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26 CLASSIFIEDS
With the recent press coverage of Austin Regional Clinic’s decision to no longer accept pediatric patients whose parents choose not to vaccinate, I thought I ought to weigh in on that subject before writing what I intended for the summer edition of the TCMS Journal.

I have a patient with Crohn’s disease who has horrible fistulizing disease of his terminal ileum and his right colon. He’s been exposed to steroids enough that he already has osteoporosis of his hip. So I advise him to use biologic therapy such as infliximab that blocks a key inflammatory mediator, tumor necrosis factor. But he declines, citing his concern over the 2 in 10,000 risk of lymphoma. Therefore, he sits there with abdominal pain and diarrhea on oral budesonide (an enterically topical steroid) waiting for what I believe is going to be an ugly meeting with a surgeon. His refusal to accept what I believe to be a small risk does not cause me to discharge him from my practice.

Vaccines have risks. The most common being a febrile reaction. However, occasional convulsions and even instances of Guillain–Barré Syndrome have been linked to some vaccines. The much hyped risk of autism has never been supported by valid scientific studies. When a family declines vaccines based on a perceived risk profile (even when their estimation of types and frequency of risk is not supported by the data), why then do we agree that they can be discharged from a practice whereas I do not discharge my Crohn’s patient?

Because of herd immunity. Vaccines are not 100% effective and patients that are vaccinated can still be vulnerable to the organism they were vaccinated against. Yet, these people are made safe by ubiquitous vaccination of the entire population that does not allow the organism to easily find a susceptible host or to be readily spread.

Oft ascribed to former Associate Justice of the Supreme Court Oliver Wendall Holmes, Jr. is: “Your freedom to swing your fists ends at my nose.” Meaning freedom of choice, speech or whatever stops when it causes harm to another. Therefore, when a family chooses not to vaccinate their child, they negatively impact the health of the entire community by allowing safe harbor for an infecting organism to reestablish in a population and to be spread more readily. Which is what happened when there was a measles outbreak in Disneyland earlier this year.

Families that refuse vaccines because of a fear or belief that the risks are higher and of a more dire nature than is supported by scientific data are well within their rights. However, the community is also well within its own
rights to isolate itself from those who make these choices. Whether it be state governments, public schools or physician practices, the public has a right to separate and protect itself from those that increase their risk of contracting a vaccine preventable illness.

Now on to what I want to write about—Vacation! I’ve been an avid reader of the “President’s” article of this journal long before I ever wrote one. I recall when Dr. Brian Sayers was president and wrote an essay on vacation that spoke to me. During this summer season, I thought I’d tackle the subject anew.

Some might have seen the Jason Bourne movies starring Matt Damon based on spy thrillers written by Robert Ludlum. The Bourne Identity begins with a man washed ashore on a beach with nonfatal gunshot wounds in his back, a Swiss bank account number tattooed on his arm and extreme memory loss. As his memory slowly returns, Bourne learns he is a competitor to the notorious world class assassin Carlos the Jackal. On his voyage to self-discovery, he creams people and beds women, and my teenage self devoured the book in a weekend. An idiom that Jason Bourne used and one that I’ve taken for myself is that: “Rest is a weapon.”

I’ve always been a believer in time off – vacation – and have guarded it as if it were sacred. I’ve just returned from a two-week break with my family. We went to Seattle then took a cruise through the Inside Passage of Alaska. The scenery was exquisite! While many find vacation restful, relaxing and rejuvenating, I found that the time to reconnect with my family was the most refreshing. Returning from vacation also serves well to view one’s life with a fresh perspective and to appreciate the things we take for granted: a collegial work environment; a rewarding practice; fine friends; climate control; a child-proofed home; available baby sitters; playgrounds; swimming pools with shallow ends; home cooked meals; regular exercise and not paying gratuity on every little thing.

I would encourage all of you to take some time off – especially those early in practice. Let me assure you that if you go away for a bit, your patients will not come to harm, your referring doctors and patients will still choose you and your long-term financial sustenance will not suffer. So just do it, vacate your office for a bit each summer. Remember, “Rest is a weapon.”
TCMS, Minions and Munchkins

What a way to spend a Sunday afternoon! TCMS families attended a private screening of the Minions at the Alamo Drafthouse and were surprised by a visit from Jerry – one of the many minions featured in the movie.

Our next family event is scheduled at Top Golf. Watch your email for details!
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2015 Legislative Wrap Up

Stephanie Triggs
Senior Director, Physician Services and Community Relations

The 84th Legislative Session was very good to medicine due to the partnership of the Travis County Medical Society, Texas Medical Association and other county medical societies. Key to the success of ensuring that physicians can continue to provide their patients the best care, were the relationships physicians and Alliance members built with local representatives and senators. Numerous TCMS and Alliance members gave their time to lobby on behalf of medicine during First Tuesdays at the Capitol with many physicians from Austin testifying before House and Senate committees throughout the session.

As with any session, there are wins and losses. Wins this year included GME funding, Medicaid fraud reform, e-cigarette regulations, tax cuts and red tape elimination. In addition, inappropriate and dangerous expansions of non-physician practitioners’ scope of practice were kept at bay. Failing to win were Medicaid payment increases, some public health improvements and insurance reforms.

