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Ray Callas, MD
Anesthesiologist in Beaumont, Texas

Trust Rewards statements were mailed out in April to enrolled policyholders, which showed the amounts that were allocated to their accounts. For the first quarter, these amounts ranged from $250 to $15,000.

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"A Blue Sunrise" (Why we love Spring in Texas). Photo by Jeffrey Lasa, MD.
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On the cover.
Big Sur, California.
Photo by Paul Keinarth, MD
I have also been preparing my paper for and the hospital. But for the past two weeks, operations and a bit of extra time in the office checks in on how I'm doing. She knows that legacy of those dots travels with me as Di of decades later on the road to Grapevine, the found that it was often better for me to sleep edge of the lane warning us of my drifting. We would be driving by Braille, the dots at the drowsy and have a "prolonged blink." Soon I drives off the island, I would frequently get from the hospital in Galveston. On longer would fall asleep at traffic lights driving home couple – I was often so tired after call that I dates back to our days as a young married case when I drive, Diane is a bit nervous. This Surgical Society meeting. As is often the drives up to Grapevine, TX for the Texas surgical examination.

It is 9 am on a Friday and Diane and I are driving up to Grapevine, TX for the Texas Surgical Society meeting. As is often the case when I drive, Diane is a bit nervous. This dates back to our days as a young married couple – I was often so tired after call that I would fall asleep at traffic lights driving home from the hospital in Galveston. On longer drives off the island, I would frequently get drowsy and have a “prolonged blink.” Soon I would be driving by Braille, the dots at the edge of the lane warning us of my drifting. We found that it was often better for me to sleep and leave the driving to Diane. Here, a couple of decades later on the road to Grapevine, the legacy of those dots travels with me as Di checks in on how I’m doing. She knows that my days have been pretty taxing lately – caring for patients with some long, complex operations and a bit of extra time in the office and the hospital. But for the past two weeks, I have also been preparing my paper for presentation to the Surgical Society.

New members are “encouraged” to give a talk as their introduction into the Society. The presentation can be about anything. Some speak about an aspect of surgical history – “Hunter Holmes McGuire: Stonewall Jackson’s Surgeon-The Rest of the Story,” others about societal issues – “Should Physicians Own Hospitals?” The community surgeons usually present case reviews while surgeons from large academic centers review their institution’s experience with management of one problem or another. I chose to review my experience of treating patients with liver cancers without doing a surgical resection. Most of these patients are not candidates for a resection with curative intent. Their liver is most often in too poor a condition to tolerate loss of the amount of normal liver it would take to resect the cancer. Also, they are not candidates for a liver transplant due to age, co-morbid condition, or lack of insurance. There are a few options left to treat this group of patients and I have been changing the way I have treated them over the last few years. A review of this seemed to be a good idea.

Pulling up the names and dates of the operations was easy with the EMR my group had been using since 2006. Then the real work began. I created a datasheet and logged birthdates, age at diagnosis, age at treatment, treatment type, co-morbid conditions, etc. Complications, recurrences of the cancer, and deaths were also recorded. For information not found in the EMR, I turned to collaborating medical oncologists and to the tumor registries at Seton and St. David’s. I remembered doing retrospective reviews like this as a resident and as a fellow – I just didn’t remember them taking as long or being this laborious.

After putting the data into the spreadsheet, I was actually able to have a bit of fun. The data tracked how my practice habits had changed over the last six years and showed how I was really doing caring for my patients. It was revealing. The patients I had treated with a certain technology – radiofrequency ablation (RFA) – had a 27% incidence of local recurrence of their cancer with all but one having cancers that were larger than 3.5 centimeters. This was identical to the data from large cancer centers which, in general, noted a 30 percent local recurrence rate for that type of treatment. In 2009, I had switched to using a microwave ablation system and, for larger tumors, began working with interventional radiologists to perform a tandem treatment involving chemoembolization (performed by the interventional radiologists) and microwave ablation. To my surprise, the patients treated with the combination therapy have experienced no local recurrences more than two years post-treatment.

Prior to this study, I had a general impression of how my patients were doing with these treatments. I think we all have a feeling for how our patients do under our care. I would even tell my patients that the complex procedures I might propose for them represented the best care available anywhere. But, truth be told, that was only an impression. Until I took time to examine the results, I did not know the whole truth.

We are entering a time where the outcomes of our care will be scrutinized by third-parties and this will, in part, determine what we are ultimately allowed to do and how we will be paid for our work. The difficulty and risk is that the third parties may not know what metrics are meaningful. For example, our group was recently notified by an insurance provider that their review of our care for their patients with colon polyps revealed that our cost was higher than the community norm. In fact, patients ended up paying several times the norm when we provided their care. As it turns out, the company’s number for the cost of taking care of a patient with a polyp was based on an outpatient colonoscopy procedure to remove the polyp. Since the only patients referred to our group with benign polyps

continued on page 8
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are those for whom colonoscopic removal is not possible, all of our polyp patients require an open or laparoscopic colon resection. They all undergo a general anesthetic and have at least 2-5 days of in-hospital care. There is no way that the cost of surgically removing an affected segment of colon can reasonably be compared to the cost for a colonoscopic polypectomy. If compared on an apples to apples basis, the costs and outcomes for our group are in line with both community and national norms. However, we had been judged incorrectly because the appropriate question was not asked and the correct treatment was not examined. We, and the patients in that insurance plan who wanted to come see us, were punished as the company unwittingly compared apples to oranges.

