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TMA Advocacy: Helping Physicians Take Care of Tennesseans

By Christopher E. Young, MD
President

What is advocacy? In its simplest form, it is the act of supporting a cause. It is the one activity TMA members want most from their organization. Advocacy also is the most visible manifestation of organized medicine to government, hospitals, payers, and the public. Advocacy can take many forms including media campaigns, testifying before regulatory boards, or filing amicus briefs in the courts. But the most common understanding of advocacy is legislative advocacy, the direct approach to legislators on issues important to physicians and their patients.

It has been said that the only reason we can practice of medicine in Tennessee is because 67 members of the General Assembly (50 Representatives and 17 Senators) say we can. This is an unfortunate but sobering fact. Each year, hundreds of bills are filed each session that can affect the way we practice medicine. And each year, the TMA Legislative Committee creates a legislative agenda and, together with the Government Relations staff, tracks bills throughout the legislative process, advocating for or against based on TMA policy and direction from the TMA board through its Legislative committee.

The political process is many times unpredictable and chaotic, and often it is hard to evaluate the effectiveness of advocacy efforts. But over time, looking at trends can give some insight into the success of our advocacy by answering the question, “Is it getting better or is it getting worse?” Every year, the TMA stops legislation that would make things worse, and that is a victory. We helped pass legislation that has improved the practice environment; one especially critical area, medical liability reform, stands out.

In 2006, Tennessee was declared a “medical liability crisis” state, with Tennessee physicians facing multitudes of frivolous lawsuits that resulted in significant problems for patients seeking access to care. Medical liability insurance rates were rising and many physicians were forced to stop providing important medical services that exposed them to unacceptable liability risk. The TMA worked with the plaintiffs’ bar to address the significant number of unmerited claims which were being filed and jointly supported passage of a law requiring expert certification of liability claims. The following year the number of medical liability claims dropped over 60 percent and resulted in a steady decrease in medical liability insurance premiums. In 2011, with the support of the Haslam Administration, the TMA led a coalition of tort reform advocates which scored another victory with the establishment of caps on non-economic damages in liability cases, causing further decreases in medical liability premiums that continue today.

Since 2009, the average medical liability premium for physicians has decreased over 35 percent, saving physicians in Tennessee thousands of dollars each year and keeping them seeing patients in the exam room instead of defending frivolous lawsuits in courtrooms.

While there is still work to be done, we can take pride in our achievements. But we must not become complacent. What can you do as a TMA member to enhance our advocacy? First, encourage all of your colleagues to become TMA members. Many physicians believe that belonging to a specialty society is all they need to advocate for their practice. It should be clear that no single specialty can claim the victories we have won in liability reform. Only when physicians work together can we make the changes that affect all physicians.

Second, become a member of IMPACT, our political action committee. Many physicians find it difficult to make political contributions. In a perfect world, making political contributions would be unnecessary. Unfortunately, we live in a competitive world where contributions do matter. Legislators often wonder why physicians, who are as well reimbursed as any profession, make relatively small political contributions. They assume physicians don’t care as much about their profession as other groups care about their respective issues.

We must change that perception.

Recent changes in Tennessee law allow for corporate contributions to political action committees that were previously prohibited. Make a point to bring up the question of a corporate contribution to IMPACT at your next business meeting. Take a small portion of the savings your practice has realized over the years from reduced medical liability premiums and support the advocacy efforts that our profession needs.

Finally, get involved! Get to know your local legislators. Establishing long-term relationships creates opportunities for communication and information. When a question comes up regarding particular legislation, a lawmaker is far more likely to listen to an old friend than a slick lobbyist. In 2012, three physicians (and TMA members) were elected to the 33-member Tennessee Senate. We have other physicians either running or considering runs at legislative seats for the 2014 election. No one understands issues important to physicians better than other physicians. Let’s do what we can to get these colleagues elected. Let’s build on our successes and help our physicians take care of their patients in Tennessee.

Join or contribute to IMPACT by visiting www.tnimpact.com.

Share your thoughts with Dr. Young at president@tnmed.org.
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No Thanks, John Rolfe: The Tobacco Wars Continue

By Loren A. Crown, MD

For a quarter century, the American Academy of Family Practice has sponsored a program called Tar Wars, designed to educate U.S. fourth and fifth graders about the consequences of smoking and to acquaint them with the advertising techniques used to market to youth. Since 1964, the U.S. Surgeon Generals, starting with Luther Terry, MD, have warned of the dangers of cigarettes. And well before that, James I, King of England in 1604, cautioned his subjects on the topic. "...loathsome to the eye, hateful to the Nose, harmful to the braine, dangerous to the Lungs, and in the blacke stinking fume thereof, nearest resembling the horrible Stigian smoke of the pit that is bottomlesse." [sic] From the Khan of Mongolia 1617, and the Czar of Russia 1634, to the Despot Emperor of China 1638, even capital punishment has failed to stem the habit.

Since the 1920s, U.S. cigarette usage rose until almost one-third of adults were habituated, but has recently dropped to about one-fifth and has seemingly plateaued.

Several factors are mentioned in regard to the onset of the surge during the middle of the 20th century. Earlier in that cigarette manufacturing had made handrolling a thing of the past, and safety matches and lighters made convenience a factor. By the end of World War I, with the multitude of servicemen given smoke breaks during the war, the climate of the Roaring '20s, and the use of cigarettes as a tool in movies which allowed the actors to do something while talking, the push to smoke was persuasive. How cool were Bogart and Bacall, Davis and Brando, as they took their drags? Seemingly, there couldn’t be an action hero, a villain, a military man, an Eastern European, an Oriental, or a frontiersman who didn’t have his cigarette, cigar, pipe or chewing plug. Another few bricks in the wall were the association of cigarettes and sex, smoking and rebellion, and even the medical establishment endorsing certain brands (“four out of five doctors choose...”). By the mid-1950s, the majority of males in this country were smokers.

What starts the habit nowadays? According to the American Cancer Society and others, although parental modeling and peer and sibling pressures are important forces, one of the prime factors seems to be advertisements. Yes, indeed, endorphin and dopamine surges keep it going, the would-be dieters complain that they need to smoke to keep the weight off, and many users voice their need for a method to “relax” as well as give themselves a daily reward. It’s the media that seem to promote the habit most effectively for the companies that are paying out the bucks to prevent their products from being regulated out of existence.

Currently about 43.8 million, or nearly 19 percent, of U.S. residents are smokers. Smoking is tied with obesity as the number one top preventable (18 percent) cause of death in our country. The habit leads to nearly half-a-million early deaths. Usage is highest among those with less education, those with no health insurance, those below the poverty level, and those between 18-24 years of age. The mentally ill are also over-represented, as smoking rates rise dramatically with those afflicted, topping up rates over 36 percent. Recently, smokeless product usage has increased. In some states up to 13.7 percent of current smokers are also smokeless product users. Those using smokeless products seem to have more difficulty quitting. Recent tobacco advertisements have encouraged cigarette smokers to switch to these products where smoking is not permitted.

Four thousand youths a day try cigarettes for the first time and a thousand of them become lifelong smokers. Tar Wars, the American Cancer Society and the FDA may need more muscle. The U.S. Court of Appeals for the District of Columbia ruled in favor of the tobacco industry concerning graphic warning labels on cigarette packs by prohibiting pictures of the consequences of tobacco use. While many countries require more than 50 percent of space on packages to state relative health information (75 percent in Canada and 80 percent in Australia) a bizarre interpretation of the First Amendment allowed the R.J. Reynolds companies to protect their customers from such knowledge. Graphic pictures do more than words to get the message across by illustrating throat and lung cancers.

With a clear link between cigarette smoking in movies and the onset of smoking by young people, a big thumbs-down from the American Academy of Pediatrics goes to Paramount Pictures for the 2011 children’s movie “Rango,” a cartoon-styled adventure where smoking was featured prominently by two-thirds of the heroes. This was followed by “The King’s Speech,” “The Help,” “Midnight in Paris,” and “X-Men,” all of which were youth-rated. Nearly half of all movies and nearly 54 percent of PG-13 movies contain tobacco imagery. Touching the problem accurately, Attorney General William Sorrell of Vermont said, “Every time the industry releases another movie that depicts smoking, it does so with full knowledge of the deadly harm it will bring to the children who watch it.” China leads the way in remedying this problem by stating that no smoking can be shown in movies for children and smoking should be restricted to a central character development.

The tobacco industry has taken steps to sell more products outside the U.S. and has increased efforts to hike sales in the second and third world countries in markets more friendly to lighter regulation and increasing disposable wealth. Already one out of four Indonesian children ages 13 to 15 are smokers. And the addition of “attractive” additives here and abroad — including menthol, sugar, licorice, cocoa, and vanilla
— help stimulate the appetites of younger smokers. These additives, however, boost the lethality of already toxic products. There is no safe level of exposure, as nicotine and other harmful smoke ingredients affect not only DNA, but also destroy respiratory tract tissue, stress the cardiovascular system, interfere with chemotherapy, the P450 system, blood sugar control, and fertility. Second-hand smokers are similarly at risk.

And how can we decrease the toll? Two-thirds of cities now forbid smoking in some public places and death rates from acute coronary syndrome events have dropped by a third in these locations.6,7 In England, asthma admissions for children have dropped nine percent with the implementation of anti-smoking bans.8 World Health Organization researchers report that ads bans and tax increases might drop global rates by about half in two decades if adopted. Countries that have adopted such steps have seen dramatic changes in smoking incidences since 1990. For example, Panama smoking rates are down 70 percent, Great Britain and New Zealand about 65 percent, and Brazil down 46 percent.11 Anti-smoking media efforts, while admittedly only part of a multifaceted approach, may help prepare the smoking addict for quitting, according to the Global Adult Tobacco Survey. Results range from Russia, where a third of smokers stated they were considering cessation, to Romania, where 90 percent stated they were swayed by health information.12 In our country less than two percent of the annual tobacco tax and tobacco settlement revenues are spent on tobacco prevention and/or treatment. Finally, as a society, efforts include provisions in the Affordable Care Act to allow insurance companies to charge smokers higher fees. Many companies already do this, even before enactment.

Concerning individual smokers in our practices, multiple approaches exist. A new CDC Public Service Announcement campaign called “Tips From Smokers,” partnering the AAP, AMA, AAP, American College of Obstetrics and Gynecology (ACOG) and the American College of Physicians (ACP), is up and running on the air. Each of the ads ends with the phone number 1-800-QUIT-NOW. The campaign reminds us that more than half of all American smokers have successfully quit and more than a million quit each year. The Tennessee Department of Health’s Tobacco Control and Prevention program offers resources including brochures, posters, pocket cards, and the Tennessee Tobacco Quit Line (free support to the individual trying to quit). Additional resources are located on the CDC website at www.cdc.gov/tobacco/campaign/ads. Resources specifically for healthcare providers are available at www.cdc.gov/tobacco/campaign/ads/groups/health-care-providers.html. Television spots will promote this effort as well. Other sites exist such as Smokefree.gov, QuitSmokingCounter.com, and StickK.com.

