2012 ELECTIONS
What Do They Mean For MEDICINE?

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The Journal:
Situs Inversus
Cesarean Delivery & BMI

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During my final year of medical school I had the wonderful experience of spending an elective semester in England studying endocrinology. Additionally, I learned first-hand the benefits and drawbacks of a socialized healthcare system and have been able to compare and contrast that system in the United Kingdom to ours in the United States.

The Brits seemed quite happy with their socialized medical system. Everyone had access to care, although it was with the family physician they were assigned to. They did not pay a fee at the time of service, but every working person paid high taxes for the privilege of that service. The care was adequate, but our attending physician only worked three days a week in the clinic and hospital. He spent the other days in a cash-only private clinic. The care was provided in his absence by the registrars (residents) and house staff comprised of trainees and students.

My training there consisted of drawing blood on patients assigned to me by the registrar, followed by performing complete histories and physicals on all the new patients admitted to the hospital. Three days a week I saw patients in the endocrinology clinic. Every patient had an appointment time of 8:30 am, even though we did not begin seeing those patients until 1:00 pm. This allowed the patients’ laboratory work to be completed by the time we began seeing them. If a patient missed their appointment for any reason, they were re-scheduled for one 90 days later and were not allowed to go to another physician within the National Health Service or to an emergency room without permission from their assigned Family Physician. Patients over 45 years old who were in renal failure were not allowed to receive hemodialysis, and patients who were active smokers were not allowed to have coronary artery bypass graft surgery.

Regardless of one’s political persuasion, employment status or philosophy on life, it would be difficult to deny that the American healthcare system is headed toward a more socialized method of delivery. Spending less of our tax dollars is the main goal and improving access is a secondary goal, all while attempting to improve the quality of the care that is delivered.

Our federal government has provided healthcare funding for over a half of a century through various programs to the impoverished, the aged, the disabled, active and retired military, native Americans, federal government workers, and railroad workers. Now our federal government is evolving into a provider of health care for everyone who resides in the United States via the Patient Protection and Affordable Health Care Act (PPCA). For those who currently have poor access to healthcare, the PPCA provides a means to improve their lot in life. However, in order to achieve that improvement, the changes to the system will be staggering.

Here are some of those changes:

2010 – Medicare payments to physicians in primarily rural areas and hospitals in low-cost areas received increased payments for two years. Medicare payments to inpatient psychiatric hospitals were reduced. Insurance plans were mandated to cover most preventive care. Hospitals in “frontier states” (ND, MT, WY, SD, UT) received higher Medicare payments for up to five years.

2011 – Medicare payments to Medicare Advantage plans, home health, long-term care hospitals, ambulance services, ambulatory surgical centers, diagnostic laboratories and durable medical equipment suppliers were reduced. Medicare reimbursement cuts for diagnostic imaging began. Medicare payments to new physician-owned hospitals were prohibited. A Medicare bonus payment of 10 percent over five years was instituted for primary care and general surgery. Additional funding for community health centers over five years was begun.

2012 – Additional Medicare payment cuts to hospitals began. Medicare payment cuts to nursing homes and inpatient facilities, and for dialysis treatment began. Medicare reduced spending by using an HMO-like coordinated care model (Accountable Care Organizations). New Medicare payment cuts to inpatient psychiatric hospitals were instituted.

2013 – 159 new agencies and programs will be created by the PPACA. Hospital pay-for-performance programs will start. Medicare payment cuts to hospitals with high readmission rates begin. Medicare payment cuts for hospice care begins. Medicare payment cuts to hospitals that treat low-income seniors begin.

(Continued on page 9)
Most physicians enter the profession with a singular motivation: to help others.

Physicians must prove their commitment to that ideal by withstanding years of training and work demands that test their resolve at every turn. And while our medical system often reveals their personal strengths, it also can expose the fragile nature of their humanity.

I have learned ...

"I have learned it is all right for doctors to ask for help, for we are human beings also - sometimes faulty ones, but still humans."

– R.B., M.D.

Tennessee Medical Foundation

Roland W. Gray, M.D., Medical Director

216 Centerview Drive, Suite 304 • Brentwood, Tennessee 37027 • (615) 467-6411
This issue focuses on the impact of politics and the November 2012 election. Change will occur in the United States, and in U.S. medicine. Projections of the U.S. government’s debt (our debt), and projections of how medical care will consume an increasing percentage of the U.S. Gross Domestic Product guarantee that change will occur.

I write this a day after Barack Obama’s re-election but reflect more on October, when I attended my 40th year medical school class reunion. My ex-classmates and I recalled that we were taught the “ulcer diet” to treat upper GI symptoms, that we learned to manage heart failure with digitalis and diuretics in patients who had had internal mammary artery ligation (not IMA grafting, but simply the now refuted ligation), and that we had first generation sulfonoureas and beef or pork insulin to manage diabetes. Change occurs, and many times it improves our lives, and our patients’ lives.

I recalled being a medical student and going to the medical school library. I would look up a topic, go to the “stacks,” find the journal I sought in a bound volume, and try to pry open the volume enough that the pages would fit flat enough on the photocopier to permit copying all the words in the article. Forty years later I returned to the medical library to see what had changed. On a Friday, medical school students were there with nametags on, and they were all busy studying with open laptop computers. Not a single student had a book or a journal, as apparently they now have access to everything they need “online,” and all they carry is a laptop or a tablet computer.

The medicine we practice today is vastly superior to what we did 40 years ago. What changes will come in the future, and how will politics and money impact what we are able to do for our patients? Time will tell.

I am still in full-time practice at 66. At my reunion I was amazed by how many of my classmates had already permanently retired, despite being in good health. Those who were retired indicated that early in their careers they enjoyed the practice of medicine, but later stopped enjoying it. The issues that motivated their premature retirement were the increasing administrative burden (i.e. “paperwork”) on physicians, and the decreasing income from practice. It was a “cost versus benefit” calculation that provoked their retirements.

A recent survey of physicians indicated 45.8 percent had at least one symptom of “burnout,” and burnout was much more common in physicians than in the population at large. Our challenge as we enter the next four years and encounter changes in the way government and insurers tell us to practice is to figure how to enjoy doing what’s in the best interest of our patients. By mastering this we will avoid “burnout,” and keep serving our patients.

Enjoy the rest of this issue! Embrace the coming changes!

Reference:

Board-certified in orthopaedic surgery and emergency medicine, Dr. Talmage practices with the Occupational Health Center in Cookeville, TN. He is a member of the Tennessee Medicine Editorial Board. Contact him at drtalmage@occhealth.md. The TMA welcomes but is not responsible for opinions expressed in this forum.
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PRESIDENT’S COMMENTS

WE’VE BEEN HERE BEFORE  (Continued from page 5)

2014 – More Medicare payment cuts for home health begin. States have the option of covering Medicaid on citizens up to 138 percent of the poverty level. Insurers cannot impose coverage restrictions on policyholders with pre-existing conditions. Insurance plans must include federal government-defined essential benefits and coverage levels. Independent Payment Advisory Board (IPAB) begins submitting proposals to reduce the per capita rate of growth in Medicare spending. (IPAB will be comprised of un-elected government officials whose proposals automatically become law unless the House, Senate and President agree on a substitute proposal. Citizens will have no power to challenge an edict from the IPAB in court.) Federal government payments to hospitals in the Disproportionate Share Hospital (DSH) program will be reduced. Employers will offer a federally-defined acceptable level of health insurance coverage to employees or pay a penalty (or is it a tax?). Individuals will be required to obtain federally-defined acceptable health insurance or pay a penalty (or is it a tax?). The goal by the federal government is to reduce the number of uninsured non-elderly people by 14 million.

2015 – Medicare payment cuts to hospitals for hospital-acquired infections begin. Additional Medicare payment cuts for home health care begin. A U.S. physician shortage of 63,000 is predicted.

2017 – Pay-for-performance program begins for all physicians.

2025 – An estimated physician shortage of 130,600 is predicted.

In July 1777, George Washington wrote a letter to one of his generals when the outcome of the Revolutionary War looked particularly bleak: “We should never despair, our situation before has been unpromising and has changed for the better, so I trust it will again. If new difficulties arise, we must only put forth new exertions and proportion our efforts to the exigency of the times.”

These monumental changes in our healthcare system will affect your patients and how you practice medicine. They will also affect you as a taxpayer. How you plan and respond to these changes will determine your professional and personal life. Being a member of organized medicine through the Tennessee Medical Association offers you the best protection from these monumental changes. Your TMA will continue to protect your interests now and into the future by putting forth new exertions and proportioning our efforts to the exigency of the times. We have been through difficult changes in the past and we have continued to provide quality care for our patients and we will continue to do so in the future.

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

Nominations now being accepted for 2013/2014

The Tennessee Medical Association’s Physician Leadership College is an intensive leadership development program designed to train TMA members in the core aptitudes to excel in leadership positions within organized medicine, medical practice and business.

For more information, visit www.tnmed.org/leadershipcollege
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BlueCross BlueShield of Tennessee, Inc. is an independent, local and regional operating subsidiary of BlueCross BlueShield of Tennessee, Inc.
Q: Since providing testimony as a medical expert is a form of medical practice, why don’t physicians who act as expert witnesses in Tennessee courts have to be licensed in Tennessee, and why isn’t this activity regulated by the Tennessee Board of Medical Examiners just like other aspects of medical practice?

A: In Tennessee, a physician must be licensed to practice medicine in Tennessee if he “shall practice medicine in any of its departments within this state” (TCA 63-6-201(a)). The Code goes further to define the “practice of medicine”:

Any person shall be regarded as practicing medicine within the meaning of this chapter who treats, or professes to diagnose, treat, operates on or prescribes for any physical ailment or any physical injury to or deformity of another. TCA 63-6-201(1)

The act of testifying as a medical expert in court does not, obviously, include any diagnosis, treatment, operation or prescription. It is the presentation of medical and scientific opinion. There are rigid statutory and court rule requirements that must be met for an expert to testify as to the standard of medical care in a civil liability action. For medical expert testimony to be considered the practice of medicine, the General Assembly would need to broaden the definition of “practice of medicine” to specifically include providing medical expert testimony in court.

