state the nature of the authorized treatment, and be signed by the person authorized to give consent. The form should be made part of the medical record. However, like any other form that goes into a medical record, it can become a liability if it is not used consistently.

Q: Can family members consent for one another?
A: No. Family members may not, as a general rule, consent to treatment of another family member. Thus, spouses may not consent, and children may not consent to their parents’ treatment. There are two exception to this rule: (1) in the case of minors, which will be covered in a future article, and (2) incapacitated adults in hospitals.

Q: Dr. Smith is working in a hospital ED. Jones is brought in by ambulance. Does Dr. Smith need to obtain “consent” to treat?
A: If a patient is unable to communicate due to injury or accident, or is unconscious; and suffers a life-threatening injury or illness, then consent for emergency care is presumed.

Q: Jones is brought to the hospital after a serious accident. After he is out of immediate danger, he is incapable of communication. How does Dr. Smith get consent to treat him?
A: The Consent to Medical Treatment Act provides a means to treat adult patients in hospitals or nursing homes who are comatose, incapacitated, or otherwise mentally or physically incapable of communication, and for whom decisions must be made regarding treatment. An adult “surrogate” who has decision-making capacity and is willing to consent to medical treatment on behalf of the patient must be found to consent. Surrogate decision-makers, in order of priority, are as follows: (1) the patient’s spouse; (2) an adult child of the patient who has the waiver and consent of all other qualified adult children of the patient to act as the sole decision-maker; (3) a majority of the patient’s reasonably available adult children; (4) the patient’s parents; (5) a person clearly identified by the patient to act for the patient; or (6) a member of the clergy. When a surrogate decision-maker consents to treatment, the attending physician must record the date and time of the consent and sign the patient’s medical record. The surrogate decision-maker must countersign the record or execute an informed consent form if necessary.

Q: What if the treatment proposed is surgery?
A: When surgery is contemplated, the consent situation gets more complicated. Old Texas case law holds if a physician performs an operation without consent, this is an assault for which an action for damages may be brought. Moss v. Rishworth, 222 S.W. 225 (Tex. 1920). While still true, these days the focus is on “informed” consent to lessen malpractice liability.

Q: What is “informed consent”?
A: In 1977 the Texas Legislature passed a law that provides that, if a plaintiff being a “health care liability claim” (a “malpractice claim”) based on the alleged failure of a physician to disclose, or adequately disclose, the risks and hazards involved in certain medical care or surgical procedures, then the only theory on which the plaintiff may obtain recovery is that of negligence in failing to disclose the risks or hazards that could have influenced a “reasonable person” in making a decision to give or withhold consent. This only protects a physician if the claim involves failure to disclose – it does not protect if the claim is negligent performance of a procedure. Further, only procedures identified by the Texas Medical Disclosure Panel are subject to the disclosure requirement.

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Q: What procedures are these?
A: The Legislature created the Texas Medical Disclosure Panel (“Panel”) to determine which risks and hazards must be disclosed, and it lists two. List A: “Procedures Requiring Full Disclosure;” and List B: “Procedures Requiring No Disclosure.”
List A: List A is expansive and a complete listing of the 87 procedures is beyond the scope of this article. Two examples are a coronary artery bypass and a valve replacement procedure which require disclosure of the following risks: (1) acute myocardial infarction; (2) hemorrhage; (3) kidney failure; (4) stroke; (5) sudden death; (6) infection; and (7) valve-related delayed onset infection. On the other hand, some listed procedures have very short lists of risk. Stress testing requires only disclosure of the risk of acute myocardial infarction. For more information about List A, see: www.dshs.state.tx.us/HFP/tmdp.shtm. Proper disclosure of List A procedures creates a rebuttable presumption of compliance.

List B: In contrast, the Panel has identified thirty-seven (37) List B procedures, including discography, sialography, hysterosalpingography, and pacemaker lead placement, that require no specific disclosures.