Dr. Gregg Mitchell, former TAPP president, urges patients to follow the American Cancer Society advice and “make a plan with a quit date” and then use the aids available. Those who fail to quit after considering the concept are often the two-thirds who do not use any EBM treatments or devices in order to help themselves. NRT (Nicotine Replacement Therapy), which includes patches, medications, and artificial aids can double the odds of success.

Electronic cigarettes are being promoted as a “quit” aid but it appears they may be serving as a “gateway” device attracting children to nicotine addiction. The FDA is currently investigating their downside and may soon provide guidelines or restrictions. Though controversial, NSNUS (a smokeless product), according to former JAMA Editor Dr. George Lundberg, offers an alternative that may reduce dependency on cigarettes and increase cessation rates.

Smokers need our help to get started on the smokefree path, and without it they don’t have a high success rate. Managing smoking cessation as we do other chronic disease states may more likely lead to greater success. Tennessee currently ranks number six in tobacco use and rises to number three on the list of states with COPD victims.13 Since 1612, when John Rolfe awarded some of his parties a new leaf that “smelled pleasant, sweete, and strong,” the afflicted have waged tobacco wars for 400 years. That ought to be enough.

References:

Dr. Crown is a family physician in Covington and a member of the “Tennessee Medicine” Editorial Board.
The MGMA estimates that half of the graduating residents will join hospitals or hospital partnered groups. Why? They are looking for a better lifestyle with more free time, stable income, less risk and less stress. Economics have dramatically swung in favor of the hospitals in the past few years. Correspondingly, there has been a hiring frenzy by the hospitals acquiring physician groups and practices in our area and throughout the country so they can hold and gain even more market share. Twenty-five percent of physicians in the Memphis area are now full-time employees or in single hospital-aligned groups. This is similar to, but far more extensive than the phenomena of physician employment by hospitals in the 1980s and ‘90s, which failed. This time there is a striking difference. It may be a one-way ticket out of private practice.

What could possibly go wrong? The pay is initially good, with no worries about making a payroll; you just practice medicine. But there are frictions. Several hospital executives have voiced concern about having physicians as employees. Unlike prison medicine where all the patients are dangerous and have attorneys, employed physicians are dangerous for hospitals because they are intelligent, independent, don’t play well together, have attorneys and accountants. The hospital could have different agendas than the physicians. The hospitals may want the physicians to service clinics hours away from the hospital. There may be unfair call schedules or other work assignments that prevent them from reaching their assigned target RVU goals, which may have been initially set too high. Not all office settings are conducive to effective RVU generation.

Whatever the issues that make a physician contemplate leaving a fully employed position, there are some major considerations to understand. The world is different this time. There are larger and more complex re-entry barriers to a physician trying to get back into the private practice market after leaving a hospital group. The first barriers are the restrictive covenants that are frequently invoked. These prevent a new practice within so many miles, for so many months or years. The doctor may have to move to a different area and lose the benefit of prior friendships and referrals built up over his or her career. This does not take into consideration family ties to a community. The options are to join another hospital-aligned practice elsewhere, or pay the buyout that many contracts offer and stay where you are. These have ranged from $80k to $110k in cash. Another set of barriers are the start-up costs for a new private practice are higher now. Premiums for health insurance for yourself and employees have recently doubled compared with a few years ago in some regions. Computers and software for electronic medical records for HIPAA compliance are estimated to be up to $60,000 per provider. Hospitals acknowledge that individual non-aligned provider reimbursement will be less in the future, such as the 47-percent reduction in Medicare payments that cardiologists faced for ancillaries. They also expect to pay physicians less in future contracts, as the hospital’s reimbursement falls. Medicare is planning more cuts for other specialties soon. Banks may not be as willing to loan the startup funds as in the past, due to the higher risk and lower returns of an individual practice venture. Coverage for nights, weekends and vacations will be more limited because of the migration of other physicians into exclusive groups.

Re-entry into private practice may not be as attractive as it was before the move into full time employment, and that may have been intentionally made so by the hospitals and the government. As one hospital executive said, keep your private practice as long as you can, for once it is gone, it is gone forever. The new hospital alignment of practices is a one-way ticket.

Dr. Thompson is a former president of The Memphis Medical Society and chairman of the TMA Insurance Issues Committee. He serves as chief of the Otolaryngology Division, Surgery Department at St. Jude Children’s Research Hospital, and chair of the Department of Otolaryngology-Head and Neck Surgery, former associate dean of Graduate Medical Education and Continuing Medical Education, and professor of Otolaryngology - Head & Neck Surgery, University of Tennessee, Memphis. Contact Dr. Thompson at jthomp18@uthsc.edu.

Tennessee Medicine welcomes, but is not responsible for, opinions expressed in this forum.
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.
WHAT ARE MY ACA OBLIGATIONS AS AN EMPLOYER?

By Katie Dageforde, JD

**Q:** I own a small private practice with only a handful of employees. What are my requirements under the Affordable Care Act for offering insurance coverage to my employees?

**A:** First of all, under the Affordable Care Act (ACA) there is no requirement that employers with less than 50 employees must provide insurance coverage, nor is there a penalty for choosing not to. The employer “mandate,” as it has been called, does not apply to small businesses. Further, if your employer-sponsored insurance plan existed before March 23, 2010, it may be considered “grandfathered” and will not be required to comply with the ACA’s new standards. Check with your insurance carrier to be sure—if you have made significant changes to your plan since March 23, 2010, it may not be considered grandfathered.

If you decide to offer employer-sponsored coverage, there are some new requirements that apply regardless of whether it is grandfathered or brand new. Plans can no longer impose lifetime limits on how much healthcare coverage people receive, and they must offer dependent coverage for young adults up to age 26.

All new health plans are required to offer certain essential health benefits (EHBs), which include preventive and primary care, emergency services, hospital, rehab services, outpatient, maternity and newborn care, pediatric, prescription drugs, labs, and mental health and substance abuse. They are also required to provide certain preventive services, such as blood pressure tests, colonoscopies, vaccines, and mammograms, at no cost-sharing to the employee.

The ACA places monetary restrictions on new employer-sponsored health plans, as well. The maximum deductible allowed in small group plans is $2,000 for an individual employee and $4,000 for a family. Also, any out-of-pocket costs must be limited to $6,400 for an individual employee and $12,800 for family coverage.

If you offer your employees the option of a flexible spending account (FSA), contributions are now limited to $2,500, and stand-alone health reimbursement accounts (HRAs) will no longer be allowed starting in 2014. Further, funds from an FSA, HRA, or health savings account (HSA) can no longer be used for over-the-counter medications—employees must have a prescription to use these funds for drugs.

Another option for employers to offer coverage for their employees will be the Small Business Health Options (SHOP) exchange, which opened for enrollment on October 1. Employers will be able to browse and apply for health plans on the healthcare.gov website. Employers who purchase coverage through the SHOP exchange and have 25 or fewer employees may also be eligible for tax credits to put toward employer contributions.

Even if you decide to buy insurance through the SHOP exchange, employers must provide notification in writing to existing employees of their option to purchase insurance through the individual exchange; the deadline for notification was October 1. For new employees, notification of the exchange option must be given upon hiring. A model notification can be found on the U.S. Department of Labor’s website at www.dol.gov/ebsa/healthreform/index.html

Need more information about ACA provisions? Contact the TMA Legal Department at 800-659-1862 or legal@tnmed.org.
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The TMA is pleased to announce the formation of a new CME Advisory Group, as part of its pursuit of accreditation by the Accreditation Council for Continuing Medical Education (ACCME) to offer CME credits for medical education.

*When the TMA was created in 1830, one of its founding principles was to ensure the delivery and availability of quality medical education.*

(Continued on page 17)
**TennCare Payment Reform Takes Effect in 2014**

The Tennessee Medical Association is actively monitoring the progress of TennCare’s new payment reform initiative, set to begin early 2014. The initiative would transform the state’s Medicaid program to one that rewards outcomes and care delivery.

Read the report on the initiative at [www.tn.gov/HCFA/forms/WhitePaper.pdf](http://www.tn.gov/HCFA/forms/WhitePaper.pdf). TMA members are involved in the technical advisory groups and are represented in monthly provider stakeholder meetings by former TMA President B W. Ruffner, MD, of Signal Mountain, and Jane Siegel, MD, of Nashville.

Over the next three to five years, the TennCare initiative seeks to migrate a majority of healthcare spending across Tennessee’s public and private sector from the current fee-for-service system to outcomes-based payment and service delivery models.

Please contact the TMA at legal@tnmed.org or 800-659-1862 with questions or concerns.

**Proposed Rule Could Impact Medicare Coverage for Urine Drug Tests**

The TMA is alerting Cahaba GBA to objections to a new proposed rule that would block Medicare reimbursement for urine drug testing in some needed circumstances – testing that physicians in Tennessee need to perform in order to comply with new state laws.


The Local Coverage Determination (LCD) rule is currently proposed only for the state of Alabama, but the TMA has weighed in, in case the same rule is extended to Tennessee.

Please contact the TMA Legal Department with any questions or concerns at legal@tnmed.org or 800-659-1862.

**AMA: CMS Should Halt Recovery on Payments for “Incarcerated Patients”**

While medical practices in Tennessee await further instructions on appealing Medicare denials for care of patients deemed incarcerated at the time of service, the American Medical Association (AMA) is urging CMS to cancel its denials and recovery efforts altogether on these claims.

Expressing opposition to the burden being placed on physicians to confirm the incarceration status of previous patients, the AMA said CMS instead should work to “improve the process used to identify periods of incarceration and clarify denial forms and notices so that providers are aware of the explicit reason justifying a recoupment.”

In a letter to CMS, the AMA said physicians and providers had little or no knowledge of these payment prohibitions, or of the broad definition of “incarcerated” that applies even when a patient is on parole, on a supervised release, on medical furlough, residing in a mental institution, or other similar situation.

If you need assistance or have questions on this issue, contact the TMA Insurance Recovery Program at 800-659-1862.
TMA PHOTOS GALLERY

TMA Medical Banking was at the Vandy/Ole Miss football game in early September, the kickoff day of collegiate football. TMA members and guests were treated to food, beverages, pre-game activities and the game, thanks to TMA partner, Insubank. TMA Medical Banking is a new member service and benefit, offering custom financing for physicians’ personal and practice needs.

