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PROGRAM OVERVIEW
This Heart Valve Summit — on the River, is designed to highlight case-based decision making for the accurate diagnosis and effective treatment of heart valve disorders. With an emphasis on functional anatomy, imaging innovation and percutaneous valve interventions this course will engage and educate cardiologists, cardiovascular surgeons, anesthesiologists, nurse practitioners, internal medicine specialists and fellows-in-training. This interdisciplinary summit will combine short presentations, debates and an ask-the-expert live valve conference to expose participants to the most relevant medical, surgical and interventional options for contemporary patient care. The topics, cases and discussions will include both accepted and controversial treatment paradigms and will offer novel perspectives and recommendations to all members of the heart valve team.

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Ice berries. Photo by Thomas F. Smith, MD.
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As the New Year begins, I have been reflecting on the challenges we face in medicine. I had an experience recently that reinforced my belief in the multifaceted approach to problems and the multidisciplinary approach to solutions.

On December 31, 2013, while in New Mexico, I was hit by a skier, who was moving at too great a speed to control his ability to turn or stop. My young daughter and husband witnessed him crash into me, causing severe injury to both of my legs. Over the course of the next several hours, I had what might be called the “full patient experience,” from ski patrol to EMS to the hospital emergency department.

X-rays confirmed bilateral fractures of my legs, which by their nature meant I was unable to walk or bear weight. There was good news, no nerve injury or compartment syndrome observed, but I was unable to stand to help my spouse with transfers. For most people this would be an enormously intimidating situation. Loss of mobility, continuous pain, uncertainties about getting home and financial considerations all swirled about in my mind as we planned our return to Austin as well as the next several weeks to months of our lives. My husband is a man who, in the time that I have known him, wakes up happy every day. He and I were now not happy, not sleeping and not at all sure we had an avenue to a solution to our problem.

But, we had something early on that gave us the ability to continue to work through our problems, get home safely and have the hope that things would work out in time - we had help. The local EMS personnel, who transported me to the hospital on the day of the injury, came to our hotel the day after my accident and helped me move to another hotel where I would have more room until we could arrange the trip home. They did this at no charge with lift chair equipment to minimize my discomfort with the transfer. They also loaned us a wheelchair on our good names so that I could get out of bed and transfer into the truck on the day we left to come home.

The ski shop owner sent me a hat and a little angel sculpture with her good wishes. The owner of the hotel hurried across the parking lot to help with phone calls and to check my status while my husband ran back and forth to pharmacies, medical supply shops and made calls to address all the issues of our 14-hour drive home.

The Boy Scout sponsors, who were there with my son’s troop, helped lift me in and out of the truck when we first got back from the hospital ED, and also when we were leaving to come home. They also took responsibility for our two children, taking them back to the ski area and making sure they had meals and activities for the two days we were planning the logistics of our return.

In Austin, two of my professional friends with trauma experience were graciously helping me plan and understand the work-up and treatment plan for my extensive injuries, so that I could communicate with our insurance company why we were going to need MRI’s, durable medical equipment (DME), specialist visits, etc. They were my intellectual lifeline that helped me keep the medical side of things stable. They also had great compassion and concern, which comforted me and relieved my anxiety.

My practice partners wholeheartedly stepped in to take the burden of our busy practice off my shoulders. They also offered help with obtaining much needed DME so that when we arrived home, there were proper assistive devices. Our personal friends drove two hours from Austin to meet us and relieve my husband from driving the last two hours of our 14-hour trip home. Friends from nursing and pharmacy met paramedics at our home as we arrived at 11 pm to help remove me from our truck and carry me inside. They also returned the next morning to help ferry me over to the MRI scanner for much needed further work-up of my injuries. They sat with me in the hospital 24-7, making sure I was safe and relieving my family of the anxiety and burden of worry while I underwent the first of two planned surgeries.

My brothers, children, nephews and niece all pitched in to build a ramp along the side of our house while I was in the hospital for my first surgery, so that I now have wheel chair access. Many friends and family have put together a caregiver calendar and are bringing meals to our family, transporting our kids to school events and checking in on us frequently now that we are home.

The generosity of our friends, family and professional colleagues is overwhelming. None of our hope or ability to cope with these unexpected challenges would be possible without their help. Long-term rehab, recovery from the surgeries and return to work would also not be possible. Our sanity is preserved, and our faith affirmed in God, friendship, human nature and the kindness of strangers. And it comes from so many different people, different professions, different specializations and talents.

