Jeffrey M. Apple, MD
2018 TCMS President
WANTED:
Doctors who just want to be doctors.

At TMLT, we have you covered.
No matter how your job evolves.

We know that seeing patients and providing excellent care is your primary goal. And we work hard to find new ways to support you. Contact us today to learn more about what TMLT can do for you at 800-580-8658 or www.tmlt.org.

TMLT
Texas Medical Liability Trust

PARTNERSHIP FOR A NEW ERA OF MEDICINE.
Dr. Simone Scumpia MD FACE FRCP FNLA

New patients seen within 3-5 days

Dr. Scumpia, medical director and founder of Austin Thyroid & Endocrinology, has served the needs of thyroid and endocrine patients in Austin for over 20 years. She is a Board Certified Endocrinologist, Fellow of the American College of Endocrinology and Fellow of the Royal College of Physicians of Canada. Her focus is the diagnosis and treatment of thyroid disorders, general hormone imbalances, pituitary, adrenal, osteoporosis, and diabetes.

The clinic has in-house thyroid ultrasound, bone densitometry, radioactive iodine uptakes and treatment, insulin pump and dietician.

Dr. Scumpia offers second-opinion consults on management of Graves’ disease and hyperthyroidism, thyroid nodules and thyroid cancer.

Call 512.467.2727 to schedule your patient with Dr. Scumpia

- New patients seen within 3-5 days
- All new patients are seen by Dr. Scumpia
- Emergency new patients seen the same day
- All commercial insurance plans accepted
- Tricare and Medicare accepted
- Direct line 512.873.7377 for your medical staff
- Doctor’s line for referring physician

Dr. Simone Scumpia, MD FACE FRCP FNLA
Austin Thyroid & Endocrinology
2200 Park Bend Drive, Building 3, Suite 300
Austin, TX 78758
512.467.2727 office
512.873.7576 fax

Thank you for entrusting your patients to Dr. Scumpia
50,000 new cancer patients every year. 1 new equestrian.

At Texas Oncology, our patients are as remarkable as our care. They’re part of a cancer-fighting community the size of Texas, with 420+ physicians, 175+ locations and thousands of patients on clinical trials. In fact, we care for more Texans with cancer than any other provider — including patients like Rodger. After cancer treatment, Rodger found strength and balance thanks to a horse named Dakota. See his story at TexasOncology.com/Rodger

TEXAS ONCOLOGY
AUSTIN • BASTROP • CEDAR PARK
HARKER HEIGHTS • KYLE • LAKEWAY
MARBLE FALLS • ROUND ROCK • SAN MARCOS
1-888-864-4226 • www.TexasOncology.com
Features and Articles

6  From the President
   Jeffrey M. Apple, MD

8  2017 Annual Awards Dinner

10 Senate Bill 11 (2017) Do-Not-Resuscitate Orders

12 Improving Safety Net Access to Specialty Care
   George Rodgers, MD and J. Stuart Wolf, Jr., MD

13 Physician Wellness Program

14 In the News

16 2018 TCMS President: Jeffrey Apple, MD
   Leanne DuPay

18 In Memoriam

20 TCM Alliance
   Melissa Smith

22 Infant Suffocation and Safe Sleep
   Philip Huang, MD, MPH, Sarah Seidel, DrPH, Sandra Lackey,
   David Zane, MPH, and Cristina Garcia, RDN, LD, IBCLC, RLC

26 The Current Deadly Epidemic: The Doctor’s Role
   William Loving, MD

30 Classified Advertising
On November 2, 2002, the USS Constellation departed San Diego on a mission to support the war on terrorism. One of the last of the Kitty Hawk Supercarriers, its origins date to 1961 when it began its service during the Vietnam War. At its command was Captain John Miller, a 46-year-old officer who had begun his career at the US Naval Academy. He was the embodiment of naval leadership. He was highly respected by his crew, a devoted family man, and most likely on his way to higher command. Also on board was a young surgeon right out of training whose role was to support the 5,000 Sailors and Marines on the Constellation and the surrounding battle group.

Our destination at that time was well known—the Persian Gulf—but the mission and events that were to transpire upon arriving were not. The excitement on our ship was palpable after the events of September 11. The route was a familiar one with stops in Hawaii, Hong Kong, Singapore, and eventually the Gulf. During the seven-month deployment I learned a lot from watching the captain. His authority and responsibility would be unfamiliar to those on land, as the captain of a Navy vessel is the final word on all matters pertaining to his ship and its crew. After all was said and done and the mission accomplished, I had time to reflect on what Captain Miller had achieved. It is no easy task to maintain discipline, morale and, most importantly, a sense of purpose when the future is so uncertain. At the end of the deployment, the ship returned safely back to San Diego with its crew and its identity intact.

Austin’s medical community is now embarking on a similar mission; in essence, a voyage of discovery. A new medical school has arrived and is attempting to transform health care and how we take care of our indigent and underserved population. Our private practice physicians are trying to redefine their roles in the community and maintain their sense of commitment and purpose for which they have worked so hard for many years. The navigation of this route should be straightforward and familiar, but it will undoubtedly be interrupted with unexpected challenges and, at times, very difficult seas.

Our region and medical community are experiencing unprecedented growth. Austin is still one of the fastest growing cities in America—both in population growth and in economic development. With this growth comes increased expectations. Our new medical school is reflective of this. Austin’s desire to compete and thrive among its larger siblings in Houston, Dallas, and San Antonio require us to take that next step. With a medical school and now three large health care systems, no one can say that Austin doesn’t provide first-class health care. Many, myself included, would argue that we have had excellent health care and outstanding physicians and nurses for years. To say otherwise would be a great disservice to those who have dedicated their lives and careers to improving medicine in this great city.

We certainly are in the midst of a sea change in medicine and health care delivery. Phone communication, electronic medical records, hospital information systems, and quality and outcomes reporting are just a part of it. Technology and the ability to purchase products with rapid delivery will continue to change the health care delivery experience even more. The recent purchase of Aetna by CVS is another indicator of how health care may be delivered in the future. We are, I feel, at a time where we can safely discard all of our past assumptions.

What I find interesting is not so much how medicine will change, but how doctors’ relationships with each other will change. There seems to be two tendencies. One is for doctors to work or align with hospital systems and the other is for doctors to align with each other and provide large-scale services to multiple networks or clinics. This latter tendency is a good sign and may reflect how physicians can shape medicine in the future. For years, groups have competed aggressively with each other, creating a sometimes confusing market for patients and a redundancy of services. The joining of physicians and the exchange of ideas and expanded resources for call coverage is probably a good thing.

Some of the anxiety and tension in our medical community may be due to the sheer rapidity of change and the fact that no one really knows where this is going. I certainly don’t. Will the medical school develop and enlarge its clinical services to where it is a major rival to the current health care systems? Will Baylor Scott & White begin an aggressive expansion within Austin and its outskirts? How will Seton and St. David’s change in order to accommodate the rapid growth of the region and its needs for new and expanded clinical services? In other words, are we going to be just like the other large cities in a few years? All of these are legitimate questions for TCMS members and local citizens.

We may all have different opinions on what the medical school and hospital systems should look like, but make no mistake, the citizens of Travis County will have the final say. We can market and advertise all we want, but eventually the truth will come out. We owe it to this city and the surrounding communities to get this right. The end product, no matter who is in charge, has to be sound and
reflect the quality and professionalism that our community expects. Hospital systems should also take notice that patients are much more savvy, educated, and discerning in their navigation through the health care system. They will not hesitate to travel if necessary for a better experience. Hopefully, we will trend toward a more streamlined, practical, and compassionate delivery model and away from the defensive barricades we’ve created in every hospital. These are all great opportunities to change for the better.

Though our vision is forward looking, we must not forget the history of this great medical community. Many have devoted their careers to improving our health care landscape and have established practices and systems that will enable their knowledge to be passed on to the next generation of physicians. The ability to create sustainable systems and groups that can be perpetuated and improved upon is critical. We cannot afford to keep reinventing the wheel every time a group is critical. We cannot afford to keep TCMS to keep informed and balanced in your assessments. TCMS members have served in numerous leadership roles in the TMA including as its president. Our medical society is the one organization designed to protect and serve all physicians who work and live in the Greater Austin community. Please use your society as a sounding board to be heard because it is here to represent you. We are physicians and TCMS is us.

