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Hong Kong at night from Victoria's Peak. Photo by Ann Soo, MD.
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Invite In and Reach Out

R.Y. Declan Fleming, MD
President, Travis County Medical Society

Invited In

“We are really happy to have you here, but you’ve got to listen, you’ve got to know these things because this is how we do it.” His tone was assertive, but not rude or condescending. He just really wanted us to understand. “We’re going to be giving you instructions, and you need to do what we tell you when we tell you.”

He already had our attention. Each of us had been trussed up in a spotting belt that had been cinched up like a 19th century corset. I was fairly certain that all my abdominal contents had been shoved up into my chest. I knew I wasn’t breathing normally. The lovely hourglass figure I had been given let me know that they were intent that the belt should not slip. None of us in the class had experience in what we were doing – regular people generally don’t get on a trapeze.

A new crop of physicians joins our ranks every month. Often, it is people moving to Austin from other practices. But at this time of year we get an influx of new doctors – people moving here to start their first practice or as many of us experienced. These new doctors might not be trained as extensively as we were, but none of us were finished with our training at the end of our residencies or fellowships. These new physicians, in truth, are just like us. They want to take care of people. They want to live a good life and experience a fulfilling profession. They, like we, have chosen Austin because it is a great place to live. We all made “lifestyle” choices as we chose our specialty, chose our town, chose to work in a group or as a solo practitioner. It is time for us to stop complaining about how different they are, boasting about our capabilities and denigrating theirs. It is time we choose to embrace them as our colleagues and as our successors.

Learning the Way

We had completed training on the low trapeze, learning to pull up and hang from our knees, and from that position, how we could release our grip and stretch to look out towards our extended hands. I had learned that I couldn’t easily pull my legs in a tuck through my arms while I was hanging on the bar. The instructor told me to straddle my legs around allowing me an easier way up, and I made it easily. “Were you a gymnast?” he asked. “I like your form and strength.” I appreciated that he took the time to give me a bit of a compliment. I’m uncertain if he was trying to encourage me, or if he just wanted to know how likely I was to get frightened up in the air. If I panicked, he would have to do a lot more work on the spotting line. I told him I had been a gymnast in college. “Good,” he said as we moved over to the high trapeze. He had sized me up and had an idea of what I might do.

Shortly after that, we learned about climbing the ladder and what to do at the end of the platform. “When you’re up on the platform we won’t say ‘go,’ it sounds too much like ‘no.’ We say ‘hep!’ When you hear ‘hep,’ you go right then.” We were to swing out, bring the backs of our knees to the bar at the end of the swing out, let go of our hands at the top of the wall in front. We practiced a couple of times before we were to be caught by someone on the other trapeze.

Unlike my trapeze experience, I didn’t have anyone in med school or residency to teach me about running a business. When I was a fellow, we didn’t emphasize how to negotiate a contract or how to introduce yourself to a practice, asking the doctors to remember you when it came time to make a referral. I was a product of large medical institutions where people often went more for the reputation of the center (we make cancer history) than for the reputation of the individual.

continued on page 8
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My partners here in Austin taught me about integrating into Austin’s medical community. My reputation, I learned, was to be my calling card. Just like my trapeze instructor, my partners sized me up so they would know how much they would need to “spot” me. I knew I could trust the advice I was being given. I was a part of the group, and they wanted me to succeed. My success meant better things for our group and, to some extent, for Austin.

Reaching Out

My last couple of times on the trapeze saw me releasing my legs at the right moment so that my “catcher” could grab me by the forearms. The actual flying part of it was pretty short, but I still had moments of freedom. There were several people involved in my flight: the platform instructor, the spotter working the ropes from the floor and my catcher. One held me until I needed to be let go, one supported me as I flew and one caught me. Everyone was excited for me as I succeeded; I was excited for me as I flew and one caught me. Everyone was excited for me until I needed to be let go, one supported me as I flew and one caught me. Everyone was excited for me as I succeeded; I was excited for me as I flew and one caught me. Everyone was excited for me as I succeeded; I was excited for me as I flew and one caught me. Everyone was excited for me as I succeeded; I was excited for me as I flew and one caught me. 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It looks like a medical school will be coming our way. Both the President of UT Austin and the Chancellor of the UT System have indicated their support, and Senator Kirk Watson has championed it in his “10 in 10” plan. Those of you who know me well know that I am a proponent of this idea. I am certain that our community will benefit from the expanded medical education, post-graduate training, biomedical research and economic stimulus that a medical school will bring. The way the school will be developed is in flux. We are at a time right now when we can choose to embrace and influence the things that are coming or we can disregard or resist them.

I learned surgery during my residency and fellowship, but I am a better surgeon now than when I moved here 11 years ago. I was 15 years ago at the end of my nine years of postgraduate training. I am a better surgeon now than when I moved here 11 years ago. I have become better because I have been embraced, engaged, instructed by and relied upon as part of a community of colleagues. I have learned the basic principles of running a small business. I have learned about negotiation, I have become involved in the legislative process as an expert witness in hearings and as a lay-lobbyist with other members of our county society and the TMA. I learned, I adapted, I have changed.

Our new colleagues and colleagues-in-training will likewise learn, adapt and change as they mature as professionals. We have the opportunity to help shape their professional lives. The things they learn in medical school and residency will be insufficient to allow them to be fully functional professionals. We can wait until we take them on as partners, or we can try to begin to get to know (and influence) them now.

