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<table>
<thead>
<tr>
<th>Sample Pricing!</th>
<th>RETAIL PRICE</th>
<th>DISCOUNTED PRICE</th>
<th>% OFF</th>
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<tr>
<td><strong>Xopenex 0.2mg/1ml</strong></td>
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*Discounted prices were obtained from Walgreens pharmacy in January 2016. Prices vary by pharmacy and region and are subject to change.

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P A R T I C I P A T I N G O R G A N I Z A T I O N S
From the Office of Civil Rights, *Individuals’ Right under HIPAA to Access their Health Information* 45 CFR § 164.524:

**Q:** A patient has asked for an electronic copy of his medical records. Is it okay to give him a paper copy instead?

**A:** When an individual requests an electronic copy of PHI that a covered entity (CE) maintains electronically, the CE must provide the individual with access to the information in the requested electronic format, if it is readily producible in that format. When the PHI is not readily producible in the electronic format requested, the CE must provide access to an agreed upon alternative readable electronic format [45 CFR 164.524 (c)(2)(ii)]. A covered entity is not required to purchase new software or equipment in order to accommodate every possible individual request, the covered entity must have the capability to provide some form of electronic copy of PHI maintained electronically. If the individual declines to accept any of the electronic formats readily producible by the CE then a readable hard copy of the PHI may be provided by the CE.

**Q:** Is $6.50 the maximum amount I can charge the patient for providing a copy of his PHI?

**A:** No. For any request from an individual, a CE (or business associate operating on its behalf) may calculate the allowable fees for providing individuals with copies of their PHI:

1 | By calculating actual allowable costs to fulfill each request; or

2 | By using a schedule of costs based on average allowable labor costs to fulfill standard requests. Alternatively, in the case of requests for an electronic copy of PHI maintained electronically, covered entities may:
   - Charge a flat fee not to exceed $6.50 (inclusive of all labor, supplies, and postage).
   - Charging a flat fee not to exceed $6.50 per request is an option available to entities that do not want to go through the process of calculating actual or average allowable costs for requests for electronic copies of PHI maintained electronically.

In some cases where an entity generally chooses to use the average cost method, or chooses a flat fee as described above for electronic copies of PHI maintained electronically, the entity may receive an unusual or uncommon type of request that it had not considered in setting up its fee structure. In these cases, the entity may wish to calculate actual costs to provide the requested copy, and it may do so as long as the costs are reasonable and only of the type permitted by the Privacy Rule. An entity that chooses to calculate actual costs in these circumstances still must— as in other cases—inform the individual in advance of the approximate fee that may be charged for providing the copy requested.
Doctors Talk Healthcare Policies at TMA Annual Meeting

The Tennessee Medical Association assembled approximately 150 of its physician members in Franklin for the 184th annual business meeting of the TMA House of Delegates.

“Doctors who are engaged in organized medicine bring different perspectives from their medical specialties, practice environments, and the places across the state where they live and work. We don’t always agree, but we all understand that working together to resolve differences and find common ground on the most important healthcare issues gives us a stronger and more influential collective voice. The policy decisions drive TMA’s advocacy and support a strong climate for physicians to practice medicine, and deliver the best possible care to our patients,” said Dr. W. Kirk Stone, a family physician in Union City and Chair of the TMA Board of Trustees.

TMA POLICY UPDATES

Physicians in the House of Delegates considered resolutions on a number of healthcare topics. The assembly overwhelmingly approved one emergency resolution calling for a ban on the sale of any flavored vaping products in Tennessee. Dr. Nita Shumaker, a Chattanooga pediatrician and 2017-2018 TMA President, authored the resolution to address serious health risks associated with addictive vaping products, which are widely popular among adolescents.

Other notable policies the association adopted or referred to the TMA Board for possible action:

- Encouraging state officials to expand access to treatment options and other resources for mental health and substance abuse disorders.
- Calling for truth in advertising for cannabidiol and other CBD products sold in Tennessee.
- Advocating for more clarity in state law around remote patient monitoring, and for appropriate reimbursement for physicians who manage patients’ chronic conditions via telehealth services.
- Addressing gap that exists between the number of medical school graduates and the lack of available spots in U.S. residency training programs, working with the American Medical Association and other national organizations.
- Affirming TMA’s position on scope of practice for midlevel healthcare providers and advocacy for physician-led collaborative practice models.