It is my great honor and privilege to serve TCMS as its incoming president. And naturally, I would encourage you to attend First Tuesdays or to come to our meetings and events, but I know the reality of our daily lives takes precedence. I would however, encourage you to do the following: take this year to reflect on what matters most to you and to your community and think about what our health care landscape should look like in five years. And take the time to visit and discuss these matters with your fellow physicians both at TCMS meetings and in your boardrooms and doctors’ lounges. In the end, I hope we create a medical community that is not so much different but simply better.

Captain Miller spoke to the crew every night as the work day ended. During that time he would address the events of the day, the challenges ahead, and encourage us to maintain our sense of purpose. He finished every night with the following: “Take care of yourself. Take care of your shipmates. Tomorrow begins a new day.”

The USS Constellation’s nickname was “America’s Flagship.” It is my hope that our medical community will be viewed in that light as well.
The annual TCMS Awards dinner and Annual Business Meeting were held in December at the Westin Austin Domain. During the event three members were honored: Brian Sayers, MD, Physician of the Year; Alinda Cox, MD, TCMS Humanitarian of the Year; and Sonia Krishna, MD, Ruth M. Bain Young Physician. The event also recognized recipients of the TCMS Foundation scholarships—Emily Rosen and Aydin Zahedivash—both students at Dell Medical School. A silent auction supporting the TCMS Foundation Physician Wellness Program was held during the reception.
DON’T SETTLE FOR LESS THAN COMPREHENSIVE VEIN CARE.

And don’t assume that spider veins, varicose veins, leg pain or ulcerated skin conditions are a minor problem. There’s no shortage of vein clinics in town, but many doctors recommend Austin-based VeinSolutions, a division of one of the most respected cardiac and vascular surgical groups in the country (CTVS). The board certified Cardiothoracic and Vascular surgeons at VeinSolutions start by diagnosing the problem, then follow an inside-out treatment approach, always using the most advanced technology available. And because unhealthy veins are a real medical issue and not just a cosmetic problem, treatment through VeinSolutions is covered by most insurance carriers, and is in network.

Learn more by calling 512-452-8346 or go to VeinSolutionsAustin.com
Senate Bill 11 (2017)
Do-Not-Resuscitate Orders

Effective April 1, 2018

Senate Bill 11, passed by the 85th Texas Legislature in its First Called Session, provides a framework that regulates in-facility do-not-resuscitate (DNR) orders. Prior to the enactment of this bill, only out-of-hospital DNR (“OOH DNR”) orders were explicitly regulated, so the bill marks a significant change. Assisting patients in making end-of-life decisions can be difficult as it involves a sensitive and highly personal subject matter. This document summarizes the new requirements relating to in-facility DNR orders based on S.B. 11; however, the touchstone for legal compliance is the language of the law itself. It may be difficult to contemplate every possible situation where an in-facility DNR order may be appropriate, so there may be outstanding questions. If there are questions about complying with the requirements of S.B. 11, one should review the law and consult with a private attorney and/or consult hospital or health care facility policy and legal counsel.

What is a “DNR order” under the bill?

The bill defines a “DNR order” as an “order instructing a health care professional not to attempt cardiopulmonary resuscitation on a patient whose circulatory or respiratory function ceases.”

Notably, this bill’s regulations apply only to “cardiopulmonary resuscitation,” which is a more narrow scope than that of an out-of-hospital DNR order (an OOH DNR order applies to life-sustaining treatment), but this term is still broader than just chest compressions. Texas law defines “cardiopulmonary resuscitation” as “any medical intervention used to restore circulatory or respiratory function that has ceased.”

It is also important to note that this bill applies to a “DNR order” issued only in a hospital or health care facility and does not affect an OOH-DNR order as the term is defined in state law. (In this document, “DNR” or “DNR order” refers to that which is defined and regulated in S.B. 11, and does not include an OOH-DNR order).

What makes a DNR order “valid”?

A physician may enter an order to not attempt CPR on a patient whose circulatory or respiratory function ceases, but unless it complies with the requirements of S.B. 11, the order would not be valid and the physician may thus be subject to civil, criminal and administrative liability. The bill establishes that in order to be valid, the DNR order must be dated, issued by the patient’s attending physician, and be in compliance with one of the following:

1. Written and dated directions of a patient who was competent at the time the patient wrote the directions
2. Oral directions of a competent patient, if the directions are delivered to or observed by two competent adult witnesses, at least one of whom is not:
   • an employee of the attending physician or
   • an employee of the facility who is:
     • providing direct patient care to the patient or
     • an officer, director, partner, or business office employee of the facility or any parent organization of the facility
3. An advance directive that was validly executed in another state
4. A properly executed written directive, meaning it is witnessed by qualified witnesses or notary public
5. A nonwritten directive of a competent patient, who has a terminal or irreversible condition diagnosed and certified in writing by the attending physician, witnessed by the attending physician and two other qualifying witnesses (one of whom must not have certain relations to the patient according to state law)

NOTE: there are subtle differences between this option and option no. 2 above. The requirements under this option are slightly more stringent, requiring more witnesses with less flexibility and specifying that the patient be certified as having a terminal or irreversible condition.

On the other hand, this option allows for types of nonwritten communication other than oral communication.

6. A directive issued on behalf of a person younger than 18 years of age, by the patient’s legal guardian
7. The directions of the patient’s legal guardian or agent under a medical power of attorney
8. A mutual decision agreed upon by the patient’s attending physician and:
   • the patient’s legal guardian or agent under medical power of attorney
   • if no guardian or agent, the patient’s (listed in priority):
     • spouse
     • reasonably available adult children
     • parents
     • nearest living relative
   • if no guardian, agent or other relative, another physician who is:
     • not involved in treating the patient, or
     • a representative of the facility’s ethics or medical committee

continued on page 28
Missing a piece of your insurance puzzle?
We can help.

www.tmait.org
1-800-880-8181

Created by and exclusively endorsed by the Texas Medical Association, the non-commissioned staff of the TMA Insurance Trust help Texas physicians, their families, and their practices find insurance plans to fit their needs.
Many people among the Travis County safety net population have difficulty accessing specialty care. It’s one of the more vexing challenges in the US health care system that results from our fragmented delivery system.

To address these barriers, on May 5, 2017, the Dell Medical School (DMS) and the Community Care Collaborative (CCC) co-sponsored a “Stakeholder Summit on Access to Specialty Care: Improving Access to Specialty Care for Adults Who Are Underinsured or Uninsured in Travis County.” More than 60 participants (including patients, health system representatives, primary care providers, specialists, and national experts) shared their expertise and participated in breakout groups that proposed initial ideas on how to improve access to specialty care. During a follow-up meeting on June 17, we devised seven pilot projects to improve access to specialty care, and then on November 2 we shared our initial results.

**Getting More Patients into Specialty Clinics**

The most direct way to increase access to specialty care is to get more patients into specialists’ clinics. Of the seven pilots, three are intended to do just that.

They will:
- Create improved processes to efficiently work through the referral waiting lists to get more specialty appointments made. Great progress has already been made with this project.
- Write better referral guidelines to help primary care providers refer the right patient, at the right time, with the right preparation.
- Provide transportation to and from specialty clinics free of charge for patients in financial need, since transportation is such a problem for so many people.

**Improving Access to Specialty Expertise**

Even with these enhancements, there is not enough capacity to provide timely specialty care to all patients. One solution is replacing “access to specialists” with “access to specialty expertise.” In general, patients greatly prefer to get their care in the office of their primary care provider instead of the office of a specialist—four of the pilot programs aim to facilitate that. They will:
- Use “e-consults” to facilitate communication between a primary care provider and specialist, giving primary care providers the information they need to help the patient or decide on a regular referral. This strategy has already been used to reduce the wait time in cardiology from 12 months to two weeks for the most vulnerable patients. A larger-scale pilot is being developed.
- Identify primary care providers to be “subject matter experts” within primary care groups to deliver some specialty care locally, with ongoing support from the specialist.
- Connect patients and specialists with telehealth applications in cases that do not require physical examination of the patient by the specialist.
- Bring some of the advanced testing that is required for specialty cardiac assessment to primary care clinics on a rotating basis using a mobile platform as an alternative to transporting the patient to a central testing location.

Advantages to these four approaches include familiarity with providers, staff and surroundings, less travel, fewer visits, and reduced co-payments. In many situations, this is the best way to provide care.