East Tennessee State University Quillen College of Medicine student Kara Kilpatrick is shown working in the Carver Peace Garden. She is among QCOM students serving as volunteer gardeners for the project, which rents space to members of the surrounding community to grow food for themselves, as well as the community.

TMA Assistant Government Affairs Director Julie Griffin takes the 2013 Legislative Update to ETSU Quillen College of Medicine Students in Johnson City (left), and to physicians and practice managers in Nashville (right). The CME/CEU session traveled statewide in September, updating the medical community on laws impacting health care and the TMA’s advocacy efforts and successes in 2013.
Allen F. Anderson, MD, of Nashville, has been named to the board of directors of Herodicus Society, a society of sports medicine veterans, and to serve as vice president of the American Orthopaedic Society for Sports Medicine. He was also recently elected to the 2013 ISAKOS (International Society of Arthroscopy, Knee Surgery and Orthopaedic Sports Medicine) Board of Directors. Board certified by the American Board of Orthopaedic Surgery in general orthopaedics, Dr. Allen is a sports medicine specialist with Tennessee Orthopedic Alliance, with a knee interest in knee injury and ligament reconstruction. He is a member of the Nashville Academy of Medicine.

Joseph B. Cofer, MD, FACS, of Chattanooga, has been elected to lead the American Board of Surgery. Dr. Cofer directs the surgery residency program at the University of Tennessee College of Medicine-Chattanooga (UTCOMC). A 2007 winner of the TMA Distinguished Service Award, he is chairman and co-founder of Project Access Community Health Partnership of Chattanooga. He is a former president of the Chattanooga-Hamilton County Medical Society.

William H. Messerschmidt, MD, a cardiothoracic surgeon with the Wellmont CVA Heart Institute in Kingsport, was recently awarded the Paul Harris Fellow award by the Bristol Virginia-Tennessee Rotary Club. Each year, two Paul Harris Fellows are recognized for their outstanding contributions to the community, in memory of Dr. Kermit Lowry, Sr., and Dr. Kermit Lowry, Jr., both past club presidents. He is a member of the Sullivan County Medical Society.

John V. Pender, MD, FAAP, of Pediatrics Associates, PC, of Memphis, has been named Senior Pediatrician of the Year by the Tennessee Chapter of the American Academy of Pediatrics. Specializing in pediatrics and adolescent medicine, Dr. Pender served as a captain in the USAF Strategic Air Command. He is a member of The Memphis Medical Society.

C. Wright Pinson, MD, of Nashville, has been awarded Surgery Alumnus of the Year by Oregon Health Sciences University. A general surgeon, Dr. Pinson is chief executive officer of Vanderbilt Health System. He currently serves on the American Heart Association Greater Nashville Board of Directors. Dr. Pinson is a member of the Nashville Academy of Medicine.

William Schaffner, MD, of Nashville, chair of the Department of Preventive Medicine at Vanderbilt University Medical Center, has received the Health Achievement Award from the National Meningitis Association (NMA). The NMA noted Dr. Schaffner’s work “has elevated awareness about the importance of vaccines across the lifespan among both professional and public audiences, and these efforts have been invaluable in helping to protect adolescents from meningococcal disease.” An expert in vaccine-preventable diseases and vaccine-related public policy, his past honors include a Nashville Business Journal 2013 Health Care Hero Award for Lifetime Achievement, a 2013 quarterly TMA Public Health Champion award, and the Walter E. Stamm Mentor Award by the Infectious Diseases Society of America. Dr. Schaffner is president of the National Foundation for Infectious Diseases, a member of the Executive Council of the Infectious Diseases Society of America and has worked with the CDC’s Advisory Committee on Immunization Practices for nearly three decades. He is a member of the Nashville Academy of Medicine.

Linda M. Smiley, MD, FACS, FACOG, of Memphis, has been appointed to the American Society of Clinical Oncology’s Quality Oncology Practice Initiative steering group. She also serves on the medical advisory board for the Ovarian Cancer Awareness Foundation and on the board of directors for the Tennessee Chapter of the National Ovarian Cancer Coalition. Board certified in obstetrics and gynecology and gynecologic oncology, Dr. Smiley joined The West Clinic in 1995, specializing in the treatment of cervical, ovarian and uterine cancers. She received the Clinical Oncology Fellowship Award from the American Cancer Society, 1989-1990. She is a member of The Memphis Medical Society.
MEMBER NOTES

Bruce W. Steinhauer, MD, professor of medicine/general internal medicine at the University of Tennessee Health Science Center in Memphis, was recently named the Lifetime Achievement winner in the Memphis Business Journal 15th annual Health Care Heroes awards. Dr. Steinhauer’s 50-plus years of medical practice include roles as former chief of medicine at Seoul Military Hospital in Korea and at Watson Army Hospital in Fort Dix, NJ. He served nine years as president and chief executive officer of the Regional Medical Center at Memphis from 1997 to 2006. Dr. Steinhauer has served on the boards of directors for a number of organizations, including the Tennessee Hospital Association, Trezevant Manor, American College of Physician Executives and Church Health Center. In 2006, he received the Distinguished Service Award from the Tennessee Hospital Association. 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.

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INDIVIDUAL
Cathy Chapman, MD, Memphis

CME ADVISORY GROUP MEMBERS ANNOUNCED
(Continued from page 13)

dication for the physicians of Tennessee. We know that excellent patient care happens when physicians are armed with the latest medical knowledge,” said TMA Chief Executive Officer Russ Miller.

Members of the panel include:

• Adele Lewis, MD, Nashville
• Matthew Mancini, MD, Knoxville
• Fred Mishkin, MD, Kingsport
• Clinton Musil, MD, Johnson City
• Pete Powell, MD, Franklin
• William Rodney, MD, Memphis
• Eugene Scobey, MD, Germantown

The panel is tasked with evaluating education “gaps,” approving educational topics, evaluating the CME program effectiveness, and resolving any conflict of interest issues with presenters. Members will review all CME applications and approve the CME calendar.

For more information on accreditation efforts or educational offerings provided by the association, contact TMA Practice Solutions at 800-659-1862 or angie.madden@tnmed.org.
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Issues facing Tennessee’s healthcare systems and current physicians also affect the men and women who someday hope to be practicing medicine. The present and anticipated physician shortage, the limited number of graduate medical education slots, the debate over intern and resident work hours, state and federal funding questions and student debt all have an impact on the medical community and those it serves.
NOT ENOUGH SLOTS

For years, several health policy organizations were predicting a shortage of 200,000 physicians in the United States by the year 2020. Medical schools across the country have worked to address this by increasing class size and that has helped, although the Association of American Medical Colleges (AAMC) reports the U.S. will still be slightly more than 90,000 physicians short by that time. Of that number, the AAMC estimates a shortage of 45,000 general practitioners and 46,000 specialists.

“There was a call to medical schools several years ago to increase the number of students by 30 percent and schools have risen to that challenge,” said Ray Stowers, DO, FACOFP, founding dean of the DeBusk College of Osteopathic Medicine and vice president of the Division of Health Sciences at Lincoln Memorial University in Harrogate, TN.

Opening up more medical student slots only addresses part of the issue. Once a medical student receives his or her medical degree, additional training is required in the form of a residency, also known as graduate medical education (GME). The number of available residency slots has not increased since the late 1990s, meaning more medical school graduates are competing for a stationary number of residency slots.

David Linville, MD, associate dean for Graduate Medical Education for the Quillen College of Medicine at East Tennessee State University in Johnson City, said there may not be enough residency positions for all the medical students in a few years’ time.

“Not having enough positions is kind of like the finger at the end of a hose. We’re restricting the outflow right now. And soon, we’re going to have a situation where we have too many medical school graduates and not enough residencies to train them in,” he said, adding, “You can’t practice in Tennessee without going on to start a residency. You can’t even get a license. If you want to practice primary care or internal medicine, the quickest you can be done is seven years after college.”

“For the first time, we had more than 500 U.S. medical school graduates not find residency positions,” reported Donald Brady, MD, FAACH, senior associate dean for Graduate Medical Education at Vanderbilt University School of Medicine in Nashville, who described this development as an historic event. “That number only looks to get worse if something isn’t changed.”

Meanwhile, not everyone is increasing class size. Bonnie Miller, MD, senior associate dean for Health Sciences Education at Vanderbilt, said her school has made a deliberate decision not to increase the number of students and that the beginning class next year will actually be a bit smaller, which seems counter to the conventional wisdom. “We feel our niche at Vanderbilt is creating future physician leaders. While we certainly acknowledge the physician shortage, we feel that our mission is to nurture the physicians who will lead us through changing and challenging times,” she said.

DOCTOR SHORTAGE

Dr. Stowers cites other reasons for the continuing shortage, including a growth in the country’s general population, aging members of the baby boomer generation with health issues and the coming of the Patient Protection and Affordable Care Act, also known as “Obamacare.” When the ACA takes effect in 2014, more than 30 million people in the U.S. who previously did not have access to health insurance will be added to the mix. The medical community, elected officials and others seem to have almost as many opinions and predictions on exactly how it will affect the delivery of healthcare.

Not only are more patients getting older, so are their physicians. One in three physicians in the U.S. is over 60, according to Robert V. Acuff, PhD, director of Federal and Health Affairs and Government and Community Relations at the Quillen College of Medicine. Approximately 1,000 people from the “baby boom” generation are retiring each day and their healthcare needs are taxing an already stressed system. On top of that, he said one in three physicians is expected to retire over the next decade.

The situation is especially serious outside large urban and suburban areas that tend to be more prosperous. “We believe that we’re really underserved in the inner city as well as rural communities,” Dr. Acuff said.
BUDGET ISSUES

Federal and state budget issues impact both state and private medical schools, albeit in somewhat different ways. State schools receive their direct funding from state and federal governments, while private schools receive grants or work with partners that receive state and federal funds. In recent years, state and federal budgets have gone through a series of cuts, which has affected medical education, especially at the graduate level.

“We don’t see much daylight right now in terms of funding for graduate medical education. I don’t see much growth either here in Tennessee or across the nation,” said Robert Fore, EdD, FAHEP CCMEM, associate dean for Academic Affairs at the University of Tennessee College of Medicine-Chattanooga.

“Where you do see growth is where there are some large hospital systems that are attempting to fund graduate medical education themselves.”

On the other hand, Vanderbilt has made some small increases in graduate medical education, according to Dr. Brady, but has done so from investment of its own resources. He points to the limited number of Federally-funded slots and proposals to cut GME funding as barriers to GME expansion.

Dr. Brady points to a third factor: the decrease in physician training programs and offset costs that are not covered by federal funding. Both he and Dr. Miller note that Vanderbilt contributes around $40 million a year to cover non-billable and other healthcare expenses that are not reimbursed.

