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In my monthly columns, I have tried to give you my thoughts on the challenges and opportunities I see in the changes being imposed on us. Most of what I have to say is already covered in those columns, but since this is my “farewell address” I will repeat myself. The theme is simple: we must stay involved and in control of as much of the change as possible. Patients’ confidence in the healthcare system is dropping but they still trust us to do the right thing. They believe that we are best able to decide the most appropriate treatment for them, under their unique circumstances. They are correct.

I think we must acknowledge that there is a problem. Costs are rising more rapidly than the country’s ability to pay. The federal government is not the only voice out there demanding change. Employers are complaining, and the patients’ share through insurance premiums, deductibles and co-pays is rising. In my view the insurance companies are passive beneficiaries of the current system. Some insurers are beginning to work with physicians to control costs and reduce premiums. The forward-thinking ones realize that if costs continue to rise and we end up with a single-payer system, most of them will be out of work.

Professional fees are a small part of the problem but the expensive tests, procedures and drugs we order are a significant part of the problem. Clearly, defensive medicine is one of the drivers and the tort reforms the TMA is working for will help, but changes in our habits will occur slowly. Comparative effectiveness research, electronic health records and specialty-driven guidelines will also help. I am particularly encouraged by the AMA’s Physician Consortium for Performance Improvement, which is slowly developing ways for individual physicians to evaluate their performance against physician-driven standards. An article in JAMA last year cited a paper reporting that over the past 15 years, there has been a five-fold increase in children having CT scans in emergency rooms. We need to ask if all of that radiation exposure was necessary.

Rebuilding our primary care base is also part of the solution. If an episode of care began with a physician who knows the patient’s medical, social and emotional history, the appropriate care would be delivered more quickly and efficiently. I am encouraged that for the second year in a row the number of medical students going into primary care has increased, but we have a long way to go.

Technology advances must be encouraged even though they increase the cost of care. Even countries with single payers and national boards that must authorize new modalities are seeing rising costs of health care. I don’t know how to solve this issue but I believe we must be slow to adopt innovations until they have been clearly shown to be better than older, less expensive ways of helping our patients.

As I mentioned in earlier articles, insurance exchanges and ACOs may be steps in the right direction but only if practicing physicians take the time to be involved, so I end as I began: we can direct our future and protect our patients’ health if we stay involved and work together. If we don’t, federal agencies and insurance companies will control us.

Share your thoughts at president@tnmed.org.
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The last two editorials I wrote were related to what is happening to doctors and our profession. This first was the fact that doctors are angry, my reasoning for why they are angry, and taking a personal stand that it is okay. The second, “A Valediction for Medicine,” was directed more to the effects of practice pressure, social interaction and troublesome ways of finding “relief.” I initially had no intention of a series of similar articles since my efforts are usually stimulated by things I read or experiences that affect me and, thus, our vocation.

Several years ago I began to have a subtle feeling that the profession I joined and loved so much was beginning to fail my expectations, not scientifically or in patient care but in the unity that makes us a profession. It has become a wall of indifference! I thought back to many years ago when I raised my hand to recite the Hippocratic Oath, and to my dream of self-respect, self-reliance, compassion and, most importantly, collegiality. These days, instead of collegiality I see conflicts, character denigration, and polarization to the extent we no longer care about colleagues and support them as we did in the past. We spend more time struggling to find niches in medical care before the insurance companies find ways of stopping the latest ingenuity in billing, than we do in caring for and about each other. An article in The Economist explains it this way:

"Professional people everywhere see themselves as master craftsmen. They serve long years in training and often possess skills that few have. They speak a strange language and their ‘trade’ is valued by society. In centuries past, professions tended to align themselves as medieval guilds and our modern associations and academies still look much the same. They did this for protection, education, job security and, most importantly, for collegiality. The latter is the thing that is decreasing most rapidly.

"Elliott Krause’s thesis in Death of the Guilds is that during much of this century the most prestigious professions—doctors, lawyers, academics and, to a lesser extent, engineers—enjoyed a remarkable success in organising themselves into modern equivalents of medieval guilds but that their organised power and professional autonomy are now everywhere in decline. This trend, he says, seems to be changing professions from something special to ‘just another way to make a living.’

"American doctors are a good example. Their guild power in the 1940s and 1950s was almost total. Membership of the American Medical Association rose to nearly 75% of all doctors in the 1960s. Through its state associations, the AMA controlled entry into the profession and dominated cognate professions like nursing, X-ray technology and occupational therapy. The AMA ensured that the proportion of doctors in the population remained almost static between the early 1930s and the early 1960s. Most doctors remained in their own office practices or operated in hospitals that they controlled. All efforts to introduce national health insurance—which posed a threat to doctors’ fees as well as their autonomy—were successfully resisted.

"Those were the days, now long gone. By 1990 less than half of America’s doctors belonged to the AMA. The profession as a whole is increasingly fragmented among specialized associations and between practitioners and academics. Restrictions on entry into the profession collapsed, and the proportion of doctors in the population nearly doubled from 151 per 100,000 in 1970 to 300 by 1990. More than half of all American doctors, far from being free standing professionals, are now salaried employees. Doctors can no longer control the previously subordinate medical professions. They can no longer control even their own places of work, with more and more decisions—even quasi-medical decisions—being taken by management boards and professional administrators. Worst of all, the AMA a generation ago proved unable to resist the introduction of schemes like Medicare and Medicaid."

A nationwide survey in the United States found that the medical profession is rated the most prestigious profession by 50 to 60 percent of the people, but this was a drop of nine to 10 percent
EDITORIAL

from several years earlier. Then why are we as medical profession-
als losing our prestige in the eyes of the public? What is eroding
our credibility? Martin Luther King, Jr. said, “Our Scientific power
has outrun spiritual power. We have guided missiles but misguided
men,” and I add, direction.

This fall in prestige of this so-called “noble profession” needs
to be explored and investigated, but clearly is not based on our
successful treatments, scientific advancements and care. Most feel
that a sense of happiness and comfort with our chosen profession
is waning and is recognized by our patients and other colleagues.

Are we lacking ethics in our profession? I don’t think so but we
are getting more commercial and businesslike in practices by ne-
necessity—that is usually no fault of the individual physician. Are we
playing with the Hippocratic Oath? There is a need to introspect
and apply self-restraint. The saying “Physician, heal thyself” should
be taken more seriously. Fiscal forces play a pivotal role in one’s
life. Dependence on technology and machinery is another factor in-
fluencing our ethics. In the company of our costly machines, we
become machine-like. Our high investment in such machines, with
its attendant obligations to bankers, compels us to change our atti-
dute toward the patient sitting across the table from us.

Thus I equate professional courtesy in the broader sense as
grounding of our collegiality. Colleague and collegiality, the two
words are originally from the Latin, meaning “ones chosen and
bound at the same time as another (together); those joined to-
gether in a common cause and duty; friend and cohort.” It implies
those with the same privileges and duties and is, in part, derived
from the word “college.” Webster’s defines collegiality as “coopera-
tive interaction among colleagues.”

Understanding what has happened in the past is the start of
changing our minds in rescuing and changing the direction of our
“guild.” A fading and lost element, in most cases, has been the
professional courtesy: This is true, as I stated, in the broader sense
of the definition, of courtesy in general but some still would like
the long and protected custom of “caring” for a colleague as
something special and honored. In my entire practice I never
knowingly charged a fellow physician or his immediate family. I
often even “dipped down” to his mother and father. Professional
courtesy has probably been a part of the profession as long as
there have been healers. The Hippocratic Oath mentions the tra-
dition. The AMA’s first code of ethics, published in 1847, required
it. The current AMA standards, however, make no mention of pro-
fessional courtesy and the tradition has fallen from favor among
many doctors at universities.

I was surprised that as recent as the late 1990s a survey of
doctors found that the custom of giving free or cut-rate care to fel-
low doctors and their families remained a strong need. As high as
95 percent would like to have provided this for their colleagues
but many were affected by things they felt were “outside their con-
trol.” The survey also found that half the doctors cared for col-
leagues for no charge, and that one-quarter gave some form of
discount or allowances.

Some professions are impacted more than others. For years, psy-
chiatrists have always billed their colleagues with the caveat that “not
paying part of the cost of getting better might affect treatment.” I sus-
pect the real reason is the volume of colleagues and their family seek-
ing “counsel,” based on the increasing stress of our profession on
doctors and their families, making the numbers they see a significant
part of their practice. However, as I pointed out, it is a small element
in our overall collegial rescue. I will continue what I can do to make
this gesture, since I feel a strong need to protect that specialness and
feel I should have the right to make my decision on who I charge or
discount. More often than the colleagues I see, the need of many of
my less fortunate patients is paramount and thus, I am a strong sup-
porter of “private contracting.”

Last, my plea is to revisit the theme of professional courtesy in
the broad sense of our relationships and hope some of us may return
to or sustain the most basic form of protecting, treating and healing
our “members.” One element is caring for the health and welfare of
our members and when we offer this “benefit of membership.” I re-
alize because of practice patterns and requirements it is often impos-
sible but when I wrote “no charge” on the bill, there were few forces
could change this behavior. As a disclaimer this is an editorial repre-
senting only my opinion and not necessarily that of the TMA.

Mr. Krause wonders aloud, “The upshot is that many entities are
trying to deprive the professions not only of their guild status but
also of their ‘specialness’ and whether consumers will be well
served under the new regime and also about what will happen to the
professions themselves.” I feel he is right, and that we are losing
sight of our professional virtues and “love” for each other. As he
quotes and I agree, “For such virtues are ever the privilege of the
privileged.”

Reference:
1. Declining Professions: Just Another Way to Make a Living: Review of Death of the
Guilds: Professions, States, and the Advance of Capitalism, 1930 to the Present. The
Q: One of the physicians in our group was told that the prescription he gave to a patient to take to a pharmacy did not comply with current Tennessee law regarding prescription format. It was created in our electronic health record system (EHR) and printed at the check-out desk for the patient. It was signed with the physician’s computer-generated electronic signature, but he was told he had to manually sign it. This really impacts our workflow and use of our electronic health record system. Is this true?

A: Unfortunately, at the present time, it is true. T.C.A. §63-6-206 (b) states that any typed or computer-generated prescription must be signed by the prescribing physician on the day it is issued. The rules from the Board of Pharmacy further enforce this requirement. There are rules regarding the signature on a prescription that is transmitted electronically and for one that is handwritten. Rule 1140-03-.04(2) discusses electronic orders that allow an electronic signature and states that an electronic order must be transmitted directly from the prescriber to the pharmacy. This rule does not apply in this instance because the prescription is not transmitted directly to the pharmacy. According to the Board of Pharmacy, since section .04(2) is not applicable then the answer is found in section .03(1), which it states a written prescription must be signed by the prescriber. The Board of Medical Examiners (BME) has indicated that when a prescription is printed the signature must be in ink, meaning the physician must sign it manually. The BME recently warned a physician, in writing, that the use of an electronic signature on a printed prescription is a clear violation of its statutes and rules.

For any practice in the same situation as the one described above, the requirement of an ink signature by the physician could require a software edit to the EHR to remove the computer-generated signature and changing the practice’s workflow in order for the physician to sign the prescription manually.

Please note there are other requirements to fulfill for a prescription to be compliant with existing law and regulation. See our Law Guide topic titled Prescriptions, located at www.tnmed.org/lawguide.

TELL US HOW THIS IMPACTS YOUR PRACTICE
The TMA needs to hear from all the practices impacted by this requirement as soon as possible. The Legal Department is planning to petition the Board of Pharmacy for a rule change to allow a computer-generated signature on a prescription that is printed from an EHR or e-prescribing system; part of our petition will include how this impacts practices and patients in Tennessee. Please e-mail the Legal Department at becky.morrissey@tnmed.org or call 800-659-1862 with your practice name and how this impacts you.
While the primary focus of every physician practice is meeting the needs of its patients, its leaders must also keep a careful eye on the organization’s own financial health and well-being. LBMC’s Physician Practice Consulting group provides you with the thorough financial check up and ongoing follow up needed to safeguard your organization’s economic health. As a single, comprehensive resource for multiple business and financial solutions, LBMC works closely with physician practices of all sizes to reach and maintain their financial visions and goals.

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For the past several years, Nashville surgeon F. Michael Minch, MD, has been working with the TMA to take a “scalpel” to its internal workings, all in an effort to improve the way the organization serves its members.

That kind of operation is an ongoing necessity, he said, and is expected to continue under his presidency. “Each year seems to be getting better. We’re not all the way there yet but hopefully we’ll move the ball a bit further along.”

Dr. Minch has served the TMA in multiple capacities, including as chair of the Board of Trustees, chair of the Medical Liability Reform Committee and its Steering Committee and of the Task Force on Supervision in Remote Settings, as well as member of the Futures Task Force. He is also a former chair of IMPACT (Independent Medicine’s Political Action Committee-Tennessee), and locally served as a TMA delegate and member of the Nashville Academy of Medicine Board of Directors. It was during his years of leadership on the BOT that the TMA created and began to implement a strategic plan for the association.

Now as TMA president, Dr. Minch said his main priority will be to continue to work the strategic plan, which he said the association’s culture is beginning to understand and use as a roadmap to stay on course. He plans to survey and stay in touch with members to find out what they need the TMA to do for them, and then do it.