Q: What forms are required for informed consent?
A: The Panel adopted a specific “Disclosure and Consent Form” to disclose risks and hazards of List A procedures. If a physician uses the form and it is signed by the patient (or person authorized to give consent) and a competent witness, then consent “shall be considered effective.” The risks and hazards disclosed under List A are considered minimum disclosure requirements and a physician may choose to disclose additional risks that a patient might incur. Penick v. Christensen, 912 S.W.2d 276 (Tex. App. - 1995). There are also special forms for radiation therapy and hysterectomies.

Q: Who must obtain informed consent?
A: Only the treating physician has the duty to disclose risks and hazards of procedures. The duty is “non-delegable” and a hospital has no duty to get a patient’s informed consent prior to surgery. Boney v. Mother Frances Hospital, 880 S.W.2d 140 (Tex. App.-1994).

In Memoriam
The Medical Society extends deepest sympathy to the family and friends of the following physicians.

Louis Melchoir Cartall, Jr., MD passed away on July 25, 2010. Dr. Cartall put himself through school and graduated from the University of Texas and University of Texas Medical Branch at Galveston. Upon graduation he enlisted in the US Navy and completed his internship at Naval hospitals in Washington state and California. He received the Order of the Purple Heart and was later given a disability retirement from the Navy. Dr. Cartall and his wife moved to Dripping Springs but maintained a presence in Del Rio where they founded Visiting Nurses of Del Rio, a home-health care enterprise with more than 800 employees. He opened another practice in Dripping Springs where he worked until retiring.

Stanley Wayne Casner, Jr., MD, passed away August 27, 2010. Dr. Casner was born in Marfa and studied civil engineering at Texas Tech before transferring to UT Austin for pre-med studies and then graduated from UTMB in Galveston. He interned at Methodist Hospital in Houston and was board certified in both family practice and emergency medicine. Dr. Casner served in the US Air Force from 1944 to 1946. His passions were flying and building airplanes. He took B29s out of mothballs at Pyote AFB, worked on the Enola Gay, and had his A&E mechanics license.

Frederick Alfred Edward Griffiths, MD passed away on July 17, 2010. Dr Griffiths was born in Toronto, Canada and graduated from University of Toronto Medical School.

William S. Moskovitz, MD, passed away on July 27, 2010. Dr. Moskovitz attended Pittsburgh University Medical School. He later entered the military and rose to the rank of Major. He served as longtime Chief of Staff at Brackenridge Hospital treating patients from all walks of life, his greatest passion was teaching surgical residents. Dr. Moskovitz was quick with a good joke, a funny story, and a big laugh. He and wife Beverly were devoted to working with Jerry Lewis and the Muscular Dystrophy Labor Day Telethon throughout their life together, earning numerous honors and awards of recognition.

John Joseph Whitaker, MD, passed away July 22, 2010. Dr. Whitaker attended Creighton University, earning a Bachelor’s degree followed by a medical degree. He worked as an intern at Mount Carmel Hospital in Detroit before serving as a medical resident and associate consultant at the Mayo Clinic. Dr. Whitaker served his country as Assistant Chief of the US Army’s Brook General Hospital in San Antonio, reaching the rank of Captain. He became the first practicing oncologist in Austin. He worked with Capital Medical Clinic, Southwest Regional Cancer Center, and treated patients at the People’s Free Clinic, which he helped to found in 1970. Dr. Whitaker liked to spend his free time hunting, fishing, playing cards, yelling at televised sports, and enjoying the company of good friends.
Vickie Blumhagen
President-Elect, Travis County Medical Alliance

Community Service Grant Applications
Applications are currently being accepted by the Travis County Medical Alliance to be awarded in 2011. Grants can now be submitted electronically at www.traviscountymedicalalliance.com. Just click on the Community Service Grant Application button where grant application procedures and guidelines are listed. If you have any questions or need further information, contact Lydia Soldano at Ltsoldano@msn.com or (512) 422.5009.