The Access to Specialty Care Summit stakeholders and their DMS and CCC partners continue to monitor these initiatives with intent of making timely access to care a reality for all members of our community.
TCMS Physician Wellness Program

What is the PWP “Coaching Program”?

• The Physician Wellness Program offers anonymous, free coaching sessions staffed by TCMS vetted psychologists.
• The program can be easily accessed and privacy is strictly protected. Our counselors are available to help with work, personal, or marital issues.
• The program is available to TCMS members and their spouses/life partners.
• Test the waters with an anonymous, 15-minute get acquainted session with one of our counselors. Cost is covered by the program.

To access the program, call the 24-hour support line: 512-467-5165.

The following generous donors have supported the TCMS Physician Wellness Program.

$10,000 and Up
- Austin Community Foundation (TCMS fund)
- St. David’s HealthCare Partnership
- Seton Healthcare Family

$5,000-$9,999
- Austin Radiological Associates
- Texas Medical Liability Trust
- Texas Oncology

$2,500-$4,999
- Austin Gastroenterology
- Austin Regional Clinic

$1,000-$2,499
- Dr. & Mrs. Donald Counts
- Brian Sayers, MD

$500-$999
- Pulmonary and Critical Care Consultants
- Dayna Diven, MD
- Nancy Thorne Foster, MD

Up to $499
- Maureen Adair, MD
- Kimberly Albert, MD
- Louis Appel, MD
- Jennifer Aranda, MD
- Carrie Barron, MD
- Jose Bayona, MD
- Nancy Binford, MD
- Dr. and Mrs. Rob Cowan
- Suzanna Dana, MD
- Josephina Diaz-Vogt, MD
- James Eskew, MD
- Raymond Faires, MD
- Thomas Falvey, MD
- J. Stuart Ferriss, MD
- Frederick Fung, MD
- Harish Gagneja, MD
- Patricia Gallagher, MD
- Wesley Glazener, MD
- Stephen Griggs, MD
- Maria Gutierrez, MD
- Russell Hayhurst, MD
- John Hays, MD
- Kim Hovanky, MD
- William Howland III, MD
- Dana Jeng, MD
- Neal Johnson, MD
- Lamir Kadir, MD
- Deepa Keriwala, MD
- Stanley Kim, MD
- Pratima Kumar, MD
- Raghuvansh Kumar, MD
- Donald Lovering, MD
- Manuel Martin, MD
- Tom McHorse, MD
- Hillary Miller, MD
- A. Cate Miller, MD
- Subrahmanyam Narra, MD
- Javier Otero, MD
- Dennis, Pacl, MD
- Michael Perkins, MD
- Lena Poole, MD
- Peggy Russell, DO
- Marshall Sack, MD
- Donovan Sigerfoos, DO
- Drs. Scott and Karon Simpson
- Senthil Sivam, MD
- Central Texas Rheumatology Society
- Allen Sonstein, MD
- Paula Starche, MD
- Karen Swenson, MD
- Oscar Tamez, MD
- Emilio Torres, MD
- Divya Varu, MD
- Mylynda Waldrop, MD
- Byron Wilkenfeld, MD
- Suvipa Wiri, MD
- Weerachai Wiri, MD
- Eleanor Womack, MD
- Guadalupe Zamora, MD
- Belda Zamora, MD
- TCMS Staff in honor of Brian Sayers, MD

Memorial Gifts

Consider honoring a colleague or friend by donating to the TCMS Foundation Physician Wellness Program.

Tom Coopwood, MD
In memory of
- Jack Boyd, MD
- Dennis Welch, MD

Charles Felger, MD
In memory of
- Henry Renfert, MD
- Virgil Lawlis, MD

Thomas Shelton, MD
In memory of
- Jack Boyd, MD
St. David’s HealthCare has appointed Ken Mitchell, MD, as senior vice president and chief medical officer. In this role, Dr. Mitchell will lead the clinical and quality initiatives that support consistent clinical performance and practice standards across the system.

Jay R. Zdunek, DO, MBA, has been named Chief Medical Officer for Austin Regional Clinic (ARC). As CMO, Dr. Zdunek is responsible for managing and providing leadership to the more than 300 ARC physicians and clinic providers, peer review/quality measurements, and helping recruit new physicians.

**Letter to the Editor**

Sara Austin’s President’s Page in the 2017 November/December *TCMS Journal* identified a major problem for the future of medical care and the financial status of physicians.

Big Pharma benefitted from the financially unsustainable Affordable Care Act. Hospitals also gained. It is unconscionable that Medicare cannot negotiate with Big Pharma when they can unilaterally make a large segment of a physician’s practice dependent on the private sector for offsetting losses.

Part D premiums in the means tested group of retirees are about $80, making the premium over double the cost of the typical generic medication needs of a Medicare patient. Finally since 67% of private insurers (Aetna, United, and BC/BS) have administrative services only (ASO) contracts with large employers, our large employers are paying these Pharma costs directly from their bottom line.

When I first joined the Physician Advisory Council at BC/BS 12 years ago, the total Pharma cost for the plan was 3% of premium dollars. When I left in 2016 that cost had risen to 16%! All of physician payments are about 20%, the same as 12 years ago.

There is no more money! We have to understand that physicians must push for an equitable solution if we expect to sustain our practices. The British have a national panel that makes unilateral decisions of availability of drugs based on their cost and efficacy (NICE). Even when we have a new, very efficacious drug such as the Hepatitis C drug, the pricing at $1000 a dose made the estimate for treating all the cases in California equal to the elementary school budget for the entire state.

Something has to change.

Bruce Malone, MD

---

**Save the Date**

**Joint Installation of Officers**

**Travis County Medical Society**

Jeffrey M. Apple, MD
2018 TCMS President

**Travis County Medical Alliance**

Mrs. Melissa Smith
2018-2019 TCMA President

**Tuesday**
**March 6, 2018**

6:30 pm - Reception
7:30 pm - Dinner

Austin Country Club
4408 Long Champ Dr
Join over 4,000 Ascension healthcare providers now practicing with Certitude.

Certitude coverage delivers:
- **Risk resources** to help you manage your practice, enhance patient safety, and save money
- **Flexible payment options** to fit your needs
- **Certitude peer input** for difficult claims and underwriting issues
- **Unified claims approach** that helps you protect your important identity
- **Enhanced coverage** for today’s ever-changing medical environment

For more information on Certitude, call ProAssurance at **800.282.6242** or visit [CertitudebyAscension.org](http://CertitudebyAscension.org).

---

3D Mammography Can Detect 41% More Breast Cancers. Thanks Mamm!

Schedule your mammogram today!
512.493.5850  ARAMammoFacts.com

A Leader in Breast Imaging
Jeffrey Apple is no stranger to fighting medical battles. From serving two tours of duty during Operation Iraqi Freedom as a naval surgeon to strategically navigating today’s medical profession, Dr. Apple is well prepared to lead the Travis County Medical Society in 2018.

Texas born and bred, Apple grew up in the Dallas area. Boots are his daily footwear and being outdoors is where he is happiest—whether he is hunting, fishing, hiking, skiing, or practicing archery. Yes—traditional archery—shooting arrows at a straw filled target Robin Hood style. “I find it relaxing. I love the simplicity and the fact that you are challenging yourself,” he explains. “I even make my own arrows.” Actually, the sport is not as obscure as one might think. It seems archery is experiencing a renewed popularity due to the movie, “Hunger Games” so the Austin Archery Club, where he sometimes practices, is usually busy.

Apple’s journey to Austin began with a stint in the Navy. “I wanted to be a fighter pilot, but I am color blind so that was out.” The timing of this ambition aligned with the first Gulf War when many Americans were inspired to serve their country. “My recruiter suggested medicine and explained how the Navy would pay for my medical school.” He selected general surgery as his specialty, explaining that it was a good match for his personality as he enjoys working with his hands. Once Apple completed medical training, he worked as a staff surgeon at the Naval Medical Center San Diego, and it was at this point that his first deployment was scheduled.

“I was stationed on an aircraft carrier—basically a floating city,” he describes. “We were well protected and safe surrounded by a ‘battle group’ made up of smaller destroyer ships.” This experience was less of a medical experience and more of a learning opportunity. Interacting with the captain and other officers, he watched an outstanding team demonstrate effective leadership strategies and enjoyed the patriotic camaraderie. During this tour, his daughter Alice was born. She was seven months old when he first held her.