To that end, students and residents are being invited to our social events. TCMS officers will be meeting with the residents’ association officers to encourage them to participate in Society activities and to become a part of the TMA. We want to learn how we, as a society, can serve and encourage them. I have seen town/gown conflicts divide a community. As our new school develops, we can see to it that our community of practicing physicians influences and informs the way these future doctors are educated and launched...
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Since 2004, when voters approved the creation of what was originally the Travis County Hospital District, we’ve seen significant changes in how we deliver health care in our community – with yet more dramatic changes on the horizon. The district, known today as Central Health, has been at the forefront of many of these changes and will continue to play a key role ensuring that health care is accessible in Central Texas to all who need it most.

As a founding member and former chair of the Central Health Board of Managers, I’ve been privileged to witness firsthand how Central Health has taken advantage of the tools at its disposal to further the vision of Central Texas as a model healthy community. From the beginning, we have functioned differently from the state’s other tax-supported hospital districts, which typically both own and operate urban public safety-net hospitals and focus on the extensive and expensive care they provide.

In Austin, the district took ownership of what is now University Medical Center at Brackenridge, (UMCB) but continued the City of Austin’s pre-existing partnership with the Seton Healthcare Family to operate the hospital. Central Health has reinvested its revenue from the Seton lease agreement both toward maintaining a high standard of care at UMCB and toward expanding access to care – particularly primary care – for the more than 20 percent of Travis County residents who lack health coverage and who depend on the public health care system.

This strategy has so far been notably successful at addressing critical health care needs in our diverse, growing and aging community. At UMCB, Central Health and Seton have created the only Adult Level 1 Trauma Center serving an 11-county region. At the same time, Central Health has funded a 50 percent increase in publicly funded primary care visits and a 150 percent increase in the number of people covered by the Medical Access Program – now numbering more than 23,000.

We’ve managed so far to make those investments, as well as others, while maintaining our tax rate at approximately the same level as when the district was founded. (Central Health’s initial tax rate was set to be revenue-neutral; the city and Travis County reduced their property tax rates by a corresponding amount.) This is in part a testament to the philosophies and strategies that have guided Central Health.

Our aim is to match people with the care they need in the most appropriate setting. To that end, primary care is funded through a network of more than two dozen clinics and 500 individual providers who deliver medical, dental and behavioral health services. We have also invested millions of dollars to create capacity in the local clinic system to better accommodate more patients and provide more comprehensive care.

Central Health matches patients to proper care with a call center that provides referrals and handles more than 90,000 calls each year. This includes not only primary care but also specialty care and hospital care funded by Central Health, with attention to gaps in care in Travis County that impact both uninsured and insured patients. These include hospital-based women’s health services that were formerly provided by the Austin Women’s Hospital in partnership with UTMB.

Our impact has been especially great in behavioral health, where the critical shortage of inpatient beds in Travis County was one of the first challenges tackled by the district. Today, Central Health funds 70 percent of the mental health crisis hospitalizations in our area, along with more than 21,000 behavioral health visits – a number that’s grown by 75 percent in the last seven years.

Central Health led an ambitious collaborative effort with multiple partners to achieve these gains in behavioral health services, which is another one of our guiding principles. We do not directly provide care but rather purchase services, and we work with a wide range of partners to develop innovative strategies for increasing access while containing costs. These range from the community-wide Central Health Connection planning initiative, to our 78744 Collaborative effort to increase access to care in the low-income Dove Springs area, to fostering the creation of TexHealth Central Texas, a low-cost health coverage program for small businesses. Most recently, we began operations of Sendero Health Plans, a nonprofit HMO serving CHIP and Medicaid patients in Central Texas.

Central Health’s track record of success as a leader and partner in Central Texas health care, and our unique mission to promote community health and meet the needs of the underserved, both come into play with our work with Senator Kirk Watson’s “10 in 10” plan and Healthy ATX initiative. The major goals of the initiative – a medical school in Austin, and a new teaching hospital to replace the aging Brackenridge facility – will both go far to further Central Health’s mission and vision.

As with the rest of Travis County and Central Texas, the population Central Health serves is both growing and aging, and we need to ensure that primary and specialty providers are available to deliver the care they need. A modern hospital can provide better care for all who need it, regardless of their income. Healthy ATX also envisions enhancements to the local clinic system and to both inpatient and outpatient behavioral health, building on the work Central Health has already accomplished.

Perhaps most importantly, Central Health can continue to act as a collaborator, planner and innovator within the framework envisioned by Healthy ATX. We have already been designated by the
state as the anchor of a Regional Healthcare Partnership covering six counties as part of Texas’ efforts under its Section 1115 Medicaid waiver. This status allows us to pursue ambitious strategies for health delivery system transformation and to draw down significant sums of federal monies to further fund uncompensated care in the region.

Our vision of a model healthy community is one where we make real, lasting progress that changes the way health care is delivered in Central Texas. But more than that, we want to achieve not just optimal care but optimal health for the people of our community. Providing access to care when people need it most helps all of Travis County stay healthy and helps the local medical community do its job better.

continued from page 8

into practice. We can help, and by helping, we can avoid those problems.

