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Lion couple in Kenya, Africa. Photo by Philip Huang, MD, MPH.
FEATURES AND ARTICLES

6 THE PRESIDENT’S MESSAGE
The World’s Tiniest Violin Playing the World’s Saddest Song
Brian S. Sayers, MD

10 Postcard from Kenya
Philip Huang, MD, MPH

12 PUBLIC HEALTH REPORT
Philip Huang, MD, MPH

14 THE LAST TO GO
Joseph M. Abell Jr., MD

16 TCMS DIRECTORY USAGE SURVEY
Owen Winsett, MD

18 HAPPENINGS

20 IN THE NEWS

22 TCM ALLIANCE
Lydia Soldano

24 PRACTICE MANAGEMENT
Failure to Admit Patient to Hospital
TMLT Risk Management

28 CLASSIFIEDS

30 TAKE 5: PSORIASIS

“Life and Death.” Morning mist rises over the cemetery in Chichicastenango, Guatemala. Photo by David Fleeger, MD.
In the introduction to his bestselling book about mindfulness and meditation, *Full Catastrophe Living*, Jon Kabat-Zinn explains the book's title, the origin of which is a passage borrowed from *Zorba the Greek*. A companion of Zorba’s asks him, “Zorba, have you ever been married?” to which Zorba replies (paraphrasing somewhat) ‘Am I not a man? Of course I’ve been married. Wife, house, kids, everything … *the full catastrophe!*’ Kabat-Zinn explains that Zorba did not mean this as “lament, nor does it mean that being married or having children is a catastrophe. Zorba’s response embodies a supreme appreciation for the richness of life and the inevitability of all its dilemmas, sorrows, tragedies and ironies. His way is to dance in the gale of the full catastrophe, to celebrate life … even in the face of personal failure and defeat.”

Most physicians’ lives encompass the full catastrophe in the positive sense that Zorba meant it; but unfortunately, too many also live the full catastrophe in the more usual sense the phrase is used to describe. We spend years of training and a lifetime in practice becoming experts about the human body without pausing to realize that we are not necessarily gifted – nor do we automatically acquire that same expertise – when it comes to our relationships with our loved ones and ourselves. Negotiating the constant balance between our professional lives and our personal relationships is both a moving target and a potential minefield. But doing so successfully is the difference between a life lived and a life lived well, between dragging ourselves to work and then home or moving with intent, anticipation, and gratitude through our days.

In the introduction to *The Medical Marriage*, the Sotiles use an excellent metaphor for achieving balance in our lives. They point out that achieving balance in our lives is often erroneously looked at as a static condition to be achieved rather than as a dynamic process akin to crossing a stream on slippery rocks – negotiating the crossing, slowly, deliberately, with constant adjustments – as a metaphor for finding balance, for crossing the uneven terrain of a full life.

When I read this it reminded me of a trip to Colorado when our children were young. One year we rented a cabin with what was usually a shallow stream running just a few yards beyond the back porch. The stream was running high and fast that year and we would fish and goof off along its banks without getting into the icy water much. One day with my daughter, maybe 6 years old at the time, we decided to cross to the other side to try the fishing or to explore the other side. With her little hand in mine, our legs quickly numb in the cold water, we struggled together, hands tightly clenched to cross the stream. The rocks were quite slippery, the water near waist deep at midstream, and with the swift current it was by no means certain what our fate would be as I led her along in our ill advised crossing, constantly feeling for firm footing, leaning into the current, holding on tightly to each other. I vividly remember her face expectantly looking at the other bank and relief when we got there, but I now have no recollection of what we did once we made it across. Regardless of what we found on the other side, that trek was made with constant adjustments, encouragement, uncertainty, and most of all, it was made together. Journeys and destinations are like that sometimes.

As a child, and then later from time-to-time, I remember that when someone would be telling a story full of self-pity or complaining about something that we all have to put up with at times, we would hold up a hand in front of our face, put our index finger against the tip of our thumb and slowly rotate it on the tip of the thumb, then move it close to our ear, as if listening. Everyone there would recognize this to be “The world’s tiniest violin, playing the world’s saddest song.” It was a somewhat mocking signal to the moaner that his plight was no worse than anyone else’s at some time or another and to get over it.

