A NEED to LEAD

Demand for Physician Leaders Grows Along with Training Opportunities

TMA Membership Remains Valuable as Healthcare Environment Changes
Dr. Keith Anderson

Next Slide, Please!
Dr. Loren Crown

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Members of the Tennessee Medical Association have taken an active role in fighting the opioid abuse epidemic and its consequences in recent years.

At TMA’s annual conference this spring, The TMA House of Delegates approved two resolutions aimed at getting treatment for pregnant women who are addicted to opiates and providing birth control to addicts.

Opioid prescriptions across the U.S. have now seen the first sustained drop in a decade. Prescriptions declined in 2013, 2014 and 2015.

Nationwide, filled opioid prescriptions have declined by 10.6 percent between 2013 and 2015. In Tennessee, the prescriptions have declined 9.3 percent.

The national trend can also be seen in Tennessee:

<table>
<thead>
<tr>
<th>Year</th>
<th>Opioid Prescriptions Filled</th>
<th>Rate of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>8,525,017</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>8,239,110</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>7,800,947</td>
<td>-10 to -14.9%</td>
</tr>
</tbody>
</table>

The progress in opioid prescriptions has yet to translate to a drop in drug deaths.

<table>
<thead>
<tr>
<th>Year</th>
<th>Drug Poisoning Deaths</th>
<th>Rate of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>1,080</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>1,090</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>1,131</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>1,187</td>
<td>-15 to -20%</td>
</tr>
<tr>
<td>2014</td>
<td>1,269</td>
<td>-10 to -14.9%</td>
</tr>
</tbody>
</table>

Tennessee Medicine is focusing its next issue on opioid abuse in Tennessee. Do you have a unique perspective or a story to tell about this epidemic? Contact Managing Editor Katie Brandenburg at katie.brandenburg@tnmed.org or 615.460.1675 to make a contribution.

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Thank you for the opportunity to serve as the 2016 president of the TMA. It is a privilege to lead by promoting the agenda of the TMA set forth by the Board of Trust and House of Delegates.

What is in store for us in 2016?

Membership remains a priority. While TMA membership is up and we had a record number of participants in Doctor’s Day on the Hill this year, the change in practice environment poses a challenge to our ability to recruit new members and retain members. As physicians are brought into healthcare organizations, dues shift from personal expenses to corporate expenses. CEOs and CFOs who may not be familiar with the benefits of the TMA are making decisions about dues and need to be educated on the associated value to both the physicians and the organization. Having their physicians become members of the TMA gives them the advantage of having a voice in healthcare policy and legislation. TMA also provides leadership training as a value to healthcare systems that employ physicians. This is a clear and immediate need, particularly with the development of new payment models. So our message has to be heard by administrators as well as physicians themselves. We need to have administrators who recognize these benefits speak directly to their colleagues who doubt the value of membership.

At the same time, we need to maintain our benefit to the physicians who are fortunate enough to maintain their independence. These members are the backbone of our history and success. The TMA agenda will continue to be inclusive of all Tennessee physicians.

Organized medicine’s efforts finally repealed the SGR. But the price is a new set of acronyms that are vaguely defined. MACRA is an acronym within an acronym, the Medicare Access and CHIPS Reauthorization Act of 2015. Ask what this is and you get more initials. “It’s a QPP (Quality Payment Program) using MIPS (Merit-Based Incentive Payment Systems) and APM (Alternative Payment Models).” No one knows what MACRA will look like, but through organizations such as the AMA and TMA, we have an opportunity to shape future reimbursement models that affect all physicians.

Enlightening lawmakers to the dysfunction of EMR, particularly the lack of functional interoperability, has resulted in CMS revising the Meaningful Use program. Again, details of its replacement are under design. But we have an opportunity to participate in the design process, eliminate duplicity and avoid having to personally key-in obscene details just to satisfy CMS payment regulations instead of to enhance patient care.

Prescription opioid abuse remains a prominent healthcare issue in our state. TMA efforts have advanced the battle against opioid abuse with physician awareness and education. But more work remains. Centers to refer patients identified as at risk or in need of chronic pain management are insufficient. Legislation to create resources to close this gap is needed at the state and federal level. Naloxone and buprenorphine access needs reform.

Telemedicine is on the rise. Treating and communicating with patients using electronic technology will expand. It is up to us to shape policy so that telemedicine helps patients and causes no harm.

TMA is closely monitoring and opposes mergers in the health insurance industry that would likely result in higher premiums, narrower scope of benefits and poorer reimbursement.

Likewise, we are monitoring the mechanisms to narrow provider networks to assure that patients have adequate access and established patient-physician relationships remain intact. These are just a few of the many subjects on our agenda. I urge you to familiarize yourselves with these important issues and participate by giving your input.

TMA services for members are stronger than they’ve ever been. Transitioning to ICD-10 was a success. Benefits of TMA membership include CME opportunities, leadership training through the Dr. John Ingram Institute for Physician Leadership, physician services and legal resources to deal with HIPAA compliance, supervision regulations, medical audits, physician employment and other aspects of medical practice.

TMA members are passionate about patient care. I am always impressed with the patient-centered focus seen at committee meetings, board meetings and wherever members gather. Providing excellent care to patients has been, is and will be our priority. However, the practice of medicine is political. Like it or not, politics affect every aspect of patient care.

Thank you for putting patients first and giving your patients the personal care they deserve. Thank you for joining the TMA to reclaim our profession. Thank you for enduring the roadblocks and taking time to lead and make medicine in Tennessee better.

Share your thoughts with Dr. Anderson at president@tnmed.org.
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Changing priorities in the medical field are creating new opportunities for physicians to become healthcare leaders. However, training and encouragement are needed to make sure today’s physicians step up to fill these important roles.

We are witnessing unprecedented change in the physician workforce as more physicians are becoming employees and part of growing health systems. Almost 60 percent of Tennessee physicians are choosing to focus on delivering lower cost, better outcome patient care while leaving the practice management worries behind.

It seems that the increase of new administrative workload flowing down from federal rules and regulations is proving to be the tipping point for many as they are giving over control of the business of medicine and applying their skills to clinical and evaluative work, quality measures and reporting.

This migration is creating a leadership chasm for new employers of physicians.

TMA has engaged a number of the state’s largest physician employers in the last few months and we see a common thread. For years we have heard of a growing reluctance from physicians to volunteer their time to hospital committees and other leadership roles outside of patient care duties. Within TMA, we have witnessed a drop off in the volume of physicians participating in leadership roles as well.