In theory, the Tennessee Board of Medical Examiners (BME) could consider inappropriate testimony given in court by a licensed Tennessee physician to be “unprofessional, dishonorable, or unethical conduct,” which is a ground for disciplinary action against a physician pursuant to TCA 63-6-214(b)(1). However, this legal theory has not been tested in Tennessee to our knowledge. It has in other states; in California there is an Attorney General’s Opinion to the effect that when a physician testifies as an expert in civil court, he may be subject to discipline by its medical board if the testimony constitutes unprofessional conduct (Op.Atty.Gen. No. 03-1201 (April 28, 2004)).

How could the Tennessee BME arrive at this conclusion? It has, by rule, adopted the AMA Code of Conduct as its own code of ethics. AMA Ethics Opinion 9.07 provides a litany of ethical standards regarding expert testimony (representation of qualifications, testify honestly, failing to characterize testimony as theory not widely accepted in the profession, etc.). A violation of any provision of this Opinion could be grounds to bring a disciplinary action based on a physician’s testimony in court. However, based on my knowledge of the BME, I believe it would be more comfortable with more specific statutory authority in order to enter the realm of expert testimony discipline.

Mr. Beatty is vice president of Advocacy and director of the Legal & Government Affairs Division of the TMA. He formerly served as a staff lawyer who prosecuted disciplinary matters before the Tennessee Board of Medical Examiners, formerly served as executive director of the board, and routinely monitors the BME on behalf of the TMA.

TMA MEMBERS CAN “ASK TMA...”

E-mail: becky.morrissey@tnmed.org
Phone: 800-659-1-TMA + Fax: 615-312-1907
Mail: P.O. Box 120909 + Nashville, TN 37212-0909

Questions and comments will be answered personally and may appear in reprint for the benefit of our members.
The ICD-10 transition is coming October 1, 2014. The ICD-10 transition will change every part of how you provide care, from software upgrades, to patient registration and referrals, to clinical documentation, and billing. Work with your software vendor, clearinghouse, and billing service now to ensure you are ready when the time comes. ICD-10 is closer than it seems.

CMS can help. Visit the CMS website at www.cms.gov/ICD10 for resources to get your practice ready.
$120 Million Settlement on Aetna Class-Action

The TMA is pleased to announce a $120 million national class-action settlement has been reached between Aetna and physicians and insured patients in connection with the out-of-network reimbursement litigation pending in federal court in New Jersey. This is the second major class-action lawsuit settlement agreement between Aetna and the TMA in a decade.

By the terms of the Settlement, Aetna will create three settlement funds valued at up to $120 million. This includes a potential $25 million provider fund through which out-of-network Aetna physicians can claim shares of the Settlement. There will be a general fund as well as a fund for subscribers (patients).

“This Settlement reflects years of hard work on the part of the physician class representatives and the TMA and potentially results in substantial benefit for physicians in Tennessee who treated any Aetna patients out-of-network between June 2003 and 2012,” said TMA President Wiley Robinson, MD.

The Settlement arises out of litigation filed in 2009 by physicians and other healthcare providers, the TMA, the American Medical Association (AMA) and several other medical associations. The litigation related to improper determination of physician reimbursement rates for out-of-network claims by Aetna’s use of, among other things, the flawed INGENIX database determining “usual and customary rates (reimbursement)” for physicians over several years.

The Settlement compensates physicians, other providers, and patients for past injury resulting from Aetna’s business practices challenged in the lawsuits. Information will be forthcoming on how physicians who treated Aetna patients out-of-network, and those patients, can collect their due shares of the Settlement funds.

“The TMA is pleased that the Settlement is a significant first step toward redressing issues on a forward looking basis for physicians and their patients,” said TMA General Counsel Yarnell Beatty, adding, “The TMA remains committed to addressing ongoing issues and I am hopeful that, through dialogue with Aetna, a framework can be developed that fosters a greater understanding, communication, and transparency between physicians, their patients and Aetna.”

For more information, contact Yarnell Beatty at 800-659-1862 or yarnell.beatty@tnmed.org.

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2013 TMA Election Nominees Finalized

The TMA Nominating Committee met on November 9, 2012, to finalize the list of nominees for TMA elected offices in 2013. Online elections will be held February 1-28; watch TMA communications and next month’s Tennessee Medicine for details on voting. Here are the candidates:

**President-Elect**
Richard Briggs, MD, Knoxville
Douglas Springer, MD, Kingsport

**AMA Delegation (10 Seats)**
Richard DePersio, MD, Knoxville
Chris Fleming, MD, Germantown
Donald Franklin, Jr., MD, Chattanooga
John Ingram, III, MD, Alcoa
James King, MD, Selmer
Robert Kirkpatrick, MD, Memphis
Lee Morisy, MD, Memphis
Wiley Robinson, MD, Memphis
Barrett Rosen, MD, Nashville
B W. Ruffner, Jr., MD, Signal Mountain

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Spend a Wednesday as Doctor of the Day

It’s that time again! The TMA needs members to act as the Doctor of the Day on Capitol Hill in Nashville, on Wednesdays throughout the 2013 legislative session. The need begins with Wednesday, January 9, and runs through the end of May.

You will have an opportunity not only to provide minor medical treatment to legislators and their staff members, but will also be able to speak with legislators about legislative issues of importance. The TMA reimburses for travel and meals.

For more information and to sign up, visit www.tnmed.org/doctor-of-the-day-program.aspx.
Neonatal Abstinence Syndrome (NAS) Now Reportable; TMA Supports “Black Box” Warning

Effective January 1, neonatal abstinence syndrome (NAS) is now a reportable condition in Tennessee.

The Tennessee Health Department is requiring hospitals to report babies born with addictions so it can better monitor what it calls a rising epidemic. Over a 10-year period, the incidence of addicted babies in Tennessee has risen from fewer than one per 1,000 births to 6.5 per 1,000 births.

“As the Tennessee Medical Association views neonatal abstinence syndrome as a serious public health problem for our state and that is why our Public Health Committee has been working on solutions to the problem,” said TMA President Wiley Robinson, MD. “Additionally, for several years the TMA has had in place a continuing medical education program for all Tennessee physicians regarding proper medication prescribing practices. That program is sanctioned by the Tennessee Board of Medical Examiners,” he said.

The CME courses are an ongoing tool to combat what TMA Public Health Committee Chairman Stuart Polly, MD, agrees is the underlying problem with NAS: prescription drug abuse. The committee is looking at a number of factors and possible solutions, as well as ways to cooperate with state efforts.

“It is a public health concern, not only for the infants involved but really as an indicator of the significant problem with drug abuse we have in our community,” said Dr. Polly. “Since we know much of the problem is due to prescription medication, this impacts public health, not only in terms of personal damage to the infants and their families but also to society for care of these infants, both neonatal and possibly later in life if they have long-term sequela.”

OPIATE LABEL WARNING

Meanwhile, the TMA has written a letter of support for the State’s request for a “black box” message on narcotic analgesics, warning pregnant women of the potential danger of misuse of those drugs for the fetus.

Signed by Dr. Robinson and Dr. Polly, the letter affirms the problem of addicted newborns is growing and could become a “serious public health problem” and thus has become a public health priority for the TMA.

“A black box warning will enhance those efforts by adding a constant reminder to consumers of the potential consequences of the misuse of narcotic analgesics during pregnancy,” it said.

(Continued on page 16)
MEET
TMA Public Health Chairman
Dr. Stuart Polly

PERSONAL
Professional Title: Medical director for the Physician Assistant Studies Program at Christian Brothers University in Memphis. Retired former chief medical officer and senior vice president for Clinical Affairs with Regional Medical Center in Memphis (19 years).

Practice Interests/Specialties: Academic faculty in Internal Medicine and subspecialty of Infectious Disease. Assistant professor and chief of the Division of Infectious Disease and the Departments of Medicine and Microbiology, Creighton University in Omaha, NE (5 years); associate professor and professor, associate chairman of Internal Medicine and professor of Medical Microbiology, Texas Tech University School of Medicine, Lubbock and El Paso, TX (10 years); professor in the Department of Medicine and assistant dean for Clinical Affairs, University of Tennessee College of Medicine, Memphis (19 years). Also, significant time in administrative medicine.

Most Important Accomplishments: Care to the uninsured and underinsured through academic practice and service in a leadership position in a large inner-city public hospital; work with organized medicine for the benefit of our patients and their physicians, particularly through the Texas, Tennessee, and American Medical Associations. I have held a number of positions, including chair of the Task Force on Indigent Healthcare and executive committee of the Texas Medical Association Hospital Medical Staff Section (HMSS); vice speaker/speaker of the House of Delegates and Board of Trustees member of the Tennessee Medical Association; delegate to the AMA HMSS/OMSS (Organized Medical Staff Section) (18 years).

Family: Wife Dianne (registered dietitian and attorney); children Matthew (practitioner of traditional Chinese medicine), Alison (nurse, nurse practitioner), Alexandra (pharmacist) and Samantha (prospective medical student); grandchildren Paloma (girl) and Bodhi (boy).

COMMITTEE
Years as Chair: Four

Why I Agreed to Step Into a Leadership Role: I believe all physicians should be members of and active in their professional organizations, particularly their state and national ones, to assure their voice is heard for the benefit of their patients and their profession. I felt I could contribute by helping that voice to be heard and progress to be made.

Goals/Philosophy as Committee Chair: I believe that through “public health,” medicine has the best opportunity to improve the overall quality of life of our community. The Public Health Committee, working with the medical and lay communities, identifies specific issues adversely affecting our community and works to correct them.

Most Important Committee Accomplishments: Helping to support and promote the TSSAA policy on extreme temperature and athletic events; the soon-to-be-released Disaster Preparedness Guide; and our role in enhancing physician participation in the Tennessee Volunteer Mobilizer. In addition, we have worked to increase the relationship between the TMA Public Health Committee and the Tennessee Department of Health.

Importance of the TMA/Committee: The TMA is an essential component of the healthcare team in Tennessee. As the statewide representative of all of medicine, it is the organ through which Tennessee physicians effect change in the direction of health care in our state. The Public Health Committee supports this effort by working with physicians, the State and others to address specific health-related issues affecting our citizenry.

Something not widely known about you: I’m a Girl Scout (something you have to do with three daughters). Also, while in high school I served for four years as a page in the Supreme Court of the United States, Washington, DC.

Currently reading: The Only Life That Mattered: The Short and Merry Lives of Anne Bonny, Mary Read, and Calico Jack Rackham by James Nelson; How Doctors Think by Jerome Groopman, MD.