It is easy as physicians to moan about the negative changes in our profession or about our failed relationships or the other things common to the human condition that we all experience. Whatever else we are, we physicians are skilled problem solvers and one of the two most important things that we can do to set ourselves right in this life is to pay sufficient attention to our relationships with our loved ones and ourselves when we leave the office at the end of the day. One might easily argue that is the time our most important work begins rather than when it ends. Those relationships that mean the most to us don’t succeed by accident any more than our medical practices do. Both take hard work, the right attitude, and constant adjustments.

continued on page 8
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Like most of you, I have had a good life – very, good indeed – but not without setbacks and challenges, some seemingly devastating at the time and still painful to recall, others now trivial in retrospect. All listed out they would, like yours, be both entirely unique and very common to things we might expect in the course of a lifetime. It is easy to let the list of things that don’t go as planned, regrets and losses, weigh you down and make you feel sorry for yourself … and the sound of the world’s saddest song rises all around you. But then, perhaps a little like Zorba, I see that list for what it is, things that are inevitable, and, in the end, pieces of the journey that have made me who I am for better or worse. And I see the richness of all I have been given – my wife, my family, friends, a beloved profession, and a world full of miracles – all of which make me glad to get up in the morning … and the music from the world’s tiniest violin fades away. Entirely.
Matt McCarty, M.D.  
Diplomate of the American Board of Anesthesiology  
in Pain Management and Anesthesiology

Gus Lowry, M.D.  
Diplomate of the American Board of Anesthesiology  
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In August of this year, Philip Huang, MD, MPH, medical director and health authority for the Austin/Travis County Health and Human Services Department took part in a mission trip to Kenya.

Traveling with his daughters, they volunteered rural at a hospital just outside of Nairobi in a town called Tigoni. The hospital was very low tech with limited resources. While there, Dr. Huang practiced family medicine and put his OB/GYN residency to work delivering several babies.

Dr. Huang commented that there are a number of HIV patients in Tigoni, but the hospital is able to maintain an adequate supply of antiretrovirals. From a public health perspective, he said that despite the rural setting and limited resources, the Tigoni hospital has had a positive impact on the spread of HIV.

Overall, the volunteer work was “an amazing experience,” said Dr. Huang.
Cancer can change and devastate lives. And it can strike anyone. Mothers. Fathers. Brothers. Sisters, spouses, cousins, coworkers and friends. Cancer affects the people we love, the relationships we thrive on and the individuals we depend on... and who depend on us.

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Cryptosporidiosis Update

Cryptosporidiosis cases often occur at higher frequency during the late summer months. The Austin/Travis County Health and Human Services Department wants to make sure that area physicians are aware of recent developments.

In August 2011, Bell County experienced a cryptosporidiosis outbreak. The majority of these cases were directly connected to a local water park.

Local Surveillance

Preliminary 2011 data, from January 1 through August 26, indicates that A/TCHHSD has identified five confirmed cryptosporidiosis cases. This number is much smaller than the number of cases in 2008, the same year that the Dallas-Fort Worth Metroplex experienced a large crypto outbreak connected to an area lake.

Recommendations

Please consider laboratory testing for cryptosporidiosis if patients present with watery diarrhea lasting 1-2 weeks and report recreational swimming, especially if swimming occurred in Bell County. To report cryptosporidiosis or another notifiable condition, please call A/TCHHSD at 512-972-5555.

Health Messages for Patients

To prevent cryptosporidiosis and the spread of illness to others:

- Practice good hygiene, wash your hands thoroughly and frequently with soap and water for 15 to 20 seconds, especially after using the toilet; after changing diapers or cleaning up a child who has used the toilet; before eating or preparing food; before and after tending to someone who is ill with diarrhea; and after handling an animal or animal waste.
- Alcohol-based hand gels and sanitizers do not kill cryptosporidium.
- At recreational water venues (pools, interactive fountains, lakes, ocean), protect others by not swimming if you are experiencing diarrhea (this is essential for children in diapers). If diagnosed with cryptosporidiosis, do not swim for at least two weeks after diarrhea stops.