HEAVY DEBT

Student debt has a greater impact on medical education and the physician workforce than many may realize. Medical school is not cheap and a student may owe anywhere from $120,000 to $160,000 or more when he or she receives a medical degree.

“That is cumulative debt that starts from the time you go to college and until you’re finished with medical school,” said Dr. Stern, who said the total debt includes both schooling and living expenses, as well as other things that are only indirectly due to the school.

“Student debt reflects several factors,” he said. “While the tuition and other fees charged by the medical school is certainly a major factor, there are also other contributing expenses – the latter often have to do with lifestyle choices such as where does one live and what kind of car you drive. We think that scholarships, in addition to loans, are an important part of helping students with debt. Financial counseling is also important so that students understand the implications of debt that they take on today for their financial picture in the future.”

“We think scholarships are an important part of helping students with that, in addition to loans, of course, but counseling is a part of that, as well, realizing what the consequences are of the loans and how one might want to live carefully,” Dr. Stern added.

Medical schools are trying to address the debt issue in several ways, including by trying to keep tuition as low as possible.

“As that margin decreases, the ability of the institution to provide that offset is becoming more difficult and so we are at a perfect storm. And I would say not just worrying about whether we increase positions, but if the funding cuts come to bear as have been proposed, I believe you’re going to see training programs around the country and around the state begin to close and it will just make that bottleneck much worse,” Dr. Brady said.

Tennessee’s medical community isn’t just waiting around for budget cuts to happen. TMA Director of Government Affairs Gary Zelizer said he and TMA members are in contact with representatives of the state’s medical schools in the area of GME. “We’re interested in broadening the programs that are available to train more Tennessee-based physicians and advocate for keeping more of them here.”

Those medical school representatives are also meeting with state lawmakers and others to find ways to add positions and work around the GME funding issue. Dr. Acuff said TMA members are also working with Tennessee’s Congressional delegation to see if the cap on GME positions can be raised. The House Academic Medicine Caucus, co-chaired by First District Congressman Phil Roe (R-Johnson City), a retired OB/GYN, held hearings on GME last year that featured testimony from Phil Bagnell, MD, a professor of pediatrics and former dean of Quillen College of Medicine. Fourth District Rep. Scott DesJarlais, MD (R-South Pittsburg) and Fifth District Rep. Jim Cooper (D-Nashville) are also caucus members.

Dr. Acuff points to several bills that have been introduced in the House and Senate, each of which would add 3,000 residency slots for five years starting in 2014, for a total of 15,000 new positions. However, he said he does not see “much enthusiasm” for the legislation, adding that similar bills introduced in the last couple of Congresses have failed to win passage.
“We have a pretty robust scholarship program, based on need and merit,” said Vanderbilt’s Dr. Miller. “We also look at the percentage of our graduates who have graduating debt greater than $200,000 and try to keep that low. We try to make Vanderbilt accessible to any of our invited applicants who want to come here.”

While many students have to pay back all their medical debt from their own pockets, which can take many years, there is often help available. Dr. Fore noted that large healthcare systems offer opportunities for young physicians, depending on their specialties. Those systems may provide a certain amount of payback for loans and other debt if the physician agrees to work for them for a specified number of years. In addition, there are public/private partnerships around the country that recruit physicians to work in more rural or underserved areas for a certain length of time and also offer assistance in paying off medical school debt.

Avoiding too much debt in the first place is also part of the plan in some schools. At UTHSC, Dr. Stern said financial counseling is part of the effort, “so that they’re aware of what they’re taking on and in what ways they might limit what they’re taking on.”

He is also “exceedingly active” raising scholarship money in hopes that students will graduate with as little debt as possible, he added, “because that clearly forces certain choices on people that they might otherwise be more engaged in community service or activities that aren’t as revenue-bearing.”

In other words, debt often forces a young physician to train as a higher-paid specialist rather than opt for family or community medicine. “Let’s say someone might want to work at Doctors Without Borders or in an underserved community where the compensation is much less. If you have a high debt load, you have to consider that,” said Dr. Stern.

In recent years, there has been talk of reducing the traditional four-year medical school program to three years, and some schools have moved toward that. Proponents have cited a shorter program as one way of getting more physicians into practice sooner. It does not seem to be in the works, though, for any of the programs in Tennessee.

“We’re not looking at changing the duration of medical school,” said Dr. Stern. “We’re looking to try to use the time that the students are with us in a more effective way with more active learning, with more chances to select clinical electives and basic science and research electives, but we’re not looking at this point to changing the number of years of medical school.”

Dr. Stern agreed there is an argument for shortening the medical school program; for instance, if a student knows from the beginning that he or she wants to be a family medicine physician, some of the electives and training might not be considered as important.

However, he points out that a lot of students are undecided on the type of medicine they want to practice. “Although
It has long been a tradition for residents to work long hours as part of their training. It has also been a point of controversy that came to a head with the Libby Zion case. Zion was a college student who died in a New York City hospital in 1984. Her parents filed suit, alleging that the residents who attended Zion were overworked and not properly supervised. A criminal investigation resulted in charges of negligence against an intern and resident, although they were ultimately exonerated by an appeals court. The Zion case resulted in a New York state law restricting the number of hours a medical resident can work. Eventually, the Accreditation Council for Graduate Medical Education imposed limits on work hours for all residents in the U.S.

Since that time, there has been a debate on whether reduced work hours have affected patient safety, quality of care and the education of residents. “Duty hours are a mixed bag,” said Vanderbilt’s Dr. Brady. “Specific duty hour rules can be debated, but having a fit and rested physician is absolutely the right approach to take.”

In addition to the issue of physicians getting rest, there are questions about the continuity of care and patient handoffs. Dr. Stern said handing off patients every eight hours becomes a time-consuming activity and if it is not done carefully, the relieving physician can get the wrong information. Which means, he said, “...On your shift, you don’t benefit from what the patient has taught you, either by how their body has responded to things or what they’ve actually said.”

More handoffs increase the probability of medical errors, according to Dr. Fore, who said it becomes a patient safety issue and one affecting resident training. “There are also those physicians who are training residents who will say that because of the restrictions on hours, there’s just not enough time during your entire residency program to get all the training that you need.”

Dr. Brady added that at times, it might be better for another member of the healthcare team to care for the patient. “We’ve done some studies here that show the actual work-hour reduction does not necessarily much change the number of patients people are actually seeing. We’re more committed to understanding what it means to be a well-rested physician, to understand your role as part of a team and to understand how to do proper handovers and ensure the quality of care that anybody would want as a patient and to make sure that patients are handled safely.”

Shorter work weeks also raise the question of whether residents are getting enough training. Dr. Linville pointed to concerns with programs that are procedure-intensive, such as surgery.

“The best way to become a surgeon is to operate. And if you are limited in the amount of time that you can work in your training, that might have an impact in terms of outcome. We’re not seeing that, necessarily, but it is on the forefront of everybody’s mind,” he said.

Patient safety remains primary, though. “We’re all concerned about patient safety,” Dr. Linville said. “We all want to make sure the residents aren’t fatigued. The duty hour frameworks provide us that. We do follow rules to the ‘T’ here. It’s sort of a big debate at the national level.”

That debate is not going away anytime soon. “We may see some tweaks in the system down the road,” said Dr. Fore, who added, “There are certainly a lot of concerns about the restrictions in hours and there are proponents and opponents.”

“I would expect some (more) changes,” added Dr. Stowers. “Having to adhere to strict guidelines has affected continuity or patient handoffs. Further study is needed and not all the answers are in yet. I think the continuing study and analysis of this issue is very much warranted at this point.”
Until there is more funding for graduate medical education, whether from federal, state or other sources, the physician shortage is likely to continue, especially in the area of family medicine. Underserved communities will continue to be at a disadvantage, too.

“It’s a problem and we’re trying to address it,” said Dr. Acuff, adding it is a concern to all medical schools across the country. “We need to have a statewide discussion about GME.”

While there are challenges with funding, having enough physicians and other issues, Dr. Fore believes his students will be ready to meet those challenges when they enter practice because they have had the best training available. “It’s as good as anything on the planet, because the United States has the best medical education system in the world.”

“It’s just a very interesting time, I think, in healthcare in general, with the changes that all the major academic health centers will have to make (to cope) with changes in funding,” Dr. Miller said. “It’s difficult for the public—and sometimes our own trainees—to understand the connection between the healthcare system and the medical education system. They are really inextricably linked. And so anything that is cutting support for healthcare delivery is also cutting support for medical education.”

Dr. Stern said he believes we will see more creative and “unthought-of” ways of funding GME in the years to come. “And that’s anything from public/private partnerships, with corporate partners that are put together appropriately, to accessing state funding for things people might not have thought of before.”

“This is about the health of Tennesseans,” concluded Dr. Brady. “This is about the health of every individual in this state, and their ability to get help when they need it by the provider they need to get the help from.”

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TMA Website: New Look, New Feel, New Experience

By Brenda Williams

The Tennessee Medical Association has a new online presence.

As part of its effort to be more responsive and member-friendly, the TMA has redesigned its website to be a better resource for and enable more interaction by Tennessee physicians. We want this site to become your personal resource for news, events and connections within the Association and the medical profession. We’d like to offer a sneak-peek of what you will find when you visit us online.

**Home**

Go to www.tnmed.org and you’ll see the home page highlighting special events, programs and services, TMA and medical industry news, our public campaigns, and across the top a quick navigation menu for all of the important things you do on our site.

**Login**

Our member login process is simpler. We have done away with the old login method; instead, your user name is your first name, last name and birth year - example: johnsmith1964. Your password will be temporary and once you use it to login, you will be prompted to change your password to something you can easily remember. If you did not receive an email or a letter with your new login information, please contact the TMA at 800-659-1862 for help.

**Join/Renew**

Perhaps the most frustrating feature from previous versions of our site, this new page will allow to join or renew your membership and pay dues easily and quickly. Our new site uses a recognizable and secure online payment system to instantly process your dues payment, which means quicker access to the resources and benefits you are entitled to.

**For Physicians**

Our “For Physicians” tab gives you quick access to the features our members use the most, such as our most-used expert and advocacy programs including Insurance, Government Relations, Legal, Health System Reform and Practice Solutions. There are links to our member search directory and our new TMA Marketplace, chock full of member discounts and special benefits from our vendor partners for your practice and personal use.

**For Patients**

Send your patients to this tab on TNMed.org. The primary feature is our “Find a Physician” directory to help them choose their next doctor among our members. It also showcases our work in the public health arena, including our priority to reduce Tennessee’s prescription drug problem, our work to promote healthy lifestyles, and our public campaigns on Choosing Wisely and Physicians Leading the Healthcare Team. We also include a page full of popular, trustworthy health information resources for patients.
Professional Growth

This important section helps members meet their educational requirements and access leadership development programs and resources. Find and register for our traveling seminars, such as our ICD-10 or Insurance Workshop programs, or search our catalog of online CME and other classes for education at your fingertips, on your schedule. Learn about and apply for our Physician Leadership College, a year-long program to develop your leadership skills and savvy. Additional resources will be added as they become available.

