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President
Christopher E. Young, MD
Chief Executive Officer
Russ Miller, CAE
Office of Publication
2301 21st Avenue South
PO Box 120909
Nashville, TN 37212-0909
Phone: (615) 385-2100
Fax (615) 212-1908
brenda.williams@tnmed.org

Editor
David G. Gerkin, MD
Managing Editor
Crystal Hogg

Editorial Board
Loren Crown, MD
James Ferguson, MD
Karl Misulis, MD
Greg Phelps, MD
Bradley Smith, MD
Jonathan Sowell, MD
Jim Talmage, MD
Andy Walker, MD

Advertising Representative: Michael Hurst – (615) 385-2100 or michael.hurst@tnmed.org

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Bringing Medicine Together — The Team Approach

By Christopher E. Young, MD
President

This inspirational quote by Henry Ford is about the power and importance of teamwork. He used the teamwork concept to become one of the most influential industrialists in history and many of these ideas can be helpful to the future success of our mission as the Tennessee Medical Association.

The most dramatic example of physician teamwork that I have witnessed happened four years ago, when a catastrophic earthquake struck Haiti, killing or injuring over 500,000 people. I was fortunate to be able to travel to Port-au-Prince a few days after the quake with a team of physicians I had never met before. We worked in a hospital and in the operating rooms with an Italian team and the few remaining Haitian hospital staff (many were killed or injured). There were hundreds of injured victims lying in the halls or on the grounds of the hospital. Despite the overwhelming need and chaotic circumstances, physicians from different cultures and different tongues were able to overcome their differences and work together as a team. Egos and self-interests were set aside. Everyone did whatever was needed because that is what was required to achieve our common purpose - the care of our patients. It was one of the most incredible and meaningful experiences of my life.

Physicians, as a group, tend to be most like-minded during medical school. We share a common curriculum and experience. We are all just doctors-in-training. As training progresses, physicians specialize into their chosen field of interest and begin to view their profession through the eyes of a specialist. (I am always impressed at the speed at which physicians categorize other physicians by specialty at social events.) We tend to join specialty societies more often than state or local medical societies because we identify with colleagues of specialties more than with other physicians, or medicine as a whole. Given our desire for independence and autonomy in practice, our geographic differences, and our differences in practice models (private vs. academic vs. employed); it is not hard to see some of the challenges in building cohesive teams.

The practice of medicine has become complex and change seems ever present and accelerating. Many physicians are choosing employment as a means of simplifying their practice or joining larger groups to achieve the scale necessary to manage the financial, technological, and regulatory burdens current today in private practice. Fees for service payments are morphing into value-based payments with optimism of reducing cost and improving outcomes. Integrated practice models and patient-centered care teams will become much more common. Insurers, hospitals and other healthcare providers all want to be part of the traditional doctor-patient relationship. While change is inevitable, physicians must carefully consider the consequences of these changes as it relates to the overall well-being of our patients. By virtue of our education and training, physicians are in a unique position to lead the implementation of the necessary changes in our healthcare system, but to do so effectively we must work together.

In applying the wisdom of Henry Ford, the first step in building a TMA team is bringing physicians together around our common goal in Tennessee, which is to improve the health of all Tennesseans by helping physicians care for their patients. This may seem too simplistic or general to some, but clarity and universality are essential characteristics when dealing with the complexities of healthcare. Second, we must find a way to keep physicians together and focused on the goal. Legitimate self-interest comes into play, and differences of opinion can and will occur. Any negative effects of these differences can be alleviated by an emphasis on open-mindedness and mutual respect by the entire team. A sense of humility on the team allows different strengths to be recognized and utilized in pursuit of improving patient care. Finally, we have to become skilled at working together. Embracing our roles, building trust, and communicating with the team and our patients are all important in working together for success.

While I have explored principles that might apply to physicians, the same ideas could apply for multi-disciplinary teams as well, such as the patient-centered, physician-led care team approach. Physicians working with physician assistants, advanced practice nurses, pharmacists, physical therapists, nutritionists, and others all have a role to play. Transforming this talent into a high performing healthcare team to improve health relies on strong physician leadership, mutual respect, and an ability to partner with our patients.

Given all the challenges we face as physicians, coming together, staying together, and working together as a team will allow us the best opportunity to improve the health of all Tennesseans. Take the opportunity and come together at the only meeting that brings all of Tennessee’s physicians together, Med Tenn 2014, April 24-27. We need you on the team, because together we are stronger.

Share your thoughts with Dr. Young at president@tnmed.org.
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I really never considered the end, until it was here. As a young adult, I was either in college and trying to get into medical school, striving to acquire the foundations of my profession in medical school, or honing my skills in a post-doctoral internal medicine residency. I was successful and next transitioned into building a family and a medical practice which extended through my middle years. Now I find myself at the Rubicon and I realize it’s already been crossed.

Idioms are metaphors whose meanings have been lost to time and culture. In 49 B.C., Julius Caesar stood on the northern edge of the Rubicon River in Cisalpine, Italy. The Roman leader Pompey and the Roman Senate warned Caesar not to bring his army across the river. To do so would mean civil war. It is said that Caesar was conflicted while standing at the river’s edge. However, after crossing the river, he told his friends that the decision came to him during meditation, and then he uttered the now-famous phrase, “The die is cast.”

I don’t see myself in heroic terms, but I find myself in open rebellion to what medicine has become. Perhaps my dissatisfaction arises from my refusal to “go along to get along.” A colleague advised me to hold your nose and stay in the game so I could be there to help my patients when they do need me. Inertia is a powerful force and so is the status quo. I contemplated my options for a year and concluded that if I stayed, I was being dishonest with myself and, by necessity, my patients.