Being judged on our decisions and our outcomes is good and it is necessary. Our patients deserve excellent care, and appropriate scrutiny will move us toward excellence. As advocates and guardians of our patient’s best interest, we need to be the first to examine what we are doing. Do our treatments work? What should we change? We have, through our training, learned how best to judge the outcomes of our care. If we do not do it ourselves, someone else will – and they might not ask the right questions.

Examinations are good and we should seek opportunities to conduct them. They will benefit us, they will benefit our patients and they will lead to more efficient and effective care.

My recent examinations have been revealing. Things have become clearer. There are other areas that I need to check and I guarantee that there is at least one thing about something you do that would benefit from an examination. The next examination for me will be a colonoscopy; I am 50. Perhaps after that I’ll look into my outcomes with laparoscopic pancreatectomies.
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The Travis County Medical Society Executive Board has been working to create new programs aimed at enhancing the value of TCMS membership. The TCMS Purchasing Program and TCMS Auto Program are the newest additions to its member benefits.

**TCMS Purchasing Program**
Through the TCMS Purchasing Program, members may save money for their practice through access to negotiated group pricing on a variety of services ranging from office supplies to medical waste disposal.

The TCMS Purchasing Program utilizes the technical and operational resources of CriticalConnection Doctor Purchasing, Inc. (Doctor Purchasing), a group purchasing organization originally established to support the community health record of a non-profit cooperative of Central Texas physicians.

Through the TCMS Purchasing Program, any TCMS member can now benefit directly from the negotiated volume discounts. In addition to direct member savings, Doctor Purchasing shares its vendor rebate revenue with the Travis County Medical Society and the CriticalConnection Central Texas Cooperative in furthering the Society’s programs and the Coop’s community health record.

“The Travis County Medical Society is excited to sponsor this program that offers great savings for necessary everyday supplies and services for our members,” said TCMS Chief Operations Officer Belinda Clare. “As health care operation costs continue to rise, this program is a great tool that will help our members save money.”

Current vendors in the TCMS Purchasing Program include Time Warner Cable Business Class, Office Depot, Verbatim Transcription, MedSharps, Marshall Shredding Co., COCARD, the Weston Group and CriticalConnection Mortgage Lending. Additional vendor relationships are continually being explored and added based on customer demand and feedback.

For more information on the TCMS Purchasing Program, email tcmspurchasing@tcms.com or call 512-697-2606.

**TCMS Auto Program**
The TCMS Auto Program is a no-cost concierge service designed to spare TCMS members the aggravation and hassle normally associated with the purchase of a new or pre-owned vehicle.

“By purchasing your next car through the TCMS Auto Program, you will receive personal service and favorable, negotiated pricing,” said Hornbeak. “Whether it’s your dream car or a gift for a family member, I will make sure you get the best rate in an honest manner with no sales pressure.”

Participating dealers currently include Acura, BMW, Fiat, GMC, Toyota, Jeep, Mercedes-Benz, Lexus, Dodge, Land Rover, Jaguar and Chrysler with more being added. The TCMS Auto Program is open to all TCMS members as well as their families and staff.

For more information, visit www.tcms.com, or contact Phil Hornbeak at phornbeak@tcms.com or 512-949-5758.
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A combination of poorly informed government decisions created a medical emergency for thousands of dual-eligible Texans and the physicians who care for them. “Dual-eligible” patients qualify for Medicare because of their age or disability. They also qualify for Medicaid assistance because of their income. Steep budget cuts now threaten their care — and may force some doctors to close their doors.

**Background:** Until January of this year, the federal government (Medicare) paid 80 percent of a dual-eligible patient’s visit to a doctor. The other 20 percent of the cost was paid by Texas Medicaid. The state Medicaid program also paid the Medicare deductible for these patients. This year the Medicare deductible is $140.

Under the new guidelines which went into effect Jan. 1, 2012, Texas Medicaid no longer pays the physician the patient’s 20 percent coinsurance. Nor does Medicaid pay the full $140 annual deductible if Medicare’s payment for a service exceeds Medicaid’s allowable. Because Medicaid physician fees are so low, this is almost always the case. And to make matters worse, both Medicare and Medicaid had computer glitches in their payment systems. As a result, some physicians have not received one cent since January for the care they provide to these vulnerable patients.

**Who it affects:** More than 320,000 dual-eligible patients and the doctors who care for them.

TMA President C. Bruce Malone, MD, told the Texas Health and Human Services Commission the new guidelines “penalize the physicians who care for the sickest and frailest Medicare patients. They hit particularly hard practices in rural, inner-city, and border Texas, as those practices serve a disproportionate number of dually eligible Medicare patients. In addition to compromising the financial viability of these practices, we fear that the rules could result in fewer physicians willing to set up a practice in the communities that most need them.”