Interested in serving on a TMA Committee? Visit www.tnmed.org/TMA_committees or contact the TMA at 800-659-1862.
The letter supports the petition by the Tennessee Health Department on behalf of the TMA’s 8,000 physician and medical student members. Read the full letter at www.tnm.org/tma-support-opi-ate-label/.

NAS STRATEGY
State officials across multiple agencies plan to announce a joint strategy in January to address the problem. The epicenter is Tennessee’s Appalachian region but cases are increasingly seen in Middle and West Tennessee.

Tennessee Health Commissioner and TMA member John Dreyzehner, MD, said the state plans to provide addiction treatment for people who need it, better control the availability of narcotics and take steps to prevent substance abuse and unintended pregnancy. The Tennessee Initiative for Perinatal Quality Care (TIPQC) is also planning to announce a pilot program in February to address the issue in hospital neonatal units.

For more information, contact the TMA at 800-659-1862 or brenda.williams@tnmed.org.
Four TMA members, all neurosurgeons with Semmes-Murphey Clinic in Memphis, are on the 2012 list of “Patients’ Choice” as rated by their patients. Kenan Arnautovic, MD, Frederick A. Boop, MD, Julius Fernandez, MD, and Kevin T. Foley, MD, are all members of The Memphis Medical Society.

John K. Duckworth, MD, FACP, of Memphis and Nesbit, MS, has received the College of American Pathologists Lifetime Achievement Award. He received the honor during the CAP annual meeting in September for his tireless devotion and commitment to the CAP Laboratory Accreditation Program. Dr. Duckworth has served in numerous capacities with the CAP including the Board of Governors, chair of the Commission on Laboratory Accreditation, vice chair on the Commission on Inspection and Accreditation, Gulf Regional Commissioner, and on the Commission on Laboratory Accreditation and Standards, receiving the CAP Outstanding Service Award in 1982. He has been an active in numerous professional societies, including the American Medical Association, American Board of Pathology, and the American Society of Microbiologists. He also served as president of the Tennessee Society of Pathologists and the Memphis Society of Pathologists. Dr. Duckworth most recently served as director of the pathology residency program and a professor in the Department of Pathology and Laboratory Medicine at the University of Tennessee Health Science Center. He is the founder and president of the Duckworth Pathology Group. Dr. Duckworth is a member of The Memphis Medical Society.

Richard Duszak, Jr., MD, FACR, of Memphis, has recently had noted research widely published regarding a correlation between volume of imaging and hospital length of stay. Dr. Duszak is chief executive officer and senior research fellow from the Harvey L. Neiman Policy Institute, which released the findings. They have been featured in numerous publications, including Orthopaedics Today and online at DotMedNews.com, ScienceCodex.com and DiagnosticImaging.com. Dr. Duszak practices with Mid-South Imaging & Therapeutics, PA, serves as medical director of Radiology at Baptist Memorial Hospital DeSoto, and is a member of The Memphis Medical Society.

Cary M. Finn, MD, of Memphis, is the new board chairman for Baptist Medical Group. Dr. Finn is a board-certified internist with Baptist Memorial Medical Group-Finn Medical Associates. He is a member of the Tennessee chapter of the American College of Physicians and an alternate TMA delegate from The Memphis Medical Society.

Karla Garcia, MD, of Chattanooga, was recently presented with the Emeline W. Haney Award by the Children’s Advocacy Center of Hamilton County (CACHC). Dr. Garcia is a pediatrician with Children’s Hospital at Erlanger and has been working with CACHC for 10 years. She is an assistant professor at the University of Tennessee College of Medicine-Chattanooga, and a member of the Chattanooga-Hamilton County Medical Society.

G. Aric Giddens, MD, of Memphis, was named Saint Francis Hospital-Bartlett Physician of the Month in November 2012. Board-certified in obstetrics and gynecology, Dr. Giddens has practiced with Memphis Obstetrics and Gynecological Association, PC (MOGA), since 1995. He is a member of the Tennessee Obstetrical & Gynecological Society and The Memphis Medical Society.

State Sen. Joseph S. Hensley, MD, of Hohenwald, was recognized as the 2012 Physician of the Year by the Tennessee Academy of Family Physicians. He has served as a district director for the TAFP. A board-certified family physician, he has run a private practice in Lewis County. After serving on the local school board, Dr. Hensley was elected to the 70th District State House seat in 2002 and, after 10 years there, won election to the State Senate in 2012. He has been a leader for the medical community on a variety of issues, most recently leading the successful battle to pass the TMA’s Interventional Pain Management legislation. Dr. Hensley is a direct member of the TMA.
**MEMBER NOTES**

**Dabney James, MD, FACP**, of Chattanooga, was recognized by Medicare Advantage insurer HealthSpring for achieving the highest possible quality compliance score and the highest score of any physician participant in the company’s Partnership 4 Quality (P4Q) initiative. Dr. James is an internal medicine specialist at Parkridge Medical Group Diagnostic Center and a member of the Chattanooga-Hamilton County Medical Society.

**David B. Reath, MD, FACS**, of Knoxville, has been named a Patients’ Choice Award Winner for 2012 by PatientsChoice.org. A previous winner of “Top Docs” and “Most Compassionate Doctor” awards, Dr. Reath is a board-certified plastic surgeon. He is chairman of the Public Education Committee of the American Society of Plastic Surgeons (ASPS), and a former member-at-large of the ASPS Board of Directors. An associate professor of plastic surgery at the University of Tennessee-Knoxville, Dr. Reath has practiced locally for over 25 years. He is a past-president of the Tennessee Society of Plastic Surgeons and the Eastern Association for the surgery of Trauma, a former member of the committee on Trauma, a member of the International Society for Aesthetic Plastic Surgery and the Knoxville Academy of Medicine.

**Hershel P. “Pat” Wall, MD**, chancellor emeritus of the University of Tennessee Health Science Center (UTHSC) College of Medicine (COM), has been honored with an endowed student scholarship fund in his name. The first recipient of the $50,000 award – dubbed the Dr. Hershel P. Wall Endowed Scholarship – will be named in fall 2013. A UTHSC alumnus, Dr. Wall has been part of the UTHSC community serving in a wide variety of roles, including special assistant to the UTHSC chancellor and special assistant to the UT president, where he focused on fundraising, capital development and alumni relations. A longtime UTHSC faculty member and administrator, Dr. Wall has also served as UTHSC chancellor, interim dean for the UT College of Medicine, associate dean for admissions and student affairs, and division chief of General Pediatrics. He is a member of The Memphis Medical Society.

**B. Alan Wallstedt, MD**, of Brentwood, is the president of the Tennessee Academy of Family Physicians (TNAFP) for 2013. Other TMA members serving as TNAFP officers: **Ty T. Webb, MD**, of Sparta, speaker of Congress; **Walter F. Fletcher, MD**, of Martin (not pictured), vice speaker; **Charles A. Ball, MD**, of Columbia, and **Timothy F. Linder, MD**, of Selmer, delegates to the American Academy of Family Physicians; and **Lee M. Carter, MD**, of Huntingdon, and **T. Scott Holder, MD**, of Winchester, alternate delegates. Dr. Wallstedt is a member of Williamson County Medical Society; Dr. Webb is a direct TMA member; Dr. Ball is a member of the Maury County Medical Society; Dr. Fletcher is a member of Northwest Tennessee Academy of Medicine; Drs. Linder and Carter are members of Consolidated Medical Assembly of West Tennessee; and Dr. Holder is a member of the Franklin County Medical Society.

**Merrill S. Wise, III, MD**, of Memphis, is the new president-elect of the American Sleep Medicine Foundation (ASMF). A neurologist and sleep medicine specialist with Mid-South Pulmonary Specialists and the Methodist Healthcare Sleep Disorders Center, he has co-authored numerous practice guidelines in sleep medicine and served on many national organizations and committees focused on sleep studies and sleep disorder treatment. He currently serves on the Board of Sleep Medicine and the ASMF. A prolific author, he has published over 80 articles, chapters and abstracts, and moderates a television show for the Library Channel titled “The Power of Sleep.” He is a member of The Memphis Medical Society.

Are you a member of the TMA who has been recognized for an honor, award, election, appointment, or other noteworthy achievement? Send items for consideration to Member Notes, Tennessee Medicine, 2301 21st Ave. South, PO Box 120909, Nashville, TN, 37212; fax 615-312-1908; e-mail brenda.williams@tnmed.org. High resolution (300 dpi) digital (.jpg,.tif or .eps) or hard copy photos required.
If that’s goal #1, then start with the right tools. The Medicare Learning Network® (MLN) develops informational resources just for Medicare Fee-For-Service providers. Billing errors can prevent physicians from receiving timely and proper reimbursement for common medical and surgical procedures. For example, the CMS’ Comprehensive Error Rate Testing (CERT) Program cites that a number of errors relate to non-compliance with Medicare coverage, coding, and billing rules.

**Evaluation and Management (E/M) Services: Complying with Documentation Requirements** is an MLN educational tool. It describes common CERT Program errors and provides information on the documentation needed to support certain claims to Medicare.

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The outcome of November voting seems to signal full speed ahead on health reform in Washington, but it’s not that simple here in Tennessee.

Officials are grappling with what the Affordable Care Act means for the Volunteer State, even as voters elected more physician lawmakers who are well-versed in the potential impacts it will have on providers and patients.
TENNESSEE ELECTIONS

To be sure, organized medicine in Tennessee saw a successful outcome: Independent Medicine’s Political Action Committee-Tennessee (IMPACT) backed all 12 of the winning state senate candidates and 50 of the 54 state house winners. The victors were from both parties, emphasized TMA Government Affairs Director Gary Zelizer.

“We try to spend contributions wisely in support of candidates who will win and will appreciate the financial support provided when they serve in the General Assembly, irrespective of party affiliation,” he said.

That bi-partisan support is affirmed by State Representative Mike Turner (D-Old Hickory), who serves as chair of the House Democratic Caucus. “I really appreciate the support of IMPACT during this election year, both for me personally and for the House Democratic Caucus,” he said. “Although we all realize it can be difficult to oppose an incumbent, IMPACT did provide financial support to a number of our Democratic candidates who were in close races against House Republican incumbents.”

Three of the state senate winners are physicians: family practitioner Joey Hensley, MD (R-Hohenwald), who formerly served 10 years in the State House of Representatives before switching chambers; emergency physician Mark Green, MD (R-Clarksville); and anesthesiologist Steve Dickerson, MD (R-Nashville). Both Dr. Green and Dr. Dickerson are first-time public servants.

