2014
Ruth M. Bain
Young Physician
Award
presented to

2014
Physician
Humanitarian
Award
presented to

Physician of the Year
2014
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CLASSIFIEDS
FROM THE PRESIDENT

Battleship - Part II

Sarah I. Smiley, DO

I recently received an email from a friend about an article in Medscape entitled “Why Physicians Won’t Unite to ‘Rescue’ Medicine.” The gist was that we physicians are failing ourselves and our patients because we cannot work together, and it outlined seven reasons why.

1. Organizing physicians is challenging because they are either too busy to participate, or under too many pressures and time commitments within their practices to even write a membership check.

One physician implied that many may have stopped writing checks also because organized medicine has had some setbacks and those are being read as serial failures by these physicians.

My personal response to this is that if we don’t take up the efforts of organized advocacy for our patients and ourselves, the government, payers and hospital systems will do whatever is actuarially indicated, with the morbidity and mortality costs of their actions considered as acceptable “collateral damage.” That is not to say that we cannot improve resource management, but we have to fight for cost-effective appropriate care for our patients, not arbitrary cutbacks that effectively limit access.

To do so, we need to maintain and increase membership in our county medical societies and in the Texas Medical Association (TMA) so that TMA can continue to lobby both in Texas and Washington, DC for issues that are important to our patients and our profession.

2. Historically physicians are poor contributors to political action committees (PAC). Nationally, we gave $12.1 million in 2008, roughly half that given by lawyers that same year.

I have to admit, I was surprised at this disparity. Physicians need to give early and often, as our incomes allow. I also think we should not give to individual politicians, but to TEXPAC, the TMA political action committee, so that they can select the candidates from ANY party who will represent the best interests of medicine.

Even fewer physicians actually participate in advocacy efforts due to many reasons (politics, time, cost, frustration, etc.). We need to give our colleagues who work with TMA on legislative advocacy the support they need to participate in these critical efforts.

3. Specialty groups tend to protect their own interests.

The reporter even gave one example of physician groups fighting each other. In this case, a bill was put forth in Arizona by one physician group to protect its interests from other physician specialty groups’ interests.

Many specialties also have their own PACs and congressional level lobbying efforts as do academic, primary care and hospital-based physicians.

If we cannot overcome our tendency to be like the specialty groups in Arizona (and many other states), then the profession of medicine will become weak and fractionated.

However, if we fuse our advocacy efforts and resources across specialty lines so that our battle front is more unified, we can be more effective. We tend to be better at this in Texas, but the influence of outside pressure and internal squabbles constantly threatens our unity.

We need to start thinking of ourselves more as physicians in a larger interdependent web and less as individual specialties. We need to form strong political alliances between physician groups and with physician assistants, as well.

4. Not all physicians are uniform in their political opinions and party alignments.

What we need to remember is that no one party embodies all the values that represent the best interests of our patients and medicine. We need to formulate a unified physician alliance for patient and provider well-being. This includes support through TEXPAC for candidates from any party who represent our collective needs. And again, we need to lobby primarily as a unified group through TMA and TCMS, and not as groups fractionated along political, specialty or economic lines. If we split ourselves and our resources, we will not be as effective.

5. Employed and independent practice physicians have different goals.

The reporter stated that many employed physicians do not choose to participate in organized medicine because they have a different agenda. One physician in private practice stated that he felt employed physicians are effectively separated from the fight with regulatory issues, payers, etc., because they are buffered from the operations of the practice. He felt this was the reason some employed physicians did not feel connected to the advocacy efforts of organized medicine.

Perhaps this might be interpreted in a different way. We need all types of physicians to take on various aspects of our battle. Some physicians are more familiar and comfortable with the business side of medicine, while others are more comfortable with the clinical side. Still others are research oriented or academically based and better at looking at scientific study evidence for practice guidelines or resource use.

Obviously, all practice types are needed in the quest to constantly improve health care delivery. Processes
and medical treatments all have to be balanced against the costs (time and money) and the evidence for clinical effectiveness. Both employed and non-employed physicians are present in all these groups and are needed to best effect changes in the system and health care delivery. Right now, these groups are all struggling to get seats at the table and are not communicating well due to fear and uncertainty. They need to have dialogue and educate each other about the needs of their practices, all within the context of what is best for patient care.

6. Improved patient access is not always in alignment with protection of income.

I think that this is a statement that many proponents for the ACA have been making since its inception. There are health care policymakers including politicians, physicians and hospital executives, who have been influenced by those physicians who’ve been vocal in their concerns about loss of income. These folks have extrapolated that physicians are fighting the ACA and other onerous regulatory requirements for reasons of greed. I think they are mistaken and their assessment is not balanced or fair.