**Action needed:** Texas physicians and their patients call on state leaders to take emergency action to help dual-eligible patients. The state Legislative Budget Board is the only entity that can mitigate or halt cuts when the legislature is not in session. Please add your name to the Medical Emergency Petition today. Share it with your colleagues, friends and family.

**Preserve access to care for Texas’ most vulnerable patients. Sign the petition.**

http://www.ipetitions.com/petition/medical-emergency/

If you practice medicine in Texas, you can’t afford not to be politically engaged.

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Health Information Technology

E-Prescribing Penalties and Incentives

Texas physicians have until June 30 to e-prescribe to avoid a 1.5 percent penalty on all 2013 Medicare Part B claims. If you do not already e-prescribe in your office, now is the time to begin. If you do not already use an electronic health record (EHR) system with e-prescribing capabilities, you can install a stand-alone e-prescribing system and still meet the approaching deadline.

Physicians must report e-prescribing via claims using G-code G8553 on at least 10 unique Medicare encounters by June 30 to prevent the penalty. Three prescriptions for one patient encounter will count as only one e-prescribing incident.

Report at least 25 times by December 31 to qualify for a 1 percent bonus of Medicare Part B claims

Incentive

Report at least 25 times by December 31 to qualify for a 1 percent bonus of Medicare Part B claims and prevent the penalty in 2014. Follow the instructions in the 2012 e-prescribing informational paper found on the TMA’s website, e-mail hit@texmed.org or call the TMA HIT helpline for more information at 800-880-5720.

If you need help with e-prescribing, turn to the Texas regional extension centers (RECs). RECs provide support to physicians to help with e-prescribing, EHR selection, workflow analysis, staff training, EHR incentives and much more. Visit TMA’s Texas REC Resource Center for more information or contact the CentrEast REC at centreast@tamhsc.edu or 979-436-0390.

The Centers for Medicare and Medicaid Services (CMS) has offered the e-prescribing incentive since 2009 to encourage the use of e-prescribing to improve the efficiency and safety of health care. E-prescribing is a way to prevent medication errors that arise due to difficulties in reading handwritten prescriptions.

If you plan to apply for the Medicare EHR incentive in 2012, note that you can’t receive the e-prescribing incentive in the same payment year. Physicians enrolled in the federal Medicare EHR incentive program can still be penalized in 2013 if they do not report 10 e-prescriptions via claims using G-code G8553. Physicians applying for the Medicaid EHR incentive are still eligible for e-prescribing incentive payments.

2012 Penalty

Physicians who did not e-prescribe and report the G-code at least 10 times by June 30, 2011, or did not apply for and receive an exemption are currently being penalized 1 percent of their Medicare Part B claims. Physicians who act this year will be made whole in 2013. There is no formal appeal or informal review process for the 2012 penalties. Physicians may submit all inquiries to the QualityNet Help Desk for CMS examination. Physicians may contact the help desk via e-mail at qnetsupport@sdps.org or via telephone at 866-288-8912 from 7 am to 7 pm Monday through Friday.

HIT Tools and Resources at Your Fingertips

TMA works diligently to give you the tools you need to tackle the challenges of technology. Whether you need help selecting an EHR or understanding the EHR incentive program or information on e-prescribing, TMA has the resources. You can find links to these tools and more on the TMA website at www.texmed.org/hit/.

If you have questions about these health information technology (HIT) tools and resources, or if you need additional help, contact the TMA HIT Helpline at HIT@texmed.org or 800-880-5720.
I WAS AFRAID CANCER MEANT I COULDN’T HAVE CHILDREN.

SARAH, 33, TWO-TIME BREAST CANCER SURVIVOR, WITH HER DAUGHTER

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For more information visit LIVESTRONG.org/yourpatients

LIVESTRONG
TCMS and TCMA installed the 2012 officers on March 29, 2012 at the Westin Hotel, Austin. Over 200 TCMS members and their guests were present to honor the 2012 TCMS President R.Y. Declan Fleming, MD and the 2012-2013 TCMA President Mrs. Lydia Soldano.
It wasn’t more than 15 years ago that the foundations of social networking were launched. In 1997, AOL Instant Messenger gave users the ability to relay messages from one computer to another in real time. That year, sixdegrees.com launched allowing profile creation and friend listing. Fast forward to five years later and sites like Friendster and MySpace pioneered the world of online communication with real-world friends. In 2004, Facebook was created in a Harvard University dorm with intentions of connecting US college students. Four years later, the site revolutionized the way people across the world communicate, share information and build/maintain relationships. Through the years, the success of social media has led to the creation of numerous sites, such as LinkedIn, Twitter, Pinterest and Instagram that draw millions of users each day.

