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FEATURES AND ARTICLES

6 FROM THE PRESIDENT
Battleship
Sarah I. Smiley, DO

10 JOINING PROJECT ACCESS
The Right Thing to Do
Tom McHorse, MD

12 IN MEMORIAM

14 MEET YOUR COLLEAGUES
Shahar Gurvitz

16 Illicit Drug Use: To Legalize or Decriminalize
William Loving, MD

18 DELIVERING PATIENT-CENTERED CANCER CARE

20 TCM ALLIANCE
Karen Kim, PhD, President

22 PRACTICE MANAGEMENT
Failure to Communicate Medication Orders
TMLT Risk Management

24 TAKE 5: GASTROESOPHAGEAL REFLUX DISEASE

25 CLASSIFIEDS
FROM THE PRESIDENT

Battleship
Sarah I. Smiley, DO

In the last two issues of the Journal, I wrote about two bedrock values of the profession of medicine: stewardship and fellowship. Based on what I'm hearing from my colleagues, the practice of medicine these days is beginning to feel more like a battleship.

- Electronic Health Record Systems
- ACOs/Shared Services Organizations
- Corporate Practice of Medicine/Employed Physician Models
- Tort Reform
- ICD-10
- Scope of Practice

These are just a few of the myriad issues facing practicing physicians today, and their ramifications are daunting. Many of the things we are now being asked (or required) to do are, at best, inconvenient to us and to our support staff. Frequently, they impact our face time with patients, leaving them with a sense that we are distracted, tired, or worse — not really focused on them at all.

Patient satisfaction surveys support that this is a real and negative consequence of the increasing intrusions into the physician practice and consequently, the physician-patient relationship.

Almost every day, I hear concerns from colleagues related to changes in the practice environment. These physicians are successful, financially stable, talented. Some are in groups, some employed and some independent. They are uncertain about the future of their practices, their autonomy. They are also concerned about their patients' autonomy and access to health services. They are fatigued from the hassles. They are unsure about their longevity within the practice of medicine as professionals, or if they will make it to retirement. They are informed and have been regularly contributing to the profession. And they are worried.

Many have successfully made the transition to electronic health records, but have not seen any dramatic improvement in their (or their patients') personal experience or outcomes. In fact many physicians find that navigating these systems is actually detrimental to physician-patient and physician-physician communication.

Even in the best of these EHR systems, documentation can be repetitive and unenlightened, making it difficult to filter out the salient information from each patient visit. Actuarial CMS "bullet point" requirements for documentation have led to the development of incessant, supernaturally boring template-based notes. They make it difficult to track patient medications, orders and team member comments. This documentation requires more time to produce and more time to filter for pertinent information. To be fair, there are some benefits like remote access to laboratory, X-ray or typewritten data. But EHR inefficiency and errors can make it seem as if these systems were designed more to provide easy access for actuarial data mining by hospitals, insurance companies and federal agencies, than to facilitate patient care.

Some physicians and physician groups are concerned that shared services organizations and ACOs will move to closed provider panels; that they may exclude practices that either cannot afford to implement the technology or staffing to meet the required metrics/data reporting, or that simply do not want to be in a unilateral association or employment arrangement. Others worry that these organizations may be bureaucratically top heavy and that much of the shared savings in these arrangements will be pulled into the managerial overhead, not passed on to the actual point-of-service providers in the system.

Employed physician models are being introduced into many health care delivery systems. Some physicians and groups feel pressured, financially and sometimes politically, to join employed physician models for business reasons — not necessarily for best medical practice reasons. They are concerned about loss of clinical autonomy, which can extend into their medical decision making or policy decisions. They're concerned about policies, processes and service denials that could be detrimental to their patients. They're concerned that their ethical duty to the practice of good medicine could be compromised. These are the things many physicians worry about.

Tort reform comes under attack at each legislative session in our state, and will remain a significant issue for physicians in the foreseeable future. We have enjoyed the benefits of tort reform for over 10 years, but it will continue to be a challenge in the face of well-funded efforts by litigation professionals to undermine this important legislation.

ICD-10 is a costly and exponentially expensive implementation for all practices, especially for procedurally based physicians. It is full of trivial designations, which will effectively result in cost savings by significantly delaying authorizations for necessary procedures for patients, and by delaying billing and collections processes for physicians. The TMA has called for the scrapping of the entire ICD-10 system, with a request that available resources be focused on developing ICD-11. They are requesting that the new system have significant revisions that will simplify its inherent complexity and the cost of implementation for all stakeholders.