We need to make sure that Congress does not place the cost of the ACA disproportionately on the backs of physicians and their practices. And we need policymakers to climb out of their ivory towers and look at the real business costs of running medical practices. Constant technology implementation and regulatory requirements never seem to stop or decrease, nor does the threat of government sanctions, penalties or legal action.

7. Membership in organized medicine lags, especially with regard to the AMA.

I have been to two sessions of the AMA House of Delegates in the last two years. I felt like I was in Washington, DC, inside Congress. It is a totally different animal compared to organized medicine at the state or county level. The cultural and cross specialty differences are actually much worse, to an extent, compared to our state.

What I also saw though, was a very coordinated effort between the TMA and Texas specialty society groups, to work together within the framework of the AMA to push forward the agenda of our state medical association. However, we now need to promote younger Texas physicians up through the ranks of these same specialty societies and the TMA, to maintain our Texas influence at the level of the AMA. The AMA has done a poor job protecting Texas physicians and patients so far, and we need to continue our grassroots approach to influence AMA policy, even as we continue to lobby directly in Congress for Texas medicine.

Physician survey results and articles like the one in Medscape tend to make me a little more tenacious about doing what is right. There are so many annoying distractions and competing forces in our lives that can pull us apart and take our focus away from the needs of our patients and ourselves. When this happens, we need to resist being divided as specialists, and reunify our efforts to focus on our common heritage as physicians. We need to gather under the big tent that is organized medicine—for the protection of our patients and the salvation of our profession.
On September 17, Clay Johnston, MD, PhD, the inaugural dean of the newly formed Dell Medical School at UT Austin, met with members of TCMS in the TMA Thompson Auditorium to give a preview of the school and answer questions. The evening was an interesting presentation of how the school will be structured and what the goals are for this new entity.

Dr. Johnston comes to Austin from San Francisco where he was the associate vice chancellor of research at UCSF. He received his medical degree from the Harvard Medical School. He continued his neurology practice in addition to his administrative duties at UCSF and plans to do the same here in Austin. His wife, Clarissa Johnston, MD is a hospitalist who will also practice in Austin.

The Dell Medical School is the seventh health institution in the UT system. Dr. Johnston sees this as an opportunity to improve medical education and ultimately remake medical care by focusing on value- and team-based models of health care. This begins with a change in curriculum.

The Dell Medical School will move away from the two years of basic science followed by clinical years, to a new form of teaching focused on continua and physiological systems. This will teach all the basic science of a system simultaneously. The curriculum will “focus on problem solving in small groups in a model similar to Harvard,” as well as on a choice of three tracts (redesign of health care, population health or research) and will integrate with other schools at UT in new innovative tracking blocks of interprofessional teams. Dr. Johnston related this will involve the use of the “flipped classroom” in which lecture materials are reviewed first outside the classroom. Teaching time will be focused on problem solving and working in integrated, interactive teams. This vision will train physicians to work effectively in team-based health care that Dr. Johnston sees as the future of medical care. He said, “We will train the leaders who will lead the evolution and transformation of health care.” He envisions this future will be less fact-based and more focused on the digital and technological ability to find information “so doctors can do what is necessary.”

Dr. Johnston also presented a review of the physical campus. There will be buildings for administration, teaching and research along with the new hospital and a medical office building. He also covered the potential for the creation of an “innovation zone” in the near vicinity of the school. As of yet, the future use of the University Medical Center Brackenridge has yet to be determined and will be led by Central Health.

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During the Q&A period Dr. Johnston responded to a wide variety of queries. He confirmed that he’s working toward an ideal in which all major clinical settings in Austin are utilized as teaching sites. The clinical faculty that is currently employed by UT Southwestern will transfer to UT Austin employment later this year. He foresees that new academic physicians hired will also practice medicine in forms that are still being created and may even include joining existing private practices in the community. The current clinical faculty will continue and he doesn’t foresee having new faculty “where there is great clinical care in the community already.”

One large challenge Dr. Johnston acknowledged will be the integration of the multiple EHRs utilizing local health information exchanges. Central Health will be a partner with the medical school in care of the poor and under-served, and the details of that arrangement are being worked out. He is aware of the challenges that currently exist around women’s health, but is also committed to providing the full array of women’s health services.

Dr. Johnston is enthusiastic about the potential for Dell Medical School to focus on the transformation and innovation of systems that health care will require in the future. TCMS looks forward to participating with Dr. Johnston in the creation of the Dell Medical School, moving our community into a new era.
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Since 1995, the women of Breast Cancer Resource Centers (BCRC) have taken their own devastating personal experiences as breast cancer survivors and used them to help others facing similar circumstances. Managing the physical and emotional aspects of breast cancer is challenging enough, with the added challenges of understanding the diagnosis, determining next steps, distinguishing between multiple providers, keeping track of appointments, procedures and other important information, it can be overwhelming. Also, diagnosis of any serious illness can be financially devastating. That’s why all BCRC services are provided at no charge.