Although the idea of a multifaceted, multidisciplinary approach to problem solving and implementation of solutions is not new to me, I think the experiences
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of the past two weeks have re-emphasized the necessity of this type of approach to large complex problems. And as we move forward during this year, I think it is crucial to the success of medicine – locally, regionally and nationally – that we continue to implement this type of strategy.

What this means to us, as members of the Travis County Medical Society, is that we must work collaboratively, across specialty, academic and community-based provider lines to achieve common goals that provide the best options for our patients and our practices. This may be achieved via policy, advocacy efforts, improved community relations for physicians, in service to our colleagues who have rehabilitation needs, in public health or mission type services to underserved populations or through fundraising for beneficent causes like The Blood and Tissue Center of Central Texas.

Many of our colleagues are becoming employed. There is real concern that physicians in independent practice and physicians in employed practice will start to fragment in brotherhood due to economic or employer forces. It will be a challenge to continue to focus on and embrace physicians’ common goals and common concerns. But we must do this to sustain the strength in numbers necessary to maximize our influence and effect solutions we feel are important to our patients and practices. As physicians, we will all need to reach across the divide to other providers as well, including allied health providers and other practitioners, with the idea that our common goals should be promoted together in the largest numbers with the patient’s best interests as our focus.

To do this effectively, we need to increase our membership and encourage our colleagues to participate in organized medicine. We are all busy with our families and community commitments in addition to the needs of our profession. It does not take as much time to complete tasks or effect change if the number participating is large. This applies to political advocacy, community volunteer opportunities, committee service and participation in the TMA and AMA delegations.

As the saying goes, “it takes a village…” to overcome obstacles and effect the best outcomes for not just one, but for all. I have the hope that TCMS will grow in numbers and participation through the coming year, so we can achieve these results. My recent experience has shown me that it is achievable.

I look forward to seeing and working with many of you this year.
TCMS Events

February

6 - Networking Social
   Baker Street Bar & Grill
18 - Business over Breakfast
   TCMS Offices
27 - Business of Medicine
   TMA Thompson Auditorium

March

18 - Business of Medicine
   TMA Thompson Auditorium
27 - TCMS Installation of Officers
   TBD

April

8 - Business over Breakfast
   TCMS Offices
24 - Auto Show
   TBD
29 - TCMS/AISD Athletic Physicals
   Burger Center

May

2-3 - TEXMED
   TMA Thompson Auditorium
6 - TCMS/AISD Athletic Physicals
   Delco Center
8 - TCMS/AISD Athletic Physicals
   Delco Center
13 - TCMS/AISD Athletic Physicals
   Burger Center
22 - Networking Social
   TBD
29 - Business of Medicine
   TMA Thompson Auditorium

June

17 - Business over Breakfast
   TCMS Offices
21 - Family Social
   TBD

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Some have asked if there will still be a need for Project Access (PA) once the Affordable Care Act (ACA) is fully implemented. The short answer is “yes.”

“We do hope that more of our patients will have access to private insurance through the marketplace,” said Tom McHorse, MD, founding chair of Project Access. “However, we realize that in reality, the insurance available to those on the lower end of the income spectrum includes such a high deductible that it will remain unaffordable to many of those we serve.”

While Project Access’ eligibility criteria and patient mix will no doubt change as the ACA evolves, the program’s goal will remain the same: to provide access to health care for uninsured, low-income residents of Travis County.

It’s been more than a decade since Dr. McHorse, in his president’s article, in the TCMS Journal, addressed the lack of resources for indigent care in the area and introduced the concept of a medical society based program of comprehensive volunteer medical care for the uninsured working poor. From that idea, Project Access became a reality through the commitment of TCMS members – primary care physicians and specialists – who agreed to see a limited number of PA patients in their offices pro bono. Since 2003, Project Access has made a direct and significant impact on the health of the community by opening the door to health care for those who have no medical insurance and are ineligible for government assistance.

Without Project Access, these patients would have been left to either live with their medical conditions or seek care through emergency departments.

Dr. McHorse recalls seeing one patient who came into the Volunteer Healthcare Clinic to get his abdominal pain checked out. The pain turned out to be a symptom of kidney stones and he was also diagnosed with kidney cancer. The patient was referred to Project Access volunteer specialists, urologist Michael McClelland, MD, and interventional radiologist John Manning, MD and was ultimately relieved of his pain and cured of his cancer. Such cases are not rare occurrences.

Today, Project Access has a volunteer community of over 1,000 TCMS member physicians plus hospitals, pharmacies, laboratories and ancillary care providers that cooperate with the program to help low-income uninsured residents of Travis County get the care they need.