By the time this essay is published the die will be cast for me, and I will have “opted out” of Medicare. I’m now looking into the option of a concierge practice that will emphasize consultation and advocacy for a small number of patients. The care of the masses will have to be done by the young physicians who will not understand this idiom or care. By focusing on a few, I will be able to provide evaluation and care by phone, text, email, face time, Skype and house calls 24 hours per day, seven days per week. Immediate and direct access to your doctor rather than a surrogate especially appeals to professionals who are intrigued to learn that their annual physicals can be done with an “office call” at their place of employment. They won’t have to lose a half-day of work and sit in a crowded clinic. Screening and diagnostic testing are readily available and billed through commercial companies often at lower rates than in traditional practice models.

Since I graduated from medical school in 1975, I have been in a traditional medical practice. Unfortunately, to older docs like me, the new order emphasizes the business model more than one that focuses on patients. An example is the mandated “annual wellness exam.” These exams done by extenders focus on ordering screening tests like mammograms, and include functional assessments of falling, depression, and cognition. No matter that these assessments were always done by competent and caring physicians. I have to admit that I allowed my staff to schedule these “examinations” out of contractual necessity. There was also the song sung by Sirens of extra money with extenders doing the “scut work.” You remember those tasks we once delegated to medical students. In other words, I rationalized. But conscience is a principled compass which strives to prevent a ship’s destruction on the Siren’s shore.

If I am honest, I will admit that I can afford my principles as I entered the last third of my life. Last year a forty-five-year-old colleague told me that he considered me lucky. He said he couldn’t afford the luxury of my current scruples. Two other colleagues in their mid-fifties told me that they had to continue medicine “until 60,” and then “I’m gone.” I recognize that I am in a place and time that afford me choices. Consequently, I do not moralize or criticize anyone who sees the world differently than I do. I chose my principles over my practice, and it was the toughest decision I’ve ever made.

What will happen as doctors leave practice prematurely? I read recently that we again face a doctor shortage in America despite the expansion of medical school graduates and burgeoning schools of osteopathy. Experts say we need 35,000 new practitioners every year to keep up with the demand. And this manpower projection assumes there will be no early physician retirees. Even with foreign medical graduates and the expansion of nurse practitioner and physician assistant training, there will be insufficient personnel to care for the tsunami of baby boomers, let alone those “undocumented” internationals who will gain access to care with Obama-care.

Before I left my traditional medical practice at midnight, December 31, 2013, I worked at 110% for 37 years. It’s been different…not having to rush to my office practice and then to the hospital to see my sickest folks. I was encouraged by multiple colleagues to simplify my life and improve the “bottom line” by leaving hospital practice. To me, an internist was not meant to take out an inflamed appendix, but was supposed to be there for his patients.

The use of physician extenders is increasingly in vogue as a way to “be more efficient” and make more money by managing nurse practitioners and physician assistants. I do believe these more narrowly trained extenders have a place alongside doctors, just as we (Continued on page 29)
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Do You Still Live in The Same Community?

By Russ Miller, CEO

Part of the TMA’s strategic plan asks us to consider today’s community of medicine. That challenge got me thinking about a bigger question: How long do we keep doing things the exact same way before it does not fit who we are anymore?

When I was little, my community was my neighborhood and all the backyards that butt up to each other. Those yards were our Superbowl, Final Four, and World Series locations all tied up in one. We wanted nothing more than to scarf down whatever meal our moms’ just put down and go play. Every night, every weekend, every kid showed up. We played until parents claimed us one by one.

Then the backyards did not fit us anymore. We went to different schools, played sports at those schools, and my community changed. My new community become schoolmates, teammates, and carpool groups. Interestingly, guys that were your competitors last year, became teammates the next. It was weird at first but we acclimated.

Time, educational needs, career needs and other influences continued to shape my personal community again and again, taking me out of the house, out of state, to embark on a new set of adventures and to join yet other communities, ever-changing, ever-growing.


What is your community of medicine today? Is it the same as when you graduated med school? Who do you ‘hang out with’, trust, rely on? Who was once a competitor but is now a colleague? What makes you a community of medicine? Is it geography, shared patients, shared business interests, insurance networks, or where you graduated medical school?

I would submit that today’s community of medicine has changed and is much broader than our definitions for organized medicine’s present design. Should our communities consist of all the actual medical professionals working together daily who want to work to improve how medicine and healthcare evolves and is delivered in their marketplace for the benefit of the patients as well as the profession?

TMA is a grassroots organization comprised of some 37 chartered medical societies, many in search of identity and relevance to today’s physicians. The key may lie in the realization that the course may need alteration to make our medical societies the vessels that bring the community of medicine together with a solid vision toward improving health for patients and efficiencies for health care, reducing obstacles between providers and patients, and achieving it all through a strong working relationship.

That’s a lot to take in, but we need to acknowledge that organized medicine must adapt to its new community and those we share it with. Who is filling this community need in your area presently? The hospital staff? Your IPA? Your group practice? Your ACO?

How do we align these emerging medical communities with existing (or new) local medical societies and TMA to make organized medicine in Tennessee more relevant, more active, and more influential? How do we fit in today’s community of medicine? How do we become today’s community of medicine?

I ask the question to start a collaborative thought process and challenge us to look hard at the very core of our being and the direction we are headed. Are we ready to provide needed services, offer collaborative assistance or consult? Are we viewed as competitors or obstacles?

The TMA is the largest physicians’ organization in the state, working every day to increase the health of Tennesseans by improving the efficacy of our members through advocacy, education, leadership development and community activation.

Do we stay the course we that has carried us for almost 200 years or start thinking about what lies ahead? Let’s start talking about purpose and mission, today’s communities of medicine and how they relate to TMA and vice-versa. To be all that TMA can be (to borrow from our military) we have to go where the physicians are and work with entities that are like-minded, motivated, willing and able.

Let’s continue this conversation at www.tnmed.org/community_of_medicine.

Share your thoughts with Mr. Miller at russ.miller@tnmed.org.
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Grassroots Advocacy: What is it?