The second deployment could not have been more different. He was sent to Western Iraq, near Jordan. This time he was based on land in a makeshift hospital resembling the MASH compound on TV. The US Marines do not have a Medical Corps, so Apple and his Naval colleagues were ordered in. These particular Marines were patrolling near Jordan and Syria. “IEDs, roadside bombs and high velocity bullets were the weapons used on our soldiers,” he says grimly. Improvised explosive devices (IED) are basically homemade bombs and the blasts from these can actually reach under a Kevlar vest. “But the hardest part of this deployment was seeing how young the soldiers were,” Apple says. “18 year olds—just kids—it was very emotional, especially when you imagine your own children in this fight.” He describes the experience as extremely stressful and not just because of the war. Just being in a foreign country in those conditions made many feel helpless, lost, and small.

One can imagine how any physician coming home from combat surgery in Iraq would find the prospect of being a small town doctor in Tennessee very alluring. The idea of a charming, southern community, ideal for his young family, sounded like heaven. “I over romanticized that position,” Apple says with a laugh. “There was no back-up; I was on-call all the time.” The quality of life he had imagined—maybe a bit like
Doc Baker on “Little House on the Prairie”—was far from the reality. “I missed Texas. When Cardiothoracic and Vascular Surgeons (CTVS) in Austin contacted me, I moved to Austin and never looked back!” Today he is a full-time vascular surgeon living in his new favorite city. His wife Trudy and their children Alice and Denton love it here as well.

According to Dr. Apple, joining CTVS has been the highlight of his career. “This is a 60-year-old private practice,” he says proudly. “We are a family and there is real longevity here—there is a surgical assistant who is 75-years-old and has worked here 41 years.” Today, a private practice is a tough path to choose. “Gone are the days when you could graduate and hang out your doctor shingle. Young doctors get hospital contracts, have no partners to back them up, and have no quality of life at all—many just get frustrated and burned out. It’s concerning.”

The current state of the medical profession is one all physicians ponder. What is good? What is bad? The best thing to happen in medicine today, according to Dr. Apple, is the speed of communication. Doctors are able to receive and send information in a matter of seconds. And we all know the value of time when it comes to serious health issues.

What is the most threatening issue in medicine in his opinion? “This CVS/Aetna purchase is a shock. Health care is becoming so out-patient and retail oriented now. People are sacrificing the doctor-patient relationship and continuous care for walk-in clinic convenience,” he explains. “And all the new systems required, like EHRs—the humanity is leaving our profession. The most threatened issue may be our identity.”

As Dr. Apple stands at the presidential podium this year, what are his priorities?

Serving during Operation Iraqi Freedom.

What inspired him to enlist to serve with TCMS? “I’m very proud to work and live in Austin. This is a great medical community and I want it to get even better. My main goal will be to make our members proud to live and work here. I want our medical school to be something the whole community can be proud of and I want to keep our members better informed. When people are underinformed, it breeds anxiety and mistrust. Knowledge is power.”
James Boynton, MD, 81, passed away November 3 of complications from a fall. A native of Lufkin, TX, Dr. Boynton went to medical school in Galveston before doing an internship at the US Naval Hospital in Newport, Rhode Island. After serving in the Navy for three years, he did his psychiatry residency and fellowship in child psychiatry at the Karl Menninger School of Psychiatry in Topeka, KS. He practiced in Austin from 1973 until 1992 before returning to east Texas and practicing in Nacogdoches for several years.

Dr. Boynton’s distinguished career included a number of years supervising psychiatry fellows at the Children’s Psychiatric Unit of the Austin State Hospital, director of The Oaks Treatment Center, more than a decade as an associate in Pastoral Theology at the Episcopal Theological Seminary of the Southwest, and serving as president of the Texas Society of Child and Adolescent Psychiatry along with other work as director or consultant for hospitals, committees, and commissions too numerous to list here.

Dr. Boynton practiced for over 50 years, served his country and profession in many ways while changing countless lives through wise counsel. As one person recalled after his passing, “He was a kind and wise gentleman who helped my family through counseling. I will forever be in his debt and he will always remain in my heart.” He is survived by his wife of 51 years, two sons, and five grandchildren.

William Glenn Gamel, MD, 81, passed away peacefully at home surrounded by his family on December 14. A native of Lampasas, he graduated from UT Austin before medical school in Galveston and his internal medicine residency and gastroenterology fellowship at Parkland in Dallas. Dr. Gamel, his wife Nancy, and their three children moved to Austin in 1967 where he began a distinguished career of patient care, leadership, and advocacy that would help shape the course of medicine in Austin, throughout Texas, and beyond for more than three decades.

He was a founding partner of Gastroenterology Associates and soon became involved with The Travis County Medical Society (TCMS), the Texas Medical Association (TMA) and the American Medical Association (AMA). He served as President of TCMS in 1981 and TMA in 1992. He received the Gold Headed Cane Award when named Physician of the Year by TCMS in 2003. Dr. Gamel’s leadership was instrumental in achieving meaningful tort reform in Texas. He served as chair of the Texas Delegation to the AMA and on the TMA Council on Legislation that was involved in critical issues affecting health care reform on a nationwide scale.

He later served as CEO of the Texas Medical Foundation (later renamed TMF Health Quality Institute), a provider of health care quality improvement services, which strives to raise health care standards in Texas. Dr. Gamel was a man of faith and active in leadership roles in the Episcopal Church. He was an avid Texas Longhorn fan, enjoyed travel with his wife, and in his later years enjoyed studying genealogy and his Texas heritage. He is survived by his wife of 57 years, three children, and three grandchildren.

Memorial Gifts
Consider honoring a colleague or friend by donating to the TCMS Foundation Physician Wellness Program.
Contact Belinda Clare at 512-206-1250 or pwp@tcms.com
Lisa Day Jones, MD, 62, passed away on November 10 after an 11 year battle with breast cancer. Dr. Jones was a native Austinite and graduate of Lanier High School. She graduated from UTMB with an occupational therapy degree in 1977 and worked at the Austin State Hospital for several years before attending medical school in San Antonio where she also completed a psychiatry residency.

For 16 years Dr. Jones concentrated on raising her five children and on her initial cancer therapy before opening a private practice in 2007. For the next decade, until just a few weeks before her death, she provided care to the patients in her practice and in Providence Place (formerly the Methodist Mission Home). Beyond her love of family and her patients, no description of her life would be complete without noting her passionate life as a Christian. Her faith inspired every aspect of her life. Dr. Jones took on almost every role imaginable in her various faith communities, serving in church leadership roles, youth ministry, Bible study leader, mentor, participant in various international faith journeys, and on medical missions to Nicaragua for breast cancer patients.

She was an oboe player, a seamstress, a quilter, a talented softball player, and film buff—all of these interests contributed to a full and faithful life. As a colleague noted after her passing, “She will be dearly missed, but her legacy will be a beacon of light for all of us to aspire to.” She is survived by her husband of 34 years and five children.

Lily Sood, MD, 67, died peacefully with family by her side on November 26. She was born in Saharanpur, India and received her medical degree from the National Medical College in Calcutta. She married Lal, her husband of 43 years shortly after medical school and the couple immigrated to the United States in 1975. She completed her residency at Brackenridge Children’s Hospital and became one of the first physicians to join Austin Regional Clinic in 1981 where she practiced pediatrics for the next 35 years.

Dr. Sood was described as an astute and meticulous clinician with enormous compassion for her patients and recognition that “a good pediatrician takes care of the parent as much as the child.” Her love of children was legendary and she was known to sneak into the newborn nursery and help feed the babies as a way of unwinding after a stressful day. She was a friend and mentor not only to a generation of Austin pediatricians, but also to her network of friends and family who loved and depended on her.

ARC Founding CEO Dr. Norman Chenven noted, “Everyone felt good around her. She was a person of absolute integrity, always solid and yet modest. She loved what she did and she was so good at it. Over her long career, Lily took care of thousands of children and then their children, always with passion and joy. She will be sorely missed.” She is survived by her husband and two sons.
December was a month long celebration for the TCMA! A great time was had by all who attended our social events. The Chic Ladies participated in their 5th annual holiday gift card exchange at Chez Zee.