Physicians voice many valid concerns, fears and reasons they prefer to keep their names offline. Many are wary that online patient engagement could lead to liability and privacy issues. Others simply choose to avoid the added time commitment. However, not having a social media presence can leave a doctor behind the times and hinder professional and/or a practice’s reputation. Before logging off from social media completely, consider the opportunities that could be missed:

**Control.** Just because you haven’t put yourself online, doesn’t mean you’re not there. Your name and contact information are probably listed on a “Yellow Pages”-type site or a physician directory, such as the TCMS online physician search. With review and location sites like Google Places and Yelp, physicians who remain anonymous online run the risk of someone else setting up a business page for them.

Therefore, you’re better off taking control and creating your own page.

**Communication.** Social media presents a unique opportunity to make people aware that physicians truly care what their patients think. An online presence offers communication and feedback. Worried about offensive complaints? People are less likely to leave negative comments when they know the doctor they’re complaining about will see it. People will also say those things regardless of whether you are online, but being online allows you to see and respond to these complaints and concerns.

**Recommendations.** Medicine is personal, and people trust the recommendations from their peers and community. If a patient has a good experience, they’re likely to sing your praises as soon as they leave your office through social media. If they can’t find you online, they probably won’t make the recommendation, which could reach and affect countless people who would come across it. In addition, a patient looking for a new physician will probably use a search engine. Without an online presence, your name is getting lost in the crowd, or more likely landing at the bottom of the search.

**Leadership.** According to an April 2011 survey by the National Research Corporation, a health care research firm based in Lincoln, NE, about 20 percent of patients already use social media to find health care information. However, since anyone can post, the information isn’t always accurate. You have the ability to be an educator and a leader by relaying credible information. There’s an opportunity to share, teach and impact people with knowledge and experience that go beyond the walls of a physician’s office.

**Efficiency.** Giving patients online access to initial visit paperwork, as well as videos and information about your background, your practice and common medical issues, can all lead to a more efficient visit and increased patient satisfaction. Help your patients take action to make the most of their time spent in the exam room.

Social media should be used with caution and boundaries. Social media can be a great and powerful tool to interact with colleagues, patients and the community. Embrace the dual-citizenship, limit your personal accounts to friends and family, create a clear boundary for your patients with professional accounts and check privacy settings weekly. Don’t miss out on the opportunities presented by social media by staying ahead of the learning curve.

If you have questions regarding social media, contact TCMS Communications Coordinator Shahar Gurvitz at sgurvitz@tcms.com or 512-206-1219.

For examples of TCMS members’ use of social media, visit:

- Dr. Owen Winsett’s Blog: http://drwinsett.blogspot.com/
- Dr. Rocco C. Piazza’s Facebook Page: http://www.facebook.com/PIAZZAplasticsurgery
- Dr. J. Alex Martinez’s Twitter: www.twitter.com/AustinAllergies
- Dr. Georgeanne Freeman’s Twitter: www.twitter.com/DowntownDr
TCMS/TCMA Joint Family Picnic
On April 29, families of the Travis County Medical Society and Travis County Medical Alliance gathered at Mayfield Park for a picnic and family activities such as face painting, music, family photos and a rock wall. The park provided shade on a sunny day and a beautiful backdrop of turtle ponds and peacocks.

Save the date for the next TCMS Family Social for a private viewing of Pixar’s “Brave” at the Alamo Drafthouse on Sunday, June 24 at 3 pm.

Retired Membership
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:

Barry L. Horowitz, MD
Albert E. Meisenbach, III, MD

To recognize outstanding science educators and ensure their students have the learning tools they need, Dr. Ernest and Mrs. Sarah Butler of Austin donated $500,000 to the TMA Foundation’s Ernest and Sarah Butler Endowment for Excellence in Science Teaching. The Butlers established the endowment in 1998 to support the awards, which annually recognize an elementary, middle and high school teacher for highly effective methods of engaging students in the sciences. This generous contribution brings their endowment to more than $1 million.

Call for Applicants for Leadership Austin Essential Class of 2013
The curriculum of the Essential Class focuses on regional issues, leadership skills and the building of strong networks to encourage innovative, collaborative solutions to the Central Texas’ challenges.

The class is targeted to individuals who have already gained experience in civic leadership roles which contained a moderate level of uncertain elements, complex problems, diverse constituents and projects requiring as long as 1-3 years to complete.

Participation in the Essential Class offers an opportunity to be part of a unique nine-month experience during which you will learn a great deal about yourself and about the many communities that comprise Central Texas. In addition, you will make lifetime friendships with individuals representing the diversity of the region. Application deadline is June 11.

For more information, visit www.leadershipaustin.org/programs/essential, email info@leadershipaustin.org or call 512-499-0435.

Who will Lead Texas Medicine into the Future?
If you are age 40 or under, or in the first eight years of practice, the Texas Medical Association Leadership College (TMALC) can put you on the path to becoming a leader for the house of medicine. The leadership college is now accepting applications for the TMALC Class of 2013. Application deadline is July 13, 2012.

TMALC was established in 2010 as part of TMA’s effort to ensure strong and sustainable physician leadership with organized medicine. TMALC graduates serve as thought leaders who can close the divide among clinicians and health care policymakers, and as trusted leaders within their local communities.