For additional Information:

Texas DSHS:
www.dshs.state.tx.us/idcu/disease/cryptosporidiosis/

CDC Healthy Swimming:
www.cdc.gov/healthywater/swimming/

Record Breaking Heat

As everyone is aware, this summer has seen record-breaking heat in Austin/Travis County. Here is summary surveillance data that A/TCHHSD has been collecting to monitor the situation. The graph shows the maximum daily heat index superimposed on the number of heat/dehydration-related ED visits at area hospitals collected from ED chief complaint data. For additional information please contact the A/TCHHS Division of Epidemiology and Surveillance at 512-972-5555.
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Inevitably, these pillars of virtue will crumble under the weight of an aging body, but I have found that I do have some control over when and how they fail me, and the sequence of their collapse. Age starts to denigrate our bodies sooner than we realize - in our thirties in fact - but old age "creeps in this petty pace from day to day" till disease and disability become the catalysts accelerating decomposition of the body. Now that I am in my life's end-run, I'm inspecting the integrity of my pillars. My dignity was the first to falter and now I'm struggling to make certain that humor is the last to go.

It was in Kennebunkport, Maine, September 2004 that my symptoms began: weak hands and awkward fingers. On May 14, 2008, three years and eight months (and hundreds of examinations and tests) after the first signs, a diagnosis was declared: Lou Gehrig's disease, amyotrophic lateral sclerosis (ALS), a neurodegenerative disease of unknown cause, no treatment and always fatal, leaving its victims unable to move, speak, or breathe. My medical school neurology textbook published in 1949 describes ALS as accurately as the 2010 edition. With nothing new to tell patients and their families, little funding for research, and no proven treatment, doctors call ALS "the orphan disease." More is known about muscular dystrophy, a group of inherited diseases due to a mutant gene responsible for the deficiency of a certain muscle protein, and multiple sclerosis, an autoimmune disease that damages nerves by destroying their protective covering. Guillain-Barre' syndrome (GBS) is another autoimmune inflammatory disease of nerves that also damages the myelin protective covering of nerves causing paralysis. Patients may suffer quadriplegia, severe pain, and even death, but in GBS there is always reasonable hope for recovery. MD, MS, and GBS, like ALS, cause muscle paralysis, but remissions and extended lives do occur. ALS, on the other hand, is relentless in its progression toward a voiceless, breathless state of quadriplegia and all patients die, most in less than two years. There is no escape from Lou Gehrig's disease.

We know that muscular dystrophy is a heritable muscle atrophy due to a mutant gene; and we know that MS and GBS are primary nerve diseases, autoimmune demyelinating dystrophies. Only ALS remains a mystery. Scientists cannot even agree on whether it is primarily a muscle or a nerve disease. Using electron microscopy they see nerve fibers disrupted where they should be engaging muscle fibers at a neuromuscular juncture, but they cannot say with certainty whether the breakdown begins in muscle or in nerve tissue.

In the beginning, I frantically researched all current ALS literature and online information; I called my academician professor, for copies of up-to-the-minute research papers on amyotrophic lateral sclerosis. Now, nearly seven years after my symptoms began, and three years since ALS was officially diagnosed, I seldom think about what may have caused this miserable malady and I no longer wonder or worry about where it's taking me. Surprisingly, I don't care. I'm too busy to worry.

What is important to me now is having meaningful work to do every day. Writing my memories and opinions has become my occupation, my physical and mental therapy. Lying awake long hours during the night, I think about what I want to say and edit what I’ve already recorded. Then, my day job is writing, using my eyes on an eye-gaze computer, work as important to me as any other I have ever done. I am never bored. With one book of articles already published in 2010, and granted more time than I expected to live, I plan to publish a second collection soon. It is my job and when it is finished depends on how soon my pillars come crashing down.

Dignity or modesty, like privacy and intimacy, we take for granted so long as we are in control of our own lives. Disabled persons, however, must forfeit control over their privacy and accept all manner of assistance from others. For example, early in my ALS journey I asked Mary, then friends and kin, and finally any stranger unthreatened by my request, to help me zip my fly up or down. And now I am totally dependent upon other people's hands to do for me everything that a man normally does with his fly open or his pants down. My dignity pillar has collapsed.

Humility is an elusive virtue that we often ignore when we are enjoying good health and success, but humility is omnipresent in my present undignified state, devoid of modesty and privacy. It is humbling for me to have to share my shower, my bathroom, and my bedroom with five women - only one of whom is legally and morally licensed to probe my nude body. In my former life this would be fantasy voyeurism, but now alas it is simply a necessity, no longer embarrassing. In truth, I sometimes enjoy it. I am patient as they attend to my scrawny body's needs.

