Time is running out!

TMLT has allocated $100,000,000 to policyholders this year but you need to enroll by December 31, 2012 for your account to be funded for the entire year.

Don’t miss out on this one-of-a-kind opportunity. All you have to do is sign up at www.tmlt.org/trustrewards.

If you haven’t signed up yet, be sure to check your mail. You’ll be receiving a statement showing how much your allocation will be when you enroll.

To enroll online: www.tmlt.org/trustrewards

Questions?
Call 800-580-8658 ext. 5050
The Austin Diagnostic Clinic Physical Medicine and Rehabilitation Specialists:
Vishal Kancherla, D.O., Sheila Patel, D.O. and Joe Volpe, M.D.

Why Choose an Austin Diagnostic Clinic Physical Medicine and Rehabilitation Specialist?

Our primary goal is to restore everyday physical function to our patients. We care for patients with acute and chronic pain, musculoskeletal problems, such as back/neck pain, tendonitis, pinched nerves and myofascial pain. In addition, we treat individuals who have had strokes, orthopedic injuries, or neurologic disorders such as multiple sclerosis, polio or ALS. We offer non-operative management and individualized treatment plans and therapy for our patients.

Drs. Kancherla, Patel and Volpe are board certified by the American Board of Physical Medicine and Rehabilitation.

To make an appointment or for more information call 512-901-4011 or visit ADClinic.com
Vases, ceramics shop in Dolores Hidalgo, Guanajuato, Mexico. Photo by Marilyn Vache, MD.
FROM THE PRESIDENT
Parting Thoughts
R.Y. Declan Fleming, MD

LEGISLATIVE UPDATE
After the 2012 Elections: What You Can Do Now
Stephanie Triggs

WEBICINE:
Creating Your Social Media Road Map
Shahar Gurvitz

PAIN MEDICINE & ACCIDENTAL LEthal Drug Overdoses In Travis County During 2011
Graves T. Owen, MD; Satish Chundru, DO; David Dolinak, MD and Krista Crockett

2012 PHYSICIAN OF THE YEAR
DAVID C. FLEEGER, MD
Shahar Gurvitz

ETHICAL ISSUES IN THE UNIVERSAL AVAILABILITY OF GENETIC TESTING
Donald Wilcox, JD and Omaima Poonawala, JD

AUTO REVIEW
Steve Schutz, MD

PRACTICE MANAGEMENT
Retained Surgical Retractor
TMLT Risk Management Department

CLASSIFIEDS
As I sit in front of my computer recognizing that I am writing my last “President’s Message,” I am able to reflect on this past year. Through the year, two important events have captured our collective attention for months and finally culminated in November. Both outcomes impact TCMS members.

First, the citizens of Travis County voted in favor of Proposition 1, a property tax increase that will fund programs by Central Health, specifically one that will allow the University of Texas to start a medical school in Austin.

Even though letters and editorials published in both the Austin American Statesman and the Texas Exes’ Alcalde implied that support of the new tax increase and medical school was nearly universal among practicing physicians, TCMS members were clearly divided with hundreds on each side of the debate. For that reason, TCMS, as a society, did not take a political position – for or against – Proposition 1.

During the campaign, organizers and proponents certainly sought physician support for their stance regarding the ballot measure. Now that the election is over, I hope the leaders of this important endeavor will continue to reach out and engage physicians in the process of developing a medical school here in Austin.

The University of Texas and the Seton Healthcare Family have made significant financial commitments in the development of the new school, but both have also made it clear that they would not have been able to move forward without the support from us, the taxpayers. We too, have a role and a responsibility to facilitate creating a “university of the first class.” (Read the Texas Constitution for that reference.)

We are fortunate in Travis County to have gifted medical practitioners and educators in the private community. Many who have previously served as teaching faculty for students, residents and fellows here and around the country would like to participate in undergraduate and graduate medical education. The students at the University of Texas at Austin School of Medicine (or whatever it will be called) would surely benefit from the opportunity to train under the guidance of members of our society.

The second important event was the reelection of President Obama. With his second term, implementation of the Patient Protection and Affordable Care Act (ACA) will continue. The newly insured patients created by the ACA will be looking for someone to provide them health care.

Although many aspects of this emerging health care environment have been debated ad infinitum, there is one that has all but escaped public notice: the universal application of the term “providers” to include physicians and surgeons, physician assistants, nurse practitioners, optometrists, chiropractors, physical therapists and others. I believe that we are duty-bound to make clear the differences that exist between physicians – MDs and DOs – and other “providers.” I was reminded of this responsibility in recent emails from two of our members.

William McCarron, MD wrote: “…doctor first means ‘teacher,’ and then the one who cares for people in all their health needs….my plea is [we honor ourselves and our] colleagues by using the word that best describes what we do, and that word is ‘doctor,’ in place of a word that we have allowed to be used by so many, provider.”

Paul Tucker, MD continues the thought: “…labeling us as providers, in my opinion, lumps us in with everyone else in the health care field. Such labeling takes away from our true title, our esteem, and even worse, it subliminally informs the patients that we are expendable cogs in the wheel of health care. We simply become technicians in their eyes, and our services and expertise become devalued. I see this attitude every day in EDs and hospital wards.”

Thinking about this takes me back to a summer day in Jasper, TX during the mid-1960s. My mom was from Jasper and each summer we would go visit the cousins. This particular summer we had a swimming party in the back yard of one of my relatives. I was standing near the shallow end talking with my cousin, Bob. Bob was seven and cool. I was five and trying to be cool like Bob. He told me that he had been taking swimming lessons and that he could swim the entire length of the pool. So Bob dove in to show me and started to swim. If I had been a bit more reflective, I might have acknowledged that most of my water experience at that point had involved splashing around with mom or dad – not much real swimming per se. A five-year-old Declan was not one to reflect too long on things, so I shouted: “me too!” and dove in after Bob. I remember kicking and stroking with my arms just like I had seen other swimmers do. I also remember how cool it looked underwater to see the increasingly deeper portions of the wall at...
By Physicians. For Physicians.

MSB is the only service of its kind in Texas owned and operated by a Medical Society. For more than half a century, we’ve been providing physicians with the highest quality service at the lowest price.

Answering Service: MSB’s Answering Service is a quality driven, low cost after hours call screening service. Whether your needs are simple or complex, require a single call schedule, multiple schedules, or just sign out to your partners, your calls will be answered on the first ring and processed with the level of accuracy and compassion you expect. At a price you’ll be pleased with, too. MSB offers web-based call schedules and call protocols, online access to your call recordings and much more.

Daytime Call Center/Switchboard/Receptionist Services: Adding staff is an expensive way to address busy signals or long hold times in your office. Instead, use MSB’s call overflow service. When your staff is unable to answer, calls are automatically diverted to our state-of-the-art call center and processed per your custom protocols.

Patient Appointment Reminders: You already know the benefits of reminding patients about their appointments. MSB’s Appointment Reminder service not only provides those benefits but also saves you substantial money each month over competitive services. Automatically remind your patients of their appointments via phone, email, text message or a combination of the three.

Patient Lab Results: Give your patients 24-hour access to their lab results without burdening office staff. MSB’s HIPAA-compliant lab result messaging solution is easy to use. Messages can be recorded with specific details for each patient, or they can be pre-recorded as standard messages for multiple patients. No additional equipment, software or phone lines are required.

For an extremely competitive quote, call us at 512-467-5200.
I’m apparently slower than most. All the members of our “health care team” – nurses, therapists, lab technicians, etc. – have incredibly valuable and necessary roles, but they are not interchangeable with that of the physician. The extra time and effort required to become a medical doctor has important consequences. Other members of the team do not carry the weight of responsibility for the patient’s well-being that the physician does. The final responsibility for a patient’s plan of care and outcome rests with physicians because we have chosen the road less traveled to make ourselves ready for that responsibility. We are not merely caregivers; we are physicians, set apart from limited license practitioners. As Dr. McCarron wrote, “Our State of Texas honors us with a very special license as a ‘Doctor of Medicine,’ not a provider.”

As our new healthcare system begins to take shape, I believe that this distinction needs to be emphasized. I would like for our local, state and national medical societies to be proactive in educating the American people about what it takes to become a doctor and why that’s so important.

In the interest of our patients, we must not allow health care reform jargon to obscure the line between limited license health care and the practice of medicine. Let us make certain that our patients and policy makers know who we are and what we do. We are physicians and surgeons. Ultimate responsibility for patient care stops here.

It has been my privilege and my pleasure to serve as the president of this society for the past year. I am honored to call you my colleagues.
MEDICAL PROFESSIONAL LIABILITY INSURANCE + RISK MANAGEMENT SERVICES

CERTITUDE
by ASCENSION HEALTH

FOR PHYSICIANS
AFFILIATED WITH
SETON HEALTHCARE FAMILY

Your record of practice is important for many reasons—
credentialed, increasing transparency with patients,
and protecting your important professional identity.