NEW TMA OFFICERS

Dr. Elise Denneny, a Knoxville otolaryngologist, was officially installed as TMA President. She is the 165th President for the association and the third female to serve in the top role.

The TMA Board of Trustees transitioned its leadership positions for the coming year, and members reelected the Speaker and Vice Speaker presiding over the business of the House of Delegates.

- Kirk Stone, M.D., will serve as Chairman of the TMA Board of Trustees.
- Tim Wilson, M.D., a Knoxville plastic surgeon, was elected to serve as Vice Chair of the TMA Board of Trustees.
- John McCarley, M.D., a Chattanooga nephrologist, was reappointed as Secretary/Treasurer.
- Kevin Smith, M.D., an internist in Nashville, will serve as TMA President-Elect.
- Edward Capparelli, M.D., a family physician in Jacksboro, was reelected as Speaker of the TMA House of Delegates.
- Charles Leonard, M.D., a family physician in Talbott, was reelected as Vice Speaker of the TMA House of Delegates.

AWARDS

TMA honored three member physicians and three organizations with awards for their professional leadership and community service. The 2019 honorees are:

**Outstanding Physician:** Joseph Armstrong, M.D. of Bristol and Bob Vegors, M.D. of Jackson.

**Distinguished Service:** Matt Mancini, M.D. of Knoxville.

**Community Service:** The Bridge in Nashville, Levi’s Legacy of Bristol, and St. Mary’s Legacy Foundation of East Tennessee.

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2019 Legislative Summary

The first session of the 111th Tennessee General Assembly brought nearly 40 new legislators and was the start of a new gubernatorial administration, so TMA entered the transitional year with an intentionally limited focus on opioids, graduate medical education funding and scope of practice.

**OPIOIDS**
While TMA was able to make significant improvements to Gov. Bill Haslam’s “TN Together” legislation in 2018, some of the unintended consequences doctors initially feared the new law would create manifested across the state. TMA worked with the General Assembly in 2019 to amend the law to address specific issues raised by doctors and patients, and to ensure that the laws did not unreasonably obstruct patients from accessing legitimate, effective pain management.

New amendments allow prescribers to give peer review committees at hospitals and medical group practices their Controlled Substance Monitoring Database reports to monitor and improve internal prescribing patterns, clarifies major and minor surgery definitions and defines a palliative care exemption, among other changes.

TMA developed a number of proprietary resources to educate doctors when the laws first took effect in 2018 and promptly updated them to reflect the 2019 changes. TMA members can access the resources at tnmed.org/opioids.

**BALANCE BILLING**
While no related bills gained traction in the 2019 session, TMA continued to work toward a reasonable solution to “surprise medical bills” that shares the burden between all parties—providers, payers and hospitals—and frees patients from unexpected charges for out-of-network treatment.

TMA continues to educate lawmakers on health plans’ narrow networks as the root cause of balance billing and advocate for physicians’ rights to be compensated fairly for the services they provide. See page 22 for a more complete report on TMA’s advocacy on this issue.
SCOPE OF PRACTICE
TMA helped defeat a version of the Doctor of Medical Science bill brought by a group of students from Lincoln Memorial University. The bill would have given physician assistants a new license for independent practice in Tennessee but gained no traction because of strong opposition from the medical community. TMA also helped defeat a measure that would have given PAs and nurse practitioners the ability to prescribe buprenorphine, which threatened patient safety and quality of care.

There were no bills in the 2019 session related to nurse independent practice, thanks to a moratorium TMA negotiated with the Tennessee Nurses Association as part of a legislative task force in 2016. The moratorium expired at the close of the 2019 session, however, and both sides laid the groundwork for 2020 during the year with the many new lawmakers on Capitol Hill who were unaware of the background.

Separately, TMA organized a coalition of the state’s largest medical specialty societies to identify and promote best practices for physician-led, team-based healthcare delivery in Tennessee and develop a solution(s) to increase access across the state. The group is examining collaboration rules to identify how the state might improve the regulatory environment to support more efficient primary care, particularly in rural, underserved areas of the state, as an alternative to nurse independent practice. TMA will continue to advocate for physician-led, team-based care as the best way to ensure patient safety and quality of care.