Physician extenders are continuously working to expand their ability to diagnose and prescribe treatments, independent of physician supervision. This is despite clear differences in the complexity and intensity of training. Policymakers have suggested that, in the new era of health care, the extender group should be the first level of providers for all patients in the system. They are expected to produce higher numbers and to be less expensive, thereby increasing health care access and decreasing cost to the system.

Continued on page 8
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The policymakers have not, however, projected the costs that would be incurred for delays in diagnosis or treatment, or serious effects from incorrect treatments for wrong diagnoses due to this discrepancy in training and experience. We should respect the contribution and knowledge of these providers, many of whom are integral contributors to the operation of many high quality medical practices. However, they should be collaborators with the coordinating physician supervisors, in a joint effort to provide the best care to the most patients.

There is also encroachment on the practice of medicine by allied health providers, despite their limited licenses, education and training compared to physicians. Chiropractors, physical therapists, optometrists, pharmacists and others are pushing, through legislative and health care policy processes, to increase their performance of procedures.

To address these many issues and the changing health care environment, physicians will need to push back. We will have to collaborate within our profession and cooperate with outside extender groups on reasonable practice guidelines to ensure that our patients and our profession are maintained. We will have to fight to keep physicians in control of clinical practice and policy development and implementation. Over the years, there have been many instances where physicians once accepted something as good practice based on research, that later changed based on new information, or where closer analysis required that previously held ideas be dropped altogether.

The same applies to many of the current changes in health care. We are finding that EHRs are not all that they were thought to be in terms of benefits for patient care. We are finding that many of the promises and projections of the ACA are not as they were touted at the time of the congressional vote. We are seeing that although there has been a shift toward employed practice models, there are also a number of physicians who are leaving employed physician arrangements. While many physician extenders and allied health providers are pushing for independence in practice, others are reconsidering how it might impact tort reform legislation or access to physician expertise for themselves and other patients in the future. These changes provide opportunities for physicians – opportunities for thoughtful, informed approaches, if not solutions.

Continued on page 11
GOOD IS
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Meet our Team of BUSINESS BANKING EXPERTS: L to R: Kara Pinnelli | Mark Hartline | Harvey Hartenstein | Laurie Logue

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Joining Project Access:
The Right Thing to Do

Tom McHorse, MD
PA Chair, Executive Committee

If you’re not familiar with Project Access, it’s the 11-year-old, TCMS-sponsored program to provide care for the medically indigent — those who do not qualify for any government health benefit or insurance program. In many cases, these patients are best characterized as the “working poor.” Project Access relies completely on volunteer physician participation of PCPs and specialists to provide medical services for these patients in need of health care. The care is provided in their office, procedure clinic or operating room. Patients are assigned a physician on a rotational basis dependent on the number of patients a volunteer agrees to see — generally four to 10 patients per year.

Why should you volunteer along with the approximately 1,000 TCMS physicians who are currently involved in the program? Logic plays a major part in our daily thinking as physicians. But, so does emotion which adds many reasons for participating in Project Access. Some of us are motivated by a religious belief in serving the poor. For others, there’s an innate sense of altruism. Still others are responding to peer pressure. If you’re motivated by logic, consider that you get nothing from those almost daily “no shows” in your office. Think about it this way, volunteering your time to care for four to 10 patients per year represents less than 0.2 percent of your practice volume per year.

I think most of us who volunteer our professional skills do it because it’s simply the right thing to do. By seeing an occasional Project Access patient, you would be helping people in need, and possibly even saving their lives. The expressions of appreciation that appear on this page illustrate the tremendous need for Project Access in our community.

The purpose of this article is to say thank you to the many physicians who have made long-term commitments to Project Access, and to recruit additional docs. Make a difference in our community and volunteer today.

Please contact Kathy Gichangah at kgichangah@tcms.com or 512-206-1118 to join the Project Access team. You can also contact me with questions at tmchorse@gmail.com. Thanks.

TO: Project Access
I would like to extend my gratitude to Jose Diaz and Kathy Gichangah for rescuing me from a situation where I thought all hope had been lost. After my accident (a broken leg), I was devastated. I had been employed for less than 3 months so insurance had not kicked in, I had no idea how or where to get the money needed.

My Mother found the program Project Access from referrals at MAP. She was able to get me an appointment with Jose to review my case.

Jose, I deeply appreciate all of your efforts to make it a great success. Thank you for all you do for our community and for me. You were able to get Dr. Sullivan to assist and do my surgery; it is as if a higher power was directing the steps.