Professionally trained and well-versed in local and regional resources, BCRC’s staff is committed to assisting women in finding their way through the complex maze of today’s health care system. Even the most groundbreaking advances in health care are meaningless if a woman can’t get to her appointments because she doesn’t have transportation, can’t find a babysitter or is paralyzed with fear.

Our patient navigators (PN) are located in five hospitals in Travis County and Williamson County: St. David’s Round Rock Hospital, St. David’s Medical Center, St. David’s North Austin Medical Center, University Medical Center Brackenridge and the Breast Care Center at Seton. However, they can also meet our clients at coffee shops, doctors appointments and infusion rooms. We provide women who are having a mastectomy with a comfort pillow and a post-surgical camisole to hold their drain bulbs. In addition, we facilitate Breast Cancer 101, a tightly focused 1 1/2 hour class designed to alleviate fear for both the newly diagnosed and their caregivers by providing practical guidance for the coming months.

We offer specialized groups for women of all ages and stages of breast cancer, including a six-week Newly Diagnosed Support Circle for those in the first year after their diagnosis. Our patient navigators inform the newly diagnosed about the practical aspects of treatment for breast cancer, including assisting them in making decisions around surgery that fit their lifestyles, family and work commitments. We advise them of their rights as an employee with breast cancer and we help caregivers understand how they can best support their loved one.

Nancy Marquez, MD is a surgeon with Capital Surgeons working in both Travis and Williamson counties. “I refer all of my newly diagnosed breast cancer patients to the BCRC, and occasionally the patient who has not been diagnosed, but is facing the same anxiety and concerns when she is confronted with an abnormal mammogram and needs to undergo a biopsy,” said Marquez. “The support and comfort that can be provided by a knowledgeable BCRC navigator, a breast cancer survivor, is something I cannot provide in the same manner.”

For some women, the prognosis is not good and they will be faced with treatment for the rest of their lives. Our patient navigators compassionately walk with these women as long as they are needed—sometimes through end-of-life. We offer special-ized groups for women with metastatic disease such as the IV League and Lotus Forum (L4). Because we know the experience of breast cancer does not end with the completion of treatment, we facilitate multiple survivor groups as well. The groups deal with issues such as sexuality, nutrition and coping with the fear around recurrence.

“Hearing the words ‘it is cancer’ is so devastating you immediately become overwhelmed,” said breast cancer survivor Andrell Johnson. “I don’t know how I could have ever processed the enormous amount of information and understood the medical terminology which would allow me to make the best decision for my health care without my PN. My PN kept me calm and sane in a time when you just don’t understand why this is happening to you. To know that someone who has traveled this road would be there at every turn for support, educating and helping to process information was a blessing. Every patient should be aware of this service,” said Johnson.
As most of us are well aware, hydrocodone combination drugs will become Schedule II (requiring a triplicate prescription) October 6 due to recent reclassification by the DEA. While this clearly will impact patients (and their physicians) across all age groups, I am afraid it will disproportionately affect our frailest elders—those in skilled nursing facilities (SNF).

Despite being inpatient facilities, the current regulations force skilled nursing facilities to be governed by outpatient pharmacy regulations. In other words, physicians cannot write an order for a controlled substance and expect it to be carried out. Instead, a separate prescription has to be written. Even after the prescription is obtained, it has to be faxed to a long-term care pharmacy (LTC) (there are only two primary ones in Austin), often miles away, where it is filled along with other medications and sent out whenever the next “run” is due—which may be in two hours or even eight hours later—then driven through Austin traffic to the various nursing homes.

Those of us practicing in post-acute care are no strangers to advocating for outpatients in order to avoid unethical delays in pain medication administrations. We had managed to work out a compromise with the LTC pharmacies whereby a small supply of medication could be kept in a locked emergency box. As can be imagined, there are significant restrictions and rules surrounding the “E-Kit” in order to prevent drug diversion, comply with state and federal law and protect all parties involved. Among the restrictions is no Schedule II medications because of the triplicate requirement. This means that as of October 6, there will be no immediate supply of hydrocodone combination drugs available for skilled nursing facility patients, not for the elderly man hospitalized with multiple fractures after an accident coming in for rehab; not for the metastatic cancer patient with bone metastases coming in for end-of-life care; not for the frail 94-year-old resident who falls in the night and has severe acute back pain and not for the patient with arthritis who had an elective total knee replacement, now coming in for rehab. All across Texas and in every SNF here in our city, patients will be adversely affected by these changes.