GME
Governor Bill Lee announced in his State of the State address in March that he would propose more than $8 million in additional funding for graduate medical education in Tennessee and the legislature passed a budget in May with a total of $8.7 million for GME. TMA for years asked government officials to increase the cap on the amount of money the state could use to fund residency training slots. We worked with the new administration and General Assembly to advocate for funding in the state budget that will allow Tennessee to train and keep more doctors in Tennessee instead of exporting them to other states, and improve healthcare access in underserved areas.

TELEMEDICINE
TMA supported a bill to ensure telehealth services would be reimbursed at the same rates as in-office visits. The bill did not pass in 2019, but it helped advance the conversation about appropriate rules and reimbursement for telehealth services. TMA’s position is that technology is critical to improving healthcare access across the state, especially in rural, underserved areas, and can be part of an efficient and effective healthcare delivery system when used as a complement to in-person care. We will continue advocating for laws, rules and regulations that support telehealth as part of coordinated, integrated healthcare delivery and bring reimbursement on par with comparable in-person services.
PARITY FOR MEDICATION-ASSISTED TREATMENT
TMA worked with the General Assembly to pass a resolution encouraging health insurance companies to include Medication-Assisted Treatment in patients’ health plans and reimburse specialists who provide MAT services at rates comparable to other treatments. TMA has long advocated for more accessible and well-funded treatment options for patients struggling with substance abuse. Using medications in combination with counseling and behavioral therapies is a necessary strategy in the ongoing fight against Tennessee’s opioid abuse epidemic.

DOCTORS ON THE HILL
TMA boasts some of the most effective lobbyists on Capitol Hill, but we’re only as strong as the number of physicians we represent and only as visible as the number of doctors who actively participate in our grassroots advocacy efforts.

- More than 350 physicians and healthcare advocates gathered in Nashville on March 26 to bring the voice of medicine to Tennessee legislators at TMA’s annual Day on the Hill.
  tnmed.org/dayonthehill

- Each week, a Tennessee physician serves as Doctor of the Day at the General Assembly for legislators and their staff. Volunteers have the opportunity to interact with lawmakers on the House and Senate floors, attend committee hearings and meet one-on-one with legislators to discuss issues most important to physicians in Tennessee.
  tnmed.org/doctoroftheday

- TMA works continually to build relationships between legislators and their physician constituents. One-on-one meetings, written correspondence and phone calls let lawmakers know where doctors stand on important issues, and TMA occasionally calls on doctors to contact legislators en masse when a key bill is up for vote in a committee or chamber floor.
  tnmed.org/grassroots

- IMPACT, TMA’s non-partisan, independent political action committee, has had overwhelming success in electing and keeping friends of medicine in the General Assembly. IMPACT needs more doctors to contribute so we can continue supporting candidates who understand healthcare issues and respect TMA’s positions.
  tnmed.org/impact

The Tennessee Medical Association in 2019 was named the most influential and trusted advocacy organization in the state,* not just in healthcare but across all industries.

*Based on an independent survey and ranking by Capitol Resources, LLC, February 2019.
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My grandfather was a very traditional individual and would write to me often when I was in college. The most traditional thing about him and one of the things I loved most about his letters were his opening words to me, "I take pen in hand to write you," which was a sign of respect and love. This same dedication of honor is directed towards those Tennessee Medicine readers no longer with us, those readers of articles in the distant past and today’s members. "I take pen in hand" to write the last editorial for our final print edition of Tennessee Medicine as a sign of honor dedication to our readers, staff and tradition.

The Tennessee Medical Association goes back many years with several different names but one of the earliest documented in 1830, was the name, Tennessee Medical Society. Philip Hamer MD wrote the Centennial history of the Tennessee State Medical Association. His description of the activities usually describes as long as there was written communication; there is probably someone called “editor” at that time. With a reasonably reliable record, the first editor was Dr. George H. Price Nashville in 1908, followed by Dr. Perry Bromberg. Dr. Jay F Gallagher served as editor until 1922 followed by Dr. Shoulders until 1950 when Dr. R. H. Kampmeier of Nashville was appointed, and he served until 1971. In 1972, Dr. John Thomison, my predecessor, was appointed and served until January 2002 when I was appointed.

John Thomison was articulate, humorous, intelligent and had a mind so quick that he could write his editorial “on the run.” It was usually about something he was thinking about that day, while as I struggled with the same preoccupation, I was a creator of subjects pitched toward solutions but not a born novelist, as was John.