I broke my leg on Sunday, May 18, 2014, saw Dr. Sullivan on Tuesday the 20th and had my surgery on Friday the 23rd of May. How amazing is that just incredible I am truly blessed to have found you and Project Access.

I was so fortunate to benefit from your contributions on a daily basis. Thank you for inspiring this great team to such a successful outcome. I am now on the road to recovery and thank God every day for his guidance and your exceptional job well done.

It was a pleasure working with you, Jose.

Clay Moore
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Contact TCMS Auto Program Director Phil Hornbeak at phornbeak@tcms.com or 512-949-5758.
IN MEMORIAM

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

Robert E. Askew, Sr., MD, past president of TCMS, passed away on July 4. Dr. Askew was a native Texan who graduated from UT Austin before serving in the US Army from 1951-1953. He returned to Texas to receive his medical degree in Galveston, graduating Alpha Omega Alpha (AOA) Medical Society, then did post graduate training at the University of Michigan. He returned to his boyhood home in Ellis County, where he practiced for several years and was elected president of the Ellis County Medical Society before returning to Galveston to complete a surgical residency and time as chief resident and instructor of surgery.

Dr. Askew returned to Austin in 1968 with his wife Jenell and their growing family which included his future surgical partner, Robert E. Askew, Jr. He went on to practice in Austin for nearly a half-century, becoming one of the most respected and admired physicians this city has ever known. Dr. Askew’s list of accomplishments, honors and leadership positions are too long to list here, and this man known for his humility would no doubt have preferred we not attempt to do so.

Suffice it to say that he was involved in dozens of professional, charitable and community organizations and more often than not served as their leader at one time or another. He was elected TCMS President in 1991 and was recognized with our highest honor the following year, receiving the Gold Headed Cane Award. With the same grace with which he practiced for so many years, he retired at the height of his skills in 2005. Like many of his generation who loved their profession and the tight knit group of physicians who practiced and cared for each other in an earlier era of Austin medicine, Dr. Askew retired wishing his career could have gone on longer. However, he did enjoy travel, time with his grandchildren and volunteerism after his retirement.

Dr. Askew often spoke of medicine as an art and of our moral duty to our patients. In his very first TCMS President’s column, Dr. Askew asked, “…wouldn’t it be most fitting that we resolve to promote the science of medicine; to propagate the art of medicine; to practice medicine with humility – without arrogance or greed, and to follow the golden rule?” While TCMS may or may not have accomplished his wish that year, by any estimate Dr. Askew did all of that in his career. He leaves behind countless patients and colleagues who were touched by his skill and humility.

Stanton W. Glazener, MD, a longtime internist in Austin, passed away on July 9. Dr. Glazener was born in Big Spring, TX but his family eventually moved to Austin where he graduated from Stephen F. Austin High School and later from the University of Texas at Austin. He received his medical training in Galveston before serving in the Air Force, being discharged as a captain in 1961. Dr. Glazener and his wife Margaret moved to Austin that same year where they raised a family while he practiced internal medicine, first in a small group, then later in solo practice until his retirement in 1989.

Like many practitioners of his era, Dr. Glazener was known for the close relationships he had with his patients, the personal, small atmosphere of his office and his availability to patients day and night including house calls which he continued to make well after most of his peers had abandoned this practice. His son, Wesley Glazener, MD, notes that medicine was changing rapidly near the end of his father’s career and at a relatively young age he retired to pursue interests in travel, music, art, gourmet cooking, his Texas Longhorns and time with his family at his lake house. Dr. Glazener suffered from a prolonged illness in his later years, making his decision to retire somewhat early a wise one that enabled him to live life to the fullest. He leaves behind his wife of 62 years, four children, 10 grandchildren and a legacy of service to his country, as well as the kind and excellent medical care that he helped provide to a generation of Austinites.
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~ Amy Salinas, MD, ARA Radiologist

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Robert Marks, MD

Born and raised in Plano, TX, Robert Marks, MD has always been fascinated by science. He was constantly analyzing, taking apart and rebuilding the world around him. There was never any doubt that he was going to be a scientist – the only question was, what kind?

By the time Robert was in middle school, his family acquired its first computer. Through trial and error, Robert discovered how to use the modem to download medical guides and CAD programs through bulletin board systems.

His father, Richard A. Marks, MD, an orthopedic surgeon in Dallas, continued to heighten Robert’s interest in medicine, bringing him on rounds and teaching him that everyone deserves equal respect and that a physician is no more important than anyone else. Robert’s father also taught him by example that a man could be a physician and still be a great dad.