Coverage is about so much more than settling claims.
Choose the protection that is like no other in supporting
the principles of high reliability.

Your Certitude™ program provides:

- Risk management resources to help you manage your practice
  and enhance patient safety
- Flexible premium payment options to fit your needs
- Physician peer input for difficult claims and underwriting issues
- A unified claims approach—with no claim settled without your consent
- Enhanced coverage for today’s medical environment
- And much more...

Call ProAssurance at 800.252.3628
for more information on Certitude.

EXPECT MORE
The power of affiliation...

Brian Novy knows Austin.
Your #1 source for medical office space.

The Brian Novy Company Specializes

- Tenant/buyer representation
- Lease negotiation / renegotiation
- Utilizes extensive network of
  Developers, Contractors,
  Architects, Attorneys,
  CPAs and Lenders
- Build to suit

Brian is home grown Austin. He will find the perfect location for
your practice and be your resource in all phases of establishing
your practice.

512-327-7613 • www.briannovy.com • novyco@austin.rr.com
The elections are over – on the national level, Barack Obama remains president and the Patient Protection and Affordable Care Act (PPACA) remains law. For the 113th US Congress, Senate Democrats maintained their majority – 53 Democrats; 45 Republicans and two independents. In the US House of Representatives, Republicans maintained their majority – the count currently stands at 234 Republicans and 195 Democrats with several races still undecided.

On the state level, the 83rd Texas Legislature stands at 19 Republicans and 12 Democrats in the Senate and 95 Republicans and 55 Democrats in the House. An unprecedented number of Texas Medical Association physicians were elected to serve in the upcoming legislature. On the Senate side, congratulations to Bob Deuell, MD; Charles Schwertner, MD (replaces retiring Senator Steve Ogden) and Donna Campbell, MD (replaces Senator Jeff Wentworth); on the House side congratulations to John Zerwas, MD; Greg Bonnen, MD; JD Sheffield, DO. In addition, Texas Medical Association Alliance member Susan King was re-elected.

Although the elections are over, there’s still plenty to do as the 83rd Texas Legislative Session will convene on Tuesday, January 8, 2013. The session doesn’t begin until January, but the first day to file bills was Monday, November 12. On the opening day, 231 bills were filed – 100 in the Senate and 131 in the House. It is anticipated once again that physicians will face scope of practice and corporate practice of medicine bills (among others) that are not in the best interest of organized medicine in Texas. TMA and TCMS will remain diligent in opposing those bills while working tirelessly to pass bills that are.

**Your Help is Needed**
It’s time for you to get off the sidelines and become part of the legislative process as TMA and TCMS advocate on behalf of you and your physician colleagues.

**Sign up for First Tuesdays at the Capitol**
Join hundreds of your colleagues from across the state at the Capitol on the first Tuesday of each month the legislature is in session – February 5, March 5, April 2 and May 7. Legislators take note when their hometown doctors walk the halls of the Capitol in their white coats.

**Become a Key Contact**
Let TCMS know if you have a personal or professional relationship with a state or federal legislator(s) or are willing to become a key contact on medical issues.

TCMS will give you all of the information you need to make contact. A simple phone call or email can make all the difference!

**Join TEXPAC**
The Texas Medical Association Political Action Committee (TEXPAC) is the political arm of TMA representing 46,000 physicians and more than 8,000 Alliance members in Texas. Legislative advocacy can work at the state and federal levels of government, but only if medicine friendly candidates are elected. TEXPAC is a bipartisan PAC that provides financial support to candidates for both state and federal offices. A contribution of any size to TEXPAC can make a huge difference.

**Get involved**
Contact TCMS Senior Director of Community and Government Relations Stephanie Triggs at striggs@tcms.com or 512-206-1124.

<table>
<thead>
<tr>
<th>Governor</th>
<th>Lieutenant Governor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rick Perry (R)</td>
<td>David Dewhurst (R)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State Senators</th>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charles Schwertner, MD (R)</td>
<td>District 5</td>
</tr>
<tr>
<td>Kirk Watson (D)</td>
<td>District 14</td>
</tr>
<tr>
<td>Donna Campbell, MD (R)</td>
<td>District 25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>US Senators</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>John Cornyn (R)</td>
<td></td>
</tr>
<tr>
<td>Ted Cruz (R)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State Representatives</th>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marsha Farney (R)</td>
<td>District 20</td>
</tr>
<tr>
<td>Jason Isaac (R)</td>
<td>District 45</td>
</tr>
<tr>
<td>Dawnya Dukes (D)</td>
<td>District 46</td>
</tr>
<tr>
<td>Paul Workman (R)</td>
<td>District 47</td>
</tr>
<tr>
<td>Donna Howard (D)</td>
<td>District 48</td>
</tr>
<tr>
<td>Elliott Naishtat (D)</td>
<td>District 49</td>
</tr>
<tr>
<td>Mark Strama (D)</td>
<td>District 50</td>
</tr>
<tr>
<td>Eddie Rodriguez (D)</td>
<td>District 51</td>
</tr>
<tr>
<td>Larry Gonzales (R)</td>
<td>District 52</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>US Representatives</th>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michael McCaul (R)</td>
<td>District 10</td>
</tr>
<tr>
<td>Lamar Smith (R)</td>
<td>District 21</td>
</tr>
<tr>
<td>John Carter (R)</td>
<td>District 31</td>
</tr>
<tr>
<td>Lloyd Doggett (D)</td>
<td>District 35</td>
</tr>
</tbody>
</table>

Do you have a personal or professional relationship with any of the elected officials below? If so, contact Stephanie Triggs at striggs@tcms.com or 512-206-1124.
FIRST TUESDAYS
AT THE CAPITOL
83rd Legislative Session — 2013

Your patients need YOU to be a lobbyist for a day! Come to Austin for First Tuesdays at the Capitol and make a difference for your patients and your practice.

Check out the First Tuesdays website www.texmed.org/firsttuesdays, or call (800) 880-1300 ext. 1361 for more information.
Creating Your Social Media Road Map

Shahar Gurvitz
TCMS Communications Coordinator

It’s that wonderful time of year – time for your winter vacation! You’ve decided on the perfect destination, bags are packed, hotel is booked and activities planned. The only obstacle standing between you and your vacation is the road ahead. But you’re not worried because you have the quickest, most efficient route already mapped out.

Folded paper maps may have become a fond memory as we now depend on instantaneous instructions from a GPS device; nevertheless, getting somewhere new without instructions is difficult and sometimes time consuming. Similar to the process of taking a vacation, successful use of social media requires planning and preparation.

Here are six simple steps to mapping out a social media plan for your practice:

1. Research
Today’s global society offers endless possibilities of destinations to visit. Likewise, social media offers endless possibilities of social networks, such as Facebook, Twitter, LinkedIn, blogs, etc. Take time to research each one, explore its tools, follow key influencers in your field and observe current user interactions. Think about which site answers the wants and needs of your practice and audience. Sometimes the best way to get answers is by simply asking, so don’t be afraid to ask your patients which social media platform they use most frequently. Focus on establishing a strong presence on one or two sites rather than going after all of them at once.

2. Identify
Now that you’ve chosen your social media platform, goals and objectives, these should be specific, measurable, achievable, relevant and timely. Specify the results you want to see with numbers and a time frame to make them happen (e.g., increase practice awareness by 10 percent in 6 months). Set yourself up for success; make sure your goals are relevant and achievable by ensuring that you have the right resources, tools and staff.

3. Prepare
Develop a timeline (preferably 6 to 12 months in advance) to identify upcoming events, certain themes and specific topics that you are aware of so that you can time your efforts in a consistent and relevant manner. For example, a family medicine physician might dedicate posts relating to diabetes in November to raise awareness of American Diabetes Month. Don’t over prepare or set in stone what you’ll want to post; things come up and plans change. But with a timeline, you will be able to create content in advance and stay on track.

4. Create
Content should meet the needs of your audience. A good rule of thumb is 90/10 – 90 percent of your content should satisfy your audience and 10 percent should be used to market your practice. Your messages should always be genuine, personable and in line with the overall goals of your practice. Optimize your posts with key words, but most importantly be creative with your presentation. Some content ideas to get started: tips; little known facts; relevant and timely statistics; stories; questions; lists; photos and videos.

5. Engage and Implement
After you’ve researched, identified, prepared and created, it’s time to implement your plan by posting your content, engaging in conversations with your audience and expressing your point of view. Make sure to stay on schedule and maintain consistency. There are plenty of tools to help monitor and schedule posts (i.e., Hootsuite, Tweet-Deck, Seesmic, etc.). Have on-hand resources and preapproved messages to respond to comments and feedback in a timely and appropriate manner.