“My job is to lead this organization toward achieving those goals — not my goals, but those goals.”

Hesitating to name a personal priority as president, Dr. Minch did say Tennessee’s prescription drug abuse ranking troubles him. “I’m tired of people telling us we’re one of the worst states when it comes to abuse of prescription medicine and I’d like to turn that around. We’ve started off in that direction but we need to do more.”

IMMEDIATE RESULTS
Since he was a young boy, Dr. Minch knew he would go into medicine and at age 15, his specialty was decided. “I helped a veterinarian do a C-section on my little dog. It was on a Sunday, it was an emergency and he didn’t have anyone else to help, so I said, ‘Sure, I’ll try.’ I have been fascinated ever since.”

The fascination continued during medical school at Ohio State University, during residency at Vanderbilt University, and over 15 years as a chest and vascular surgeon in Nashville. He liked the immediate results: “You were able to achieve some good and you could see it happen almost right in front of you, and it was challenging,” he said.

Now retired after fulfilling a number of roles in medicine, Dr. Minch said his experience as a practicing physician and as an employee of both a large hospital company and the insurance industry has prepared him for the challenges ahead as a leader of organized medicine.

“That’s given me perspective from a lot of different angles; I can see how the system works and sometimes see it through the eyes of people who are not physicians. And I think that gives me an opportunity to find some sort of balance where we can make agreement that is workable.”

“It takes a village to practice medicine,” he continued. “It’s not just about the doctor; this is about hospitals and insurance companies and allied health professionals. We all need to play a part in this and have a system that is sustainable. There has to be a balance where everybody is doing what they’re supposed to do and everyone is reasonably happy with the outcome.”

**Dr. Minch – At a Glance**
- **Age:** 63
- **Education:** The Ohio State University undergrad and MD; Vanderbilt surgical residency
- **Family:** Wife Sue; children Justin and Allison
- **Interests:** Travel, boating, gardening, investing
- **Favorite quote:** “Don’t save all your time-outs for the fourth quarter; tomorrow is promised to no-one.”
- **Currently reading:** *Fresh Medicine* by Phil Bredesen and *Health Care You Can Live With* by Scott Morris, MD
- **Most important accomplishment:** Being able to view adversity and change as opportunity
THE VOICE OF PHYSICIANS

As part of that village, Dr. Minch said physicians need to realize the TMA is their voice. “In this state, particularly, we are consulted on every issue that comes up in the legislature that involves health care,” he said. “That means we influence not just what happens with physicians but also what happens with allied professionals and insurance. If we don’t participate in this process, those decisions will be made without our feelings being considered.”

Share your thoughts with Dr. Minch at president@tnmed.org.

As MLR Steering Committee Chairman, Dr. Minch helped anchor the TMA’s “Reform Now or Pay Later” campaign that led to Tennessee’s first medical liability reforms won in 2008.
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TMA Wants Expanded Services for TennCare Patients, a Ban on “Bath Salts,” Safer MediSpas

The TMA adopted new policies to waive treatment limits on the sickest TennCare patients, ban the “bath salts” designer drug, and regulate medical spas not affiliated with physician offices or outpatient surgery centers during its 176th annual meeting in Nashville on April 15-17.

The statewide physician’s organization also heard briefings on health reform and the budget crisis from Tennessee’s congressional delegation, installed new officers, presented annual awards and hosted a number of educational classes and forums during MedTenn 2011.

“MedTenn brings physicians together from across the state each year to look out for the future of medicine, patient care and our profession,” said Dr. Michael Minch, a Nashville surgeon who was installed as the TMA’s 157th president during the meeting. “This year’s theme, ‘Achieving Meaningful Medicine,’ touched on a host of important issues for physicians: the importance of good, quality medicine we are committed to providing; crucial changes facing our profession in the coming years; and cutting-edge tech-

(Continued on page 18)

BCBST Delays Amendment Deadline to May 23

A TMA meeting with BlueCross BlueShield of Tennessee (BCBST) has resulted in the delay of the deadline for controversial contract amendments from April 22 to May 23.

The 30-day delay followed an appearance by Robert Mandel, MD, senior vice president of healthcare services for BCBST, at the TMA Board of Trustees meeting in April.

BCBST had sent letters to participating providers in late March, requiring decisions on whether to accept, take no action or reject the amendments, which would affect contracted fee schedules for Networks P and S. The amendments affect the contracted fee schedule for Networks P and S and are time sensitive. Physicians have three options:

1. Accept the amendment in writing on or before May 23;
2. Take no action, in which case the amendments will be deemed accepted; or
3. Reject the amendments in writing, in which case BCBST has the option of terminating you from the networks

TMA members should already have received the letter with contract amendments. If not, you should contact your BCBST provider representative or local BCBST office immediately. Again, this is time-sensitive material.

The TMA cannot advise members as to whether to accept or reject the BCBST contract amendments. Each practice must carefully evaluate, before May 23, how the amendments would affect its bottom line and decide whether to accept the amendment or try to negotiate an alternative based on specialty or location.

For details, contact the TMA Legal Department at 800-659-1867.
Survey: Most Tennesseans Support Limits on Non-Economic Damages

More than 60-percent of Tennesseans are in favor of placing limits on so-called “pain and suffering” damages in medical malpractice lawsuits, and the strongest support comes from Tennessee’s senior citizens.

Those are among the highlights of a TMA-commissioned survey conducted by Catalyst Healthcare Research in April. Of 620 Tennessee consumers surveyed, ages 18 and over, 61 percent said they favor a bill to cap jury awards for non-economic damages. For Tennesseans aged 65 and older, the support rises to 72 percent—the highest percentage among all age groups.

“This survey is a fair snapshot of adults in our state and it shows most of our citizens understand how high jury awards— or the threat of them— affect rising healthcare costs and their access to their doctor,” said TMA President-elect Michael Minch, MD, of Nashville, adding, “Despite what some of our opponents claim, older Tennesseans get the connection and want us to establish fair boundaries for these emotional awards, which have nothing to do with actual economic losses.”

Tennesseans are worried about losing their doctors if the state’s litigation climate does not improve, according to the results. Ninety percent said they are “very concerned” or “somewhat concerned” about doctors in Tennessee leaving the state or closing their practices due to the high cost of malpractice insurance or the fear of lawsuits; nearly 80 percent said they are worried about losing physicians to states that have passed tort reforms; and 70 percent believe similar reforms would encourage more doctors to locate in Tennessee.

“Tort reform is imperative for Tennessee to recruit and retain top physicians,” said Dr. Minch. “Governor Haslam’s proposed legislation will address Tennesseans’ concerns by creating a better climate for physicians to practice medicine, helping attract new physicians to Tennessee and improving care for patients.”

The Tennessee Civil Justice Act of 2011 (SB 1522/HB 2008) would make a number of changes to the state’s tort laws, including a $750,000 limit on jury awards for non-economic (pain and suffering) damages in medical malpractice cases, except in catastrophic cases, where the limit would be $1.25 million; and a limit on punitive damages of two times the compensatory damages or $500,000, whichever is greater. At press time the bill had passed out of the House Judiciary Committee and was headed to the House Calendar and Rules Committee.

For more information, visit www.tnmed.org/reform_survey.
BCBS Settlement Set to Expire May 31

The national class action settlement between the TMA and Blue Cross Blue Shield of Tennessee (BCBST) in 2007 expires May 31, 2011, and physicians need to prepare to protect their practices in case there are changes in the relationship with their Blue Cross plan.

Under the settlement insurance plans, including Blue Cross, agreed not only to repay physicians for denied claims and underpayments, but also to implement payment policy, contracting, and other changes to make their business practices fairer in the eyes of physicians.

Other national private payers, such as Cigna and Humana, voluntarily agreed to continue some of these business practices when their national settlement agreements with physician groups expired. TMA officials plan to follow up with BCBST in the hope of receiving a similar agreement.

WHAT YOU SHOULD DO
To prepare for potential changes in your relationship with the Blues and protect your practice, you should:

1. Ask your local Blue Cross plans which, if any, of the settlement protections they intend to keep. They may tell you even if they haven’t announced it publicly.
2. File a compliance dispute before May 31, if you have one. Filing is free, but the complaint must be filed within 90 days after the dispute first arose or reasonably could have been known to you, whichever is later, according to Winegard. For the complaint form and a step-by-step guide for filing, go to www.hmosettlements.com/pages/bluecross.html. If you have questions, contact Winegard at dwinegard@gmail.com or 404-607-8222. She’ll continue to resolve complaints in process after May 31 as long as she receives them before the settlement agreement expires. To date, the TMA believes no Tennessee physician has filed a compliance dispute.
3. Watch for communications from the TMA. PAI is encouraging state societies to contact their local Blues plans to address what will happen when the settlement agreement expires. The TMA has plans to follow up with BCBST and advise members on any developments.

For more information, contact the TMA Legal Department at 800-659-1862 or visit www.tnmed.org/BCBS_expire.

New EHR FAQs are Online!

There is new help online for providers who have questions about registration and attestation for CMS Electronic Health Record (EHR) Incentive Programs.

“Tennessee’s Medicaid incentive program (TennCare) was in the first group of states that made registration available for the incentive payments to providers and hospitals,” said TMA eHealth Services Director Angie Madden. “Registration was available on January 4th and the attestation process became available to receive provider attestations in April.”

GENERAL FAQS
The CMS has posted FAQs about topics including eligibility, registration, meaningful use and attestation that have been posted to the FAQ section of the EHR Incentive Programs website. A few of the new FAQs include:

1. What is the definition of “reasonable cost” for critical access hospitals (CAHs) under the Medicare and Medicaid EHR Incentive Programs? The reasonable costs for which a CAH may receive an EHR incentive payment are the reasonable acquisition costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would otherwise apply.
2. How is hospital-based status determined for eligible professionals (EPs) in the Medicare and Medicaid EHR Incentive Programs? A hospital-based eligible professional (EP) is defined as an EP who furnishes 90% or more of their covered professional services in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital.
3. For large practices, will there be a method to register all of the EPs at one time for the Medicare or Medicaid EHR Incentive Programs? Can EPs allow another person to register or attest for them? At this time there is no method available for a third party to register multiple EPs for the Medicare and Medicaid EHR Incentive Programs.

REGISTRATION FAQS
To help ensure the registration process goes smoothly and for easy reference, CMS has provided an answer to one of the most common registration questions from FAQs on the CMS, located at www.cms.gov/EHRIncentive-Programs:

1. How will EPs and eligible hospitals apply for incentives under the Medicare and Medicaid EHR Incentive Program? Registration for the Medicare and Medicaid EHR Incentive Programs began on January 3, 2011. However, the Medicaid Incentive Program is rolled out on a state-by-state basis. An updated schedule of state-planned Medicaid Incentive Program start dates can be found on the CMS website.

Visit www.cms.gov/EHRIncentivePrograms for the latest news and updates. The TennCare incentive program website for registration and attestation is www.state.tn.us/tenncare/pipregistration.html.
TMA WANTS EXPANDED SERVICES ...
(Continued from page 15)

Technologies that will transform the practice of medicine in our lifetime,” he said.

CONGRESS COMES TO THE TMA
MedTenn 2011 featured appearances by U.S. Senator Bob Corker and U.S. Representative Phil Roe (TN-1). During a luncheon address, Sen. Corker told TMA members that physicians would be caught “in a whipsaw” between healthcare system changes and the nation’s budget crunch. The Senator outlined his Commitment to Prosperity Act (CAP), which he described as a legislative “straitjacket” to control and dramatically cut government spending over the next decade.

Sen. Corker and Rep. Roe warned doctors to expect cuts in entitlement programs, including Medicare and Social Security, as the nation works to solve its spending issues. Both lawmakers also restated their commitments to finding a permanent solution for the flawed SGR formula that plagues physicians with annual or semi-annual threats of drastic reimbursement cuts.

RESOLUTIONS OF INTEREST
The TMA’s policy-making body, the House of Delegates (HOD), took action on a variety of issues facing Tennessee doctors and their patients. Among a slate of 13 resolutions were the following decisions:

- The TMA will petition the Haslam administration to make modifications to the TennCare II Demonstration Project to assign the sickest patients to patient-centered medical homes (PCMH); waive limits on their care and treatment; and provide more compensation for PCMH care.
- The TMA will support or seek legislation to ban the sale or use of the “bath salts” designer drug.
- The TMA will seek to expand the definition of the practice of medicine in Tennessee to include all aesthetic medical and surgical procedures, and seek legislation to regulate all medical spas to the same extent as those affiliated with physician offices or outpatient surgical centers.
- It is now the TMA’s official position that Tennessee’s Certificate of Need (CON) law does not promote or encourage competitive markets, economic efficiencies or the continued development or quality of the healthcare industry.
- Official TMA policy now states that physicians do not have an ethical obligation to accept non-emergency consultations, and hospitals should fairly compensate those who do.
- The TMA will oppose any restrictions on physicians offering certain medical procedures and services they are properly trained and have demonstrated their qualifications for, such as imaging, as well as oppose insurance company efforts to pay less for such services based on where the service is rendered.