In second grade, Robert met a girl in Sunday school named Amanda. Even back then, they somehow knew they would spend their lives together. The Marks have two children, a boy and a girl, and are currently expecting their third child in October. They volunteer and fundraise regularly for various local and national charities. When Dr. Marks isn’t practicing medicine as a pain specialist, volunteering or spending time with his growing family, he enjoys running and playing the piano.

How hard is it to balance your career and personal life?
Being a solo practitioner, the amount of time I dedicate to the practice is significant. I work most weekends, but I try to do as much as I can from the house so I can still spend time with my wife and children. One of the best parts about having a cloud-based system is that I can do administrative work at the same time that my daughter is braiding my hair and my son is showing me how many times he can bounce a balloon in the air.

What do you feel is your biggest accomplishment so far in your career?
I started from scratch with no patients, no connections, no knowledge of the medical community and no guarantees. Strictly by practicing pain management in a way that I genuinely believe is the most ethical and most cost-effective for my patients, I have been able to grow a viable practice. I sleep well at night knowing that I work to help each of my patients on a completely individualized level.

How do you keep yourself motivated?
I think about the impact of what I do and how it affects people. I love hearing patients tell me how they can do things they couldn’t do for years or how they have finally reached their goals. Many of my referrals are from patients, and this is one of the biggest compliments I can imagine.

What foreign city would you like to visit?
This would be a toss-up between somewhere in Asia or somewhere in Africa. I’m fascinated by the vast cultural differences that exist in this world, and I would love to spend time learning more about others.
Miranda Hardee, MD

Miranda Hardee, MD grew up the oldest of four children on a cattle ranch in north Florida. Working on a ranch was an important part of her upbringing as it instilled in her the values of hard work and perseverance. The ranch lifestyle also exposed Miranda to medicine at an early age, albeit for animals rather than humans. Regardless, this experience strongly influenced her decision to become a physician.

As a pre-med student, Miranda volunteered at UF Health Shands Hospital at the University of Florida. During this time, she developed a friendship with an inspiring young lady who had just been diagnosed with osteosarcoma. Miranda’s experience with this patient heavily impacted her desire to become a physician, and also to work in a specialty that treated cancer.

Like some of us, Dr. Hardee didn’t always want to be a physician. She wanted to sponsor a fishing show, but notes she’s “not that good of a fisherman.” However, she says if she wasn’t a physician, she likely would have pursued a career in genetics since it has always been an interest of hers.

Beyond practicing medicine as a urologist, Dr. Hardee loves to travel. When she’s grounded in Austin, she enjoys boating, hiking, cooking and, of course, live music.

What are some pressing challenges you see facing the medical community today?
I think the coordination of delivering and ensuring quality health care to our country remains the biggest challenge. In spite of the many controversies in health care these days, I still feel being a physician is extremely rewarding, and I encourage individuals who are interested to pursue a career in this field. As physicians, we are given the opportunity to help many people with very difficult problems, which is both humbling and satisfying at the same time. I would advise everyone going through medical training to do whatever it takes to get as much experience as possible.

As a physician, what has been one of the most memorable experiences that you’ve had?
I recently received a call from a wife whose husband had died from metastatic cancer the previous day. She expressed her gratitude for everything I had done for them. This was a patient I had cared for during residency and had not seen in two years. Experiences like that, even when the outcome is not a very positive one, are the most memorable for me because they involve helping patients through their most difficult times. They also remind me that my role as a physician extends far beyond the medication I prescribe or the surgery I perform.

What do you feel is your biggest accomplishment so far in your career?
When my patients express gratitude, refer family members to me or trust me to help make important life decisions, I feel those relationships are my greatest accomplishments. I have been given the opportunity to make a difference in someone’s life every day and to work with some of the world’s finest people.

If you could have dinner with a famous person (living), who would it be?
Tough one. Without getting too intellectual, I’d say Matthew McConaughey. Why? It would probably be a good time.
Illicit Drug Use: To Legalize or Decriminalize
William M. Loving, MD

Until recently, the US has dealt with illicit drug use, including marijuana, cocaine, heroin, LSD, methamphetamine and ecstasy, through the judicial system, with possession carrying misdemeanor or felony charges, and sometimes prison time. Critics argue that a disproportionate number of minority prisoners (African-American and Hispanic), who sometimes receive lengthy prison sentences for possession, make this approach unfair. From a pragmatic point of view, this criminalization approach has not significantly decreased the possession and use of illicit drugs, and many say the “war on drugs” has failed. Research has shown drug-dependent people have a central nervous system (CNS) disease that is due to a disorder in the mesolimbic area of the brain involving imbalances in dopamine. Physicians specializing in addiction medicine and certified by the American Board of Addiction Medicine treat these patients in hospitals and outpatient settings with the aid of medication and psychosocial programs involving teams of counselors, social workers, nurses and psychologists. So the question is, should people with drug problems be treated as criminals or patients?