By Rebecca Lofty
Grassroots Advocacy Coordinator

A top priority. A new initiative. A fresh face and an all-encompassing grassroots program to address the deficit in grassroots participation. What does this really mean to you? Members weren’t getting involved in areas of interest to them or taking advantage of all the resources and opportunities afforded them through their TMA membership. Leadership responded by taking an innovative approach and hiring a new staff member to coordinate a grassroots program that will rally physicians to get involved and become engaged. The program aims to educate members on how to amplify the physician voice by helping physicians learn how to create, maintain and effectively leverage relationships with legislators.

The progressive grassroots trend attempts to stimulate politics through a very specific community base. It’s an on-going process of recruiting, educating and motivating TMA members on how to use their political power to positively influence legislation, and providing TMA members with the necessary tools to do so meritoriously. It is empowering healthcare professionals to help themselves in advancing constructive medical practices.

Still in its infancy, the program thus far has proven to be a great learning experience for many physicians and legislators alike. Both benefit from gaining the other’s perspective. Healthcare professionals do not have to be political experts to make a difference. They just need the desire to make an impact. Our hope is that physicians will serve as trusted sources of information to legislators. Only healthcare professionals can give legislators the most accurate picture of how issues really affect the practice of medicine in Tennessee on a day-to-day basis. On average, 300 pieces of legislation filed by the Tennessee General Assembly annually affect the healthcare industry. The most powerful weapon in advancing the cause of physicians and their patients, is the physicians themselves.

Through the grassroots program, TMA intends to customize the membership experience by considering the needs and interests of each member. While some physicians may wish to hone their leadership skills by participating in the Physician Leadership College, others may enjoy serving as a figurehead at the Tennessee General Assembly by either volunteering as the Doctor of the Day or becoming a key legislative contact. We also recognize that time is a valuable resource and not available to all physicians. Physicians are also encouraged to join in the fight by making a contribution in the form of a monetary donation to the IMPACT program.

TMA’s grassroots advocacy approach is both quantitative and qualitative. First, by seeking to get as many members involved as possible and second, by identifying those members who wish to lead the charge and equipping them to lead efficiently. The program is not limited to physicians alone. Practice managers, healthcare staff, patients, and spouses are encouraged to educate themselves and take action alongside physicians on issues they are passionate about.

The budding grassroots movement is democratizing health information and emerging a more interactive healthcare landscape, seeking to increase the overall quality and access of care. Traditionally, physicians reactively get involved in health-related legislation. TMA, however, hopes to shift physician participation, strategically, to becoming more proactive. Taking on the challenges bestowed upon us, the TMA grassroots program aspires to create and exemplify a sophisticated culture of service excellence. This requires a great deal of planning, preparation, persistence and, of course, participation, but the deeper our roots grow, the more self-sufficient the program will become.

Medicine is an industry that is becoming more heavily regulated every day, as federal mandates and legislation seek to stay in the forefront of the healthcare revolution. In the midst of reform, many corporate players seek to influence the political process, offering up a number of solutions for the wide array of issues. Perhaps, however, the best solutions come from community-based physicians – those who are willing to speak up and be heard. Doing your part as a physician is pivotal in making such outcomes as affirmative as possible.

As your medical oath says, it is your duty to protect and advocate for the best interest of your patients and to use your medical knowledge in an advantageous way. Furthermore, it is your duty to increase the quality of healthcare in your practice, in your community and in our state. Let’s work together to secure a sustainable future for physicians and patients alike. What better way than by becoming more involved in TMA’s grassroots program? Help us help you! Take advantage of every aspect your TMA membership has to offer and challenge your peers to do the same.

Interested in getting involved with our grassroots advocacy program? Email Rebecca Lofty at rebecca.lofty@tnmed.org.
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Bringing Medicine Together at MedTenn 2014

MedTenn 2014 will not be the Annual Meeting experience that longtime TMA members are accustomed to. This year, it’s not just for TMA leadership. It’s not just for physicians. And it’s not just for TMA members.

The TMA is Bringing Medicine Together in Franklin on April 24-27 with a multi-specialty meeting for all medical groups across the state to gather and network with their colleagues and peers, participate in professional growth and development opportunities, stay ahead of the latest industry trends and, most importantly, have a lot of fun!

The House of Delegates will still meet. Current TMA president, Chris Young, MD, will still pass the gavel and inaugurate the incoming TMA President Douglas Springer, MD, FACP FACG. But for most attendees, the appeal of this year’s convention will be the four days of exclusive education, networking, vendor booths and special events designed to deliver more value than any other medical event in Tennessee.

Physicians can earn up to 16.75 hours of CME while practice managers can earn 10 hours of CEU credits in one weekend, and at a fraction of the typical cost. Agenda highlights include specific education tracks for physicians and practice managers on topics like:

- ICD-10 Coding and Implementation Strategies
- Prescribing Guidelines for Pain Management & Patient Safety
- Emerging Payment & Employment Models
- Health Reform, Government Initiatives & EHR Performance

Medical societies from the state’s largest metropolitan areas will be represented, along with a select group of specialty medical societies, but TMA invites all physicians, administrators, practice managers, nurses and other medical professionals to come experience the redefined annual event.

Keynote speaker Kevin Pho, MD is a board-certified internal medicine physician and founder of KevinMD.com, which Forbes called a “must-read health blog.” Klout.com, a website known for social media, named him the web’s top social media influencer in healthcare and medicine, and CNN named @KevinMD one of its five recommended Twitter health feeds. Dr. Pho also co-authored the book, Establishing, Managing, and Protecting Your Online Reputation: A Social Media Guide for Physicians and Medical Practices.

Of course, MedTenn isn’t all about business. A special evening gala on Saturday, April 26 will feature great food, music and entertainment to benefit the Pat Summit Foundation and the fight against Alzheimer’s disease. Join us for this great cause!