NEW OFFICERS
In addition to Dr. Michael Minch’s installation as president, delegates to the annual meeting installed the following leaders for 2011-2012:

- Dr. Wiley T. Robinson, a Memphis internist and hospitalist, will serve as president-elect for 2011-2012, and serve on the TMA Board of Trustees.
- Dr. Matthew L. Mancini, a Knoxville surgeon, will serve as chairman of the TMA Board of Trustees.
- Dr. Keith G. Anderson, a Germantown cardiologist, is the new vice-chairman of the TMA Board.
- Dr. Charles E. Leonard, family physician from Talbott, will serve as secretary-treasurer for the TMA.
- Dr. John W. Hale, Jr., family physician from Union City, will serve as speaker of the TMA House of Delegates (HOD).
- Dr. Jane M. Siegel, Nashville hand and orthopedic surgeon, will serve as vice-speaker of the TMA HOD.

AWARDS
The TMA also presented its 2011 annual awards to the following deserving individuals and organizations:

- Outstanding Physician Award – John W. Lacey, III, MD, Knoxville; Tom E. Nesbitt, MD, Nashville; Martin Coyle Shea, Jr., MD, Cordova
- Distinguished Service Award – Keith W. Hagan, MD, Nashville; Gordon J. Kraus, MD, Memphis; James M. Osborn, MD, Chattanooga; Douglas J. Springer, MD, Kingsport
- Community Service Award – Dr. William Roy Mercy Dental Clinic, Chattanooga; Hands On Nashville, Nashville; Sen. Mark Norris, Sr., Esq., Memphis

For final resolutions and other MedTenn news, visit www.tnmed.org/medtenn.
We are proud to announce the TMA Physician Leadership College Class of 2012

The TMA Physician Leadership College was created to offer opportunities for our physician members to gain invaluable experience and training in the core aptitudes to excel in leadership positions within organized medicine, medical practice and business.

www.tnmed.org/leadershipcollege

Karin Covi, MD
Hixson, Dermatology

Danielle Hinton, MD
Germantown, Physical Medicine & Rehabilitation

Pushpendra K. Jain, MD
Cookeville, Family Medicine

Jay Jhala, MD
Alcoa, Internal Medicine

Paul Klimo, Jr., MD
Memphis, Neurological Surgery

James C. Kneff, Jr., MD
Kingsport, Emergency Medicine

Adele M. Lewis, MD
Nashville, Forensic Pathology

Terry A. Melvin, MD
Chattanooga, Internal Medicine/Geriatrics

Justin Monroe, MD
Memphis, General Surgery

Robin Williams, MD
Hermitage, General Surgery
Doctors’ Day recognition ceremonies in Chattanooga honored 10 local physicians for their contributions, selected from among 85 nominations. Pictured here with Honoree Dr. Mandeep Grewal (second from left) are Chattanooga-Hamilton County Medical Society President-elect Dr. John McCarley; CHC Medical Foundation President Dr. Phyllis Miller, and Nordia Epps, WDEF-News 12 Anchor. Other honorees included Drs. Ronald Brooksbank, Donald Chamberlain, Kent Childs, Mark Hays, S. Clark Kennedy, Stephen Kerley, Jerrold Selzer, Bill Moore Smith and Munford Yates.
Authors Patricia LaPointe McFarland (left) and Mary Ellen Pitts pose with St. Jude pediatric surgeon Dr. Bhaskar Rao, who is pictured on the front cover of their book, Memphis Medicine – A History of Science and Service. The book is published by the Memphis Medical Society and chronicles health care in Memphis and the contributions of Memphis physicians along the way.

Dr. Kirk Brody and wife Donna were among attendees at the 6th annual Denim & Diamonds gala in late February, hosted by the Chattanooga-Hamilton County Medical Society, its Foundation and Alliance to benefit Project Access.
Match Day at TN Medical Schools

THE TMA IS HONORED TO RECOGNIZE ITS STUDENT MEMBERS ON THEIR GRADUATION AND CELEBRATE THEIR MATCHES FOR RESIDENCY TRAINING.

East Tennessee State University Quillen College of Medicine

Kajin Abdullah, U TX Swstrn Med Sch, Int Med
Keerthi Akkineni, Barnes-Jewish Hosp-MO, Psych
Jessica Albright, ETSU, Ped
Jeremy Bartley, ETSU, Med-Prelim; LSU-Shreveport, Ophthal
Darrell Benton, U TN Grad SOM-Knox, Trans-Rad/Rad-Diag
Collin Bills, U TN COM-Mem, Ortho Surg
Maikel Botros, ETSU, Med-Prelim; Med Coll WI Affl Hosps, Rad Onc
Jessica Boyd, Greenville Hosp Sys/U SC SOM, Ped
Megan Browder,*U AL at Birm, Psych
Joseph Bynum, U TN COM-Mem, Int Med
Kristin Cardona, U Louisville SOM, Fam Med
Amanda Clouse, IN U SOM, Em Med
Shae Connor, U TN Grad SOM-Knox, ObGyn
Michael Derrick, Med U SC, Ped
Stephen Evans, ETSU, Med-Prelim, U VA, Anesth
Christen Gregory, Orlando Hlth, Em Med
Bernadette Helton, U TN COM-Chatt, Em Med
Mallary Hodges, VUMC, Int Med
Keith Hollister, IN U SOM, Surg Gen
Laura Howell, U Utah Affl Hosps, ObGyn
Jen Jackson, Med U SC, Int Med
Brett Kindle, ETSU, Med-Prelim; Mayo Sch Grad Med Ed, Phys Med Rehab

Katie Lawson, ETSU, Ped
Jessica Littman, ETSU, Med-Prelim; Georgetown U/Wash Hosp, Ophthal
J.B. Mason, U FL COM-Gainesville, Surg-Prelim/ Urol
Erin Miller, OR Hlth Sci U, Psych
Rachel Nelson, U TN COM-Chatt, Surg-Prelim; Med U SC, Rad-Diag
Chrissy O’Hara, SAUSHEC-Brooke Army Med Ctr, Em Med
Matt Oliver, Mem Hlth/U Med Ctr-GA, ObGyn
Brandon Pace, U KY Med Ctr, Em Med
Celia Ridley, Greenville Hosp Sys/ U SC SOM, ObGyn
Mimi Shaffer, UC San Diego Med Ctr-CA, ObGyn
Tom Soike, Med U SC, Path
Stew Stancil, Darnall Army Med Ctr, Em Med
Austin Thompson, Pitt Co Mem Hosp/Brody SOM, Em Med
Misty Thompson, SAUSHEC-Brooke Army Med Ctr, Ped
Jacqueline Vidosch, Wright Patterson Med Ctr, Ob & Gyn
Larry Waldrop, VA Commonwealth U Hlth Syst, Ortho Surg
Brian Wetherington, U KY Med Ctr, Int Med
B.J. Whitt, ETSU, Med-Prelim; U Louisville SOM, Rad-Diag
Brett Wilhoit, Trident Med Ctr, Fam Med
Stuart Winkler, Wake Forest Baptist Med Ctr, ObGyn
Lora Worsham, U TN/Bapt-Nash, Int Med
Jennifer Ziock-Price, Baylor COM, ObGyn

ETSU QCOM graduate and TMA member Jen Jackson (left) reacts upon learning she will do her internal medicine residency at Medical University of South Carolina. Photo: Phillip Sholes/Quillen College of Medicine.
Meharry Medical College
Benyam Addissie, Mayo Sch Grad Med Ed, Int Med
Eminajulo Adekoya, U TX Hlth Sci Ctr, Urol
Ariel Aguillard, Einstein/Montefiore Med Ctr, Fam Med
Roneisha Alexander, Alton Ochsner Clinic Found, Anesth
Natalia Ballesteros, U Louisville SOM, Urol
Akiiah Bates, Temple U Hosp, Int Med
Erik Benitez, Lehigh Valley Hosp, Gen Surg
Lynikka Bernard, Westchester Med Ctr, ObGyn
Ananta Bhatt, U Hosp/U Cincinnati COM, Int Med
Orville Bignall, Cincinn Child Hosp Med Ctr, Ped,
Alesia Billingslea, Wake Forest Baptist Med Ctr, Med-Primary
Tiffany Black, Baylor COM, Psyh
Ryan Bliss, LA State U SOM, Ortho Surg
Brandon Blue, Barnes-Jewish Hosp Med Ctr, Int Med
Nia Bodrick, Orlando Hlth/Orlando Reg Med Ctr, Ped
Whitney Boon, VUMC, Urol, Child Neurol
Brittany Brown, St. Louis Child Hosp/Wash U, Ped
May Cho, Barnes-Jewish Hosp Med Ctr, Int Med
David Chunn, Meharry/Metro Nash Gen, Int Med
Tiffany Clay, Orlando Hlth/Orlando Reg Med Ctr, Med-Prelim; St. Louis U SOM, Derm
Charlene Cole-Suttlar, U AL SOM, Fam Med
Tiana Crawford, U Penn Med Ctr Presb Shadyside, Trans; Estm VA Med Schl, Rad-Diag
Tonya Dixon, U Hosp/U Cincinnati COM, Ortho Surg
Ada Egbeju, State U NY, Urol
Lakeshia Entzminger, U So AL Hosp, Int Med
Karen Francois, NY Presb Hosp-Weill Cornell Med Ctr, Anesth
Christian Ghattas, U So CA, ObGyn
Susan Goggans, U FL COM, Em Med
Tiffany Hailstorks, Howard U Hosp, ObGyn
LaVonne Hairston, Alton Ochsner Clinic Found, ObGyn
Mary Hall–Vanlear, U Louisville SOM, Em Med
Jennifer Haynie, Meharry/Metro Nash Gen, Int Med
Doris Hoskins, U So CA, Int Med
Prescilia Isedeh, Brigham & Women’s Hosp, Med-Prelim

Kaya Jackson, So IL U SOM Aff Hosps, Ortho Surg
Justin Jamison, Long Is Jewish Med Ctr/Albert Einstein COM, Psych
Tiffany Jones, U So CA, ObGyn
Anjali Khurana, St. Mary Mercy Hosp, Trans/ Penn Hosp, Rad-Diag
Damien Larkins, Baylor COM, Psyh
Stephanie Lewis, U MO-KC Pgms, Em Med
Mandy Lucas, Mem Hlth-U Med Ctr, Fam Med
Ricardo Lugo, Hosp U Penn, Int Med
Maila Martin, UCSF, Ped

TMA student members Sean LeNoue (left) and Paul Bryant show off their residency assignments during Match Day ceremonies at the University of Tennessee Health Science Center in Memphis.

Aleaa Maye, UC Davis Med Ctr, Med-Psych
Camille McLean, Greenwich Hosp/Yale New Haven, Int Med
Milton Moore, U TX Swstrn Med Schl, Med-Prelim
Jebhar Patterson, Einstein/Jacobi Med Ctr, Ped
Stephanie Pearson, U TX Hlth Sci Ctr, Phys Med-Rehab
Sarah Price, U TX Swstrn Med Schl, Ped
Sheena Pullman, Alton Ochsner Clinic Found, ObGyn
Tiffany Richburg, Med Coll GA, Anesth
Star Rogers, U TX Swstrn Med Schl, Anesth
Dorothy Russ, Meharry/Metro Nash Gen, Fam Med
Sasha Smith, Mercer U SOM/Med Ctr Cent GA, Fam Med
Calvin Spelman, UNM SOM, Ped
Stephen Spencer, West VA U SOM, Em Med
Micheca St.Hilaire, U Hosps, Int Med
Anza Stanley, U Hosps, Ped
Lauren Sullivan-Larke, VUMC, Ped
Dominic Tang, VUMC, Urol
Carmelita Taylor, U TX Med Schl, Ped
Grace Toledo, Miami Child Hosp, Ped
Stephanie Turner, U TN COM, Ped
Daniel Whiteclocke, U TN COM, Gen Surg
Brandi Wright, Kaiser Perm, Int Med
Christina Yi, Wayne St U/Detroit Med Ctr, Gen Surg

(Cont.)
Member News

University of Tennessee Health Science Center

Steven Allen, U TN COM-Chatt, Ped
William Arnett, Med Coll GA, Em Med
Margaret Atkins, Cincinnati Child Hosp MC-CH, Ped
Derek Bauer, U TN COM-Mem, Med-Prelim; U TN COM-Mem, Neurol
Phillip Bell, Carolinas Med Ctr-NC, Ortho Surg
Christopher Bledsoe, U TN COM-Mem, Derm
Justin Blinn, Hershey Med Ctr/Penn State-PA, Ortho Surg
Christopher Bruno, U TN COM-Mem, Med-Prelim; Bapt Mem Hosp-TN, Rad-Diag

