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There is no catch, there is no cost! This is simply another wonderful benefit of being a TMLT policyholder. Don’t let this opportunity pass you by – complete your enrollment form today!

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Pennebacker bridge, over Lake Austin, Texas. Photo by David McCarron, MD.
From the President

Dangerous for Good

R.Y. Declan Fleming, MD
President, Travis County Medical Society

Full disclosure, I have come to the realization that I am a big nerd. I realized this when I recently reminisced about my favorite hero from when I was just a kid.

Sure, I loved such legends as Jim Bowie, Neil Armstrong and Steve Wooster, but the man who impressed me most was Robert Koch.

What? No pre-teen, Central Texas boy ever idolized a mid-19th century German physician and bacteriologist. Probably the only other person to idolize Herr Doktor Koch was his mother.

But if you saw what I saw, you’d idolize him too.

It was a television show called “You Are There,” narrated by fellow Texan, Walter Cronkite. During the show, the viewer was brought into a real-life event. I remember the scene – cholera was a disease devastating the land. Koch had observed that a person who had been exposed to the disease once would develop immunity to the condition later in life. According to the narrative, Koch had suffered cholera as a child and survived. He was convinced that exposure to a weakened form of cholera would convey immunity against any more severe form of the disease, but the medical experts of the time were skeptical.

Koch felt he had to do something so dramatic that the skeptics would be overwhelmed by what he knew to be the truth – compelling them to support his work to vaccinate people against the disease.

The climactic moment of the show had Dr. Koch drinking a vial of cholera bacilli, “enough to kill a city,” if my memory of the show’s narrative does not fail me. He, of course, survived the dangerous display of confidence in his scientific observations. This act, it was explained in Walter Cronkite’s deep, resonant voice, led directly to the widespread adoption of the medical principle of acquired immunity and vaccinations against disease.

Koch was a hero. He took advantage of his training as a scientist, his detailed observations, his communication skills, his showmanship and his bravery to do something that affects us to this very day.

As a kid, I enjoyed the episode and I idolized Koch, not because he was a brilliant scientist, physician and communicator, but because what he did was dangerous. I loved the danger of the display. I admired him because he put himself at risk for the benefit of others. He was, in a term coined by one of my favorite contemporary authors and speakers John Eldredge, “dangerous for good.”

“Dangerous for good” is an interesting concept. “Good and safe” is a concept we all understand – we’ve heard it for years. In medicine, we have core safety measures. I haven’t heard of a core danger measure yet, but I think that C.S. Lewis gives a good perspective on dangerous and good in “The Lion, the Witch and the Wardrobe” describing Aslan, the Lion King of Narnia:

Don’t you know who is the King of the Beasts? Aslan is a lion – the Lion, the great lion.”

“Oh!” said Susan, “I’d thought he was a man. Is he – quite safe? I shall feel rather nervous about meeting a lion.”

“Then he isn’t safe?” said Lucy.

“Safe?” said Mr Beaver; “don’t you hear what Mrs Beaver tells you? Who said anything about safe? Course he isn’t safe. But he’s good.”

“Dangerous for good” is not risk entered into unadvisedly. It is not having Roman candle wars in mid-summer in Gus Fruh Park. Yes, the fire department was able to control the blaze easily, though we did learn that home fire extinguishers and water from a nearby swimming pool are not as effective as one would believe. It is not using a mini-trampoline to allow for more rotation when you flip off of the cliffs at Paleface Bluffs. Those are acts of random riskiness – the consequences of which were not weighed and judged carefully. “Dangerous for good” is a choice to move wisely or strategically, to act despite known risks because the potential for benefit outweighs the potential for harm. It does not miss an opportunity to try for something better.

We are all attempting to be dangerous for good. Our profession is all about taking measured, acceptable risks in dangerous situations. Patients are willing to accept risks if they feel that their problem is real and that the risks are reasonable. They often, however, do not have a realistic view of their own circumstance. I cannot tell you the number of people I see that smoke, are obese, have diabetes or some other chronic medical condition and do not recognize (or perhaps refuse to acknowledge) the problems that these issues create for them and their health. Part of our charge as physicians is to operate under the principle of informed consent – our patients should be allowed to understand the risks, benefits and alternatives for each thing we recommend. Do they know?