To learn more about TMALC and the application process, go to www.texmed.org/leadership. The new class starts in Austin on October 19, 2012, and completes at TexMed in San Antonio, May 17-18, 2013.
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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Volunteer of the Year – Mari Josey

Lydia Soldano  
President, Travis County Medical Alliance

Congratulations to Travis County Medical Alliance Volunteer of the Year, Mari Josey! A Houston-native, Mari attended Hollins University in Roanoke, Virginia where she received her Bachelor’s Degree, as well as a Master’s Degree in Psychology. After completing school, Mari worked as a counselor. Mari met her husband, Robert, an orthopedic spine surgeon in high school, and they have been happily married for 14 years. They have three children Taylor, 10, Lila, 9, and Travis, 6.

Mari joined the TCMA in 2004, and since then, has held numerous leadership positions including Chair of the Holiday Luncheon. Most recently, Mari served as VP Membership on the Executive board, as well as an extra term to fulfill the new VP Membership-Elect position. She has spent countless hours at various Alliance and Society events in effort to attract new members. Mari graciously opened her home to the Alliance last fall for the November General Meeting and has hosted the Annual Board Retreat at Tarry House for two consecutive years.

When Mari is not busy with her family, serving with the Alliance or traveling, she volunteers with other community projects. Recently, Mari ran a large fundraiser at St. Andrew’s Episcopal School and served on the board at All Saints’ Episcopal School. Mari is truly an outstanding volunteer in our Alliance and our community.

Thank you Mari for giving so much to all of us in your time, dedication and friendship!

Join today!

TRAVIS COUNTY MEDICAL ALLIANCE

Community Service
The Umlauf Sculpture Garden and Museum was the perfect venue to host our seven grant recipients and hear about each of these organizations.

The 2011 – 2012 grant recipients are Austin Smiles, Hospice of Austin, LifeWorks, Peoples Community Clinic, St. Louise House, UT Children’s Wellness Center and Volunteer Healthcare Clinic.

During the meeting, the Community Service Committee was able to collect school supplies and backpacks for the Volunteer Healthcare Clinic’s annual Back-to-School event.

Once again, the Alliance joined efforts with the Travis County Medical Society at the annual AISD Physicals/Immunizations event on April 12 & 17 at the Delco and Burger Centers. Approximately 300 students are now ready to participate in next year’s extracurricular activities. Thank you to our volunteers who gave of their time helping students through each station of the physicals!

Membership
Thank you to everyone who attended the March New Member event at the Mean Eyed Cat. The Alliance is excited to welcome new and potential members. Currently, TCMA has approximately 293 members, and we always need YOUR help recruiting more. Remember, all Travis County Medical Society members and their spouses are eligible for membership in our Alliance. Visit our website at www.tcmalliance.org.

Consider bringing a prospective TCMA member to our upcoming TCMS event:

Sunday, June 24: Family Social, Alamo Drafthouse, Pixar’s “Brave” at 3 pm.

Lydia Soldano
President, Travis County Medical Alliance

Mari accepts the Volunteer of the Year award from TCMA past president Vickie Blumhagen.
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– Aeschylus

Stanley S. Wang, MD, JD, MPH, has a unique skill set both educationally and professionally. He is a trained physician and attorney. In addition to being a practicing cardiologist with Austin Heart, Dr. Wang serves on the Texas Medical Board, as director of the Sleep Disorders Center at Heart Hospital of Austin, as a specialty society delegate to the Texas Medical Association’s House of Delegates and as an active member of the Travis County Medical Society. When he finally finds a spare moment, he enjoys spending time with his family at home, or at one of Austin’s many great restaurants or music venues. Dr. Wang also enjoys songwriting and has compiled several CDs-worth of music ranging in genres from classical to contemporary.

“I try to capture the doctor-patient relationship in song,” said Dr. Wang. “I have written several pieces about the care of a patient who is having a heart attack. There is something inherently emotive about heart disease that makes it such a meaningful subject for any art.”

As one of only two board certified sleep medicine-cardiologists in Central Texas, Dr. Wang explains that sleep disorders are directly linked to heart disease. He believes that modern day health care should include monitoring a patient’s diet, exercise and sleep, and in 2008 the American Heart Association agreed as it publicly recognized in a consensus document that sleep disorders play a significant role in cardiology.

“Sleep apnea is not only associated with sleepiness and motor vehicle death, it also causes major cardiovascular problems and significantly increases the risk of heart attack, stroke, hypertension and death,” said Dr. Wang.

Dr. Wang began his medical career long before medical school. Growing up, he worked in his father’s practice and observed firsthand the interaction between a doctor and his patients.

“My father, himself a retired cardiologist, was the one who first encouraged me to become a physician,” he said. Through this experience, Dr. Wang also saw the gratitude and appreciation of his father’s patients which amplified his aspirations to become a physician.

As advice to physicians who recently entered the field, Dr. Wang emphasizes to always remember to put the patient first by making good medical decisions, as well as through counseling and communicating with patients.