Nine years ago, TMA launched its Physician Leadership College to address the needs of TMA and medical societies within our state. Since that time, nearly 100 TMA members have graduated and put their learned leadership skills to good use within organized medicine, and within their practice environments. The last two chairs of our Board of Trustees have been PLC graduates, as is our president-elect. A growing number of representatives to the TMA House of Delegates have also participated in the PLC.

We still hear from employers, however, that they need a plan to help educate and train physicians about how to participate in corporate leadership and governance. There are critical roles within hospitals, health systems, academic institutions and other organizations that affect the performance and the financial viability of the institutions that physician leaders can fill. Without physician leadership, these organizations will not meet the goal of better patient care delivery at lower costs.

Many physicians feel participation on this level creates extra administrative hassles and that their input really won’t make a difference. Employers lament that it’s exactly the opposite. Without the leadership of physicians, the work still has to be performed and will be done with or without physician insight.

This is a wakeup call.

Choosing to practice as an employee requires a change in mindset. New healthcare models require a higher-level team strategy with a skill set that is not requisite training in medical schools and residencies. It is simply not enough to work your shift and call it a day.

One priority objective of the TMA strategic plan is to help physicians lead in the changing healthcare market. To that end, we are implementing programs and strategies to give members the tools to lead, whether it’s in the community, the office environment, the hospital or beyond.

The new healthcare environment is larger and more complex than it was even a few years ago. The challenges are more difficult, reflecting more need for leadership skills and collaborative tact. It’s worth the effort because, when leadership is practiced on a larger stage, the ultimate return on investment will also be larger in the long run.

If physicians sit on the sidelines, burying themselves in their singular work, employers and administrators are going to look to others to lead. By not engaging, you may not like the results and, what is much worse, you will lose your voice in the process.

So when asked or recruited to serve, step up. The environment is changing, but the core purpose of caring for patients is the same.

Don’t let opportunity pass you by.

Share your thoughts with Mr. Miller at russ.miller@tnmed.org.
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Next slide, please! For those who matriculated after lantern slides had become obsolete, but before PowerPoint presentations came about, this is an alert to be ready for the next phase of your life. Remember how you sat in a darkened medical school auditorium waiting for the next revelation concerning the fascinating world you were just entering? After nearly five decades in the world of medicine, I am not only ready for the “next slide,” but for a whole new dimension – retirement.

Like most of my silver-haired peers, I have witnessed the conquest of smallpox, the advent of ICUs, the transformative developments in oncology (especially at St. Jude) and the miraculous arrivals of “centers” (trauma, burn, OB, pediatrics, stroke, crisis and more to come). But I have also seen the increase in medical liability cases, the onslaught of the metabolic syndrome in our patients and the disappointment of “legislative medicine” whereby certain diseases get funding through focus group action while other disorders are controlled not by medical judgment but by the court or via congressional action. For every step forward there have been a few fallbacks; the greatest truth remains, however: this too shall pass.

When I started emergency medicine, there were few effective measures for things like pulmonary edema. We had rotating tourniquets, intravenous morphine, furosemide and digitoxin (the last part of the name indicates its lethality). Patients suffered through open cardiac massage, early models of automatic external chest compressors, IV aminophylline for asthma and intracardiac adrenaline, insulin shock for depression and lobectomies.

Early on in family medicine, I did locums tenums for a practitioner who had a BMR apparatus that looked like H.G. Wells’ time machine. He also did office tonsillectomies. I’ve even seen, in a rural treatment room, a hook in the ceiling through which a rope was passed, one end going out the window to a waiting vehicle, and the other attached to the patient to reduce a dislocated hip. In my childhood, I saw doctors promoting cigarette brands on TV and my first ED offered ashtrays for the use of the attendings (I hope to see a time where tobacco subsidies cease). I am now in an era where “mid-level” providers are probably destined to assume much primary care, especially in the rural areas, and physicians are required to function under the burden of EHR. But also, we are on the threshold of great advances in genetic medicine, monoclonal approaches to oncology and the use of robotic-assisted surgery.

My grandmother had abdominal surgery performed on the kitchen table with the use of chloroform and restraint by relatives, my father nearly died of strep before antibiotics arrived, my older brothers were home delivered (one breech) and I grew up filling cards with coins for the March of Dimes. We’ve come a long way to the present, where my new ED colleagues show up proficient in the use of portable ultrasound machines, which they use more often than stethoscopes. MRIs can discern fractures my generation only suspected but could not prove. And catheters extract clots from brains like we kids used to grab toys from machines at the county fair. I watched my own family members suffer from polio and measles, but now we worry about HIV and Ebola (oops, now Zika).

As I leave the craft to the younger generation, I gladly abandon issues such as call schedules (I have been more or less “on call” for 42 years), quality assurance meetings (never volunteer for any committee that has a “Q” in it) and the dilemma of the inequality of healthcare affecting the inhabitants of this country. I no longer have circadian rhythm disturbances from my 24 hour ED shifts, worries about office overhead, departmental staff disputes or concerns about CME shortages (Did I forget that two-hour controlled substance program again?).

I am now gloriously involved in shepherding nine grandchildren, in reading all those novels I never got around to (instead I scanned one to three journals daily) and in knocking off all those “bucket list” travel destinations abroad. No more office, hospital, emergency department, stat pages or CPR courses. I do participate in a couple of teaching assignments and manage a low to moderate intensity clinic or two (mostly voluntary). I also am involved in some non-medical community activities that help me adjust to “lay person” status while still helping my fellow citizens. And as with most of my age cohorts, I also find myself frequently held hostage as a patient; it is particularly revealing to find out what life is like on the other side of the admissions window. I recommend it highly to enlighten those of you who have never experienced the role of a patient waiting for the “great ones” to administer their healing magic.

The “next slide” after retirement is coming soon, and, in addition to all the perils of aging, it will probably be a prelude to the biggest wonderment yet; I hope to be alert enough to appreciate that part of existence as much as I enjoyed my first slide show in the amazing world of medical science.
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There is a lot of confusion among my colleagues as to a physician’s legal authority to bill TennCare patients directly for covered medical services (not bill a TennCare MCO).

One colleague is a TennCare participating physician. In one of his practices, he contracts with a couple of the TennCare managed care organizations (MCOs). He also has another practice which is a suboxone clinic that has a separate tax ID number. He does not have any MCO contracts through the suboxone clinic. However, he does plan to refer TennCare patients needing treatment for addiction to opioids to his suboxone clinic. He told me he is confused as to whether the suboxone clinic could bill the referred TennCare patients directly since he does participate with TennCare in other clinics or healthcare settings.