Oh patience, you are my most elusive virtue, the one most appreciated by my
caregivers, yet the hardest for me to give them. Even though I know that patience is the pillar most necessary to hold my temple upright, it escapes me every time. My impatience too easily becomes anxiety, precursor to a heart attack or stroke in my debilitated state of health. Knowing that and struggling to demonstrate my deep appreciation to those who care for me, I pray for patience day and night.

Like patience, my confidence is fast fading. My self-esteem and self-confidence are fragile. Formerly, self-confidence was one of my defining character traits, but now I accept helplessness. Two years have passed since I last walked, a year since I've been able to breathe without a ventilator or to sit in any chair other than my wheelchair. I fear a breakdown in my ventilator; I never have enough air to breathe. I insist on having a spare ventilator and extra batteries, hoses, and masks. Every transfer from chair to bed and bed to chair frightens me. Early in 2011, I became weaker and less able to help with transfers. I was dropped several times. Both my hands are nonfunctioning now and my legs collapse under my weight. I depend entirely on the strength and skill of caregivers and an electric Hoyer Lift to transfer me safely, and I am frightened every time. I am apprehensive when I'm alone and insist on wearing an alarm on my wrist when my caregiver leaves the room. I know I cannot use a telephone, shout, or move; I am tethered to an airway. Everyone knows that I welcome noise and fear silence. Voices, kitchen noises, and vacuuming comfort me. A silent house threatens me; it says I could be alone. Aware that there is no means whereby I could summon help, I even worry that Mary may fall or faint when we are alone at night. I hope that doesn't happen.

Hope really is eternal. We hope for little things, silly things, and for big things; and sometimes we turn virtue into vice when we hope bad things will happen to another person. I no longer hope for much, but I do share a universal hope for a good death. Every night I pray, “God, give me the strength and the courage to deal calmly with whatever you have planned for me; and God, I hope you won't be too hard on me.” I hope to die peacefully and painlessly, in Mary's arms. Both of us will welcome that; we are well past tears. I am sure that we will be smiling.

If I have learned nothing else from my ALS experience, I have discovered that humor is the only effective treatment for this disease and humor is my antidote against depression and despair. A sense of humor keeps me socially connected and humor lightens the burden I place on my caregivers. Of this I am certain: my sense of humor will be the last thing to go.
This summer, TCMS conducted a survey to collect information regarding usage of the TCMS Pictorial Directory, the Roster, and DocBookMD. The survey had a 13% response rate and generated interesting answers and comments – most of which were positive.

This year, the Society saved $15,000 by printing on regular offset paper rather than the more expensive crystal silk paper used in prior years. The majority of respondents approved of the cost savings and would like to see it continue but with some improvements to the quality of photos. Staff should be able to correct this issue next year.

When asked about DocBookMD, the majority of respondents were aware of this member benefit. Of the respondents who utilize the app, more than half say it does not replace the pictorial directory. For more information on DocBookMD see next page.

Among suggestions received for additional features, many noted the need for updated contact information and photos. The Society provides each member with a profile giving them the opportunity to update contact information and photos prior to publication. Be on the lookout for your profile early next year and make sure the Society receives your current information by the deadline.

More than half of the respondents do not utilize the 5x7 roster. However, the majority of those who do utilize it find it helpful.

Some of the suggestions regarding the TCMS Pictorial Directory are addressed below:

- **Have an online physician search engine.** A physician search engine can be found on the TCMS homepage – www.tcms.com. TCMS active members can be searched by first name, last name, zip code, and/or specialty. Information includes photo (if supplied), practice specialty, board certifications (if any), medical school and year matriculated, and office address(es). Also available are links to location map and website.

- **List the name of the medical group/practice under individual member’s profile.** In 2010, the pictorial directory began including the group/practice name as part of the member profile.

The majority of respondents found the pictorial directory very useful with the member and specialty sections the most utilized features. Other sections referenced most often included practice and pharmacy listings (see graph).
Include email addresses (include for all members; include in the photo section). Physician emails are in a separate section of the directory which is removed when sold to non-TCMS members. Some members choose not to provide an email address to the Society, so 100% participation is not possible for e-mails, faxes, doctor’s line, etc.