Josey Bryant, Northwestern McGaw/NMHNA-IL, Fam Med
Paul Bryant, U TN COM-Mem, Int Med
Jason Buckner, Emory U SOM-GA, Ped
Elizabeth Campbell, Duke U Med Ctr-NC, Int Med
Antonio Capps, U TN COM-Mem/JXN, Fam Med
Jeffrey Caughran, U TN COM-Mem, Int Med
Daniel Chatham, U TN COM-Mem, Ped
Michelle Chi, VA Commonwealth U Hlth Sys, Int Med
Kevin Childers, U TN COM-Mem, Int Med
Thomas Christianson, U TN Grad SOM-Knox, Trans/Anesth
Stephen Clendenin, VUMC-TN, ObGyn
Erik Cohen, Rhode Is Hosp/Brown U, Ortho Surg
Erika Collins, U Louisville SOM-KY, Ped
Brittany Cook, Bapt Hlth Syst-AL, Med-Prelim
Seth Cooper, U So FL COM-Tampa, Ortho Surg
John Copeland, U NC Hosps, Psych
Alex Cravanas, U Louisville SOM-KY, Anesth
Andrew Dake, U TN Grad SOM-Knox, Int Med
Patrick Davis, Wake Forest Baptist Med Ctr-NC, Gen Surg
Ross Dawkins, U AL Med Ctr-Birm, Neurol Surg
Sheetal Dedania, U TN COM-Mem, ObGyn
Kefu Du, U Utah Affl Hosps, Surg-Prelim
Scott Duncan, U TN COM-Mem, Int Med
Angela Earhart, Barnes-Jewish Hosp-MO, Path
Raven Elsiesbo, U TN COM-Mem, Med-Prelim; IN U SOM, Derm
Stacey Evans, U TN COM-Mem, Ped
Brian Flemming, U TN COM-Mem, Med-Prelim; Med U SC, Rad-Diag
Graham Foster, St Louis U SOM-MO, Em Med
Britney Friesen, U TN COM-Mem, Int Med
Brian Fuller, VUMC-TN, Psych
Matthew Gordon, U TN Grad SOM-Knox, Trans; Mayo Sch Grad Med Ed-FL, Dem
Katie Greene, U TN COM-Mem, Med-Ped
Heidi Griffith, LSU SOM-New Orl-LA, Ped
John Harkess, U TN COM-Mem, Ortho Surg
Lindsey Hartsell, U TN COM-Mem, Surg-Prelim; U TN COM-Mem, Urol
Meghan Hofto, Cincinn Child Hosp MC-CH, Ped
Samuel Huddleston, U TN COM-Mem, Int Med
Andrew Irwin, U TN COM-Mem, Ped
Bradley Jaqueith, U Hosp-Cincinn-OH, Ortho Surg
Benjamin Johnson, U TN COM-Mem, Gen Surg
Jeshonna Johnson, U TN COM-Mem, ObGyn
Joanna Kaczmarska, U AL Med Ctr-Birm, Ped
Neha Kakkar, Rush U Med Ctr-IL, Int Med
Megan Kempe, U TN COM-Mem, Path
Brian King, U TN COM-Mem, Int Med
Lindsey Lans, U TN COM-Mem, Int Med
Jessica Lange, Wake Forest U SOM-NC, Urol
Sean LeNoue, U CO SOM-Denv, Psych
Lisa Mabry, Bapt Hlth Syst-AL, Med-Prelim; U AL Med Ctr-Birm, Rad-Diag
Joseph Malek, U AL Med Ctr-Birm, ObGyn
Justin Marlar, U TN COM-Mem/JXN, Fam Med
Margaret Mays, U TN COM-Mem, Rad-Diag
Julia McMillen, U IL COM-Chic, ObGyn
Thomas Meredith, Ehring Bergquist Hosp-Offutt AFB NE, Fam Med
Shayla Merry, U TN COM-Mem, Int Med
Adam Militana, U TN COM-Mem, Med-Prelim; VUMC-TN, Rad-Diag
Christopher Miller, Jewish Hosp-OH, Med-Prelim; U Hosp-Cincinn-OH, Rad-Onc
Adrienne Moul, Jackson Mem Hosp-FL, Path
Mary Nagle, St Francis Hosp Ctr-IN, Fam Med
Darshan Naik, U TN COM-Mem, Int Med
Janice Nazario, U TN COM-Mem/JXN, Fam Med
Catherine Obeng, U So CA, Int Med
Benjamin Oberman, Hershey Med Ctr/Penn St-PA, Otoar
Sylvestre Onyishi, U TN COM-Mem, Surg-Prelim
Travis Pagliara, U MN Med School, Surg-Prelim; U MN, Urol
Trey Pegram, U TN COM-Mem, Trans; U TN COM-Mem, Rad-Diag
Thuy Pham, U MD Med Ctr, Em Med
Jennifer Poole, U CO SOM-Denv, Int Med
Sarah Prince, U TN COM-Mem, Surg-Prelim
Brian Qualls, U TN COM-Mem/JXN, Fam Med
Heather Reed-Day, U VA, Em Med
Kelly Ridder, U TN COM-Mem, Med-Prelim; U FL COM-Jacksonville, Neurol
Megan Rogers, Scripps Mercy Hosp-San Diego-CA, Int Med
Susan Sapp, U TN COM-Mem, Ped
Kristen Schmitts, U FL COM-Shands Hosp, Path

Meharry grad Christian Chattas celebrates his Ob-Gyn residency match to the University of Southern California. Photo: James Lewis/Meharry

Afi Semenya, U NC Hosps, Fam Med
Ali-Reza Sharif-Ashfar, Cedars-Sinai Med Ctr, Surg-Prelim/Urol
Christopher Shaw, U KY Med Ctr, Em Med
Jonathan Sherrod, SAUSHEC-Brooke Army Med Ctr-TX, Int Med
John Stites, Brookdale Med Ctr-NY, Urol
Matthew Stone, U TN Grad SOM-Knox, Int Med
Philip Sutherland, U TN COM-Chatt, Fam Med
Kathleen Thornton, Harbor-UCLA Med Ctr-CA, Int Med
Michael Ulm, U TN COM-Mem, ObGyn
Brian Wakefield, U TN COM-Chatt, Ped
Jeremy Walker, Northwestern McGaw/NMHNA-IL, Anesth
Member News

The IMPACT Board of Trustees recognizes the following IMPACT donors who have become Capitol Hill Club members in the past month. We greatly appreciate all IMPACT contributors for their help in assuring that candidates supportive of organized medicine receive generous financial support from IMPACT. To join IMPACT or the Capitol Hill Club, please contact Amy Bowland at 800-659-1862 or e-mail amy.bowland@tnmed.org, or log on to www.tnimpact.com.

Platinum Club ($5,000)
George Woodbury, MD, Memphis

Capitol Hill Club
Lee Berkenstock, MD, Memphis
Ed Capparelli, MD, Jackson
Hammond Cole, MD, Memphis
Charles Eckstein, MD, Nashville
Eric Fox, MD, Cookeville
John Hale, MD, Union City
James Hannifin, MD, Memphis
Lee Hunter, MD, Columbia
John Ingram, MD, Alcoa
Benjamin Johnson, MD, Nashville
James King, MD, Selmer
Robert Kirkpatrick, MD, Germantown
Matthew Mancini, MD, Knoxville
John McCarley, MD, Hixson
William McKissick, MD, Knoxville
Fredric Mishkin, MD, Kingsport
Perry Rothrock, MD, Cordova
Nita Shumaker, MD, Chattanooga
David Steed, JD, Nashville
Sue Vegors, Jackson
Raymond Walker, MD, Bartlett
Charles Womack, MD, Cookeville
Christopher Young, MD, Signal Mountain

Vanderbilt University School of Medicine
Brian Cruz, Tulane U SOM, Int Med
Christopher Estopinal, Exempla St Joseph Hosp, Med-Prelim; VUMC, Ophthal
Mark Fritz, NYU SOM, Oto
Tera Howard, Northwstm McGaw/NMH/VA, ObGyn
Britni Jacobs, VUMC, Oto
Marlon Joseph, Rush U Med Ctr, Med-Ped
James Kynes, VUMC, Surg-Prelim; Brigham & Women’s Hosp, Anesth
Brent McNew, VUMC, Anesth
Caitlyn Mooney, Med U SC, Ped
William Nobis, Northwstm McGaw/NMH/VA, Med-Prelim/Neurol
Olutoyin Okanlawon, Caritas Carney Hosp, Med-Prelim; Brigham & Women’s Hosp, Anesth
Piotr Pilarski, VUMC, Int Med
Jennifer Rymer, Duke U Med Ctr, Int Med
Stephen Schleicher, Brigham & Women’s Hosp, Int Med
Anjali Shah, VUMC, Int Med
Christina Speirs, VUMC, Med-Prelim; Barnes-Jewish Hosp, Rad-Onc
Chinenyenwa Usoh, Wake Forest Baptist Med Ctr, Int Med
Eric Wise, U MD Med Ctr, Gen Surg

Capitol Hill Club
Timothy Walls, U Chic Med Ctr-IL, Path
Douglas Wellons, U TN COM-Mem, Med-Prelim; U AL Med Ctr-Birm, Anesth
John Williams, U Utah Affl Hosps, Ortho Surg
Anna Winter, U TN COM-Mem, Med-Ped
Adam Wright, U TN COM-Mem, Trans; Mayo Sch Grad Med Ed-MN, Ped

Tennessee Medicine  +  www.tnmed.org  +  MAY 2011
Ralph C. Atkinson, III, MD, with Nephrology Associates, PC, in Nashville, has been appointed to the Tennessee Department of Health’s Renal Advisory Committee. The committee works to develop and expand kidney disease care programs across the state. Board certified in nephrology and internal medicine, Dr. Atkinson serves as chief of staff and director of the kidney transplant and acute dialysis programs at Centennial Medical Center. He previously served at Centennial as president of the medical staff and chief of internal medicine. Dr. Atkinson is a member of The Nashville Academy of Medicine.

Leila M. August, MD, of Gallatin, has been named medical director of Sumner Hospice at Sumner Regional Medical Center. Board certified in family medicine, Dr. August has been a Sumner Hospice medical staff physician since early 2010, concentrating on treating geriatric patients in long-term care facilities. She is a direct member of the TMA as well as the American Academy of Family Practice, Tennessee Academy of Family Practice and American Academy of Hospice and Palliative Medicine.

Ken D. Berry, MD, of Camden, has co-authored a children’s book called Oh Gary, Dr. Berry isn’t Scary, aimed at calming children’s fears about going to the doctor. Board certified in family medicine, he is owner of The Berry Clinic. Dr. Berry is a member of the Benton-Humphreys County Medical Society.

Three TMA members are among new officers elected by the medical staff at Athens Regional Medical Center for 2011. Joseph C. Lauterbach, MD, FACOG, a specialist in OB/GYN and pelvic surgery with Athens Womens Clinic, is vice chief of staff; David R. Childress, MD, a family physician with Athens Family Practice, is secretary; and Iris G. Snider, MD, a board-certified pediatrician with Athens Family Practice, is now immediate past chief of staff. All three are members of the McMinn County Medical Society.

Stephen F. Daugherty, MD, FACS, medical director and owner of Veincare Centers of Tennessee in Clarksville, has been named to the board of directors for the American College of Phlebology Foundation (ACPF), and has accepted a position as chairman of the ACPF Grants Review Committee. The board directs fundraising efforts and makes funding decisions to advance the science of phlebology and the availability of specialized vein care. Dr. Daugherty is one of 248 physicians earning the first certification offered by the American Board of Phleboloby in 2008. Certified in vascular and general surgery, as well as vascular technology, ultrasound of the blood vessels and phlebology sonography, he is a member of the Montgomery County Medical Society.

Gary W. Kimzey, MD, of Germantown, and Frank L. White, III, MD, of Memphis, were among a group of 10 alumni recently inducted into the Christian Brothers High School Hall of Fame. Dr. Kimzey is an anesthesiologist with Medical Anesthesia Group of Memphis; serves on the board of directors for MetroCare Physicians, The Memphis Medical Society and Health Choice; is a former president of the Tennessee Society of Anesthesiologists, Memphis and Shelby County Society of Anesthesiologists, Medical Anesthesia Group and Hippocratic Society; and is a member of the TMA Legislative Committee and a former member of the TMA Board of Trustees. Dr. White is a senior pathologist with Duckworth Pathology Group, director of laboratories at Methodist University Hospital and assistant clinical professor of pathology at the University of Tennessee Health Science Center. A former chair of the TMA Continuing Education Committee, Dr. White is a member of The Memphis Medical Society.

Christine S. Mestemacher, MD, FACOG, of Germantown, has been named by the Best Doctors organization as one of the top obstetrician/gynecologists in the Memphis/Shelby County area. A member of The Memphis Medical Society, she is owner of the Mestemacher Clinic for Women, PLLC. In addition to her practice, she serves as chair of the Department of Obstetrics and medical staff president at Baptist Women’s Hospital, and vice-chair of the Baptist Metro Medical Executive Committee.

Kofi W. Nuako, MD, of Union City, has been named Physician Champion for the Fourth Quarter of 2010 by Baptist Memorial Hospital-Union City. A member of the Northwest Ten-
Tennessee Academy of Medicine, Dr. Nuako is a board-certified internist specializing in gastroenterology; he practices with Advanced Gastroenterology in Union City. He is a published author on topics including colon cancer, ulcerative colitis, and ischemic colitis.

**Robert E. Rhea, MD**, of Ashland City, has been recertified by the American Board of Family Medicine. A solo practitioner, Dr. Rhea is a direct member of the TMA.

**William Schaffner, MD**, of Nashville, was among key contributors honored at the T.J. Martell Foundation Honors Gala in late March. The Foundation raises money for leukemia, cancer and AIDS research. Dr. Schaffner was honored along with Rascal Flatts, Nashville Mayor Karl Dean and Tennessee Titans owner Bud Adams. A member of the Nashville Academy of Medicine, Dr. Schaffner won the 2011 Sedgwick Medal for Distinguished Service in Public Health by the American Public Health Association. Dr. Schaffner is chair of the Department of Preventive Medicine, a professor of Medicine and Preventive Medicine at Vanderbilt University School of Medicine, and noted national expert and advisor on infectious disease.