Get Involved

Taking action and becoming a part of carrying out the TMA mission is easier with this new site ... “Get Involved” will help you do exactly that. Take a look at our ongoing advocacy efforts and where we stand on issues of importance to medicine. Sign up for upcoming events, such as PITCH (Physicians Involved at Tennessee’s Capitol Hill), Doctor of the Day and our all-important political action committee, IMPACT.

Media

Last but not least, our “Media” section showcases and presents the public side of the TMA. Check out our TMA Blog, written by our experts on pertinent healthcare trends and topics; read the latest TMA and healthcare news; read the newest issue of Tennessee Medicine online; check out our videos and download our issue whitepapers.

Top Navigation

At the very top right of each page you will find additional links including the Login page, your personal TMA page, a link to TMA history, mission and priorities, our calendar and our important contact information.

We hope you find the TMA’s new website easy to use, visually pleasing, better organized, and more community-oriented. The site will no doubt continue to undergo some changes as we receive member feedback on how things are working. Please give us a call at 800-659-1862 or email info@tnmed.org to let us know how you like the new tnmed.org!
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Intravenous Gammaglobulin as Rescue Therapy in a Patient with Sickle Cell and Septic Shock

By Ivan Romero-Legro, MD; Dipen Kadaria, MD; Luis C. Murillo, MD; and Amado X. Freire, MD, MPH, D-ABSM, FACP, FCCP, FCCM, FAASM

ABSTRACT

**Introduction:** We present a case involving a patient with sickle cell and hyposplenism, in which refractory septic shock quickly responded after the infusion of intravenous gammaglobulin (IV-GG) given as an adjuvant-rescue therapy.

**Case Description:** A 30-year-old African-American female with history of Sickle Cell disease was admitted for acute chest syndrome, septic shock and respiratory failure. Despite aggressive therapy the patient remained on two vasopressors and with persistent bacteremia. Within one day of starting IV-GG, both vasopressors (norepinephrine and vasopressin) were able to be discontinued.

**Discussion:** Patients with hyposplenism have functional opsonization failure. Infusion of IV-GG has been shown to improve such function in patients with hyposplenism. We were able to document a *temporal association* between IV-GG rescue therapy and septic shock improvement.

**Conclusion:** The utilization of intravenous gammaglobulin should be considered in patients with sickle cell disease and hyposplenism as an adjuvant therapy for refractory septic shock.

INTRODUCTION

Sepsis is the most frequent diagnosis on admission to a medical ICU. Standardization of management and process of care have been accomplished by the surviving sepsis campaign (recently updated, 2013) and by initiatives that address the appropriateness and timing of other components of medical care (i.e. sedation, anemia, and glucose control). Management of special pathophysiological conditions cannot be covered on clinical guidelines directed for the general population. Functional hyposplenism is one such condition. An intact spleen function is required for sufficient immunoglobulin production and for encapsulated organisms’ opsonization. Disorders of hemoglobin production can be associated with anatomical and functional hyposplenism; consequence of the natural history of lifelong auto-splenectomy.

We describe a case of a patient with sickle cell disease and spleen size half of normal (anatomic hyposplenism) in which septic shock refractory, after fluid resuscitation, to conventional medical care (adequate antibiotic coverage, vasopressors, and steroids) quickly responded after the infusion of IV gammaglobulin given as an adjuvant-rescue therapy.

**CASE DESCRIPTION**

A 30-year-old African-American female with history of homozygous Sickle Cell disease, protein S deficiency and a history of previous DVT and PE presented to the ER with fever, chills, confusion, right shoulder, chest and back pain for the last 24 hours. Vital signs on admission were blood pressure 77/40 mmHg, pulse 175 beats per minute, respiratory rate of 26 per minute, temperature of 105 °F; and an oxygen saturation of 95% on 4L nasal cannula. Physical examination of the chest revealed bilateral inspiratory crackles. The remainder of the examination was within normal limits. Her respiratory status deteriorated and the patient was intubated for respiratory failure and to support her work of breathing. Initial laboratory results are shown in the Table. Chest x-ray revealed bilateral alveolar infiltrates.

Exchange transfusion was performed for management of her acute chest syndrome precipitated by an infection. With a clinical diagnose of septic shock due to community-acquired pneumonia, early goal-directed therapy was started. Sedation and glucose control were prescribed following hospital protocols. She received fluid boluses and after 5L of normal saline vasopressor support was initiated with the intent to maintain a MAP of 65 mm Hg. The patient required three vasopressors for hemodynamic support (norepinephrine 70 mcg/kg/min; phenylephrine 150 mcg/kg/min; and vasopressin at a fixed dose of 0.04 unit/min). She was started on steroid (hydrocortisone 200 mg bolus followed by a drip of 240 mg over 24 hours), prompt empiric broad spectrum antibiotics (piperacillin/tazobactam, vancomycin and ciprofloxacin), and was admitted to the medical intensive care unit where appropriate glucose control was achieved. Chest CT scan showed bilateral lower lobes air space disease and absence of PE. Next day blood culture came back positive for Klebsiella pneumoniae and antibiotics were tailored per the organism sensitivity.

Despite aggressive therapy on day four, the patient remained in refractory septic shock on two vasopressors (Figure), and with persistent bacteremia. Transthoracic
echocardiogram was negative for vegetations. CT scan of abdomen showed a small spleen (6 cm) but was negative for abscesses. Rescue treatment with gammaglobulin was discussed by the medical team. Intravenous gammaglobulin (IV-GG) was started (70 grams IV daily for three days). Within one day of starting IV-GG, both vasopressors (norepinephrine and vasopressin) were able to be discontinued. Over the next day systemic inflammatory response syndrome resolved and negative blood cultures were obtained.

On day 19 she had a new episode of sepsis, this time from a catheter-induced infection, and broad spectrum antibiotics were initiated. Blood culture was positive for methicillin-resistant staphylococcus epidermidis. She required vasopressor support with norepinephrine. Due to her previous clinical response to gammaglobulin, she received a new dose of adjuvant gammaglobulin. Within one day vasopressor support was discontinued and her blood culture came back negative. The patient was discharged from ICU after 35 days and later from the hospital alive.

**DISCUSSION**

We present a patient with sickle cell disease and anatomical hyposplenism (6 cm spleen; normal = 11 cm) who developed refractory septic shock due to bacteremia with an encapsulated organism. Persistent and poor clinical response in spite of adequate volume resuscitation and strict adherence to surviving sepsis campaign recommendations troubled the medical team caring for this patient.

Intravenous gammaglobulin (IV-GG) was used as a rescue therapy in our patient. We were able to document a *temporal association* between IV-GG rescue therapy and septic shock improvement demonstrated by a decrease requirement of vasopressor support (Figure). The *consistency of the observation* during the two episodes of bacteremia also enhances the validity of our finding (Figure). Patients with hyposplenism have functional opsonization failure for encapsulated organisms. Infusion of IV-GG has been shown to improve such opsonization function in patients with hyposplenism. The events observed in our patient have *biological plausibility* and such experience supports our recommendation for the use of this rescue therapeutic intervention in patients with functional or anatomical hyposplenism (i.e. sickle cell disease) or overwhelming bacteremia.

Current sepsis management recommendations address general population needs. Special population like the one discussed in this report (functional hyposplenism) are not individualized in the surviving sepsis campaign management recommendations. Our observation is important for supporting this form of rescue therapy in patients with functional hyposplenism (i.e. sickle cell disease) as we were able to demonstrate: temporal relationship, consistencies of the results during two episodes of bacteremia, and biological plausibility (opsonization enhancement against encapsulated organisms).

There are several reports on the use of intravenous gammaglobulin. Results of these observations in sepsis do not have sufficient consistency to generate a general recommendation for the use of this therapy in the general population. We propose that narrowing the indication to patients with functional hyposplenism or overwhelming bacteremia will be necessary to achieve better outcomes with the intervention (IV-GG).

Even though ours is a single patient observation in a special population (sickle cell disease and hyposplenism) the strength of

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*IV-GG = Intravenous gammaglobulin*
our clinical observation is sufficient to propose the consideration of this rescue therapy in similar situations. Final recommendations regarding this therapy should wait for definitive randomized clinical trials. Meanwhile, evidence like this should not be ignored and be considered as supportive of this rescue therapy for the benefit of our patients.

CONCLUSION
In summary, we cared for a patient with sickle cell disease and anatomical/functional hyposplenism with refractory septic shock due to an encapsulated organism. In spite of a strict adherence to surviving sepsis campaign recommendations, our patient did not improve clinically. As a last resort the medical team decided to provide, in a rescue therapy fashion, intravenous gammaglobulin. Such intervention was associated with clinical improvement and survival of our patient.

The utilization of intravenous gammaglobulin should be considered in patients with sickle cell disease and functional hyposplenism as an adjuvant therapy for severe sepsis or refractory septic shock. +

References:

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The Burden of Lung Cancer in Tennessee—Adopting a Regional Perspective

By David Blackley; Bruce Behringer; and Martin Whiteside

INTRODUCTION
The most recent data from the Centers for Disease Control and Prevention has Tennessee ranked third worst among all states for age-adjusted, all-cancer mortality rates. Tennessee is also third worst among all states when analysis is restricted to lung cancer. Tennessee’s all-cancer mortality rate is 12 percent higher than the national rate, while the lung cancer mortality rate is 30 percent higher than the national rate.

Use of tobacco is the single most preventable cause of mortality and morbidity in the country, and lung cancer is the leading cause of cancer death for all Americans regardless of race, ethnicity or gender. Approximately 90 percent of all lung cancer cases are smoking related. Other risks, such as environmental exposures, may also contribute to lung cancer incidence but to a much lesser extent. No reliable population-based early detection method exists for lung cancer. Despite national and state-level efforts to reduce tobacco use, about one in four Tennessee adults still smokes cigarettes—a significantly worse prevalence than in the United States as a whole. Tennessee has the fifth-highest percentage of adult cigarette smokers of all 50 states.

The Tennessee Cancer Coalition has set a goal to reduce the burden of lung cancer in the state by preventing smoking initiation, promoting quitting and eliminating second-hand smoke exposures. Smoking prevalence data have been reported at the state and regional levels in Tennessee, and lung cancer incidence and mortality data are available by county. However, we are unaware of any integrated presentation of cigarette smoking prevalence, lung cancer incidence and lung cancer mortality by region for the entire state. Within states, there are often regional variations in health outcomes, and many cancer control and public health initiatives are designed and implemented regionally. Data presented at the Tennessee Department of Health region level may provide a more sensitive tool to help determine areas of greatest need for lung cancer prevention activities (Figure).