Meet the New TMA President 2014-2015: Douglas Springer, MD, FACP, FACG

TMA President Christopher Young, MD, will hand down the gavel to incoming president, Douglas Springer, MD, FACP FACG in April at MedTenn, 2014. Originally from Calgary, Alberta, Canada, Dr. Springer came to Tennessee in 1978 as part of a young physician’s program to move physicians to underserved areas in Tennessee. Now a naturalized U.S. Citizen, Dr. Springer has a distinguished medical career, serving 35 years as a gastroenterologist in Kingsport, TN. He has earned Fellowship in the American College of Physicians and the American College of Gastroenterology. He has also published several papers in peer review medical journals.

Dr. Springer also served as president of Sullivan County Medical Society and got involved with the TMA through a colleague’s challenge to get as many people to join TMA in a year. After calling 150 people, Dr. Springer says he won the challenge by talking most of the people he called to join TMA. For Dr. Springer, meeting and talking with physicians across the state versus just in his region was a different experience. As president, Dr. Springer hopes to carry out the TMA strategic plan and wants everyone who is a member of TMA to become as a disciple for TMA. He would like to equip each member with the knowledge base to share with others about why it is important.

Dr. Springer is married and has two children, and two grandchildren. His interests outside of medicine include hiking, golfing and traveling. A memorable trip for Dr. Springer is hiking up mount Olympus in Greece.

TMA Physician Leadership: Dr. Hale Voted President-Elect

John W. Hale, Jr., MD, of Union City, has been chosen the President-elect of the Tennessee Medical Association, and will serve as president of the Association for 2015-2016. He will succeed Douglas Springer, MD, FACP, FACG, of Kingsport. Practicing with Doctors’ Clinic of Union City, Dr. Hale is board-certified in family medicine. He is a graduate of James H. Quillen College of Medicine.

Founded in 1830, the Tennessee Medical Association is the state’s largest organization for MDs and DOs, with a mission to protect patients and enhance the effectiveness of physicians throughout the state. Its leadership serves as physician advocates for the profession and for patients in Tennessee.

TMA physician leadership elections were held online from February 1-28. Final results were certified by the TMA Election Committee, comprised of TMA President Christopher Young, MD and Immediate Past-President Wiley T. Robinson, MD. All new officers and committee members will be installed during the TMA annual meeting, MedTenn 2014, April 24-27, in Franklin, TN. Full election results are posted on www.tnmed.org/elections.

ELECTION RESULTS

TMA members also elected the following physicians:

Board of Trustees
Region 2 – Bob Vegors, MD, FACP, Jackson
Region 4 – Michel A. McDonald, MD, Nashville
Region 5 – James Batson, MD, Hixson
Region 7 – Richard M. Briggs, MD, Knoxville

Judicial Council
Region 1 – Paul Klimo, Jr., MD, MPH, Memphis
Region 3 – S. Steve Samudrala, MD, Brentwood
Region 5 – Pushpendra K. Jain, MD, Cookeville
Region 7 – Edward W. Capparelli, MD, Jacksboro

For more information, log on to www.tnmed.org/elections or call 800-659-1862.
Loss of Two Former Presidents

The Tennessee Medical Association is mourning the loss of two former presidents within a month’s time. Tom Edward Nesbitt, Sr., MD, of Nashville, died on February 12; and Clarence Sanders, MD, of Gallatin, died on March 2.

Dr. Nesbitt, Sr., practiced urological surgery in Nashville for almost 50 years. Over the course of his career, Dr. Nesbitt has dedicated his time and knowledge to a number of organizations, achieving the highest role as President of the House of Delegates for both the Tennessee Medical Association, 1970-1971, and the American Medical Association, 1978-1979. He remains the only TMA president that has achieved presidency of the American Medical Association.

The milestones achieved during his tenures as TMA and AMA President included legislative and public advocacy efforts initiated in the late 1960s and continued when he was president in 1970. As an advocacy leader, his strategies in home district meetings with state lawmakers, annual trips to Washington, DC, to meet with members of Congress, editorial board and news media meetings are still being used by TMA today. Dr. Nesbitt in 1971 debated with U.S. Senator Ted Kennedy over national health insurance, when the Senator brought a nationwide tour on his HR-1 bill to Nashville.

In 2011, Dr. Nesbitt won the TMA Outstanding Physician award for his lifetime of exemplary achievements both in his practice and in his advocacy and leadership roles.

Dr. Sanders was a family practitioner for over 49 years in Gallatin, TN. After serving in the U.S. Navy during the Korean Conflict on the USS Kearsarge from 1951-1955, Dr. Sanders graduated University of Tennessee Center for Health Science in 1960 and started his own practice in Gallatin, Tennessee, in 1962.

As a longtime member of the House of Delegates, Dr. Sanders held the TMA presidency from 1985-1986. Other honors and community services include Rotary Club president, Long Rifle Award & Silver Beaver Award, and longtime team physician for Gallatin High football and receiving Sports Medicine Person of the Year Award in 2003 from the TN Athlete Trainers Society.

The TMA is extremely sad to be missing these leaders of medicine. Both of these mean have made historic contributions to healthcare, to organized medicine, and specifically to our Association.

Doctor of the Day: Dr. Byron Wilkes

Bryon N. Wilkes, MD of Memphis spent Thursday on the hill in February as a volunteer for TMA’s Doctor of the Day program. Dr. Wilkes has been active with TMA for the past year with the Physician’s Leadership College. He believes it is important for physicians to become part of the legislative process and says, “There is so much unknown right now with medicine at the federal level, but change is the thing that is certain. We as physicians need to be a part of this change, and help guide the decisions that are being made right now with the practice of medicine.”

Dr. Wilkes plans to continue working with the TMA and PLC. “I can see how time can become a barrier, but from my own perspective, looking at advocacy from a philosophical view, giving up some time in my practice and taking up advocacy allows me to give back to the practice of medicine, and most important, to my patients.”