6. Measure
After the plan has been executed, measure your results and revise for the future. Look at Facebook Insights, Google Analytics and various online metrics (most offered for free) for information on who is reading your content, who is interacting with you and what kind of information your audience enjoys the most. Use this information to tailor your future strategies.

Planning and preparing a vacation in advance can make a huge difference in your overall experience. A solid social media strategy and execution plan is your roadmap that will guide you successfully to your destination.

If you have any questions or would like a personal tutorial regarding social media, contact TCMS Communications Coordinator Shahar Gurvitz at sgurvitz@tcms.com or 512-206-1219.
I WAS AFRAID CANCER MEANT I HAD ONLY WEEKS TO LIVE.

HEATHER, 36, DESMOID SARCOMA

LIVESTRONG can help your patients understand their cancer diagnosis, the importance of a second opinion and treatment options. We also provide services and resources that may help your patients preserve their fertility, manage their finances and receive emotional support, and we can help them navigate a complex system. Learn how LIVESTRONG supports health care professionals and their patients toll-free at 855.220.7777.

For more information visit LIVESTRONG.org/yourpatients
The United States currently has a prescription drug abuse epidemic. The unintentional lethal prescription overdoses (OD) has increased in proportion to opioid prescribing patterns. Opioids are the primary drug resulting in these preventable deaths. For each unintentional lethal prescription OD, nine people are admitted for substance abuse treatment, 35 visit the emergency department, 161 people report drug abuse or dependency and 461 individuals report non-medical use of opioid analgesics. Among the victims of lethal prescription OD, the rural and more impoverished counties, Medicaid populations and mental illness are overrepresented. Deaths from opioid prescriptions now exceeds deaths from cocaine and heroin combined.

The opioid prescription drug morbidity and mortality rates correlate with the per kilogram/10,000 population sales of opioids. States with higher opioids sales have a higher opioid death rate for unintentional overdoses. While Texas was the 43rd highest state for drug overdose deaths, Texas is surrounded by states with significantly higher drug OD problem.

It is estimated that 4.8 percent of the US population age 12 or older uses opioids non-medically. Drug OD deaths are approaching the number of deaths from motor vehicle accidents, the leading cause of injury death.

The use of chronic opioid therapy (COT) has been controversial, but the controversy is increasing as there are no outcome data to justify COT. Recent information has clearly demonstrated a significant risk of adverse outcomes up to and including death. About half of the lethal OD involved at least one other CNS depressant including alcohol.

| Figure 1 |
| Number of unintentional drug overdose deaths involving opioid analgesics, cocaine, and heroin — United States, 1999–2007 |

<table>
<thead>
<tr>
<th>Year</th>
<th>Opioid analgesic</th>
<th>Cocaine</th>
<th>Heroin</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>2,000</td>
<td>4,000</td>
<td>1,000</td>
</tr>
<tr>
<td>2000</td>
<td>4,000</td>
<td>8,000</td>
<td>2,000</td>
</tr>
<tr>
<td>2001</td>
<td>6,000</td>
<td>12,000</td>
<td>3,000</td>
</tr>
<tr>
<td>2002</td>
<td>8,000</td>
<td>16,000</td>
<td>4,000</td>
</tr>
<tr>
<td>2003</td>
<td>10,000</td>
<td>20,000</td>
<td>5,000</td>
</tr>
<tr>
<td>2004</td>
<td>12,000</td>
<td>24,000</td>
<td>6,000</td>
</tr>
<tr>
<td>2005</td>
<td>14,000</td>
<td>28,000</td>
<td>7,000</td>
</tr>
<tr>
<td>2006</td>
<td>16,000</td>
<td>32,000</td>
<td>8,000</td>
</tr>
<tr>
<td>2007</td>
<td>18,000</td>
<td>36,000</td>
<td>9,000</td>
</tr>
</tbody>
</table>


| Figure 2 |
| Drug OD rates |
| Deaths per 100,000 in 2008 (2) |

<table>
<thead>
<tr>
<th>State</th>
<th>OD Rate</th>
<th>National Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>11.9</td>
<td>NA</td>
</tr>
<tr>
<td>New Mexico</td>
<td>27.0</td>
<td>1st</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>15.1</td>
<td>9th</td>
</tr>
<tr>
<td>Louisiana</td>
<td>15.0</td>
<td>11th</td>
</tr>
<tr>
<td>Arkansas</td>
<td>13.1</td>
<td>22nd</td>
</tr>
<tr>
<td>Texas</td>
<td>8.6</td>
<td>43rd</td>
</tr>
</tbody>
</table>
One hundred percent of these deaths were preventable.

The public needs to be aware of the extent that these prescription drugs are being abused and causing death. These drugs (and alcohol) can combine to cause respiratory depression or arrest. These deaths are preventable. Physicians and other health care providers are cautioned about the large extent in which prescription drugs are being abused and causing death.

Ensuring that reasonable alternative treatment options are explored and a quality risk assessment is performed prior to initiating COT and ensuring that an objective and clinically meaningful therapeutic outcome is achieved once COT is started should reduce the problem of deaths related to COT from a single practitioner prescribing high dose COT.

If a therapeutic benefit is not obtained after a reasonable titration, then the medical necessity to continue COT has not been achieved. There is no reason to expect that a higher dose of COT is necessary if a therapeutic benefit has not been achieved at low to moderate doses. The higher doses are known risk factors for adverse events including unintentional lethal OD. Early use of COT after occupational injuries has been associated with decreased function and increased disability rates.\(^{5,6}\) COT should be reserved for treatment at later stages after exhausting conservative care in well-selected individuals if used at all.

Empirical observations by pain management physicians suggest that COT in well selected individuals is an effective treatment. However, “well selected” is the key concept. The fact that 79 percent of the TCMEO deaths had legitimate prescriptions illustrates that we are not exhausting conservative care, not performing adequate risk assessments, not ensuring a therapeutic benefit has been achieved and not discontinuing treatments when it is ineffective.

Additional information on this, and 10 other “safe living” tips can be viewed at the TCMEO website at: www.co.travis.tx.us/medical_examiner.

References
6. Webster BS; Verma SK; Gatchel RJ; et al., Relationship between early opioid prescribing for acute occupational low back pain and disability duration, medical costs, subsequent surgery and late opioid use. Spine. 2007; 32:2127-32.
TCMS Foundation Lecture
On November 8, over 250 physicians and their guests packed the Westin Hotel at the Domain for the TCMS Foundation annual lecture. This year’s presenter Anna Pou, MD discussed medical legal and ethical challenges of disaster medicine and the consequences when there are no disaster plans in place for physicians, hospitals and other health care workers. For more pictures, check out the TCMS Facebook page at www.facebook.com/TravisCMS. Dr Pou is pictured with Brian Sayers, MD chair of the Travis County Medical Society Foundation - top right photo of this page.

More photos available at www.tcms.com click on facebook.
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.

At Austin Cancer Centers, our commitment is to people, and our goal is recovery for every person that we see. By leading with our hearts for more than 30 years, we've had a dramatic impact on the lives of thousands of people. And we've earned a reputation for commitment, excellence and innovation. We've introduced many new treatments. We use advanced technologies offered by no other center. We've established a large network of specialists and support services. And we've maintained our independence, high standards and principles, all of which are centered around one thing:

*Treating people, not just their disease.*
“David Fleeger is not only a good doctor, but is also an exceptional leader,” said Joseph P. Annis, MD, the 2011 TCMS Physician of the Year. “He is really respected because he is a straight shooter,” continued Dr. Annis, who has also become a close personal friend of David over the years. “He will tell you exactly what he thinks in a very respectful fashion. He is someone you can trust.”

David Fleeger didn’t grow up in any single location. From the time of his birth in Germany to his mid-high school years, David’s family moved all over the US almost every year. Once his father retired from the Army, they established a permanent home in Houston. “My family was very good at packing up and moving to the next post,” he said.

At the young age of 15, he already knew that his future would be dedicated to medicine. As a child, David had several illnesses that required hospitalizations and surgeries which surrounded him with medical professionals. It was those experiences that planted the seed of his passion for the medical field. He also considered following in his favorite uncle’s footsteps and choosing a career as an archeologist. “I have to say that although archeology might have been a fun thing to do, I’m glad I went into medicine. It’s hard for me to imagine doing anything else,” he said.