Breakdown of Wins

- Graduate Medical Education: Legislators appropriated enough money for the next two-year budget to keep residency slots added in 2013 and to create up to 200 new slots. Senate Bill 18 created a permanent endowment of approximately $300 million to be used solely to help expand GME starting in 2018.
- Medicaid Fraud Investigation Reforms: Senate Bill 207 calls for due process improvements in overzealous Medicaid fraud investigations by the Office of the Inspector General (OIG). The reforms included clarification that “fraud” does not include unintentional technical, clerical or administrative errors, and the OIG is required to give physicians a detailed summary of its evidence relating to the allegation.
- E-Cigarette Regulations: Senate Bill 97 applies many existing state rules on tobacco cigarettes to vapor products, namely barring sales of e-cigs to minors and prohibiting use on public school campuses and at school functions.
- Tax Relief: House Bill 7 eliminates the $200 occupation tax physicians and other professionals pay each year.
- Red Tape Cut: Senate Bill 195 moves the Prescription Drug Monitoring Program from the Texas Department of Public Safety to the Texas State Board of Pharmacy and allows physicians to delegate access to the database to any HIPAA-trained staff member.
- Scope of Practice: No bills passed that would expand the scope of practice of midlevel providers beyond what is safely within their education, skills or training. Almost all of the scope bills were left bottled up in committee. Supported was a bill that will allow emergency medicine technicians to practice in hospitals under the direct supervision of an emergency department physician.
- Budget Included
  - $50 million increase for women’s health
  - $20 million investment for infectious disease prevention and response
  - $11 million for tobacco cessation programs

Other wins included vaccination bills that allow the storage of childhood vaccination records until the age of 26 and provide liability protections to schools, pharmacists and physicians who encourage the unassigned epinephrine autoinjectors on school campuses for use in emergency anaphylactic reactions; a bill that will help practices identify and educate patients who may fall under the 90-day grace period for subsidized plans purchased through the ACA marketplace exchange – ID cards must now include “QHP” (qualified health plans) and a Medicaid bill that allows payment for some home telemonitoring services.

A $1,000 minimum balance for mediation of any out-of-network services from facility-based physicians for any balance due was negotiated down to $500.

Bills Not Passed

- Medicare-parity payment for primary care services in the 2016-2017 state budget
- Parents’ right-to-know bill on vaccine exemptions on school campuses
- Ban on health plans’ use of virtual credit cards to pay physicians
- Statewide ban on texting while driving
- A bill that would allow physicians to prescribe over the phone without establishing a patient-physician relationship
- Removal of the statutory requirement that the Texas Medical Liability Trust insurance is for TMA members only

Vetoed

- Senate Bill 359 that would have allowed a four-hour emergency department hold for mentally ill patients who the physician believe would be of danger to their self or others
- House Bill 225 that would have protected people who seek emergency care for someone suffering from drug overdose from prosecution and would have allowed first responders to administer an opioid antagonist to save someone from fatal overdose

For information on these and other legislative issues, contact Senior Director of Physician Services and Community Relations Stephanie Triggs at stripps@tcms.com or 512-206-1124.

Source: Texas Medical Association
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- Testing only patients with elevated ALT’s may miss 50% of infection
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- Care and treatment can help prevent Hepatitis C-related disease and deaths
Victory for Medicine – The SGR Has Been Repealed!  
What the MACRA Means for Physicians

This year, medicine achieved its biggest victory since the passage of Texas’ 2003 tort reform liability protections. After 12 years and 17 temporary, cut-averting patches, both sides of the political aisle and both chambers of Congress worked together to pass the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, permanently repealing Medicare’s flawed Sustainable Growth Rate (SGR) formula.

MACRA was passed by the US House of Representatives on March 26 by a vote of 392 to 37. On April 14, just hours before a 21 percent pay cut to physicians was set to take effect, the Senate approved the bill by a vote of 92 to 8. The bill was signed into law by President Barack Obama on April 16.

The bill contains sweeping changes for how Medicare pays physicians. It directs the secretary of the US Department of Health and Human Services (HHS) “to establish a Merit-based Incentive Payment (MIP) system under which eligible professionals (including physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists) shall receive annual payment increases or decreases based on their performance.” The MIP program will replace Medicare’s multiple quality reporting programs and make it easier for physicians to earn rewards for providing high-quality, high-value health care.

MACRA also requires “specific incentive payments to eligible participants in an alternative payment model.” This means that HHS will support and reward physicians for participating in new payment and delivery models to improve the efficiency of care while preserving fee-for-service as an option.

In addition, it preserves the current 10-day and 90-day global periods for over 4,000 surgical service codes that Medicare had planned to unbundle.

Here is a chronological list that shows when the legislation’s major provisions go into effect.