The luncheon benefitted the Austin Angels Christmas Basket Program that helps children in the foster care system to feel loved, validated, cherished, and supported. The book club enjoyed their annual holiday potluck brunch as well. Members brought both a dish and a book suggestion to share. We also had our annual holiday luncheon at Westwood Country Club that benefitted BookSpring. We raised over $500 and gave 25+ new books to them in order to help build early literacy in children and families in the Austin area. The TCMA also helped families in Austin prepare for Christmas by adopting eight families through the Volunteer Healthcare Clinic. Presents were bought and wrapped for both the children and the parents. The TCMA members and children were able to meet with the families during a wrapping/cookie party. A cookie exchange and lunch at the president’s house for the board and committee chairs was the final event that had us all in the Christmas spirit!

**Member Spotlight: Ronsey Chawla**

Ronsey Chawla grew up in Tempe, AZ which is sometimes called the Valley of the Sun. Before calling Tempe his childhood home, he had already lived in Asia, Africa, and Europe.

Ronsey received his BS in Biomedical Engineering at Washington University in St. Louis and his MBA from Stern School of Business at New York University. He worked as a management consultant for 15 years, crisscrossing the country on client assignments, finally landing in Austin.

Today he works as a financial advisor at Per Stirling utilizing his management consulting experience assisting clients in medicine, consulting, and technology.

His hobbies include racket sports, reading, traveling, and time with family and friends. His favorite books are *A Random Walk Down Wall Street* and *The Mayo Clinic Guide to Stress-Free Living*. Ronsey, like many people today, is pursuing the ideal work-life balance.

*For more information—www.tcmalliance.org*
The Travis County Medical Society appreciates the generosity of the following organizations in underwriting TCMS events.

**Diamond Level Sponsors**

- Merchants & Professional Credit Bureau
- Texas Medical Association Insurance Trust
- Texas Medical Liability Trust

**Platinum Level Sponsor**

- Texas Oncology

**Gold Level Sponsors**

- Atchley & Associates, LLC
- Austin Cancer Centers
- First Citizens Bank
- MedPro
- SkylesBayne, Russell Davis

**Silver Level Sponsors**

- ProAssurance
- The Brian Novy Company
- Wilson Goldrick Realtors, Julia Schlitt
From 2011-2016, 48 children under age one in the city of Austin died of suffocation as a result of an unsafe sleep environment. These infant deaths due to suffocation accounted for 8.2% of all deaths to infants under the age of one. In Austin and Travis County as a whole, suffocation due to an unsafe sleep environment is the number one cause of injury-related death for infants between 1-12 months of age. An unsafe sleep environment can include bed-sharing with an adult or child, the use of soft bedding such as pillows, comforters or blankets, crib padding, and/or a stomach (prone) sleep position. Unsafe sleep environments can result in infant death due to suffocation or strangulation (see Table 1 for definitions). Of the 48 infant deaths due to suffocation between 2011 and 2016, 31 (65%) were due to an unsafe sleep environment, and 17 (35%) were due to bed-sharing with an adult, child, or other unspecified person.

Understanding SUIDs, SIDS, and Suffocation

Sudden Unexpected Infant Deaths (SUIDs) is an umbrella term for infant deaths that occur suddenly and unexpectedly and whose manner and cause of death are not immediately obvious prior to investigation. Sudden Infant Death Syndrome (SIDS) is used to classify the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation is conducted, including a complete autopsy, examination of the death scene, a review of the child and family’s clinical and social history, and sample collection. The classification of an infant death as due to SIDS is one of exclusion, in other words, when all other explainable causes of sudden unexpected infant death have been ruled out. If it is determined that an unsafe sleep environment resulted in infant death, the death is classified as Accidental Suffocation and Strangulation in Bed (ASSB) (Table 1).

Surveillance & Epidemiology of Infant Deaths

3,700 infants died suddenly and unexpectedly in the United States in 2015. Different practices in investigating and reporting sudden unexpected infant deaths have made it difficult to accurately monitor trends and characteristics among regions and across time. Approximately 43% of these sudden unexpected infant deaths (SUIDs) were attributed to sudden infant death syndrome (SIDS), 32% to ill-defined or unknown causes, and 25% to accidental suffocation and/or strangulation in bed (ASSB).

Table 1. Common SIDS, SUID and Safe Sleep Terms and Definitions

<table>
<thead>
<tr>
<th>Key Word</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudden Unexpected Infant Death (SUID)</td>
<td>Umbrella term that describes all infant deaths that happen suddenly and unexpectedly. The manner and cause of death are not clear before an investigation is done. After a full investigation, these deaths may be diagnosed as Suffocation; Entrapment; Infection; Ingestion; Metabolic Disease; Cardiac Arrhythmia; Trauma (accidental or non-accidental); SIDS; Undetermined</td>
</tr>
<tr>
<td>Sudden Infant Death Syndrome (SIDS)</td>
<td>Refers to the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation is conducted. This includes a complete autopsy, examination of the death scene, and review of the medical history.</td>
</tr>
<tr>
<td>Accidental Suffocation and Strangulation in Bed (ASSB)</td>
<td>Used to identify infant deaths caused by suffocation or asphyxia (blockage of the infant’s airway) in a sleeping environment, including: Suffocation (by soft bedding); Overlay (by another person or animal); Wedging or Entrapment; Strangulation</td>
</tr>
<tr>
<td>Co-Sleeping (Child may or may not be in same bed as adult)</td>
<td>A sleep arrangement in which the parent (or another person) and infant sleep in close proximity (on the same surface or different surfaces) so as to be able to see, hear, and/or touch each other. Co-sleeping arrangements can include room sharing or bed sharing. The terms “bed sharing” and “co-sleeping” are often used interchangeably, but they have different meanings.</td>
</tr>
<tr>
<td>Bed-Sharing</td>
<td>When infant shares a sleep surface (adult bed, sofa, recliner, or other surface used for sleep) with a parent, other child, animal, and/or another adult caretaker.</td>
</tr>
<tr>
<td>Room-Sharing (Child sleeps on separate sleeping surface)</td>
<td>A sleep arrangement in which an infant sleeps in the same room as parents or other adults, but on a separate sleep surface, such as a crib, bassinet, infant co-sleeper, play yard, mattress, or child’s bed. This is the recommended sleeping arrangement for all children under one year of age.</td>
</tr>
</tbody>
</table>

Source: Adapted from Task Force on Sudden Infant Death Syndrome and National Institute of Child Health and Human Development.
The use of SIDS (International Classification of Diseases, Tenth Edition Code R95) to classify sudden and unexpected infant deaths has decreased since 2000, and many county medical examiners no longer classify infant deaths as SIDS (Travis County included). Though SUIDs have dropped over the past decades, deaths that may have previously been attributed to SIDS are now classified with greater specificity. This diagnostic shift has resulted in the number of deaths reported as unknown or “other ill-defined and unspecified causes of mortality” (R99) and deaths reported as due to ASSB (W75) to increase. Overall, sudden and unexpected infant deaths (SUIDs) have declined since the early 1990s, largely attributable to safe sleep practices.

Unfortunately, despite a decline, infant deaths due to suffocation occur at a higher rate among African-American infants in Austin (Table 2), followed by Hispanic and white infants. In the City of Austin, the rate of death due to unsafe sleep environment for African-American infants is more than six times the rates for white or Hispanic infants. These disparities also exist in Travis County, Texas, and the US as a whole.iii Studies have found that African-American parents and caregivers are more likely to place their babies on their stomach or side to sleep and more likely to share the same bed. Data from the national Pregnancy Risk Assessment Monitoring System (PRAMS) indicated that in 2010, 28% of mothers nationwide reported that most of the time they did not place their babies on their backs to sleep, and 24% reported they usually bed-shared with their infant. The most recent data from Texas (2010) indicate that 33% of mothers did not place their babies on their backs to sleep most of the time and 30% usually bed-shared, higher than the national percentages (Graph 2). African-American mothers in Texas were 2.2 times more likely to report not placing their babies on their backs to sleep and 2.9 times more likely to report bed-sharing than white mothers were.ix Lower maternal age and lower maternal education are also associated with not placing children on their backs to sleep and bed sharing among Texas mothers.