As a first time Doctor of the Day volunteer on Capitol Hill, Dr. Wilkes says he was unsure of what to expect when he walked into the plaza building that morning. “The legislative process seemed overwhelming at first, there is all of this conversation and action taking place on the floor when you first approach it. But once you break it down and get to know who your senator are, it becomes a very welcoming process. It becomes easy to discuss legislation and specific bills with your senators and representatives at the house. I found it exciting and it was a great experience…I encourage all physicians to become active with advocacy.”

Tennessee Medicine  www.tnmed.org  APRIL 2014
TMA’s Day on the Hill, on March 12, had over 150 participants storm Capitol Hill. Physicians spent the day advocating for organized medicine with their legislators. A special highlight included a luncheon addressed by Governor Bill Haslam. George Woodbury, Jr., MD, a long-time participant of TMA’s Annual PITCH Day says, “It is important to help focus awareness to the senators and representatives on health care related issues; particularly for this year, the payer accountability bill.”
Leonard Brabson, Sr., MD, instructs his students on legislation and the bills that impact the medical profession.

Douglas Springer, MD, FACP FACG, incoming president of TMA, meets Senator Joey Hensley.

Representative Ryan Haynes listens to members of the Knoxville Academy of Medicine.

Physicians met with Lt. Governor Ron Ramsey and discussed legislation on Payer Accountability.
MEMBER NOTES

Frederick M. Azar, MD, of Germantown, was named president of the American Academy of Orthopaedic Surgeons. He also serves as the chief of staff for the Campbell Clinic in Germantown. In addition to his work at Campbell Clinic, Dr. Azar is a professor and director of The Sports Medicine Fellowship Program at the University of Tennessee – Campbell Clinic Department of Orthopaedic Surgery, where he previously served as research director. He is a graduate of Tulane University of Medicine and is a member of The Memphis Medical Society.

Nancy Barrett, MD, of Lebanon, has been re-elected as chief of surgery for a second term at the University Medical Center. Dr Barrett is a board-certified general surgeon, trained at Duke University Medical Center, Vanderbilt School of Medicine and University of Massachusetts. She has a special interest in laparoscopy, including hernia, biliary, and colon surgery. Dr Barrett is a member of the American Society of Breast Surgeons and Wilson County Medical Society.

Julie Haun, MD, of Hixson, has been named the medical director for Hearth Hospice in Chattanooga. Dr. Haun has worked in hospice and palliative care since 2007. She also works in private practice with Galen Medical in Hixson. Dr. Haun graduated from the University Of Tennessee College Of Medicine and is a member of the Chattanooga-Hamilton County Medical Society.

Gary W. Kimzey, MD, of Germantown, has been named the 137th president of The Memphis Medical Society. Dr. Kimzey is an anesthesiologist with the Medical Anesthesia Group and is a graduate of the University of Tennessee in Memphis. Since 2005, he has served on the Medical Society’s legislative and finance committees. He is also president of the Medical Society Business Bureau and serves currently on TMA’s Board of Directors. Dr. Kimzey is a past president of the Memphis and Shelby County Society of Anesthesiologists.

Paul LeDoux, MD, of Murfreesboro, was chosen by his peers at St. Thomas Rutherford Hospital as Physician of the Year. Dr. LeDoux is a board-certified anesthesiologist and a partner with Murfreesboro Anesthesia Group. Offices held by Dr. LeDoux include director of anesthesia, past chief of staff, chair of the Quality Committee, and chair of Staff Advisory Committee. Dr. LeDoux is a graduate of University Tennessee Health Science Center in Memphis and is a member of Stones River Academy of Medicine.

Rob Nichols, MD, of Tullahoma, has been named the medical director of NHC Healthcare Tullahoma. Dr. Nichols is the current Chairman of Medicine at Harton Regional Medical Center and serves as medical director of the Tullahoma office of Hospice. He graduated from the University of Tennessee in Memphis and is a member of the Coffee County Medical Society.

Blaise Baxter, MD; Thomas Devlin, MD, PhD; and James Creel, MD are recipients of the 2014 Distinguished Physicians Award presented by the Baroness Erlanger Foundation. The award recognizes physician leaders who are characterized by unquestionable integrity and committed to improving the health of all people in their community. Recipients were honored at the 11th Annual Dinner of Distinction at the Chattanoogan Hotel.

Blaise Baxter, MD, of Chattanooga, has helped develop the Southeast Regional Stroke Center at Erlanger, one of the largest stroke centers in the United States. In addition, he has trained physicians – nationally and internationally – on stroke interventions. Dr. Baxter is board-certified by the American Board of Radiology and a Fellow of the Royal College of Physicians and Surgeons in Diagnostic Radiology. He is a graduate of Dalhousie University in Novia Scotia and is a member of the Chattanooga-Hamilton County Medical Society.
MEMBER NOTES

Thomas Devlin, MD, PhD, of Chattanooga, is Division of Neurology Chairman at the Erlanger Health Systems and the University of Tennessee, College of Medicine, and serves as the director of The Erlanger Southeast Regional Stroke Center. Dr. Devlin, along with Dr. Baxter, have built the Stroke Center into a world renowned acute stroke treatment facility. He also the founder of the non-profit Pleiades Foundation for Advanced Neuro-Medical Education. Dr. Devlin graduated from Baylor College of Medicine is a member of the Chattanooga-Hamilton County Medical Society.

James Creel, MD, of Chattanooga, is the chief medical officer of Erlanger Health System. Most recently he has served as Chief of Emergency Medicine at Erlanger, and Chief of Staff. Dr. Creel has been a pioneer in the implementation of advanced skills for emergency medicine. He developed the first Emergency Medicine Residency Program at the University Of Tennessee College Of Medicine in Chattanooga, the first program of its kind in the UT system. His service to the community includes the roles of Medical Director Hamilton County EMS and Walker County EMS, First Responders and Chattanooga Fire, Team Physician for Hamilton County SWAT, Medical Director of Hamilton County Jail and Silverdale and Director of Hyperbarics. Dr. Creel graduated from the Autonomous University of Guadalajara and is a member of the Chattanooga-Hamilton County Medical Society.