My hope is that as physicians we can use our knowledge and leadership to help figure out a solution(s) for this problem. As a start, those of us in post-acute care are trying to partner with hospitalists to get triplicate prescriptions written by the discharging physician at the time of hospital discharge so that there is no delay in getting the prescription faxed to the pharmacy. However, that is just a first step. As with many of the significant changes being thrown at us, we physicians have to work together to preserve good patient care and maintain our own sanity in the process.

Additional Impact of DEA’s Hydrocodone Combination Products Rules

Drugs that contain hydrocodone combinations are reclassified from Schedule III to Schedule II effective October 6, 2014 under a final rule published by the US Drug Enforcement Agency (DEA).

What does this mean?

- Prohibits physicians from delegating authority to APNs and PAs to prescribe these drugs outside of a hospital or hospice setting;
- Prevents physicians from calling in these prescriptions to pharmacies (except in emergencies and with limited quantities, in which case the oral prescription must be followed up with a written prescription within seven days);
- Official prescription pads from DPS required;
- Prohibits refills of these drugs without a patient visit or consultation;
- Schedule II drugs can only be prescribed for a 90-day period and
- E-prescribing – through Electronic Prescribing for Controlled Substances (EPCS) – is allowed for, but physician must use an EPCS-certified e-prescribing vendor. EPCS in Texas is still in early stages.

For more information:


Source: Texas Medical Association
New Member Welcome

TopGolf—August 21
What better way to help new TCMS members get into the “swing” of things than with a “Par-TEE” at one of Austin’s premier fun spots, TopGolf. A big THANK YOU to everyone who made the New Member Welcome a “big hit.”
Look around your office space. You are not alone if you’ve become so familiar with your surroundings that you’ve failed to notice the worn carpet or mismatched furniture. Or worse, you’ve noticed areas needing attention and said, “good enough” or “no one will care.”

Truth is they do care, especially new patients whose first impressions of your practice are often formed by the look, feel and condition of your office.

Consider these excerpts from actual postings on Yelp, the online review site:

• “[T]he office is a little old and does need some revamping.”
• “I might give him another try again but I would not want to recommend anyone until I get to know him better and until they do something about their facilities.”

Many patients can’t evaluate the quality of your care immediately, so they rely on other clues to assure themselves that they are in good hands.

Good design and maintenance contribute to a welcoming environment, instill confidence and minimize stress. They help form positive first impressions and generate higher patient satisfaction, which increases referrals and return visits.

Design Is More than Aesthetics

Design goes beyond the look and feel of your office space. Evidence-based design research has demonstrated that design aids in infection control and risk management, improves patient outcomes and increases efficiency, which can raise staff morale.

Whether you have an existing practice or are starting a new one, take the Medical Office Space Checkup.

Your answers can reveal insights about the health of your practice, your business strategy and whether design changes need to be made to accommodate patients of different backgrounds, ages and needs.