As I was about to leave the building, my ground instructor, the one who had been working the ropes said, “You know, we need to get you back here, you could be a catcher.” I don’t think I’m up for that as a second career, but I walked out encouraged with my ego a bit inflated. We all can compliment and encourage young physicians in training. We can help usher them into our fellowship of service and in so doing, we can serve our community for years to come. Now is the time to do this … hep!

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The Austin/Travis County Health and Human Services Department (A/TCHHSD) has recently released its Critical Health Indicators 2012 report which provides an overview of the well-being of the more than one million residents of Austin and Travis County. This report represents the department’s inaugural effort to gather, analyze and present information on selected diseases, conditions and risk factors. A wide range of health indicators are included in this report: leading causes of death; reportable conditions; HIV/AIDS/STDs; maternal, child and adolescent health; chronic disease conditions and risk factors and suicide. The report illustrates both the overall burden of disease and areas where improvement is needed, including health disparities that exist in our community. The report establishes a baseline of health for residents of Austin and Travis County which A/TCHHSD expects will help the community better understand the issues that impact the quality and productivity of their lives. The document represents one of several tools that A/TCHHSD will use to continue the development of strategies toward becoming an even healthier community.

Highlights of the report include:

Mortality: The leading causes of death among Travis County residents over the past decade mirror state and national trends and include cancer, heart disease, accidents, stroke and chronic lung disease.

- Tobacco remains the leading cause of preventable death in Austin and Travis County. In 2008, almost 600 deaths in Travis County were caused by cigarettes and other tobacco products.
- Twenty percent of deaths were caused by heart disease (n=917 deaths), with mortality due to heart disease concentrated in persons over 45 years of age.

Maternal, Child and Adolescent Health:

- Infant mortality rates among Black mothers is over twice times higher than infant mortality rates among both Hispanic and White mothers.
- Hispanic and Black females had the highest percentage of births to teen mothers – four and eight times the percent for White mothers, respectively.

Chronic Diseases:

Cardiovascular disease and diabetes are two chronic diseases that affect residents in Travis County. Risk factors for these and many other diseases include tobacco use and obesity or being overweight.

- Blacks and Whites have about two times the rate of cardiovascular disease than Hispanics.
- Eight percent of Travis County adults report being told by a doctor they have diabetes.
- About one-fourth of adults in the county, over 118,000 persons, are considered clinically obese.

Health Disparities:

- The mortality rate from diabetes among Blacks and Hispanics was more than double the rate for Whites.
- From 2006 to 2008 the percentage of mothers who identify as Black and Hispanic with “late or no prenatal care” was over twice that of White mothers. Late or no prenatal care is often related to a mother’s ability to access medical care and low birth weight.
- Babies born to Black mothers were at highest risk among the three race/ethnicity groups to be born prematurely and/or with a low birth weight.
- Blacks have higher rates of HIV, AIDS and selected STDs.
- Blacks and Hispanics are at higher risk of being overweight and being diagnosed as clinically obese, than Whites.
- The lack of any kind of health care coverage is associated with a higher prevalence of being overweight and obese in the county.

The complete report can be found on the City of Austin’s website at: www.austintexas.gov/news/2012-critical-health-indicators-report-released.
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You’ve seen the consequences of those who dared to cross the brutal beast. You’ve heard the horror stories of those who came in contact with this cruel creature. You watch your every written or spoken word to make sure you don’t awaken the ferocious monster, but now its time to face the HIPAA monster and social media.

Physicians are considered the trusted source on medical topics and HIPAA should not deter them from using social media to share that knowledge. Instead, HIPAA laws should guide physicians to use social media appropriately, professionally and in a way that protects their patients. Using social media while avoiding a HIPAA violation isn’t impossible, but it can be tricky. Here are 10 easy tips to help you use social media successfully:

1. **Be general.** Never saying a patient’s name might seem obvious enough, but that’s not the only violation that can disturb the HIPAA monster. Don’t put out any information that could identify a specific patient. It is often possible for others to figure out the patient’s identity, especially if they are familiar with the patient and their injury/illness. Don’t spend time trying to disguise patients; instead be general. If you do want to share a personal patient story, have the patient sign a consent form agreeing to release the information online.

2. **Create content.** Fill your social media with helpful, insightful and accurate information. Talk about conditions, treatments and research in universal terms. Send practice-related updates, announcements and reminders, but don’t stop there. Share links, pictures and videos. Social media is a visual tool, use it as such.

3. **Watch your tone.** Remember that social media is a permanent reflection of you and can easily be shared or reposted. Don’t use social media as a way to vent your frustrations. Feel free to show passion towards a cause. If you are planning to write something funny about medicine or patients, have a friend review it before you post.

4. **Double check yourself.** Before you send any post, ask yourself whether it would be appropriate to say in a crowded elevator or coffee shop. Read it aloud to yourself, or ask a colleague for an opinion. Take particular care when responding to others, especially in real-time venues like Twitter. Although timing is a key aspect to social media conversation, it’s ok to take a minute, step back and think before answering. Also remember that social media is based on sharing – but don’t share your secrets.

5. **Protect your privacy.** This one is simple but vital. Protect your accounts and check your privacy setting periodically, preferable once a week as they can change with little notice.