Are you a member of the TMA who has been recognized for an honor, award, election, appointment, or other noteworthy achievement? Send items for consideration to Member Notes, Tennessee Medicine, 2301 21st Ave. South, PO Box 120909, Nashville, TN, 37212; fax 615-312-1908; e-mail crystal.hogg@tnmed.org. High resolution (300 dpi) digital (.jpg, .tif or .eps) or hard copy photos required.

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IMPACT Capitol Hill Club

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SEARCHING FOR WAYS TO COME TOGETHER

A Fragmented Community

By Crystal Hogg
Perhaps in our near future, ads like the one to the right will thank the hospitals and large group practices, the physician assistant in the drive-through window, or better yet, the insurance company that has authorized a specific rate for the patient to see the physician who has cured him or her. It’s becoming less common for physicians to work with other physicians in single practices. Many modern physicians work with a team of administrators, nurse practitioners, assistants, within corporate-owned practices. Some patients love the convenience of not having to wait in a doctor’s office, but rather hit the doc in the box in the nearest drug store clinic.

One upon a time in our not-so-distant past, ads such as this one reiterated the fact that physicians were valued and honored within the patient-physician relationship. Physicians made house calls, talked to patients one-to-one on the phone, and more often than not, practiced on their own.

Charles White, Sr., MD, a family practitioner for more than 50 years in Lexington, TN remembers these days. “In those days, we didn’t have nurse practitioners or physician’s assistants; we were in complete charge of our patients,” he says. There were no insurance companies dictating procedural prices, there were no large hospital or company-owned practices, nor malpractice suits. “We colleagues would talk amongst ourselves for how much to charge for services,” he continues. Medicare didn’t come into existence until the first year of his practice, and physicians at that time did not take Medicare. “We would give the patient a bill, and the patients had to file on their own to pay us.”

As a solo practitioner, Dr. White, Sr., worked in the local emergency room, rotating shifts with five other physicians. Dr. White remembers being on call most nights during this time, making family life difficult. But it didn’t stop him from spending time with his children. “Depending on what was going on at home, I would take my son, then six, to the emergency room while I was stitching someone up or delivering a baby,” he chuckles.

Charles White, Jr., MD, also a family practitioner in Lexington, recalls these trips to the emergency room with his father. “One of my earliest memories of the hospital was watching my father treat patients. He would take me to the emergency room with him, and I had to stay in one place as best as I could.”

“My son doesn’t recall this, but when he was real small, I took him to the emergency room to deliver a baby, “Dr. White Sr., reminisced, “I told him to sit on a stool just outside the door. Well, I turn around with the baby in my hands, and there was my son looking at me!”

When asked what his greatest achievement was as a physician, Dr. White, Sr., says, being able to treat patients. He says they were loyal, not all of them were able to pay for his services, but they made up for it in other ways. Dr. White Sr., received candy, cookies, and baked goods from grateful patients. During the course of his career, he treated and saw generations in some of these patients. “They kept coming back to me. One little lady I treated back in the ’60s, I now treat her grandkidds.”

His son, Dr. White, Jr., who works for the Veterans Hospital, says of his father, “The community respected him as someone with integrity and they looked to him to take care of them.” It’s no surprise that he would want to follow in his father’s footsteps, first in serving the country in the armed forces like his father, and next, serving the community by practicing medicine as a family physician.

The patient-physician relationship was strong. So was organized medicine, something else that continues to change within the community of medicine. John Dorian, MD, a family practitioner of 45 years in Cordova says, “You had to be part of the local medical society at that time to have hospital rights.” But it was more than just that, Dr. White., Jr., says, “The community of medicine had more collegiality back then. Outside the office,
As the community of medicine becomes more fragmented, the role and value of local and component medical societies must evolve accordingly. Dr. White, Sr., says “The communities and medical societies don’t seem to be as important to the younger physicians.” Institutional-owned practices fulfill the physicians’ basic professional need for financial security, but do not serve the profession with programs historically accessed through organized medicine, such as education, legislative advocacy, and protecting patients. “Hospitals tell physicians that they will take care of them financially,” Dr. Springer adds, “It is important to educate younger physicians that this part may be true, but the hospitals are not necessarily doing what is in the patient’s best interest.”

As medical societies and organized medicine continue to adapt to these trends, a much agreed upon concern remains with all physicians: how their patients are affected. Patients no longer see the same physician for generations, as insurance companies may bump a physician out of network for profit values. “One of the major challenges to corporate medicine is when an insurance company wants to treat a patient one way, when you as a physician, know that another treatment plan, though maybe more expensive, would be more ideal for the patient,” says Dr. Khan. Dr. White, Sr., says that the insurance companies “Want us physicians to care for patients like a cookie cutter, but not all patients fit into the same mold.”

Retail and drive-through medicine is taking away the patient-physician relationship in some ways. “Most of the time, patients are being seen by these physician assistants who may not even have a physician overseeing them, and if they do, physicians are so spread out that it would be hard to closely monitor that PA,” explains Dr. Dorian. “Patients may receive quick service, but the quality of medical care is just not there. The golden age of medicine, when families went to the same physician, is long gone.”

Physicians are now working in a community in which they no longer have sole control of their patients. A team has been put in place, and physicians need to learn to be leaders of the team, or risk losing influence they need to deliver the best patient care. Physicians need a unified approach and voice across the state in order to uphold the profession, and protect their patients. Both Dr. White, Sr., and his son agreed that organized medicine provides the mechanism for physicians to advocate for issues that their employers can’t, or won’t. “Physicians need to be involved in their medical societies. They need to advocate for their patients, and have a say in the inner workings of the large scale decisions being made,” Dr. White, Sr. says. His son sums it up with, “As medicine continues to change, challenges will arise. But as physicians, we come together in organizations such as the TMA to overcome the challenges. We can do so much more if we work collectively.”
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Best Wishes
Om Shanthi
C. K. Hiranya Gowda MD, FACS
SGR Repeal and State Payment Reform Initiative: Eerily Similar

By Yarnell Beatty

The long awaited bill to do away with the Sustainable Growth Rate (SGR) formula for the Medicare fee schedule, HR 4015, was gaining momentum in Congress only to potentially be run aground by politics. In its way is the issue of how to pay for the $152 billion tab to pay off the remnants of SGR. The House’s solution — repeal Obama-Care. With a Democratic Senate and President, it looks like a recipe for another short-term band-aid. The SGR’s eventual replacement is still worth a look because of its design. It would place Medicare participating physicians and other health care professionals at financial risk for failing to perform, but also gives providers a chance to earn bonus payments for meeting certain quality measures.