<table>
<thead>
<tr>
<th>MEDICAL OFFICE SPACE CHECKUP</th>
</tr>
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<tbody>
<tr>
<td><strong>Yes/No</strong></td>
</tr>
<tr>
<td><strong>Layout</strong></td>
</tr>
<tr>
<td>Are your exam rooms arranged in a horseshoe shape around a centrally located nurse station?</td>
</tr>
<tr>
<td>Significance: This layout improves site lines, increases response times and staff efficiency and reduces physician and staff fatigue.</td>
</tr>
<tr>
<td>Is your furniture and seating in the reception area arranged in clusters to avoid the feeling of a bus station?</td>
</tr>
<tr>
<td>Significance: Clustered seating arrangements facilitate greater patient interaction with family members and create a more welcoming environment.</td>
</tr>
<tr>
<td>Can your reception area accommodate patients who come with multiple family members?</td>
</tr>
<tr>
<td>Significance: It is not uncommon for people from certain cultures to bring multiple family members. In Austin, for example, you should allow for 20 percent more space in the reception area for family members.</td>
</tr>
<tr>
<td><strong>Code Compliance</strong></td>
</tr>
<tr>
<td>Are check-in counters at least three feet from patient seating and 32 to 36 inches high?</td>
</tr>
<tr>
<td>Significance: Height and positioning are mandated by HIPAA and the ADA.</td>
</tr>
<tr>
<td>Can exam rooms and hallways accommodate patients in wheelchairs, and are they sufficiently soundproofed to ensure patient privacy?</td>
</tr>
<tr>
<td>Significance: ADA requires hallways be at least four feet wide, and soundproofing is a HIPAA requirement.</td>
</tr>
<tr>
<td><strong>Furniture</strong></td>
</tr>
<tr>
<td>Does your furniture meet the requirements of your practice specialty?</td>
</tr>
<tr>
<td>Significance: Different specialties require different types of furniture to accommodate patient needs.</td>
</tr>
<tr>
<td>Does your lighting and furniture accommodate elderly and bariatric patients who have special needs when entering or exiting chairs?</td>
</tr>
<tr>
<td>Significance: Proper lighting and furniture create a welcoming environment, reduce stress and discomfort and lessen furniture wear and tear.</td>
</tr>
<tr>
<td><strong>Infection Control and Life Safety</strong></td>
</tr>
<tr>
<td>Does your office have non-slip flooring, non-porous surfaces and round edges on countertops?</td>
</tr>
<tr>
<td>Significance: Finishes and flooring designed for health care can reduce infection and minimize injuries.</td>
</tr>
<tr>
<td><strong>Maintenance</strong></td>
</tr>
<tr>
<td>Is your furniture mismatched from repeated replacements, or are finishes worn from overuse and poor maintenance?</td>
</tr>
<tr>
<td>Significance: Well-maintained offices instill patients with confidence about the quality of the care they are receiving. Poor maintenance can lead to infection control issues.</td>
</tr>
<tr>
<td><strong>Amenities</strong></td>
</tr>
<tr>
<td>Does the reception area have Wi-Fi and accessible outlets for patients or family members to plug in laptops or mobile devices? Is there an area for patients to have access to coffee and water while waiting?</td>
</tr>
<tr>
<td>Significance: Amenities reduce stress and can keep patients and family occupied while they wait for procedures and exams to be completed.</td>
</tr>
</tbody>
</table>
Do you know a TCMS member who exemplifies the qualities of a “physician’s physician”? What about a member who works tirelessly to help people in need? Can you think of a young TCMS physician who already has a stellar list of accomplishments?

This year, Travis County Medical Society members will recognize three of their colleagues in the following categories: Physician of the Year, Physician Humanitarian and Young Physician.

This is your opportunity to nominate someone you respect and admire.

The Society is currently taking nominations for all three awards. The awardees will be recognized at the Annual Business Meeting on December 2, 2014 at the Westin Hotel, Domain.

Here’s a Look Back at Some Previous Award Recipients

2012 TCMS Physician of the Year
David C. Fleeger, MD

David Fleeger, MD encourages his patients to do the best they can to improve their circumstances, and takes an active role in the medical community. He has held various positions of leadership with the AMA, TMA and TCMS. As the Society’s president in 2007, Dr. Fleeger established the TCMS Foundation Lecture Series. After being named Physician of the Year, Dr. Fleeger vowed to continue to do his best to represent physicians at the local, state and national level. Making good on that vow, he has taken on another leadership role as a member on the TMA Board of Trustees. A dedicated humanitarian, Dr. Fleeger is a volunteer for Project Access and makes yearly trips to Central America to provide medical treatment to poverty-stricken people.
2013 Humanitarian Award
Robert L. Rock, MD

Thousands of people around the world have a better outlook on life thanks to ophthalmologist Robert Rock, MD, a tireless humanitarian. He has worked with the Austin nonprofit Casa Marianella, which provides an emergency shelter for adult immigrants, a transitional shelter for women and children escaping violence and a community and education center. He volunteers for numerous missionary projects, including one in Pakistan where he and another ophthalmologist performed hundreds of cataract surgeries in a single week. Additionally, along with about 20 other ophthalmologists, Dr. Rock funded work that has led to the near elimination of river blindness in several African countries.

2011 Ruth M. Bain Young Physician Award
Chad P. Dieterichs, MD

An avid SCUBA diver, Chad Dieterichs, MD wanted to share his love for underwater exploration with others – especially those with disabilities and/or special needs. He co-founded the nonprofit Eels on Wheels which teaches them how to SCUBA dive. The organization demonstrates that limitations can be overcome, and that even an adventure sport such as SCUBA diving can be an option for anyone. A career anesthesiologist, Dr. Dieterichs has served in several leadership roles in the Seton Healthcare Family Network.

Take a moment now to nominate someone you know for one or all of these awards. Information on how to submit nominations is on the following page. www.tcms.com
Who do you know that fits these descriptions? Nominate a colleague today.

2014 Physician of the Year

The Physician of the Year Award is presented to a physician who has been a member of the Travis County Medical Society for 20 years or more and is considered and admired by their colleagues as a model physician.

For a complete listing of eligible candidates for Physician of the Year visit www.tcms.com.

In making a nomination, consider your nominee’s knowledge; integrity; service to the community or the profession; humility and compassion for patients and fellow workers.

Taking the above criteria into account, provide a brief narrative on the physician’s qualifications for Physician of the Year.