Decriminalization of drugs makes possession of small amounts of illicit drugs a civil, and ultimately, a public health issue. It prohibits possession and illicit use, unlike legalization, which allows possession and use of the drugs. Possession of large amounts of a drug indicate drug trafficking or dealing, and remains a criminal offense under decriminalization. In the case of marijuana, the states of Colorado and Washington have legalized the drug, while several states (California, Alaska, Connecticut, Massachusetts, Mississippi, Rhode Island, Maryland, Nebraska, North Carolina and Vermont) have decriminalized possession of small amounts of marijuana for personal use.

Portugal was the first country to decriminalize possession of all illicit drugs (heroin, cocaine, marijuana, LSD, ecstasy and methamphetamine) in small amounts – defined as less than a 10-day supply, e.g., 25g cannabis, 2g cocaine, 1g heroin. The Portuguese law was changed in 2001 due to a growing problem of drug abuse and dependency in the 80s and 90s, high rates of HIV and hepatitis, an increase in numbers of people using drugs and even some public use of drugs. A governmental committee studied the problem and viewed it as a public health issue, and recommended that the Ministry of Health handle the problem rather than the Ministry of Justice. Possession of small amounts of illicit drugs was decriminalized.

When a person is caught by the police, a citation is issued and the person is assessed in a few days by the Dissuasion Committee, composed of one legal expert and two treatment experts (psychologist, social worker or physician). The committee meets with the person (a potential patient now) in a non-threatening environment to recommend treatment, and to issue certain civil sanctions such as forfeiture of licenses (taxi driver, physician, etc.), fines, prohibition of travel or continued monitoring by the committee. If treatment is accepted, sanctions are dropped.

At first, critics of this approach feared Portugal would see an increase in drug use, and see the country become a travel destination for drug users, causing the drug problem to only worsen. Studies 10 years after the law change have shown that decriminalization has actually worked. Incidence of HIV and hepatitis has decreased (HIV cases in 2000 = 1430 and in 2008 = 352), drug abuse in the critical age group 15-19 has decreased, more people have entered treatment and the burden of cases on the judicial and prison system has decreased. Drug use has not increased. The new law also included provisions for more education about the dangers of drug abuse and needle exchange and outreach programs in communities with high drug use.

Since the 80s, the US incarceration rate has quadrupled. The US has five percent of the world’s population, but 25 percent of the world’s prison population. Additionally, 80-85 percent of those in prison either did the crime impaired on alcohol or drugs, or the crime was related to a drug problem in some way, such as stealing to support a habit, assaults related to drugs or drug dealing. Studies have shown even with stringent laws, more people in the US have tried and used cocaine and marijuana than in the liberal Netherlands. The punitive, repressive, criminalization approach is not working well to stem the tide of drug use in the US. With a recognized disease being a big part of the problem, the affected people should be treated as patients not criminals. Exceptions to this would include traffickers and some of those who commit severe crimes like assaults, murders and repeated thefts that would have to be dealt with by the judicial system.

The experience in Portugal of decriminalizing drug possession has proved helpful to its society. Legalization of drugs does not prohibit illicit drug use and does nothing to encourage treatment. Decriminalization discourages drug abuse and encourages treatment when handled as a public health problem. Criminalization of the whole problem ignores and denies the proven existence of chemical dependency as a disease.

The US already has drug courts. For health professionals, we have the Texas Peer Assistance Program for Nurses...
(TPAPN) and impaired physicians’ committees that emphasize getting help for the problem rather than punishment. Some states, as noted, have already decriminalized possession of small amounts of marijuana. Much of this information comes from the European Monitoring Center for Drugs and Drug Addiction (EMCDDA) which has 15 offices across Europe, with its main office in Lisbon, Portugal. The EMCDDA (www.emcdda.europa.eu) collects data and publishes monographs on treatment, policy and new drugs of abuse, e.g., “bath salts.” Evidence shows decriminalization rather than legalization could be the best approach, if we can generalize from Portugal’s experience.