Individuals applying for enrollment must provide documentation to ensure they meet eligibility criteria. Eligible patients also sign a patient responsibility agreement that requires them to be on time for appointments, follow the physician’s treatment plans and they must inform the program if there are changes in income or contact information. Patients are eligible as long as there is proof they continue to meet eligibility and follow Project Access rules.

The Project Access staff assigns patients to a medical home, then coordinates and tracks referrals to specialists. The staff manages the referral process so the physician will not be assigned more patients than their commitment pledge, thus effectively removing the issue of disproportional referrals as a barrier to physicians’ good faith participation.
Congratulations to Cliff Ames who is retiring after 12 years as Project Access Program Director. Cliff will be moving to Iowa to be near his family. He will be leaving Project Access in the capable hands of Kathy Gichangah and Jose Diaz who will continue to enroll patients and coordinate their care with the physicians who volunteer with Project Access.

At the time of the program’s launch, Brian Sayers, MD immediately got involved. He saw Project Access as a meaningful opportunity to show the community that their physicians care for them. For him, he says that participation in the program is of little extra effort, but extremely rewarding.

“With all the hassles we endure in our practices today, with all the worries about income and overhead and where medicine is going, sometimes it’s just nice to have a breath of fresh air in your office, a moment that is just practicing medicine in its purest sense – a doctor and a patient in a room together – without any thought of money or insurance,” Dr. Sayers said.

In spite of the well-intentioned implementation of the Affordable Care Act, the need remains for physician volunteers to provide for those who fall through the cracks in the system. While physician recruitment for Project Access was at an all-time high in the early years after its launch, physicians who have moved to the area in the last few years might be unaware of the program and its benefits to the community. Volunteer physicians can help carry on the program’s long-standing success and demonstrate the medical profession’s tradition of caring for the under-served, low-income and uninsured. Project Access and TCMS leadership encourage those not yet involved to consider joining your colleagues, and help spread the load of indigent care.

“Let’s keep this program vigorous,” Dr. Sayers urges. “And perhaps even use all the changes and uncertainty spinning around us in health care to be a force that motivates us to reexamine how to continue our mission and bring in a new generation of TCMS members to participate.”

For more information on Project Access or to sign up as a volunteer physician, contact Kathy Gichangah at kgichangah@tcms.com, 512-206-1118 or visit www.projectaccessaustin.com.
In 2010, the Centers for Disease Control and Prevention estimated that over one million people in the US were living with human immunodeficiency virus (HIV) infection. Of those people, about 16 percent do not know they are infected. Persons Living with HIV (PLWH) include persons with HIV (without acute immunodeficiency syndrome (AIDS) and persons with AIDS.) As of December 31, 2012, over 5,000 PLWH resided in the Greater Austin Area. The Greater Austin Area comprises the counties of Bastrop, Caldwell, Hays, Travis and Williamson. Since 2006, the number of PWLH in the Greater Austin Area has increased by 40.6 percent.

During 2010-2012, 815 new cases of HIV infections were reported in the Greater Austin Area. Most (88 percent) of the new HIV cases were males and most (75 percent) of these new cases reported an exposure or transmission category of men who have sex with men (MSM). During the same period, 457 new acquired immunodeficiency syndrome cases were also reported.

Table 1 shows the number of persons living with HIV by race/ethnicity for the years 2006 through 2012. In 2006, Whites comprised 50 percent of the persons living with HIV while Hispanics comprised 24.9 percent of the persons living with HIV. In 2012, the percent of persons living with HIV who were White decreased to 46.3 percent while the percent who were Hispanic increased to 30.2 percent. The percentage of PLWH who were African American decreased slightly from 24.2 percent in 2006 to 22.1 percent in 2012.

Figure 1 shows the HIV prevalence rates by race/ethnicity for the Greater Austin Area. Rates for African Americans were consistently higher for each year compared with Whites, Hispanics and other. Rates for African Americans were over three times higher for each year compared with the rates for Whites. Rates for each year for Whites and Hispanics were similar.

Table 2 shows the number of PLWH in the Greater Austin Area in 2012 by gender and age group. A majority (85.3 percent) of PLWH are males. Twelve persons were 12 years of age or younger. Overall, a majority (60.7 percent) of PLWH are between the ages of 35 to 54.

In the US, HIV is transmitted primarily by having sex with or sharing drug injection equipment with someone who is infected with HIV. However, transmission or exposure categories vary by gender. For male persons living with HIV in the Greater Austin Area, male-to-male sex accounted for 78.2 percent of the infections. Heterosexual sex was the exposure category for 70 percent of the females. Intravenous drug use accounted for 27.4 percent of females living with HIV compared with 6.6 percent for males living with HIV.