It is never ceased to amaze me how I became editor! I thought perhaps John had researched my meager academic background and saw that I had a minor in literature, writing, and German, but when I asked him why he chose me, he said I was the only President that wrote his Presidents pages without a single error, which only meant he did not have to rewrite the whole submission which, confidentially, he loved to do so to show the Journal’s importance to literary prose.

During the last two decades that I was Journal editor I had the privilege of working with an outstanding editorial board, and impressive community of scholars. The first editorial board had dedicated members as follows: Lauren Crown MD, James Ferguson MD, Debra German MD, Ronald Johnson MD, Robert Kirkpatrick MD, Karl Misulis MD, Greg Phelps MD, Bradley Smith MD, Jonathan Sowell MD, and Jim Talmage. In more recent times, we lost our friend and member Robert Kirkpatrick MD and Drs. Crown, German, Talmage, and Johnson retired from the board but added Andy Walker MD.

…but when I asked him why he chose me, he said I was the only President that wrote his Presidents pages without a single error, which only meant he did not have to rewrite the whole submission which, confidentially, he loved to do so to show the Journal’s importance to literary prose.
I have been privileged to work with them, and there is simply no adequate way to acknowledge their contributions or to repay my debts. Knowledge and integrity of service have been a collective effort in every sense of the word, and I shall look back on my tenure as the richest of experiences, the rarest of honors to serve with them.

I want to offer my thanks to the many managing editors who have worked closely with me; to record my gratitude for the moral and material support provided to the Journal. I can only quote and thank those I have worked with over the last 17 years. Jean King worked with Dr. Thomison for many years and then with me, followed by Brenda Williams, who served for many years and not only kept me out of trouble but made me look good. They were
followed by those of short tenure but effective, Crystal Hogg and Katie Brandenburg. Our current managing editor, Julia Couch, is incredible in this transition and our recent publication efforts.

Lastly, the staff, those who helped are numerous to mention but I’m indebted to CEOs Don Alexander and Russ Miller; and Yarnell Beatty, Dave Chaney, Audrey Smith and Amy Campoli.

Further, you may be surprised with my following comments because of my love for Journal and its splendid history but I agree with the leadership and staff that printed peer-reviewed journals will and should not survive in a new time of the increasing digital technology but more important because our members and colleagues need rapid access to required information and the incentive to seek solutions. There are many reasons, but most are related to the production time with a print issue and the rapid progress of both public health, medical diagnosis and treatment and the medication upsurge making the reliability questionable even for only two months of delay. I also know fully that the current business model for such a publication will not survive the economic future.

Being editor for as many years has led to all sorts of events humorous, challenging, sad and difficult. First, the sad, loss of a great man, a thinker and a friend, Robert “Bob” Kirkpatrick. There were many humorous events that occurred, and I will mention a few both to “rat” on myself and others. Brenda Williams, now Brenda Williams Denbo, someone I knew well because of the skills she had demonstrated as a guest writer for articles for the Journal. She called on the telephone to interview me and introduced herself as the new managing editor of *Tennessee Medicine*. The process went well, at least, from my perspective and I filled her head with many good things and bad things and she barely got a word in during the conversation. She wrote Don Alexander.
to inform him that she had done her task and that we had a great talk, but I was somewhat “wordy.” She made the mistake of copying me by accident and I never let her forget it the rest of her career.

As modern technology in auto editing progressed, many submitted articles and some even from those who would be considered patriarchs of their work and church were caught unknowingly using an occasional swear word or a sexy term and when I returned for further editing, their answer was humble apology with an apparent fear of disclosure. Occasionally some would admit they thought it was reasonable to use that term in today’s open society. You can see my difficulty.

I have hundreds of examples but the last two were some of my favorites. John Thomison was a very proper, precise, articulate and intellectual giant. I described above how he selected me but during my early “shadowing,” the first few months before he actually allowed me to do my own thing, I made the mistake of submitting a treatise that I called an editorial, my new right as editor pro tem, and he quickly answered that there is only one editor of the Journal, and that was him and I never forgot that.

Lastly, just before I became the full-time editor, Brenda and I carefully schemed to add a little color to the years of green covers and pages. You should have been around for the explosion that occurred when we slipped in a brown cover while he was still the editor. I’m sure today he would be in total apoplexy at the enormous changes made in color and formatting. I (we) still miss the great man and as much as I’m going to miss the Journal and print; I am glad he is not around because it would be an end of his era, at least he would think so.