Unfortunately, I believe that we often do a poor job as a profession of communicating the danger that lies in treating disease. We have become accustomed to the danger that is inherent in what we do. Everyone we treat has something wrong, everything we do is risky, we judge and act believing that the benefits of what we are attempting to do outweighs the risks. It is all part of the routine; however, each operation I perform as a surgeon causes an injury. Others in our profession are no less dangerous: we burn up a little bit of the heart when we ablate a focus of an arrhythmia; chemotherapy is poison; antihypertensives, antihyperglycemics, even antiarrhythmals can all

continued on page 8
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be mis-dosed or can cause a catastrophic allergic reaction. Even something as seemingly innocuous and frequently performed as a CT scan radiates the body, increasing the risk of developing a cancer. But these things are often necessary parts of diagnosing and treating our patients.

Do you let your patients know, in a way they can understand and accept, that they have a very real problem? Do you take the time to outline the real risks of the things your patient is going through? It is telling that most medical malpractice suits and complaints to the Texas Medical Board do not stem from care that falls outside of accepted standards of the community or is grossly negligent. They are more often due to a poor outcome compounded by a physician’s failure to communicate well or connect with their patient. To minimize the risk of becoming a defendant, it is imperative that we labor as diligently at communicating our concern for our patients as we do at administering the correct treatment. We need to ensure that our patients feel that they are heard and that they have our time and attention. We need to communicate well or connect with their patient. To minimize the risk of becoming a defendant, it is imperative that we labor as diligently at communicating our concern for our patients as we do at administering the correct treatment. We need to ensure that our patients feel that they are heard and that they have our time and attention. We need to recognize our own limitations and take advantage of the expertise of our colleagues. We need to let patients know why we are choosing one particular course of treatment versus another. If we do these things, we will be an invaluable resource for those under our care. If we do not, we will lose the position of trust that our profession has earned over the years. Rather than being seen as a physician laboring for the good of our patient, we will be a “health care provider” dispensing this procedure or that medicine as part of our job, no better in people’s minds than any other provider of goods or services. Our relationship with our patients will not be valuable, and there will be no reason for them to resist when one payer or another tells them who they may see and where they can go for care.

I hope that we all will continue to do a great job of addressing the ills and dangers that our patients face, and that we continue to connect and communicate well with our patients. The pressure to work more quickly, to engage less deeply, to avoid all risk in an attempt to practice “cost effective” medicine will continue, but we can follow Dr. Koch’s example. We can observe and address problems well, we can communicate thoroughly and effectively, we can act with appropriate boldness and take some acceptable risks. In doing these things, we will continue our legacy of honor, and we will be dangerous for good.
Cancer can change and devastate lives. And it can strike anyone. Mothers. Fathers. Brothers. Sisters, spouses, cousins, coworkers and friends. Cancer affects the people we love, the relationships we thrive on and the individuals we depend on… and who depend on us. At Austin Cancer Centers, our commitment is to people, and our goal is recovery for every person that we see. By leading with our hearts for more than 30 years, we’ve had a dramatic impact on the lives of thousands of people. And we’ve earned a reputation for commitment, excellence and innovation. We’ve introduced many new treatments. We use advanced technologies offered by no other center. We’ve established a large network of specialists and support services. And we’ve maintained our independence, high standards and principles, all of which are centered around one thing: Treating people, not just their disease.


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The communications committee recently met to review TCMS publications and new communication initiatives, such as social media. The committee agreed that a series of articles dedicated to social media would be appropriate for the TCMS Journal. The articles will examine the importance, benefits and possible threats of social media, as well as explain the different platforms and how to use each appropriately.

TCMS is on the leading edge of the social media frontier. Join us:

‘Like’ TCMS on Facebook
Facebook: A large social network where people create profiles (soon to be timelines), exchange messages, report status updates and share photos, videos and links. ‘Like’ TCMS on Facebook to become our fan and receive networking and educational event information as well as the latest practice management and advocacy updates.

Follow @TravisCMS on Twitter
Twitter: A microblogging service that enables users to send text-based posts of up to 140 characters. Get real-time updates, news and latest information from TCMS on Twitter by following us through our username @TravisCMS.

Join the TCMS Group on LinkedIn
LinkedIn: A social network for professionals to discuss issues, share information and network with colleagues in their profession and industry. Send a request to join the TCMS group to engage in discussions, share professional knowledge, post current job openings and network with fellow physicians.