On a faster track, the State of Tennessee has now spent nearly a year developing the Tennessee Health Care Innovation Plan. Consultants and stakeholders have been meeting and providing input to the State on this payment reform initiative. The work product culminated in a draft white paper released on December 9, 2013, as a blueprint for a Federal Innovation-Grant that the State is seeking. The State intends to reach 80% of Tennessee’s population through episodes of care that also provide value-based payment and delivery models. The SGR’s eventual replacement is still worth a look because of its design.

In 2018, the current Physician Quality Reporting System (PQRS), the Value-Based Modifier (VBM), and Meaningful Use of electronic health records (MU) will be consolidated to comprise the MIPS. At the end of 2017, the penalties for failure to report PQRS and for failure to meet MU will end. MIPS will assess the performance of physicians and other health care professionals in four categories. Each year, HHS will publish the list of quality measures for the following year. Physicians will select which measures on the list to report and on which to be assessed. Physicians will receive a composite performance score of 0-100 based on performance in each of the four categories but only on the ones that apply to them. Each physician’s composite score will be compared to a performance threshold known in advance. Those above the threshold will receive a positive payment adjustment, but the amount will depend on how far they score above the threshold. Those below the threshold will pay back money to the Medicare fund, with the amount depending on how far they score below the threshold.

Participants in APMs that involve financial risk, and a quality measure component will receive a 5% bonus each year from 2018-2023. There are two pathways by which to receive this bonus. One is by receiving a significant percentage of Medicare revenue through an APM. The second is based on receiving a significant percentage of APM revenue combined from Medicare and other payers. Medicare and Medicaid patient-centered medical homes will be exempted from downside risk if proven to work in their respective populations.

Of course, this is a nosebleed level description of the scheme. Until the final version passes and CMS has added its 600 gazillion pages of incomprehensible rules and regulations, and interpretive guidelines, we won’t have the full picture of just what we were thinking when we fought to get rid of SGR.

THE TENNESSEE HEALTH CARE INNOVATION PLAN

Commonly referred to as the “TennCare Payment Reform Initiative,” don’t let that moniker fool you. The State envisions the initiative will reach 80% of Tennessee’s population in five years. It will start with the TennCare and the State employee insurance programs, but the State wants a government payer/commercial multi-payer approach to payment and delivery system reform using three primary strategies: pa-

(Continued on page 27)
Why Physicians Misprescribe

By Roland Gray, MD, MAAP, FASAM

According to Gil Kerlikowske, our National Drug Czar, prescription drug abuse has become the number one drug problem in the United States. Currently in fifteen states where the information is available you are more likely to die from an overdose of prescription drugs than you are from being killed in an automobile accident. Most of these overdoses are from opiates and sedatives/hypnotics. Although Tennessee is not alone in dealing with this problem, there is a significant problem of drug diversion in the state of Tennessee. In Tennessee physicians currently write more prescriptions for hydrocodone than any other drug. Because of the significance of the problem, Tennessee’s Board of Medical Examiners now requires every physician to have one hour of continuing medical education (two hours starting in July) designed specifically to address proper prescribing practices.

There are a number of theories as to why physicians mis prescribe. One theory regards the patient types. There are some areas of the state, particularly some of our rural areas where prescription drug abuse and prescription drug diversion is principally significant. If physicians are willing to easily prescribe for these patients, it doesn’t take long until they have a practice full of drug seeking patients.

Another theory relates to a lack of current pharmacologic knowledge. This is the physician who does not keep up with current trends in medicine. He or she is not aware of the addictive potential of many of these drugs nor are they aware of the problem of prescription drug diversion.

There may be problems within the practice system which leads to misprescribing. Lastly, there are family of origin issues which cause physicians to overprescribe. It is this last category that I will talk about in this article.

The American Medical Association divides the overprescriber into four large categories. First, is the “Dated” physician. Again this is the physician who doesn’t keep up with their current CME and is unaware of the significance of the problem drug dependence and diversion in the state of Tennessee.

There is a “Dishonest” physician. Fortunately this is a small number of physicians, however, they do contribute significantly to the problem of drug diversion in the state of Tennessee. These individuals are willing to write prescriptions for cash. The dishonest physician is best handled through the criminal justice system.

Then there is the “Disabled” physician who diverts drugs for his/her own use. These physicians are brought into our program and given the opportunity to recover from their dependence. Statistically there are only 3% of the physicians in this category who are unable to return to the practice of medicine.

Lastly, there is the “Duped” physician. This is the physician that most frequently comes to the Tennessee Medical Foundation’s Physicians Health Program for assistance regarding their misprescribing.

The best way to describe the “Duped” physician is that he or she is one of the nicest physicians you will ever meet. They always assume the best about their patients and are very gullible. They are trusting and honest to a fault. It is not unusual for them to leave script pads lying around. Probably the best way of describing these physicians is that they are codependent and are just unable to say “no” to these patients. Interestingly, over 80% of the “Duped” physicians who have come to the Physicians Health Program for assistance are adult children of alcoholics. Those who grow up within an alcoholic household tend to assume several roles.

First is the “Lost Child”, this is the child who fades into the background. There is the “Scapegoat” who acts out for attention. The most common adult children of alcoholic (AAOA) role of a “Duped” overprescriber is that of a “Hero” child.