Another colleague does not participate with TennCare MCOs in her medical office at all. However, she provides professional services to a facility that bills patients’ TennCare MCOs for her services rendered at the facility. Sometimes she will see a TennCare patient or two on referral. Does she have to bill TennCare for the referral work done in her medical office? She is registered with TennCare and has a TennCare ID number.

In these situations, please demystify when my colleagues may lawfully bill TennCare patients.

A physician who is registered with TennCare and accepts some form of TennCare reimbursement is a “TennCare provider” under the TennCare rules and interpretive Policy No. PRO 08-001 (Rev 9). For instance, if a provider is enrolled with at least one TennCare MCO, he or she is considered a “TennCare provider.” The policy further states that, in order to become a non-TennCare provider, a physician must terminate his or her registration with TennCare.

Buprenorphine products for opiate addiction treatment for enrollees aged 21 and older are covered services under TennCare rules 1200-13-13-.04(1)(c)(9) and 1200-13-14-.04(1)(c)(9). Suboxone is a buprenorphine product. By agreeing to be a TennCare provider through a primary practice, a physician agrees to accept the TennCare allowable as payment in full for covered services, including suboxone. Balance billing a TennCare patient is not permitted.

When a medical service is not covered by TennCare, and the physician has informed the enrollee that the service is not covered before providing it, the physician is allowed to bill the enrollee. Where this situation might come into play is when a patient exceeds his or her benefit limit for suboxone. Under the TennCare rules, buprenorphine products have a dosage benefit limit. For enrollees 21 and older, the rules specify a dosage limit over which TennCare will not pay for the treatment. Dosage shall not exceed sixteen milligrams (16 mg) per day for a period of up to six (6) months from the initiation of therapy, according to TennCare rules 1200-13-13-.04(1)(c)(9)(i) and 1200-13-14-.04(1)(c)(9)(i). [Note that the rules also indicate a lifetime therapy limit for buprenorphine products. However, TennCare has not instituted this limit.]

Bottom line, with TennCare, a provider is either in or out as a “TennCare provider.” If in, a provider cannot bill the patient outside of the patient’s MCO for a covered service under any circumstances.

Since your colleagues are registered with TennCare and accept some form of TennCare reimbursement, it is the interpretation of the legal staffs of TMA and SVMIC that they are considered in. It is also our interpretation that the TennCare rules and interpretive policy do not allow your suboxone clinic colleague to start another business, even under a practice with a separate tax ID number, that is not contracted with any TennCare MCO in order to furnish covered services to TennCare enrollees at rates higher than the TennCare allowable rates. He must bill through the patient’s MCO.

Further, since your other colleague is registered with TennCare to perform services at an in-network facility, and she accepts some sort of reimbursement for serving TennCare patients at the facility, she is in and must bill for any covered service(s) provided in her medical office through the patients’ MCOs even if her practice is not contracted.
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TWO TMA MEMBERS INDUCED INTO HALL OF FAME

Paul Stanton Jr., MD and Henry Foster Jr., MD were inducted into the Tennessee Health Care Hall of Fame in May. They were among six individuals inducted into the hall of fame in 2016.

Dr. Stanton is a former dean of Quillen College of Medicine and president of East Tennessee State University. He is now president emeritus and a professor emeritus of surgery at ETSU.

He also served as a member of the Governor’s TennCare Roundtable and helped conduct the first review of Tennessee’s Medicaid program and recommended changes.

Dr. Foster is professor emeritus and former dean of Meharry College’s School of Medicine. He was President Bill Clinton’s senior advisor on teen pregnancy reduction and youth issues.

The Tennessee Health Care Hall of Fame was created by Belmont University and the McWhorter Society and is supported by the Nashville Health Care Council.

MEMBERS IN THE NEWS

DR. THROCKMORTON WINS NEER AWARD

Quin Throckmorton, MD, of Memphis was presented in March with a Charles S. Neer Award for clinical research focusing on the shoulder and elbows, according to the Memphis Daily News.

The award is presented by the American Shoulder and Elbow Surgeons medical group.

Throckmorton won the award for research into outpatient total shoulder replacements. He is a surgeon at Campbell Clinic, where he has worked since 2009.

DR. LACEY HONORED ON WALL OF DISTINCTION

The University of Tennessee Medical Center has created the John W. “Jack” Lacey Wall of Distinction. Dr. Lacey was also the first honoree on the wall. He is the former senior vice president and chief medical officer at UTMC. Dr. Lacey retired on March 31.
Don’t give up the fight. We need your support to continue making a difference and ensuring friends of medicine are in the Tennessee General Assembly.

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Medical school and residency training didn’t fully prepare Chetan Shah, MD of Hixson to open his practice. Running a practice also means running a business, and Dr. Shah said he wasn’t trained in those skills when he started a medical practice soon after completing his residency training.

“We have learned the medicine, but we have not learned the art of leadership,” he said.

Dr. Shah was lucky to find a mentor to help him learn about the business side of practicing medicine, but he is now seeking more formal training on the subject by taking part in the Physician Leadership Lab, part of TMA’s John Ingram Institute for Physician Leadership.

DEMAND FOR TRAINING

Dr. Shah is among a growing contingent of physicians nationwide who are seeking out training in how to be better leaders.

A 2015 survey of more than 2,300 physician-members by the American Association for Physician Leadership showed that a large number of healthcare organizations are investing in physician leadership development. Among survey respondents, 47 percent said their organization conducts some kind of leadership development program, and another 16 percent said they are aware of plans to create one. The survey also showed that about 67 percent of respondents said their organization places a high or very high value on physician leadership.

The Tennessee Medical Association is at the forefront of the national trend of offering physician leadership training. TMA has offered leadership training to its members for nearly a decade through the Physician Leadership College, and many of the organization’s current leaders are alumni of the program.

In 2015, TMA rebranded and expanded its leadership offerings to create the John Ingram Institute for Physician Leadership. The institute currently includes two leadership courses – the multi-month Physician Leadership Lab, which focuses on improving care through better clinical teamwork, and the Physician Leadership Immersion Program, which covers foundational leadership skills over two weekend sessions.

Changes to the healthcare environment in Tennessee and across the U.S., including payment reform and a need for more care coordination, require a team-based approach with doctors as the leaders, and TMA is working to prepare members for current and future leadership roles.
The association fought for the physician-led, team-based vision of healthcare during the 2016 legislative session with the Tennessee Healthcare Improvement Act, which would have created a more collaborative relationship between doctors and advanced practice nurses. The bill was taken off notice this session, but a multidisciplinary task force was created and is meeting this summer and fall to examine scope-of-practice issues.