“For the last four years I’ve been the only physician in the legislature, so that will go from having one in the House to having three in the Senate,” said Dr. Hensley, adding it will be a benefit when it comes to defeating legislation organized medicine opposes, although it may not be enough to ensure passage of critical legislation in both chambers. Increased physician presence in the General Assembly will certainly be important when it comes to scope of practice bills that are filed consistently and relentlessly each year. He cited the TMA’s interventional pain bill as an example – it faced heavy opposition by mid-level practitioners last year but narrowly passed thanks to an outpouring of calls and emails from the physician community. Those types of fights are persistent, he said, and will need heavy grassroots support.

None of the three knew whether health reform decisions, such as setting up the health insurance exchange or expanding Medicaid/TennCare, will actually come before the Senate this year but according to Dr. Dickerson, one thing is certain: “The interaction between government and health care appears to be increasing. As a result, having physicians who understand the practical implications of legislation and regulation on both our profession and on our patients’ well-being is essential.” He cited prescription drug abuse, obesity and premature birth as three issues with serious implications for Tennessee that he hopes to address as a legislator.

Dr. Green added that physician lawmakers bring their unique expertise and skills to bear on every issue that comes before the body. “My critical reasoning as a physician, my ability to get to the heart of the matter in medicine and find out the real issue – which is something you’re trained to do as a physician – my insistence on seeing the data before making a decision ... I think that’s a skill set I bring that goes beyond just healthcare in the Senate,” he explained.

TMA legislative staff members agree that having this kind of expertise and support in the legislature will be vital in the coming year, on issues related to health reform as well as the TMA’s own legislation.
The TMA anticipates fighting several scope battles. Legislative priorities for this year include addressing public health issues such as addicted newborns and concussions in young athletes; liability reform related to EMTALA services; and insurance reform related to coordinated care organizations’ governance and payment transparency. (See “2013 Legislative Package” in this section.)

“We have said for many years that legislators need to hear from physicians,” said TMA Assistant Government Affairs Director Julie Griffin. “Now, having three of their own colleagues in the Senate to discuss these issues is going to make our position stronger, particularly when those doctors are on the same side as we are,” she said.

“Still there’s no guarantee the three physicians are going to agree with every position the TMA takes,” added Zelizer. “In fact, we have experiences in the past where physician members have disagreed with our positions but we’re much more able to work through the differences of opinion.”

Dr. Green, for example, said he is not inclined to fall in lockstep on every issue. On scope of practice matters, for example, he plans to consider each question individually.

“For the most part I am for making sure that people who are trained are allowed to do the job they’re trained to do. I’m an ER physician, I use PAs (physician assistants) in the ER and they’re critical to our success. When you’ve got an emergency physician working on a trauma case, is he going to leave the trauma to go sign the prescription for a narcotic? We have to be careful that our scope adjustments don’t impact the way we provide care,” he said. “However, I want to make sure the people who are practicing medicine are actually trained to do it. When you’re sticking a needle in someone, the person doing that should be trained in the procedure. That’s a no-brainer.”

CONGRESSIONAL REPS

Nationally, medicine has the same representation in Washington as in the previous election – a New York doctor lost his re-election bid while a California doctor beat an incumbent, so there are still 20 physicians in Congress, 17 in the House of Representatives and three in the Senate. U.S. Rep. Phil Roe, MD (R-1), is one of two doctors in Congress from Tennessee.

Along with a continued fight to overturn the SGR formula, Cong. Roe has been strong in opposing the Affordable Care Act and said he will continue to fight implementation of its more troublesome provisions, particularly the IPAB (Independent Payment Advisory Board), which he calls an “un-elected board of bureaucrats.” Under the ACA, this board has the authority to determine which benefits are covered and how much physicians are paid. Dr. Roe, who is now co-chair of the congressional physician’s caucus with Cong. Phil Gingrey, MD (R-GA), said most Americans have no idea the havoc this panel will wreak on their health care.

“That board gets appointed next year and will become active in 2014 – that’s 13 months from now,” said Cong. Roe, who said the biggest problem is the lack of judicial review. “It takes 60 votes in the Senate (to override an IPAB decision); you couldn’t get 60 votes in the Senate to say the sun is coming up in the east.”

Faced with provider cuts built into the Act and the vexing SGR dilemma, physicians will be disincentivized to fill the gaps that will likely broaden under expanded healthcare coverage, he added. A longtime OB/GYN from Johnson City, Dr. Roe said his own experience with TennCare leads him to predict the Affordable Care Act will collapse under its own weight within 10 years.

“I saw what happened in Tennessee,” he said. “It got so expensive and overblown we basically had to cut people off the rolls. Why would this be any different? It’s not going to be… there’s nothing in the ACA to help control the cost of care.”
Back in Nashville, in the halls of the Haslam Administration, the re-election of President Barack Obama means there are questions awaiting answers and, depending on those answers, decisions to be made on ACA provisions.

On December 10, Governor Bill Haslam made his first decision on a health reform option. After months of consideration, he announced Tennessee will not operate a state-run health insurance exchange, citing the complexity of federal guidance and uncertainty about the finer details.

“What our administration has been working to understand is whether we’d have the flexibility for it to be a true state-based exchange, how the data exchange would work, and if it would work,” the Governor said.

“Since the presidential election, we’ve received 800-plus pages of draft rules from the federal government, some of which actually limit state decisions about running an exchange more than we expected. The Obama administration has set an aggressive timeline to implement exchanges, while there is still a lot of uncertainty about how the process will actually work. What has concerned me more and more is that they seem to be making this up as they go.” He added the state would reconsider the decision if it makes sense at a later time. (Read his full statement in this section.)

The state has a longer time period to decide on whether to expand its Medicaid (TennCare) program. In early December, TennCare Director Darin Gordon said Tennessee was among states seeking clarification from the U.S. Centers for Medicare and Medicaid Services (CMS) on what options are available. “As an example, could a state choose to expand just to 100 percent, instead of 138 percent? If they expand, would they be allowed to use this (federal) money to buy people into the health insurance exchange?” he said. “The only clarity we have is that CMS has said there’s no timeline on when states need to make a decision.” There are other questions, too, about whether “essential benefit” rules will allow states room to limit the benefit packages offered and thus, give them a way to control the cost.

Since the interview with Mr. Gordon, the federal government issued guidance answering some of these questions. As of press time, state officials were analyz-
ing options in light of the newly acquired guidance.

Whatever the final decision, Gordon said expanding TennCare would be a challenge but one the state is better able to handle than it once was.

“Our systems have been stress-tested for a much larger program than we currently have,” he said, referring to peak years when TennCare served almost 1.5 million people. In addition, Gordon said the program’s managed care organizations have far more experience and are more capable than before, and the reduced number of health plans has allowed for greater program oversight by the state. He added the MCOs are also significantly more financially stable and the provider community stronger and more sophisticated in terms of working within a Medicaid managed care system.

State officials are aware that the rate of expansion, particularly the initial rush of newly-qualified Tennesseans to enroll, would need to be controlled.

“TennCare in 1994 started very quickly, the pace by which people accessed the system was rapid – that adds concern for folks out there in how you handle the initial wave,” he said, adding, however, “We’re in a better situation to handle it than most (states) because we’ve seen the system drastically improve over the last 10 years.”

Under an expansion, current pilot medical home projects for TennCare would grow. Director Gordon said he has been pleased with early successes and some improvement in quality scores. “The whole goal is to raise that level of medical home engagement beyond what we have today, and it will vary based on locale and the needs of the community,” he added.

Physician leadership of those projects has been vital, he added. “It was instrumental for them to be engaged in the process – to have that leadership within a practice, the top level leadership, to really push and improve the overall approach. Without that I can’t say we would have been as successful.”

A decision not to expand TennCare would have its own challenges. Disproportionate share hospital payments for uncompensated care will be reduced but to what extent is not yet known. If the state chooses not to expand TennCare, Gordon said it is believed by some that it could lead to an increase in hospital charges to insured patients to cover the gap, which in turn could raise their premiums.

“Some changes to other state-operated healthcare programs may be necessitated based on the decisions made around the Medicaid expansion,” said Gordon. “I think the impact would be less on Cover Kids than on Cover Tennessee programs, but what those changes are will depend on other decisions that have yet to be made. We are waiting for clarity by federal officials.”

Existing TennCare programs could also be affected by the loss of federal funds if solutions to the fiscal cliff involve changes to existing match rates and/or restrictions on provider assessments. The level of impact depends on the ultimate outcome of the fiscal cliff negotiations which, at press time, were still underway.

**CONGRESSIONAL REPS**

With the reforming of health care nationally and in Tennessee, physician legislators are urging their non-legislator colleagues to stay engaged in the decisions that will affect their patients, their profession and their livelihood.

“There’s an old saying: you either have a seat at the table or you’re going to be on the menu, and I wanted to have a seat at the table,” said Dr. Dickerson of his new Senate role. The same goes for his fellow physicians. “We’re moving down the road; a lot of people intend to ride in the cart but not many people are willing to get out and pull the cart. Doctors need to be willing to pull the cart – with patient advocacy, reimbursement, regulation, scope of practice, there are numerous areas where our input could be helpful,” he added.

All three senators said physician support helped them
PRACTICING MEDICINE

win their respective races, and in turn they plan to represent
their colleagues on the issues that matter most to them and
their patients.

“Everyone told me doctors wouldn’t get involved, but
they certainly did for me,” said Dr. Green. “They gave me a
great deal of financial support as well as man-hours, knocking
on doors and making phone calls.

“I would not have won if it was not for physicians – they were
my biggest supporters,” agreed Dr. Hensley. “I’m not only a
member of the TMA but a long-time Capitol Hill Club contrib-
utor of IMPACT, so I encourage other physicians to be mem-
bers and get involved. Even if they can’t run for office, they
can get involved with their money and their expertise. Legis-
lators really do listen to physicians.”

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John Proctor, MD, Franklin
Doug Springer, MD, Kingsport
“Tennessee faces a decision this week about health insurance exchanges created by the Affordable Care Act.

“I’m not a fan of the law. The more I know, the more harmful I think it will be for small businesses and costly for state governments and the federal government. It does nothing to address the cost of health care in our country. It only expands a broken system. That’s why I’ve opposed it from the beginning and had hoped we would be successful in court and at the ballot box this year.