“Good bedside manners and physician-patient relationships are not only important for the patient’s experience, they have been shown to enhance the effectiveness of therapies and reduce the likelihood of complaints and litigation when bad outcomes occur, even when they are unavoidable,” he said.

In addition to the practice of medicine, his father also inspired Dr. Wang to get involved in advocacy and make a meaningful impact beyond direct patient care. He served as chair of the TMA Medical Student Section during medical school, and has been an active member of the Travis County Medical Society and Texas Medical Association since his return to Texas in 2008 after post-graduate training at Duke and University of North Carolina. Dr. Wang’s persistent dedication to organized medicine is also motivated by the people and mission of the medical society.

“We all have an obligation to advocate for our patients on a higher level, beyond the bedside or exam room. Organized medicine provides an important and incredibly effective way to do this,” said Dr. Wang. “I think organized medicine in general, and TMA and TCMS specifically, serve such a vital role in legislative and regulatory activism on behalf of our patients and colleagues.”

Dr. Wang encourages new colleagues to join TCMS and TMA and become active in organized medicine as it can go beyond helping fulfill personal goals, both professionally and socially. He adds that through his involvement with TMA and county medical societies, he has made lifelong friends with fellow physicians who now also serve as sources of consultations and referrals. Dr. Wang credits these relationships with the development of his career within organized medicine which has provided him the opportunities to serve multiple positions on both the county and state levels.

“Whether it’s walking around the Capitol with our home group on First Tuesdays or communing at TMA conferences, I always feel like I have a great group of friends to support me and with whom I can work as a team to advocate for our patients,” said Dr. Wang.
Harold Wayne Brumley, MD passed away peacefully on January 31, 2012 surrounded by family.

Born in Memphis, Texas in 1932 to Raymond and Florence Brumley, Harold grew up in Austin, graduating from Austin High and the University of Texas. In 1953, he married Marilyn Lyles and began his medical career at the University of Texas Medical Branch in Galveston before doing his residency in obstetrics and gynecology at Kansas City General Hospital. In 1962, he returned to Austin where he practiced medicine for the next 46 years, and along with Marilyn, raised their four children in a loving, adventurous home until her death in 1995.

During his years in practice, Dr. Brumley delivered a good part of an entire generation of new Austinites into the world while providing cutting edge and compassionate care for his patients. Later in his career he devoted his practice to helping women with fertility problems, becoming a pioneer in an emerging field that included in vitro fertilization, a procedure which at that time was in its infancy. He was active in leadership roles in area hospitals, the American Cancer Society, the Travis County Medical Society and its Blood Center during its early years. He volunteered countless hours helping indigent women in his office and at clinics and hospitals around Austin and training a new generation of doctors.

In the late 1970s, Dr. Brumley looked at an obscure, thickly overgrown corner of Lion’s Municipal Golf Course and turned it into a vision that became West Austin Youth Association (WAYA). For several years he begged, borrowed and encouraged much of West Austin, as well as UT and city officials, into making his vision come true - sometimes being found on a bulldozer between surgical cases or in the dead of night trying to clear the raw parcel of land himself if a workman failed to do it fast enough during the day. Since it opened, WAYA has served countless Austin youths, giving them and their families a place to play and congregate in a positive way.

In 1999, Harold married Kay Willis Smith and entered a new phase in his life. Harold will be remembered for his generosity, playful sense of humor, hospitality and energy that endeared him to patients, family, his childrens’ friends and an amazing group of friends and colleagues by whom he was beloved.

Cleto Elequin, Jr., MD passed away on January 19, 2012. Dr. Elequin was born in Antique, Philippines and moved to the US in 1957 to complete his medical training. On May 1, 1963, Dr. Elequin proudly became a naturalized citizen. He graduated from Far Eastern University in April of 1957 with a Doctor of Medicine. He served as an intern at Good Samaritan Hospital in Lexington, KY and completed his residency in psychiatry at Danville State Hospital and Delaware State Hospital in 1963. Dr. Elequin relocated to Austin in 1973 when he accepted a position as Deputy Commissioner of MHMR for the state of Texas and later opened a family practice. During his retirement, he volunteered his services as a psychiatrist and physician through many venues.
In 2011, the *Austin Business Journal* recognized the Travis County Medical Society as a Health Care Hero for the TCMS / AISD Athletic Physicals program. Now in its fourteenth year, the community service project, sponsored by the TCMS Public Relations Committee, continues to be a worthwhile endeavor with AISD Student Health Services to provide free athletic physicals to students who are uninsured or have financial restrictions and other barriers to health care. For many of these students, this is the only time they see a physician for a well-visit.

Physicians from numerous specialties were joined by 65 volunteer nurses and school health assistants from Children’s / Austin ISD at the Burger and Delco Activity Centers over the course of four nights in April and May to examine over 600 students. Volunteers from the Travis County Medical Alliance and the *Lend a Hand* program at The Blood and Tissue Center of Central Texas also volunteered their time as crowd control and chaperones.