6. **Understand your platform.** If you choose to use Facebook, understand the difference between a status update, a comment and a message. If you choose to use Twitter, know the difference between a tweet and a direct message (DM). It’s important to learn the tools of the platform and observe how to use them before diving in headfirst.

7. **Establish a social media policy.** Create a social media policy for your practice and staff stating acceptable use of social media on behalf of the physician or practice. Specify who is allowed to post, what material is appropriate, how to respond to certain posts and what avenues will be used. Write preapproved responses to frequently asked questions. It is also wise to state consequences for noncompliance by your employees and emphasize personal responsibility and good judgment.

8. **Separate your accounts.** Separate your personal account from a professional account. A good suggestion for Facebook is to create a Personal Page to keep up with friends and family and a Fan Page to connect with patients, the community, office staff and other professionals. Or use different platforms for different uses, such as a professional Twitter account and a personal Facebook account.

9. **Use your name.** Social media is a highly effective tool in communication because of its ability to humanize and give a real voice to brands, icons and community leaders. As a physician, you are considered a trusted leader by your patients. Don’t lose that respected voice in online anonymity. Use your voice to promote healthy habits, market your practice and provide accurate information. Anonymity can breed bad behavior and provide a false sense that there are no consequences; both are bound to awaken the HIPAA monster.

10. **Avoid e-treatment via social media.** If a patient approaches you through social media means, i.e. a Tweet or Facebook post, it is insufficient authorization to respond in the same method, especially involving medical advice. Address the situation by asking the patient to call your office, or discuss the issue at a future appointment. Social media also has no state lines, unlike medical licenses. Avoid offering specific, direct and personal medical advice to any person via social media. It is also a good idea to add a disclaimer to any Facebook, Twitter and blog profiles stating that the content you provide is information and not personal medical advice.

Overall, when using social media remember to enjoy and be yourself. Your patients, colleagues, community and other thought leaders want to connect with you, not a robot, an automated machine or a salesperson. People assume you’re the same doctor online as the one they’re going to be seeing at their appointment.

If you have questions regarding social media, contact TCMS Communications Coordinator Shahar Gurvitz at sgurvitz@tcms.com or 512-206-1219.
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Take advantage of the full benefits of the TCMS Auto Program!
Around the office and to his patients, he’s known as Dr. David Butler, but around the racing track and to his teammates, he’s known as Dr. Danger.

David Butler, MD is a family physician, who has recently returned to his practice in Northwest Austin after serving aboard the USS Ronald Reagan CVN 76 as a captain in the United States Naval Reserve. A few years ago, Dr. Butler began exploring his interest in cars by working on a few side jobs with a friend who happened to be a mechanic. As his knowledge of cars grew, so did his love for the racing track, and he was transformed into a racecar driver. Dr. Butler now participates in the ChumpCar World Series, a grassroots endurance race series, and races on tracks from Texas World Speedway in College Station to Harris Hill Raceway in San Marcos.

While the name, ChumpCar, might spark a chuckle, the idea behind the series gives everyday people the opportunity to fulfill the thrill of racing without breaking the bank. The current value of the car has to be $500 or less; however, there are no monetary limits on safety equipment. According to Dr. Butler, unlike other races, ChumpCar is not a venue for trained professionals or expensive cars, only good folks with a passion for cars and racing.

“The whole theory behind the ChumpCar race is to make it an every man’s race,” said Dr. Butler. “With this race series, it’s affordable. It’s not cheap in the sense that you have to invest in safety equipment and time, but it’s affordable, especially in comparison to other races out there.”

Although affordability is a key feature of the ChumpCar World Series, Dr. Butler admits that one of his favorite personal aspects is the overall encouragement for teamwork and the strong sense of unity that surrounds the racing tracks.

“You have a team of four working closely together on the car and racing it,” said Dr. Butler. “Sometimes you’re the one fueling the car, and sometimes it’s someone else. There’s not a division between drivers and crew pit.”

There is also an environment of good sportsmanship among the opposing teams. Instead of cut-throat competition, all the participants work on their cars and prepare for the race together under one garage, sharing tips and lending tools. For instance, Dr. Butler recalled a time that he stayed awake until 3 am to work on another team’s car that was his competition only several hours later.

“Everyone borrows each other’s tools and helps out,” said Dr. Butler. “In professional races, you would never think about borrowing another team’s tools, but in ChumpCar refusing to lend is looked down upon. That’s just how it is, but that’s a big draw to it.”

The emphasis of a ChumpCar race is endurance, in other words, how many laps your car can go in a set number of hours. In a last-car-standing race that averages anywhere between 12 to over 24 hours, people aren’t focused on speed or bumping the competition off the track. Such conduct is against the rules and outside the true spirit of the race. To Dr. Butler and other participants, ChumpCar is not just a race series; it’s a community that offers endless learning experiences.

“You learn a lot from the other people,” said Dr. Butler. “You learn about how your car is put together, and how other cars are put together. You can learn what works for your car and what doesn’t, but also get ideas.”

Unlike the oval shaped tracks typically seen in Daytona 500 or Indianapolis 500 races, all of the tracks used are different shapes; however, they all incorporate a series of turns and several straightaways that create a real race adventure. Dr. Butler remembers the thrill of the adrenaline rush as he passed someone going 130 mph on a straightaway at the Texas World Speedway track in College Station.
Surprisingly, it’s not racing at high-speed, or fixing a car under tight regulations and budget that pose as the greatest challenges in the race.