List specialty by location. In 2010, the TCMS by Specialty Codes section was arranged so that physicians are listed by city using their office zip code. Physicians who have more than one specialty and/or office are listed within each specialty under each city.

Misc suggestions: training, insurance, languages spoken, mobile numbers. Several items suggested have not been included for reasons such as limited space, information changes too frequently, or because directories are sold to non-physicians. The Practice Listing section is available for individual physicians or groups to include items such as accepted insurance and languages spoken.

Include surrounding area physicians in the pictorial directory. With over 3,200 members and added features, a decision was made by the Communications Committee to keep it manageable by printing on thinner paper and no longer including non-TCMS members.

Include NPI numbers. NPI numbers can be found in the 5x7 roster.

Some suggestions regarding the Roster are addressed below:

Include more doctors’ back lines. The doctor's line is listed on the yearly profile, however, not all physicians have a separate line or they choose not to provide one to the Society.

Include photos, name of group/practice, and insurance accepted. The “Little White Book” was created as a pocket directory which has evolved into a 5x7 desk reference. The idea was to include items that only physicians and office staff might use, such as NPI numbers and emails. Keeping the size small and printing costs low prevents including additional information which can be found in the pictorial directory.

To order copies of the TCMS Pictorial Directory or the Roster, contact the Society at 512-206-1249 or tcms@tcms.com.

DocBookMD featured among iTunes’ top medical apps!

DocBookMD, a physician only electronic version of the TCMS Pictorial Directory available for iPhone, iPad, and Android devices was recently named as one of the top healthcare apps allowing physicians to communicate at the point of care with patients.

TCMS DocBookMD includes member profile information and HIPAA compliant communication tools for texting and image sharing and is available free to TCMS members.

For more information regarding this member benefit, contact Steve Hinojosa 512-206-1252, shinojosa@tcms.com, or visit www.docbookmd.com.
TCMS Health Care Heroes

Recently, the *Austin Business Journal* presented awards to “Health Care Heroes.” The nominees included individuals and organizations recognized for their contributions to a healthier Central Texas.

The Travis County Medical Society would like to recognize the following members who were honored by the *Austin Business Journal* as health care heroes: Phillip Church, MD of Cardiothoracic and Vascular Surgeons; John Dory, MD of Austin Samaritans; Roger Gammon, MD of Austin Heart; Renee Lockey, MD of Austin Regional Clinic; Bruce Malone, MD of Austin Bone & Joint Clinic; John “Chip” Oswalt, MD of Cardiothoracic and Vascular Surgeons; Audelio Rivera, MD of Pediatrix Medical Group; Ghassan Salman, MD of Austin Diagnostic Clinic; Aravind Sankar, MD of Surgical Associates of Austin; William Streusand, MD of Texas Child Study Center; and Christopher Ziebell, MD of Emergency Service Partners.

The Society was recognized for its community service/volunteerism. For more than 13 years, the Society has partnered with the Austin Independent School District to provide free athletic physicals and immunizations to uninsured students who do not have affordable access to health care. Since the inception of the program, more than 1,000 physicians have provided free athletic physicals to over 10,000 students. This is the only well check up some students will receive.

In addition, Tom Coopwood, Sr, MD, received the “Health Care Special Achievement Award” for his tireless work in health care for more than 30 years. A retired surgeon, Dr. Coopwood is now board chairperson of Central Health, formerly known as the Travis County Hospital District.

Events

On August 23, TCMS members got together for an evening at The Flying Saucer Draught Emporium in the Triangle. Members enjoyed appetizers and a wide selection of brews as they networked and caught up with colleagues.

Don’t miss out on upcoming TCMS events! Join your colleagues for another evening of networking on October 13 at The Park in the Domain. On November 3, find out how to meet EMR meaningful use criteria when TCMS hosts a Business of Medicine dinner – *Health Information Exchanges: Everything You Need To Know*.

To find out more about these events and others, visit www.tcms.com or call 512-206-1146.
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In Memoriam

John Norwood Spencer, Jr, MD passed away on June 30, 2011 at the age of 43. He graduated from UT with a BA in biology receiving his medical degree from the UT Health Science Center at San Antonio in 1993. He completed his psychiatric residency in Austin and worked for the Austin/Travis County MHMR before starting a private practice.