METHODS
This paper presents an analysis of lung cancer statistics by Department of Health regions (n=8, metros combined with respective regions) as an approach to understand regional differences that may be useful for state and regional cancer control planning and implementation. Since no single indicator offers a complete picture of lung cancer disparities, we offer four using current data (Table 1).

Indicators included in analysis are 1) percent current smokers, 2) lung cancer incidence rate, 3) lung cancer mortality rate and 4) lung cancer mortality-to-incidence ratio (MIR). County-level data for indicators are combined to derive regional percentages, rates and ratios.

Percent current smokers is a behavioral measure. Data for the percentage of current smokers by region, combined with embedded metros, are from the 2007 Tennessee Behavioral Risk Factor Surveillance System. This measure applies to cigarette smokers over 18 years of age.
Age-adjusted lung cancer incidence rates represent the number of newly-diagnosed cases of lung cancer occurring in a defined population during a defined time period.\textsuperscript{5} 2004-2006 county-level data are from the Tennessee Office of Cancer Surveillance.

Age-adjusted lung cancer mortality rates represent the number of deaths due to lung cancer occurring in a defined population during a defined time period.\textsuperscript{5} 2003-2007 county-level data are from the National Center for Health Statistics, and statistical calculations are performed using the National Cancer Institute’s SEER\textsuperscript{®}Stat 6.6.2 software package. Multi-year incidence and mortality rates are provided to stabilize potentially volatile single-year rates in regions with small populations.

Lung cancer MIR is the age-adjusted mortality rate divided by the age-adjusted incidence rate.\textsuperscript{7} This indicator provides a population-based approximation of survival. MIRs differ since there are wide variations in survival depending on the cancer type. An MIR less than 1.0 is better than an MIR greater than 1.0, since a lower MIR indicates fewer lung cancer deaths relative to the number of incident lung cancer cases in the same region during the defined time period. Thus, calculating MIRs while looking at regional lung cancer burden can enrich our understanding of mortality rates given incidence data.\textsuperscript{7}

**RESULTS**

The state of Tennessee fares worse than the U.S. as a whole for percent current smokers (24.3 percent vs. 19.8 percent), lung cancer incidence rate (81.9 vs. 62.5) and lung cancer mortality rate (68.1 vs. 52.5). However, the MIRs for Tennessee and for the United States are nearly identical.

**Percent Current Smokers:** The Northwest and Northeast regions have the two highest percentages of current smokers. Each of these is about 50 percent higher than in the U.S. Addressing smoking rates will be a crucial piece of any effective population-based lung cancer control program.

**Incidence Rate:** Incidence rates derived from the total at-risk population are usually good comparative indicators.\textsuperscript{7} All regional incidence rates exceed national rates (range: four percent to 41 percent). Four regions (East, Northeast, Northwest and Mid-Cumberland) have age-adjusted incidence rates higher than 80 per 100,000. Three regions (Upper Cumberland, Southwest and Southeast) have noticeably lower age-adjusted incidence rates below 70 per 100,000. The East region, which has the fifth-highest percentage of current smokers, has the highest incidence rate. The Northeast and Northwest regions, which have the highest percent current smokers, have the second and third-highest lung cancer incidence rates.

**Mortality Rate:** All regional mortality rates exceeded the national rate by at least 20 percent (range: 20-49 percent). The Northwest region has both the highest mortality rate and the highest percentage of current smokers. Conversely, the Southwest region has both the lowest mortality rate and the lowest percentage of current smokers. Other regions’ rankings are mixed. For example, while the East region has the worst incidence rate, it falls in the middle of all regions for comparative mortality rates.

**Mortality-to-Incidence Ratio:** Two regions, Upper Cumberland and South Central, have MIRs that exceed 1.0, indicating the age-adjusted mortality rates exceed the age-adjusted incidence rates. The East, Mid-Cumberland and Northeast regions have the lowest MIRs, equal to or below the national level. The East region has the worst incidence rate but ranks in the middle of all regions for mortality rate; its MIR is the lowest (best). It is notable that the two regions with high MIRs are largely rural; timely access to diagnostic services and treatment could play a role in the elevated ratios.

**DISCUSSION**

Intuitively, mortality may seem to be the most appropriate indicator when describing regional lung cancer disparities. However, disparities can be driven by a complex set of cultural, economic, social and health system factors that show regional variations in their respective contributions to poor cancer outcomes. Mortality rates could be very high for a cancer site with low or moderate incidence rates but very low survival likelihood. Alternately, there may be high mortality rates for a different cancer site that has high incidence but a relatively good prognosis.\textsuperscript{7} As these lung cancer data demonstrate, mortality and incidence often do not mirror each other, so it is important to consider both simultaneously when quantifying an area’s cancer burden.

MIRs can be used to better visualize and understand divergences of mortality and incidence rates that are often assumed to be directly related. The reasons for these divergences are not fully understood but may be rooted in health system and biologic variables. Comparing MIRs within states can enrich our understanding of variations in lung cancer burden.

**TABLE 1. Selected indicators of regional lung cancer burden in Tennessee.**

<table>
<thead>
<tr>
<th>Region</th>
<th>% Current Smokers\textsuperscript{a}</th>
<th>Incidence Rate\textsuperscript{b}</th>
<th>Mortality Rate\textsuperscript{c}</th>
<th>Mortality-to-Incidence Ratio\textsuperscript{d}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>29.4</td>
<td>82.8</td>
<td>69.8</td>
<td>0.84</td>
</tr>
<tr>
<td>East</td>
<td>23.7</td>
<td>88.0</td>
<td>70.4</td>
<td>0.80</td>
</tr>
<tr>
<td>Upper Cumberland</td>
<td>23.5</td>
<td>65.1</td>
<td>70.8</td>
<td>1.09</td>
</tr>
<tr>
<td>Southeast</td>
<td>24.3</td>
<td>68.6</td>
<td>65.0</td>
<td>0.95</td>
</tr>
<tr>
<td>Mid-Cumberland</td>
<td>22.2</td>
<td>80.2</td>
<td>65.3</td>
<td>0.81</td>
</tr>
<tr>
<td>South Central</td>
<td>25.5</td>
<td>70.9</td>
<td>74.4</td>
<td>1.05</td>
</tr>
<tr>
<td>Northwest</td>
<td>30.3</td>
<td>82.1</td>
<td>78.4</td>
<td>0.95</td>
</tr>
<tr>
<td>Southwest</td>
<td>21.4</td>
<td>67.1</td>
<td>63.0</td>
<td>0.94</td>
</tr>
<tr>
<td>Tennessee</td>
<td>24.3</td>
<td>81.9</td>
<td>68.1</td>
<td>0.83</td>
</tr>
<tr>
<td>United States</td>
<td>19.8</td>
<td>62.5</td>
<td>52.5</td>
<td>0.84</td>
</tr>
</tbody>
</table>


\textsuperscript{d} Age-adjusted mortality divided by age-adjusted incidence for each geographic area.
cancer outcomes by region. High MIRs are often attributed to deficiencies in early detection, resulting in more late-stage diagnoses.7 No reliable or cost-effective population-level early detection method exists for lung cancer, so variations in availability and access to these services is unlikely to explain much of the variation in MIRs. The MIR is a method to examine a proxy for population-based survival that could give clinical and public health practitioners a tool for more prudent allocation of limited funds. Survival studies are expensive and not always practical, so MIRs should receive more consideration as an alternative option for studying cancer outcomes.7

Relevance to Clinicians
Lung cancer is the leading cause of cancer death in Tennessee, and state incidence and mortality rates far exceed those in the United States. Preventing lung cancer is a priority for the Tennessee Cancer Coalition, which calls for both primary and secondary prevention strategies.3 We describe two approaches: one patient-centered and the other youth-targeted.

Patients consider their primary care physicians to be credible sources of information, and are likely to be receptive to smoking cessation messaging.8,9 Between 70 percent and 80 percent of those who smoke see a primary care provider every year, and most are hopeful they can quit.8,9 Nearly half try to quit each year.8 These numbers offer a unique opportunity to primary care providers. Regular appointments offer a cost-effective, convenient venue to disseminate cessation messaging.

Clinicians are often reluctant to directly and comprehensively address tobacco use with patients, even though smoking prevalence remains high.8 In a random sample of U.S. primary care physicians, 74.8 percent of respondents reported advising smokers to quit at all or almost all visits, a prevalence that has remained constant since the 1990s;6 63.7 percent of primary care physicians reported recommending the patch always or often; while 67.3 percent reported prescribing bupropion. Recommendations for non-pharmaceutical cessation strategies were less frequent, with 10 percent of physicians reporting referrals to cessation experts often or always, and 25.9 percent reporting referrals to cessation programs.3 Research has shown those receiving counseling and patches are 28 percent more likely to abstain from smoking at one year after quitting than those who use only nicotine patches.8 When clinicians are trained in the 5As (ask, advise, assess, assist, arrange) clinical practice model, research suggests patients could double cessation rates compared to those seeing a provider prior to training in the model.5 Research has produced targeted initiatives for clinicians, including 1) improved education for physicians on drugs available to help patients quit smoking, 2) better training for physicians on how to counsel their patients about consequences of smoking and options for quitting and 3) training of clinical support staff in counseling methods.9

It is worthwhile to complement physician-reported data with those from a patient perspective. Only half (49.6 percent) of Tennessee adult smokers who had seen a health professional in the past year reported being advised to quit at every visit. About one-third (36.1 percent) of those surveyed were never advised to quit during this time.6 Of those who reported being advised to quit smoking by their provider, 63.3 percent indicated that drugs to help quit were not discussed or recommended; 62.8 percent also reported that no non-pharmaceutical methods or strategies for quitting were discussed after being advised to quit.4 Only a minority of smokers trying to quit use evidence-based cessation treatments under the supervision of a clinician.8 Research suggests a majority of patients who smoke show willingness to participate in clinic-based cessation programs and prefer more intensive treatment options when given the choice.8 The Tennessee Department of Health published a Tobacco Cessation Directory, which provides lists of cessation resources organized by region. The Directory includes a range of options to facilitate quitting and is designed for smokers, clinicians and friends/family of smokers.10

Differences in perception between patients and physicians regarding smoking behaviors, lung cancer risk and cessation strategies lead to ineffective communication and counseling. Underuse of the array of behavioral and/or pharmaceutical cessation interventions could lessen the effectiveness of cessation attempts. Simple facts that highlight high lung cancer incidence and mortality rates in Tennessee and public announcements by health professionals about region-specific issues could act as supportive reinforcements for clinician efforts to help patients quit smoking.