Summary:
- Over 5,000 Persons Living with HIV (PLWH) reside in the Greater Austin Area. Since 2006, the number of PLWH has increased 40.6 percent.
- During 2010-2012, 815 new cases of HIV infection, including 457 new AIDS cases were reported.
- 88 percent of new HIV cases were male and 75 percent of these new cases were men who have sex with men.
- Between 2006 and 2012, the percent of PLWH who were Hispanic increased from 24.9 percent to 30.2 percent, while the percent who were Whites decreased from 50 percent to 46.3 percent, and the percent who were African American decreased from 24.2 percent to 22.1 percent.
- Over the last seven years, rates of HIV prevalence among African Americans were consistently higher.
Figure 1.
HIV prevalence rates by race/ethnicity, Greater Austin Area, 2006-2012

<table>
<thead>
<tr>
<th>Age Group (Years)</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;2</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2 - 12</td>
<td>6</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>13 - 24</td>
<td>35</td>
<td>172</td>
<td>207</td>
</tr>
<tr>
<td>25 - 34</td>
<td>110</td>
<td>744</td>
<td>854</td>
</tr>
<tr>
<td>35 - 44</td>
<td>213</td>
<td>1,134</td>
<td>1,347</td>
</tr>
<tr>
<td>45 - 54</td>
<td>254</td>
<td>1,484</td>
<td>1,738</td>
</tr>
<tr>
<td>≥55</td>
<td>131</td>
<td>795</td>
<td>926</td>
</tr>
<tr>
<td>Total</td>
<td>749</td>
<td>4,335</td>
<td>5,084</td>
</tr>
</tbody>
</table>

Source: Texas Department of State Health Services, eHARS.

Table 2.
Number of persons living with HIV by age groups and gender, Greater Austin Area, 2012

for each year compared with Whites, Hispanics and other.
• 85.3 percent of PLWH are male, and 60.7 percent of PLWH are between the ages of 35 and 54 years.
• For male PLWH, male-to-male sex accounted for 78.2 percent of infections.
• For female PLWH, heterosexual sex accounted for 70 percent of infections.
• IV drug use accounted for 27.4 percent of female PLWH compared with 6.6 percent for male PLWH.

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"I can’t imagine enjoying any profession the way that I enjoy what I currently do," said the 2014 Travis County Medical Society President Sarah Smiley, DO when answering a question on what she would be doing if she wasn’t a physician. As a philosophy on sustaining interest and momentum in medicine as the years go by at a busy pace, she tries to set goals to move forward, improve and make positive changes. “I’m not a person that looks back. That’s the way I was brought up,” she said.

As one of five children, Sarah grew up in Lamesa, a small North Texas town between Midland and Lubbock comprised mostly of cotton farmers. Sarah was exposed to medicine at a young age through her parents, both busy physicians in the community. She credits her parents for planting the seed of interest in medicine, and participation in community and family. Setting an example, Sarah’s mother was a family practice physician who balanced her private practice, her work for the county health department and the many demands of a large family.

“Every Thursday, my mother would pick me up from kindergarten, and we would travel to neighboring counties to see patients, give immunizations and take care of public health issues. I got to see how she took care of her patients, how she would talk to them with such care and how they treated her – good or bad,” Sarah tells.

Once her mother quit working for the health department, Sarah joined her in making nursing home rounds and house calls on those Thursday afternoons.

“She had a lot of patients and was often their doctor for everything as they couldn’t afford to see specialists. That had a profound influence on my decision to get into medicine.”

Her medical exposure didn’t stop there. Sarah’s father was a surgeon, and when things were calm at home, he would frequently take her along to the emergency department while he was doing night calls. She remembers sitting there while watching her father interact with his patients as he diagnosed their injuries and illnesses. Sometimes her medical exposure came directly to the front door.

“People would drive up and knock on our door seeking help. It was a small town, so there was a lot of medical treatment dispensed out of the doctor’s bag in our living room,” Sarah said.

Sarah moved to Austin to attend the University of Texas. When she wasn’t in her pre-med classes, she spent time volunteering at Holy Cross Hospital where she was trained to be an operating room technician and had the opportunity to scrub in with surgeons in the community, such as Hector Morales, MD; Marvin Cressman, MD; Victor Li-Pelaez, MD and Albert LaLonde, MD. They provided her with encouragement and mentorship toward her decision to pursue medicine as a career.

After graduating from medical school at the University of North Texas Health Science Center, Dr. Smiley completed her residency in internal medicine and started practice in Austin as a hospital based internist.