Be-Wise Immunize and Hard Hats for Little Heads
TCMA members assisted the UT Children's Wellness Center in Del Valle on August 14 to provide bike helmets for children and assist the clinic in providing free immunizations for low-income and medically underserved children. Thousands of vaccines are given each year through the program. Thanks go to all Alliance members who volunteered!

Member Spotlight: Karen Kim
Alliance member Karen Kim and her husband Stanley Kim, MD, a neurosurgeon have two children, Matthew (7) and Natalie (6). Karen grew up in Cherry Hill, New Jersey and attended Wellesley College, where she double majored in sociology and Japanese Studies. After college, she worked in Japan and then returned to the Boston area for graduate school. She received her AM and PhD in sociology from Harvard University, then held post-doctoral fellowships at The City University of New York and Rice University. Before moving to Austin, Karen was a professor of sociology at the University of Houston. Her area of expertise is the intersection of race and religion. She is a co-author of United by Faith: The Multiracial Congregation As an Answer to the Problem of Race.

Although caring for her family is now her main focus, Karen is currently a research affiliate at the Population Research Center at the University of Texas. In addition, she serves as the treasurer of the Alliance and works on outreach through her children’s school. For the past seven years, Karen has served as an admissions representative for Harvard, interviewing local applicants. Although she is still an East Coast girl at heart, Karen feels greatly blessed to have such a wonderful life in Texas!
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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 58-year-old woman was referred to a general surgeon for a lesion in her left breast. The surgeon performed a two needle-directed biopsy of the left breast.

Physician action
The next day, the defendant pathologist interpreted the first specimen as ductal carcinoma in situ and the second specimen as invasive mucinous adenocarcinoma. Two months later, the same surgeon performed a left radical modified mastectomy. The defendant pathologist interpreted the specimens submitted from the mastectomy. She found no evidence of ductal carcinoma in situ in the resected mastectomy specimen.

A few days later, the original biopsy specimens were sent to two independent pathology centers for review. Both pathologists found no evidence of ductal carcinoma in situ in the resected mastectomy specimen.

Allegations
A lawsuit was filed against the pathologist, alleging misdiagnosis that required an unnecessary radical mastectomy with permanent scarring and deformity. The patient also alleged significant emotional pain for herself and her spouse.

Legal implications
This claim was reviewed by two board-certified pathologists and a general surgeon. Both pathologists opined that, although the breast biopsy samples were benign, they were “busy with lots of activity or atypia.” They agreed that the defendant’s microscopic diagnoses other than DCIS (including fibrocystic change with florid ductal hyperplasia, sclerosing adenosis, apocrine metaplasia and the like) were correct. The reviewing pathologists also mentioned that atypia could imply an increased risk to the patient as their presence indicates cells that are already growing in the wrong direction and can, on the continuum, eventually develop into neoplasia/cancer.

One of the reviewers commented that, in some cases, if the atypia were not localized but extended throughout the breast, in light of the increased risk for cancer to develop, some patients might elect to have a prophylactic mastectomy with reconstruction. However, both reviewers felt the defendant’s diagnosis of DCIS was incorrect and based upon the information reviewed, a mastectomy was not indicated.

The general surgeon who reviewed this case stated sclerosing adenosis is a benign lesion of the breast and agreed that a mastectomy should not have been done. The surgeon further indicated that sclerosing adenosis can occasionally appear to be malignant on first examination. He further stated that a pathologist would be aware of the possibility of misdiagnosis in that condition and obtain a second opinion.

Two other consulting pathologists were asked to perform a blind read of the plaintiff’s tissue samples along with some dummy slides to assure fair interpretation. Both were of the opinion that the specimens did not reveal DCIS, and the defendant had misdiagnosed the findings in her final report.

Disposition
This case was settled on behalf of the pathologist.

Risk management considerations
With microscopic diagnoses in addition to DCIS, the defendant had time before the surgery was scheduled to request a second and independent review of the slides. Another reason to request a second review and interpretation in this case was the possibility that this patient may have synchronous, unrelated cancers.