CONCLUSION
Analysis of lung cancer data requires awareness of the long latency period between smoking initiation and development of most lung cancers. Tobacco use among Tennessee youth has traditionally been high and continues to be higher than the national rate (Table 2). Cigarettes are the primary tobacco product used by Tennessee middle and high school students, and cigarette use in Tennessee youth is higher than in U.S. youth.6 Prevalence of cigarette use is more than twice as high among high school students as middle school students for both Tennessee and the U.S., and high school and adult smoking prevalences are nearly identical for both groups. These data suggest most youth smokers acquire the habit around the transition to high school. Public health and clinical practitioners should be aware of this critical period when planning lung cancer prevention interventions.

(Continued on page 41)

**TABLE 2.** Percentage of students who reported current cigarette use,* Tennessee and U.S.

<table>
<thead>
<tr>
<th>Region</th>
<th>Middle School</th>
<th>High School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tennessee</td>
<td>9.7</td>
<td>25.5</td>
</tr>
<tr>
<td>United States</td>
<td>8.1</td>
<td>20.0</td>
</tr>
</tbody>
</table>

* Smoked cigarettes at least one day during the past 30 days.


**U.S. Centers for Disease Control and Prevention. Tobacco use, access, and exposure to tobacco in media among middle and high school students—United States, 2004. MMWR 54(12), 2005.**

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Tennessee’s Smokefree Policy: It’s Time for Local Control

By Hadii M. Mamudu, PhD, MPA, and Sreenivas P. Veeranki, MD, DrPH, MPH

ABSTRACT
Tobacco use in Tennessee is higher than the national average and the decline in usage rate has stalled. The smokefree policy enacted to address this health issue contains several exemptions and does not repeal preemption that was introduced in 1994. In March 2013, the Governor unveiled Health and Wellness Initiatives, including reduction in the use of “tobacco products.” To achieve this goal, two approaches should be considered and integrated into the initiative to facilitate the decline in tobacco use — policy and population. On the policy approach, the Governor should consider working for the repeal of state preemption of local tobacco control policymaking by the 1994 Prevention of Youth Access to Tobacco Act, and for removing exemption for certain venues from the Non-Smoker Protection Act. On the population approach, the Governor should consider focusing on young adults as an integral part of the target group and tobacco-free campuses as a strategy for addressing tobacco use among such group. All these conform to the Initiatives’ strategy of “localized ownership.”

COMMENTARY
Background of Tobacco Use and Control in Tennessee
The health and economic burden of tobacco use and secondhand smoke (SHS) exposure in the United States (U.S.) and worldwide has been well-documented. In Tennessee, the third largest tobacco-growing state in the U.S., tobacco use continues to be the major risk factor for the leading causes of death, accounting for approximately 9,900 deaths annually. Additionally, tobacco use imposes about $5.1 billion in economic costs to the state in terms of direct healthcare cost and productivity loss. In 2007, Tennessee promulgated and implemented the Non-Smokers Protection Act (NSPA) to deal with this public health problem. While the NSPA made most public places and workplaces smokefree, it exempted others such as bars and places patronized by only people aged 21 years and above.

The NSPA did not repeal the 1994 Prevention of Youth Access to Tobacco Act (PYATA), which preempted all tobacco regulation after March 15, 1994. Nevertheless, at the time the NSPA was promulgated and implemented in 2007, it was considered as one of the best smokefree policies (SFPs) among major tobacco-growing states and those in the Southeast U.S. The American Lung Association (ALA) stated in its report State of Tobacco Control, 2007, that “Tennessee is the first traditional tobacco-growing state to pass strong restrictions on smoking in public places and workplace.” As such, using a detailed methodology for evaluating SFPs in 2007, the ALA awarded Tennessee a “B” grade for its SFP coverage (“A,” if not because of the preemption). Since then, there has been a tremendous improvement in the development and implementation of SFPs in the country, including states in the Southeast U.S. As a result, the latest report by ALA in 2013 awarded Tennessee a “C” grade for its SFP. Although the report indicated that Tennessee’s SFP is relatively strong than other neighboring states, the low grade indicates it does not adequately protect all Tennesseans from SHS exposure as well as reduce tobacco use. This generates the need to explore how to reduce tobacco use in the state in a manner envisioned by the state’s public health goals and Governor Bill Haslam’s Healthy Tennessee: Health and Wellness Initiatives, which was launched in March 2013.

Although cigarette smoking in Tennessee is lower than most neighboring states and the pattern of decline is similar to the national trend, the usage rate has remained consistently higher than the national average (e.g., 23.0% vs. 21.2% adult current smokers in 2011, Figure 1) and ranked 36th nationwide in 2011. With the stalled decline and higher level of tobacco use, it will require going beyond current policies to contribute towards the attaining the Healthy People 2020 goal of a 12 percent national adult smoking rate. Indeed, while passing the NSPA in 2007, the state simultaneously allocated $10 million to develop and implement cessation programs, followed by an additional $5 million in 2009. Moreover, the excise tax on tobacco was raised by 42 cents in 2007, making the total tax rate 67 cents, yet, no significant decline in smoking rate in the state has been observed. This stalled declined in tobacco use in the state amidst policy change implies that exploring other alternatives to accelerate the rate of decline is a necessity. Thus, this commentary illuminates how to facilitate the realization of the visions and goals of the Governor’s Health and Wellness Initiatives pertaining to tobacco use through public health policy. With the increasing realization that laws can be used to create the environment for attaining positive health outcomes, and regulation at local or community level being its essential components,
the authors call for the repeal of the state preemption of the tobacco policy by the 1994 PYATA to give local entities more control in a manner that is consistent with the Healthy and Wellness Initiatives’ strategy of “localized ownership,” and removal of exemptions in the NSPA to ensure protection of all Tennesseans from the health hazards of tobacco use and SHS exposure.

SFPs have proliferated nationwide since they emerged in the U.S. in the 1970s. They have been well-documented in the U.S. and worldwide as the most effective way of addressing tobacco use by creating smokefree environment.5 SFPs prevent smoking initiation and aids smokers to quit, while protecting nonsmokers from the hazards of tobacco smoke exposure.6 Additionally, they improve health outcomes, including reduced hospitalization for myocardial infarction and heart attacks. In the classic case of Helena, MT, hospital admission rate for acute myocardial infarction declined by 40 percent during the six months the local SFP was in place and rebounded after its suspension.7 Furthermore, SFPs contribute to decline in economic burden by reducing healthcare costs. Moreover, evidence from places around the country has demonstrated that implementing SFPs do not harm businesses. Indeed, the Tennessee Restaurant Association (now the Tennessee Hospitality Association) joined the Smokefree Tennessee Coalition during the development of NSPA, because not only were customers demanding smokefree environments but the owners were of the view that SFPs would be good for business.2

Additionally, there is increasing evidence that the ability for an SFP to achieve these benefits depends on the nature and scope of policy.9 Therefore, while calling either for development and/or modification of a policy, both the Institute of Medicine (IOM)’s For the public’s health10 and the U.S. Centers for Disease Control and Prevention (CDC)’s Healthy People 2020 advocate for and against certain specific components in a policy. In the case of an SFP, the emphasis thus far has been on eliminating exemptions and repealing state preemption (if any existed). It is necessary that the SFP move closer to people by strengthening tobacco control at the local level.

Healthy Tennessee Initiative: The Governor’s Campaign for Health and Wellness
In March 2013, Governor Bill Haslam launched the Healthy Tennessee: Health and Wellness Initiative with four visions: 1) lower healthcare costs, 2) reduce absenteeism, 3) increase productivity, and 4) improve the overall quality of life in the state. Among the measurements for this initiative is “percentage decrease (from determined baseline) in the number of people who use tobacco products” [emphasis added] (unpublished). The initiative will be overseen by a non-profit Wellness Task Force (WTF) and funded by a mixture of state and private funds. The total estimated budget for the Governor’s Health and Wellness Initiative is $72.4 million, of which $43 million will be dedicated to anti-smoking and anti-obesity efforts. While this should be applauded, particularly with the emphasis on “tobacco products,” not limited to smoking alone, there are two important issues that should be considered as components of this initiative to help accelerate the decline in tobacco use in the state: 1) current status of Tennessee tobacco control policy; and 2) targeted populations of the initiative.

Current Status of Tennessee Tobacco Policy
The most effective approach for reducing tobacco use is a comprehensive program1 because all the parts such as smoke-free environments, health warnings, excise taxes, advocacy and media campaigns, and cessation programs, reinforce each other to enhance an individuals’ knowledge about the harmful effects of tobacco use and SHS exposure, awareness of support mechanisms for cessation, and promotion of nonsmoking norms. In this respect, SFPs are the most effective and necessary measure to protect nonsmokers from exposure to secondhand tobacco smoke, which contains more than 7,000 hazardous chemicals, of which over 70 are toxic and carcinogenic to humans.1 However, the incorporation of preemption and exemptions in a SFP, just as in Tennessee, undermines the effectiveness of a SFP in protecting nonsmokers and reducing tobacco use.

Preemption and the Prevention of Youth Access to Tobacco Act (PYATA), 1994
State preemptive laws prohibit localities from enacting tobacco control policies that vary from that of the state law or are more stringent.9 The state takes absolute control of a certain spheres of the policy, generating concerns for tobacco control policies in the U.S.9 With local governments usually being
the creation of state legislatures, such policies are often used to inhibit their ability to enact more stringent measures than those at the state level. In other words, preemptive policies can create ceilings, instead of floors for nurturing and enhancing local innovations in health policy.

State preemption of local tobacco control measures became popular and peaked in themid-1990s, when 31 states incorporated some sort of preemption in their tobacco control laws. In response to the federal government’s requirement under the Synar Amendment that all states enact laws to limit minors (people under 18 years) access to tobacco products, the tobacco industry promoted preemptive laws to the states, including Tennessee, which enacted one of the broadest preemptive laws in the country, the 1994 PYATA. While most of the preemptive laws pertained to worksites, private sector worksites and restaurant, few states such as the Tennessee explicitly preempted the entire field of tobacco policy (i.e., a “super preemption”). However, beginning with Delaware in 2002, several states started to rescind preemptive laws and by December 2012, out of the initial 31 states, there were only 14 states with some sort of preemption, the state of Tennessee among them.