Dr. Shah is part of the inaugural Leadership Lab class, which began in December and will conclude this month. He is also a participant in the Leadership Immersion program.

He has sought to take on leadership positions in the past. For example, he ran a group called Chattanooga Association of Physicians from India for about four years.

“I want to be doing something more than just practicing medicine,” he said.

For Theresa Woodard, MD, of Cordova, the Leadership Lab offered the opportunity to learn more about the business and administration side of providing healthcare.

“I just wanted to be more well-rounded with the knowledge that I need to be efficient in healthcare overall,” she said.

People naturally expect physicians to be leaders, said Dr. Woodard.

“Even if you don’t see yourself as a leader, other people are looking to you and expecting you to be one,” she said.

Dr. Woodard describes herself as a “go-getter,” who has always wanted to make changes to benefit her patients and colleagues. She believes the skills she learned with the Leadership Lab have made it easier for her to make those kind of changes in a shorter time frame, with quicker buy-in from key staff members.

Changes to the healthcare landscape prompted John Binhlam, MD of Nashville to take part in TMA’s Leadership Lab.

Dr. Binhlam said it is even more important for physicians to be active leaders in their sphere of influence and to represent the medical profession well as paradigms for healthcare delivery, payment models and patient care continue to evolve.

There is also personal gain from being a more effective leader, Dr. Binhlam said. He runs a practice with 15 employees.

“I want to see how I can also improve my ability to lead my team of healthcare providers,” he said.

Changes in the healthcare environment were also motivation for Michael Beckham, MD, FACP of Nashville to get physician leadership training.

“Even if you don’t have any formal training in leadership, and that was true for me,” he said, “We sort of lead based on instinct.”

Dr. Beckham said he was glad to learn about more established leadership tools to help in his practice and as a chief medical officer for a group. Dr. Beckham and Dr. Binhlam are students in TMA’s Leadership Immersion program.

“The days when the doctor’s the boss, and everybody does what he or she says are over,” he said. “We really are having to work more as a team with our nurses and with the administrators, so learning the art of negotiation and developing support for initiatives becomes more important.”

On a bigger scale, doctors need to learn to work with other providers as well as entities that are part of providing care, such as insurance companies and health systems, Dr. Beckham said.

“Now that we’re forced to look at the value of the care we provide, we need physicians who can help guide other groups of physicians toward initiatives that improve the quality of patient care, improve our preventive medicine services and serve as a liaison between doctors and these non-medical entities,” he said.

Leadership Lab student Jacob Dowden, MD of Chattanooga said he thinks there are many opportunities for physicians who are interested in leadership positions, be it within their medical group or on a larger scale.

“It’s a way to contribute to making healthcare better and helping patients,” he said.

Leading a team is essential to Dr. Dowden’s job as a surgeon, but he thinks there’s always room for physicians to develop better leadership skills.

“In the operating room, as a surgeon you have to lead the team and be a leader and control how things go, but you also have to create an environment where everyone on the team feels like they can say something if they see something that’s wrong,” he said.
Evidence shows that physician leaders are good for healthcare organizations. Out of 15 hospitals on the U.S. News & World Report’s 2015-2016 “Honor Roll” of Best Hospitals, nine have physicians as president or CEO. Physicians lead the top seven hospitals on the list.

Overall hospital quality scores are 25 percent higher for hospitals run by doctors, according to a 2014 white paper from the American College of Physician Executives. Rankings for cancer care at hospitals run by physicians were 33 percent higher than those run by nonphysicians.

And the number of physician leaders in hospitals is growing. About 5 percent of hospital leaders are physicians, and that number is expected to grow as value-based care models are instituted, according to the ACPE white paper.

Now working as a hospitalist for CHI Memorial Hospital in Hixson, Dr. Shah has already started using the skills he is learning through the Leadership Lab to make improvements.

Each participant in TMA’s Leadership Lab plans and executes an improvement project to practice the skills he or she is learning in class sessions and webinars. Dr. Shah decided to focus his efforts on getting doctors at his hospital to write discharge orders before 10 a.m. each day.

That metric is important because the earlier the discharge order is written, the earlier a patient can leave the hospital, he said. While the change may seem small, it increases patient satisfaction and frees up hospital beds more quickly for patients in the emergency room. Dr. Shah created a checklist of things that need to be done before a patient is discharged to help doctors plan ahead for discharging a patient.

When he started work on the initiative, the rate of discharge orders written before 10 a.m. each day averaged around 7.5 percent for each doctor. Dr. Shah has made the project into a competition, giving prizes to the doctors with the highest percentage each month. Last month, one doctor had a 21 percent discharge order rate before 10 a.m.

“It is working, and I think that makes me more excited because all my hard work is paying off,” he said. “It makes me feel like I am doing something good for the hospital and the patients.”

Though she is now doing medical consulting, Dr. Woodard did her Leadership Lab project at a rural clinic in Brownsville. There, she implemented a medication reconciliation form to go along with patient charts with a goal of seeing it used in at least 80 percent of cases. She said the effort has been largely successful.

Equal communication, where all the people involved in the project feel free to speak up, was key to that success, she said.

“It’s good to see that culture change, and I think it’s just positive for the patients as well,” Dr. Woodard said.

Communication is also key to Dr. Dowden’s project. He is creating a database of physicians he works with along with cell phone numbers to make communication between them more efficient.

“I think it’s making progress,” he said. “I certainly learned a lot from the Leadership Lab. I learned how to structure a program and learned how to be successful at it.”

For his project, Dr. Binhlam is focusing on improving wait times at his practice, aiming to keep wait times to 15 minutes or less.

“A significant concern for all involved is that we want to be respectful of all of our patients’ time, and we want to be as efficient as possible with getting people processed through the office,” he said.

In initiating the project, Dr. Binhlam set up a leadership change team of key office staff. Everyone in the office has to work together to achieve results, he said.

Dr. Binhlam said he will be able to use the skills learned through the Leadership Lab to make other improvements in his practice moving forward.

“The skills that we’ve learned in terms of how to engage our staff to be active in making a change in this project can be extrapolated to other things that we can do to improve our office functions,” he said.

He also wants to use his leadership to work as a leader within TMA to help the association.

“I would like to be able to give back and hopefully help the TMA,” Dr. Binhlam said.

Dr. Beckham also focused on improving patient wait time in his office for his Leadership Lab project.

“It’s been very interesting to see how approaching a problem with an eye on teamwork and communication have really helped achieve the results we want,” he said.