2015
• The SGR formula is permanently repealed.
• In lieu of scheduled 21 percent SGR cut for 2015, MACRA provides updates of:
  - 0 percent through June 2015
  - 0.5 percent in July 2015 through December 2019.
• Over 4,000 surgical service codes retain their 10-day and 90-day global periods.
• Provisions of the “Standard of Care Protection Act” prevent quality programs from setting “standards of care” in medical liability actions.
• The MACRA provides quality measure development funding of $15 million per fiscal year, FY 2015 to FY 2019, from Medicare Trust Fund.
• Physicians may opt out of Medicare on a continuous basis, without having to renew their status every two years.
• Members will be appointed to the Physician-Focused Payment Model Technical Advisory Committee, which evaluates alternative payment models (APMs).
• Non-physicians may document their own face-to-face patient encounter under Medicare requirements for durable medical equipment (DME).

2016
• The MACRA provides technical assistance funding of $20 million per fiscal years, FY 2016 to FY 2020, to assist small practices (up to 15 professionals) to participate in APMs and the new Merit-Based Incentive Payment System (MIPS) program.
• Physician groups (as well as individuals) may report quality measures for the Physician Quality Reporting System (PQRS) via qualified clinical data registries (QCDRs).
• A new “Measure Development Plan” sets priorities for new quality measures for MIPS and APM quality reporting.
• Medicare Part D claims must include the prescriber’s NPI number.
• Information blocking by Meaningful Use (MU) professionals and hospitals is prohibited.
• The secretary of HHS must clarify how the “Common Rule,” that protects research subjects, applies to clinical data registries, including QCDRs.
• Qualified entities and QCDRs may have access to Medicare claims data.
• The secretary sets criteria for physician-focused payment models.
• The annual list of MIPS quality measures is due by November 1 of each year.
• The IRS may collect up to 100 percent of Medicare payments due to overdue taxes.
2017
- The secretary begins collecting data on the accuracy of global service packages.
- All physicians are subject to payment adjustments (bonuses or penalties) for their resource use under the Value-Based Payment Modifier (VBM).
- Many federal programs are funded through FY 2017 (September 30, 2017) including the Children’s Health Insurance Program (CHIP), Teaching Health Center GME Payment Program, community health centers, and Medicare-dependent hospitals (MDHs).

2018
- Medicare claims must identify the care episode, patient condition, and patient relationship, to attribute resource use to the appropriate physician or other eligible professional (EP) under the MIPS program.
- Higher income beneficiaries begin paying higher premiums under Parts B and D.
- Separate PQRS, MU, and VBM reporting and penalties sunset on December 31, 2018.
- The MACRA sets a goal of achieving interoperability of EHR systems by the end of 2018 and allows penalties and other consequences if this does not occur.
- The secretary must inform each physician (and other EP) of their upcoming MIPS payment adjustment, at least 30 days in advance.
- A 3.2 percent increase in the base rate for inpatient hospital payments (scheduled for FY 2018 under the AmericanTaxpayerReliefAct of 2012) will instead be phased in at 0.5 percent per fiscal year, from FY 2018 through FY 2023.
- The 2018 post-acute care update is limited to one percent (for skilled nursing and inpatient rehabilitation facilities, home health, hospice, and long-term care hospitals).

2019
- The MIPS program takes effect, consolidating and replacing PQRS, MU, and the VBM.
  - Annual MIPS composite scores include four categories: quality (PQRS) – 30 percent; resource use (VBM) – 30 percent; MU – 25 percent; and clinical practice improvement activities – 15 percent.
  - The annual “performance threshold” is based on the median/mean performance of all EPs for a prior period.
  - The secretary may weight the categories differently.
  - Individual EPs can join “virtual groups” and report together.
  - EPs with substantial revenue from qualifying APMs or with few Medicare claims are exempt from the MIPS program.
  - MIPS EPs include physicians, dentists, podiatrists, optometrists, chiropractors, physician assistants, clinical nurse specialists, and nurse anesthetists.
  - MIPS penalties and bonuses (for scores below or above the annual performance threshold) are on a sliding scale, with maximum MIPS penalties:
    - Up to 4 percent in 2019; 
    - Up to 5 percent in 2020; 
    - Up to 7 percent in 2021; and 
    - Up to 9 percent in 2022 and beyond.
  - MIPS bonuses can go even higher (up to 3 times these levels). But total MIPS bonuses and penalties must balance each other.
  - An extra “exceptional performance” bonus of up to 10 percent is available from 2019 through 2024, up to $500 million each year.

2020
- The payment update under MACRA for 2020 through 2025 is 0 percent, subject to further action by Congress (pursuant to recommendations by MedPAC).
- Medigap plans for new enrollees may not offer “first dollar” coverage; beneficiaries must pay at least the Part B deductible (currently $147 per month).

2021
- The secretary may expand the MIPS program to social workers, psychologists, dietitians, nutritionists, physical and occupational therapists, speech pathologists, and audiologists.
- Medigap plans for new enrollees may not offer “first dollar” coverage. Beneficiaries must pay at least the Part B deductible (currently $147 per month).

2026 and Beyond
- The payment update under MACRA for 2026 and beyond is 0.75 percent for qualifying APM participants and 0.25 percent for all others, subject to further action by Congress.