Preemption has several implications for localities as well as the general public,8 which is why both the Institute of Medicine (IOM)4 and the Healthy People 2020 have called for repeal of state preemption throughout the country. Although state laws cover larger populations, preemption impedes local efforts to enact more stringent laws or tailor laws to address local circumstances and eliminate local debates and media coverage associated with the consideration of such ordinances that perform educational campaigns and normative changes about tobacco use in their local municipalities or communities. Additionally, state preemptive laws are associated with fewer ordinances restricting smoking, reduced level of worker protection from SHS and reduced support for comprehensive SFPs among current smokers. In Tennessee, progress in the development of SFPs in counties such as Davidson, Knox, and Sullivan was impeded with the 1994 PYATA.2 Thus, removing the preemption should be a salient part of the Governor’s Health and Wellness Initiative to reduce tobacco use in the state.

**Exemptions and Comprehensive Smoke-Free Policy**

Research has established that exposure to SHS increases the risk for several non-communicable diseases (NCDs) among adults and children, including lung cancer, heart disease, asthma and sudden infant death syndrome (SIDS). Indeed, there is no known safe environmental level of SHS exposure, and studies have suggested that even 30 minutes of exposure is hazardous for nonsmokers.10 Additionally, exposure to SHS influences one’s norms and values in perceiving smoking behavior. Research has consistently shown that children exposed to the smoking of others, particularly parents and peers, are more likely to become future smokers, and subsequently permanent smokers, if they are either addicted or nicotine-dependent, along with cultivating negative attitudes toward tobacco control measures. These negative effects generate the need to increase coverage of SFPs, with a goal to reduce tobacco use and SHS exposure, and promote positive attitudes toward tobacco control measures.

The key issue in the development and implementation of SFPs in the country is exemptions, particularly for tobacco venues such as bars and other hospitality venues. In Tennessee, the NSPA contains 10 exemptions, which means significant proportion of Tennesseans are not covered by the SFP and are exposed to SHS. Such policy results in differential impacts and creates health disparities among those protected and not protected, particularly nonsmoking workers, and those working in bars; hence the need to remove exemptions in the NSPA. Additionally, with the strong link between SFPs and smoking cessation, exempting places patronized by people aged 21 years and above does not likely facilitate the creation of non-smoking norms because these are the ones with the highest smoking rate in the state, i.e., those aged 18-54 years. Therefore, along with repealing state preemption, the authors call for the removal of exemptions in the existing NSPA as part of the Governor’s Health and Wellness Initiatives.

**Local Control Over Health Policy Issues**

Current cigarette smoking rate in the country has consistently declined from the 1960s when about one in two adults smoked to about one in five, currently. Central to this public health achievement is the strategy by the tobacco control community to work for the passage of local SFPs; hence, the emphasis on community approaches to reducing tobacco use. It has been documented that the most comprehensive smoking restrictions usually originate from the local level,11 and that local laws often impose more stringent smoking restrictions to protect health of residents in their respective communities. As such, proponents of SFPs in the U.S. have strongly advocated for a bottom-up approach to SFP change, given the strong influence of tobacco industry and allies in state legislatures. Indeed, much of the progress in public health observed in the U.S. in the past decades has been attributed to local control, which does not only make policies closer to the people but also create local ownership for such policies. Therefore, it is important to give local control over SFP in the state in a manner consistent with the “localized ownership” strategy of the Governor’s Health and Wellness Initiatives.

**Targeted Population**

The Governor’s Initiatives target vulnerable populations, primarily teenagers, pregnant women and women with infants. While it is true that tobacco use is a “pediatric disease” because up to 90 percent of smokers begin smoking before 18 years of age, it has also been found that the young adults aged 18-24 years have one of the highest smoking rates in the country.12 For example, in 2011 the current smoking rate among young adults in Tennessee was 26.6 percent (vs. 24.0 percent nationwide). Young adults constitute a population that the tobacco industry can legally target with advertising, marketing and promotions and are in a zone of transition from intermittent or social smoking to regular smoking; yet, they are usually lost in strategies to reduce tobacco use. As a result, the U.S. Surgeon General published Preventing Tobacco Use among Youth and Young Adults in 2012 to bring attention to the high tobacco use among such people.12 Thus, while the long tradition in the state
since the 1890s to protect youth from smoking initiation should be continued, perfected and reinforced, there is the need to explore tobacco use among other categories of the population, particularly young adults, to help accelerate the decline in tobacco use.

A key policy proposal to address tobacco use among young adults by the Healthy People 2020 is tobacco-free college and university campuses. In Tennessee, although the legislature granted higher educational institutions an exemption from the state preemption and the flexibility to enact and implement tobacco control policies, as of April 2013, only seven (Belmont University, Dyersburg State Community College, East Tennessee State University, Freed-Hardeman University, Lipscomb University, Milligan College and Tennessee Technological University) of about 99 institutions in the state had a 100-percent tobacco-free policy. Studies involving the East Tennessee State University’s tobacco-free policy, Tennessee’s first 100-percent college tobacco-free policy, found that it was not only highly favored by both employees and students, nonsmokers and smokers but also had a significant impact on reducing tobacco use on campus.15,14 Thus, given the fact that all the higher educational institutions have some sort of smoke-free policy, it is important to explore tobacco-free policies for higher educational institutions as an integral part of the Health and Wellness Initiative to reduce tobacco use in the state. It should be pointed out that lessons could be learned from North Carolina where the implementation of statewide tobacco-free campuses did not only contribute to reducing tobacco use but also improved sanitation on campuses.15

CONCLUSION
The decline in tobacco use in Tennessee has stalled (Figure) despite the enactment of policies such as the NSPA. In March 2013, Governor Haslam of Tennessee unveiled Health and Wellness Initiatives to address this issue. Because the existing policies are inadequate in significantly reducing the usage rate, two issues should be addressed with respect to the state’s SFP — policy and population. Addressing three aspects of SFP in Tennessee, preemption, exemption and local control, could accelerate decline in tobacco use in a manner consistent with a strategy for Governor’s Health and Wellness Initiatives, “localized ownership.” In 1994, the PVATA introduced “super-preemption” in Tennessee and arrested local progress in tobacco control and needs to be repealed so that the NSPs will provide the floor for local tobacco control activities, which could lead to innovative policies for reducing tobacco use in the state. Given that the exemptions in the NSPA deny protections for all Tennesseans and create health disparities, it is important to remove them as part of the Health and Wellness Initiatives. Finally, it is important to recognize that the majority of current adult smokers in the state are between 18 and 54 years of age. Since young adult smokers aged 18-24 years often transition to regular smokers, they should be considered as a priority, along with strengthening tobacco-free college or university policies to reduce tobacco use among these populations. The comprehensive approach integrating localized ownership of health policies by repealing the NSPA preemption, increasing smoke-free environments by removing exemptions, and targeting young adults by strengthening campus tobacco-free policies could lead to the development of innovative tobacco control measures to achieve goals in consistent with the core values of the Health and Wellness Initiatives and the public health goals of the Volunteer State and the U.S.

References:

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THE BURDEN OF LUNG CANCER
(Continued from page 35)

References:

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The TMA Alliance held its annual fall meeting, called UPDATE, recently in Chattanooga. It was well attended by a strong group of committed Alliance members from across the state, and graciously hosted by the Chattanooga-Hamilton County Medical Society Alliance.

It is always rewarding when a group of dedicated, intelligent people come together for the sole purpose of helping others. In our case, we are working together for the betterment of health in Tennessee. We will accomplish this by partnering with the TMA through vehicles which include health projects, legislation and membership initiatives.

The TMAA will continue its efforts with TMA’s signature public health project to reduce prescription drug abuse. Our vice president of Health Promotions, Lorrie Villeneuve, will be distributing posters and educational materials throughout Tennessee. We will also work on two AMAA projects, SAVE Today (Stop America’s Violence Everywhere), which is the second Wednesday of October each year, this year October 12. In the spring, we want to work with local law enforcement agencies and others to promote a “Take Back,” the safe disposal of unused or expired prescription drugs.

We are thrilled to announce a new legislative program, the brainchild of Julie Griffin, TMA’s assistant director of Government Affairs. Ms. Griffin spoke to us about the Grassroots Communication Network that would engage Alliance members in each legislative district of Tennessee. When important health-related issues demand, we will become the voice for medicine by initiating communication with our respective legislators via visits, phone calls, emails, etc. This program affords the Alliance another opportunity to be a valuable asset in insuring the good health of our state.

We have some “new” old ideas regarding membership recruitment: we want to meet you face-to-face and tell you why the TMA is good for you, your family and your community. We agree with Jan Headrick, our vice president of Membership, who said, “There is nothing as effective as meeting in person and asking potential members to join us.”

We were grateful that our own Jo Terry, AMA Alliance president, was in attendance and gave the keynote address. Jo is only the fourth Tennessean to serve as the national president. Jo, as always, was inspiring and uplifting. Our members are overwhelmingly proud of her and will support her in every way.

It was exciting to hear from Robin Hutchins, Membership chair, about a strong recruitment effort to reach intern, resident and medical student spouses. Sue Vegors, IMPACT (Independent Medicine’s Political Action Committee - Tennessee) representative, stressed the importance of joining IMPACT along with your spouse. Sue was also very informative about the formation of a new AMAA partnership, the Alliance Health Education Initiative (AHEI), a foundation to support community health initiatives across the country.

We thank all the members who attended UPDATE. We left encouraged and ready to get to work!

We are “Better Together!”

FOR THE RECORD

TMA ALLIANCE REPORT

“Coming together is a beginning; keeping together is progress; working together is success.”
— Henry Ford

TMAA Holds Fall UPDATE

By Heidi Dulebohn, TMAA President

Sheila Barnett, Knoxville, TMAA Immediate Past-President Beth Kasper, Clarksville, and Cynthia Gash, Knoxville, shown at the TMA Fall UPDATE.

Sue Vegors of Jackson (left) poses with AMA Alliance President Jo Terry of Knoxville.

For membership information, contact Jan Headrick at 423-344-6206 or GoJoMama@aol.com; or TMAA Executive Assistant Judy Ginsberg at 615-460-1651, 800-659-1862 (toll free) or tmaa@tnmed.org.
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IN MEMORIAM


JACKSON HARRIS, MD, age 87. Died September 5, 2013. Graduate of Yale University School of Medicine. Member of Nashville Academy of Medicine.

ROBERT E. TOOMS, MD, age 79. Died September 10, 2013. Graduate of University of Tennessee Health Science Center. Member of The Memphis Medical Society.

CORRECTION

In the article entitled “Online CME Helps Tennessee Physicians Meet Continuing Education Requirements” in the September issue (Tennessee Medicine, Vol. 106, No. 8, p. 13), we erroneously stated that the TMA is “recognized by the Accreditation Council for Continuing Medical Education (ACCME) as the accrediting body for hospitals, specialty societies, and other medical organizations in the state of Tennessee…” The TMA is pursuing but is not yet an ACCME-recognized accrediting organization. Tennessee Medicine regrets the error.
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