**Claudette J. Shephard, MD, FACOG**, of Memphis, has joined the UT Medical Group board of directors. Dr. Shephard is chief of Pediatric and Adolescent Gynecology at UT Medical Group, and associate professor at the University of Tennessee Health Science Center. She serves on the board of The Memphis Medical Society; her professional memberships include the American Medical Women’s Association, American Professional Society on the Abuse of Children, American Public Health Association, Bluff City Medical Society, Central Association of Obstetricians and Gynecologists, National Medical Association, North American Society for Pediatric and Adolescent Gynecology and the Society for Adolescent Medicine.

**Jon P. Ver Halen, MD**, of Memphis, has been certified by the American Board of Plastic Surgery. Practicing with UT Medical Group, Dr. Ver Halen is a surgeon in the Division of Plastic and Reconstructive Surgery at St. Jude Children’s Research Hospital and an assistant professor of plastic surgery at the University of Tennessee Health Science Center. He is a member of The Memphis Medical Society.
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Add three more letters to the long list of acronyms that have heads spinning throughout the healthcare industry: ACO. The ACO (accountable care organization) is a byproduct and key component of HSR (health system reform; by name, the Patient Protection and Affordable Care Act (PPACA)).

Medical experts and entities across the country are currently heads down, translating government-speak to figure out what this new type of practice model will mean for patients, physicians and other practitioners, and for the overall future of health care. Tennessee is no different, where the TMA and other statewide groups are analyzing proposed regulations issued on March 31 by the Centers for Medicare and Medicaid Services (CMS) and trying to brief members on the legal ins and outs, as well as probable risks and benefits.

“The regulations are 429 pages long,” said TMA General Counsel Yarnell Beatty, JD. “We’re still looking at them and it’s going to be a while before we can thoroughly review them.” Beatty has already embarked on a speaking tour of...
component medical societies, hospital staffs and practices across the state as part of an education program for members. “As word gets out and physicians become more interested, the TMA will be called on to give an overview of the legal requirements and answer questions for physicians who are considering forming or joining ACOs,” he said.

**WHAT’S AN ACO?**

The term “accountable care organization” first surfaced in 2006, credited to health policy expert Elliott Fisher, MD, MPH, director of the Center for Population Health at Dartmouth Medical School. Since then, the concept has gained traction and culminated in inclusion as a new payment and delivery model in the health reform bill of 2010.

An ACO is an organization of healthcare providers that agrees to be accountable for the quality, cost and overall care of Medicare beneficiaries assigned to it. The ACO shares both risk and reward for saving healthcare costs and meeting quality benchmarks among the assigned patient population. The rewards depend on which of two models the organization chooses to follow – a full at-risk model with higher incentives, or a delayed-risk model with lower incentives. Beginning in January 2012, approved ACOs will sign contracts with the Medicare Shared Savings Program (MSSP) for periods of at least three years, and will agree to receive and distribute payments to participating providers and partners.

While it has been compared (both favorably and unfavorably) to or seen as a rebirth of the HMO (health maintenance organization), the ACO will be smaller in size, minimally required to exceed 5,000 patients by regulation, and reportedly more flexible – patients can still see the doctor of their choice, even those who are not part of the ACO.

TMA Immediate Past President B W. Ruffner, MD, has studied and written extensively for the TMA on health reform and ACOs. He said comparisons to the managed care organization (MCO) are already being made. “A lot of people have just assumed that’s what these are going to end up being.”

Dr. Ruffner said this new model should speed up the much-needed adoption of electronic health records (EHRs) and health information exchange (HIE) – something he championed during his tenure as president. CMS draft regulations require that at least 50 percent of physicians involved in an ACO must utilize EHR systems. “That makes all the sense in the world,” said Dr. Ruffner. “I don’t think it will be possible to have a well-functioning ACO unless the vast majority of your physicians have EHR. So their requirement is really pretty modest but at least it’s in there.”

**WHO’S ELIGIBLE?**

Under CMS proposed rules, eligible participants may include the following types of providers and suppliers of Medicare-covered services:

- Physicians and other professionals in group practices;
- Physicians and other professionals in networks of practices;
- Partnerships or joint venture arrangements between hospitals and physicians/professionals;
- Hospitals employing physicians/professionals; or
- Other forms the Secretary of Health and Human Services may determine appropriate.

To participate, an ACO organization must:

- Have a formal legal structure to receive and distribute shared savings;
- Have a sufficient number of primary care professionals for the number of assigned beneficiaries (5,000 at a minimum);
- Agree to participate in the program for not less than a three-year period;
- Have sufficient information regarding participating ACO healthcare professionals as the Secretary determines necessary to support beneficiary assignment and for the determination of payments for shared savings;
- Have a leadership and management structure that includes clinical and administrative systems;
- Have defined processes to a) promote evidence-based medicine, b) report the necessary data to evaluate quality and cost measures (this could incorporate requirements of other programs, such as the Physician Quality Reporting Initiative (PQRI),
The proposed rules state that ACO governing bodies must be made up of 75 percent Medicare enrolled providers or suppliers. This will allow large integrated multi-specialty practices or networks of practices to develop their own ACOs. If they want to, they can enter into formal legal relationships with hospitals, labs or other specialists needed to treat the number of assigned Medicare beneficiaries and meet the medical needs of the patients.

In Knoxville, the 220-physician Summit Medical Group meets the criteria and is already making preparations to form an ACO. The practice has filed the necessary legal paperwork; leased and outfitted 4,000 feet of office space; is moving toward full adoption of EHRs by the end of 2011; and has formed an entity called the East Tennessee Health Network (EHTN) to begin the work of establishing necessary partnerships with local hospitals and key specialists.

According to Summit Chief Medical Officer Randall Curnow, MD, the ACO concept fits the practice’s ongoing strategy of transitioning from a fee-for-service to a fee-for-value healthcare entity. Summit is already Tennessee’s first

Weigh In on ACO Proposed Rules*

The Centers for Medicare & Medicaid Services expects a significant number of public comments on the proposed ACO rule before the comment period closes at 5 p.m. June 6. All comments must refer to the rule’s file code, CMS-1345-P.

- Make comments online (www.regulations.gov). Follow the “Submit a comment” instructions and type “accountable care organizations” or “CMS-1345-P” in the “keyword or ID” field.
- Mail comments to: Centers for Medicare & Medicaid Services, Dept. of Health and Human Services, Attention: CMS-1345-P, P.O. Box 8013, Baltimore, MD 21244-8013
- Send by express or overnight mail to: Centers for Medicare & Medicaid Services, Dept. of Health and Human Services, Attention: CMS-1345-P, Mail Stop C4-26-05, 7500 Security Blvd., Baltimore, MD 21244-1850


recognition Patient-Centered Medical Home and one of the largest PCMH practices in the country.

“In addition to an ever-increasing focus on patient-centeredness, our medical home model has a strong emphasis on electronic infrastructure, clinical registries, active care management and improved support for our physicians. We feel those are really the paradigm shifts going on in health care in general,” said Dr. Curnow, adding that forming an ACO through the MSSP seems to be the best venue to take Summit’s fee-for-value focus to the next level.

MORE RISK THAN REWARD?

Summit’s ETHN Director Mike Barrett agreed. If done properly, he said the ACO model has the potential to realistically achieve the goals of lower cost and improved quality of care for Medicare patients. Both Barrett and Dr. Curnow, however, expressed concern over the proposed rules issued in March.

“Flatly, if what was recently produced for the regulations of the national program stand, we have concerns that it could
actually be done,” said Barrett. He cited the change from an anticipated 80/20 split of shared savings with Medicare to a more modest 50/50 split in the proposed regulations; a hefty increase in the required quality metrics that must be met, from an expected 10-30 over three years to 65; and a proposed requirement to have ACOs compete against their own margins rather than an established set of benchmarks.

“Essentially, groups that are very efficient entering the program would be penalized for their efficiency; those that are not efficient would be far more profitable,” explained Dr. Curnow, because they have more room for improvement. “If you’re graded against yourself and you’re already at 90-percent efficiency, you won’t get much money out and you’re not going to see much incentive from that.”

The overall risk-versus-reward scenario under the current regulations is not sustainable, both said.

“With the risk involved in year three, not only will doctors not get any upside while they are putting forth administrative costs – they will be losing money from that perspective – but if the costs and actual losses are greater than projected, the group will have to cut a check to CMS for the loss,” said Dr. Curnow. “This is a highly unanticipated and real burden for groups hoping to get involved. We’re hoping that with the loud cacophony of voices in the medical arena and the healthcare environment (saying) this is a bad idea, that they’ll hear that and remove that.”

Barrett said Summit will comment on the proposed rules, urging CMS to adjust the risk level and rewards as well as the performance standards to encourage involvement by groups at both ends of the efficiency spectrum. “We’re concerned that this is a real good idea that, as described, might not have enough people entering into it to make it viable at a national or federal level,” Barrett said.

The risk/reward ratio has been addressed by recent studies. A Commonwealth Fund report in April agreed that successful implementation of ACOs could lead to better care, better health and lower costs and recommended ways to ensure success, including streamlined and innovative payment models with timely payment that reward high performance.

Meanwhile, a March 23 study published online in The New England Journal of Medicine declared that most ACOs may lose money in the first few years. An analysis of the CMS Physician Group Practice Demonstration, which became the ACO pilot program, found that early adopters did not recoup their ACO costs and investments in the first three years of operation. Study authors concluded the model has potential but that final rules need to take into account the lessons learned in early projects.

A GOOD THING … IF WASHINGTON GETS IT RIGHT

Another statewide group preparing its members for ACO implementation echoed Summit’s concerns.

“We think the regulations are way too complex and definitely will need to have some significant changes,” said Craig Becker, president of the Tennessee Hospital Association. The THA will comment on problems with the proposed regulations, Becker said, adding the current payment model “doesn’t make a whole lot of sense” but there are other avenues, including capitation and bundled payments.

“Having said that, we are still encouraging our members to continue moving down the road of integrating physicians into this, making sure we’re partnering with them; and that our hospitals need to get their quality and patient safety issues in line, and also work on their costs.” Tennessee hospitals forming ACOs will likely work though the Center for Innovation at CMS, which offers funding and administrative assistance. Becker said the THA is also exploring a possible ACO partnership with BlueCross BlueShield of Tennessee, focusing on quality indicators.

Even if hospitals don’t become an actual ACO as defined by the federal government, Becker said the THA is pushing them to become “ACO-like.”

“I think that’s where we all need to be,” he explained. “I don’t think ACOs as defined by the CMS regs are going to
be the be-all and end-all; I really think there will be lots of options.” Whatever the options, he said they all point to a permanent shift in the way health care is delivered. “We have said hospitals must focus on their patient safety and quality; they have to integrate and partner with their physicians; and they’re going to have to get involved in serious process improvement to assure they can respond to any of these future challenges we’re going to have.”

Summit’s Dr. Curnow agreed.

“The statement ‘Change is coming’ is no longer accurate; change is here and the entire healthcare industry – that includes people paying for health care – needs to work together to create a new paradigm of care delivery that focuses on value for all the constituents involved,” he said.

“Moving forward, we hope the MSSP will adopt a sustainable model that will allow groups to participate in the opportunity to demonstrate value and be compensated and incentivized for providing such value. We remain cautiously optimistic that the MSSP is that avenue. We are very disappointed in the regulations we’ve seen so far. We will be moving in the direction of enhancing value with or without the MSSP, but certainly hope the new regulations will be congruent with sustainability goals,” said Dr. Curnow.

TMA RESOURCES

The TMA’s Yarnell Beatty said momentum has already kicked in for this new practice model and if successful, it will transform the delivery of health care in this country. For physicians, he said it could mean survival down the road.

“Physicians have to be cautious that if they’re left out of the process in certain markets, it could cut off access to a lot of patients,” Beatty said. “The ACOs will form alliances, they will accumulate the primary care doctors and specialists they need, and everybody else is going to be outside the ACO, meaning they’re going to have to find a competing ACO or thrive on their own under the current model – and that can be daunting.”

The TMA is working to summarize the proposed regulations by CMS and will comment by the June 6 deadline. Meanwhile, a new TMA Law Guide topic on accountable care organizations is available for members at www.tnmed.org/lawguide. Beatty added that TMA members have a valuable resource in the Legal Department; his staff offers consultation and analysis on what final ACO regulations will mean to their practice, as well as advice and resources on how to navigate the coming changes resulting from health system and regulatory reform. Contact the Legal Department at 800-659-1862 or yarnell.beatty@tnmed.org.
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Under the capable leadership of our Board President J. Mack Worthington, MD, the TMF in 2010 oversaw a total of 261 physicians currently under contract with the PHP or involved in aftercare. There are currently 142 participants enrolled in and being monitored by the urine drug screening program, 31 of whom are voluntarily enrolled post-contract.

Vince Parrish, LCSW, has taken a position as development director and coordinator of the worksite monitoring program; he also assists with fundraising. Field Coordinator Jeanne Breard manages the cases of 91 physicians currently under contract who do not have BME involvement, contacting each one quarterly and traveling statewide for face-to-face meetings twice a year in Memphis, Jackson, Chattanooga, Knoxville and Johnson City, as well as Nashville.