“Now we’re faced with the fact that the law remains, and it requires every state to participate in an insurance exchange. Our decision is whether the state or federal government should run it, and the deadline for that decision is Friday.

“I’ve said that I think Tennessee could run a state exchange cheaper and better, and my natural inclination is to keep the federal government out of our business as much as possible. What our administration has been working to understand is whether we’d have the flexibility for it to be a true state-based exchange, how the data exchange would work, and if it would work.

“Since the presidential election, we’ve received 800-plus pages of draft rules from the federal government, some of which actually limit state decisions about running an exchange more than we expected.

“The Obama administration has set an aggressive timeline to implement exchanges, while there is still a lot of uncertainty about how the process will actually work. What has concerned me more and more is that they seem to be making this up as they go.

“In weighing all of the information we currently have, I informed the federal government today that Tennessee will not run a state-based exchange. If conditions warrant in the future and it makes sense at a later date for Tennessee to run the exchange, we would consider that as an option at the appropriate time.

“This decision comes after months of consideration and analysis. It is a business decision based on what is best for Tennesseans with the information we have now that we’ve pressed hard to receive from Washington. If this were a political decision, it would’ve been easy, and I would’ve made it a long time ago.

“I believe my job is to get to the right answer. That’s what Tennesseans expect of me and elected me to do.”

“Tennessee Governor Bill Haslam announced on December 10, 2012, the state will not operate a state-based healthcare exchange under the federal Affordable Care Act. Gov. Haslam made the following statement on the issue:

Gov. Haslam

TMA Supported State-Run Exchange but Understands Gov’s Decision

OFFICIAL STATEMENT OF THE TENNESSEE MEDICAL ASSOCIATION

Attributable to Wiley Robinson, MD, President

“The Tennessee Medical Association believes that since the Affordable Care Act requires our state to have an insurance exchange, the job would best be performed at the state level rather than by a federal government agency. We expressed this to Governor Haslam this summer during discussions with him and his staff. However, given the scarcity of details provided by the federal government, his decision to forgo a state-run exchange is certainly understandable and we support the Governor’s decision.

“The Affordable Care Act will continue to affect the cost, access and quality of health care to Tennesseans in the foreseeable future. As the professional association for more than 8,000 physicians in our state, the TMA will continue to participate in every debate and discussion that impacts our ability to provide quality medical care to the citizens of Tennessee.”

Dr. Robinson
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Physicians are no strangers to bending over backwards to comply with federal and state laws affecting their practice of medicine. In the realm of protecting patient information, HIPAA compliance has been top priority for physicians for years. However, most physicians, especially those in smaller practices, may not even be aware of the Payment Card Industry Data Security Standards (PCI-DSS) required for anybody who accepts credit card payments, including physicians.

The PCI-DSS are standards adopted by the PCI Security Standards Council, made up of five global payment brands (Visa®, Mastercard®, Discover®, American Express®, and JCB International®), to ensure data security for clients who use their credit cards. While the council does not enforce compliance or impose penalties on its own, the individual brands will impose penalties to their merchant members. For example, Visa will impose fines up to $500,000 per security breach incident for merchant members who are not compliant at the time of the incident. For merchants, the fines are typically imposed on their acquiring bank, but there is nothing stopping the banks from passing those fines on to their merchant members. Therefore, it is important for merchants to maintain compliance with the PCI-DSS to avoid these fines.

Merchants, or anyone who accepts credit card payments, fall into one of four levels depending on how many transactions they complete per year. While the council has given definitions for each tier, it is ultimately up to each credit card company as to which tier merchants may fall. Physicians are encouraged to consult their financial advisor or bank regarding which level of compliance they will be required to adhere. The lowest tier, Level 4, is typically for merchants who process fewer than 20,000 transactions annually, which is likely where most small-to-mid-sized physician practices would fall. Level 3 pertains to merchants who process 20,000 to one million annually. Each level has different requirements for compliance.

For Level 4 and Level 3 merchants, the organization must first complete a Self-Assessment Questionnaire (SAQ). The SAQ a merchant must complete is determined by its validation type, or type of credit card transactions it processes; each merchant will be considered an A, B, C, or D merchant. Below is a chart defining each type of merchant.

All of the SAQ documents can be found on the PCI Council’s website at www.pciscu ritystandards.org/security_standards/documents.php?category=saqs.

The different SAQs have varying details of compliance but they all center on the PCI Council’s 12 PCI-DSS requirements:

1. Install and maintain a firewall configuration to protect cardholder data

<table>
<thead>
<tr>
<th>SAQ</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Card-not-present (e-commerce or mail/telephone-order) merchants, all cardholder data functions outsourced. This would never apply to a physician practice because it excludes face-to-face transactions, unless the practice performs only e-health services.</td>
</tr>
<tr>
<td>B</td>
<td>Imprint-only merchants with no electronic cardholder data storage, or standalone, dial-out terminal merchants with no electronic cardholder data storage. This would apply to physician practices with carbon copy imprints or Square® card readers.</td>
</tr>
<tr>
<td>C-VT</td>
<td>Merchants using only web-based virtual terminals, no electronic cardholder data storage. This would apply to a physician practice that uses an online payment service, such as PayPal.</td>
</tr>
<tr>
<td>C</td>
<td>Merchants with payment application systems connected to the Internet, no electronic cardholder data. This would apply to physician practices with card-reader software downloaded on the office computer.</td>
</tr>
<tr>
<td>D</td>
<td>All other merchants not included in descriptions for SAQ types A through C above, and all service providers defined by a credit card company as eligible to complete an SAQ.</td>
</tr>
<tr>
<td>P2PE-HW</td>
<td>Merchants using only hardware payment terminals included in a PCI-SSC-listed, validated, P2PE solution, no electronic cardholder data storage.</td>
</tr>
</tbody>
</table>
2. Do not use vendor-supplied defaults for system passwords and other security
3. Protect stored cardholder data
4. Encrypt transmission of cardholder data across open, public networks
5. Use and regularly update anti-virus software
6. Develop and maintain secure systems and applications
7. Restrict access to cardholder data by business need-to-know
8. Assign a unique ID to each person with computer access
9. Restrict physical access to the cardholder data
10. Track and monitor all access to network resources and cardholder data
11. Regularly test security systems and processes
12. Maintain a policy that addresses information security

The SAQ may not require all 12 of the requirements to be met, depending on the merchant-type. For example, a category B merchant would not need to complete the first requirement—install and maintain a firewall configuration to protect cardholder data—because it would not electronically store data. Further, each individual SAQ will determine the steps required to become compliant. Some require the merchant to complete and pass a vulnerability scan performed by an Approved Scanning Vendor (ASV) as determined by the PCI Security Standards Council. ASVs are organizations that validate adherence to certain DSS requirements by performing scans of a merchant’s Internet-facing environment, and there are more than 130 ASVs from which to choose. The PCI Council requires that some merchants perform these scans every three months for maximum compliance.

After the SAQ and any other required steps are finished, the merchant must complete and sign the Attestation of Compliance that corresponds with the SAQ they already completed. Finally, the merchant must submit the SAQ, evidence of a passing scan (if necessary), and the Attestation to the payment brand. All of these steps are required annually to maintain compliance. There are a number of companies, such as Solversas Payment Solutions, that provide payment services for small businesses and will ensure PCI compliance for their clients. The TMA recommends you either check with your payment services company to make sure they are following PCI-DSS or consider contracting with a payment service company to maintain compliance.

References:
5. Id.
6. Id.

Ms. Dageforde is assistant general counsel for the TMA. Contact her at katie.dageforde@tnmed.org or 800-659-1862.
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Situs Inversus

By Abiola Atanda, MSIV; Tiffany Chambers; and Derrick J. Beech, MD, FACS

ABSTRACT
Situs Inversus is a rare condition with unique clinical and radiographic characteristics. We present a case highlighting important clinical factors associated with Situs Inversus.

INTRODUCTION
Situs Inversus is a rare condition characterized by dextrocardia as the major underlying component of this abnormality. It was first described by Matthew Baillie nearly a century after Marco Severino recognized dextrocardia as a clinical entity. Situs Inversus is a right-to-left anatomic reversal along the midline longitudinal axis where the organs of the chest and abdomen are arranged in a perfect mirror image. Because the arrangement is a perfect mirror image, the relationship between the organs is not altered, thus functional problems rarely occur.

Situs Inversus has not been associated with heredity or genetic etiologies. It is typically sporadic. There have, however, been suggestions of potential genetic predisposing defects. Situs Inversus can occasionally develop in several family members but it is often an isolated event. Our report documents the rare occurrence of Situs Inversus with a brief review of relevant clinical and radiographic findings.

CASE REPORT
C. M. is a 57-year-old woman who initially presented with changes in her bowel habits and associated constipation. She reported noticing a decrease in the caliber of her bowel movements and less frequent stools over the last several months. She denied bloody rectal drainage, abdominal pain, abdominal distention or weight loss. She was otherwise without complaints. The patient denied a history of hypertension or diabetes and was taking no medications. Her past medical history was otherwise unremarkable. She denied the use of alcohol or cigarettes. She had undergone no previous operations. Her family history was negative for any type of malignancy, specifically, she had no family history of colon or rectal cancer.

Physical examination demonstrated a thin woman in no distress. Her lungs were clear to auscultation. She had regular cardiac rhythm with noted prominence of her heart tones at the right sternal border. There were no cardiac murmurs, rubs or gallops. Her abdomen was soft and non-distended with no palpable masses and normal active bowel sounds. There were no palpable masses on rectal exam. Her stool was guiac positive. Laboratory studies, including a complete blood count electrolytes and serum carcinoembryonic antigen, were within normal limits.

Radiographic studies included an abdominal/pelvic computed tomography, which demonstrated no evidence of metastatic disease and complete Situs Inversus (Figure 1a, b, and c). Colonoscopy was performed with endoscopic biopsy confirming adenocarcinoma. The remainder of her colon was normal on endoscopic evaluation. After appropriate preoperative staging the patient underwent...
an exploratory laparotomy with sigmoid resection. Intraoperative findings confirmed Situs Inversus (Figure 2). The patient’s postoperative course was uneventful. She was discharged home in stable condition on postoperative day number eight with a pathological confirmed Stage III adenocarcinoma of the sigmoid colon, for which she would also receive systemic adjuvant chemotherapy.