He was a member of the TCMS, Texas Medical Association, Texas Society of Psychiatric Physicians, and the American Psychiatric Association.

Dr. Spencer loved the outdoors, boating, his dogs, and especially his motorcycles.

Lansing Stephen Thorne, Jr, MD passed away on May 31, 2011. He attended the University of Texas at El Paso and the University of Texas at Austin. He earned his medical degree from Southwestern Medical College in 1944. His pediatric residency was completed at Cincinnati Children’s Hospital.

Dr. Thorne was a Diplomate of the American Board of Pediatrics and served as a physician in the US Army and the US Public Health Service before beginning his private practice. After retirement, he became the Medical Director for PCA Health Plan.

He was an avid outdoorsman who enjoyed gardening, hunting, and fishing. Dr. Thorne also served on the Vestry of the Episcopal Church of the Good Shepherd.

George Willeford, Jr, MD passed away on August 22, 2011. He received a BS degree from Texas A&M University and received his medical degree from the University of Texas Medical Branch, Galveston in 1946. Prior to residency training in pediatrics and psychiatry he served as a flight surgeon in the Fifth Air Force in the Far Eastern Theatre during World War II.

In 1969, Dr. Willeford changed his specialty to psychiatry and received a Fellowship in Psychiatry at the UT Health Science Center in San Antonio. He was a member on the Board of Directors of the Texas Youth Commission, then as Chairman, and finally served as Medical Director.

He was a member of the TCMS, Texas Medical Association, American Medical Association, Texas Psychiatric Society, and American Psychiatric Association. He was a member of the Vestry of the Episcopal Church of the Good Shepherd.

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

Dawn Buckingham, MD was celebrated as a woman of distinction at the Austin Business Journal’s annual Women of Influence – Central Texas Profiles in Power awards. Winners were recognized for their success as business owners, managers, or key contributors to the community.

Dr. Philip Huang, medical director for the Austin/Travis County Health and Human Services Department was named the 2011 recipient of the Texas Academy of Family Physicians (TAFP) Public Health Award during the organization's annual meeting in Dallas in July. The award recognizes individuals who are making extraordinary contributions to the public health of Texans.

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Lydia Soldano  
President-Elect, Travis County Medical Alliance

Summers are a great opportunity to spend time with families, to relax, and recharge batteries. I know that I enjoyed the easier summer routine as well as having fun with the kids and not worrying about some of the pressures from school. As the summer came to an end and vacations and camps were over, it was time to start focusing on getting the kids back to school and everything that it entails. While our kids focused on getting new clothes and shoes, and the ever important school supplies, parents had the unwelcomed task of scheduling hearing and eye exams and making sure immunizations were up-to-date.

This summer the Travis County Medical Alliance not only worked on having family fun and getting our children ready for school, but we also helped local elementary, middle, and high school kids be safe while bike riding and skateboarding, as well as helped them get ready to begin a new school year. This was done by attending immunization clinics and by partnering with Texas Medical Association’s Be Wise Immunize and Hard Hats for Little Heads to help provide these services to underserved children in Travis County.

One such event was held at the Volunteer Healthcare Clinic on August 6, 2011. This “Healthy Kids Day” helped about 40 local children and young adults with no health insurance. At this clinic, school and sports physicals were given and every child was asked to bring an immunization card so that everyone would be current on immunizations and boosters by the end of the day. The TCMA also had helmets available for any child that wanted one and for some that didn’t. This is part of the Hard Hats for Little Heads program that promotes wearing a helmet during wheeled sports to help prevent head injuries. This program realizes that it just takes one wrong fall to wind up with a serious head injury. Since its conception more than 100,000 helmets have been given away. We are so happy to be a part of this program and are grateful that we are able to help these kids – most of whom have never owned a helmet – but are still riding bikes. An added bonus at this event was our ability to give each student a backpack loaded with school supplies that had been collected earlier in the year by the TCMA.

Another event was located at the UT Children’s Wellness Center in Del Valle. Del Valle is located in Austin and the community is defined by the school district. This rural school district is working hard every year to bring school children current on their immunizations so that they are able to meet the requirements needed to enroll in school. The TCMA has helped with this clinic for several years and each year the number of immunizations given increases. Around 900 shots were administered this year. Fortunately, the Hard Hats program was going strong at this event and many children left with a helmet to help them forget about all those shots.