Dr. Fleeger received his medical degree from Texas A&M University at College Station, where he also married Jamie, who shared his interest in medicine and traveling. Not long after the two tied the knot, a residency in general surgery at the Mayo Graduate School of Medicine moved the couple to Rochester, MN. During their time there, the couple welcomed their daughter, Lauren. These days, Lauren works with her husband at a major medical software company in Madison, WI. David often says his two ladies are the twin stars about which his world revolves.

The beautiful Rochester countryside and the bold fall colors of the area inspired Dr. Fleeger to capture those sights and led him to develop an interest in amateur photography. Since setting up practice in Austin, the self-trained photographer’s work has frequently been featured in the TCMS Journal, most recently in the September/October issue.

After his fellowship in colon and rectal surgery at LSU Schumpert Medical Center in Shreveport, LA, David began to practice with Andy Hibbert, MD in Austin. Unfortunately, after five years of co-practice, Dr. Hibbert unexpectedly passed away. “Suddenly, I became a solo practitioner and that was sort of traumatic. I had to run the business and the practice during some tough times,” Dr. Fleeger said. Eventually, however, he brought in Ernest Graves, MD, who has been his partner for the past 12 years. “Being his partner and friend, keeps me sharp and makes me a better doctor,” said Dr. Graves. “Our association is rewarding, both personally and professionally, and I look forward to many more years of working with Dave.”

Three years ago, the two physicians brought together all colon and rectal surgeons in Austin to form Central Texas Colon and Rectal Surgeons with a fundamental mission to be a provider of high quality and efficient medical care. The merger was not an easy task. Beyond the financial and legal undertaking of consolidating the practices, there were also the hurdles of melding together different practice environments and cultures. Luckily, the surgeons in the area have always had good relationships, even when they were theoretically in competition with one another. This integration stands as one of

Jamie and David exploring Bhutan.
Dr. Fleeger’s proudest career moments.

Since moving to Austin in 1991, Dr. Fleeger has been a tireless volunteer with the Travis County Medical Society, Texas Medical Association and American Medical Association. He credits his involvement in organized medicine for allowing him to stay at the forefront of the evolving medical landscape at the local, state and national level. During a time when change is occurring rapidly and more dramatically than ever before in the history of medicine, he believes that physicians, especially those in private practice, must stay current. “Physicians have to prepare for what’s ahead in order to keep their practice viable; organized medicine can help us do that,” he said.

As chair of the TMA Council of Practice Management Services, Dr. Fleeger led in the development of programs to equip physicians to handle specific challenges, such as how to choose an EMR and demonstrate meaningful use. “Overall, it was a very rewarding experience,” he said. “We provided practical tools to help physicians cope in this changing environment.”

Dr. Fleeger has also served on many other TMA committees and chaired several of them. His many leadership roles in the Travis County Medical Society include serving as its president in 2007. Under his leadership, the Society instituted term limits to encourage the development of physician leaders, as well as launched new programs designed to engage young physicians and their families in organized medicine and established the TCMS Foundation Lecture Series.

In 2000, Dr. Fleeger was elected alternate delegate from the TMA House of Delegates to the AMA House and has been a delegate to the AMA since 2008. He has served on the prestigious AMA Reference Committee on Finance and Governance for three years, including one as its chairman. “People who serve at that capacity are well respected and considered as being thoughtful leaders,” said Dr. Annis, who originally met Dr. Fleeger as his anesthesiologist during surgeries, but has since worked with him on all levels of organized medicine.

Beyond his commitment to the profession, Dr. Fleeger is dedicated to serving the community at large. Locally, he volunteers with the Society’s Project Access program and has a genuine passion for medical mission work. He first became involved after a Christian Medical Mission presentation by church members and trip directors. The organization’s concentration on indigenous people of Central America, such as the Kuna, Embera and Maya Indians drew him in. Since his first trip in 2001, Dr. Fleeger has returned to Central America yearly to treat those who don’t have access to general medical or dental care. “First time I went was a wonderful experience. Now it’s become like a bad habit because we’ve gone every year on a total of 12-14 trips, but each year is still a great experience,” he said.

Dr. Fleeger highlights the last several years of working in a single village in the highlands of Guatemala. Returning to the same location annually has given him the opportunity to follow the same people; particularly the children who he has watched grow. “It’s a wonderful experience and I would certainly encourage any of my peers to get involved in something like that – it reminds you of why you went into medicine in the first place and really grounds you,” he said. “It might be better for me than for the patients I see.”

Dr. Fleeger’s favorite aspect of practicing medicine is the daily interaction with his patients. Whether in the office or hospital, he helps them do the best they can under the circumstances of their illness. Dr. Fleeger hopes to continue doing so as a private practitioner for a long time. However, that future might be compromised as he sees some critical challenges in medicine that threaten the existence of independent practice; therefore, he encourages fellow physicians to use their influence to try and change that trend so that meaningful private practice can continue to be viable in America. “It’s the nature of my personality to never look back and always look to what to do next,” said Dr. Fleeger. “Looking in a crystal ball into the future, I see myself continuing to do my best to represent physicians at the local, state and national level.”
The 2012 Physician Humanitarian Award is presented to married physicians Tracey Haas, DO, MPH and Timothy Gueramy, MD in recognition of their work in providing medical care to orphans in India and to disaster victims around the world from Haiti to Libya, and most recently in Misrata, site of one of the longest and bloodiest battles of the 2011 Libyan revolution. Their relief efforts don’t end with their return home from the many trips they make; back home in Austin, the couple continues their outreach by providing long-distance consultation as needed.

Dr. Gueramy, an orthopedic surgeon who specializes in foot and ankle surgery, had plenty to do in Haiti and Libya, from complicated reconstructions to therapeutic amputations. In each location, he was able to work with local surgeons and residents to teach updated techniques, leaving them vital new skills each time.

Dr. Haas’ passion has been for the more than 500 Indian orphans supported by The Miracle Foundation, whom she examines on her annual trips to India. As volunteer medical director of the Austin-based foundation, she continues to consult and review routine and emergent care from Austin on a weekly basis. Dr. Haas also holds degrees in tropical medicine and global public health, which helps her contend with the variety of challenges these underserved areas face, especially in a post-disaster environment. Women’s health issues in each of these locations have become a major focus for change that she continues to be a champion for, both at home and abroad.

Drs. Gueramy and Haas have not only volunteered their time and medical expertise, but have organized the building of a prosthetics clinic, a hospital and community health centers, encouraging and helping local residents to become community health leaders.

The 2012 Ruth M. Bain Young Physician Award is presented to Mark Shen, MD for his leadership at Dell Children’s Medical Center of Central Texas (DCMC).

This is evident in his role as medical director and physician leader of the Pediatric Consultation and Referral Service (PCRS), a program that he took over after DCMC opened in 2007. Under his leadership, PCRS has played a key role in making DCMC a safe and family-centered place for kids in Central Texas to receive inpatient care. Dr. Shen’s group provides high quality pediatric asthma care that has been nationally recognized by the Environmental Protection Agency and Joint Commission for their exemplary efforts. PCRS also represents the core faculty for the UT Southwestern Austin Pediatric Residency program.

Active at the state and national level regarding research into the provision of inpatient care in children’s hospitals, Dr. Shen works to support a Seton pilot project for the most medically complex and fragile children. He is also a founding steering committee member of the Value in Inpatient Pediatrics Network (VIP), which is now a member of the American Academy of Pediatrics’ Quality Improvement Networks (QuINN). Through VIP, he oversees a national effort to change the transition of care through improved hospital discharge communication with primary care pediatricians, making the overall process more efficient for patients and their families.

Ruth M. Bain Young Physician Award

The 2012 Ruth M. Bain Young Physician Award is presented to Tracey Haas, DO, MPH and Timothy Gueramy, MD in recognition of their work in providing medical care to orphans in India and to disaster victims around the world from Haiti to Libya, and most recently in Misrata, site of one of the longest and bloodiest battles of the 2011 Libyan revolution. Their relief efforts don’t end with their return home from the many trips they make; back home in Austin, the couple continues their outreach by providing long-distance consultation as needed.

Dr. Gueramy, an orthopedic surgeon who specializes in foot and ankle surgery, had plenty to do in Haiti and Libya, from complicated reconstructions to therapeutic amputations. In each location, he was able to work with local surgeons and residents to teach updated techniques, leaving them vital new skills each time.

Dr. Haas’ passion has been for the more than 500 Indian orphans supported by The Miracle Foundation, whom she examines on her annual trips to India. As volunteer medical director of the Austin-based foundation, she continues to consult and review routine and emergent care from Austin on a weekly basis. Dr. Haas also holds degrees in tropical medicine and global public health, which helps her contend with the variety of challenges these underserved areas face, especially in a post-disaster environment. Women’s health issues in each of these locations have become a major focus for change that she continues to be a champion for, both at home and abroad.