“You’re inexperienced, and as a doctor, you’re used to knowing everything,” said Dr. Butler. “The first time I pulled on to a track, I was thinking ‘what am I doing here?’ I had no race experience, and there I was on a track I had never been on about to drive a car that I had never driven.”

In an opportunity to do something other than medicine, Dr. Butler finds many similarities between his hobby of car restoration and his profession as a physician.

“As a doctor, working on these cars is stimulating because mechanically you’re working on something that you don’t know, but it’s something that you know can be figured out,” said Dr. Butler. “It’s something you can logically work through. It keeps your brain active.”

ChumpCar World Series creates the safest events possible for its participants. Risks of accidents still exist as Dr. Butler and his 1984 Ford Mustang experienced in a recent race. Going around a curve, he collided with a car that was traveling at a speed of 70 mph. Luckily for Dr. Danger, he had installed a HANS device in his racecar, a safety item that reduces injuries to the head and neck in an event of a crash; however, the car was totaled.

Despite the accident, Dr. Butler plans to rebuild a new car with his teammates in their Sanger, Texas garage and continue racing. The team’s greatest struggle in rebuilding the car will be the summertime heat without air conditioning in the garage. Nonetheless, Dr. Danger will eventually face the ChumpCar race track once again.

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In Germany, certain cars get respect on the autobahn while others do not. If you have one of “those” cars, people move out of your way quickly, but if you don’t, they take their time. It’s like that here, too. I had a graphic reminder of that reality a few years ago when I spent a week driving a Hyundai Elantra and found that other drivers were reluctant to yield to me or would preferentially cut in front of me in traffic. It was weird: I’m the same guy driving the same way, yet I was treated differently because I was driving a car that was perceived as lesser.

By any measure, the Mercedes S-class is an alpha car, and that was certainly the case during my time driving one recently in southern California. Whether zooming along in the fast lane of I-405, gently cruising through Santa Barbara, or checking into a hotel, the S-class got plenty of respect.

Part of the reason for that is history. Since the 1960s and before, full-size Mercedes sedans have been staples of successful people with good taste. Growing up in a medical family in the 1970s—my mother was an ob-gyn—I would regularly wander through doctors’ parking lots to check out the cars. As is the case now, there was a spectrum of vehicles represented, but the Mercedes S-class always caught my eye, particularly the mighty 6.9. (For readers too young to remember that iconic model, it was a stock-looking S-class into which had been stuffed a huge, 6.9-liter V8 motor and all the tech Mercedes could muster in those dark automotive days, including a self-leveling hydraulic suspension. It was the first stealthy supercar I ever saw, and I love it to this day.)

Anyway, even as it nears the end of its life cycle, the current (ninth-generation) S-class, on sale here since 2007, has managed to stay fresh with regular updates, including cosmetic enhancements and new hybrid and diesel engine options.

The hybrid S400 is actually a “mild” hybrid, which means it can’t run solely on electric power. Basically, Mercedes took the S-class sedan, added a 3.5-liter V6, and supplemented that with an electric motor powered by a lithium-ion battery. The engine and motor combine to produce a respectable 295 horsepower, considerably less than the 382-horsepower you get with the V8 S550, but still enough to propel the 4,474-pound S400 from zero to 60 mph in just 7.1 seconds. As you’d expect, fuel economy is much improved, jumping from 15 mpg city/23 highway in the S550 to 19 mpg city/26 highway in the S400. For the record, the diesel S350 does even better at 20 mpg city/31 highway.

Interestingly, at just under $92,000, the S400 is the cheapest (if that’s the right word) S-class for sale in the United States and is eligible for a $1,150 federal tax credit.

While the extra hardware and electronics on the mild hybrid S400 are presumably less involved than in the Lexus LS600h or Fisker Karma, this is a new arena for Mercedes, which has lots of experience with diesels but very little with hybrids. That may explain two glitches I encountered: a check-engine light that appeared for 36 hours then vanished, and a key-fob low-battery light that did the same thing later on. If I were a real owner, that would have required a trip to the dealer.

Not surprisingly, the S400 drives a lot like the S550. The open road is where the S-class feels most at home, and pointing one down any highway is a delight. Solid and confident are accurate descriptors, but somehow they don’t capture just how good this car is on the interstate.

Around town, the start-stop feature that turns the engine off when you’re not moving is noticeable—though not unpleasant—and the six-cylinder engine sounds more like the Bluetec diesel than the S550’s mighty V8.

While the S-class’ exterior design is aging nicely, it looks out of step with newer Mercedes models, which are becoming more angular and visually assertive than they used to be. Expect the next S-class to resemble the new SL that just launched.

Inside, the S400 is attractive and comfortable, as you’d expect for any car in this price range. Luxury is turned up to 10, and the ergonomics are superb, thanks to top-shelf materials and a COMAND multi-function control system that’s well integrated and easy to use.
Naturally, the S400 comes with a plethora of standard equipment, and numerous options are available to enhance the ownership experience, should you so desire. Space constraints do not allow a full rundown here. TCMS Auto Program Director Phil Hornbeak can provide additional information (phornbeak@tcms.com or 512-949-5758).