One of the things he learned during the program was about “Stop the Line” behavior, meaning any employee can feel comfortable speaking up when he or she sees someone going outside of standard work protocols.

For example, Dr. Beckham is making an effort to stay off of his cell phone to help reduce wait times, and employees are encouraged to speak up if they see him on his phone.

“I think that really by paying attention to all these little things, keeping our eyes on this key result, has really helped us all work together and support each other,” he said.

While he is still measuring results, Dr. Beckham said he is seeing a reduction in wait times. He and his staff began interventions to try to improve those times in April.

“I think that the principles behind this project have been very helpful for me to understand how organizations get things done,” Dr. Beckham said.

His instinct is to tackle a problem head on, and using the methods he learned in the Leadership Lab he has shown him that a team approach is most effective.
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PHYSICIANS GATHER FOR TMA ANNUAL CONFERENCE, TAKE ON ISSUES INCLUDING OPIOID EPIDEMIC

TMA’s annual conference drew more than 300 physicians, practice managers and other healthcare professionals to Murfreesboro this spring. Participants took part in CME training on pressing medical topics, social and networking events and the annual policymaking meeting of TMA’s House of Delegates.

Addressing opioid abuse was one of the prominent topics of the event. Roland Gray, MD, DFASAM covered the topic with a new proper prescribing course “Prescribing Practices in Tennessee: What Happened and Where We Are Headed,” and the TMA House of Delegates approved two resolutions related to opioid abuse and the reduction of neonatal abstinence syndrome in the state.

“We are continually looking for ways to stay relevant to an increasingly diverse mix of physicians who are working in different specialties, changing practice environments and encounter a variety of unique market dynamics,” said John W. Hale, Jr., MD, a family physician in Union City and TMA Immediate Past President. “One of the ways TMA achieves that is by delivering convenient, cost-effective medical education and other resources that help doctors find solutions to common challenges, regardless of where or how you practice.”

HOUSE OF DELEGATES

TMA’s House of Delegates debated policies on opioid abuse and neonatal abstinence syndrome, TennCare audits, graduate medical education and medical spa registration, among others. In all, the House of Delegates approved 16 resolutions during MedTenn16.

Two resolutions were approved by the House of Delegates to address opioid abuse.

One calls for TMA to explore methods of encouraging use of birth control for women who are prescribed opiates. A second resolution requires TMA to advocate for increased funding for education, prevention and treatment programs for pregnant women addicted to opiates and other illicit drugs, and for comprehensive medical oversight for treatment of polysubstance-addicted pregnant women.

The House of Delegates also approved a resolution calling for continued advocacy for Tennessee physicians subject to audits and recoupments of Medicare rate bumps, including asking the American Medical Association to assist with advocacy on the federal level.

Another resolution calls for TMA to lobby for increased graduate medical education funding on the state and federal level.

A resolution to revise the state’s medical spa registry application was also approved during the annual meeting. TMA’s resolution calls for a new application to include the number of hours of supervision, the number of hours a medical director must spend on site, and the percentage of ownership by medical directors. It also calls for public access to the medical director’s average hours of supervision and number of hours on site.

The House of Delegates also approved a dues increase for members starting with an increase of $25 in 2017. Dues will be raised an additional $10 per year for the following five years, bringing TMA dues to $560 by 2022. The House of Delegates last raised dues in 2003. Visit tnmed.org/MedTennHOD for more information on these and all actions of the House.

CME SESSIONS

TMA offered a total of 32.25 hours of continuing medical education during MedTenn16 on a wide variety of topics.

TMA’s newest proper prescribing course, taught by Dr. Gray, covered state efforts to combat drug over-use, prevention of neonatal abstinence syndrome and an evidence-based look at medical marijuana. The course is also available online at tnmed.org/education and satisfies the Tennessee Board of Medical Examiner’s requirement of 2 CME hours in prescribing.

NEW LEADERS

Keith G. Anderson, MD, a cardiologist in Memphis, officially began his one-year term as TMA president during MedTenn16. He is the 162nd president of TMA.

Dr. Hale presented Dr. Anderson with the presidential gavel and medal at a ceremony on April 30.

“I’m very much looking forward to the platform and responsibility of the coming year,” Dr. Anderson said. “Healthcare is in constant flux. TMA is the most effective vehicle we have as physicians to share our expertise in the legislature, to acquire medical education and leadership training, and to positively influence issues that directly affect our patients. In 2015 we saw one of the largest membership increases in the past decade because we are galvanizing physicians toward a shared vision and purpose. But we still have a lot of work to do. It is a privilege for me to serve as TMA President.”

Dr. Anderson is a cardiovascular disease specialist and managing partner at Sutherland Cardiology Clinic, and serves as a clinical instructor with the University of Tennessee Health Science Center College of Medicine, Department of Cardiology. He is a past president of The Memphis Medical Society and has been actively involved as a Memphis representative to the TMA House of Delegates and member of the TMA Board of Trustees. He is a member of the American College of Cardiology, the American Medical Association and the American Heart Association.

A native of Memphis, Dr. Anderson received his medical degree from the University of Tennessee-Memphis, where he also completed his internship, residency and fellowship.

A number of other TMA members began terms for 2016-2017 leadership positions during MedTenn:

• James Batson, MD, a Cookeville pediatrician, will serve as Chairman of the TMA Board of Trustees.

• James Ensor, MD, FACP, an internal medicine specialist in Memphis, will serve Vice Chair of the TMA Board of Trustees.

• Ted Taylor, MD, a pediatrician in Johnson City, was reappointed as Secretary/Treasurer for the TMA.

• Nita Shumaker, MD, a Chattanooga pediatrician, will serve as TMA President-Elect. She will be just the second female ever to serve as TMA President when her term begins next year.

AWARDS

TMA’s annual awards were presented during MedTenn16 to honor some of Tennessee’s most prominent physicians, medical advocates and community leaders.

OUTSTANDING PHYSICIAN AWARDS

Three physicians were honored this year with the Outstanding Physician Award: Jerre Minor Freeman, MD, Roland W. Gray, MD, and the late Nat Edens “Ed” Hyder Jr., MD.

The Outstanding Physician Award is presented each year to TMA member physicians who have made a mark on the profession of medicine, colleagues and peers during their career.

Dr. Freeman, who was nominated by The Memphis Medical Society, is a humanitarian, research scientist and inventor. He has practiced ophthalmology in Memphis for 50 years.