In addition to physical exams, the Travis County Medical Alliance through the TMA Be Wise - Immunize project supported the onsite immunization clinic for middle school students. The clinic continues to assist AISD in bringing down the vaccine delinquency rate for the school district.

TCMS sends gratitude to the more than 80 physicians who volunteered their time. A number of them volunteered for multiple days and/or shifts. Also, thank you to the Alliance and TCMS Friends of the Society: Austin Radiological Association and the University Federal Credit Union. Their generosity provided financial and in-kind donations to provide healthy snacks and water for the students.

Without the generosity of TCMS physicians, nurses, non-medical volunteers and corporate sponsors, the Society could not continue to offer this program. Thank you for your continued support!
2012 Athletic Physicals Volunteer Physicians

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Micaela Aleman, MD
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Barbara L. Bergin, MD
Robert E. Blais, MD
Sheila D. Boes, MD
James R. Brown, MD
Richard C. Bryarly, MD
Michael W. Burris, MD
Erin Chaffe, MD
C. Mark Chassay, MD
Esther J. Cheung-Phillips, MD
Vanessa L. Chiapetta, MD
Vineet Choudhry, MD
Lisa K. Clemons, MD
Thomas B. Coopwood, MD
Bianca Marie Davenport, MD
John P. Dice, MD
Andrea Michelle Diebel, MD
Steven B. Dobberfuhl, MD
James R. Eskew, MD
Marion M. Forbes, MD
Wesley D. Foreman, MD
Liam M. Fry, MD
Binaca Gaglani, MD
A. Paiman Ghafouri, MD
B. Seth Goldstein, MD
Vivek J. Goswami, MD
David D. Grayson, MD
Tara Greendyk, MD
Kristen M. Hawthorne, MD
Isabel V. Hoverman, MD
E. Elizabeth Howard, MD
Amy Hunt, DO
Mark H. Hutchens, MD
Anand Joshi, MD
Parviz K. Kavoussi, MD
Pradeep Kumar, MD
Win W. Kyu, MD
Daniel J. Leeman, MD
John C. Luk, MD
Christopher R. Manees, MD
Kristy M. Marsillo, DO
Christine Mathew, MD
Catherine B. McCoy, MD
John E. McDonald, Jr., MD
Hillary Miller, MD
Kenneth W. Mitchell, MD
Hector E. Morales, MD
Beth W. Nauert, MD
William R. Otto, MD
Ojas Piyush Patel, MD
Enrique B. Pena, MD
Stephen J. Pont, MD, MPH
Anuradha Prabhu, MD
Tara Ramirez, DO
Raju M. Reddy, MD
Rhetta A. Reed, MD
Paul E. Round, DO
Stuart A. Rowe, MD
Nadia A. Sabri, MD
M. Catherine Sargent, MD
W. Randall Schultz, MD
Kenneth M. Shaffer, MD
Ronald B. Shapiro, MD
Sheila X. Shung, MD
Sarah I. Smiley, DO
Allen Sonstein, MD
Joseph L. Spann, MD
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Elliot J. Tresler, MD
John M. Uecker, MD
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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 37-year-old man came to the emergency department (ED) complaining of chest pain. The pain was located in the left anterior chest region, and began 30 minutes before he arrived in the ED. The patient reported that he felt weak and sweaty.

Physician action
The patient was triaged immediately. An emergency medicine physician evaluated him and began cardiac protocol. An IV was started, and the patient was given an aspirin and sublingual nitroglycerin every 5 minutes for 15 minutes. The patient’s EKG was interpreted as borderline normal with no acute ischemic changes. The chest x-ray was reported as clear. Lab work was ordered.

The patient continued to have considerable chest pain, described as non-radiating and located in the left anterior chest area. He was given 4 mg of morphine intravenously with minimal response. Approximately 40 minutes later, he was given 30 mg of Toradol intravenously. A second EKG was performed. Thirty minutes passed and the patient was still experiencing significant pain. He was given 8 mg of intravenous morphine. Shortly after receiving this dose of morphine, the patient’s discomfort was greatly relieved.

The emergency medicine physician reported that the second EKG showed no changes, although the patient developed mild bradycardia. The lab work indicated normal chemistries and normal cardiac enzymes. Due to the difficulty in alleviating the chest pain, the emergency medicine physician ordered a CT of the chest to rule out a pulmonary embolism. The CT was reported as normal.

The patient was now reporting that his chest pain had improved significantly. After a discussion with the patient about obtaining a cardiac evaluation, the emergency medicine physician called a cardiologist and scheduled a stress test for the patient. Approximately four hours after presenting to the ED, the patient was discharged with a diagnosis of atypical chest pain. He was advised to take aspirin and to return to the hospital if the pain recurred.

Early the next morning, the patient was found gasping for breath. His wife called EMS. The paramedics documented that the patient was in asystole and apneic. He was immediately intubated, started on oxygen and given drugs to stimulate his heart. CPR was initiated. After eight minutes, the patient regained a heartbeat and spontaneous respirations. He was transported to the hospital. Upon arrival, he was found to have had a full cardiac arrest. He was posturing and had a seizure, which suggested some hypoxic cerebral damage.