Submit your nomination to tcms@tcms.com.

Previous Recipients

2013 Richard M. Holt, MD 2001 Tracy R. Gordy, MD
2012 David C. Fleeger, MD 2000 James M. Graham, MD
2011 Joseph P. Annis, MD 1999 Thomas D. Kirksey, MD
2010 C. Bruce Malone, III, MD 1998 Joseph M. Abell, Jr., MD
2009 Homer R. Goehrs, MD 1997 Grover L. Bynum, Jr., MD
2008 James W. Fox, MD 1996 Albert A. La Londe, MD
2007 Christopher S. Chenault, MD 1995 Earl L. Grant, MD
2006 William J. Deaton, MD 1994 Charles E. Felger, MD
2005 Tom S. McHorse, MD 1993 H. S. “Hap” Arnold, MD
2004 Thomas B. Coopwood, MD 1992 Robert E. Askew, Sr., MD
2003 William G. Gamel, MD 1991 Mathis W. Blackstock, MD
2002 David P. Wright, MD 1990 James E. Kreisle, Sr., MD
1989 Ruth M. Bain, MD
2014 Physician Humanitarian Award

The Physician Humanitarian Award is presented to a physician member of the Travis County Medical Society who provides exceptional volunteer service to others, beyond the normal scope of practice. All TCMS members are eligible to be nominated for this award.

In making a nomination for the Physician Humanitarian Award, describe how the nominee’s service to others significantly benefitted or affected humanity.

Submit your nomination to tcms@tcms.com.

Previous Recipients

2013  Robert Rock, MD
2012  Tracey Hass, DO, MPH & Timothy Gueramy, MD
2011  John D. Doty, MD

2014 Ruth M. Bain Young Physician Award

The Ruth M. Bain Young Physician Award is presented to a physician member of the Travis County Medical Society who is 40 years or younger, or who has been in practice 8 years or less and is considered and admired by their colleagues as a model physician.

For a list of eligible candidates visit www.tcms.com

In making a nomination, consider your nominee’s leadership; knowledge; integrity; service to the community or the profession; humility; and compassion for patients and fellow workers.

Taking the above criteria into account, provide a brief narrative on the physician’s qualifications for Ruth M. Bain Young Physician of the Year.

Submit your nomination to tcms@tcms.com.

Previous Recipients

2013  Jason Reichenberg, MD
2012  Mark Shen, MD
2011  Chad P. Dieterichs, MD
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Welcome to the Travis County Medical Alliance!

Karen Kim, PhD
President, Travis County Medical Alliance

On September 16, the TCMA held its first general meeting at the Texas State Capitol. We watched a presentation, *An Insider’s Guide to the Texas State Legislature*, by Shalla Sloyter, deputy parliamentarian of the Texas House of Representatives, followed by a private tour.

We have a wonderful series of fall events scheduled and welcome all physicians and their spouses to join us! Please visit our website, www.tcmalliance.org, for details on membership.

Join the TCMA email list to receive the latest information about upcoming events.


Upcoming General Membership Events

- **September 30, 11:00 am: Fall Fiesta Luncheon.** Help us welcome our new TCMA members with a fresh taco bar on the patio of Zocalo Café. It’s free for all members.
- **October 26, 6:00–9:00 pm: Toast to Doctors** at The Cedar Door, 201 Brazos Street. Tickets $15 per person. Visit tcmalliance.org to purchase.
- **November 4, 10:30 am: General Meeting #2** at Zilker Clubhouse. Special guest speaker will be Clay Johnston, MD, dean of Dell Medical School. Stay for a complimentary lunch after the meeting. Meet our state alliance leaders President Angela Donahue and President Elect Patty Loose. At this meeting, we will also be collecting basic hygiene items such as toothbrushes, toothpaste, shampoo, soap and deodorant to support the ongoing needs of families at Saint Louise House (outreach to homeless women and children).

Enrichment Groups & Seminars

- **October 17, 10:00 am–12:00 pm: Seminar #2** TCMS boardroom. Professional counselor Dr. Pamela Monday will lead a seminar titled *Creating a Fulfilling Medical Marriage: Growing the Self, Setting Boundaries and Finding Purpose*. RSVP to Wendy Propst at wendywpropst@gmail.com.
- **October 6, 11:30 am: Ladies Who Lunch.** Meet for lunch at Odd Duck restaurant. Contact Mary Jane Moran for more information at mj@iknowaustin.com.
- **Walk, Talk & Roll** is an enrichment group that meets regularly to walk along Lady Bird Lake. Contact Edie Finch at efinch@ediefinch.com for details.
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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

On March 19, a 61-year-old man was transported via EMS to the local emergency department (ED) with symptoms of an acute myocardial infarction. During transport he received 5,000 units of heparin by IV. The patient’s history included a previous MI four years earlier which required two stents and placement of five additional stents a month before this current episode.