Dr. Freeman holds 18 patents in ophthalmology and has been inducted into the Society of Entrepreneurs, a prestigious Memphis Society. He has served as president of The Memphis Medical Society and president of the American Board of Eye Surgery.

He is also well-known for his humanitarian work. In 1978, he founded the World Cataract Foundation, which has a mission of helping combat the vast problems of cataract blindness in developing countries.

Dr. Gray, who was nominated by the Nashville Academy of Medicine, was recognized for work including more than a decade of service with the Tennessee Medical Foundation Physician’s Health Program.

He was a practicing pediatrician from 1976 to 2001 and has served as the medical director of the Tennessee Medical Foundation’s Physician’s Health Program since 2002. Because of his work, more than 1,900 doctors in the state have received treatment for addictive diseases, mental or emotional illness.

Dr. Gray has treated more than 10,000 patients for addictive diseases since being certified in addictive diseases in 1987 and serves as a special government employee and consultant to the FDA Subcommittee on Drugs and Medical Risk Management.

Dr. Hyder, nominated by the Washington-Unicoi-Johnson County Medical Society, was a civic leader, a solider, a teacher and, above all, a healer. He practiced medicine for 55 years and was 86 years old when he died in October 2015. The award was presented to his daughter, Gretchen Byrd.

Dr. Hyder joined the military in 1947, serving as a clerk and medic in the U.S. Army. He later served his country by joining the Medical Corps of the U.S. Army Reserve.Dr. Hyder also served his country in later years by joining the Medical Corps of the U.S. Army Reserve and later serving in the National Defense Service Command.

He has served in leadership positions including member of
the Tennessee Public Health Council, president of the Tennessee Academy of Family Physicians and TMA president. In 1974 he was named Family Physician of the Year in Tennessee.

**DISTINGUISHED SERVICE AWARDS**

TMA’s Distinguished Service Awards honor members for notable achievements during the past year. The 2016 Distinguished Service Award winners were: Kelly Arnold, MD, James Gray, MD, Michel McDonald, MD and Jane Siegel, MD.

In March 2015 Dr. Arnold opened Clinica Medicos, Chattanooga’s first comprehensive bilingual medical clinic targeting the city’s Latino population. The clinic, created as a model for other communities to follow, has seen an overwhelming number of patients since it opened.

Dr. James Gray has helped revitalize the Putnam County Medical Society and improve relationships and camaraderie between physicians in the Upper Cumberland region. He has also worked with Cookeville Regional Medical Center to encourage membership in the PCMS-TMA and advocated for the 2015 repeal of the Tennessee Intractable Pain Treatment Act, a law that inadvertently contributed to neonatal abstinence syndrome.

Drs. McDonald and Siegel were presented with a joint award for serving in landmark leadership positions. Dr. McDonald became the first female chair of the TMA Board of Trustees in 2015 and Dr. Siegel also presided over the House of Delegates as TMA’s first ever female Speaker of the House.

Dr. McDonald has served as president of the Tennessee Dermatology Society and member of the Board of Directors of the International Society for Dermatologic Surgery. Dr. Siegel is a Founders Circle member of the American Foundation for Surgery of the Hand and has served as president of the Tennessee Hand Society.

**COMMUNITY SERVICE AWARDS**

TMA’s Community Service Awards recognize contributions of physicians, community leaders and organizations to advance the overall public health and well-being of their communities.

Recipients of the 2016 Community Service Awards were: Kathi Potts, CMPE, Representative Ryan Williams, Safety Net Consortium of Middle Tennessee and A Step Ahead Foundation.

Ms. Kathi Potts was recognized for her advocacy for physician issues in the Tennessee General Assembly and her longtime support of organized medicine.

Potts has almost 20 years of medical office administrative experience and volunteers her time on many important physician issues. She serves on the TMA Legislative Committee and chairs the legislative committee for the Tennessee Medical Group Management Association.

In this position, she has given an exceptional amount of time in support of TMA’s Healthcare Provider Stability Act and increase engagement of TMGMA members in the legislative process.

Rep. Williams was recognized for working closely with members of the Putnam County Medical Society and Power of Putnam Anti-Drug Coalition to study and identify ways to combat the state’s opioid epidemic, specifically in the Upper Cumberland region. He also sponsored a bill to repeal the 2001 Tennessee Intractable Pain Treatment Act.

Safety Net Consortium of Middle Tennessee was honored for the work it does to bring together clinics, providers, academicians and consumer and community leaders to improve the health and healthcare of low income, uninsured residents of Nashville.

The Safety Net Consortium of Middle Tennessee celebrated 15 years of service in 2015. The Bridges to Care Program, later renamed Project Access Nashville, was the consortium’s first initiative. Since its inception in 2002, more than 62,150 patients have been seen through the program’s primary care referrals, and more than 208,450 prescriptions have been filled through the program.

A Step Ahead Foundation is dedicated to recognizing and providing financial support for promising young women in the greater Memphis community who are committed to public service in the areas of academic success and effective, responsible life planning.

A Step Ahead Foundation, founded in 2011, provides free, long-acting reversible contraception to the women of Memphis and Shelby County to prevent unplanned pregnancies and provides scholarships to young women in the greater Memphis area who plan to pursue a career in public health or social services.

**PUBLIC HEALTH HERO AWARD**

The William Schaffner, MD Public Health Hero Award is given jointly by TMA and the Tennessee Public Health Association every two years to individuals who demonstrate extraordinary efforts in the advancement of public health in Tennessee.

Timothy F. Jones, MD won the award during MedTenn16.

Dr. Jones, currently the State Epidemiologist with the Tennessee Department of Health, has led investigations into a number of disease outbreaks in the state including LaCrosse encephalitis, tuberculosis, West Nile virus and many others.

He has served in leadership positions nationally and internationally, including as a consultant for the World Health Organization and a Polio Eradication Project Consultant for the Republic of Yemen.

Locally, Dr. Jones volunteers and serves on the board of directors for Siloam Family Health Center in Nashville, a faith-based indigent care center.
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Currently, employees who could focus on patients or other important tasks are opening envelopes, sorting the contents, keying paper EOBs and routing payments. Processed paper documents take up valuable space both on and off site—and when you need to retrieve one of those files, you waste time searching and hoping that the papers are where they belong. (Up to 15 percent of paper documents are misfiled or misplaced.)

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Scanners and specialized software capture the vital data on checks, EOBs, correspondence and other documents. With remote deposit, payments are not only routed to your bank accounts faster—they are also rejected sooner if they are fraudulent or bad. The resulting electronic files—all of which are HIPAA compliant—go directly into your system so that employees with access privileges can do their jobs.