Note: The Travis County Medical Society has not taken a position on the decriminalization of drugs. Any opinions expressed in this article are solely those of the author and not the Travis County Medical Society or TCMS Journal.
In 2013, the Institute of Medicine released a report urging a new course for cancer care that puts the patient at the center of the system. The report stressed the need to combat various factors that negate best treatment outcomes such as the growing demands, shrinking workforces, demographic disparities and lack of health information technology. It claimed that the system should do more to support patients and treat them based on their needs, values and preferences, and that this new model needs to shift to support the engaged patient, who is the future of cancer care.

As the number of cancer survivors in America grows to more than 14.5 million, the LIVESTRONG Foundation has taken aim at those challenges, seeking to turn patients and survivors around the world into the engaged patients, who can actively participate in decision making with their physicians regarding their health and well-being. The Foundation also provides free services for cancer patients, survivors and caregivers, while advocating for policies that improve their access to care and quality of life. Anyone affected by any cancer, at any stage, can use the Foundation’s free, bilingual services by email, phone, online (www.LIVESTRONG.org/WeCanHelp) or in person at its East Austin headquarters.

Along with Conquer Cancer Foundation and Genentech, LIVESTRONG hosted the Rev Forum in May, in pursuit of avenues to navigate cancer care in the era of personalized medicine. Specialists from around the country convened to redefine quality of care, generate ideas to empower patients and accelerate progress through data access and technology. As a result of the two-day discussion, a white paper will outline the next steps to be taken in the field that will help usher patient-centered cancer care to the forefront of treatment planning.

Continuing on the progress, the LIVESTRONG Foundation asked the question, “What if we could build a system of patient-centered cancer care with all the innovations we could possibly imagine?” On June 12-13, the Foundation hosted a symposium in Austin with experts from the entire cancer care continuum to answer the question and create a collective roadmap for implementation of a community-based, patient-centered care model to serve as a pilot for creation of models that are relevant both nationally and globally. Specialists in the field shared their thoughts on the essential elements for a patient-centered model, a panel broke down the stumbling blocks to create solutions from real challenges and a patient panel discussed patient and family preferences, values and needs. From these discussions, participants grouped together to form their own patient-centered models, one of which was chosen that will serve as a pilot program in Austin and will soon be spread far beyond.

LIVESTRONG knows that collaboration is the key to unlocking a patient-centered future. The system cannot be altered or fixed by one person or one organization alone. As LIVESTRONG Foundation President and CEO Doug Ulman said, “We all want patient-centered cancer care. And it’s going to take all of us to build it.” The cancer community now needs everyone to band together, add their voice to the discussion, improve the model and help the patient-centered dream become a reality.
What do you do when you hear: “I’m pregnant and plan to take 9 weeks of maternity leave.” “I’ve taken a new job – this is my two week notice.” “We need an extra hand for our EHR conversion – ASAP.”?

The Travis County Medical Society now offers quality, cost-effective staffing resources to physician practices and health care facilities in Central Texas.

This service provides a resource pool of qualified professional staff that can step in on short notice to assist you in maintaining a consistent level of quality service. If you need office staff, health care professionals or physicians to fill short-term needs or full-time openings, TCMS Staffing can assist. TCMS members will receive preferential pricing.

Our provider, Favorite Healthcare Staffing, is certified by the Joint Commission (JCAHO) and partners with health care practices and institutions to solve staffing issues by placing employees on per diem, temp-to-hire, travel and permanent assignments.

To take advantage of this member benefit, contact TCMS Staffing Services Recruiter Mandy Clare at 512-206-1221 or visit www.tcms.com.
Welcome to the Travis County Medical Alliance!
Karen Kim, PhD
President, Travis County Medical Alliance

Welcome to the Travis County Medical Alliance! TCMA membership consists of Travis County Medical Society physicians’ spouses as well as physicians themselves. Founded in 1924, the Alliance has a history of supporting the citizens of Travis County. Through TCMA, members have access to general meetings and special member seminars, community service projects, legislative advocacy events, networking opportunities and more. Although we enjoy making friends and supporting the family of medicine, we are most proud of raising thousands of dollars each year to award as grants to local nonprofit organizations.

When my family moved to Austin in 2003, I attended a Travis County Medical Society event with my husband, Stanley Kim, MD. There, I met Alliance members who invited me to a meeting. Like many spouses of physicians, I had until this point built up my own identity and my own career. It never occurred to me to join an organization that was based on my husband’s occupation, but because I was new to Austin, I decided to give it a try. Through the Alliance, I have learned so many things about Austin and have made lifelong friendships.