Finally, as a farewell dictum, editors generally are individualistic and leave their stamp of emphasis upon the direction of a journal and its editorial expression. It is also valid as the editor of Tennessee Medicine, I have never been subject to the dictates of the staff, leadership or House of Delegates and have enjoyed incredible editorial privilege.

In closing and farewell as the last editor of the print journal, a quote by Richard Smith, a former editor of the British Medical Journal so appropriately quoted as leaving from it leadership about journal editors role: “Stir up, prompt debate, upset people, legitimize and set agendas.” And stirring and setting agendas may create animosity, but should this occur, I take solace in the advice of Ernst Hart, the first editor of the BMJ: “An editor needs and must have enemies; he cannot do without them. Woe be unto the journalists of whom all say good things.” And this captures the essence of the role of any general medical journal’s editor worth his or her salt: to practice the art of “living dangerously!”

Farewell.

Dr. Gerkin was recognized for his service as editor of Tennessee Medicine, Journal of the Tennessee Medical Association, at the 184th Annual Meeting of the Tennessee Medical Association.

Under his guidance and direction, TMA produced more than 170 editions of the magazine, from a monthly editorial and scientific abstract journal to more recent editorial-only issues on a quarterly basis, each with a circulation of more than 8,000 Tennessee physicians and other readers.

Dr. Gerkin, while leading an editorial board of volunteer member physicians and collaborating with TMA staff and third-party resources in the production of each magazine, has edited hundreds of articles, editorials and scientific abstracts on behalf of TMA.

He has faithfully attended nearly every board meeting and annual meeting for almost three decades, actively participating in the work of the organization and reporting on status of the magazine, in addition to his many other professional and civic engagements.
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The explosive case against Dr. Larry Nasser involving young athletes in training with USA Gymnastics held the nation’s attention last year; it was a heinous case and the most recent to turn the spotlight onto professional sexual misconduct and boundary violations within the medical community. If you search you will find varying studies and statistics but experts agree the overall problem is underreported.

Fortunately, the Tennessee Medical Foundation rarely sees these cases, but they do happen. We as physicians need to know and understand the definitions, expectations, and the consequences of crossing a boundary with a patient.

Boundary violations exist at several levels but they can cross into the most severe: professional sexual misconduct. It is important to understand general boundary violations before focusing on sexual boundary violations.

**Boundary Violations**

A boundary violation occurs anytime a physician misuses his or her power to exploit a patient for tangible or intangible benefit or gain, or anytime the relationship becomes anything other than about patient welfare. There are many types and examples of boundary violations. They all have a similar thread, which is the violator wants to gain influence over the other person. A common example is when a patient brings the physician an expensive gift with the expectation that the physician then provides special services. Those may include giving the patient their cell phone number or email address, special access or appointments, or even house calls. Lavish and expensive gifts should be refused.

A common theme (especially in Music City) is for a VIP to provide backstage passes to gain influence. The physician grows to like the easy access to the celebrity and the prestige and in time gets starstruck. Then the VIP or someone in the band/entourage asks the physician to prescribe a controlled substance, usually a stimulant or opioid. The physician realizes that if they refuse, they won’t be invited back, so they cross this boundary and keep crossing it. The misprescribing accelerates until disaster happens.

**Professional Sexual Misconduct**

Boundary violations cross into even more dangerous territory as professional sexual misconduct (PSM), which is any behavior that exploits the physician-patient relationship in a sexual manner. PSM happens any time physician-patient sex occurs. It may be verbal, physical, or subliminal. It can be initiated by either party and includes but is not limited to sexual intercourse, masturbation, genital-to-genital contact, oral-to-genital contact, or any skin-to-skin contact that can be perceived as sexual. It may include expressions of thoughts, feelings, or gestures that are either overtly sexual or construed by the patient as sexual.

Professional sexual misconduct is behavior between a physician and a patient of the same or different gender of a sexual nature that can be welcome or unwelcome. If unwelcome, the behavior occurs through intimidation, coercion, or manipulation. This can include frotteurism (touching without consent), coercing or pressuring for sexual acts, forced intercourse, unnecessary contact with body parts, or demanding sex in return for a prescription (sextortion).