**DISCUSSION**

Situs Inversus, or Situs inversus viscerum, is a rare congenital abnormality. It represents the rotation of the thoracic and abdominal visceral organs around the sagittal plane, thus organs appear to be mirror images of their normal positions. It develops as a defect in the embryogenesis of the human left-right asymmetry during embryo growth.1 Several genes have been identified to play an important role in the determination of abnormal left-to-right rotation asymmetry in humans. These genes include EGF-CFC genes, for which loss of function due to a mutation results in human left-right laterality defects.2 This mutation manifests various phenotypic appearances in the thoracic and abdominal cavities. In the abdomen, major organs like the spleen and stomach are on the right side and the gallbladder and liver on the left side. The intestines and the mesenteric vessels are reversed as well.

In the thorax, the right lung is bi-lobed and the left lung is tri-lobed, indicating the lungs are in a reversed position. Also in the thorax, the apex of the heart can be anatomically on the right side. Clinically known as Situs Inversus with dextrocardia or Situs Inversus totalis, it has an incidence of approximately one in 12,000 in the general population.3 There are also rare conditions where the apex of the heart remains on the left side of the thorax; this condition is clinically referred to as Situs Inversus with levocardia or Situs Inversus incomplectus. Contrary to reports that patients who have Situs Inversus totalis with Dextrocardia later develop atherosclerosis, there are new findings that these patients can have normal longevity with similar life expectancy as any patients in the general population.6 The malrotation of the gastrointestinal organs are the most noncardiac malformation in patients with dextrocardia.3

Situs Inversus may be associated with other abnormalities such as Primary Ciliary Dyskinesia (PCD), bronchiectasis, sinusitis and infertility, leading to a clinical manifestation known as kartagener syndrome observed in about one-fourth of the patients. PCD is a syndrome caused by immotile cilia, which manifests itself during embryological development. Patients with PCD have up to a 200-percent chance of developing congenital heart disease.7

Situs anomalies in adult patients are usually detected incidentally. Primary Ciliary Dyskinesia and other associated anomalies, including congenital heart disease or gastrointestinal, typically are manifested after radiographically confirmed Situs Inversus. Typically, Situs Inversus is detected when patients present for evaluation of unrelated clinical problems that require radiographic or operative intervention, such as cholecystitis, cholelithiasis, appendicitis or other thoracic and abdominal clinical symptoms. An astute clinical can detect visceral organ translocation on physical examination, such as cardiac auscultation or liver percussion. However, the majority of patients have the diagnosis of Situs Inversus confirmed by radiographic studies.

**CONCLUSION**

It is critical for the clinician to recognize the longitudinal axial rotation with the associated diagnostic and therapeutic implications. Surgeons must be aware of the incidence and radiographic findings of Situs Inversus to avoid possible pitfalls of misdiagnosis of common surgical emergencies in this population. The use of imaging increases the physician’s chances of detecting the alteration in anatomical positions in a Situs Inversus patient.8 In the case of a surgical operation in a patient with Situs Inversus, a careful preoperative anatomical assessment is mandatory.9

**References**


Dr. Beech is professor and chairman of the Department of Surgery, Meharry Medical College, Nashville, TN.

Mr. Atanda was a Meharry student who graduated in 2011, and Ms. Chambers is a data entry research assistant at Meharry. Please send correspondence to Dr. Beech at Meharry Medical College, 1005 Dr. D. B. Todd Jr. Blvd, Nashville, TN 37208; phone: 615-327-6555; fax: 615-327-5579; assistant email: dalexander@mmc.edu.
Association Between Cesarean Delivery Rate and Body Mass Index

By Jodi A. Berendzen, MD, and Bobby C. Howard, MD

ABSTRACT

Objective: The purpose of this study was to evaluate the association between cesarean delivery rate and body mass index (BMI) for the patient population served by the University of Tennessee Medical Center in Knoxville, TN.

Study Design: A retrospective, cohort study was conducted using the perinatal birthlog from January 1, 2009 through December 31, 2009. The database totaled 2,399 women. Women who delivered ≥23 weeks gestational age were included. Those missing data imperative to our study (height, weight, mode of delivery) were excluded. Thus, our study included 2,235 women. Cesarean delivery rate was calculated for each of the five BMI categories. Univariate analysis using Chi square, Mann-Whitney U test and independent t-test were used to describe associations between body mass index, mode of delivery and other independent variables. Additional analyses were made on the subset of nulliparous women.

Results: Using prepregnancy BMI, 6.7 percent of our population was underweight, 44.3 percent normal weight, 22.6 percent overweight, 20.6 percent obese, and 5.8 percent morbidly obese. The overall cesarean delivery rate was 36.2 percent. Twenty-six percent of underweight and 31.4 percent of normal weight women required cesarean delivery, while 39.1 percent of overweight, 40.8 percent of obese and 56.6 percent of morbidly obese women required cesarean delivery. In addition to cesarean delivery, hypertensive disorders (OR 3.29; 95% CI 2.51-4.31) and diabetes (OR 5.27; 95% CI 3.73-7.44) complicated significantly more pregnancies of obese women than normal weight women.

Conclusion: There was an increased rate of cesarean delivery as BMI increased. Increased BMI is also associated with other pregnancy complications, including hypertensive disorders and diabetes.

INTRODUCTION

In the United States, the prevalence of obesity has continued to rise despite increased awareness and prevention campaigns. The most recent data published by the Center for Disease Control and Prevention reports that in 2009, not a single state met the Healthy People 2010 obesity target of 15 percent, and the number of states with obesity prevalence of ≥30 percent increased from none in 2000 to nine in 2009.1 Tennessese is one such state, weighing in with an obesity rate of 32.9 percent, third nationwide, behind Mississippi (35.4 percent) and Louisiana (33.9 percent).1,2 Obesity is associated with many serious health conditions, including type 2 diabetes, hypertension, cardiovascular disease and an overall increase in mortality.3

To the obstetrician, obesity poses even more tangible risks of adverse obstetric outcomes and increased cesarean delivery rate.4-9 As the rate of obesity rises, the current increased rate of cesarean delivery is concerning. In the obese population, inherent complications of cesarean deliveries are of even greater risk, including anesthesia-related morbidity, increased operative times, blood loss, and infectious morbidity.10,11

The purpose of this study was to evaluate the association between cesarean delivery rate and prepregnancy body mass index.

MATERIALS AND METHODS

The University of Tennessee Medical Center in Knoxville, TN, utilizes a perinatal clinical information system for intrapartum monitoring, data collection of admission forms and flow sheets, and delivery, operative and recovery records. The system provides a searchable birthlog for specified information. The Institutional Review Board at the University of Tennessee granted approval for the review of this birthlog for the purposes of this study (IRB #2990).

The birthlog for all women who delivered at the University of Tennessee Medical Center from January 1, 2009 through December 31, 2009 was studied and contained a total of 2,399 women. Of these, 164 were excluded from our study due to either missing data (height, weight, mode of delivery) or delivery occurring prior to 23 weeks gestational age; therefore, a total of 2,235 women were included in our analysis.

Body mass index was calculated for each patient using self-reported values in
the formula: prepregnancy weight (kg) divided by height (m²). Patients were then sub-divided into five BMI categories as grouped by World Health Organization criteria: underweight (BMI <18.5), normal weight (BMI 18.5-24.9), overweight (BMI 25-29.9), obese (class I&II, BMI 30.0-39.9), and morbidly obese (class III, BMI ≥40.0). 12

In addition to prepregnancy weight and height, other data collected included the following: maternal age, maternal weight at delivery, gravity, parity, birthweight of neonate, gestational age at time of delivery, fetal presentation, primary indication for cesarean delivery, history of prior cesarean delivery, urgency of cesarean delivery and pregnancy complications, specifically noting preterm labor, premature rupture of membranes, hypertensive disorders and diabetes.

Analysis included descriptive and univariate statistics (Chi square, nonparametric Mann-Whitney U test, and independent sample t-test) for describing associations between independent variables and body mass index, as well as mode of delivery. Separate analyses were also made for nulliparous women.

RESULTS

The 2,235 women included in our study were sub-divided into BMI categories as described in Table 1. Overall, 6.7 percent of our population was underweight (BMI<18.5), 44.3 percent normal weight (BMI 18.5-24.9), 22.6 percent overweight (BMI 25-29.9), 20.6 percent obese (BMI 30-39.9), and 5.8 percent morbidly obese (BMI ≥40). Nulliparous and multiparous women are similarly characterized in this table.

There was an increased rate of cesarean delivery with increased BMI category. While 26 percent of underweight and 31.4 percent of normal weight women underwent cesarean delivery, 39.1, 40.8, and 56.6 percent of overweight, obese and morbidly obese women, respectively, underwent a cesarean delivery, as shown in Table 2. Additionally, Table 2 demonstrates the distribution of cesarean deliveries for nulliparous and multiparous women by BMI categories. Cesarean delivery was performed in 37.7 percent of overweight, 45.2 percent of obese and 64.6 percent of morbidly obese nulliparous women.

There were statistically significant differences in age, prepregnancy BMI, delivery BMI and gestational age at delivery between women who delivered vaginally versus those who delivered by cesarean, as described in Table 3. However, there was not a statistically significant difference in the amount of weight gain during pregnancy or a significant difference in neonatal birthweight between the group that delivered vaginally and the group that underwent cesarean delivery. Yet, the mean neonatal birthweight for obese women, 3,178g (±762g), was statistically greater than the mean birthweight of neonates of normal weight women, 3056 (±670g) (p=0.001).

Obstetric outcomes for obese and morbidly obese were combined and compared with normal weight women and are demonstrated in Table 4. Patients who were obese (BMI ≥30) were 3.29 times more likely (95% CI 2.51-4.31) to have pregnancies complicated with hypertensive disorders, including chronic hypertension, gestational hypertension, preeclampsia, and HELLP syndrome. Diabetic disorders were 5.27 times more likely (95% CI 3.73-7.44) in the obese population. Non-vertex fetal presentation was 1.74 times more likely (95% CI 1.14-2.67) in the obese population. In total, obese women (BMI ≥50) were 1.74 times more likely (95% CI 1.41-2.15) to require cesarean delivery. Nulliparous obese women were 2.75 times more likely (95% CI 1.97-3.85) than normal weight nulliparas to require cesarean delivery.

Although the risk of having preterm labor was significantly different between vaginal delivery group versus the cesarean delivery group (OR 0.68, 95% CI 0.49-0.95), the gestational age at delivery, calculated by independent sample t-test revealed a non-significant between the two groups (38.0 versus 37.9, p=0.181).