It is the role of the family “Hero” as a child to constantly seek approval and affirmation. These individuals are super responsible and over conscientious. In spite of their achievements, they always feel inadequate. These individuals are very adverse to any kind of conflict. It is not difficult to see how the family “Hero” adult child is easy prey for the drug seeking patient. Because of their psychological make-up they want all of their patients to be happy with them and to leave happy. Obviously, the easiest way to accomplish this with the drug diverting patient is to give them whatever they want.

When the physician “Hero” child begins accommodating the drug seeking patient it does not take long before he or she has a practice absolutely full of these patients. The drug seeking patient will go to great lengths and travel long distances to find physicians who are an easy touch for whatever drug they are seeking.

In working with these physicians, the most effective treatment is therapy for their adult children of alcoholics’ issues and find...
out what it is they have within themselves that require them to need approval from all of these patients. The drug seeking patient is a specific type of difficult patient. All of the physicians who I have talked to who were disciplined for overprescribing knew on some level there were problems with the way they were practicing medicine. The best analogy I can make is to take the same care you do when driving on wet slippery roads. The natural thing to do on dangerous roads is to slow down, be cautious and take your time. I would urge you if you feel uncomfortable about prescribing mood altering drugs to slow down, take your own inventory and carefully navigate the curves along your route. +

The Tennessee Medical Association is sponsoring a statewide continuing medical education program to help physicians and other authorized prescribers satisfy the newly enacted State of Tennessee Board of Medical Examiner’s requirement for two hours of CME on appropriate treatment of chronic pain. The course is offered in a number of settings throughout the year. The first will be April 25, at MedTenn 2014. The second will be part of a statewide roadshow series during the spring and summer. There is a continual web-based training available at www.tnmed.org.

Presented by Dr. Gray, participants will engage in a comprehensive review of new definitions, laws and other regulatory changes affecting chronic pain management. The program will help health care providers understand and adhere to prescribing guidelines to keep patients safe, and protect themselves from inadvertently contributing to Tennessee’s exploding prescription drug abuse epidemic.

Check www.tnmed.org for dates and locations as they become available, or contact Angie Madden at 615-460-1662 or angie.madden@tnmed.org for more information.

SGR REPEAL AND STATE PAYMENT REFORM INITIATIVE
(Continued from page 25)

tient-centered medical homes, retrospective episodes of care based payment, and long-term care reform.

The seven or so pages of the December 9 release describing PCMHs provide an overview of everything except how PCMHs will be paid. Can you say capitation? Otherwise, there really aren’t any surprises. The highlight is that the State has convinced at least the TennCare MCOs to “align on a set of common design decisions.” When translated, this means that, for the most part, major features of the PCMH program, such as quality metrics, will almost be the same.

In the retrospective episode-based payment design, 75 episodes of care will be designed within five years starting with three being rolled out in a few weeks: perinatal care, asthma exacerbation, and total joint replacement. Each episode will be assigned a “quarterback” who assumes the risk for the episode. For instance, the “quarterback” for the total joint is the orthopedic surgeon. Each episode will have threshold quality measures that must be met in order to receive a bonus. The other threshold is being below the cost “gain sharing” limit for the episodes in a given time period. There is downside risk for the quarterbacks for being above the “acceptable” rate for the cost of the episodes for a given time period.

COMMON ELEMENTS
Even from below the nosebleed seats, these designs look eerily similar. First, in payment design, both contain upside and downside risk for providers. Second, the two systems demand that health care providers meet measurable quality standards either through MIPS or, in the State’s initiative, PCMH accreditation and episode quality thresholds.

As of this writing, the SGR replacement has not passed, but it will. No Tennessee physician “quarterback” has received a monthly MCO Performance Summary yet. It is all but in the mail. The train is leaving the station with a systemic reform trend speeding toward PCMHs for primary care and episode-based payments for acute events. Wouldn’t it be nice if Medicare modernization and the State pay reform initiative were consistent in design so medical practices, or PCMHs as the case may be, could be consistent in operations and health care delivery? It can happen if the State’s plan becomes an approved APM. Oh, the hassles we could all avoid. +
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NEW MEMBERS
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CROSSING THE RUBICON
(Continued from page 7)

Once worked as interns and residents alongside our attending physicians. Actually, I came to trust the work of the nurse practitioner who worked in my group practice more than some physicians’ otherwise disconnected care. But what if doctors give up the bedside and become mere managers. Is this another business model?

I once imagined my life and career as a transcontinental airplane journey. The first third of my life was spent packing my brain as one might carefully pack luggage for a long journey. I then boarded the plane, roared down the runway and soared into life. Until just recently, I’ve been metaphorically cruising at 35,000 feet with career inculpation into the fabric of Ferguson. I’ve been to lots of places, but always as a doctor. We’ve all experienced the medical question at a party where we’re asked to replace our party-hat with a doctor’s chapeau. This transformation has also occurred during crises that bring us to another place of function, as during a resuscitation. I’ve observed an almost out of body persona in those moments of CPR which allowed me to do my best even with all Hell breaking loose.

I heard a commercial recently that said retirement is where you pay yourself for doing what you really want to do. My career in medicine was always what I wanted to do. As a professional, my life’s work was not just a job or done during a shift. It was a philosophy of being inculcated into the fabric of Ferguson. I’ve been to lots of places, but always as a doctor. We’ve all experienced the medical question at a party where we’re asked to replace our party-hat with a doctor’s chapeau. This transformation has also occurred during crises that bring us to another place of function, as during a resuscitation. I’ve observed an almost out of body persona in those moments of CPR which allowed me to do my best even with all Hell breaking loose.

I had thought to spend the last third of my life seeking the Master, raising grand kids and tending my garden and grapevines, like a Don Corleone. However, it seems that the beat goes on, and I will again be multitasking as I answer the call of stewardship and use my talents rather than burying them in the ground.

My final destination is known, but the quest continues and is, once again, exciting! +

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