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

Presentation
A 51-year-old man came to the emergency department (ED) of a regional medical center at 2:55 pm on Thursday. The patient had previously been seen at his employer’s health clinic for complaints of mild chest pain, right arm pain, left arm pain, and thigh pain. Before that visit, the patient had played one hour of tennis, which he did each day. His employer’s clinic called his family physician who instructed him to go to the ED immediately.

Physician action
The triage nurse at the ED reported that the patient was complaining of chest tightness and joint discomfort since 10 am. The discomfort worsened with activity. His initial vital signs were: blood pressure, 151/101 mm Hg; pulse, 106 bpm; respirations, 22. He was placed on a monitor and pulse oximeter and was noted to be in no acute distress.

An emergency medicine physician examined the patient at 3:25 pm. He noted the patient was in mild distress, but was otherwise asymptomatic. When specifically questioned by the physician, the patient refused to use the term “chest tightness” for what he had experienced, but rather called it a “chest sensation.” He told the physician his symptoms had started the day before and that he had undergone a physical one month earlier. He reported that he took no medications, had no prior surgeries, and had borderline high blood pressure. He played tennis for exercise, did not smoke, but drank beer.

The physician completed a thorough physical exam and the results were normal. He ordered a monitor, chest x-ray, pulse oximeter, oxygen, a heplock, and lab work including a CBC, UA, Chem7, cardiac enzymes, and PT/PTT. He ordered two baby aspirin to be given during the work-up. The physician’s recollection is that the patient’s chest sensation was not continuing at the time he saw him.

The patient’s lab results and chest x-ray were within normal limits. An EKG revealed a normal sinus rhythm with nonspecific T-wave changes laterally. Because the patient did not have chest pain during his visit to the ED and his symptoms had started (as reported to the physician) more than 24 hours earlier with no enzyme elevation, the physician did not recommend admission. At 5:15 pm, the emergency physician called the patient’s family physician to schedule a follow-up appointment. Though the details of this conversation were not documented, an appointment was scheduled for 11:30 Friday morning. The patient was given two baby aspirins and discharged at 5:30 pm. He was instructed to follow up with his family physician, resume a normal diet, and take ibuprofen 3 times a day. He was further advised to rest and report to the ED if persistent or worsening symptoms arose.

The patient did not keep the Friday follow-up appointment. He died two days after the ED visit (Saturday) while playing basketball with his son. The autopsy report listed the cause of death as “a cardiac arrhythmia due to myocardial ischemia due to severe coronary atherosclerosis (heart attack).”

Allegations
Lawsuits were filed against the emergency medicine physician and the patient’s family physician. The plaintiffs alleged that the emergency medicine physician was negligent for not immediately admitting the patient to the hospital. Allegations against the family physician involve the scheduling of the patient’s follow-up appointment.

Legal implications
The plaintiffs were able to locate credible expert testimony that both physicians fell below the standard of care. An emergency medicine expert stated the patient should have been admitted for serial EKGs and cardiac enzymes to rule out acute coronary syndrome. A prompt stress test should also have been scheduled. The plaintiff’s emergency medicine expert indicated that had the patient been admitted, he would still be alive. The family physician expert claimed that the standard of care was breached when the patient’s appointment was rescheduled by the family physician’s office staff. He further stated that if the patient had been seen as scheduled, it was likely that investigation, treatment, referral, or advice could have been rendered that would have prevented his death.

Defense consultants who reviewed this case noted that an appropriate cardiac work-up was completed in the ED. This work-up showed that the patient was not having a myocardial infarction at the time of the ED visit. Further, the patient was appropriately referred to his family physician for follow up the next day but failed to keep that appointment. To the defense experts who reviewed this case, including two cardiologists and three emergency medicine physicians, the main weakness of the case was that the physician did not admit the patient or order repeat EKGs or cardiac enzyme tests.

The emergency physician stated that there were four pieces of information that he did not receive from the patient: history of playing tennis when the pain started; history of high cholesterol; history of having been seen at his employer’s health clinic that day; and history of a prior cardiac work-up by a cardiologist. If the physician had known that the patient’s pain started when he was playing tennis, he would have admitted him as an urgent, but stable patient.