Stay tuned for more.
If you have questions or need help setting up your social media accounts, contact TCMS Communications Coordinator Shahar Gurvitz at sgurvitz@tcms.com or 512-206-1219.
1 in 5 persons living with HIV does not know it.

- People accessing health care are NOT routinely tested for HIV.
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Scan the code to learn how we can help you lessen the uncertainties you face in medicine.
The Department of Health and Human Services has proposed new rules for Stage 2 of the Medicare and Medicaid electronic health record (EHR) incentive programs that detail proposed expectations for physicians. This is the second of three stages of meaningful use that physicians are required to meet to earn EHR incentives through the Medicare or Medicaid programs.

The proposed rules focus on using EHRs to improve health and health care while reducing the burden on physicians and hospitals where possible. TMA, through the Ad Hoc Committee on Health Information Technology (HIT), will review and comment on the proposed rules. Interested physicians may send comments to Director of TMA's HIT Department Shannon Moore at shannon.moore@texmed.org or 512-370-1411.

Physicians needing help with their HIT needs may also turn to the Texas Regional Extension Centers (RECs), which provide on-site consulting at subsidized and below-market rates.

### The Three Stages of Meaningful Use

| Stage 1 | (which began in 2011 and remains the starting point for all physicians): "meaningful use" consists of transferring data to EHRs and being able to share information, including electronic copies and visit summaries for patients. |
| Stage 2 | (to be implemented in 2014 under the proposed rule): "meaningful use" includes standards such as online access for patients to their health information and electronic health information exchange between physicians and other providers. |
| Stage 3 | (expected to be implemented in 2016): "meaningful use" includes demonstrating that the quality of health care has been improved. |

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Brain Kidney Liver Lung Pancreas Prostate Spine
For more than 20 years, TMA has helped physicians resolve insurance related problems with the Hassle Factor Log (HFL). Through HFL, members can submit claims problems to TMA and get assistance in resolving disputes with health plans. TMA meets regularly with Medicare, Medicaid, health care payment plans and large insurers to discuss specific problems that members bring to their attention.

Hassle Factor Log Program User Guide
Please observe the following HFL guidelines to help TMA expedite processing while maintaining the integrity and credibility of the program.

General Guidelines
• The Texas Medical Association accepts HFLs from current TMA members only.
• Submit HFLs by mail to Payment Advocacy Dept., Texas Medical Association, 401 W 15th St, Austin, TX 78701; or by fax to 512-370-1632. (No need to mail originals of faxed information.)
• Exhaust and document reasonable attempts to resolve your claim issues, including the appeals process, before submitting an HFL unless you are submitting an HFL as “informational only.”
• Clearly identify health plans and/or contractual relationships on the HFL form.
• Keep in mind that Medicare’s Correct Coding Initiative (CCI) determines bundling standards.
• Do not report slow-pay issues until 45 to 60 days after you have submitted the claim and you have received confirmation that the claim is being processed.
• TMA copies the physician on any letter sent to a health plan regarding his or her HFL.
• TMA generally processes HFLs within two to four weeks of receipt. TMA cannot guarantee a response from the health plan.

Using the Form
• Use the current HFL form available on the TMA website (or opposite page).
• Fill out the HFL form completely and legibly.
• Give a brief description of the hassle on the form. If you need to include a more detailed description, attach it to the form.
• You may use one form to submit multiple hassles that address the same issue and are from the same health plan.
• Use separate forms to submit multiple hassles that are dissimilar in nature or are similar but from different health plans.
• Use separate forms to submit hassles from different TMA physician members.
• All HFLs require attachments to be processed.

Attachments
Attachments should contain only the protected health information (PHI) that is relevant to the patient(s) for whom a physician is submitting an HFL. Physicians should delete all other patient information from the attachments. TMA will return to the practice any HFLs that have non-pertinent PHI.

Examples of frequently needed attachments are:
• CMS-1500 claim forms;
• Remittance notices (e.g., EOBs, RAs, R&S reports) with definitions of comment indicators and/or denial messages;
• Copies of relevant prior correspondence to and from the health plan, including appeal letters and/or denial letters;
• Reports for proof of timely filing (e.g., batch acceptance reports from the payer or clearinghouse showing the payer accepted the claims);
• Operative notes/medical records;
• Patient insurance identification cards;
• Preauthorization/Referral forms.