Talking to Your Patients about Safe Sleep for Babies

There is evidence that interventions promoting supine sleep position and a safe sleep environment that combine caregiver education, health care provider education, and hospital safe sleep policies for newborns and infants can result in behavior change to improve the safety of infant sleep environments. Some patients may have concerns about placing babies on their backs to sleep or about sleeping apart from their babies. Mothers also commonly report falling asleep while breastfeeding. Addressing common myths and misinformation (Table 3) as well as patient concerns is an opportunity to provide correct information and facts. Additionally, the American Academy of Pediatrics (AAP) affirms the promotion of “exclusive breastfeeding for the first six months, followed by breastfeeding in combination with the introduction of complementary foods until at least 12 months of age, and continuation of breastfeeding for as long as mutually desired by mother and baby” as further protective factors for the risk of sudden infant death. Lastly, many

Table 2. Unsafe Sleep Deaths by Type of Sleep Environment and by Race/Ethnicity of Child, City of Austin 2011-2016

<table>
<thead>
<tr>
<th>Category or Subgroup</th>
<th>Number of Unsafe Sleep Deaths</th>
<th>Percentage of Unsafe Sleep Deaths (N=48)</th>
<th>Percentage of All Deaths &lt;1 year in City of Austin (N=587)</th>
<th>Rate per 100,000 live births in City of Austin*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsafe Sleep Environment</td>
<td>31</td>
<td>64.6%</td>
<td>5.3%</td>
<td></td>
</tr>
<tr>
<td>Co-Sleeping (Bed-sharing)</td>
<td>17</td>
<td>35.4%</td>
<td>2.9%</td>
<td></td>
</tr>
<tr>
<td>All Races</td>
<td>48</td>
<td>100.0%</td>
<td>8.2%</td>
<td>40.6</td>
</tr>
<tr>
<td>White</td>
<td>15</td>
<td>31.3%</td>
<td>2.6%</td>
<td>30.2</td>
</tr>
<tr>
<td>Black</td>
<td>17</td>
<td>35.4%</td>
<td>2.9%</td>
<td>203.4</td>
</tr>
<tr>
<td>Hispanic</td>
<td>15</td>
<td>31.3%</td>
<td>2.6%</td>
<td>30.5</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2.1%</td>
<td>0.2%</td>
<td>9.1</td>
</tr>
</tbody>
</table>

*Note: Number of live births used to calculate rates is race/ethnicity-specific. Birth and death records are not linked; thus, infant deaths occurring in the City of Austin may not be of infants who were born in the City of Austin.

Data Source: City of Austin Office of Vital Records 2011-2016

Graph 2. Unsafe Sleep Practices among Texas Mothers by Race/Ethnicity, 2010

![Graph 2](image-url)

Data Source: PRAMSStat, 2010
Table 3. Common Myths Regarding Safe Sleep Environments & Suggested Talking Points

| Myth 1: If I place my baby on his or her back, he or she might choke. | Talking Point 1: Babies automatically cough up or swallow fluid that they spit up or vomit — it’s a reflex to keep the airway clear. Because of the way the body is built, babies who sleep on their backs can clear these fluids better than if they were sleeping on their stomach or side. |
| Myth 2: If I place my baby on his or her back, he or she might not be able to fall asleep or stay asleep. | Talking Point 2: Babies will learn to sleep on their backs and will get used to it quickly even if they don’t seem to sleep well at first. A baby who wakes frequently is normal. Safety is the most important consideration for how an infant sleeps. Back is always best. |
| Myth 3: If parents sleep with their babies in the same bed, they will hear any problems and be able to prevent SIDS from happening. | Talking Point 3: Because SIDS occurs with no warning or symptoms, it is unlikely that any adult will hear a problem and prevent SIDS from occurring. Sleeping with a baby in an adult bed or on a couch, recliner, or any other shared surface increases the risk of suffocation and other sleep-related causes of infant death. Recommend room-sharing — keeping the baby’s sleep area separate from, but right next to, the parent’s sleep area in the same room — for at a minimum the first six months, and ideally the first year. Room sharing is known to reduce the risk of SIDS and other sleep-related causes of infant death. |
| Myth 4: Putting my baby to sleep on his or her back will lead to a flat head. | Talking Point 4: Pressure on the same part of the baby’s head can cause flat spots if babies are laid down in the same position too often or for too long a time. These flat spots are usually not dangerous and typically go away on their own. Make sure to give your baby plenty of supervised Tummy Time when they are awake. Also, holding your baby upright when awake and limiting time in car seats (when not in a vehicle), strollers, bouncers, and reclining swings can help prevent flat spots. |
| Myth 5: There is a link between immunizations or vaccines and SIDS or unexpected death of an infant. | Talking Point 5: There is no evidence that there is a link between immunizations and SIDS. In fact, recent evidence suggests that shots for vaccines may have a protective effect against SIDS. All babies should see their health care providers regularly for well-baby checkups and should get their shots on time as recommended by their health care provider. |

Source: Adapted from NICHD Safe to Sleep Campaign FAQs and Myths and Facts pages

For further linguistically and culturally appropriate National Institutes of Health Safe to Sleep Campaign Materials, visit:
- https://www.nichd.nih.gov/sts/materials/Pages/default.aspx
- https://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx

Sources
ii In Travis County, from 2010-2014, 50 out of 57 deaths due to injuries for infants 1 year or younger were due to accidental and unspecified threats to breathing.
iv National Institute of Child Health and Human Development. Common SIDS and SUID Terms and Definitions. Available at: https://www.nichd.nih.gov/sts/about/SIDS/Pages/common.aspx
vii CDC Wonder Database. Available at https://wonder.cdc.gov/lbd-current.html
ix Prevalence Ratios: African-Americans(56/100)/Whites(25/100) = 2.24; African-Americans (49/100)/Whites (17/100) = 2.88
WHEN A NEW YEAR BEGINS, SO DO NEW OPPORTUNITIES

And Broadway Bank Wealth Management can help you seize them

A fresh new year means fresh new chances to bring your financial goals into focus. It's the ideal time to decide whether to rebalance your portfolio or make adjustments, and our investment management group has the vision and expertise to help you plan for tomorrow.

OUR FINANCIAL KNOWLEDGE IS YOUR FINANCIAL EDGE.

broadway.bank/wealthmanagement
512.465.6594

BROADWAY BANK
We're here for good.

Wealth Management | Investments | Trusts & Estates Foundations | Real Estate | Oil & Gas
35+ Financial Centers

INVESTMENTS ARE NOT FDIC INSURED | NOT GUARANTEED BY THE BANK | NOT A DEPOSIT NOT INSURED BY A FEDERAL GOVERNMENT AGENCY | MAY LOSE VALUE
Death from an accidental drug overdose is now the leading cause of accidental death in the US, surpassing motor vehicle accidents and gun violence for the first time in history. The number of overdose deaths has actually lowered the average life expectancy in the US. The crisis of accidental drug overdoses has been called “this generation’s HIV epidemic,” because in 2015 it caused more than 52,000 deaths, while at the peak of the HIV epidemic, 51,000 died from AIDS. In 2015 the number of deaths from accidental overdoses just about equaled the number of soldiers killed in the entire Vietnam War. The press has started to publicize this crisis, or epidemic, now which has been going on since 2002. Deaths are continuing to increase each year. In 2016 more than 64,000 died.

Most of these overdose deaths are from opioids, i.e., prescription pain medication like hydrocodone, oxycodone, morphine, and also from illicit drugs like heroin and black market fentanyl from China. The number of people addicted to heroin has doubled in the past 10 years, and overdoses from heroin have quadrupled. Most addicts start with opioids in the form of prescription pain pills. As a person becomes addicted, tolerance kicks in, and the addict needs a higher and higher dose over time. Obviously, when this occurs, the addict needs a greater supply of the drug, and if this is pain pills, sometimes as many as 20-30 tablets per day are needed. To keep up with their needs, the addict has to doctor shop: borrow pills from friends and relatives; look in medicine cabinets to steal drugs, e.g., a medicine cabinet in a real estate open house; order the drug on the internet; or buy it “on the street” for $8 to $10 per pill. When the opioid addict learns that heroin is much cheaper than pain pills, the change to heroin is made, which accounts for the increased number of heroin addicts. Not all addicts use heroin IV, some smoke or snort it.

In the last 15 years, drug companies have made huge profits on prescription opioids. These drugs were marketed aggressively to physicians with false claims that the rate of addiction was low and that these drugs were suitable for treating chronic pain. Some states in the US have recently filed law suits against large drug companies for fraudulent marketing. One county in East Texas has filed such suits. Many believed the marketing claims, probably because most physicians know very little about chemical dependency. This subject is not taught in medical school even though every doctor sees addicts as patients for other complaints. Doctors diagnose and treat what they know—the chief complaint—an injury, hepatitis, endocarditis, infection, HIV, etc., while the underlying problem is often addiction.