This patient had a high cancer suspicion level as she had a mole removed on the bottom of her left foot diagnosed as level IV malignant melanoma requiring a below the knee amputation 43 days before the mastectomy. Consequently, requesting a second opinion and interpretation of the biopsy specimens would have reflected conservative, careful investigation and may have avoided the mastectomy.

As reflected in the PIAA summary of pathology claims in this issue, breast cancer cases continue to have high frequency and severity. To address this, the College of American Pathologists (CAP) meeting in October 2009 included a focused curriculum on breast pathology.
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pathology with courses that fulfill some of the requirements for CAP's new Breast Predictive Factors Certificate Program. The program is designed to offer pathologists the opportunity to acquire new knowledge and skills in an innovative or focused area of pathology. It is intended to deliver best practices in laboratory evaluation and interpretation of breast cancer predictive factors to better treat patients(2).

Sources
1. Some studies have found that women with sclerosing adenosis have about the same risk of developing breast cancer as do women with usual hyperplasia. Their risk is about 1.5 to 2 times the risk of women with no breast changes. American Cancer Society. Non-cancerous breast conditions. Available at http://www.cancer.org/docroot/CRI/content/CRI_2_6X_Non_Cancerous_Breast_Conditions_59.asp. Accessed October 1, 2009.


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. © Copyright 2010 TMLT.

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- Satisfies other study entry requirements (as evaluated by study site staff)

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HIV INFECTION: THE BASICS

Human immunodeficiency virus (HIV for short) is the virus that causes AIDS (acquired immunodeficiency syndrome). AIDS is a serious, life-threatening illness that has a variety of symptoms. HIV infection can be treated with medications to make patients feel better and to prolong life. However, there is no cure for HIV infection or AIDS. Approximately 33 million people are infected with HIV worldwide.

HOW HIV IS TRANSMITTED

You cannot get HIV infection from drinking from a water fountain, contact with a toilet seat, or touching an infected person. You can get HIV infection from

- Bodily fluids, including semen and vaginal secretions (through sexual contact with an infected person) and blood. There is no evidence that HIV infection is transmitted through saliva or mosquito bites.
- Infected blood from shared drug injection needles or an unintentional needlestick with a needle contaminated with infected blood.
- Infected blood and blood products through transfusion (this is rare in developed countries but still occurs in countries with inadequate blood donor testing programs).

Women with HIV infection can transmit the virus to their babies during pregnancy or delivery or through their breast milk.

SYMPTOMS OF HIV-RELATED DISEASE

Individuals with HIV infection may not feel sick at first. However, HIV infection is often accompanied by a variety of symptoms, which can vary depending on how long a person has been infected. Since HIV affects the way the immune system functions, people who are infected develop illnesses that could previously be fought off by the immune system. Symptoms tend to increase in severity and number the longer the virus is in the body if the individual remains untreated.

- Symptoms may include
- Fever, chills, and night sweats
- Weight loss
- Persistent tiredness
- Blurred vision and headaches
- Swollen lymph nodes
- Diarrhea
- Coughing and shortness of breath
- Skin sores
- Development of other infections, such as certain kinds of pneumonia

PREVENTING HIV INFECTION

- Do not have sexual contact with any persons (opposite- or same-sex partners) unless you are sure they are free of HIV infection. This includes oral, anal, or vaginal contact of any type.
- If your partner has had prior sexual experience, even if you believe you are in a mutually monogamous relationship, to protect yourself, use a new latex condom every time you have any sexual contact unless you are certain that your partner is HIV negative. However, keep in mind that condoms can break. If you are allergic to latex, polyurethane condoms are available.
- If you inject drugs, seek treatment and do not ever share needles with others. Use only a new, clean needle each time you inject.

For More Information

- Centers for Disease Control and Prevention: www.cdc.gov/hiv
- Division of Acquired Immunodeficiency Syndrome: www.niaid.nih.gov
- National Institute of Allergy and Infectious Diseases: www.nih.gov/about.nih.gov
- World Health Organization: www.who.int/hiv/en

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