Physician action

A cardiologist performed a cardiac catheterization shortly after the patient arrived in the ED. Results showed the patient’s left anterior descending (LAD) coronary artery had 90% in-stent stenosis extending almost the entire LAD. There was also 90% stenosis of the first diagonal artery. After an unsuccessful percutaneous transluminal coronary angioplasty (PTCA) of the LAD, a cardiovascular surgeon performed a 3-vessel coronary artery bypass graft (CABG). This procedure resulted in the administration of additional heparin.

Postoperatively the patient remained critically ill with evidence of hypotension. His blood pressure dropped from 120/63 mm Hg to 84/63 mm Hg, and medications to increase his blood pressure were administered. This resulted in a stabilized blood pressure within the 90-100/50-60 mm Hg range. His hands were noted to be warm while his feet were described as cold. Although extubated postoperatively, the patient began having breathing problems and was intubated 24 hours later.

On March 20, brisk capillary refill with 3+ radial pulses and ankle pulses were noted by Doppler. On March 21 the patient’s hands were reported to be cool to the touch and lab results revealed a drop in platelets from 147,000/ml to 40,000/ml. A hematologist diagnosed disseminated intravascular coagulation (DIC) and ordered plasma and coagulation factor support. On the same date the cardiovascular surgeon ordered an antibody test for heparin-induced thrombocytopenia (HIT) while simultaneously ordering the discontinuation of the use of heparin.

The result of the antibody test for HIT was negative. The order to continue the use of heparin remained in place. Although a “no heparin order” was written in the chart and “no heparin” signs were placed in the patient’s room and on the IV pole, the plaintiff alleged the nursing staff continued to administer heparin to the patient due to the lack of documentation in the electronic medical records that heparin was not to be administered. The patient’s urine output dropped below 30 cc and a nephrologist was consulted.

On March 22, the patient’s platelet’s dropped to 26,000/ml. His hands and feet were reported to be cold and cyanotic with evidence of acute tubular necrosis. The nephrologist recorded a voice order for hemodialysis. The voice order specifically advised “no heparin” to be given. There was a question whether or not the catheter was packed with heparin after the voice order was received.

On March 26, the patient’s platelet count was 32,000/ml. His condition continued to deteriorate with worsening symptoms and decreasing organ function. The cardiovascular surgeon noted the clinical appearance of HIT including the gangrenous appearance of his hands and feet. A repeat HIT antibody test was ordered and came back positive two days later.

On March 28, argatroban, which is excreted renally, was ordered to treat the arterial blood clotting caused by suspected HIT. It was administered in a reduced dose due to signs and symptoms of renal failure. The patient continued to develop progressive gangrene of his feet and fingers resulting in bilateral below-the-knee amputation and bilateral amputations of portions of all his fingers.

Allegations

A lawsuit was filed against the cardiologist, hematologist, nephrologist and hospital nursing staff. The allegations included failing to stop the administration of heparin and failing to timely consider/diagnose HIT and treat with argatroban therapy.

Legal implications

The plaintiff alleged the physicians failed to consider HIT in a timely manner and the hospital’s nursing staff continued to administer heparin despite the physician’s order for the discontinuation of heparin. It was suggested by the plaintiff’s expert that had HIT been considered earlier in the course of illness, heparin discontinued and therapy ordered, significant tissue damage to the patient’s fingers and legs would have been avoided. It was his opinion the patient’s care fell below the standard of care.

The plaintiff’s expert maintained that once HIT was considered by the cardiac
surgeon, he and the hematologist should have instituted argatroban therapy. Further, this expert witness believed the consulting physicians failed to monitor the course of care being provided to the patient and did nothing to stop the continued exposure of heparin, thus contributing to the proximate cause of the patient’s injuries.

The defense experts were supportive of the care provided by the defendant physicians in this case. An expert and leading authority on HIT was convinced the patient did not suffer from HIT but instead suffered from DIC, as diagnosed by the defendant hematologist. He took the position the DIC resulted from the MI, decreased organ function and various comorbidities of the patient.

Risk management considerations
According to the Institute of Medicine, “When health care team members do not communicate effectively, patient care often suffers…communication among health care team members…profoundly impacts patient safety.”(1)

A communication breakdown between physicians and nurses easily result in an adverse event. Both interpersonal communication (verbal exchange between two or more individuals) and informational communication (exchange of written data and information) are required for the provision of safe patient care.(2)

The Joint Commission estimates that “80% of serious medical errors involve miscommunication [between] medical providers while the majority of avoidable adverse events are due to a lack of effective communication.”(3) Precise, unambiguous, face-to-face communication is the best way to ensure safe patient care.(4)

One simple and effective interpersonal communication technique is the practice of “repeat back.”(5) Use of this technique may have ensured the proper understanding and implementation of the physician’s “no heparin” order. In this instance, the recipient of the information would have been asked to repeat the order and the physician could have verified understanding of the information.