Drs. Gueramy and Haas have not only volunteered their time and medical expertise, but have organized the building of a prosthetics clinic, a hospital and community health centers, encouraging and helping local residents to become community health leaders.

2012 TCMS Awards Recipients
In the News

Retired Membership is granted to those physicians who have retired from the active practice of medicine. Upon nomination from the Board of Ethics, the TCMS Executive Board elected the following to Retired Membership:

Kira Carey, MD

Life Membership is granted to those physicians who have been a dues paying member of organized medicine for 35 years, of which 25 years must have been dues paying years in the TMA and who has reached a point of comparative inactivity in the practice of medicine, as determined by the Society. Upon nomination from the Board of Ethics, the TCMS Executive Board elected the following to Life Membership:

Larry W. Hill, MD
Wilbert A. Polson, MD
William A. Robinson, Jr., MD
Paula N. Starche, MD

Cancer can be devastating. Treatment doesn’t have to be.

No pain. No incision. No hospital stay.

The CyberKnife is revolutionary technology in the fight against cancer. It treats tumors and lesions throughout the body by focusing pinpoint beams of radiation that destroy the cancerous cells without affecting the surrounding healthy tissue. For you, it means an outpatient procedure that requires five treatments or fewer with no pain. You can then focus on what’s most important – living your life.

Call or visit our website for more information.

512-324-8060
AustinCyberKnife.com

Brain Kidney Liver Lung Pancreas Prostate Spine

1400 North Interstate Highway 35 • Austin, Texas 78701

Urgent Care and Occupational Medicine
OPEN 8am - 11pm, Every Day

Physician on duty at all times
No appointment needed • Most insurance accepted
Lab, EKG + digital X-rays
Lower costs than hospitals + freestanding ERs

Serving South Central Texas since 1982
**TCMA** kicked off the fall with many activities to serve the health care needs of Central Texas as well as foster friendship among medical families. The September meeting was at **by george**, a fashion boutique, and featured fall fashion must haves. We had record attendance and were thrilled to welcome many new and returning members.

The October meeting was themed “the Power of Pink” at the home of Steven and Stacy Thomas. Dedicated to Breast Cancer Awareness Month, the meeting featured Allison Shilick the creator of the Brobe, a front-opening bra inside a robe for coverage and support. Thomas Coopwood, MD Central Health board member and Monica Crowley from Healthy ATX were also in attendance and provided information about the proposed medical school in Austin.

**2012-13 Grant Recipients**
- Family Eldercare
- Hospice Austin
- Lifeworks
- St. Louise House
- Volunteer Healthcare Clinic

**St. Louise House**
The TCMA has been honored to work with St. Louise House, a local charity that provides affordable and supportive housing for low income homeless women (who are working or attending school) and their children with the goal of helping families develop long-term stability. Our members provide healthy meals for their life skills classes, and in September, members Lydia Soldano, Loren Gigliotti, Yvonne Bailes, Julie Cowan, Vickie Blumhagen, Lara Norris, Berenice Craig, Vickie Zagrodzky and Amy Roberts helped set up and decorate a new apartment for a family of four.

**Honorary Member**
The TCMA is pleased to announce Cindy Nelson as the newest Honorary Member. Cindy joined the TCMA in 1994 shortly after moving to Austin from San Antonio. In her 18 years of service to the TCMA, Cindy has served as the President (2003-2004), Secretary, Vice President of Communications, Gala Co-Chair and Capitol Watch Chair. She has also served on the Long Range Planning Committee, Finance Committee and has been active in the Book Review, Preschool Parents, Ladies who Lunch, Capitol Watch and First Tuesdays. Since 2009, Cindy has been instrumental in the setup of the TCMA website and is currently the website manager.

**Save the Date**

For information on upcoming events, visit the TCMA website at www.tcmalliance.org or contact Loren Gigliotti at lorengigliotti@yahoo.com.
On average, homes listed with Realty Austin sell 21% faster than the Austin-area average.

Our listings are on the market 17 days less and sell 2% closer to asking price.

What is your home worth? Call Keri and Michelle today!

Let one of Realty Austin’s Multi-Million Dollar Producers help you with all of your real estate needs.

Call Keri & Michelle, Realty Austin home marketing specialists, to show you how your home can be featured above all other search results in MLS and receive maximum exposure to buyers.

Keri Chmelik, REALTOR®
Multi-million dollar producer
512.633.9680
keri@realityaustin.com
SearchWestAustinHomes.com

Michelle Jones, REALTOR®
Multi-million dollar producer
512.470.3173
michelle@realityaustin.com
LakeHomesInAustinTx.com

New office located in Lakeway at 620 S and Lohmans Crossing!
Scientific breakthroughs in genetic technology have surpassed the realms of the human imagination, giving rise to several ethical implications in the process. It is difficult for physicians to know the scope of their duties when the laws are not sufficiently laid out to encompass advances in medical technology.

I. Informed Consent Implications
Divulging genetic information is widely considered by both legal and medical professionals to be a privacy issue. As a result, it is always necessary to obtain the patient’s permission prior to disclosure. Texas law stipulates that the release of genetic information is permitted only in limited circumstances, imposing a $10,000 fine on individuals who wrongfully divulge genetic information. This can be a difficult hurdle to overcome when physicians are faced with increasingly complicated situations. For example, when the illness is particularly debilitating or even fatal and is largely hereditary, how does the physician inform other related patients of their risk if the patient does not consent to the release of any medical information?

Physicians must comply with the laws mandating patient privacy, but it must be equally balanced against the professional duty to do no harm. If the illness at issue can be effectively treated by preventive measures, does the medical duty override the legal duty? More importantly, if legislatures begin to create such an exception to the law, who would make the determination of under what circumstances one duty may supersede another?

Another equally complicated scenario arises when a patient has informed their physician of their preference to remain ignorant of possible genetic mutations. This can occur in cases involving incurable illnesses such as Hodgkin’s disease that have a late onset and can be predicted with relatively high accuracy. If a physician is treating both parent and child with two conflicting preferences, knowledge will eventually become inevitable for both individuals. What duties does this then create for the physician? The laws do not address the physician’s exposure to liability nor are there adequate measures in place to assist physicians in limiting potential liability.

The Texas Medical Disclosure Panel was established in 1977 in order to determine which aspects of medical and surgical care must be disclosed to patients by their health care providers. It publishes informed consent forms for patients to sign and to assist physicians in knowing what to disclose to their patients. Considering the various informed consent issues implicated in genetic testing, it is advisable that the Panel develop guidelines in order to aid physicians and address concerns such as who should be offered testing and what future risks to disclose to patients who choose to obtain it.

A recent Texas appellate court case held that physicians are not negligent for their failure to disclose risks and hazards that have not been prescribed as such by the Medical Disclosure Panel. The list of the risks involved in obtaining genetic testing is vast and will only grow with the expansion of technology. Physicians face considerable confusion in ascertaining which risks are of sufficient importance to warrant disclosure, opening themselves up to increased liability based on breach of informed consent. In fact, if disclosure of the risks and hazards of a procedure has not been addressed by the Panel, the physician still has a legal obligation to disclose them but in accordance with the ‘reasonable person’ standard instead, which is vague and can even serve to aggravate uncertainty. The ‘reasonable person’ standard is a legal standard most commonly utilized in the area of tort law, particularly in issues concerning negligence or medical malpractice. It is an assessment of the duty that one owes to others by ascertaining what a ‘reasonable person’ would do under similar circumstances. What makes this standard so confusing is that there is no specific framework involved in the analysis of what a reasonable person would do, rather it is an arbitrary and objective standard. By issuing a written protocol for physicians to adhere, the Panel would provide guidance and certainty with respect to the disclosures.

II. How to Prioritize Access to Genetic Testing
Newborn screening programs are the only form of genetic testing that is universally available to the public. By implementing newborn screening, treatment and counseling programs in every state, for every child, our society has demonstrated its commitment to caring for the health of one of its most vulnerable populations. The enactment of new health care reform laws alongside the rapid advancement of genetic technology potentially lead to a future where access to health care services is regularly rationed out. If genetic testing were offered to everybody the overwhelming demand would be to force policymakers to ration testing.

Ways to prioritize genetic screening.

---

1 2 Tex. Occ. Code § 58.00
3 Id.

continued on page 26

24
Austin Wound and Lymphedema Care

We specialize in the management of wounds and lymphedema.

We Have Solutions!

In association with
Copulos and Associates
Physical Therapy
3220 Manor Road
Austin, Texas 78724
(512) 291-3984
fax: 512-291-3985

Cecilia Cervantes, M.D., C.W.S., C.L.T.