The advantages to image lockboxes include:

• Faster payments. Remote deposits process sooner than paper checks.
• Better response time to bad and fraudulent checks.
• Easy access. Authorized employees can view files from their workstations and work with multiple electronic documents at the same time.
• Better patient care. Workers can focus on patients, not paperwork.
• More efficiency. The streamlined workflow improves the entire process, from receiving the mail to seeing payments in your bank accounts.
• Lower costs. From more efficient employees to less expensive processing and storage fees, you save money.

Feel free to contact Blake Wilson with TMA Medical Banking with any questions or if you are interested in learning more at 615.515.4272 or bwilson@tmamedicalbanking.com. +

Chris Dixon works at InStream, a TMA Medical Banking partner. Meredith Williams is Director of Healthcare Solutions at InStream.
There is a lot of myth and misinformation about marijuana. As the Tennessee Medical Foundation consults more on prescribing issues, I was recently asked to develop a presentation for the state on medical marijuana. I set out to look at the drug from an evidence-based perspective and ask: Does the literature support its use as medicine, and are there indications for therapeutic use?

Marijuana was used by the Chinese more than 5,000 years ago. In America, in the 19th and early 20th centuries, it was used for muscle spasms, stomach cramps, and in patent medications. The Marihuana Tax Act of 1937 put the lid on marijuana use, due to a Federal Bureau of Narcotics Commissioner who felt it caused a lot of criminal behavior and severe mental illness. In 1970 the Controlled Substances Act made it a Schedule I drug, which meant it was deemed as having no medical value. In 1971, President Richard Nixon began his war on drugs, imposing severe consequences for possessing relatively small amounts of marijuana. As of 2016, there are 23 states and the District of Columbia, and one more state pending, with medical marijuana laws on the books.

In the 21st century, certain requirements must be fulfilled to bring a medicine to market. First, there has to be known purity of the drug. With marijuana, even the dispensaries cannot validate the concentration of the different strains they sell. Second, there need to be specific indications, or evidence, of efficacy. And third, there has to be an accurate, specific dosage and knowledge of adverse side effects. The question is, has this been fulfilled with marijuana?

**MARIJUANA IN TENNESSEE**

There is some legal use of medical marijuana in Tennessee; the legislature is being very careful as it moves forward and tracks how medical marijuana laws are impacting other states.

Charlotte’s Web or Realm Oil is legal to use if recommended by physician, but it is not available for purchase in the state. Charlotte’s Web was named after Charlotte Figi, a little girl with Dravet’s Syndrome whose seizures were successfully diminished with the use of medical marijuana. It is also called Hippie’s Disappointment because, with its low level of THC, you could smoke a roomful of it and never get high. Current state laws don’t allow for smoking the substance, but it can be ingested.

Dranabinol (Marinol) is a Schedule 3 drug used for chemotherapy-induced nausea and vomiting and AIDS-wasting syndrome. Nabilone (Cesamet) is Schedule 2 and has been approved for chemotherapy-induced nausea and vomiting. These are available in Tennessee by prescription, but very few patients use them because there are better drugs for these conditions.

**PROS VS. CONS**

A 2010 review by Cochrane Drugs and Alcohol examined the claims made by proponents of medical marijuana:

- **Chemotherapy-induced nausea and vomiting** - Reviewers said it was probably effective in children but with a high incidence of side effects; they found inadequate evidence for its use for these purposes in adults.
- **Insomnia** - Cochrane cited a study that did show sleep improvement, but the studied population was small.
- **Fibromyalgia pain** - Cochrane concluded there were too many different preparations, and it was hard to compare since there is no standardization even where it is legal.
- **Glaucoma** - Cochrane concluded it is not effective in “reasonable doses.” Studies have shown for it to be effective a patient would have to smoke one joint per hour around the clock.
- **AIDS-wasting syndrome** - the Cochran review said studies were flawed, and there was inadequate evidence for efficacy.

Cochrane noted some of the cons include addiction in 3 to 7 percent of the patient population, impaired motor skills and possible cognitive and motivational impairment. The review found that these effects were more prevalent in children and adolescents.

In June 2015, the *Journal of the American Medical Association (JAMA)* published a research paper on medical marijuana from University Hospitals Bristol NHS Foundation Trust in the UK. The study examined 79 randomized trials and found:

- Moderate quality evidence for reducing chronic pain, spasticity in multiple sclerosis or paralysis.
- Low quality evidence for efficacy in chemotherapy-induced nausea and vomiting, AIDS-wasting syndrome, sleep disorders and Tourette’s syndrome.
- Adverse side effects including common dizziness, dry mouth, nausea, fatigue, somnolence (sleepiness) and euphoria; less common was more severe psychosis, disorientation, loss of balance and vomiting. In the review, 2 percent of individuals in the studies had to withdraw because of side effects.

**CONCLUSION**

One of the reasons for our opioid overuse is that these drugs were promoted and prescribed without evidence justifying their use among patients with chronic non-cancer pain. With medical marijuana, I believe the train has left the station, but wouldn’t it
**NEW MEMBERS**