The cardiac arrest resulted in a 23-day hospital stay that included a cardiac catheterization and angioplasty with stents. The patient was sedated and remained intubated during the early part of his hospitalization.

At discharge, the patient was alert, communicative, in good spirits and looking forward to returning to work. His discharge diagnoses included ventricular tachycardia and fibrillation; cardiac arrest; anoxic encephalopathy; and acute inferior wall myocardial infarction status post emergency angioplasty and triple stenting of the right coronary artery. The patient was released to cardiac rehab and instructed to follow up with the cardiologist and a neurologist to monitor his seizure activity. The patient eventually returned to work, but claimed he could not perform as well due to his cognitive deficits and inability to concentrate.

Allegations
A lawsuit was filed against the emergency medicine physician. The allegations included failure to order serial 12-lead EKGs; failure to seek a cardiac admission for 23-hour observation; and failure to order diagnostic testing, including serial cardiac enzymes. It was alleged that the patient would not have suffered a cardiac arrest and anoxic encephalopathy if the defendant had more thoroughly evaluated the patient.

Legal implications
The plaintiff’s experts criticized the patient history taken by the defendant. It was “missed” that the patient smoked two packs per day for 20 years. This information was documented by subsequent health care professionals. It was also alleged that the diagnostic work up fell below the standard of care. The emergency medicine physician listed myocardial ischemia or infarction as the first differential diagnosis, but she failed to order a six hour troponin that would have helped rule out that diagnosis. The plaintiffs argued that a patient with severe, continued on page 31
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intermittent pain, a history of tobacco dependency and two abnormal EKGs with dynamic changes should be considered an acute coronary patient in the absence of any other explanation for the symptoms.

Defense experts were generally supportive of the care provided by the emergency medicine physician. However, they agreed that the patient should have been admitted for observation and repeat enzymes. While defense experts were impressed that a cardiology opinion was obtained, given the patient’s history of tobacco use, they felt it would have been prudent to have the cardiologist examine the patient before discharge.

Risk management considerations
Emergency medicine physicians are responsible for conducting a basic evaluation and providing a reasonable assessment of a patient’s medical condition. A thorough patient history is critical to this process; perhaps even more so when a patient complains of chest pain. The fact that the patient was a long-time smoker is a key piece of information affecting treatment decisions. In this case, the patient denied smoking, but his wife stated that he was a 2.5 pack per day smoker. She stated that anyone could tell the patient smoked by standing close to him. Had the emergency physician known this, she would have admitted the patient for observation and requested a cardiac consult. This may have led to a more timely diagnosis.

Using all reliable sources to gather health information—including risk factors—can affect timely treatment and improve patient outcomes.

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

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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**Retinal Detachment**

The retina is a light-sensitive, transparent tissue located in the back of the eye. Light is focused on the retina by the cornea and the lens. The retina then converts the image into neural impulses and sends them to the brain via the optic nerve (the nerve connecting the eye to the brain). Retinal detachment is the separation of the retina from the tissues underneath it. It is important to distinguish retinal detachment from posterior vitreous detachment (in which the jelly in the eye peels away from the retina), which is a natural aging process that occurs in many people. Every year, about one to two people per 10,000 develop retinal detachment. Retinal detachment is a medical emergency.

**Risk Factors**

Nearsightedness is an important risk factor for retinal detachment: 67 percent of people who develop retinal detachment are nearsighted. Other risk factors include retinal detachment in the other eye, cataract surgery, a family history of retinal detachment, uncontrolled diabetes, and blunt trauma to the eye.

**Symptoms**

Symptoms of posterior vitreous detachment may include sudden onset of floaters, bright flashes of light and blurred vision. A small percentage of people with posterior vitreous detachment may develop a retinal tear (the vitreous jelly rips the retina during the process of posterior vitreous detachment), which can progress to a retinal detachment if it is not treated. An increasing area of grayness in one eye (“curtain of darkness”) can mean that a retinal tear has progressed to a detached retina. Patients with symptoms of posterior vitreous detachment or retinal detachment should immediately consult an ophthalmologist (physician specializing in diseases of the eye). The goal is to prevent detachment of the macula (central region of the retina) because this is the portion of the retina responsible for fine, detailed central vision.

**Treatment**

The chances of recovering vision are greater when the retina is repaired before the macula is detached. Most people with retinal detachment need surgery to repair it, either immediately or after a short time. There are several types of surgery used depending on the severity and type of detachment. Patients with tears or small detachments can often be treated in the office with laser surgery, gas bubble injection, or a freeze treatment called cryopexy. Patients with more severe retinal detachment need to go to the operating room, where different types of surgery can be performed to reattach the retina. Once the retina is reattached, vision often improves or stabilizes. A person’s ability to read with the affected eye after surgery depends on whether the macula was detached, how long it was detached, the severity of the retinal detachment and the type of treatment performed.

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