Informational Only HFLs
TMA adds the following types of HFLs to its database as “informational only”:
• The HFL was submitted to TMA expressly for “informational only” purposes.
• The claim currently is being appealed with the health plan for the first time.
• The claim is for services older than 12 months.
• The physician office failed to follow up timely on the claim.
• The information submitted is a copy of a complaint filed with the Texas Department of Insurance.
• The hassle is not clear, legible or understandable.
• The HFL contains unclear issues and/or conflicting information.
• Physician billing errors are construed as payer hassles.
• The HFL lacks appropriate attachments.

For your convenience, TMA’s Hassle Factor Log is available in two formats – an online version and a downloadable PDF. Both formats can be found at www.texmed.org/hasslefactorlog.

You must have a TMA member number to submit an HLF form and a log-in user name and password to access the online version. To receive your member number and/or log-in information, contact the TMA Knowledge Center at knowledge@texmed.org or call 800-880-7955.
Physician Name ____________________________ TMA Member # ________________

Specialty ____________________________ Address ____________________________

Date Submitted ____________________________ Contact Person ____________________________

E-mail __________________________________ Phone ____________________________ Fax ____________________________

Name of Insurance Company ____________________________ Amount in Dispute ________________

Name of Network ____________________________________________________________

Request in relation to (circle one):

- Commercial HMO
- Medicaid (TMHP)
- Medicare Advantage Plan
- Third Party Administrator

- Commercial PPO
- Medicare (TrailBlazer)
- PBM (Pharmacy Benefit Manager)
- Tricare

- Medicaid (HMO)
- Medicare Part D - drug plan
- Class Action Settlement
- Workers’ Comp

Type of problem (circle all that apply):

- Appeal Pending
- Excessive Telephone Hold Time / Busy
- Preauthorization

- Bundling (list specific codes):
- Filing Deadline
- Quantity Billed Amounts

- Inaccurate Data Entry by Insurer
- Referral Denial

- Medical Record / Documentation Requests
- Claim Denial

- Non recognized/Incorrect/Omitted CPT, HCPCS, Modifiers
- Claims/Documents Lost

- Overpayment/Refund Request
- Downcoding

- Payment Delay
- Out of Network Payment

Other (specify):

Brief Description of the Problem (required):

________________________________________________________

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________________________________________________________

Important: To achieve optimal results utilizing the Hassle Factor Log (HFL) Program, please review the HFL User Guide for complete program guidelines. The most current version of the form and user guide may be obtained at www.texmed.org/hasselfactorlog. For HIPAA privacy compliance, a one-time business associate agreement (BAA) must be on file with TMA before submitting any protected health information (PHI). TMA/HFL program is not responsible for missed claims and/or appeal deadlines.

Any questions, need a BAA? Contact: (800) 880-1300, ext.1414.

A limited license to reproduce this form has been granted to TMA members, state medical societies, and national medical specialty societies.

Internal use only: Processed date: ____________ Entry date: ____________
In one of this year’s most successful Travis County Medical Alliance (TCMA) fundraisers, the Diamond Disco Ball Gala held on Saturday, February 11, 2012 at the Downtown Omni raised a record-breaking $49,750 in underwriting.

With fabulous themed drinks like Solid Gold-Tinis, delicious food, dazzling disco dancing and an amazing silent auction – and of course, who could forget Drs. Jack Carsner and Matt Roberts’ disco attires – the 2012 TCMA gala was sensational. This year’s event raised more than $44,000 after expenses for local non-profit, health related organizations. Grant recipients include: Austin Smiles; Camp Braveheart; Lifeworks Street Outreach for Homeless Youth; St. Louise House; UT School of Nursing Children’s Wellness Center; People’s Community Clinic and Volunteer Healthcare Clinic.

A special thanks to gala attendees, TCMA Dancing Queen and Gala Chair Lara Norris and the Gala Committee for organizing a spectacular event, as well as to Vice President of Financial Development Melissa Smith and the Diamond Disco Ball Gala sponsors.

Community Service Update
Amy Roberts, Julie Schlitt, Berenice Craig, along with other TCMA Board members have been visiting local non-profit, health related organizations to explore the possibility of adding new community service projects next year.