I’m happy to see that Mercedes has seen fit to green-up their flagship with a hybrid option to please drivers who want the benefits of S-class ownership in a more fuel-efficient package. After all, even with an eco-friendly powertrain, the Mercedes S-class is the kind of car that commands respect anywhere it goes. And for hard-working TCMS members, that’s a good thing.

Steve Schutz, MD, is a board-certified gastroenterologist who lived in San Antonio in the 1990s when he was stationed in the US Air Force. He has been writing auto reviews since 1995.
The Travis County Medical Alliance (TCMA) is comprised of TCMS physicians and their spouses. TCMA’s mission is to assist the Travis County community with health-related needs and to foster social networks for medical families. The TCMA works in conjunction with the Travis County Medical Society and is an affiliate of the Texas Medical Association Alliance and the American Medical Association Alliance.

Why you and your spouse should consider joining TCMA:

- Develop friendships and support other medical families.
- Promote community health and education.
- Participate in legislative activities such as First Tuesdays at the Capitol along with Texas Medical Association Political Action Committee (TEXPAC) and the Texas Medical Association.
- Learn about hands-on volunteer opportunities in our community such as Bookspring, the Volunteer Healthcare Clinic and St. Louise House.
- Participate in enrichment groups: book clubs, playgroups, movie groups, health initiatives and other family-friendly activities.
- Help raise funds and awareness for other local nonprofit health related organizations. (In 2012, TCMA raised nearly $50,000.00 for our grant recipients.)
- We have FUN!

For membership information, contact Edie Finch at efinch@ediefinch.com, or Sahar Askew at saharaskew@gmail.com.

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Not pictured are: Treasurer, Tera Ferguson; Secretary, Jeni Lowry; VP Financial Development, Kimberly Chassey; VP Medical Affairs, Yvonne Bailes and VP Membership Elect, Sahar Askew.

The Travis County Medical Alliance Wins Statewide Award
At the May 2011 AllMed Meeting of the Texas Medical Association Alliance (TMAA) in Dallas, TCMA won a “Dedication to the Mission” award. This award is presented to the county with the project that most clearly epitomizes the promotion of the TMAA mission. It was noted that “each year, the Travis County Medical Alliance raises money for local health care-related nonprofit groups through its gala. This year, the net proceeds from the gala were nearly $50,000. Five local nonprofits were the recipients of these funds, including two health care clinics which serve the uninsured and underinsured; Camp Braveheart, which supports children who have lost loved ones to cancer; Lifeworks, a program for homeless and runaway youth and St. Louise House, which benefits homeless mothers and their children.”

Accepting the TMAA “Dedication to Mission” award are: Lydia Soldano, Loren Gigliotti, Vickie Blumhagen, Bridget McKeever (Immediate Past President of TMAA), Patricia Wallis and Patty Loose.
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5 BD 3.5 BA +/- 4,244 SQ FT .27 acres
Listed by Michelle Jones

19500 SINGLE PEAK CV $650,000
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4 BD 4 BA +/- 2956 SQ FT 3.43 acres
Listed by Keri Chmelik

15094 BARRIE DR $549,000
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4 BD 4 BA +/- 3260 SQ FT .28 acres
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John Oswalt, MD, FACS, a thoracic surgeon and founder of HeartGift Foundation has been awarded the Ashbel Smith Distinguished Alumnus Award. The award is the highest honor bestowed to the alumni of the School of Medicine of the University of Texas Medical Branch at Galveston, and recognizes Dr. Oswalt for his outstanding service to the medical profession and to humankind.

Cathy Scholl, MD, was recently appointed to the Physician Consortium for Performance Improvement Anesthesiology and Critical Care Maintenance Workgroup, which develops performance measures that are then submitted to the National Quality Forum and the AQA Alliance (formerly the Ambulatory Care Quality Alliance) for use in national quality improvement programs.

Michelle Berger, MD, Austin, Jorge Restrepo, Michael E. Speer, MD, Houston, and Deborah A. Fuller, MD, Dallas pose at the TMA House of Delegates meeting where Mr. Restrepo and eight other students received a 2012 TMA Minority Scholarship to support their first year at a Texas medical school. TCMS is an annual donor to the TMA Foundation in support of this program which aims to increase the diversity in medicine to better serve Texas’ increasingly diverse population.

In Memoriam

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

Mathis Wilhoite Blackstock, MD passed away on July 3, 2012. Dr. Blackstock was a premed student at the University of Texas in Austin and received his Doctor of Medicine degree in 1948 from the University of Texas Medical Branch at Galveston. He interned at Herman Hospital in Houston, and then served as a Navy doctor during the Korean War. Following completion of a general practice residency at the University of Colorado in Denver in 1953, Dr. Blackstock moved to Austin and began practicing family medicine. In 1978, he became the Associate Director of the Family Practice Residency program at Brackenridge Hospital, which operates the Family Health Center, renamed the Blackstock Family Health Center in 1991. Despite retirement from active practice that year, Dr. Blackstock continued his association with the Blackstock Family Health Center. He was well known for his medical education efforts in the community.

Joseph L. DesRosiers, MD passed away on July 3, 2012. Dr. DesRosiers received his Doctor of Medicine degree in 1957 from the St. Louis University School of Medicine. He then completed his internship and residency at Walter Reed Army Hospital. In 1965, following a distinguished military career, Dr. DesRosiers moved to Austin and became the first board certified OB/GYN in the area. He served the community as a doctor of obstetrics and gynecology, as well as Seton’s Director of Obstetrics Care. Delivering approximately over 10,000 babies at Seton over the course of 43 years, Dr. DesRosiers selflessly provided countless women and their unborn children with medical care for nearly five decades.