Sources
Dallas County Medical Society
American Medical Association
New Member Spotlights

Rebecca Teng, MD
A native of Dallas, Rebecca Teng is the daughter of an internist and an ESL teacher. While a Plan II/Spanish major at the University of Texas at Austin, she volunteered as a Spanish interpreter at Austin’s Volunteer Healthcare Clinic, where its intersection of medicine, language and service inspired her to become a physician.

Teng completed her medical degree from the University of Texas Southwestern Medical Center in Dallas and her residency in obstetrics and gynecology at Tufts Medical Center in Boston. In private practice, she was selected as “Rookie of the Year” by Morton Hospital in Taunton, MA.

Even with her success on the East Coast, Dr. Teng never forgot her roots in Texas and Austin, where she had met her husband, Argyrios Saccopoulos, a fellow Longhorn. Joining Central Texas Ob/Gyn Associates, she practices as a generalist Ob/Gyn at Oakwood Women’s Centre at Seton Williamson.

“The preventive care and medical/surgical aspects of gynecology are fascinating,” said Teng. “I also love providing prenatal care and having the privilege of delivering babies. There’s nothing like the joy and excitement of a beautiful delivery!”

Away from work Rebecca enjoys traveling and spending time with family and friends.

Chris Chun, MD
Dr. Christopher Chun calls himself the “black sheep” of his family. Many of his relatives are in the dental field, so choosing a career in medicine made him a bit of a rebel.

Chris spent most of his childhood in the Dallas/Fort Worth area, and attended college and medical school in California where he specialized in anesthesiology and pain management. It was during medical school that Chris met his future wife, Susan. They have two daughters Madeline 10 and Savannah 7 years old.

Returning to Texas in 2009, Dr. Chun founded the Huguley Center for Pain Management near Fort Worth. He later joined a spine practice and helped start Star Medical Center in Plano.

A longtime violinist and singer, Dr. Chun is a big fan of Austin’s music scene and its laid back environment. So, when the opportunity arose to join Pain Specialists of Austin, he and his family headed south.

Dr. Chun says his favorite part of practicing medicine is helping people restore their quality of life by managing their acute or chronic pain. “I use a multidisciplinary approach to pain management which includes medication and a myriad of interventional techniques,” said Chun. “I am a big proponent of education for patients, especially with regard to procedures, injections and realistic expectations.”
James Halgrimson, DO
A native of the Chicago area, James Halgrimson was always fascinated by discovering how things work, especially the human mind. Early in his career he was a research scientist in biochemistry and psychopharmacology, but he wanted to use that scientific knowledge to help patients directly. In 2011, Halgrimson received his medical degree from Des Moines College of Osteopathic Medicine. Residency brought him to Texas where he attended Baylor Scott and White’s Psychiatric Residency Program in Temple.

Dr. Halgrimson finds it rewarding as a psychiatrist to meet patients when they are experiencing their greatest moment of need and working with them to improve. Halgrimson said, “I have the privilege of helping patients overcome their obstacles and learn to cope on their own. I get to see this almost every day.” Halgrimson recently joined NeuroPsychiatric Associates of Austin (NPA).

He finds his own quality of life in Austin by spending time with his wife, Katherine and their first child, a newborn baby boy named Adam. Dr. Halgrimson is also an avid runner and an accomplished guitarist, pianist and singer who can occasionally be seen rocking out on stages around Austin.

Lady Docs Make a Big Splash on Facebook
Lauren Crawford, MD

We often hear physicians talk about how stressful their work can be. For female physicians, additional stresses of managing maternity leave, taking care of children and often being the primary head of the household are present. There are also issues unique to being a woman in medicine such as income inequality. With these in mind, I wanted to create a place on the web where female physicians could go to share information with each other about life and work in the Austin area. Plus, it is simply lovely to have immediate access to a true peer group.

Lady Docs of Austin is a Facebook community exclusively for female MDs and DOs in the Austin area. Members post comments about professional topics – information about hospitals, EMR/software systems, practice management, medical events, medical groups and charitable opportunities. We also share advice and frustrations about personal issues – housing, schools, daycare, nannies, fitness or house cleaning services. Since it’s a closed group, members feel free to be very candid, and any topic is fair game as long as the comments are not offensive and remain true to the spirit of supporting each other.

The response to Lady Docs has been phenomenal. The group started on April 15, and through word of mouth in the medical community it grew to more than 330 members in just one month. We had our first meetup on May 28 with approximately 40 members attending. They filled the room with great energy! There is always room for more. If you are interested in being a part of the community, search for Lady Docs of Austin via Facebook and ask to be added to the group!
Unsung Hero Recipient

The TCMS Unsung Hero Program is designed to recognize the extraordinary abilities and professionalism of practice administrators and office managers within the medical community to assist in delivering quality care to patients.

We congratulate the “unsung hero” of the second quarter Jan Ream, office manager for Austin Internal Medicine Associates. Jan is described by the physicians in the practice as “the glue that holds the practice together.” Jan was recognized with a certificate and gift card and will be entered into a grand prize drawing at the end of the year.

To recognize your “unsung hero,” submit the nomination form found at www.tcms.com to the Society by the last day of each quarter.