So far these opportunities include projects at St. Louise House, People’s Community Clinic and Austin Relief Nursery.

Upcoming Events
April 17 – General meeting at Umlauf Sculpture Garden and Museum: Presentation of Grants and Volunteer of the Year

April 29 – Family picnic with TCMS at Mayfield Park
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15307 JOSEPH DRIVE  $444,000
Exquisite details and meticulously maintained landscaping set the tone for this lovely home in the Preserve at Lakeway. With 3 bedrooms and a study on the main floor, this home features a guest suite and additional living room with built in bar & cabinets on the second story. The backyard is designed for private relaxation with covered patios, a cozy fireplace and arbor.

211 CANYON TURN TRAIL  $5,250,000
Santa Barbara style home to be built by New Austin Homes by Terry Polston on estate sized 1.5 acre waterfront lot in Rough Hollow. This delightfully conceived home by Cornerstone Architects maximizes the stunning views of Lake Travis. Home may be built as drawn or plans can be re-designed to suit your needs. Lot alone priced at $650,000.

Whether buying or selling, let’s make the move together.

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Michelle Jones, REALTOR®  Multi-million dollar producer
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Shigella:
The number of shigella cases reported in 2011 (n=319) is the highest it has been in over a decade. The Austin/Travis County Health & Human Services Department (A/TCHHSD) is providing this information to ensure that area physicians are aware of recent developments to facilitate public health efforts in our community.

Local Surveillance
Preliminary 2011 data shows the number of shigella cases increasing dramatically in the Fall of 2011. Individuals most impacted by shigella in 2011 seem to be children ages 1-3 and 4-8 years old. Overall, cases of shigella by gender are almost exactly even. More detailed review of the data shows, however, differences by age group for each gender. Cases among younger males and older females are reported with more frequency than their similarly aged counterparts.

Of note, in 2011 10% (n=32) of all cases did not have an onset available to include in Figure 1. Any cases with an onset before 2011 are also not included.

Recommendations for Physicians
Please consider laboratory testing for shigellosis if patients present with watery or bloody diarrhea. The CDC recommends that when many persons in a community are affected by shigellosis, antibiotics are sometimes used to treat only the most severe cases. Antidiarrheal medications can potentially make the illness worse and should be avoided.

If you have any questions or to report suspected or confirmed cases of shigella, contact the Disease Surveillance Program in the A/TCHHSD Epidemiology and Health Statistics Unit directly at 512-972-5555.

Recommendations for Patients
To prevent shigellosis and the spread of illness to others:
- If you or your child has symptoms of shigella, see your physician.
- Stay home if you or your child is ill.
- Practice good hand washing and personal hygiene practices.
- If you are ill, do not prepare food for others.

For additional Information:
Visit the City of Austin website at www.austintexas.gov/department/epidemiology-and-disease-surveillance.
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Chairman and CEO, The Doctors Company

The Doctors Company and Advocate, MD have officially joined forces. With the addition of Advocate, MD, we have grown in numbers, talent, and perspective—strengthening our ability to relentlessly defend, protect, and reward our 71,000 members nationwide. To learn more about how we can protect your livelihood and reputation with our medical professional liability program, call (800) 686-2734 or visit us at www.thedoctors.com.

We relentlessly defend, protect, and reward the practice of good medicine.
Retired Membership is granted to those physicians who have retired from the active practice of medicine. Upon nomination from the Board of Ethics, the TCMS Executive Board elected the following to Retired Membership:

Robert E. Connor, MD
Paul K. Stansberry, MD

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

Arthur J. Farley, MD
Alex S. Hill, III, MD

TMLT Trust Awards Program
Enroll now in TMLT’s Trust Awards Program. This financial reward program is funded and distributed annually by TMLT’s Board of Trustees dependent upon the financial performance of the Trust. A $100 million has been set aside for policy holders who enroll in 2012.

The new program is a “nest egg” contributed to solely by TMLT with funds distributed at the time of retirement, disability or death.