TMF PHP Administrator Mike Todd has been involved with the case management of 73 participants, most of whom require quarterly reports to the Tennessee Board of Medical Examiners. He is also involved in assisting participants with pre-board issues.

As medical director, in addition to the day-to-day operation of the program, I have been called on to educate medical professionals both statewide and abroad about the spectrum of services the Tennessee Physician Health Program provides. Our presentations have expanded from talking solely about alcohol and drugs to teaching about proper prescribing practices, appropriate professional boundaries, disruptive behavior in the workplace, and all aspects of professionalism. I serve on the State Commissioner’s Task Force on Physician Prescribing Practices, as a consultant and voting member of the FDA’s subcommittee on Drugs and Medical Risk Management, and as a consultant to the ONDCP (Office National Drug Control Policy) for the 2011 national drug control strategy.

As always, if you or a colleague need assistance the TMF or Physicians Health Program can provide, please contact Ms. Breard at 615-467-6411. To make a tax deductible contribution to the PHP, contact Mr. Todd at 615-467-6411, visit www.e-tmf.org or write to the Tennessee Medical Foundation, 216 Centerview Drive, Suite 304, Brentwood, TN 37027.

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It has been over a year since the Patient Protection and Affordable Care Act (ACA) became law, readying the way for sweeping changes to this country’s healthcare system. While you and your practice are no doubt working to keep abreast of the changes, you have also almost certainly taken note of the recent challenges to the constitutionality of the health reform law.

Although many portions of the law are controversial, the one opponents have used to challenge the law in federal courts is the individual mandate. This provision requires everyone who can afford to purchase health insurance to do so or pay a penalty to the IRS. Many believe the mandate amounts to an unconstitutional expansion of the federal government’s Commerce Clause powers.

The Commerce Clause of the U.S. Constitution gives Congress the power to “regulate Commerce among the several states.” Because the federal government has no general police power, it can only enact law under powers specifically granted to it by the Constitution — with one of the most oft-used such powers being the Commerce Clause. On the whole, the Supreme Court has been defining that power ever-broadly: a 1937 case held that any wholly intrastate economic activity that had a “substantial relationship” to interstate commerce would be deemed interstate commerce; even more, Wickard v. Filburn, decided in 1942, held that such wholly intrastate economic activity, even if private and of such a trivial nature that it could not possibly affect interstate commerce on its own, could be aggregated with the same private and trivial activities across the state to amount to an activity that Congress could control under the Commerce Clause. This judicial activism has been the rule, with very few exceptions, for the modern court as well; in fact, a decision in 2005 unequivocally reaffirmed Wickard.

ACTIVITY VS. NONACTIVITY

The President’s individual mandate, many argue, would extend the Commerce Clause past what should be its breaking point — from allowing the federal regulation of economic activity to allowing the federal government to proscribe economic inactivity. Opponents of the mandate assert that there is a difference between an individual being forbidden from taking specific action that could affect interstate commerce on one hand, and on the other, an individual being required to engage in an activity in order to positively affect interstate commerce. Under the ACA, citizens won’t be prevented from taking action that could harm interstate commerce — they will be forced to take economic action in support of the government. While the difference is subtle, it has proven salient: Judge Henry Hudson of Virginia has used such reasoning to strike down the mandate as unconstitutional, while upholding the rest of the ACA, and Judge Roger Vinson of Florida has taken it one step further, striking down the ACA as a whole — asserting (under principles of statutory interpretation regarding severability that are too complicated to delve into in this article) that the Act cannot stand without the individual mandate, which was intended to provide the market participation necessary for the law as a whole to succeed. Indeed, both sides of the issue have argued that the individual mandate is inextricably linked to the ACA’s requirement that insurers cover all applicants with pre-existing conditions.

CONSTITUTIONAL MANDATE?

It will ultimately be up to the Supreme Court to determine whether the individual mandate is constitutional and, if not, whether the ACA can still be found valid and enforceable once the mandate is severed from the Act. If the Court holds that the individual mandate is constitutional, the Act will stand unperturbed, save for potential amendments — some currently foreseeable, some not. If, however, the Supreme Court agrees that the individual mandate violates the Constitution but holds that the ACA can stand without the provision, things will become even more complicated. While the Court may decide the
(Continued on page 44)
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TMA
Tennessee Medical Association
Physicians Caring for Tennesseans
Tort Reform: Background and Case Studies

By Judith Regan, MD, MBA, JD, and Edward Hadley, JD

A tort is a private civil wrong or injury for which the law provides a remedy in the form of money damages. Tort suits consist of such actions as medical negligence, personal injury, bad faith and products liability claims. If the negligence or wrongful conduct of another party can be proven, the injured party may be entitled to monetary compensation from that party in the form of economic and non-economic damages. Economic damages compensate a victim for more easily quantifiable financial losses such as medical bills, lost wages, loss of household services and future medical expenses. Non-economic damages are damages awarded for injuries such as pain, suffering, loss of enjoyment of life, disfigurement and loss of consortium (affection and services of spouse, parent or child). These types of economic and non-economic damages are called compensatory damages and are intended to compensate an injured person for his losses. Punitive damages are another type of damages. Their two-fold purpose is to punish wrongful conduct and to deter others from engaging in similar conduct in the future. Punitive damages have been awarded by Tennessee’s courts for over 100 years. To recover punitive damages, an injured party must typically prove that a defendant intended to cause harm, or acted recklessly, fraudulently or maliciously. While punitive damages have not become commonplace in Tennessee, they have become prevalent in specific types of tort cases. They are more frequently awarded in the nursing home industry where claims of elderly abuse and reckless practice have been alleged, and in the trucking industry when drivers have a criminal record, a poor driving record, drug abuse histories or the company has followed reckless maintenance practices.

EXISTING TORT LAW

Tort reform has been enacted in various forms in a number of states. While an exhaustive review of the various forms is beyond the scope of this article, a brief review of tort reform in a few states serves as a reference for comparison with the tort reform bills proposed for Tennessee. Most tort legislation seeks to control non-economic and punitive damages. Some states focus on limiting damages in only certain types of tort cases; other states apply limits broadly to all types of tort claims. Mississippi, West Virginia and Texas have established laws that limit the amount of non-economic damages a plaintiff can receive. They are summarized in Table 1.

The Tennessee General Assembly is now considering placing caps on non-economic damages and punitive damages in all types of tort cases. Limits on damages recoverable in tort actions are not an entirely new phenomenon in Tennessee. As part of the Medical Malpractice Act of 1975, the legislature prohibited injured parties from stating to the jury a specific amount of money sought for non-economic damages in a medical malpractice action. Additionally, medical expenses recoverable in medical malpractice cases were limited by Tenn. Code Ann. § 29-26-119. This statute prohibits plaintiffs from recovering as damages medical expenses paid by health insurance or other third-party payor, unless the plaintiff actually paid premiums for the health insurance or the third-party payor held a right of subrogation for the charges for medical treatment regardless of whether the plaintiff paid the health insurance premium and regardless of whether there is a right of subrogation.

Prior to 1999, plaintiffs in Tennessee were also limited in the amount of damages they could receive in wrongful death tort cases. At that time under Tennessee law, plaintiffs could recover economic damages and pain and suffering damages in a wrongful death case, but could not recover damages for loss of consortium. In effect, this was a type of cap on non-economic damages in wrongful death cases because loss of consortium damages typically would be the type with the greatest monetary value. However, in the 1999 case of Jordan v. Baptist Three Rivers Hospital (984 S.W.2d 593(Tenn. 1999)), the Tennessee Supreme Court overruled precedent and determined that damages in a wrongful death case could include monetary damages for the loss of the deceased’s love, affection and consortium. This led to larger verdicts and made wrongful death cases without significant economic damages now profitable for attorneys to prosecute. Some proponents of tort reform point to large verdicts rendered since the Jordan decision as evidence of the need for tort reform in Tennessee (Table 2).

Notably, many of the largest verdicts are reduced by appellate courts or settled...
for lesser amounts while appeals are pending. Statistics show that although verdicts are larger in medical malpractice cases, they still remain infrequent. These numbers may also reflect the fact that large verdicts have tended to scare physicians into resolving cases merely due to the fear of facing a verdict exceeding their insurance coverage, rather than evaluation of the merits of the claims.

In Tennessee from 2005-2010, seven of the medical plaintiffs—3.4 percent of all those that went to trial—received 65.6 percent of the awards. By contrast, the other 96.6 percent of plaintiffs in these cases took 34.4 percent of the awards (Table 3).9

### SPECIAL FEATURE

**TABLE 1. State Caps on Non-Economic Damages.**

<table>
<thead>
<tr>
<th>State</th>
<th>Limit on Non-economic Damages for Medical Malpractice Cases</th>
<th>Number of Plaintiff Caps</th>
<th>Year of Implementation</th>
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<tbody>
<tr>
<td>Texas</td>
<td>The limit on non-economic damages for medical malpractice cases varies based on whether the defendant is a healthcare provider, including a physician, or a healthcare institution.</td>
<td>$250,000 per claimant cap applies to non-economic damages, regardless of the number of defendant providers.</td>
<td>Tex. Civ. Proc. &amp; Rem. Code Ann. § 74.301(a)</td>
</tr>
<tr>
<td>Mississippi</td>
<td>Mississippi has a cap of $500,000 on non-economic damages in medical malpractice cases.</td>
<td>$250,000 limit for non-economic damages, limit goes up beginning in 2004 according to inflation index. Physicians must carry at least $1 million malpractice insurance to qualify for limits.</td>
<td>Miss. Code Ann. § 11-1-60</td>
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<tr>
<td>West Virginia</td>
<td>The original definition of non-economic damages excluded damages for “disfigurement,” but an amendment applicable to actions filed on or after September 1, 2004, eliminates this exception. The amendment also clarifies that the cap applies to an entire claim, not separately for each defendant.</td>
<td>$250,000 limit for non-economic damages.</td>
<td>Miss. Code Ann. § 11-1-60</td>
</tr>
</tbody>
</table>

**TORT LEGISLATION**

Several tort reform bills are pending in the Tennessee legislature this session (Table 4). These bills are likely to be changed in any number of ways before ultimately being enacted. They apply to all tort cases and impose certain limitations on specific types of damages. At the time of publication, HB 2008/2009 appeared to be getting the most legislative attention.

Proponents of these tort reform bills argue that caps on damages will lead to a fairer, more just system and boost the state economy.10 They maintain that the size and frequency of large jury awards and settlements in medical malpractice cases is behind the rapid increase in malpractice insurance premiums and the rising costs of healthcare. It is not necessarily large verdicts in tort cases that drive up healthcare costs, but proponents argue that physicians are required to practice defensive medicine to protect themselves from future possible lawsuits, therefore leading to additional tests that may not be clinically indicated. They also maintain that high malpractice rates are driving physicians out of business or prompting them to move to states which have laws capping malpractice awards. In general, proponents assert that caps on damages are becoming excessive, citing Ernst v. Merck (No. Civ.A.H-02-3490, 2002 WL 3443652 (S.D. Tex. Oct. 23, 2002)). In Ernst v. Merck, a Texas Vioxx products liability case, the jury issued a verdict of $24 million in non-economic damages for a widow of a 59-year-old triathlete who died from arrhythmia, which the plaintiff alleged could have been prevented had Merck provided warnings about the drug. Tort reform supporters criticized the award as excessive because the widow had not been married to the decedent very long.

Opponents argue that caps will harm those patients who suffer the most damage and who need help the most, and that payments for medical malpractice claims are not the underlying cause of rapidly increasing malpractice premiums or higher healthcare costs. They also argue that under our legal system, the amount of damages should be determined by a jury of peers not by the government.11

Texas, Mississippi and West Virginia have stated that the effects from caps on non-economic damages have led to the following positive developments in their states:

- Reduced medical malpractice liability insurance premiums for physicians;
- Increased physician recruitment and retention; and
- An increase in the number of businesses coming into the state.12

On the other hand, critics point to several studies conducted after California enacted its 1975 law limiting non-economic damages. These studies found the following negative impacts on injured persons:

- The most severely injured patients...
TABLE 2. Top Verdicts by Type of Tort Case in Tennessee, 2005-2010.7

<table>
<thead>
<tr>
<th>County</th>
<th>Type of Case</th>
<th>History of Case</th>
<th>Amount of Verdict</th>
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<tr>
<td>Davidson</td>
<td>Products Liability</td>
<td>An infant a rear seat passenger in a Chrysler minivan was killed when the seat in front of him collapsed onto him.</td>
<td>$105,500,000</td>
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<tr>
<td>Shelby</td>
<td>Medical Malpractice</td>
<td>A young woman (24) reported a lump in her breast to her OB/GYN. The doctor thought it was nothing. Months later the plaintiff was diagnosed with terminal cancer.</td>
<td>$23,600,000</td>
</tr>
<tr>
<td>Fed Chatt.</td>
<td>Medical Malpractice</td>
<td>Suffering a broken leg in a serious car accident, plaintiff was hospitalized. She left the hospital paralyzed from the waist down.</td>
<td>$22,266,261</td>
</tr>
<tr>
<td>Davidson</td>
<td>Medical Malpractice</td>
<td>Pediatric surgeon botched a scrotal surgery and removed almost all of an infant’s bladder.</td>
<td>$16,400,000</td>
</tr>
<tr>
<td>Bradley</td>
<td>Nursing Home Abuse</td>
<td>Global neglect was alleged in a case involving an elderly nursing home patient. While the jury awarded $10 million in punitive damages, the trial court has since ordered a new trial.</td>
<td>$11,500,000</td>
</tr>
<tr>
<td>Davidson</td>
<td>Auto Negligence</td>
<td>The defendant drank to excess at a bar and then crashed into the plaintiff. The plaintiff was left a paraplegic by the impact.</td>
<td>$7,234,787</td>
</tr>
<tr>
<td>Warren</td>
<td>Medical Malpractice</td>
<td>Presenting to the emergency room with signs of a stroke and triaged only by a nurse, the plaintiff was discharged. Within hours, he was dead of a stroke.</td>
<td>$7,206,907</td>
</tr>
<tr>
<td>Shelby</td>
<td>Premises Liability</td>
<td>Fall on a slick mall floor, brain injury sustained.</td>
<td>$4,000,000</td>
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had the greatest reduction in damage awards;
• Verdicts for injuries such as deafness, numbness, disfigurement and chronic pain which do not impair physical functioning or cause wage loss or high healthcare costs were virtually wiped out by the cap; and
• Women and elderly individuals suffered the most significant disparate impact from the caps because they typically have the lowest value economic damages.15

To illustrate the effect of caps on plaintiff’s awards, listed below are some examples of monetary damage awards under the proposed legislation HB 2008/SB 1522.