For questions, contact Senior Director of Physician Services and Government Relations Stephanie Triggs at striggs@tcms.com or 512-206-1124.

TMAF’s Lawn Party Success

The Texas Medical Association Foundation’s (TMAF) May 1 gala, A Lawn Party, held in Austin during TexMed 2015 raised more than $386,000. Thanks to the leadership of co-chairs Drs. Michelle Berger and David Tobey of Austin and Drs. Susan Pike and Harry Papaconstantinou of Georgetown, the generosity of sponsors and nearly 500 guests, the 22nd annual gala broke previous fundraising efforts.

The donations enable the Foundation to support TMA’s annual award-winning programs such as Hard Hats for Little Heads, the Minority Scholarship Program, Walk With a Doc Texas, as well as dozens of local programs sponsored by county medical societies, Alliances and medical student chapters of TMA.

Learn more about TMAF and the outstanding programs it makes possible at www.tmaf.org.

Adventures of an Ebola Volunteer

The world watched in fear as the Ebola epidemic took thousands of lives in West Africa – threatening to spread in the US and beyond. A recent retiree, TCMS member Joe Spann, MD, knew he was in the perfect position to help. Spann spent 10 weeks volunteering in Ebola Treatment Units in Southeastern Liberia. Along the way, he chronicled his experiences via email for family and friends back home. Now, Dr. Spann has published those occasionally humorous and often heart wrenching tales in a book titled Letters from Liberia: The Adventures of an Ebola Volunteer.

The book includes many photos Spann took while in Liberia. He plans to give away copies of the book, and while he’s asking for a $10 donation in return, he says he’ll refund the money to anyone who doesn’t like it. It’s certainly not a money making venture for him. Spann says “In the unlikely event that my book actually makes a profit, I will be sending the money back to Liberia to help with the tuition for Rose, a Liberian midwife who wishes to become an Ob/Gyn doctor and Reuben, a Liberian nurse who wishes to become a psychiatric nurse.”

Letters from Liberia can be found online at www.amazon.com.
What happens when you give children everything they ask for? They get spoiled, of course. Any parent can tell you that.

The problem is that you’re trying to raise children to (eventually) be responsible adults. Part of this is teaching them that you can’t always win, you should always share, and you can’t always get what you want.

Most kids don’t like it. (I know I didn’t.) They only see that the candy or toy they want is being refused and don’t grasp the long-term plan of growing up to be a decent person. Across a thousand human cultures, any parent would agree.

But the same principle doesn’t seem to apply in modern health care. What would you think is more important in a hospital: competent staff or having a beverage offered to you after being checked into the emergency department?

Sadly, things like the latter seem to be winning because of the recent emphasis on patient satisfaction scores. In today’s world, 30% of a hospital’s Medicare reimbursement is based on these scores. That’s a lot of money.

Unfortunately, quality of care doesn’t necessarily have the same meaning between doctors and patients. The former will say it means you left the hospital with a good outcome. The latter will agree but also will throw in things like whether they got enough pain meds or their call light answered fast enough. If you’re having chest pain or severe dyspnea, getting that call light answered quickly is pretty important. But if all you want is a soda or for someone to hand you the TV remote … not so much.

The problem is that the patient satisfaction surveys (and yes, speed of call-light response is on there) don’t take that key point into account. What might make some patients happy isn’t necessarily in their best interest. The post-CABG patient who wants a double cheeseburger won’t be thrilled if he gets a salad instead. Another patient in for detox won’t be pleased if she doesn’t get Dilaudid on demand. A third will be angry that he’s not allowed to smoke. Those refusals are an integral part of their successful treatment and recovery plan, but they may not see it that way. And they’ll be sure to mark it on the survey.

As a result, the hospital gets penalized in spite of the fact that they’re doing their best to provide quality care. And the business-minded CEOs, who generally have no medical background, only care about this part of it.

Measuring what counts is important. But the idea that hospital care should be held to the same standards as Burger King and Walmart is fundamentally flawed. The things that are done in hospitals – cut people open, draw blood, biopsy bone marrow, put in endotracheal and feeding tubes – aren’t intended as recreational experiences. We try to make them as painless as possible, but in health care “do no harm” often means doing some harm in order to prevent a catastrophe.

The side effects of chemotherapy are (hopefully) offset by the successful treatment of cancer. But that doesn’t mean hair loss, nausea, vomiting, diarrhea, and other toxic symptoms are part of “customer satisfaction.” One study even found that the most satisfied patients had the highest mortality.

We owe patients the very best care we can give them, but they also need to understand that “best care” doesn’t always mean what they want in the short term. We’re focused on a goal that’s beyond the immediate horizon.