“I was with some of the first hospitalists in the nation at a time when...
The usefulness of hospital based internists was not really recognized. It’s been a great decision. Sometimes your colleagues see something in you that you don’t see. They’ll push you down a certain path by making suggestions,” she said. “I just keep trying to improve how we conceive of, implement and deliver health care to the hospitalized patient. How we can do it better and better over time.”

One of the ways Dr. Smiley has kept her career stimulating is through teaching. She has taught medical students, nurse practitioner candidates and pharmacy interns ever since she finished her residency in 1994. She credits her students with helping her see problems from different directions, especially now that medicine is more complex than ever.

“You learn from them because they ask questions, they see things that you may not see, they hear things that the patient says that you may not have heard,” she explains. “Beyond the medical aspect, interactions with my students also teach me a lot about the nonmedical world, and how younger people think about everything.”

Unsurprisingly, Dr. Smiley’s interest in organized medicine was rooted through her parents, who were active members in their five-county medical society – they regularly attending meetings, CME presentations and TMA delegations for years.

As a young girl, Dr. Smiley remembers talking to her parents about the importance of physician involvement in a medical society and in the governance of the issues that affect medicine. After being involved in student organizations through medical school, not participating in the county medical society didn’t even cross her mind. Dr. Smiley joined the Travis County Medical Society as a resident.

“Organized medicine is the best way to address the politics, frustrations and hassles that impact medicine and the way we provide health care for our patients. It unites the multiple voices of the community at large and the profession to create a collaboration that can move the issues and solutions forward,” she said.

As the 2014 TCMS president, Dr. Smiley is aware and wary of the effects and the complexities of the Affordable Care Act as they impact physicians and their practices. However, as part of trying to be a forward and positive thinker, one of her goals is to encourage her colleagues to search for humor through the frustrations.

“Just like when you have a difficult case in the hospital, sometimes laughing is all you can do to keep yourself from crying. Laughter is a great release,” she said. “You embrace the absurdities of the situation. Then, you refocus and solve the problems to reach the best outcome for your patient. That same approach will be helpful in pacing ourselves through the policy making and fixing aspects of the Affordable Care Act.”

Married to Andrew, a groundwater specialist, and mother to Colin (13), and Grace (12), Dr. Smiley’s family is her priority.

As a family, they enjoy traveling to places from Canada to Peru and often seek outdoor adventures such as hiking and biking.
2013 ANNUAL BUSINESS MEETING AND AWARDS DINNER
December 5, 2013 at the Austin Country Club

2013 TCMS Physician of the Year Richard Holt, MD (right) was joined by family and friends as David Fleeger, MD congratulated him with the gold-headed cane.

Physician Humanitarian Award recipient Robert Rock, MD (left) and Ruth M. Bain Young Physician Award recipient Jason Reichenberg, MD.
**In the News**

**Norman Chenven, MD**, is the new treasurer of the American Medical Group Association (AMGA).

**Bruce Levy, MD** received the Patient Advocate Award, which goes to a Texas Society of Gastroenterology member who shows tireless efforts to provide access to medical care to patients.

**William Rice, MD** was appointed by Governor Rick Perry to the Oversight Committee of the Cancer Prevention and Research Institute of Texas.

January has been declared National Volunteer Blood Donor Month to raise awareness and honor the individuals who save the lives of countless patients through the selfless act of blood donation.

The Blood Center of Central Texas is a nonprofit affiliate of the Travis County Medical Society. We strongly encourage Medical Society members to support this unique community asset and its efforts by donating blood once a quarter if eligibility requirements are met; encourage family, friends and patients to do the same and consider a tax-deductible contribution to The Center.

All donors must be in good health, at least 17 years old and weigh at least 115 pounds to donate whole blood or 110 pounds to donate platelets. Some health conditions, medications and travel may temporarily or permanently prevent people from donating blood.

The Blood Center is fully accredited and the exclusive provider of therapeutic blood products for over 37 health care facilities in ten Central Texas counties.

For more information on The Blood Center of Central Texas and how to donate, please visit www.inyourhands.org or call 512-206-1266.

**Communications Committee**

**A call for members!**

Would you like to help develop the Travis County Medical Society’s communications and publications? The TCMS Communications Committee will soon be launching an updated TCMS website, reviewing the future of the TCMS Journal and discussing the use of social media.

If you are interested in working with the Communications Committee and taking part in the strategic planning of TCMS publications, contact Belinda Clare at bclare@tcms.com or 512-206-1250.