Walter Reifslager, Jr., MD passed away on May 15, 2012. Dr. Reifslager served in the Air Force as a flight instructor in World War II before graduating from the University of Texas Medical Branch at Galveston. In 1958, he relocated his family to Austin where he formed one the first private psychiatric practices and offered the community more than half a century of devoted health service, improving the quality of life of thousands of grateful individuals throughout Texas and beyond. Over the last two decades, a handful of individuals have been honored with the Seton Fund’s Dr. Walter E. Reifslager, Jr. Award, established to recognize exceptional generosity and dedication to the mission of the Daughters of Charity.

Walter Samuel Parks, Jr., MD passed away on June 4, 2012 at the age of 92. Dr. Parks received his BA from the University of Texas at Austin. He attended the University of Texas Medical Branch at Galveston where he graduated with a degree in medicine in 1942. Dr. Parks, then, interned at Philadelphia Graduate Hospital where he met his wife-to-be Jeanie Wilson Tennant. During WWII, Dr. Parks was a battalion surgeon as a member of the European Theatre 1041h Infantry Division. Holding the rank of captain, Dr. Parks was captured by the Germans, spent the winter at Oflag 64 in Poland and was later liberated by the Russians. Dr. Parks was instrumental in pioneering the use of the Pap Smear in 1951, the laparoscopy in 1965, the electronic fetal monitoring system and many surgical techniques. He established the Midland Women’s Clinic which is still active today. In 1989, semi-retired Dr. Parks moved to Austin and continued to practice gynecology at Bergstrom Air Force Base. He retired from medical practice at the age of 91.
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Failure to Treat Postoperative Infection

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Presentation

A 69-year-old woman was referred to an orthopedic surgeon for a defect in her Achilles tendon. She was diagnosed with a chronic rupture of the Achilles tendon. The patient was given the options of either living with the defect or undergoing reconstruction to regain strength and function. The patient chose to proceed with the reconstruction. The orthopedic surgeon – the defendant in this case – performed a repair with transfer of the flexor hallucis muscle.

The surgery was uneventful, and the patient was administered a one-time dose of vancomycin post-operatively. Vancomycin was selected because the patient was allergic to penicillin. The patient was discharged the following day with instructions to leave her foot in a splint. She was to follow up with the orthopedic surgeon within 10 days.

Physician action

The patient returned a week later, and the sutures were removed. The wound was observed to have some minimal wound granulation and drainage from the incision. These observations of the wound were written in a different handwriting from the surgeon’s, but were not initialed. The surgeon believed that they were in his nurse’s handwriting, but he could not be sure. It was also unclear if the entry was what the patient had relayed to the nurse, or if those observations were made by the nurse herself. The patient was fitted with a splint to continue immobilization of the foot and was told to only remove the splint to bathe. She was also advised to complete wet-to-dry dressing changes, to monitor the wound for signs of infection, and to return to the office in four weeks.

Nearly one week after this office visit, the patient called the surgeon’s office and received a prescription for ciprofloxacin. The only record of this encounter, which occurred five days after the patient’s last visit, was the pharmacy record. There is no record of the phone call, what was discussed, or the reason for the prescription.

Two days later, the patient came to the surgeon’s office complaining that her foot was “feeling hot” and noting a “hole” in the wound. She was not wearing her splint. The patient claimed that she was not advised to do wet-to-dry dressing changes, but instead was told by the surgeon’s nurse to clean the wound with peroxide, then dress with dry gauze. The surgeon examined the wound, noted minimal cellulitis, but did not feel the area was hot. He advised the patient to continue taking ciprofloxacin, discontinue the improper peroxide cleanings, and proceed with wet-to-dry dressing changes.

The patient called three days later, while the surgeon was on vacation, to report that the wound drainage was getting worse and now had an odor. The patient was advised to come to the office, and was seen by the surgeon’s partner. This office note was incomplete, only stating: “post-op wound infection, culture taken.” This second surgeon, not realizing the patient had a penicillin allergy, gave the patient a prescription for amoxicillin clavulanate. Fortunately, this mistake was caught by the pharmacy, and another antibiotic was substituted. The patient stated in her deposition that this was what made her lose confidence in the surgeon’s office. She sought treatment from a wound care facility four days later. The wound care physician diagnosed her with full thickness dehiscence, necrotic subcutaneous fatty tissue and necrotic areas of the tendon in the wound base.

Six days later after the patient’s appointment with her surgeon’s partner, the lab results were returned indicating staphylococcus and actinomycyes meyeri infections. The patient was called and asked to come to the surgeon’s office that day. She was emergently referred to a plastic surgeon, who admitted her for IV antibiotics and several debrideamments of the wound.

 Allegations

A lawsuit was filed against the orthopedic surgeon, alleging that he failed to timely and adequately treat the patient’s post-operative infection. She claimed that function of her lower leg was impaired as a result of the infection and the failed Achilles tendon graft.