Dr. Block has a solo neurology practice in Scottsdale, AZ. Reprinted with permission of Internal Medicine News.
IN MEMORIAM

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

George Michael Decherd, IV, MD, a third-generation Austin physician, passed away on May 12 at age 79. Dr. Decherd excelled intellectually at an early age - reading many literature classics as a young child, graduating from Austin High School at age 15 and from the University of Texas at age 18. A childhood friend recalls time spent playing with him and his brothers in central Austin in the 1940’s around the UT campus, the old Clark Field, Waller Creek and surrounding areas as a time of great fun and adventure. He went on to graduate from the UT Medical Branch at Galveston, completed his training at Temple in Philadelphia and the Cleveland Clinic and served our country as a medical officer in Korea. He returned to Austin in 1965 and was cofounder of Austin Urology Associates, practicing until his retirement at age 65. His brother, TCMS member Dr. Jonathan Decherd, recalls him as a voracious reader, a man of profound intellect and curiosity, possessing almost an encyclopedic fund of knowledge but concealing it with humility and humor. Dr. Decherd retired to his farm in Fredericksburg where his hobbies included cultivating wildflowers and a variety of wildflower seeds. He is survived by his wife Mary, five children and grandchildren, as well as brother Jonathan and his wife, Holly.

Arthur J. Farley, MD, passed away June 17 at age 74. A native of Iowa, Dr. Farley spent much of his life in Houston where he graduated from Bellaire High School and the University of Houston. He received his medical degree from the UT Medical Branch at Galveston. In the years that followed, he did his internship at Moffitt Hospital in San Francisco, residency in child, adolescent and adult psychiatry at UCLA and served two years in the Army at Fort Lewis, Washington. In 1976, Dr. Farley and his wife Harriette moved back to Houston where he practiced psychiatry and psychoanalysis for the next 36 years until his retirement in Austin in 2012. He was very active in a number of specialty society leadership positions during his career and helped establish The New School at the Heights, an innovative school providing a specialized educational experience for “children with good or superior intelligence whose social-emotional delays interfere with success in school and life.” Dr. Farley was an enthusiastic sportsman, enjoying hunting, fishing and kayaking. He is survived by his wife of 51 years, two daughters and three grandchildren. A grateful memorial written for Dr. Farley noted, “Art saved my life years ago through therapy when I was a teenager, and I have never forgotten the caring and devotion he showed me during my time of difficulty…I would not be the person I am today if I had not met him.”

James Edsel Risinger, MD, 80, passed away on June 17 at his home with his loving wife at his side. A native Texan and highly respected radiologist with Austin Radiological Association, much of his early life centered around military service. In 1956, Dr. Risinger joined the US Air Force, beginning a distinguished career as a pilot. During the Vietnam War he volunteered for a top secret squadron, Fast Forward Air Controllers, piloting F100s. With the call sign “MISTY,” he was pilot #32 among the elite group of 157 pilots, eventually flying 53 missions and receiving decorations that included the Silver Star, the Distinguished Flying Cross with 4 oak-leaf clusters and the Air Medal with 13 oak-leaf clusters. After Vietnam, Dr. Risinger received his medical degree in San Antonio followed by a radiology residency with the US Navy at the Naval Regional Hospital in Oakland where he met his wife Juliette “Mimi” Schmidt, a Navy nurse. Retiring from the military, he practiced radiology in Austin from 1980 until his retirement in 1999. In retirement he recounted his experiences from Vietnam days in a book, Misty, published in 2003. A member of Christ Church, Dr. Risinger’s faith played a major role in his life. In the days following his passing, this remarkable man was described many times with adjectives including patriot, hero, friend, man of faith, skilled physician, colleague, friend, family man. He is survived by his wife of 32 years, son Ed, and two grandchildren.
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Central Texas may feel like a healthy place to live, however our rate of childhood obesity remains strikingly high with approximately one third of our kids challenged with being overweight or obese. When we look at more economically challenged areas the rates are even higher. Some schools in Austin ISD have rates as high as two thirds of children being overweight or obese! There are a lot of resources in Austin and value healthy living, so we can and should be doing better. While we definitely need more healthy opportunities and service providers in Central Texas, a good number of opportunities are already available. How can we connect our patients with the opportunities that do exist?

I’m excited to let you know about a new, great and free resource that just launched in Central Texas. “IT’S TIME TEXAS” and Dell Children’s Texas Center for the Prevention and Treatment of Childhood Obesity have partnered to create and launch the Choose Healthier app and website – www.choosehealthier.org. Additional generous financial support for this project was provided by H-E-B, Blue Cross and Blue Shield of Texas, Texas Health and Human Services’ SNAP program, the RGK Foundation and the Seton Healthcare Family’s Family and Child Obesity 1115 Medicaid Waiver Project.

The Choose Healthier app provides hyper-localized information on health promoting programs, activities and events in and around the Austin area. Just open the app or visit the website then enter a zip code or use your phone’s location, and you’ll immediately see a number of healthy opportunities. The app is available in the Apple store and Google Play store and is free to download. The goal of the app is twofold as we hope to provide a resource that can be used anywhere in Central Texas: (1) to connect people with available healthy opportunities and (2) to identify areas that do not have access to healthy opportunities, but who continue to have need and interest, so that we can work with partners to make healthy opportunities available in these areas as well.

Once the app is downloaded, you can filter activities based upon a number
of options, including activity type (physical activity, health & wellness and food & nutrition); level of activity (beginner through expert); audience (kids through seniors); distance from your location and price. We have worked hard to include many free activities, low cost opportunities and classes that offer a free trial period. Your help is needed to continue to identify more! If you attend a boot camp, aerobics class, healthy cooking program or mindfulness workshop let them know we’d love to list their activities in the app!