The site of action for mood-altering drugs like opioids, marijuana, stimulants, benzos and alcohol, is the reward center, which is located in the mid-brain (the primitive brain). The ventral tegmentum and nucleus accumbens in the limbic lobe make up the reward center or pleasure center. Normally, the reward center is stimulated by things that are necessary for survival like sex/intimacy, food, exercise, and completing a meaningful task. About 15-18% of our population is more prone to addiction due to a very sensitive reward center to intoxicating drugs. When someone from this addiction-prone group exposes their reward center to such a drug, the super-sensitive reward center releases much more dopamine than usual in the mid-brain, which causes a very intense “high.” This person doesn’t just “like” the feeling, he/she “loves” the feeling and wants to repeat the experience over and over. The initial feeling of “love” later becomes a “need,” and addiction ensues. The primitive mid-brain is concerned with instinctual behaviors, while higher functions like rational thought, judgment, impulse control, and insight reside in the neocortex. When the primitive brain sends messages to the rest of the brain that something is truly needed, this overpowers functions of the neocortex. The mid-brain then is running the show, and the neocortex is just along for the ride. The drugs “highjack” the reward center and the addict’s life. The neocortex can only function to rationalize and lie to cover for out-of-control behavior that
inevitably follows. Most chemically dependent people are not liars or psychopaths, but act that way when impaired.

The fact that just 15-18% of the population is very prone to addiction contributes to the confusion about whether marijuana is addictive or not. Marijuana is addictive to that group of people and they smoke it daily. Alcohol is addictive to that same portion of our population. The other 85% or so of the population do not get out of control with alcohol or marijuana, so they may be able to use those substances socially. It is difficult and almost impossible for a person to become addicted if that person does not have the variation (or disorder) of the super-sensitive reward center. Nature is more important than nurture in addiction.

Fortunately, addiction is treatable. It is a chronic disease, so it cannot be cured but can be managed like other chronic diseases such as asthma, diabetes, and hypertension. The success rate of treatment or the recovery rate is on par with other chronic diseases. Recovery depends on compliance to a recovery plan involving a change in lifestyle such as abstinence. Compliance is compromised by the inability to accept the reality of the diagnosis. No one wants to be an alcoholic or addict. People with chronic diseases usually have initial denial in accepting the diagnosis and then trouble making the changes necessary. Recovery doesn’t happen until denial is worked through. It may take a few relapses or runs through treatment to finally achieve sobriety.

The specialty of addiction medicine (American Society of Addiction Medicine) has grown and many treatment centers for chemical dependency, both outpatient and inpatient, have sprung up. Medicare and other insurances will even pay for treatment of this disease. The physician with training in addiction works with, and leads a team of, well-educated counselors, nurses, and social workers in these treatment centers. Cognitive behavioral therapies, education, motivational enhance therapies, and twelve-step facilitation are some of the techniques used in treatment. Patients are taught how to use twelve-step groups effectively and are introduced to other sober people in recovery. Peer support, mentoring or sponsorship is important.

The twelve-step groups (AA and NA) are free support groups that are available all over the world. These groups are helpful and thrive even though there has never been a CEO, president, or marketing director. No one profits monetarily from these groups. NA and AA are the ultimate grass-roots support groups and exist only because they are helpful and many people need that help. Medication-assisted treatment can be very important in a recovery plan.

Doctors can prescribe Naltrexone which is used to decrease alcohol craving and also to block the effects of opioids. Naloxone can save a life if given soon enough in the case of an opioid overdose. Antabuse causes alcohol to metabolize to a poison (acetaldehyde), which makes a patient violently sick and deters drinking. The treatment of co-occurring psychiatric disorders such as major depression, PTSD, and bipolar illness is vital. A patient with an unstable psychiatric disorder will self-medicate and relapse. Harm-reduction strategies, such as prescribing methadone or buprenorphin, can be effective in treating opioid addicts. Buprenorphin has been very successful in this regard. It is a partial agonist, while other opioids are true agonists. At lower doses, buprenorphin is an agonist, giving the positive opioid effect, but at higher doses it becomes an antagonist. This puts a ceiling on tolerance developing, so higher and higher doses are not needed. On the proper dose of buprenorphin, the patient is not impaired, not “high” and has no craving of opioids. The patient can then work a plan of recovery and can get his/her life back.

Addiction is a primary chronic disease of the brain effecting the reward, motivation, memory, and related circuitry. It can be successfully treated. Most doctors know little about it, yet every doctor has patients in his/her practice who are chemically dependent or alcoholic. Doctors can impact this terrible epidemic by learning more about chemical dependency, watching their prescribing habits (including the over-prescribing of benzodiazapines), and by at least entertaining addiction as part of the differential diagnosis leading to referral of patients for treatment.
9. A physician’s reasonable medical judgment, if the patient has not conveyed directions against a DNR order at a time when the patient was competent, and if the physician’s judgment is that:
- the patient’s death is imminent (though the bill does not specify a time frame for what is meant by “imminent”) regardless of the provision of CPR; and
- the DNR is medically appropriate

A valid DNR order takes effect at the time of issuance as long as it placed in the patient’s medical records as soon as practicable. When placing the order in the patient’s medical records though, a physician should keep in mind that: (i) certain notice requirements (discussed next) apply to DNR orders issued under certain circumstances, i.e., option 9 described above and (ii) some of these notice requirements must be satisfied before placing the order in the medical record.

The bill leaves open the question of whether failure to provide the required notice before placing the order in the medical records could invalidate the DNR order itself. Ensuring compliance with the notice requirement before the DNR order is placed in the medical records is thus of significant importance.

Is a physician required to provide notice of a DNR order?

If an attending physician issues a DNR order under option 9 above, i.e., on the basis that the DNR order is not contrary to the directions of a patient who was competent at the time the patient conveyed the directions, and in the physician’s reasonable medical judgment: (i) the DNR order is medically appropriate and (ii) the patient’s death is imminent, regardless of the provision of CPR, two distinct notices may be required. Both notices apply after the decision to issue the DNR order has been made, but one notice is conditional upon the occurrence of a trigger.

1. The first notice: before the DNR order is placed in a patient’s medical record, the physician or a physician assistant, nurse, or another person acting on behalf of a health care facility or hospital shall inform the patient of the order’s issuance, or if the patient is incompetent, make a reasonably diligent effort to contact the patient’s legal guardian or agent under a medical power of attorney, or, if no guardian or agent is known, the patient’s spouse, adult children or parents. For liability protection purposes, record of the notice or notice effort should be placed in the patient’s medical record.

2. The second notice: if an individual arrives at the patient’s hospital/health care facility and notifies a physician, physician assistant, or nurse providing direct care to the patient that the individual has arrived and if the individual is the patient’s known agent under a medical power of attorney or known legal guardian, or (if the patient has no known agent or guardian) the patient’s spouse, adult child or parents, the applicable physician, physician assistant or nurse is required to disclose the DNR order to the arriving individual and, for liability protection purposes, should record the notice in the patient’s medical records. If one person has already received this notice, it is not required that additional persons receive the same notice.

The bill does not clarify how these two notice requirements work together. In some cases, it may be that notice to one individual may satisfy both requirements. On the other hand, there may be other circumstances in which physicians must provide two distinct notices. Because of the lack of clarity surrounding the notice provisions, being aware of the requirements and making a good faith effort to comply and recording that effort is crucial. The bill provides that a person who makes a good faith effort to comply with the notice requirements and contemporaneously records those efforts is afforded protection from civil liability and criminal, as well as from disciplinary action from the person’s licensing authority, i.e., the Texas Medical Board.

Can a DNR order be overridden?

The short answer is yes. S.B. 11 requires a physician providing direct care to a patient for whom a DNR order is issued to revoke a DNR order for a patient if the patient, or as applicable and if the patient is not competent, the patient’s agent under a medical power of attorney or the patient’s legal guardian, either:

1. effectively revokes the advance directive, in accordance with Texas Health and Safety Code Section 166.042, on which the DNR order was based, i.e., by destroying or defacing the directive, by signing and dating a written revocation, or by orally stating an intent to revoke the directive or

2. expresses to anyone providing direct care to the patient a revocation of consent to the DNR order or an intent to revoke a DNR order.