To learn more about the program or to sign up:
• Visit www.tmlt.org/trustrewards
• Email customerservice@tmlt.org
• Call 800-580-8658 ext 5050

At the October 21, 2011 annual meeting and election of the TMAIT Board of Trustees, Kimberly Carter, MD, was reelected to a final three-year term.
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• Post Surgical Wounds
• Diabetic Foot Ulcers
• Decubitis Ulcers
• Lymphedema

Medicare and most managed care plans accepted
This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. 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 physicians’ defensibility. The ultimate goal in presenting this case is to help physicians practice safe medicine. An attempt has been made to make the material more difficult to identify. If you recognize your own claim, please be assured it is presented solely to emphasize the issues of the case.

**Presentation**

A 66-year-old man came to an internal medicine physician with a complaint of shuffling gait. He had a complex medical history, including a history of stroke. The internal medicine physician referred the patient to a neurologist. Before the patient’s scheduled appointment with the neurologist, the patient was admitted to the hospital with increasing weakness of the lower extremities. A cardiac work-up was completed and cardiac insufficiency was diagnosed.

**Physician action**

Two weeks after the initial referral, the neurologist saw the patient. A neurologic examination was documented as hyperreflexia of the lower extremities (later this was reported to be a transcription error and should have read hyporeflexia). Also noted on the exam was decreased sensation in both feet. Differential diagnosis at this time included chronic polyneuropathy with a suspicion for chronic inflammatory demyelinating polyneuropathy and normal pressure hydrocephalus (NPH).

The neurologist ordered lab work, nerve conduction studies and a lumbar puncture. The neurologist noted that he would call the patient’s cardiologist to discuss stopping the patient’s warfarin before the lumbar puncture. There is no documentation of a phone call between the neurologist and the cardiologist. Before the lumbar puncture could be done, the patient developed a viral illness and was admitted to the hospital under the care of a hospitalist.

Following this hospital stay, the patient returned to the neurologist. The neurologist dictated a letter to the patient’s internal medicine physician and the patient’s cardiologist that nerve conduction studies showed decreased reflexes and that a lumbar puncture had been scheduled.

During his deposition, the neurologist stated that he instructed the patient and family to stop the warfarin; however, these instructions were not documented in the medical record.

The lumbar puncture under fluoroscopy was completed as an outpatient procedure at a local hospital. The patient did not report any problems to the neurologist during a post-procedure phone call. There was no mention in the medical record about the patient’s warfarin. The hospital records did not include any discharge instructions given by the neurologist or the hospital staff.

Seven days after the lumbar puncture, the patient returned to the neurologist. Analysis of the spinal fluid revealed protein 40mg/dL; WBC 18 (100 percent lymphocytes); and glucose 51mg/dL. The neurologist confirmed the diagnosis of Guillain-Barre Syndrome with cervical canal stenosis. The neurologist recommended treatment with IVIG. There was no documented review of the patient’s current medications or a documentation of a discussion about restarting the patient’s warfarin.

Following this visit to the neurologist, the internal medicine physician saw the patient. Documentation from this visit did not include any discussion of the patient’s medications.

Before the patient could be started on the IVIG treatment, he suffered a stroke and died.

**Allegations**

Lawsuits were filed against the internal medicine physician and the neurologist. The allegations were based on the patient’s discontinuation of warfarin and the failure of the physicians to address restarting the medication. The plaintiffs claimed this was the cause of the patient’s CVA and death.

**Legal implications**

During the investigation of this claim, there was considerable disagreement about the discontinuation of the patient’s warfarin. The neurologist stated that he instructed the patient to hold the warfarin for only a few days before the lumbar puncture. The internal medicine physician, home health records and the family all agreed that the warfarin was stopped approximately two weeks before the procedure, as instructed during the patient’s first visit.

The neurologist’s medical records did not make any reference to the patient’s warfarin.

**Risk management considerations**

Documenting the review of current medications at each office visit is good practice. This gives the physician the opportunity to identify compliance or noncompliance with medication plans. Both the neurologist and the internal medicine physician saw the patient after the procedure and had an opportunity to determine that the warfarin had not been
Complex medical problems, multiple medications and a compliment of medical specialists may result in confusion for patients and their families. This can lead to noncompliance with the medical management plan. In this closed claim, the discontinuation of warfarin to facilitate a lumbar puncture may have contributed to the patient’s subsequent CVA. Communication between providers and patients is essential to ensure compliance. Documentation in the medical record of special instructions and patient/family understanding of them is important in the defense of insured physicians.

Disposition
This case was settled on behalf of the neurologist. The case against the family physician was dismissed.