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Prostate cancer is the second-leading cause of cancer deaths among men in the US. Yet, when detected in its early stages, prostate cancer can be effectively treated and cured. Routine screening helps in detection of prostate cancer, and involves a blood test and an exam. Recently there has been some debate on how often to screen, at what age and if to screen at all. The American Urological Association (AUA) has updated the guidelines for prostate cancer screening and addressed some of these topics.

What is the prostate?
The prostate is a small, walnut-sized gland in men, located below the bladder and surrounds the upper portion of the urethra (where urine exits). The function of the prostate is to secrete fluids that make up part of the semen.

Prostate Cancer
Prostate cancer is an important health problem in the US due to its high significance. It is different from most cancers in that sometimes this cancer can be small, slow growing and present limited risk to the patient. Other times, it can progress rapidly. Risks factors include family history of prostate cancer, obesity and African-American ethnicity. Prostate cancer usually does not have any symptoms that are noticeable to the patient, especially in the early stages.

Current Screening Guidelines
The easiest thing you can do to detect prostate cancer and catch it early is to be diligent about getting screened. Screening involves a prostate-specific antigen (PSA) blood test and a prostate exam (also known as a digital rectal exam). This can be done by your primary care physician or urologist. The following guidelines are per AUA recommendations:

- Men under the age of 55 with no risk factors do not need to be screened.
- For men younger than age 55 years at higher risk (e.g. positive family history or African American race), decisions regarding prostate cancer screening should be individualized.
- Age 55-70 with low risk factors should be screened every two years.
- Over the age of 70 can continue to be screened if life expectancy is greater than 10 years.

If your physician feels that a screening test was suspicious, he may check your PSA more frequently until it is stable.

Why is there a debate about screening?
There are questions among health care professionals regarding the over-diagnosis and overtreatment of prostate cancer. However, screening to see if cancer is present is still important. If the physician suspects cancer, then he may decide to proceed with a prostate biopsy. We recognize that not all patients need to be treated if they have prostate cancer. For example, an elderly patient (>age 80) with a small amount of prostate cancer may not necessarily be affected by the cancer due to its slow growing nature. In certain patient populations, treatment may lead to more harm than good. Each patient has a different story, and while we recommend routine screening, further diagnosis and treatment is at the physician’s discretion based on each individual case.
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Even through the holiday season, the Travis County Medical Alliance members were busy volunteering and spreading cheer.

In November, Alliance members worked with Saint Louise House to clean and decorate an apartment that would be the new home for a former homeless family.

In December, TCMA helped put together a holiday event at the Volunteer Healthcare Clinic, distributing gifts to families and children. Alliance members also enjoyed the annual Holiday Luncheon at the Westwood Country Club, bringing together new and old members while gathering donations for BookSpring, a local nonprofit.

The Alliance Annual Gala scheduled for Saturday, February 1, benefits these non-profits:

- Lifeworks
- Family Eldercare
- St. Louise House
- Hospice Austin/Camp Braveheart
- Casa Marianella
- Camp Bluebonnet
- Volunteer Healthcare Clinic

Member Spotlight
Cindy Blaydon was born in Aberdeen, MD, but moved around the country about every three years with her father, a US Army cardiologist and her mother. She studied nutrition science at the University of California at Davis. After graduation, she followed in her father’s footsteps and joined the US Army as a 2nd Lieutenant. Cindy went on to complete her dietetic internship at Walter Reed Army Medical Center in Washington, DC, and later, her master’s degree in health care administration. Cindy was awarded Fellow of the American Dietetic Association in 1998 and Fellow of the Academy of Nutrition and Dietetics in 2013 for her numerous contributions to her profession. Cindy practiced as a registered dietitian for 20 years in the US Army prior to retiring.

During her second tour at Walter Reed, she met her future husband Sean Blaydon, who was completing his ophthalmology residency. Sean then followed her to Tripler Army Medical Center in Honolulu, HI where they got married. Cindy had her last duty assignment at Brooke Army Medical Center in San Antonio. After Sean completed his fellowship in ophthalmic plastic and reconstructive surgery, Cindy and Sean settled in Austin, where he joined Texas Oculoplastics Consultants (TOC).

Cindy and Sean have two children, Lauren, 11, and Ryan, 10. She stays busy volunteering at her children’s school, cheering them on at their various sporting events and traveling with her family. Cindy joined the Travis County Medical Alliance in 2005 and is currently serving on the Executive Board as VP of Enrichment. Last year Cindy served as Fund Drive Committee Chair. In the past, Cindy has enjoyed serving on various committees including Be Wise Immunize and Membership. Cindy says the Alliance is a wonderful group, and it has been an extremely rewarding experience.
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Failure to Report Injury to a Child

The following closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician’s defensibility. An attempt has been made to make the material less easy to identify. If you recognize your own case, please be assured it is presented solely for the purpose of emphasizing the issues of the case.