This is also consistent with the general “last-in-time” principle stated in the bill. The bill states that if a DNR order conflicts with a treatment decision made in compliance with the laws related to DNR orders or another advance directive, that decision or directive, if made later in time, would control. On the other hand, if a valid DNR order is issued later in time and conflicts with a previous treatment decision or advance directive, the DNR order would control.

Additionally, the bill states that an attending physician may at any time revoke a DNR order if the DNR order was issued on the basis set forth in option 9 above, i.e., on the basis that the DNR order is not contrary to the directions of a patient who was competent at the time the patient conveyed the directions, and in the attending physician’s reasonable medical judgment: (i) the DNR order is medically appropriate and (ii) the patient’s death is imminent, regardless of the provision of CPR.
What happens if an attending physician does not wish to execute or comply with a DNR order or the patient’s instructions concerning the provision of CPR?

Whenever an attending physician does not wish to execute or comply with a DNR order or a patient’s instructions concerning the provision of CPR, the physician is required to inform the patient, the legal guardian or qualified relatives of the patient, or the agent of the patient under a medical power of attorney of the benefits and burdens of performing CPR on the patient.

If the attending physician and the patient or other person authorized to make decisions on behalf of the patient are still in disagreement after the physician has explained the benefits and burdens of performing CPR on the patient, the physician or facility must make a reasonable effort to transfer the patient to another physician or facility that is willing to execute or comply with the DNR order or the patient’s instructions concerning the provision of CPR.

Taking the aforementioned steps does not permit the physician to issue a DNR order that would otherwise be invalid. When there is still disagreement about a course of treatment for a patient after a reasonable but unsuccessful effort to transfer the patient, it is important that a physician consult with a private attorney and/or consult hospital or health care facility policy and legal counsel to determine how to proceed.

Is there any liability protection for a physician who issues or executes a DNR order?

The bill does provide limited liability protection (and protection from disciplinary review and action) for physicians and other health care professionals who act in good faith to issue a DNR order under the subchapter or who, in accordance with the subchapter, cause CPR to be withheld or withdrawn from a patient in accordance with a DNR order. Similarly, the bill provides that physicians and other health care professionals are not liable or subject to disciplinary action if they fail to act in accordance with a DNR order of which they have no actual knowledge.

Are there any additional legal risks associated with DNR orders?

The bill added a criminal Class A misdemeanor offense that applies when a physician or other person intentionally conceals, cancels, effectuates or falsifies another person’s DNR order, or if the person intentionally conceals or withholds personal knowledge of another person’s revocation of a DNR order in violation of the law.

Additionally, a physician or other health care professional is also subject to review and disciplinary action by the Texas Medical Board or other appropriate licensing board if the person intentionally fails to effectuate a DNR order in violation of the law, or intentionally issues a DNR order in violation of the law.

These two enforcement provisions are drafted very broadly and it thus may be difficult to properly and adequately assess associated legal risks. Thus, it is recommended that physicians consult with private counsel and/or consult hospital/health care facility policies and legal counsel in order to understand where individual physicians may face the greatest legal risks.

What is the effective date of S.B. 11 and will any rules be promulgated regarding DNR orders?

S.B. 11 takes effect April 1, 2018.

The law specifies that the new subchapter, which regulates in-facility DNR orders, applies only to a DNR order issued on or after the effective date of the law.

The executive commissioner of the Health and Human Services Commission is required to adopt rules necessary to implement the new law as soon as practicable after the effective date of the law.

Source: Texas Medical Association
1 S.B. 11, 85th Texas Legislature, 1st called session; available at: http://www.capitol.state.tx.us/tlodocs/851/billtext/pdf/SB00011F.pdf

**NOTICE:**
The Texas Medical Association provides this information with the express understanding that 1) no attorney-client relationship exists, 2) neither TMA nor its attorneys are engaged in providing legal advice, and 3) that the information is of a general character. This is not a substitute for the advice of an attorney. While every effort is made to ensure that content is complete, accurate and timely, TMA cannot guarantee the accuracy and totality of the information contained in this publication and assumes no legal responsibility for loss or damages resulting from the use of this content. You should not rely on this information when dealing with personal legal matters; rather legal advice from retained legal counsel should be sought.

---

**Save the Date - Tuesday, February 27, 6:00 pm**

“Dealing with Difficult Patients and Avoiding Being Labeled as a Disruptive Physician”

Concerned about being labeled “a disruptive physician”? Have one of those “difficult patients” you don’t know how to handle?

The TCMS Physician Wellness Program will host a 2-hour ethics CME on Tuesday, February 27 at the TMA Thompson Auditorium. Dinner at 6 pm, presentation starts at 6:30 pm.
TCMS Classified Advertising

A “go to” resource for physician readers and excellent visibility for advertisers.

**Classified Advertising**
- Rent/Lease or Sale

**Medical Office for Rent:** Central Austin at 2911 Medical Arts #7. Approx. 1000 square feet available with 3 exam rooms with private reception space, plus spacious fully furnished waiting room. Free parking for tenants and patients in large central parking lot. Available immediately. Rent negotiable.
  
  Contact Mary Peters at 512-582-1201 ext 100.

**For Sale:** Gynecology practice for sale in Austin! Active patient count of 3,140. Averages 48 new patients monthly. Payment breakdown is 87% PPO, 10% HMO, and 3% FFS. 2016 collections total $419,416. Located in a 1,600 square feet professional building with 3 exam rooms, including one for procedures. Contact Paula at 469-222-3200 or Paula@adstexas.com.

**Sleep 360 Sleep Diagnostic Center**
- Pecan Park Professional Plaza
- 10601 Pecan Park Blvd, Suite 203
- Austin, 78750

**Our Services**
- Physician Consultation
- Physician supervised sleep studies with quick turnaround time for results
- CPAP/BPAP compliance clinic
- Cognitive Behavioral Therapy (CBT) for insomnia management
- Home sleep studies

**Contact:**
- Vani Vallabhaneni, MD
- AASM Accredited 4-Bed Sleep Center
- Call 512-810-0380 • Fax 512-918-0351 • www.sleep360md.com

**Office Space**

**Medical Exam Rooms for Rent:** Two medical exam rooms for rent in Taylor, TX. Call 512-352-7664.

**Equipment**

**Medical Equipment for Sale:**
- GE Logiq 200 series sono with vag/rectal probe and camera
- Midmark Ritter M11 Ultraclave autoclave
- Gynetech colposcope Model 8101AL
- Cryotherapy therapy unit with cervical and condyloma probe and two nitrous oxide canisters
- Centrifuge for hematocrit
- Centrifuge for urine/blood specimens
- Mechanical medical scale
- 3 wall mount large blood pressure cuffs and stethoscopes
- 3 exam tables
- Graves vaginal speculums, uterine sounds, tenaculums, cervical dilators, pickups, scissors, needle holder

Contact Brad Price 512-699-5659 or beeprice@grandecom.net

**Business Card Ads**
Advertise your practice or specialty
Celebrate a new partner or location
Retiring or selling your practice

$200/issue

For more information:
Contact Chantel Pearson at cpearson@tcms.com or 806-640-4553.
Think inside the box.
Running out of space to store years of patient files?

Before you completely space out, contact us!

TCMS Document & Data Services offers discounted rates on medical record storage, retrieval and disposal.

Open up your filing space—take advantage of our secure warehouse.

Need a file from storage? Expect timely delivery to your office.

Safe and secure storage of electronic records.

For professional, compliant document destruction, use our shredding services. A certificate of destruction is provided.

Discounted rates for TCMS members
512-554-1818
tcms@tcms.com
or visit www.tcms.com
WE KNOW YOU HAVE CHOICES WHEN REFERRING YOUR PATIENTS...

That’s why we go the EXTRA MILE.

TRUSTED PARTNER for 37 YEARS OF SERVICE

CONVENIENT ACCESS

34 DOCTORS with 18 LOCATIONS

COMPREHENSIVE CARE

TREATING COMMON, CHRONIC and COMPLEX GI/LIVER CONDITIONS

ABOVE & BEYOND

EXCEEDING NATIONAL QUALITY BENCHMARKS

LEADING THE WAY IN GI AND LIVER CARE IN THE GREATER AUSTIN AREA SINCE 1980.

To find Physicians and Locations visit us at AustinGastro.com.