This is version 1.0, the first ever release, so we definitely hope to make further adjustments and enhancements based upon the feedback received. If you would like more information about Choose Healthier, to order free promotional cards, to see our Choose Healthier health professional promotional video and to get involved, please visit www.itstimetexas.org/choosehealthier.

In addition to the development and launch of the Choose Healthier app and through funding from the 1115 Medicaid Waiver project, the Dell Children’s based childhood obesity center has expanded substantially over the last 18 months. Program expansions include our multidisciplinary, childhood obesity clinic ACES (Activating Children Empowering Success); clinician-led group and individual family-based programs that address nutrition, physical activity and behavioral health for kids aged 2-6 years called Healthy PIECES (Parenting Intervention for Early Childhood, Education and Skill-Building); for kids 6-12 years, there’s Healthy Living Happy Living and for teenagers there’s TEEN (Teens Empowered for Exercise and Nutrition). Moreover, we have expanded our health and wellness initiatives at Dell Children’s and in the community. Soon a primary care provider learning collaborative addressing childhood obesity in primary care clinics will be established. In addition to training and resources, this initiative will provide American Board of Pediatrics Maintenance of Certification (MOC) quality improvement credit.

Don’t Forget to Choose Healthier!
Dell Medical School at the University of Texas at Austin officially announced on June 29 that it has received preliminary accreditation from the Liaison Committee on Medical Education (LCME), opening the door for students to submit applications for the school’s charter class to begin in June 2016.

Part of what sets Dell Medical School apart is an innovative medical curriculum and a new approach to medical education. Susan Cox, MD, executive vice dean for Academics and chair of the medical school’s Department of Medical Education, shared some of what makes the curriculum unique.

TCMS: How does Dell Medical School’s curriculum compare to other medical schools?

Dr. Cox: As we develop and refine our curriculum, the focus is on innovation and creativity. Our ground-breaking curriculum is designed to train and support physician leaders who are as comfortable taking on transformational health challenges as they are caring for patients. It also pulls from the most creative and effective teaching practices nationwide and adds new innovations to ensure that our students get an education that reflects the challenges of modern medicine.

The curriculum is fully integrated and will take full advantage of the Dell Medical School’s unprecedented connection with its community. For example, students will have longitudinal primary care experiences, during which they follow patients through specific providers and clinical sites to gain greater insight into the prevention and management of disease and chronic health issues over time. They will also work in interprofessional teams on community service projects.

TCMS: What are some specific examples of unique elements of the curriculum?

Dr. Cox: With a focus on student-centered learning and problem-solving skills, students will learn in small groups that function as teams. Students will have the opportunity to help guide and shape their own education by identifying learning objectives and managing their approaches to achieving those objectives. The first class of 50 students will be divided into two societies – encouraging community and collaboration for the students in this intense curriculum – and groups of five students will be matched with physician mentors who will follow them over their entire student experience.

From day one, electronic health records will play a part in the curriculum, giving students a thorough understanding of an important component of clinical life that until recently has largely been overlooked in medical school preclinical years.

Significantly, medical students will also become very familiar with other health care professions and their contributions to high-quality and safe patient care, so they will more easily gravitate toward team-based health care and instinctively work collaboratively with other professions. Signature Integrated Interprofessional Activities are designed to immerse medical students in community and clinical experiences throughout the entire four-year curriculum. Designed and delivered in collaboration with other schools on the UT Austin campus, medical students will work in small teams together with nursing, social work and pharmacy students to address important health care issues and challenges. The focus is on developing skills related to communication, teamwork, ethics, values, roles and responsibilities.

Among the most important signature elements of the curriculum is the third year experience, known as the Innovation, Leadership and Discovery Year. Students will have the option to work on projects related to care delivery redesign, population health and informatics or more traditional research.

Dell Medical School Curriculum Breakdown:

Year 1: Scientific foundations for medicine. Curriculum is integrated and accelerated with problem-based or case-based small group sessions and interactive large group sessions.

Year 2: Clerkship experiences focused on health care delivery, patient safety and interprofessional team-based care.

Year 3: Innovation, Leadership and Discovery year focused on care delivery redesign, population health and informatics with an option to pursue a research-based project or a dual degree.

Year 4: Internship level experiences, clinical electives, community service and capstone.
Students will get a one-of-a-kind immersion into fields influencing medical practices and design strategies to improve health and will produce a quality improvement project focused on providing benefit to the community. They also will have the opportunity to pursue a dual degree, including a master’s in business, public health or biomedical engineering. The focus is on training students to become future medical leaders, and they will be encouraged to take individualized paths to that leadership.

**TCMS: How was the curriculum developed? What and who influenced the direction?**

**Dr. Cox:** Creation of the curriculum was a team effort and we owe a big thanks to our collaborators. More than 250 UT Austin faculty, Austin-area physicians, directors of residency programs, education experts and others played a role in developing this signature curriculum. All efforts were focused on taking full advantage of the opportunity to create a curriculum from scratch, without legacy programs that might delay innovation and change. In late 2012, former UT Provost Steve Leslie created a steering committee to help guide development of the curriculum. Several committees and task forces worked on different elements, and processes were formed to ensure a successful accreditation and expedited timeline for admitting the first class of Dell Medical School students. We really have created something singular here at UT, and our community can be proud of that.