COMMENT

In this analysis, we studied the association between BMI and cesarean delivery rate. Other studies have shown an increased rate of cesarean delivery in obese women,5,6 and our study confirmed such findings in our population. Tennessee is the third most obese state2 and ranks 16th in cesarean delivery rate.6 Compared to data from the CDC with the rate of obesity (BMI ≥30.0) in Tennessee at 32.9 percent, the obesity rate of our population was 26.4 percent. Based on 2007 data from the CDC, the cesarean delivery rate in the United States was 31.8 percent; in Tennessee, the rate was 33.3 percent.13 Our findings from 2009 indicate that our institution had a 36.2 percent rate of cesarean delivery in total, and 33.5 percent for nulliparas. This increased rate may be a consequence of being a tertiary center; however, the impact of differences in institutions in the rate of cesarean deliveries has not been fully established. Further studies may be warranted to delineate this association.

Our study indicates there was a statistically significant difference in the prepregnancy BMI and BMI at delivery between those delivering vaginally versus those delivering via cesarean. However, our study failed to show a significant difference in weight gain between the two groups.

Many studies have described increased rate of hypertensive disorders and diabetes in women with pre-pregnancy obesity.3,11,14 Our study concluded similarly. Obese women were 3.29 times more likely to have hypertensive disorders and 5.27 times more likely to have diabetes than normal weight women.

Our study also showed an increased rate of non-vertex fetal presentation in the obese population. This outcome has not been evaluated in many other studies, yet, this is an important finding since obese patients have lower success rates with external cephalic versions.15

Outcomes regarding preterm labor and premature rupture of membranes have been varied.11,12 Sebire, et al. noted a decrease in the rate of preterm delivery in obese women, as did our study,11 while Baeten, et al. described an increased risk of preterm delivery in association with higher BMI.14 In our study, the rate of preterm labor was higher in normal weight women yet, in total, the mean gestational age at delivery was not significantly differ-
ent between normal weight women and obese women. This discrepancy is likely due to statistical analysis and not clinical significance. The rate of premature rupture of membranes was not significant in our study, similar to the findings of Weiss, et al.3

Studies that have evaluated the association between maternal weight and neonatal birthweight also have dichotomous results. Some studies have shown an increased risk for IUGR in women with obesity,6 while others have shown an increased risk of fetal macrosomia and large-for-gestational age neonates.5,11,14 Our data conclude a small but statistically significant increase in the birthweight of neonates born to obese women.

Other studies have shown an increased risk of operative and post-operative complications, including increased anesthesia-related morbidity, increased blood loss, longer operative time and more post-operative wound infections.10,11 These risks, as well as the increased risk of cesarean delivery, need to be discussed with patients long before the onset of labor.

Our study was limited by the data contained within the perinatal birthlog and the completeness of the admission forms. Further demographic data was not available to search from the birthlog and 5.2 percent of women admitted to Labor and Delivery had missing information. We also relied on the accuracy of self-reported height and weight data for this retrospective study. We chose to focus our analysis on prepregnancy BMI because the WHO criteria for BMI categories have not been established to account for the weight gain that occurs during pregnancy. Future analysis from the data we collected could include the association of BMI with primary indication for cesarean delivery, the role that prior cesarean delivery plays in the success of a trial of labor, and the association of BMI with the urgency for which a cesarean delivery was performed.

Our findings support the assertion that as the obesity epidemic increases, so, too, does the increased risk of pregnancy complications and cesarean delivery. Obstetricians can use this data to aid in preconception counseling for obese women.+

References:

TABLE 1. Body mass index characteristics in nulliparous and multiparous women.

<table>
<thead>
<tr>
<th>BMI Group</th>
<th>N (% )</th>
<th>Nulliparas</th>
<th>Multiparas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight (BMI &lt;18.5)</td>
<td>150 (6.7)</td>
<td>58 (6.1)</td>
<td>92 (7.1)</td>
</tr>
<tr>
<td>Normal weight (BMI 18.5-24.9)</td>
<td>991 (44.3)</td>
<td>466 (49.2)</td>
<td>525 (40.8)</td>
</tr>
<tr>
<td>Overweight (BMI 25.0-29.9)</td>
<td>504 (22.6)</td>
<td>199 (21.0)</td>
<td>305 (23.7)</td>
</tr>
<tr>
<td>Obese (BMI 30.0-39.9)</td>
<td>461 (20.6)</td>
<td>177 (18.7)</td>
<td>284 (22.1)</td>
</tr>
<tr>
<td>Morbidly Obese (BMI &gt;40.0)</td>
<td>129 (5.8)</td>
<td>48 (5.1)</td>
<td>81 (6.3)</td>
</tr>
<tr>
<td>Total</td>
<td>2235</td>
<td>948</td>
<td>1287</td>
</tr>
</tbody>
</table>

TABLE 2. Cesarean delivery rate by body mass index for nulliparous and multiparous women.

<table>
<thead>
<tr>
<th>BMI Group</th>
<th>N (% )</th>
<th>Nulliparas</th>
<th>Multiparas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight (BMI &lt;18.5)</td>
<td>39 (26.0)</td>
<td>10 (17.2)</td>
<td>29 (31.5)</td>
</tr>
<tr>
<td>Normal weight (BMI 18.5-24.9)</td>
<td>311 (31.4)</td>
<td>122 (26.2)</td>
<td>189 (36.0)</td>
</tr>
<tr>
<td>Overweight (BMI 25.0-29.9)</td>
<td>197 (39.1)</td>
<td>75 (37.7)</td>
<td>122 (40.0)</td>
</tr>
<tr>
<td>Obese (BMI 30.0-39.9)</td>
<td>188 (40.8)</td>
<td>80 (45.2)</td>
<td>108 (38.0)</td>
</tr>
<tr>
<td>Morbidly Obese (BMI &gt;40.0)</td>
<td>73 (56.6)</td>
<td>31 (64.6)</td>
<td>42 (51.9)</td>
</tr>
<tr>
<td>Total</td>
<td>808 (36.2)</td>
<td>318 (33.5)</td>
<td>490 (38.1)</td>
</tr>
</tbody>
</table>

TABLE 3. Perinatal variables by mode of delivery.*

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Vaginal delivery</th>
<th>Cesarean delivery</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td>25.2 ±5.8</td>
<td>27.3 ±6.2</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Prepregnancy BMI</td>
<td>25.7 ±6.6</td>
<td>28.2 ±8.5</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Delivery BMI</td>
<td>30.4 ±7.5</td>
<td>33.4 ±10.1</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Weight gain, lbs</td>
<td>27.3 ±30.7</td>
<td>28.9 ±29.2</td>
<td>0.212</td>
</tr>
<tr>
<td>Birthweight, g</td>
<td>3123 ±641</td>
<td>3037 ±823</td>
<td>0.193</td>
</tr>
<tr>
<td>Gestational age at delivery, wks</td>
<td>38.3 ±2.6</td>
<td>37.4 ±2.9</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

*Data presented as mean value ± standard deviation.

TABLE 4. Obstetric complications by maternal obesity.

<table>
<thead>
<tr>
<th>Complication</th>
<th>Normal weight n=991</th>
<th>Obese (BMI&gt;30.0) n=590</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertensive disorder</td>
<td>104</td>
<td>164</td>
<td>3.29 (2.51-4.31)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>50</td>
<td>129</td>
<td>5.27 (3.73-7.44)</td>
</tr>
<tr>
<td>Nonvertex fetal presentation</td>
<td>45</td>
<td>45</td>
<td>1.74 (1.14-2.67)</td>
</tr>
<tr>
<td>Preterm labor</td>
<td>149</td>
<td>63</td>
<td>0.68 (0.49-0.93)</td>
</tr>
<tr>
<td>Premature Rupture of Membranes</td>
<td>34</td>
<td>23</td>
<td>NS¹</td>
</tr>
<tr>
<td>Cesarean delivery</td>
<td>311</td>
<td>261</td>
<td>1.74 (1.41-2.15)</td>
</tr>
<tr>
<td>Total</td>
<td>122</td>
<td>111</td>
<td>2.75 (1.97-3.83)</td>
</tr>
</tbody>
</table>

¹NS – not significant
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ABSTRACT
Spontaneous resolution of giant pulmonary bullae occurs infrequently. The mechanisms responsible for the natural elimination of giant bullae are variable. We report a patient who experienced spontaneous total regression of his giant bulla following intensification of his inhaled bronchodilator and airway anti-inflammatory therapies. This occurrence suggests that smoking cessation and optimization of inhaled bronchodilator and anti-inflammatory therapies should be undertaken before referral for surgical bullectomy. These relatively simple measures may obviate the need for an invasive procedure.

INTRODUCTION
Bullous emphysema is a fairly common consequence of smoking tobacco products. Multiple small bullae develop more frequently than giant bullae. The natural course of a giant bulla is typically progressive enlargement in size with compressive atelectasis of the surrounding pulmonary parenchyma. As the bulla expands, the patient experiences increasing respiratory compromise.

Rarely, giant bullae resolve spontaneously. There are 10 cases of complete resolution and six with partial regression of giant bullae recorded in the English literature. We report a patient who had a decrease in respiratory symptoms following total radiographic resolution of his giant bulla. The reason his giant bulla completely resolved could not be determined precisely, but a review of the medical literature regarding the pathophysiology of bulla resolution suggests intensification of his bronchodilator and anti-inflammatory therapy may play a role. We identified another case report of partial regression of a giant bulla that occurred after intensification of bronchodilator and anti-inflammatory therapy.

CASE REPORT
A 62-year-old male was referred for evaluation of chronic obstructive pulmonary disease (COPD). He complained of shortness of breath with exertion and had a chronic cough productive of clear sputum. The patient stated that he had been diagnosed with bullous emphysema 10 years earlier. He had a 30 pack-year history of tobacco use and was currently a cigarette smoker. The patient’s respiratory medications were inhaled albuterol and ipratropium. He used these medications only as needed.

His breath sounds were distant and wheezes were present in all lung fields. His pulmonary function tests (PFTs) documented a severely decreased forced expiratory volume in one second (FEV1.0) of 0.64 liters, with a significantly increased residual volume (RV) of 260% of predicted. His chest radiograph demonstrated a giant bulla in the left upper lobe (Figure 1).
The patient’s respiratory medications were changed to inhaled formoterol (12 mcg) every 12 hours, mometasone (220 mcg) once a day, and tiotropium (18 mcg) once a day. An albuterol metered dose inhaler was provided to use on an as-needed basis. The patient was instructed on proper use of each inhaler and on the importance of compliance with the prescribed therapy.