The patient underwent subsequent surgeries with a plastic surgeon to remove the original tendon transfer due to necrosis of the tissue. Tissue from the patient’s wrist was transplanted to the
original surgical site to fill the void left by the removed tissue. The patient claimed that subsequent surgeries resulted in the loss of sensation in her fingers.

Legal implications
TMLT consultants who reviewed this case were generally supportive of the orthopedic surgeon. Infection is a known complication of Achilles tendon repair. There also appeared to be some question of patient compliance. However, all of the consultants had some concerns about the lack of adequate documentation pertaining to justification of the antibiotics chosen.

The surgeon’s partner had also missed elements of the documentation, and did not provide detail about why he chose amoxicillin clavulanate. However, the only defendant in this lawsuit was the orthopedic surgeon who performed the repair.

Disposition
This case was settled on behalf of the orthopedic surgeon.

Risk management considerations
Although infection is a known complication inherent in any surgical procedure, there were several problems with the surgeon’s documentation that complicated the defense of this case.

It is recommended that all phone calls between the patient and physician be documented, particularly calls in which medical advice is given. There was no record of the patient’s call that triggered a prescription for ciprofloxacin, or reason for the change in the treatment plan. Documentation of the patient’s symptoms, description of the wound and any noted changes, and the physician’s reasoning behind treatment not only creates a thorough chart, but in this case, it would have provided additional information to the surgeon’s partner when he saw the patient.

Implementing a protocol that requires all staff making entries in the chart to initial or sign their entries will assist in identifying who made the entry in case it needs to be verified at a later date.

It is recommended that physicians have a policy and procedure manual for the practice to ensure that all personnel are operating under the same guidelines, as expected by the physician. This may include any routine instructions that are commonly given to patients, such as how to perform a wet-to-dry dressing change. It is further recommended that important instructions to the patient be developed into a handout that can be given to the patient and to document that the handout was given. Patients often become confused when instructions are given in the office, which can make compliance difficult. Should a claim occur, the printed instructions could be used as evidence to show precisely what information was given to the patient.

It is appropriate for medication allergies to be consistently and boldly documented on the front of the chart to prevent them from being overlooked. All physicians in the same practice should standardize how allergy information is displayed if they cover for one other. It was fortunate that the pharmacy caught the error before the prescription was filled; however, the error made the patient lose confidence in the practice. A patient and/or the patient’s family are more likely to file a lawsuit if they perceive that the care they are receiving is substandard.

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.

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INTERSTITIAL CYSTITIS

In interstitial cystitis or bladder pain syndrome (IC/BPS), the lining of the bladder is constantly irritated, causing pain during urination and urinary frequency. It is not certain why individuals have IC/BPS, but it is thought to be due to chronic inflammation of the bladder, possibly from defects in the inside wall of the bladder. It may also be partly an autoimmune disorder, in which the body makes substances that attack the lining of the bladder. Sometimes IC/BPS runs in families. IC/BPS occurs in men and women, but is five times more common in women. It may be more common than previously thought because individuals with other painful conditions of the pelvis may also have IC/BPS that has not been diagnosed. Your primary care doctor may refer you to a urologist, a doctor with specialized education in the management of problems with the urinary system, including the kidneys, the urethra, the bladder and the urethra.

SIGNS AND SYMPTOMS

- Urinary frequency, urinating more than 8 times per day or at night
- Urgency to urinate, sometimes immediately after urinating
- Pain or discomfort that worsens as the bladder fills or is improved after emptying the bladder
- Pelvic pain or pelvic pressure
- Pain with sexual intercourse

DIAGNOSIS AND TESTING

Most cases of IC/BPS can be diagnosed through a medical history and a physical examination. Urinalysis is usually done to exclude a urinary tract infection (UTI) because UTIs can cause the same symptoms but is treatable with antibiotics. Cystoscopy, inserting a small flexible lighted tube into the bladder through the urethra, is often done in the urologist’s office, with the patient under local anesthesia. More complicated cystoscopy, biopsy or other procedures using the cystoscope are done in the operating room, using sedation or anesthesia.

TREATMENT

- Some foods (citrus, tomatoes, and other acid-containing foods), beverages and alcoholic drinks may make interstitial cystitis worse for some individuals. Changing your diet and no longer drinking alcohol may help to reduce symptoms of interstitial cystitis.
- Quitting smoking is an important step for anyone with bladder problems.
- Relaxation techniques and stress management can help to improve symptoms. Stress does not cause IC/BPS but can make its symptoms worse. Support groups can be useful sources of information about coping with IC/BPS.
- If lifestyle changes do not improve symptoms, physicians may recommend medications or therapies such as hydrodistention. This is a procedure that fills the bladder with fluid through a cystoscope.

FOR MORE INFORMATION

National Kidney and Urologic Diseases Information Clearinghouse
www.kidney.niddk.nih.gov

Interstitial Cystitis Association
www.ichelp.org

American Urological Association Foundation
www.urologyhealth.org
**OPPORTUNITIES**

**Physician Opportunity:** MOBILE DOCTORS - seeks a physician to make house calls to the elderly and disabled, in the Austin area, on full-time or part-time basis. A company car and Certified Medical Assistant are provided. No on-call, nights or weekend work. Great flexibility while maintaining a work/life balance. Practice primary care with patients who really appreciate you. Email CV to Nick at nick@mobiledoctors.com or call 312-848-5319.

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