Before I got involved, I thought of the Alliance as some sort of archaic group whose members derived their main identity from being married to physicians. Now, I know that our members are talented, well-educated and ambitious women and men who all understand the unique challenges that face medical families. Finding a group that recognizes individuality, but offers social support while encouraging me to step outside my own life and serve others has made me a better mother, a better partner to my husband and a better person. I hope you will join us for our many enriching activities and events this year!

TCMA Has an Exciting Lineup of Meetings and Seminars for 2014-2015

September 16, 2014 at 9:30 am:
The first general meeting is at the Texas State Capitol. Join us in the Members’ Lounge to hear Deputy Parliamentarian of the Texas House of Representatives Shalla Sluyter speak and give a private tour!

November 4 at 10:30 am:
The second general meeting is at the Zilker Clubhouse with guest speaker Dean of Dell Medical School Clay Johnston, MD. Stay for a complimentary lunch after the meeting.

TCMA also has a lineup of upcoming small-group seminars led by highly-respected experts in areas such as the college admissions process, public speaking, home accounting and finance and protecting our children from sexual predators.
1 in 5 persons living with HIV does not know it.

- People accessing health care are NOT routinely tested for HIV.
- Persons unaware of their HIV infection are unable to benefit from care.

Learn more at www.testtexashiv.org
Failure to Communicate Medication Orders

TMLT Risk Management Department

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. The study has been modified to protect the privacy of the patient.

Presentation
A 79-year-old man fell from a ladder and was brought to the emergency department (ED) of a local hospital. Diagnostic imaging confirmed a right hip fracture.

Physician action
An internal medicine physician admitted the patient who was described as an elderly male in chronically poor health. His medical history included diabetes, hypertension, prostate cancer, elevated cholesterol and COPD. The family physician recommended cardiac clearance.

An orthopedic surgeon ordered traction, pending cardiac clearance for surgery.

The patient informed the internal medicine physician and the orthopedic surgeon that he had a history of heart problems for more than 20 years. He indicated that he had been taking two antihypertensive medications, a statin, an oral diabetic medication and a respiratory inhaler.

A cardiologist cleared the patient for surgery three days after admission. Prior to clearance, an echocardiogram revealed an ejection fraction of 60% with no left ventricular wall abnormalities, left atrial enlargement, mild tricuspid and mitral valve regurgitation. In his dictated report, the cardiologist indicated that the patient would need postoperative long-term anticoagulation therapy for atrial fibrillation. The recommendation for long-term anticoagulation was noted in the internal medicine physician’s visit note on the day of the cardiac consultation.

Following cardiac clearance, the orthopedic surgeon performed a hemi-arthroplasty of the right hip. The procedure went well.

Postoperatively, the orthopedic surgeon wrote orders for anticoagulation therapy with heparin 5000 units subcutaneously every 12 hours. The patient progressed well with physical therapy and a decision was made to transfer him to a rehabilitation center.

The internal medicine physician wrote discharge orders including warfarin 5 mg orally each morning. He also ordered continuation of all medications the patient was taking before the hospitalization. One of those medications was aspirin.

On the third postoperative day, the patient was transferred to the rehabilitation center. Staff at the center stated that they did not receive the internal medicine physician’s order for warfarin or the discharge planning sheet that indicated warfarin was to be continued along with other medications. A nurse at the rehabilitation center faxed routine orders to the internal medicine physician, which he signed. These orders did not include orders for warfarin or aspirin. Therefore, the patient did not receive warfarin or aspirin after his transfer.

The internal medicine physician, who was also the medical director of the center, stated that he signed off on the routine orders after a cursory review and did not catch that the warfarin and aspirin were not in the orders.

Ten days after his admission to rehabilitation center, the patient developed nausea, vomiting and chest pain. He was transferred back to the hospital and subsequently transferred to a larger medical center. There he underwent cardiac catheterization that revealed diffuse atherosclerosis, ejection fraction of 35% and massive anterior apical hypokinesis that was secondary to 80% stenosis of the left anterior descending artery (LAD) with plaque rupture and thrombosis. The patient had a stent that was placed in the LAD. The patient was discharged to home. As a result of the myocardial infarction (MI), he has a reduced ejection fraction.

Allegations
A lawsuit was filed against the internal medicine physician. The allegations included negligence in signing off on transfer orders that did not include aspirin and warfarin. It was alleged that the failure to assure proper anticoagulation of the patient at discharge contributed to his MI.