LYMPHEDEMA TREATMENT:
- Primary Lymphedema
- Post Operative Lymphedema
- Breast Cancer – Lymph Node Dissection
- Cosmetic Surgery
- Knee and Hip Replacement
- Post Traumatic Lymphedema
- Lympho-Venous Insufficiency
- Pregnancy – Swelling and Leg Pain

WOUND MANAGEMENT:
- Acute Wounds
- Non-healing Wounds
- Leg Ulcers
- Post Surgical Wounds
- Diabetic Foot Ulcers
- Decubitis Ulcers
- Lymphedema

Medicare and most managed care plans accepted

KHOURI LAW
LAW OFFICES OF MICHAEL J. KHOURI

MEDICARE / MEDICAID AUDIT DEFENSE
MEDICARE / MEDICAID FRAUD DEFENSE
CRIMINAL DEFENSE FOR HEALTH CARE PROVIDERS

TELEPHONE: (866) 231-3670
CELL: (949) 680-6332
1701 N. MARKET STREET
SUITE 318 LB45
DALLAS, TEXAS 75202

WWW.TEXAS-MEDICARE-LAWYER.COM
“PROTECTING HEALTHCARE PROFESSIONALS FOR 30 YEARS”
and treatment options include overall effectiveness however, effectiveness varies with each disorder and among individuals. Effectiveness is measured by improvements in functioning, accuracy in diagnosis, decreased mortality rates, severity/prevalence of the disease and the availability of a cure. These factors differ among populations, thus the precariousness of a universal definition.

III. Genetic Screening and the Future
The question is not the appropriateness of rationing medical services but rather the methodology used to ration them. Opponents of genetic testing cite its rising effect on the costs of health care. Pharmacogenomic research provides tools to aid in preventive care and aids in controlling cost. Instead of waiting until harm occurs, health care costs will be significantly diminished by implementing preventive treatment.

The public, medical professional societies and the government should all be involved in shaping the future of genetic testing. Physicians have called for the US Food and Drug Administration to have regulatory authority over genetic testing and for a scientific body to develop practice codes, set standards and make regulatory recommendations. Factors to consider are the availability of treatment and harms/benefits resulting from early detection. As screening is an ongoing process, the establishment of facilities for monitoring, education and other follow-up services will be necessary.

IV. Conclusion
The advancement of genetic technology has the capability to make significant contributions to society. Physicians will have the ability to look into the genetic makeup of an individual and analyze their susceptibility to certain illnesses and potential responses to various treatments. Thousands of lives will be impacted by this progress. It is easy to overlook the potential dangers of such advances however, as medical technology advances, the laws must also expand to encompass these changes. Medical and legal professionals must cooperate with one another to ensure that both professions stay up to date on all aspects of this growing issue.

---

4 Id. at note 13.
5 Id. at note 51.
6 Id.

7 Id. at note 17.
8 Id.
9 Id.
10 Id.

---

Early diagnosis and treatment of HIV saves money and improves health outcomes.

Routine HIV testing in health care settings is as cost effective as other screening programs, including type 2 diabetes and breast cancer mammography.

Learn more at [www.testtexashiv.org](http://www.testtexashiv.org)

The Travis County Medical Society appreciates the generosity of the following organizations in underwriting TCMS events.

**DIAMOND LEVEL SPONSORS**
- Medical Service Bureau
- Texas Medical Association Insurance Trust
- Texas Medical Liability Trust
- TCMS Auto Program
- TCMS Purchasing Program
- TCMS Staffing Services

**PLATINUM LEVEL SPONSORS**
- Austin Radiological Association
- University Federal Credit Union

**GOLD LEVEL SPONSORS**
- Atchley & Associatesm, LLC
- Austin Brokerage Company
- The Brian Novy Company
- Texas Oncology

**SILVER LEVEL SPONSORS**
- Bell Wealth Management
- Independent Bank
- Keller Williams Realty
- TaxResources
The “think global, act local” movement has evolved into the organic farming phenomenon, where buying produce from local farms is encouraged, while choosing fruits and vegetables from places such as Mexico or Chile is a no-no. I’m not a member of either PETA (People for the Ethical Treatment of Animals) or Greenpeace, but the idea of supporting nearby farmers and ranchers appeals to me.

Still, I wonder why there’s such a fuss over vegetables, while applying the same logic to cars seems even smarter. I mean, does it make sense to buy all your groceries at the farmer’s market and then drive them home in a Prius? After all, the Prius gets the nickel for its batteries from mines in Canada or Montana, sources many parts such as the battery guts from China, and then undergoes final assembly in Japan before it even gets to the showroom floor.

Given all that, maybe the best car to buy from an environmental standpoint is the BMW X3. It’s built in South Carolina from mostly North American parts by US workers who, by the way, pay their taxes and spend their money largely in the Spartanburg area, near Charlotte. And sending it by railroad or truck to South Texas uses almost no carbon when compared to a trip from Japan. Helping the environment has probably never been so pleasant. The new X3 is an excellent piece of machinery that I suspect many TCMS members would be happy to own. A second-generation luxury crossover, the new X3 is significantly better than the original version, which was too small and rough riding to tempt many prospective customers to give up their Lexus RX 350s.

And, truth be told, for almost 15 years the Lexus RX has been the benchmark in this class. It’s quiet and luxurious, relatively spacious, completely trouble free and visually attractive. When BMW re-designed the X3, it was obvious they wanted to beat the RX at its (highly profitable) game. And they did.

For starters, the new X3 is bigger than the last one in every dimension, particularly luggage and passenger space. In fact, the new X3 has almost the same carrying capacity as the original BMW X5. And for the record, yes, the X3’s dimensions are similar to the Lexus RX’s.

The cabin is as luxurious, too. Soft-touch surfaces abound, and the controls and gauges are 5-series-esque, which is to say excellent. As always, my favorite part of the interior is the gear selector on the center console that looks like the nicest cell phone you ever saw and feels just right in your hand. If you own a first-gen X3, don’t sit in a new one, you’ll end up hating your car.

Driving the new X3 is best in class, which means better than the Audi Q5, Mercedes CLK, Cadillac SRX and Lexus RX. Supple over bumps yet firm through tight corners, the X3 maneuvers like a slightly overweight 3-series sedan, which it pretty much is. But that’s not a bad thing, and it means that the X3 will handle anything short of a track day with aplomb. Even long trips on the interstate - which I tried and enjoyed more than I thought I would, considering I usually take my long trips in a Lexus LX 570 - are a pleasure in the new X3. The rough riding of the last X3 is gone.

The design of the X3 has also evolved toward the Lexus RX. While the last X3’s appearance could easily be described as severe, the new one is softer and more visually inviting. The front end seems to smile softly, and the profile view is much less angular than it was. If the goal of BMW’s designers was to make the X3 an 80 percent X5, I’d say they succeeded. (It’s indicative of how competitive this market segment has become that the X3, Lexus RX, Audi Q5, Mercedes CLK and Cadillac SRX all look really good.)

A 3.0-liter inline-6 engine powers both X3 models, the xDrive28i and the xDrive35i. The former uses a 240 hp normally aspirated engine, while the 35i version gets a turbocharged variant of the same motor that’s good for 300 hp. An eight-speed automatic transmission with automanual mode is standard on both models, as is AWD. In published testing, an xDrive35i like my test vehicle went from zero to 60 mph in 5.6 seconds. Expect fuel-economy figures of 19 mpg.
city/25 mpg highway for the 28i, and 19/26 for the 35i.

Prices for the X3 range from around $37,000 for a base X3 28i to about $45,000 for a well-equipped 35i. As always, there are numerous option packages and stand-alone features that may tempt you.

The second-generation BMW X3 is much better than its predecessor, and it is now the best compact luxury crossover in a very competitive field. It’s bigger, better looking and nicer to sit in and to drive. And it’s built in the United States, so buying one is a “green thing,” too. No wonder sales are up about 300 percent over the last one.

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.

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

TCMS Auto Program . . .

• Can locate the vehicle for you at the best price, with your choice of color and equipment.
• Arrange for a test drive at your home or office. We make the process easy!
• Can arrange all of the paperwork for you. You just sign.

If you want to visit the dealership, TCMS will put you in touch with our contact.

Commercial leases are also available.

Take advantage of the full benefits of the TCMS Auto Program!
Abdominal pain was the initial complaint. The patient was referred to his gastroenterologist, who performed a barium enema. The gastroenterologist noted a radiopaque material in the abdomen. The patient was then referred to a urologist, who performed an intravenous pyelogram (IVP) and found a metallic density on the film, which was determined to be a wire mesh from a previous surgery.

Over the next year, the patient continued to experience abdominal pain. In the third year, the patient was admitted to hospital B for evaluation of acute abdominal pain. The patient had a history of a partial gastrectomy 18 months prior. The patient was admitted with complaints of severe lower stomach pain, and an abdominal x-ray was performed. The radiologist noted metallic clips in the upper portion of the abdomen.