**The October 1 implementation of ICD-10 is just around the corner and with it comes a recent announcement from the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) regarding a 12 month “grace period.”**

This grace period does not delay implementation of the ICD-10 billing and coding system. On the day of implementation, you must use ICD-10 codes on claim forms and an ICD-10 code from the right family of codes. Medicare as well as other payers will not pay if you don’t use ICD-10 codes beginning October 1.

In the words of TMA President Tom Garcia, MD, the grace period is “a giant burden slightly eased.” It gives practices and Medicare payers time to adjust to the new system and work out problems without threat of crippling payment delays or penalties for physicians.

**CMS Grace Period Facts:**
- For 12 months starting October 1, Medicare will not deny claims solely on the specificity of the ICD-10 diagnosis codes as long as the physician submitted an ICD-10 code from an appropriate family of codes.
- To avoid potential problems with mid-year coding changes in CMS quality programs (Physician Quality Reporting System, value-based payment modifier and meaningful use) for the 2015 reporting year, physicians using the appropriate family of diagnosis codes will not be penalized if CMS experiences difficulties in accurately calculating quality scores. CMS will continue to monitor implementation and adjust the duration if needed.
- CMS will establish an ICD-10 Ombudsman to help receive and triage physician and provider problems that need resolution during the transition.
- CMS will authorize advance payments if Medicare contractors such as Novitas Solutions are unable to process claims within established time limits because of problems with ICD-10 implementation.

In addition to the grace period, CMS is setting up a communication and collaboration center for monitoring the implementation of ICD-10 to quickly identify and initiate resolution of issues that may arise.

**Resources for Implementation:**
- CMS ICD-10 Resource Center - www.cms.gov/Medicare/Coding/ICD10/
- Clarifying Q&A Related to Grace Period - http://go.cms.gov/1S0X4Pi
- Road to 10: The Small Physician Practice’s Route to ICD-10 - www.roadto10.org/
- TMA ICD-10 Resource Center - www.texmed.org/ICD-10/

**Sources:**
Centers for Medicare & Medicaid Services
Texas Medical Association
Noninvasive Prenatal Testing

Noninvasive prenatal testing (NIPT) can help detect certain chromosomal abnormalities in a developing fetus.

Most DNA is contained within cells, but a small amount circulates freely in the bloodstream. During pregnancy, a small percentage of cell-free DNA in a woman’s blood is from the placenta and usually matches the DNA of the fetus. With NIPT, cell-free fetal DNA can be examined for evidence of aneuploidy (an extra or missing chromosome). For example, NIPT can be used to look for Down syndrome, which is caused by an extra copy (trisomy) of chromosome 21.

When is NIPT Used?

Noninvasive prenatal testing is not a routine prenatal test, which means it is not automatically performed during pregnancy. It is usually offered when a pregnant woman has an increased risk of having a child with aneuploidy. The American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM) recommend the test when

- A woman will be aged 35 years or older at the time of delivery
- A routine prenatal test result is positive for aneuploidy
- A woman has a history of pregnancy with fetal trisomy
- An ultrasound shows a fetal abnormality that could be caused by aneuploidy
- A parent has a history of certain chromosomal abnormalities

The ACOG and the SMFM do not currently recommend NIPT as a first screening test in low-risk or multiple pregnancies. Scientists continue to study NIPT, but its accuracy has not yet been demonstrated in large numbers of women in these groups.

If your doctor recommends NIPT, you will need to have a sample of blood drawn. The test is done after the 10th week of pregnancy, and results are usually available in about a week.

Noninvasive prenatal testing is accurate for detecting trisomy 21 and trisomy 18 (Edwards syndrome) in high-risk pregnancies but is less reliable for trisomy 13 (Patau syndrome) and sex chromosome abnormalities like Turner syndrome and Klinefelter syndrome.

Even though NIPT is very good for detecting certain trisomies, a positive result is not used for diagnosis. This is because in certain conditions, cell-free fetal DNA may not exactly match the DNA of the fetus. If you have a positive result, it is usually recommended that your doctor perform a follow-up test to confirm the result.

Cell-Free DNA and Cancer

In patients with cancer, some cell-free DNA comes from cancer cells that have died and released their mutated DNA into the bloodstream. Recently, scientists have been studying ways to use this tumor DNA to detect and monitor cancers.

A study in the July 14, 2015, issue of JAMA reports on how NIPT was used to detect maternal cancer. For some women, an abnormal NIPT result was due to an undiagnosed cancer.

The authors of this study followed up the results of NIPT in a way that is not routinely done. The NIPT results themselves were not diagnostic for cancer, and NIPT is not currently used to screen for maternal cancer. Further research is needed to determine the clinical importance of this finding.

For More Information

Mayo Clinic
www.mayoclinic.org/tests-procedures/noninvasive-prenatal-testing/basics/definition/prc-20012964

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