EXAMPLE 1
Ms. X is a 40-year-old housewife with no college education. After marrying she decided not to pursue further education or a career but to stay at home and raise a family. Ms. X was prescribed a new medication for upper respiratory infections. After several doses, she developed a severe side effect from the medication that had been recognized during clinical trials. This disorder caused a scalding like condition to her skin that resulted in her hospitalization. She remained in significant pain, eventually succumbing to the complications from the disorder within two weeks of her diagnosis and admission to the hospital. Her children, six and eight years of age, who also witnessed their mother’s condition, have been diagnosed with post-traumatic stress disorder and are unable to sleep or function well at school since her death. The family has sued the drug manufacturer for placing a defective and dangerous product on the market without sufficient clinical trials and has sued the physician who prescribed the medication for prescribing it without attempting alternative treatments first.

Damages claimed are:
• Economic losses: 1) medical bills of $90,000 related to her two-week hospitalization for this injury; 2) loss of earning capacity of $485,000 if she returned to work through her work life expectancy; and 3) value of loss of household services $325,000.
• Non-economic losses: 1) children’s and husband’s claims for loss of consortium and any emotional injury; and 2) Mrs. X’s claims for pain and suffering and disfigurement before her death.

Assuming Mrs. X prevailed at trial, there is no damage limit under existing law. Loss of consortium damages of about $1 million for the spouse and each child have been awarded in these types of cases. Thus, a verdict in the range of $4 million is a reasonable possibility.

Under the proposed legislation, the maximum damage award would be $1.65 million. The non-economic losses (claims of the patient, husband and children for pain and suffering, loss of consortium, loss of enjoyment of life, disfigurement, negligent infliction of emotional distress, etc.) are capped at $750,000. Although there are two defendants (drug manufacturer and physician), this action would be a healthcare liability action and the cap of a single limit per occurrence would apply. The damages for economic losses (medical bills, loss of earning capacity, and loss of household services) total $900,000 and are not capped.

Notably, if this case was not a healthcare liability action and the deceased had been killed by a driver, then the maximum damage award would be $3 million – each plaintiff would be permitted a recovery of $750,000.14

EXAMPLE 2
Mr. Y is 64 years of age. He recently retired from a factory blue-collar position because decreased mobility prevented him from performing the physical demands of the job. Mobility limitations preclude him from meaningful work, although he has no serious health concerns affecting his life expectancy. He and his wife of 40 years live alone in Nashville, TN. They have several
children and grandchildren who live out of state. After saving for 20 years, they have purchased a small motor home and plan to spend the next several years traveling and enjoying their golden years together. Mr. Y was involved in a car accident when the other driver ran a red light. The other driver is a wealthy businesswoman known in the community and listed in business magazines as one of the wealthiest individuals in the United States. She ran the red light because she was driving under the influence of alcohol. Mr. Y suffered serious injuries and died in the emergency room from complications of the accident injuries. Mrs. Y has suffered from depression as a result of the loss of her husband of 40 years and their retirement dream. Mrs. Y sued the negligent driver and the country club for wrongful death, seeking compensatory and punitive damages.

Damages claimed are:
- **Economic losses**: medical bills of $5,000 for EMS transport and ER treatment. No significant damages can be shown for loss of earning capacity due to the deceased’s retirement, age, and limited physical capacity for work.
- **Non-economic losses**: 1) Mrs. Y's claim for loss of consortium and emotional injury; and 2) claims for pain and suffering of Mr. Y.

Assuming Mrs. Y prevailed at trial, there is no limit under existing law. Several factors will motivate a jury to give a large award: 1) the emotional component of the lost retirement dream; 2) the drunkenness and wealth of the driver; and 3) one defendant is an exclusive country club with significant assets, insurance, and wealthy members. These types of facts typically anger a jury and often result in verdicts of compensatory damages alone in the tens of millions of dollars or more.

Under the proposed legislation, the maximum damage award for compensatory damages would be $1,505,000 ($750,000 x two defendants plus $5,000 in economic damages). Notably, most tort lawyers charge a contingency fee equal to one-third of the total damage award plus typical litigation expenses. Punitive damages, if proven and awarded, would not exceed $500,000. For comparison, under the other two proposed bills, HB 0183/SB 0938, the maximum damage award would be $6,865,000. Due to the apportionment of fault between the cardiologist and bypass surgeon, the cardiologist would be responsible for 70 percent of the verdict, or $4,805,500. The bypass surgeon would be responsible for 30 percent of the verdict, which equals $2,059,500. These damages remain significant in spite of the caps. Notably, juries appear to award less money to wealthy individuals in spite of proof of loss.

**EXAMPLE 3**
Mr. Z is a 52-year-old electrical engineer and businessman in Nashville, TN. For the past 20 years, the manufacturing company he owns has continued to expand its product line and customer base in spite of foreign competition. Industry analysts project continued growth and success due to Mr. Z’s innovation and ability to create unique, patent protected product lines. Unfortunately, his success and lifestyle have led to poor cardiac health. During a multiple artery stenting procedure, he experiences a perforation of the aorta and is rushed to surgery; he dies in surgery when grafting attempts fail. He is married and has four minor children. Mrs. Y sues the cardiologist performing the stenting procedure and the surgeon performing the bypass procedure. The case is tried before a jury, and the jury apportions fault — 70 percent to the cardiologist and 30 percent to the bypass surgeon.

Damages claimed are:
- **Economic losses**: 1) medical bills of $115,000 for the stenting procedure and bypass surgery; and 2) Mr. Z’s projected loss of earning capacity of $6 million.
- **Non-economic losses**: 1) Mr. Z’s claims for pain and suffering; and 2) Mrs. Z’s and the children’s claim for loss of consortium and any emotional injuries resulting from Mr. Z’s death.

Under existing law, there is no limit. Under the proposed legislation, the maximum damage award would be $6,865,000. Due to the apportionment of fault between the cardiologist and bypass surgeon, the cardiologist would be responsible for 70 percent of the verdict, or $4,805,500. The bypass surgeon would be responsible for 30 percent of the verdict, which equals $2,059,500. These damages remain significant in spite of the caps. Notably, juries appear to award less money to wealthy individuals in spite of proof of loss.

These examples illustrate that damage awards can vary broadly, based on factors not inherently related to the damages. For example, a loss can be significantly impacted by whether the defendant is a healthcare provider and the number of defendants involved. They also illustrate that large verdicts may still result when the value of economic damages, such as loss of earning capacity, loss of household services and medical expenses, is high.
If caps of any form are enacted, the landscape of tort litigation will change. Defendants in some cases will not feel pressured to settle claims solely to avoid the risk of financial ruin. On the other hand, some claims may no longer be economically viable for personal injury attorneys to pursue. However, the legal profession has historically tended to adapt to changes in the law. Their first response will most likely be a challenge to the constitutionality of any tort reform legislation enacted. However, before loss of consortium damages were recoverable in wrongful death cases, injured parties frequently hired economists to quantify damages for loss of earning capacity and loss of household services to circumvent the caps. For example, a cause of action under the Tennessee Consumer Protection Act has been allowed against a physician arising out of a surgery. The Tennessee Consumer Protection Act (TCPA) allows recovery of treble damages and attorneys’ fees, which are not typically recoverable in tort actions. Because the TCPA allows treble damages, it would specifically conflict with the reform legislation capping punitive damages at two times the compensatory damages. Although a TCPA claim would appear to be a type of tort action because it is based on conduct such as fraud, it is not clear whether a court would interpret any of the recently introduced tort reform bills to supersede the specific causes of action and damage remedies of the TCPA. Thus, the Tennessee Supreme Court’s interpretation of any tort reform legislation enacted will impact its effectiveness.

Although the pending legislation contains notable differences, enactment of tort reform in Tennessee will most likely eliminate the staggering few verdicts of tens or hundreds of millions of dollars. However, total damage awards are still likely to fall into the range of $1 to $3 million in many cases. Although the threat of financial ruin may be decreased through tort reform, practitioners and businesses will want to maintain insurance coverage or reserves commensurate with their exposures under any tort reform legislation.

References:
1. Workers’ Compensation claims are not included although a type of tort. Workers’ Compensation claims have long been subject to a type of cap determined through a formula based upon the body part injured, the degree of physical and vocational impairment resulting from the injury, and the worker’s average weekly wage at the time of the injury.
LEGAL CHALLENGES TO FEDERAL HEALTH REFORM ADD TO UNCERTAINTY
(Continued from page 37)

ACA can legally be implemented sans the individual mandate, implementing the ACA without this provision will likely prove difficult in principle. Without the mandate, insurance companies will be in a position of having to cover everyone who applies, quite often at a loss, without the off-setting profitability, healthy patients that would have been provided by the individual mandate. Of course, these losses will be passed on to consumers as higher premiums – premiums which, without the individual mandate, may encourage healthy individuals who are insured to forgo coverage, leading to still higher premiums.

Finally, if it is decided the mandate is unconstitutional and cannot be separated from the ACA as a whole, it will obviously be back to the legislative drawing board. Who’s ready for another round?

References:

The Court opined that labor purely intrastate labor disputes can be regulated by Congress if the activity (here, manufacture of steel) has a significant effect on interstate commerce.

2. Wickard v. Filburn, 317 U.S. 111 (1942). This case held that the federal government could regulate the amount of wheat a farmer could grow for home consumption, because even though the farmer was growing wheat for his own use, the fact that he would, as a result, not purchase wheat on the open market has a substantial effect on interstate commerce when you consider what would happen if everyone grew wheat for home consumption instead of engaging in commerce.

3. The two well-known exceptions to expansion of the Commerce Clause by the Supreme Court are United States v. Lopez, 514 U.S. 549 (1995), and United States v. Morrison, 529 U.S. 598 (2000). In Lopez, the Court struck down the federal Gun-Free School Zones Act, holding that the government’s commerce power would not allow federal regulation of possession of handguns locally, specially where there can be no clear nexus shown between such possession and the interstate economy. Morrison held that provisions of the federal Violence Against Women Act that authorized a federal remedy to victims of gender-motivated violence were similarly unconstitutional expansions of the commerce power.

4. Gonzales v. Raich, 545 U.S. 1 (2005), held that Congress can criminalize the production and use of home-grown marijuana—utilizing essentially the same reasoning as that of Wickard v. Filburn.


For example, should the Court determine that the individual mandate is constitutional, President Obama has already stated an intent to back a proposal by members of Congress to allow states to opt out of a number of ACA’s requirements as they become effective, including the individual mandate, so long as the states can provide the same benefits to citizens through other means.

Ms. Shields is assistant government affairs director for the TMA. Contact her at ashley.shields@tnmed.org or 800-659-1862.

SPECIAL FEATURE

6. Davidson v. Severson, 72 S.W. 967 (Tenn. 1903).


Dr. Regan is an associate with North Pursell Ramos & Jameson, PLC, in Nashville; Mr. Hadley is a partner with NPRJ, with a practice that includes defending physicians in malpractice and licensure actions.
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Diabetic Ketoacidosis Presenting with Acute Pancreatitis and Visceral Vein Thrombosis

By Nicole Pant, MD; Dipen Kadaria, MD; Wael Nasser, MD; Luis C. Murillo, MD; and Amado X. Freire, MD, MPH, FACP, FCCP, FCCM, FAASM

ABSTRACT
Abdominal pain is a frequent manifestation in patients presenting with Diabetic Ketoacidosis (DKA). Usually it is attributed to severe metabolic acidosis but it can be due to underlying abdominal pathologies (i.e., pancreatitis, appendicitis). We report a case of a 19-year-old female who presented with DKA and severe abdominal pain and was found on further examination to have underlying pancreatitis and visceral vein thrombosis. The patient improved with treatment for the mentioned co-morbidities, including anticoagulation.