Written communication and orders — such as daily treatments, medications, and labs — should be reviewed regularly by all members of the health care team. Although documentation of care is used for legal and billing purposes, it is also an important communication tool that reflects the patient’s clinical status. Review of the patient progress notes not only provides important information for each member of the health care team, but also offers a system of checks and balances of patient care practices.

Disposition
The cases against the cardiologist, the hematologist and the hospital were settled. The case against the nephrologist was dismissed.

Sources

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.
A total of 3500 calories equals 1 pound of body weight. This means if you decrease (or increase) your intake by 500 calories daily, you will lose (or gain) 1 pound per week. (500 calories per day \(\times 7\) days = 3500 calories.)

All foods have carbohydrate, protein, and fat. Carbohydrates provide 4 calories per gram. Proteins provide 4 calories per gram. Fats provide 9 calories per gram.

Carbohydrates are either simple or complex. Simple carbohydrates cause more weight gain than complex carbohydrates. Simple carbohydrates include sugar and starches (potatoes, pasta, and rice). Complex carbohydrates include fruits, vegetables, and whole grains.

To lose weight, you must change your habits. This will happen slowly. Losing 1 to 2 pounds each week is great progress. Your goal should be better health and well-being. Speak with your doctor if you have significant health problems. Such problems include type 2 diabetes, heart disease, or kidney disease. If you take regular medications, check with your doctor because the doses may need to be adjusted as you lose weight. This is especially important if you have diabetes or high blood pressure.

Choose a fun activity and start moving. For example, walk or hike. Take tai chi or tap dancing classes. Or join a bowling or basketball league. Exercise will tone your muscles and help to limit flabby skin. Exercise also builds muscle. This will increase the number of calories you burn each day. Aim for at least 30 minutes of activity each day. Walking, even slowly for 10 minutes, is excellent. Pedometers (step counters) can help you track how much you walk. They can also motivate you.

Know your starting point. Keep a food diary for 3 to 5 days. During this time, eat what you usually eat. Write down everything you eat or drink. Measure portions for items without a nutrition label. For each item, determine the total calories and the grams of carbohydrate, protein, and fat. You can get this information from calorie-counting books, smartphone apps, or computer programs. A database of food nutrients is available at ndb.nal.usda.gov/ndb/foods. For each item, record the total calories and grams of carbohydrate, protein, and fat.

Find the problem. Look at your daily calorie totals. If you are gaining weight, you are eating too many calories. If your weight is stable, you know that many calories works for weight maintenance. But you will need to decrease your calorie intake to lose weight.

Fix the problem. Stop eating (or eat less of) foods with empty calories. Such foods do not provide enough of the nutrients you need. Examples are sodas, alcohol, and sweets.

Pick a reasonable calorie goal. Start by cutting 500 to 1000 calories from your current daily intake. Within this range, adjust your calories so that you lose 1 to 2 pounds each week. If you are comfortable after 1 or 2 weeks and want to lose weight more quickly, you can cut back further. Do not eat less than 1000 calories each day without medical supervision. Some people can lose weight eating 3000 calories each day. Others may need to limit intake to 1100 calories each day.

There is no ideal blend of carbohydrate, protein, and fat for weight loss. However, most health experts recommend a balanced diet that provides approximately 15% to 20% of calories from protein, 20% to 35% of calories from fat, and the rest from complex carbohydrates.

Make sure you eat enough protein. The average-sized woman needs 50 to 60 grams each day. The average-sized man needs 65 to 75 grams each day. If you are bigger, athletic, or ill, your protein needs could be much higher. Eat more protein if you are hungry after regular meals. If you eat only a small salad all day, your metabolism will slow down. This is not helpful if you want to lose weight. Here are some typical protein amounts in common foods: 3 ounces of lean meat = 25 grams; 3 ounces of fish = 20 grams; 8 ounces of milk = 8 grams; 1 ounce of cheese = 7 grams; 1 egg = 6 grams.

Snack on vegetables and fruit. For example, eat baby carrots or celery sticks with salsa instead of chips. Use berries instead of chocolate chips. Eat apples instead of apple pie.

For More Information
- NAT (Nutrition Analysis Tool) www.myfoodrecord.com
- US Department of Agriculture www.choosemyplate.gov
- Academy of Nutrition and Dietetics www.eatright.org/public

Helpful Hints and Reminders

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