Approximately 18 months later, the patient was admitted to hospital A with complaints of severe lower stomach pain. An abdominal x-ray was performed, and the radiologist noted metallic clips in the upper portion of the abdomen. The patient was referred to a urologist for evaluation.

Two years after the visit to hospital B, the patient was admitted to hospital B for evaluation of acute abdominal pain. The patient had a history of a partial gastrectomy 18 months prior. The patient was admitted with complaints of severe lower stomach pain, and an abdominal x-ray was performed. The radiologist noted metallic clips in the upper portion of the abdomen.

Three years and 10 months after the surgery, the patient was admitted to hospital C with complaints of severe lower stomach pain. An abdominal x-ray was performed, and the radiologist noted metallic clips in the upper portion of the abdomen.

Presentation and physician action

A 29-year-old man with a long-standing history of abdominal complaints was referred to general surgeon A for evaluation of a duodenal ulcer. After examination, general surgeon A diagnosed a chronic peptic ulcer and recommended vagotomy and subtotal gastric resection.

The surgery was performed. A sponge count was completed at the end of the surgery, but an instrument count was not conducted and no instrument count was printed on the OR record. In the following weeks, the patient seemed to do well. He last saw general surgeon A eight weeks after the surgery.

Approximately 18 months later, the patient came to his family physician with complaints of severe lower stomach pain for three or four months. This physician noted that the patient had undergone a partial gastrectomy 18 months prior. Over the next year, the physician provided conservative treatment. When this failed to alleviate the patient's abdominal symptoms, he was referred to a radiologist for an air contrast barium enema.

Radiologist A reported that the films demonstrated “a very large unusual radiopaque structure in the anterior abdomen. It appears very thin and flat and extends virtually the length of the abdomen. It is located anteriorly and may be superficial in the anterior abdominal wall, although its exact location and etiology is not known. It may be related to the patient’s midline incision, aside from this the patient’s abdomen appears unremarkable on the scout film.”

Two weeks later, the patient next saw a gastroenterologist on referral from his family physician. The gastroenterologist did not have the patient’s records or radiographic studies available at the time of the examination. He believed that the patient suffered from chronic abdominal pain syndrome, but he planned to locate the patient’s records and evaluate them. The records were relayed to the gastroenterologist, including the barium enema study that noted the radiopaque material in the abdomen. The gastroenterologist concluded this material was an unusual form of surgical mesh related to the patient’s surgical procedure. He believed the patient was suffering from prostatitis and felt there was not a GI source for the symptoms.

Three days after his final visit to the gastroenterologist, the patient came to the emergency department (ED) of hospital A. He complained of lower scrotum and abdominal pain, and was seen by ED physician A. An abdominal x-ray was ordered and was read by radiologist B. He concluded “there is an anteriorly located ‘mesh’ in the subcutaneous tissue most likely related to an abdominal anterior wall hernia correction. There are several surgical clips in the left upper quadrant and surgical staple line to the right of the mesh at the L2 level. There are dense probably residual contrast collections either in the appendix or Secale region in the lower right quadrant. The bony structures are unremarkable. There are minimal degenerative changes.” Radiologist B believed there were surgical changes in the abdomen with no evidence of acute abdominal process.

ED physician A diagnosed acute prostatitis, and advised the patient to continue taking the medication prescribed by the gastroenterologist.

Over the next year, the patient continued under the care of the family physician. The medical records indicate the patient continued complaining of abdominal pain.

Three years and 10 months after the surgery, the patient came to the ED at hospital B. ED physician B’s impression was that the patient suffered from acute abdominal pain, left ureterolithiasis, and hematuria with a high grade left renal ureter obstruction. ED physician B noted in his chart that there was an intra-abdominal metallic foreign body. A urologist examined the patient and reviewed the IVP with radiologist C. They both noted a small distal left ureteral stone and observed a metallic density on the film, which they believed to be mesh related to the patient’s prior surgery. The urologist discharged the patient, as he was pain free.

The patient returned to the ED five days later and was seen by the same urologist. He felt the patient was suffering from a left ureteral stone and ordered the patient’s admission. The next morning, the patient was pain free. The urologist encouraged him to increase the pain medication to strain his urine and attempt to pass the stone. The patient was discharged and told to return to the urologist in one week. The patient did not return to the urologist. However, after receiving a notice of claim regarding this patient, the urologist made two additional entries into the patient’s chart indicating the patient failed to keep appointments.

Two years after the visit to hospital B, (now five years and nine months after the surgery) the patient came to the ED at hospital C. An x-ray was reported as unremarkable, but the patient reported that he was known to have a wire mesh in his abdomen. The impression by ED physician C was acute abdominal pain. The patient was seen again in the ED of hospital C nine days later. The x-ray report noted metallic clips in the upper portion of the abdomen due to the prior surgery with two wide plates superimposed over the right paravertebral region, possibly representing...
a back brace. The x-ray results were again reported as negative.

Following these two visits to hospital C, the patient came to general surgeon B who ordered a CT scan and reviewed the previous abdominal x-rays. General surgeon B diagnosed a retained metallic foreign body, probably a surgical ribbon retractor, as the cause of the patient’s pain. The patient was taken to surgery, and the surgeon found and removed a 3-inch-wide x 13-inch-long surgical ribbon retractor.

The patient’s medical records indicate that he had not undergone any other abdominal procedures other than the vagotomy and subtotal gastric resection. It appears that the retractor was left at the time of this surgery. The patient testified that since the removal of the retractor he has experienced no other abdominal complaints.

Allegations
A lawsuit was filed against general surgeon A and the hospital where the surgery took place, alleging negligence in leaving a ribbon retractor in his abdomen during the surgery. The patient also filed suit against all the physicians who treated him after the surgery, alleging negligence in failure to diagnose the retained retractor. Named in the suit were the family physician, the gastroenterologist, the urologist, the three ED physicians, and the three radiologists. This incident was featured in a news story on medical mishaps and aired on a network investigative news program.

Legal implications
The plaintiffs in this case effectively developed their case to pursue two claims: the act of leaving the retractor and the subsequent failure to diagnose it. The surgeon who removed the retained retractor provided a report critical of all those involved in the first surgery.

Defense radiology experts were critical of radiologist B for describing the metal as “mesh,” and that this description led to a delay in diagnosis and removal of the foreign object. This report should have triggered further work up by the referring physician. The consultants also concluded that radiologist A’s report fully described the retractor, and that the referring physician should have followed up on the report.

Other defense consultants were not entirely supportive of the actions of the urologist and the gastroenterologist. The main weakness in the case against the gastroenterologist was the failure to follow up on the cause of the patient’s abdominal pain and the radiology report submitted by radiologist A. Regarding the actions of the urologist, he was under the impression that the prior physicians and the patient were aware of the foreign object based on the previous radiology studies. However, other urology experts were critical of his apparent inability to recognize the retained object as a surgical retractor. The urologist’s alteration of the medical record also undermined his defense.

As is often the case when claims involve multiple defendants, finger pointing became an issue. The plaintiff’s attorney was able to develop conflicting testimony and criticisms between the various subsequent physicians. This, coupled with the damaging testimony from the plaintiff’s own experts, significantly hindered the defense of this case.

Disposition
Given the “shock value” of this case and the difficulty in obtaining supportive defense testimony, this case was settled with the consent of the physicians. Settlement was made on behalf of general surgeon A, the gastroenterologist, the urologist, and radiologist B. The case against radiologist A was dropped. The hospital where the surgery took place also settled this case. The outcome of suits against the other defendants is unknown.

Risk management considerations
Given the benefit of hindsight, it is easy to identify several areas where the care of this patient broke down. When the patient was first taken to surgery, a sponge count was completed but an instrument count was not. Hospitals have protocols to prevent the retention of foreign objects in surgical patients. Physicians and their surgical staff should follow these protocols.

Compounding the initial error was the lack of follow up by the subsequent physicians. Radiologist A accurately described the foreign object, but his report did not trigger follow up. Radiologist B’s use of the term “mesh” in a later report sent the physicians in a different direction and affected their interpretation of the patient’s symptoms.

When a patient has continuing symptoms of unknown origin, further testing may be warranted. Would further testing (i.e., an abdominal CT) have helped the physicians diagnose the cause of the patient’s recurring abdominal pain? Likewise, would contacting general surgeon A to carefully correlate the patient’s surgical history have alerted these physicians to the true reason for the patient’s symptoms?