INTRODUCTION
Diabetic Ketoacidosis (DKA) is a frequent reason for hospital admission and so is acute pancreatitis (AP). A significant number of patients with DKA present with abdominal pain. This pain can be due to underlying severe metabolic acidosis or due to concurrent abdominal pathology.1 A high index of suspicion should be kept for abdominal pathologies like pancreatitis or appendicitis as a cause of abdominal pain in patients presenting with DKA and severe abdominal pain. Further, AP can be an abdominal manifestation of antiphospholipid syndrome (APS) and pancreatitis has been reported to cause portal vein and splenic vein thrombosis. We report a case of a 19-year-old female who presented with DKA and was found to have AP along with portal, splenic and superior mesenteric vein thrombosis.

CASE REPORT
A 19-year-old African-American female known to have multiple sclerosis and type 1 diabetes mellitus presented with nausea, vomiting and abdominal pain for three days, with constipation for the last two. The patient gave a history of being compliant with her medications including insulin. Past medical history was negative for pancreatitis, venous, or arterial thrombosis. On examination, blood pressure was 142/83 mm/Hg, pulse rate was 144 bpm, respiratory rate was 20 and she was afebrile. Further physical examination revealed signs of dehydration, abdominal tenderness and absent bowel sounds. Initial laboratory results showed blood sugar of 560 mg/dL, an anion gap of 26 and urine and serum positive for ketones. Her ABG showed pH of 7.32, pCO2 of 21, pO2 of 127 and bicarbonate of 11. Our patient also had elevated lipase 534 U/L and amylase 224 U/L. Patient was started on treatment for DKA.

Because of significant abdominal tenderness, a CT of the abdomen was done to evaluate other causes for abdominal pain. It showed pancreatic necrosis, hepatic infarction and portal, splenic and superior mesenteric vein thrombosis.

FIGURE 1. CT scan of abdomen showing portal vein thrombosis and pancreatic necrosis.

FIGURE 2. CT scan of abdomen showing hepatic infarction.
thrombosis; the CT scan and USG of abdomen were negative for gallstones. The patient was started on anticoagulation for her portal vein thrombosis. Causes for hypercoagulability were sought and she was found to be positive for lupus anticoagulant. Anticardiolipin antibody, Antiglycoprotein antibody, ANA and RA were all negative. The patient improved with the treatment provided. Follow-up CT scans at three weeks showed patency of her visceral veins. She was discharged home in stable condition.

**DISCUSSION**

Patients with DKA can present with abdominal pain, which is believed to be caused by the underlying severe metabolic acidosis and is expected to improve once acidosis resolves. Further investigation for pain is recommended if it is severe, persists after resolution of acidosis or is present without severe acidosis.1 Abdominal pain in these patients can be caused by other conditions (i.e., acute pancreatitis (AP), appendicitis, gastritis, or gastroparesis)2 which need to be considered, sometimes even before resolution of acidosis.

The association between DKA and AP has been reported previously. According to the literature, DKA may mask a coexisting AP in up to 10 percent of cases.3 The presence of abdominal pain and non specific hyperamylasemia in cases of DKA may be the reason for overlooking AP. The pathogenesis of AP in DKA is not well explained. Hypertriglyceridemia, which can occur during DKA, has been implicated as one possible cause.4 Usually AP was seen more commonly in patients of DKA with severe metabolic acidosis (low pH and high anion gap).3

AP has been reported as one of the abdominal manifestation of Anti-Phospholipid Syndrome (APS)5 and is also considered a cause for visceral vein thrombosis, especially portal vein thrombosis.6,7 Our patient had AP in her presentation with DKA; her CT scan showed portal, splenic, superior mesenteric vein thrombosis in addition to pancreatic necrosis and hepatic infarction. She was also found to be positive for lupus anticoagulant. We do not know the precipitating cause for her pathologies but this case also suggests consideration of APS and visceral vein thrombosis in cases of AP. Early initiation of anticoagulation in visceral vein thrombosis has shown to improve outcome.8 No relationship between DKA and APS was found in the literature.

In this case, we were confronted with challenging decision of starting anticoagulation in presence of pancreatic necrosis. Her pH also suggested at least one another metabolic derangement present, apart from DKA, which might be early Diabetic Ketoalkalosis due to repeated vomiting.

**CONCLUSION**

Clinicians need to have a high index of suspicion for an underlying abdominal pathology in patients presenting with DKA and severe abdominal pain. Early diagnosis and treatment of comorbid conditions can improve outcome.

**References:**


Dr. Pant is an Internal Medicine resident; Drs. Kadaria, Nasser and Murillo are with the Division of Pulmonary, Critical Care, and Sleep Medicine; and Dr. Freire is professor and chief of the Division of Pulmonary, Critical Care, and Sleep Medicine.
Asymptomatic Colonic Histoplasmosis in a Patient Receiving Methotrexate

By Randy O. Odero, MD; Kerry O. Cleveland, MD; John H. Webb, MD; and Mack A. Land, MD

ABSTRACT
Disease due to infection with *Histoplasma capsulatum* usually manifests as a disseminated infection in patients with the Acquired Immunodeficiency Syndrome (AIDS). However, it may also present with focal disease in patients with or without AIDS. Unusual presentations or less well-recognized risk factors may make diagnosis of histoplasmosis more difficult. We describe the case of a patient who presented for screening colonoscopy and was found to have isolated asymptomatic colonic histoplasmosis.

CASE REPORT
A 72-year-old patient presented for preventive screening colonoscopy. There was a history of orally controlled diabetes mellitus, osteoarthritis treated with nonsteroidal anti-inflammatory drugs (NSAID), and an idiopathic skin disease (presumed to be of autoimmune nature) treated with methotrexate 5 mg orally weekly for the preceding 13 years. There were no complaints and fever, weight loss, cough and change in bowel pattern were denied. Physical examination was unremarkable, as were the results of a complete blood count and serum multichemistry panel.

Colonoscopy revealed diffuse, patchy aphthous ulcerations and multiple diverticuli, but no active bleeding (Figure). Biopsies of the sigmoid colon and rectum were obtained. The patient's NSAID use was discontinued, as it was felt the diffuse aphthous ulcers of the colon might represent nonspecific colitis due to the NSAID.

Examination of the biopsy specimens revealed colonic mucosa with distortion of the crypt architecture, focal ulceration, neutrophilic cryptitis and poorly formed granuloma. Gomori-methenamine silver and periodic acid-Schiff stains demonstrated budding yeast consistent with Histoplasma.

Therapy with itraconazole 200 mg orally twice daily for one week, followed by itraconazole 200 mg orally once daily, was begun and continued for six months. Use of methotrexate was stopped. Endoscopy of the esophagus, stomach and duodenum was unremarkable. Chest radiograph was normal. Antigen to Histoplasma was not detected in the patient's urine. Serum antibodies to Human Immunodeficiency Virus were not detected.

A colonoscopy was repeated seven months after diagnosis and the lesions were noted to have completely resolved. The patient has done well for the past two years without evidence of recurrent histoplasmosis.

Histoplasmosis is an endemic mycosis caused by *Histoplasma capsulatum* (HC), a dimorphic, saprophytic fungus endemic to the soil in the Ohio and Mississippi river valleys. Infection is acquired through inhalation and subsequent spread in macrophages throughout the reticuloendothelial system. Individuals with intrinsic or extrinsic defects in cell-mediated immunity are susceptible to developing disseminated disease. Important predisposing conditions include acquisition in infancy, acquired immunodeficiency syndrome (AIDS), solid organ transplantation, administration of immunosuppressive agents such as corticosteroids or tumor-necrosis factor antagonists, hematologic malignancies, and various forms of congenital T-cell deficiencies. There have also been reports of histoplasmosis in patients with no known immunodeficiency. A few reports have been published of histoplasmosis in patients receiving low-dose methotrexate.

Methotrexate is a disease-modifying antirheumatic drug (DMARD) used in the treatment of various rheumatological diseases. The complete mechanism of action of this drug is unclear. Immunologic abnormalities in humans receiving low-dose methotrexate are not well described.

While gastrointestinal (GI) involvement is common in disseminated disease (HC is identified in 70 to 90 percent of patients with progressive disseminated histoplasmosis who undergo autopsy), GI disease is rarely identified during life, causing symptoms in only three to 12 percent of affected patients. Histoplasmosis may involve the entire GI tract.
from the oral mucosa to the rectum but is found most commonly in the terminal ileum, presumably because of abundant lymphoid tissue in the form of Peyer’s patches. Endoscopic findings may include erythema, ulcerations, mass lesions, perforation or intestinal obstruction.

Presenting clinical symptoms may include abdominal pain, fever, weight loss or diarrhea. Patients may also present with gastrointestinal hemorrhage, obstruction or perforation. Endoscopic findings may be incorrectly attributed to inflammatory bowel disease.

Detection of Histoplasma antigen, especially in the urine, may aid in the diagnosis. False-negative urine antigen testing may result from focal dissemination of disease. Most data related to antigen detection is from studies of disseminated histoplasmosis in AIDS patients.

Treatment guidelines do not contain specific recommendations for focal intestinal involvement with histoplasmosis. Treatment based on recommendations for disseminated histoplasmosis or focal pulmonary disease seems reasonable but the choice and duration of therapy may need to be adjusted, based on the individual clinical case.

References:

Drs. Odero, Cleveland and Land are with the Division of Infectious Diseases, Department of Medicine, University of Tennessee Health Science Center, Memphis, TN. Dr. Webb is with Gastroenterology Associates of North Mississippi, Oxford, MS.

Acknowledgements: No financial support was available, No conflict of interest exists, and no off-label or research drug was used.

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The Tennessee Medical Association Alliance met on April 15-16, 2011 for our annual meeting in conjunction with the TMA convention. This meeting is our opportunity to install the new slate of officers. The new TMAA president for 2011-2012 is Mrs. Barbara Blanton from Shelbyville, TN in Bedford County. She is married to Dr. Ted Blanton, a retired otolaryngologist. They have three children and seven grandchildren. They are both from Mississippi. Barbara served as a Republican state senator in Mississippi from 1988-1992; she has been involved in the medical alliance in Mississippi and Tennessee, and the Southern Medical Association Alliance. We know her experience from the past will help lead the TMAA this coming year. Please welcome Barbara as our new TMAA president.

The annual meeting this year had several great opportunities for the Alliance members. The TMA invited alliance members to join its keynote luncheon, “Improving Tennessee’s Health,” with guest speaker U.S. Senator Bob Corker. TMA President Dr. B.W. Ruffner and the TMA also invited alliance members to the president’s reception on Saturday evening. Alliance members who are also members of the Independent Medicine’s Political Action Committee-Tennessee (IMPACT) members were also invited to attend the IMPACT dinner following the reception. The speakers for this dinner were U.S. Congressman Phil Roe and Tennessee Speaker of the House State Rep. Beth Harwell. What a privilege to have this opportunity as an Alliance member. The message I took away from all of these events is how important it is for physician spouses to be involved in legislation that pertains to medicine and how physicians practice.

During our own annual meeting, we heard reports from Gary Zelizer and Julie Griffin, the TMA government affairs staff, who brought us up to date on important legislation. Mike Todd of the Tennessee Medical Foundation also shared information about the TMF and how important it is to support this organization. I urge you as physicians to continue to share information with your spouse on these important subjects and areas that concern physicians. Another important function during the alliance’s annual meeting is the awarding of Health Grants from our Health Promotions Committee. This year we were able to make awards to all the requested grant projects. I feel certain we are making a difference in the health of Tennesseans through this program. It is through the generous support of the TMA that we are able to award these grants.

Many of you know of the success the TMAA has had over the past 35 years raising money for the AMA Foundation; this year was no different – we once again did an excellent job. As of March 1, 2011, we had raised $52,619 through donations to the annual TMAA Sharing Card. These gifts go solely to support medical student scholarships, and we appreciate the generosity of physicians and their spouses across the state. THANK YOU!

I want to end with the message I have shared many times this year: membership. Without members, we cannot do the work in all the other areas the alliance is involved in. This is true for the TMA as well. Take every opportunity you have to ask your colleagues to join the TMA and encourage them to get their spouses to join the TMAA through their local alliance. Together, the TMA and TMAA can make a difference in the House of Medicine and the health of Tennesseans!
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IN MEMORIAM

JAMES W. LIMBAUGH, MD, age 78. Died March 31, 2011. Graduate of University of Tennessee Health Science Center. Member of Montgomery County Medical Society.

SANDEFORD JULIUS SCHAEFFER, JR., MD, age 89. Died April 1, 2011. Graduate of University of Tennessee Health Science Center. Member of The Memphis Medical Society.

MICHAEL KOSANOVICH, MD, age 76. Died April 7, 2011. Graduate of Indiana School of Medicine. Member of Chattanooga-Hamilton County Medical Society.

DAVID T. WATSON, MD, age 76. Died April 11, 2011. Graduate of University of Tennessee Health Science Center. Member of Knoxville Academy of Medicine.

CORRECTION

TMA members Larry Todd Breeding, MD, and Alan Lee Cox, MD, both of Johnson City, were incorrectly listed as new members from Sullivan County Medical Society in the April issue of Tennessee Medicine (Vol. 104, No. 4, page 45). The list should have read:

SULLIVAN COUNTY MEDICAL SOCIETY
Maria L. Becka-Fitzpatrick, DO, Kingsport
Michael P. Kauzlarich, DO, Kingsport
David W. Marden, DO, Bristol
Jeffrey Dale Sargent, MD, Kingsport
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Tennessee Medicine regrets the error.
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