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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Inflammatory bowel diseases (IBD) such as ulcerative colitis and Crohn disease make the bowel (intestine) inflamed, irritated, swollen and unable to function in a healthy way. Ulcerative colitis affects the large intestine (the colon) and the rectum but does not involve the small intestine (the part of the bowel that connects the stomach to the colon and that is responsible for almost all the body’s food digestion and absorption of nutrition). Crohn disease affects both the small intestine and the colon.

Ulcerative colitis is found almost equally in men and women and tends to appear in young adults, although it can be diagnosed at any age. Ulcerative colitis occurs in families in approximately 2 percent to 5 percent of cases, which is a higher frequency than expected by chance, meaning that it sometimes has an inherited (genetic) pattern. The main symptom of the disease is bloody diarrhea, and a person who has this symptom is usually referred to a gastroenterologist, a doctor who specializes in the management of digestive disorders.

Signs and Symptoms

- Diarrhea, which may be bloody
- Rectal bleeding
- Abdominal pain and cramping
- Anemia
- Weight loss
- Arthritis, mouth sores, skin rashes and eye inflammation may accompany ulcerative colitis in some individuals.

Diagnosis and Testing

Medical history questions focus on bowel habits and other possible reasons for gastrointestinal (GI) symptoms. Physical examination looks for these other causes of GI problems, as well as for joint, mouth, skin and eye symptoms.

Complete blood cell count and blood chemistries may be ordered, looking for anemia (low red blood cell count) and other abnormalities, including those from dehydration.

Stool specimens are usually examined to exclude infectious causes of diarrhea or bleeding.

Colonoscopy uses a lighted flexible instrument, inserted through the rectum, to look at the inner surface of the colon. Biopsies (samples of colon tissue sent to the laboratory) may be taken to confirm the diagnosis and to exclude infections or other GI problems with similar symptoms.

Other tests, including x-ray tests of the GI tract or computed tomography (CT scan), may be done.

Treatment

Medications including aminosalicylates (drugs related to aspirin), steroids, immunosuppressive agents and other anti-inflammatory medications are often used alone or in combination to reduce injury to the lining of the colon.

Anxiety and depression should be treated if present. It is common to have these mental health issues along with any chronic disease. Stress reduction techniques may also help to reduce intestinal symptoms, even though stress is not a cause of the disease.

In more severe ulcerative colitis, consultation with a surgeon may be necessary. Removal of the involved part of the colon, called a colectomy, may be required if treatment with medications does not help.

Individuals who have ulcerative colitis may have an increased risk of developing colon cancer.

For More Information

National Institute of Diabetes and Digestive and Kidney Diseases
www.niddk.nih.gov
Crohn’s & Colitis Foundation of America
www.ccfa.org
### Classifieds
Call 512-206-1245.

#### Opportunities

**Physician Opportunity:** Board certified family medicine physician opening at an established practice near Bee Cave & Loop 360 to see patients 5 yrs and up. Monday–Friday from 7:30 am–4 pm starting mid-Feb or early March 2012. Three years experience in family practice desired. Excellent benefits and hours with a great family practice. Email CV to staff@innovativemds.com.

**Registered Respiratory Therapist** (RRT) needed to run a CPAP compliance clinic and DME program at an accredited sleep center. Fax resume to 512-918-0361.

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**Psychologist** specializing in CBT (Cognitive Behavioral Therapy) for insomnia management needed at an accredited sleep center. Fax resume to 512-918-0361.

**Marketing Opportunity:** An accredited sleep center is seeking an experienced person in marketing to build their practice. If interested, please fax your resume to 512-918-0361.

**Physician Opportunity:** Experienced preventive-medicine-oriented family physician who wants to move or relocate in Austin, Texas, and take over an active existing practice. Start date: on or after August 22, 2012, with a 4 to 6 month transition period. Office hours: Monday through Friday, 9 to 5 with telephone call one night per week and one weekend out of every four. Hospitalists cover hospitalized patients. Most insurance plans accepted. Patients include children 2 years and older and all ages of adults. Send an email to tcms@tcms.com with FP Opportunity in the subject line or fax CV to 512-450-1326.

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**For Sale/Lease:** Medical offices near Seton–2,500 to 4,000 sq/ft. Negotiable. Call 512-263-2200.

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**EQUIPMENT**

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