The patient was re-evaluated six months later. He claimed to be compliant with the prescribed therapy and stated that he was less short of breath with exertion. Although his breath sounds remained distant, the wheezes were markedly diminished. A repeat chest radiograph failed to identify the previously seen left upper lobe bulla (Figure 2). Pulmonary function testing now demonstrated an FEV1.0 of 0.72 liters and an improvement in hyperinflation with a RV of 148% of predicted.

The patient denied any acute illness since the earlier examination. He specifically denied any acute respiratory illnesses. In addition, he had not experienced chest pain or increased shortness of breath that might suggest the occurrence of a pneumothorax. Flexible fiberoptic bronchoscopy was performed. No endobronchial lesions were identified and all major bronchi were patent.

**DISCUSSION**

By definition a giant pulmonary bulla occupies at least one-third of the involved hemithorax. They usually involve the upper lobes, developing most often in men. Cigarette smoking is the leading cause of giant bullae. While the mechanism of expansion of the bulla is not well defined, the most widely held theory is that a giant bulla results from dilation of the airspace distal to the terminal bronchioles due to a check-valve effect in the proximal airways. This ball-valve phenomenology results in increasing positive end expiratory pressures within the bullae, promoting gradual expansion.1,2

Spontaneous reduction in size of a giant bulla is an infrequent occurrence (Table). Ten cases of complete spontaneous resolution of giant bullae have been reported in the English medical literature.3-8,13,14 Six cases of partial spontaneous regression of giant bullae have also been reported.9-12 Our patient represents the eleventh patient with a complete spontaneous resolution of a giant bulla. Similar to our patient, most of the other cases documented in the literature had bullae in their upper lobes.

Most of the patients described in the English literature with spontaneous reduction of a giant bulla have been males (Table). The reason for this gender bias is not known but probably reflects the greater use of tobacco products by men in the past. As the percentage of females with COPD increases, giant bullae will likely be observed more frequently in women. An elderly female with a partial spontaneous closure of a right upper lobe giant bulla was recently reported.12 It seems likely that spontaneous changes of giant bullae in female patients will be reported more frequently in the medical literature.

The pathophysiology behind spontaneous resolution and regression of a giant bulla is most commonly attributed to an infectious process.3,6,8 Five of the patients de-
scribed in the English medical literature had an air-fluid level within the giant bullae with subsequent disappearance of their giant pulmonary bullae. It is hypothesized that airway inflammation results in closure of the communication between the airway and the bullae. The gases within the now-closed space are slowly absorbed. The absorption of the gases results in loss of volume and collapse of the giant bullae. Our patient’s history was not suggestive of an infected bulla.

An association between lung cancer and giant bullae is well established. One patient reported in the literature had partial regression of an left upper lobe bulla due to obstruction of the airway from adenocarcinoma of the lung. In addition, there is a report of a patient whose giant bulla resolved due to obstruction of the communicating airway by a benign nodule. Because of these observations, patients with vanishing giant bullae should probably undergo flexible fiberoptic bronchoscopy to visualize the airways and rule out an obstructing endobronchial lesion. Flexible fiberoptic bronchoscopy in our patient failed to identify an endobronchial obstructive process.

Spontaneous pneumothorax occurred in two patients with spontaneous regression of their giant bullae. In each of these patients it was the giant bulla that ruptured and resulted in the pneumothorax. Both patients were successfully treated with tube thoracostomy. Evacuation of the air from the pleural space resulted in re-expansion of the lung, without reappearance of the giant bulla. Presumably, a ball-valve mechanism allowed the pressure to increase in the bullae until they ruptured. The narrowed airways in these two patients then closed the check-valve segment, allowing the lung to re-expand without further leakage of air into the pleural space. A spontaneous pneumothorax was suspected by history as the cause of a third patient’s spontaneous regression of her giant bulla. Our patient’s history was not consistent with a spontaneous pneumothorax as a cause for the resolution of his giant bulla.

To our knowledge, there has been a single case report of partial regression of a giant bulla following intensification of inhaled bronchodilator and anti-inflammatory medication. Similarly, our patient’s giant bulla resolved after intensification of his inhaled bronchodilator and anti-inflammatory medication. In addition, some of the patients reported in the literature had stopped smoking cigarettes prior to the disappearance of their bullae. One nocarcinoma of the lung. In addition, due to obstruction of the airway from adenocarcinoma of the lung, one patient reported in the literature had partial regression of an left upper lobe bulla due to obstruction of the airway from adenocarcinoma of the lung. In addition, there is a report of a patient whose giant bulla resolved due to obstruction of the communicating airway by a benign nodule. Because of these observations, patients with vanishing giant bullae should probably undergo flexible fiberoptic bronchoscopy to visualize the airways and rule out an obstructing endobronchial lesion. Flexible fiberoptic bronchoscopy in our patient failed to identify an endobronchial obstructive process.

Seven of the patients reported in the literature enjoyed a decrease in their symptoms of COPD following spontaneous closure of their giant bulla. In addition, four patients had a documented improvement in their pulmonary function tests. Each of the three patients, pulmonary function tests improved dramatically after resolution or regression of their giant bulla. Each of these three patients experienced improvement in respiratory symptoms. Two additional patients improved symptomatically despite having no change in their measured pulmonary function. Our patient’s dyspnea on exertion improved, as did his over-inflation as measured by RV. The improvement in his FEV₁₀₀ was modest and is an expression of the severity of his underlying disease. Given the small change in airflow despite the intensification of inhaled bronchodilator and anti-inflammatory medications, we propose that the elimination of his giant bulla and the subsequent decrease in air trapping contributed most to the relief of his dyspnea with exertion and well-being.

The natural history of a giant bulla is typically gradual enlargement over time. The giant bullae often compress normal lung as they enlarge. Patients with giant bullae occupying 30-50 percent of the hemithorax and who have compressed normal adjacent lung are often considered for surgical removal or bullectomy. The surgical resection of the giant bullae may allow for re-expansion of the compressed lung with subsequent improvement in symptoms and lung function.

CONCLUSION

Some patients experience a spontaneous reduction of their giant bullae. The available medical literature suggests that, at least in some patients, a reversible airway process may play a role in the formation of their bullae. By some token, removal of airway irritation by smoking cessation, coupled with improved airway patency from bronchodilator and anti-inflammatory therapy, has been observed to effect partial and total elimination of giant bullae in two patients. These simple interventions should be undertaken prior to surgical consultation for bullectomy.

References:


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You Can Make a Difference!

By Gail Brabson, TMAA Legislative Chair

I don’t know about you but I was ready for the election season to be over! I grew weary of all the T.V. ads and especially the mailings from candidates. I am an avid recycler and I promise I did my best to save all those trees they used to send out those mailings. Our newly-elected candidates are beginning their new roles in office. So where do we, as medical families, fit into the legislative picture?

As I was preparing to write this article for Tennessee Medicine, I came across the new edition of the American Medical Association Alliance (AMAA) magazine, Alliance in Motion. As I was reading the legislative article by Beth Irish, chair of the AMAA Legislative Committee, the mission statement caught my attention. The article states, “The mission of the AMA Alliance Legislative Committee is to enhance the advocacy accomplishments of the AMA Alliance at all levels of the federation on behalf of the best possible health care and access to health care for all Americans.” We must stop blaming the other party, the other candidate, the other side. I have always loved the quote, “If you are not at the table, you are probably on the menu.” I would hope that most physicians and their spouses would much rather be at the table to help be a part of the solution.

You ask how we come to the table; it is really very simple: know the issues. During legislative session the TMA will send out an update on Friday afternoons. Important points and legislative bills will be highlighted each week. For TMA Alliance members, your email will come from the TMAA office. For that reason we need to make sure we have your correct email address. Send your current email to our administrative assistant Judy Ginsberg at tmaa@tnmed.org.

Make sure you know who the legislators for your home district are. You can find your legislator at www.capitol.tn.gov. It only takes a few minutes to contact them and let them know how we feel about bills important to the TMA.

Even if you don’t consider yourself “political,” you can make a difference in legislation that affects medicine. Many times we forget the state legislature is the body that sets forth the rules and regulations by which physicians can practice. You as a physician spouse can help make a difference and be a voice for medicine. When your spouse is busy taking care of patients, you can let your voice be heard for them. And physicians, please take a few minutes to discuss with your spouse the legislative issues that are important. My last bit of advice: please mark your calendar today so that you both can attend PITCH (Physicians Involved at Tennessee’s Capitol Hill) Day on Wednesday, March 6.

Remember, the things physicians disagree on are small; the things physicians have in common are much greater. Together, we are stronger!
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LEON L. REUHLAND, MD, age 77. Died October 4, 2012. Graduate of Loma Linda University School of Medicine. Member of Stones River Academy of Medicine.

WILLIAM W. SHACKLETT, MD, age 94. Died October 9, 2012. Graduate of University of Tennessee Health Science Center. Member of Stones River Academy of Medicine.

JAMES E. HAMPTON, MD, age 83. Died October 20, 2012. Graduate of University of Tennessee Health Science Center. Member of Montgomery County Medical Society.

WINSTON P. CAINE, JR., MD, age 75. Died October 23, 2013. Graduate of Johns Hopkins School of Medicine. Member of Chattanooga-Hamilton County Medical Society.

JOHN THOMAS EVANS, MD, age 85. Died October 23, 2012. Graduate of University of North Carolina School of Medicine. Member of Chattanooga-Hamilton County Medical Society.

BLAINE C. COLLINS, MD, age 98. Died October 29, 2012. Graduate of University of Tennessee Health Science Center. Member of The Memphis Medical Society.

THOMAS F. CARTER, MD, age 83. Died November 1, 2012. Graduate of University of Tennessee Health Science Center. Direct member of the TMA.

Edward Ross Campbell, MD, age 75. Died November 2, 2012. Graduate of University of Florida College of Medicine. Member of Chattanooga-Hamilton County Medical Society.


ALEXANDER MCKNIGHT MCLARTY, MD, age 87. Died December 7, 2012. Graduate of Loma Linda University School of Medicine. Member of The Memphis Medical Society.

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