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<th>BLOUNT COUNTY MEDICAL SOCIETY</th>
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<td>James D. Briggs, MD, Maryville</td>
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<td>Kristen O. Broadhead, DO, Lenoir City</td>
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<td>Seema Abbasi, MD, Memphis</td>
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<td>Nabil Abouchala, MD, Memphis</td>
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<td>Barry Boston, MD, Memphis</td>
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<td>Catherine J. Clarke, MD, Memphis</td>
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<td>Andrew W. Crothers, MD, Memphis</td>
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<td>Ravis B. Curry, MD, Memphis</td>
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<td>Gregory W. Fink, MD, Germantown</td>
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<td>Andrew S. Pierce, MD, Germantown</td>
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<td>Mark L. Reed, MD, Memphis</td>
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<td>John A. Sandoval, MD, Eads</td>
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<td>Bradley A. Wolf, MD, Memphis</td>
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<tr>
<th>NASHVILLE ACADEMY OF MEDICINE</th>
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<tbody>
<tr>
<td>Tara M. Allen, MD, Nashville</td>
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<tr>
<td>Douglas C. Altenbern Jr., MD, Nashville</td>
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<td>Howard A. Aubert, MD, Nashville</td>
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<td>Michael J. Belsante, MD, Hermitage</td>
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<td>Kyle D. Campbell, MD, Nashville</td>
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<td>Sean P. Casey, MD, Nashville</td>
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<td>Thomas C. Cheetham, MD, Nashville</td>
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<td>Sriram Dasari, MD, Nashville</td>
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<td>Olumuyiwa A. Esuruoso, MD, Nashville</td>
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<td>Mark D. Flora, MD, Nashville</td>
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<td>Ashley A. Hendrix, MD, Nashville</td>
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<td>Christopher C. Hill, MD, Nashville</td>
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<tr>
<td>Jonathan A. Holt, DO, Nashville</td>
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<td>Gautam Jayram, MD, Nashville</td>
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<td>L. Dean Knoll, MD, Nashville</td>
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<td>Whitson Lowe, MD, Nashville</td>
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<td>Paul M. McCurry, MD, Nashville</td>
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<td>Christopher J. Ott, MD, Nashville</td>
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<td>Ilaben B. Patel, MD, Brentwood</td>
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<td>Phillip P. Porch III, MD, FACS, Nashville</td>
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<td>Corinne L. Puzio, MD, Nashville</td>
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<td>John S. Rich Jr., MD, Nashville</td>
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<td>Jeff D. Whitfield, MD, Nashville</td>
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<td>Mitchell L. Wiatrak, MD, Nashville</td>
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<td>Claude H. Workman III, MD, Nashville</td>
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<th>STONES RIVER ACADEMY OF MEDICINE</th>
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<tr>
<td>Kelly C. Baldwin, DO, Murfreesboro</td>
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<td>Gena R. Carter, MD, Murfreesboro</td>
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<td>Thomas M. Helton, MD Murfreesboro</td>
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<td>Faryab F. Lohrashi, MD, Smyrna</td>
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<tr>
<td>Willie V. Melvin III, MD, Smyrna</td>
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<td>Pezhman S. Shoureshi, DO, Murfreesboro</td>
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<th>TMA DIRECT MEMBERS</th>
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<tr>
<td>Katherine A. Bertram, MD, Sparta</td>
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<tr>
<td>Adam K. Franson, DO, McMinnville</td>
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<tr>
<td>Gilbert R. Ghearing, MD, Celina</td>
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<td>Walter F. Little III, MD, Hendersonville</td>
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<td>David S. Morris, MD, Hendersonville</td>
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<tr>
<th>UPPER CUMBERLAND MEDICAL SOCIETY</th>
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<tr>
<td>Meiklejohn D. McKenzie, DO, Cookeville</td>
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<tr>
<td>Maria Teresa S. Ramos, MD, Cookeville</td>
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<td>James P. Tompkins, MD Cookeville</td>
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<tr>
<th>WASHINGTON-UNICOI-JOHNSON COUNTY MEDICAL ASSOCIATION</th>
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<tr>
<td>Jacob E.R. Holt, MD, Johnson City</td>
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<tr>
<td>Paulina C. Mosca, DO, Johnson City</td>
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<tr>
<td>Dawn M. Nuckolls, DO, Johnson City</td>
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<th>WILSON COUNTY MEDICAL SOCIETY</th>
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<tr>
<td>Charles M. Gill Jr., MD, Lebanon</td>
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*Does not include student or resident members.*
IN MEMORIAM

Henry L. Adkins, MD, age 92. Died March 25, 2016. Graduate of the University of Illinois College of Medicine. Member of The Memphis Medical Society.

Travis L. Bolton, MD, age 81. Died March 8, 2016. Graduate of the University of Tennessee Center for Health Science. Member of the Tipton County Medical Society.

James M. Brakefield, MD, age 86. Died February 27, 2016. Graduate of the Tulane School of Medicine. Member of the Nashville Academy of Medicine.

John W. Carson III, MD, age 56. Died March 1, 2016. Graduate of the University of South Florida College of Medicine. Member of the Lakeway Medical Society.

Donald A. Cole, MD, age 61. Died April 1, 2016. Graduate of the Virginia University Commonwealth School of Medicine. Member of the Wilson County Medical Society.

Malcolm B. Daniell, MD, age 81. Died April 10, 2016. Graduate of Baylor College of Medicine. Member of the Chattanooga-Hamilton County Medical Society.

Robert G. Demos, MD, age 96. Died May 13, 2016. Graduate of the University of Tennessee Center for Health Science. Member of the Chattanooga-Hamilton County Medical Society.

Bruce A. Elrod, MD, age 90. Died April 8, 2016. Graduate of the University of Alabama School of Medicine. Member of the Chattanooga-Hamilton County Medical Society.

Clarence L. Fennewald, MD, age 65. Died May 2, 2016. Graduate of the University of Missouri School of Medicine – Columbia. Member of the Chattanooga-Hamilton County Medical Society.

James R. Hamilton, MD, age 92. Died May 9, 2016. Graduate of Vanderbilt University School of Medicine. Member of the Nashville Academy of Medicine.

Arthur S. Headley, MD, age 54. Died April 10, 2016. Graduate of the University of Alabama School of Medicine. Member of The Memphis Medical Society.

Charles T. Langford Jr., MD, age 77. Died May 9, 2016. Graduate of the University of Tennessee Center for Health Science. Member of The Memphis Medical Society.

James G. McClure, MD, age 91. Died May 10, 2016. Graduate of the University of Tennessee Center for Health Science. Member of The Memphis Medical Society.

Harold A. McCormack, MD, age 78. Died May 12, 2016. Graduate of the University of Tennessee Center for Health Science. Member of The Memphis Medical Society.

Evelyn B. Ogle, MD, age 92. Died May 5, 2016. Graduate of the University of Tennessee Center for Health Science. Member of The Memphis Medical Society.

John L. Sawyers, MD, age 90. Died March 18, 2016. Graduate of Johns Hopkins University School of Medicine. Member of the Nashville Academy of Medicine.

Michael L. Vernon, MD, age 70. Died May 18, 2016. Graduate of the University of Tennessee Center for Health Science. Member of The Memphis Medical Society.

William B. Wadlington, MD, age 89. Died May 18, 2016. Graduate of Vanderbilt University School of Medicine. Member of the Nashville Academy of Medicine.

James W. Wall, MD, age 78. Died April 1, 2016. Graduate of Baylor College of Medicine. Member of the Knoxville Academy of Medicine.

IS MARIJUANA MEDICINE? (Continued from p. 26)

be nice to slow down the train and look at the evidence for the use of marijuana as medicine?

In talking with physicians about marijuana, I find they’re either very supportive or they think it’s the devil’s drug. I believe the truth is somewhere in between. We do know, however, that young developing brains and psychoactive drugs do not mix. We need to slow down and look at the evidence.

For more information, contact the TMF at 615-467-6411 or visit e-tmf.org. +
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