Altering the medical record seriously jeopardizes a physician’s credibility. Upon reviewing the medical record when served with a notice of claim, physicians may be tempted to add information that they believe will assist in their defense. While the information may be accurate, the addition of such information after the event is detrimental to the defense. Plaintiff’s attorneys will use this information to discredit the physician by suggesting that he or she did something wrong and is trying to cover up. While there may be no breach of the standard of care, record alterations are difficult to defend at trial and frequently result in settlements out of court. When notified of a claim, it is recommended that the medical record be placed in a secure location to protect the authenticity and avoid any temptation to alter information.

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

©Copyright 2012 TMLT.
Bariatric Surgery

Millions of individuals in the United States and around the world are overweight or obese (severely overweight). When weight increases to an extreme level, it is called morbid obesity. Obesity is associated with diabetes, heart disease, high blood pressure, some types of cancer and other medical problems. Bariatrics is the field of medicine that specializes in treating obesity. Bariatric surgery is the term for operations to help promote weight loss. Bariatric surgical procedures are considered only for people with severe obesity (having a body mass index greater than 40 [about 100 pounds overweight], or having a body mass index greater than 35 [about 50 pounds overweight] with established complications of obesity) and not for individuals with a mild weight problem.

Obesity

Body mass index (BMI) is a standard way to define overweight, obesity and morbid obesity. The BMI is calculated based on a person’s height and weight — weight in kilograms (2.2 pounds per kilogram) divided by the square of height in meters (39.37 inches per meter). A BMI of 25 or more is considered overweight; 30 or more, obese; and 40 or more, morbidly obese. Bariatric surgery may be offered to patients with severe obesity when medical treatments, including lifestyle changes of healthful eating and regular exercise, have not been effective.

Considerations for Bariatric Surgery

Viral gastroenteritis is caused by person-to-person spread and can occur in an outbreak or epidemic (a sudden increase in a particular disease within an area or population). A medical history looks for exposure to other persons with gastroenteritis, travel or eating food prepared by others. Because diarrhea, nausea and abdominal pain may be caused by many types of illnesses, it is important to consider other causes of these symptoms, such as appendicitis, bowel obstruction, hepatitis and other gastrointestinal conditions. Laboratory testing to identify the specific virus is not usually done, but blood or stool tests, x-rays and other testing may be done if the symptoms last longer than a few days or if a more serious problem is suspected.

For More Information

- National Institute of Diabetes and Digestive and Kidney Diseases
  win.niddk.nih.gov/publications/gastric.htm
- Centers for Disease Control and Prevention, BMI Calculator
  www.cdc.gov/nccdphp/dnpa/bmi/calc-bmi.htm

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

Call 512-206-1245.

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.

MOBILE DOCTORS - seeks a podiatrist to make house calls to the elderly and disabled, providing general routine care in the Austin area. Work either on a full-time or a part-time basis. Make your own schedule, with no on-call, nights or weekend work. Email CV to Nick at nick@mobiledoctors.com or call 312-848-5319.

MedSpring Urgent Care Austin: Seeking staff physicians for new urgent care locations in Austin. Gorgeous, centrally located centers featuring 12 hour shifts, no nights, no call and no overhead. We offer occ med, primary care and urgent care services. We are looking for doctors who want a variety of practice types, with heavy emphasis on urgent care. MedSpring is dedicated to getting patients “back to better,” and are looking for doctors who seek to provide outstanding service to every patient. MedSpring is poised to become an industry leader in urgent care and we are looking for doctors to grow with our company. Excellent compensation, annual bonus, benefit package, licensure and CME reimbursement, paid medical insurance, and excellent opportunities for leadership. Contact Julianne Sherrod, Director of Recruiting: julianne.sherrod@medspring.com or 512-861-6365.

OFFICE SPACE

Medical Office: Partially furnished medical office for lease (1800 sq. ft) in Elgin (30 min from Austin). Part or full-time terms negotiable. Call 512-707-8928 or email to rcullen@medtranslator.com.

Primary Care Medical Practice in the DFW area for sale. 30 years well-established practice with 4,000 patients in the database and growing. Adult and Medicare. Very desirable area. Completely paperless, using Allscript Pro EHR. Grossing in the last 3 years = $800,000. Open Mon-Thurs (no evenings, weekends or holidays). Sell price is $250K. Contact Debbie Cain, CPA, at dcain@dcaincpa.com or 817-763-0346.

MEDICAL OFFICE: 4207 James Casey #302, across from St. David’s South Austin Medical Center, 1240 sq.ft. 3 exam rooms, office, lab, restroom, reception office and waiting room. Available Jan 2013 or possibly sooner. Call broker/owner at 512-327-5706 or email to mpjohn@austin.rr.com.

SERVICES


For Sale: Ortho/sports medicine supplies. Stryker cast saw and spreaders, casting, brace and splint supplies, hard sole shoes. Contact 512-413-1903.

EQUIPMENT

MEDICAL OFFICE: 817-763-0346. Debbie Cain, CPA, at dcain@dcaincpa.com or 512-861-6362. Sell price is $250K. Contact Debbie Cain, CPA, at dcain@dcaincpa.com or 817-763-0346.

For Sale: Ortho/sports medicine supplies. Stryker cast saw and spreaders, casting, brace and splint supplies, hard sole shoes. Contact 512-413-1903.

MEDICAL OFFICE: 817-763-0346. Debbie Cain, CPA, at dcain@dcaincpa.com or 512-861-6362. Sell price is $250K. Contact Debbie Cain, CPA, at dcain@dcaincpa.com or 817-763-0346.

Office for Sale: Medical Office: Partially furnished medical office for lease (1800 sq. ft) in Elgin (30 min from Austin). Part or full-time terms negotiable. Call 512-707-8928 or email to rcullen@medtranslator.com.

Primary Care Medical Practice in the DFW area for sale. 30 years well-established practice with 4,000 patients in the database and growing. Adult and Medicare. Very desirable area. Completely paperless, using Allscript Pro EHR. Grossing in the last 3 years = $800,000. Open Mon-Thurs (no evenings, weekends or holidays). Sell price is $250K. Contact Debbie Cain, CPA, at dcain@dcaincpa.com or 817-763-0346.

MEDICAL OFFICE: 4207 James Casey #302, across from St. David’s South Austin Medical Center, 1240 sq.ft. 3 exam rooms, office, lab, restroom, reception office and waiting room. Available Jan 2013 or possibly sooner. Call broker/owner at 512-327-5706 or email to mpjohn@austin.rr.com.

SERVICES


For Sale: Ortho/sports medicine supplies. Stryker cast saw and spreaders, casting, brace and splint supplies, hard sole shoes. Contact 512-413-1903.

EQUIPMENT

MEDICAL OFFICE: 817-763-0346. Debbie Cain, CPA, at dcain@dcaincpa.com or 512-861-6362. Sell price is $250K. Contact Debbie Cain, CPA, at dcain@dcaincpa.com or 817-763-0346.

For Sale: Ortho/sports medicine supplies. Stryker cast saw and spreaders, casting, brace and splint supplies, hard sole shoes. Contact 512-413-1903.

Equipment

MEDICAL OFFICE: 817-763-0346. Debbie Cain, CPA, at dcain@dcaincpa.com or 512-861-6362. Sell price is $250K. Contact Debbie Cain, CPA, at dcain@dcaincpa.com or 817-763-0346.

For Sale: Ortho/sports medicine supplies. Stryker cast saw and spreaders, casting, brace and splint supplies, hard sole shoes. Contact 512-413-1903.

EQUIPMENT

MEDICAL OFFICE: 817-763-0346. Debbie Cain, CPA, at dcain@dcaincpa.com or 512-861-6362. Sell price is $250K. Contact Debbie Cain, CPA, at dcain@dcaincpa.com or 817-763-0346.
Our doctors are pretty special. So we treat you that way.

Peace of mind.
With an A (Excellent) rating by A.M. Best, we strongly protect and defend you. So you can relax and practice medicine.
www.medicusins.com
When you choose Austin Radiological Association for your medical imaging, you benefit from the experience and expertise of hundreds of Central Texas’ top healthcare professionals.

Our priority is YOU, whether it is scheduling your appointment, getting a medical scan or talking to one of our radiologists.

YOUR CHOICE

Schedule at 512.453.6100  ausrad.com
At least 32 million U.S. households own insurance policies that aren’t right for them.¹

Make sure you have the right insurance to help you protect the life you’ve worked so hard to build.


Talk to a TMAIT Advisor about insurance for you, your family, and your medical practice. TMAIT is exclusively endorsed by the Texas Medical Association, and we are committed to helping you find the right coverage from an array of plans, including medical, dental, vision, life, short-term disability, long-term disability, long-term care, and office-overhead expense.

Call 1.800.880.8181  contact@tmait.org

Request a quote at www.tmait.org