This case was complicated by conflicting continued on page 26
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testimony from the family physician and the emergency physician about the scheduling of the follow-up appointment. The family physician testified that he told the emergency physician to have the patient call his office the next day to schedule an appointment. The emergency physician testified that the family physician said to have the patient come in the next day at 11:30 am, but because the front office was closed, to call the next morning and confirm that time. The conversation between these two physicians was not documented.

The patient’s wife and the family physician also gave conflicting accounts regarding the rescheduled appointment. The patient’s wife testified that when her husband called on Friday to confirm the appointment, a staff person told him the physician was booked all day and could not see him. An appointment was made for him on Monday.

The family physician’s medical assistant testified that when the patient called, he stated he was feeling better and did not want to come in that day. She told him that was fine and to come in on Monday, and in the meantime to follow the doctor’s instructions from the hospital. The medical assistant did not check with the physician before telling the patient it was all right to come in on Monday. This conversation is documented in the medical record as “feels better and wants to wait until next week.” However, the medical assistant also testified that she made this entry on Monday after the office had learned that the patient died. The entry was dated Friday.

Patient accountability became an issue in this case. In his discharge instructions, the emergency medicine physician told the patient to rest. The patient’s wife acknowledged that the patient knew he should not play sports. The patient did not follow those instructions and was playing basketball when he collapsed and died. Additionally, the patient failed to follow up with his family physician on Friday as instructed.

Disposition

This case was settled on behalf of the emergency physician and the family physician. Though it was felt that the patient shared a good percentage of responsibility for the outcome, defense experts were concerned that the patient was not admitted to the hospital and that his appointment was changed at the family physician’s office.

Risk management considerations

Many lawsuits against physicians involve actions of staff. Developing guidelines describing staff responsibility and decision-making in regard to patients will serve to prevent staff from exceeding their authority and rendering advice without your knowledge.

Strict protocols for documentation in the medical record apply to physicians and staff. Phone calls function as a key component of health care. In this case, the conversation between the emergency and family physicians was not documented. Secondly, the phone call between the patient and medical assistant was not documented contemporaneously but was written as a late entry that was not identified as such.

It is frustrating that patient accountability was not the sole focus of this claim. In retrospect, if the patient had been admitted from the emergency department, he might be alive today.
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Psoriasis

Psoriasis is a common skin disease that affects more than 7 million people in the United States. Patients usually have red, scaly, small to large raised areas of skin called plaques. These commonly affect the scalp, trunk, elbows, knees, and genital areas but can affect any part of the body, including the nails. About a quarter of patients develop pain, stiffness, and swelling in their joints (psoriatic arthritis). Patients with severe psoriasis may have an increased risk of obesity, diabetes, high cholesterol, and cardiovascular disease. Psoriasis also increases risk of depression.

Psoriasis is a genetic-based (inherited) disease that affects the body’s immune system. Infections, stress, alcohol, and some medications may worsen the disease. Psoriasis is not contagious.

Determining if you have Psoriasis

Psoriasis is usually relatively straightforward to diagnose because of the very typical appearance of the red, scaly plaques. Occasionally, a small sample (biopsy) of skin may be needed to help diagnose the condition. Psoriasis is a disease that can improve and worsen over time, but it usually does not go away completely. Treating psoriasis can improve the skin and may improve quality of life. Dermatologists are doctors with specialized training in treating diseases of the skin and nails, including psoriasis.

Psoriasis Treatment Options

- **Topical** treatments (on the surface of the skin), including corticosteroid creams (to reduce inflammation), or vitamin D preparations
- **Phototherapy** (treatment with light) in specially equipped ultraviolet light machines
- **Systemic** medications, including oral (by mouth) or injected medications that act on the whole body

Individuals with psoriasis should take care not to injure their skin or nails. Although light therapy is often an important part of psoriasis treatment, sunburn should be avoided because it can make psoriasis worse and increases the risk of skin cancer. Your doctor needs to individualize your treatments for psoriasis because the disease may affect you in many ways.

For More Information

American Academy of Dermatology www.aad.org
National Psoriasis Foundation www.psoriasis.org
National Institute of Arthritis and Musculoskeletal and Skin Diseases www.niams.nih.gov

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