Presentation and physician action
A 16-month-old girl came to the pediatrician for evaluation and treatment of a burn to the back. The child’s mother and her boyfriend brought the child to the appointment. At the time of the accident, the mother was not home and the child was in the care of the mother’s boyfriend. The boyfriend claimed the child leaned against the oven door and touched the glass window, which caused the burn.

The pediatrician examined the patient and noted a second-degree burn on the child’s back approximately 6 by 8 inches. Silvadene and a dressing were applied. During the exam the pediatrician asked the mother if she suspected abuse and she said no. Although not documented, the pediatrician claimed she examined the child for other evidence of abuse and found none. She did not, however, remove the patient’s diaper.

The child’s biological father called the pediatrician later that same day and expressed concerns that the burn was not accidental. The pediatrician told the father that she thought the story was plausible, but if the father thought that the patient was being abused, he should notify Child Protective Services. The patient’s father made the report that day; however, the complaint was not investigated until several days later.

The following day, the boyfriend was again at home alone with the child. That evening, the boyfriend called 911 because the patient was unresponsive and not breathing. EMS arrived to find the patient in cardiopulmonary arrest. They intubated her and gave epinephrine and atropine via ET tube. The child was brought to the emergency department with CPR in progress. She was admitted and transferred to the PICU.

The patient’s physical exam showed complete unresponsiveness, fixed and dilated pupils, multiple bruises (forehead, occipit, shoulder, legs, trunk and feet), and a second-degree burn on her back, between the scapulas. Vaginal and anal bruising were also present. A head CT revealed subarachnoid blood and subdural hematomas. A skeletal survey showed a fractured second rib. An ophthalmology exam revealed bilateral retinal hemorrhages. The patient was diagnosed with battered child syndrome with molestation.

The following day, the patient had a cerebral blood flow study that revealed no flow to the brain. The patient also had an apnea test that showed no spontaneous respirations. She was later declared brain dead and removed from life support.

An autopsy revealed the following: blunt force injury to the head; external and subgaleal contusions; subdural and subarachnoid hemorrhage; traumatic brain swelling with herniation and multi-layered retinal hemorrhages. It also revealed a thermal burn to her back, genital and anal abrasions, contusions and superficial lacerations, contusions and abrasions to the torso and extremities, but no significant internal trauma. Focal bronchopneumonia was also noted. The autopsy report concluded the cause of death was “blunt force trauma of head” and the manner of death as “homicide.”

Allegations
The patient’s biological father brought a lawsuit against the pediatrician and the entity that employed her. The allegations included:

- negligence in failing to timely, adequately and/or properly recognize the serious condition of the child;
- failure to timely and properly diagnose the child;
- failure to timely and/or properly report the injury to the child to CPS and
- failure to timely, adequately and/or properly care for and treat the patient.

It was also alleged that the pediatric group was vicariously liable for the actions of the pediatrician.

The Texas Medical Board also investigated the case for the possibility that the pediatrician violated the Medical Practice Act. The allegations investigated included:

- unprofessional or dishonorable conduct specifically related to failure to report child abuse/neglect of a child to Child Protective Services and
- failure to practice medicine in an acceptable, professional manner consistent with public health and welfare, specifically not performing a thorough physical examination based on the injury.

The Disciplinary Process Review Committee recommended that the investigation be closed and the recommendation was ratified by the full Board. However, the investigation included a review that indicated that the exam lacked vital signs, weight or a detailed description and measurement of the burn, and that the child was not examined for other injuries. It was pointed out that an active 16-month-old child rarely leans against anything.

While the investigation concluded that the pediatrician should have notified CPS, the investigators also stated that it would not have made a difference in this case as CPS probably would not have begun their investigation within 24 hours.
Legal implications
The physician reviewers of this case felt that the pediatrician treated the child’s burn correctly; however, failed to suspect that it was abuse. Both indicated they would probably not have suspected abuse either because the mother did not express concern about the possibility of abuse. In fact, the mother left the patient with the boyfriend again the next day. This suggests that she did not have significant concerns that the burn was due to abuse. The reviewers felt that a more thorough physical exam should have occurred, and that there was enough evidence to warrant a call to CPS for inadequate supervision.

Disposition
The pediatrician had taken care of this child since she was an infant, and never saw any evidence of abuse. When asked, the mother denied any abuse; however, there were other persons who thought abuse was possible. Unfortunately the pediatrician did not have the benefit of that information. Although expert reviewers felt this case was defensible, the possibility of a sympathetic verdict resulted in a settlement to the patient’s biological father.