Legal implications
The plaintiff’s expert alleged that the internal medicine physician breached the standard of care by failing to order anticoagulation therapy at the rehabilitation center as had been intended. Further, had the anticoagulation and aspirin therapy been started as planned, the patient would not have suffered the MI.

Physician consultants who reviewed this case had varied opinions. The supportive comments included:

- the patient had an MI due to multiple risk factors, along with 80% stenosis of the LAD;

- it was possible that anticoagulation therapy could have prevented the
MI, but it was not likely and
• the patient was on anticoagulation therapy to prevent a stroke, not an MI.

Criticisms included:
• failure to transition the patient from heparin to warfarin while the patient was still in the hospital;
• signing off on orders that did not include an order for warfarin;
• signing off on orders that did not include serial Protamine and INR testing to monitor anticoagulation and
• failure to order warfarin to prevent a cardiovascular event in a 79-year-old with chronic atrial fibrillation and a recent hip fracture.

Risk management considerations
Physicians should know the process of medication reconciliation used at each hospital they admit to. Physicians should carefully consider each step in the medication reconciliation process as a significant component of patient safety.

A successful reconciliation process can reduce the work or subsequent duplication of efforts associated with management of medication orders and errors at transitions in care and upon discharge.

Communication during transitions of care is very important to patient outcomes. Physicians should work with both acute care hospital and subacute facilities to establish processes to ensure accurately written discharge communications are sent to the subacute facility.

According to the Journal of General Internal Medicine, 49% of hospitalized patients experience at least one error in medication continuity, diagnostic workup or test follow-up. The most serious errors result from a breakdown in communication between acute care and post discharge care providers. (1)

Physicians should verify that the discharge summaries of patients transferred from acute hospitals to subacute facilities include all pertinent information about anticoagulation. This includes dosing information and the expected duration of therapy.

Disposition
The case was settled on behalf of the internal medicine physician.

Source

The information and opinions in this article should not be used or referred to as primary legal sources nor construed as establishing medical standards of care for the purposes of litigation, including expert testimony. The standard of care is dependent upon the particular facts and circumstances of each individual case and no generalization can be made that would apply to all cases. The information presented should be used as a resource, selected and adapted with the advice of your attorney. It is distributed with the understanding that neither Texas Medical Liability Trust nor Texas Medical Insurance Company is engaged in rendering legal services. © Copyright 2013 TMLT.
Gastroesophageal Reflux Disease

Heartburn, acid reflux and acid indigestion are all terms used to describe a burning feeling in the chest or a backwash of stomach contents into the mouth or the esophagus (the tube that connects the throat to the stomach).

If you have these symptoms more than twice a week for more than a few weeks, you may be diagnosed as having gastroesophageal reflux disease (GERD).

Symptoms
The most common symptoms of GERD are a burning feeling in the chest (heartburn) and regurgitating food or liquid into the throat. Other symptoms include dry, chronic cough; wheezing or asthma; sore throat or hoarseness and tooth erosion.

If you have pain or pressure in your chest, shortness of breath, nausea or vomiting or back or arm pain, you might be experiencing a heart attack. Seek emergency medical attention right away.

Diagnosis
Your doctor will most likely diagnose GERD based on your symptoms and whether your symptoms improve with medication. Other tests that are sometimes used include:

- Endoscopy, in which the doctor uses a video camera to look at the esophagus
- X-ray scans of the upper gastrointestinal tract to look for narrowing of the esophagus or other problems
- Manometry to measure the muscle contractions of the esophagus

Treatment
There are a number of treatments you can try at home. You may need to use one or more treatments on an ongoing basis.

- Medication: Over-the-counter medications include antacids and two types of medicines that reduce stomach acid: H2 receptor blockers (such as ranitidine) and proton pump inhibitors (such as omeprazole).
- Changes in diet: Some people find it helpful to avoid eating or drinking chocolate, coffee, peppermint, greasy or spicy foods, tomato products and alcohol.
- Other treatments: quit smoking, avoid overeating, avoid eating within two to three hours before bedtime and trying to lose weight if you are overweight. If your symptoms are worse at night, it may help to prop up the head of your bed about six to eight inches. Using extra pillows will not help GERD.

Surgery
Left untreated, GERD can cause problems in the esophagus, including ulcers, swallowing problems or Barrett esophagus, a condition that increases risk of esophageal cancer.

For More Information
National Library of Medicine
digestive.niddk.nih.gov/ddises/pubs/gerd

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