Criminal charges were brought against the mother’s boyfriend. He was ultimately convicted of murder and sentenced to life in prison.

Risk management considerations
With the growing rate of child abuse in this country, physicians are often faced with the difficult task of determining if a child is in danger. In this particular case, there were no apparent warning signs outside of the burn incident that caused the physician to be concerned. The abuser in this situation was educated, well spoken and the child’s mother did not display concern about the possibility of abuse.

The physician assessed the patient for other physical bruises or indications of abuse and did not find any evidence; however, this detail was not noted in the chart. Documentation of all findings during an examination is recommended in order to provide an actual description of the patient’s status. Additionally, the physician did not remove the child’s diaper to examine her for any signs of sexual abuse. In hindsight, both reviewers for this case felt that a more thorough examination should have occurred.

Reporting abuse
The State of Texas has rules and guidelines in the Family Code that address requirements for reporting child abuse or neglect. If a professional such as a physician or other health care provider has cause to believe a child is being subjected to abuse, a report shall be made no later than the 48th hour after the hour the professional first suspects that the child has been or may be abused or neglected or is a victim of the offense of indecency with a child.

Reports of abuse or indecency with a child should be made to:
• Texas Department of Family and Protective Services (DFPS) via the DFPS Texas Abuse Hotline at 800-252-5400 operated 24 hours a day, seven days a week or via secure web site www.txabusehotline.org. The website should only be used for reporting situations that do not require an emergency response.
• Law enforcement, in case of emergency. An emergency would be a situation where a child faces an immediate risk of abuse or neglect that could result in death or serious harm. Emergency reports should be made by calling 911 or contacting local law enforcement agencies. More information is available at the site listed above.
There are two types of blood thinners, anticoagulants and antiplatelet drugs.

Blood clots can cause problems when they prevent blood from flowing freely, especially to the heart and brain. Sometimes a doctor may not want a patient’s blood to clot as easily and will prescribe a blood thinner.

**CONDITIONS THAT MAY BENEFIT FROM AN ANTIPLATELET DRUG**
- Heart disease or prior heart attack
- Blood vessel disease
- Prior stroke or transient ischemic attacks
- Diabetes
- Being overweight or having metabolic syndrome
- Being a smoker
- Taking certain other medications
- Certain operations, such as angioplasty

**CONDITIONS THAT MAY BENEFIT FROM AN ANTICOAGULANT**
- Atrial fibrillation (abnormal heart rhythm)
- Prior surgery on a heart valve
- Congenital (since birth) heart defect
- Deep vein thrombosis
- Pulmonary embolism
- Pulmonary hypertension

**TYPES OF BLOOD THINNERS**
The two types of blood thinners work in different ways (Figure). Blood-thinning drugs have been used for many years. Newer medications are now available, but they may be more costly or less convenient or have other drawbacks compared with older drugs. Some commonly used anticoagulants are heparin, enoxaparin or other low-molecular-weight heparins, fondaparinux and warfarin; newer anticoagulants are dabigatran, rivaroxaban and apixaban. Common antiplatelets include aspirin, aspirin plus extended-release dipyridamole, clopidogrel, prasugrel and the newer drug cangrelor.

**FOR MORE INFORMATION**
National Library of Medicine


**TREATMENT WITHOUT BLOOD THINNERS**
Antiplatelets are usually given orally. Sometimes, the anticoagulant heparin is given continuously through the veins in the hospital. Warfarin is started orally while a patient is receiving intravenous heparin and is continued after the heparin is stopped. Once the INR (international normalized ratio, a test of blood clotting) is stable, heparin is stopped and the patient continues to take warfarin after leaving the hospital. It takes some care to maintain the correct level of warfarin. Patients must keep track of foods they eat that contain vitamin K, especially green leafy vegetables. Patients typically have their blood tested daily, then monthly, based on the INR, which shows how well the warfarin treatment is reducing blood clotting. Some conditions require lifelong treatment with blood thinners.

In some circumstances, enoxaparin or fondaparinux can be used instead of heparin and/or warfarin. Although they require daily injections, they do not require routine INR testing of blood clotting.

If you are prescribed a blood thinner, be sure to tell your doctor about any other medications you take. And if you are taking a blood thinner, you need to be cautious about using over-the-counter medications or herbal (dietary) supplements. Although some new anticoagulants do not interact with vitamin K, their interaction with other substances has not been well studied.

Make copies of this article to share with your patients.
### Classifieds

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