To help with identification and understanding it is easier to look at PSM as a continuum that exists between the extremes of the “lovesick” physician and the physician with predatory behavior. While on opposite ends of the spectrum, neither is acceptable nor appropriate. Both of these extremes and everything in between are harmful to the therapeutic alliance formed between the physician and patient, and to quality patient care.

The lovesick physician is the physician of any gender who falls in love with their patient. It sounds benign and innocent; however, it can lead to the same problems and cause the same harm as other sexual boundary violations because it can never be consensual due to the power disparity.

As mentioned at the beginning of this article, the most recent and egregious example of predatory sexual violations is Dr. Larry Nassar, who brazenly used his position of power as a team doctor over young vulnerable women to sexually violate them. Because of that position, power, and

“**In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill doing and all seduction, and especially from the pleasures of love with women or with men.**”

—HIPPOCRATIC OATH
patient vulnerability, he did not have the opportunity or even the need to utilize “grooming” techniques described below to achieve this end. However, physicians in the customary office-based practice usually utilize grooming to sexually exploit their patient.

Grooming
The term “grooming” is often used to describe the behavior that frequently occurs as a lead-in to sexual boundary violations. Grooming is generally a slow and methodical process of manipulating a person to a point where they can be victimized in a sexual manner. Grooming by the physician begins with treating the patient in a special way. The physician’s motives are to gain influence over the patient to achieve a sexual act. The physician and patient can be any gender. As an example, the physician schedules follow-up appointments on a Friday afternoon when fewer staff are on hand or stay late. The physician spends extra time with the patient and discounts the patient’s fee or copay. Then the appointments are moved outside the office to a coffee shop. The physician engages in self-disclosure and may reveal confidential information about themselves or other patients. The physician initiates physical contact with a hug or even a kiss. Over time there is an increasingly blurred line between the professional and personal relationship. The grooming is consummated when a sexual relationship occurs with the patient.

Grooming is also the process used when the patient is the initiator or perpetrator of the sexual boundary violation. When the patient is the initiator their motives are to gain undue influence over the physician, usually in order to get prescribed controlled drugs. Once sexual contact happens, even when completely and totally initiated by the patient, the physician is placed in a position to be extorted. The patient threatens to report the physician if they don’t do what is asked. The ask is usually to prescribe the requested scheduled medications, usually stimulants and opioids. The misprescribing for the patient is then expanded to include their friends and family. Very quickly the physician is prescribing significant amounts of scheduled medications without any justification. Sometimes the ask is not for drugs but instead is for money, and lots of it. Being extorted by a patient does not negate the culpability incurred for the professional sexual misconduct.

Sexual behavior between a physician and a patient is never diagnostic or therapeutic and is always harmful to the patient. The repercussions can be devastating to both the physician and the patient. It is always the physician’s responsibility to prevent such occurrences, even when the sexual behavior is initiated by the patient. A sexual relationship between a physician and the patient can never be consensual, based on the disparity of power inherent in the physician-patient relationship. That relationship is the keystone to quality care, to the healing process, and to optimal patient outcomes.

Consequences
The consequences of PSM are devastating to both parties. Penalties on the physician side include suspension and/or revocation of a medical license by the Board of Medical Examiners. If the behavior is perceived as predatory then criminal prosecution can occur, resulting in fines, jail time, and registration as a sexual offender. Civil lawsuits are also a possibility, which may not be covered under a medical malpractice policy.

The consequences to the patient from PSM run the gamut from development of Post-Traumatic Stress Disorder as a result of the sexual trauma, to poor quality care and decreased compliance and not trusting the practice of medicine.

The best way to prevent PSM is by education, the use of well-trained chaperones that are used for every patient, and avoiding special treatment for any patient. Another preventative measure is to avoid dual relationships; this is when the physician-patient relationship overlaps with another type of relationship. For example, when the patient is also a spouse, first-line relative, office nurse, or best friend. In rural areas dual relationships may be necessary due to healthcare workforce shortages, but in urban or suburban areas there is little reason to cross boundaries by embracing a dual relationship.

Get Help
Boundary violations — especially sexual relations of any kind between a physician and a patient — are never acceptable because they are harmful to the patient. As stated earlier, we cannot fail to emphasize that the onus is always on the physician, as it can never be consensual because of the disparity of power.

There are many other types of sexual and non-sexual boundary violations. The AMA Code of Ethics and the Tennessee Board of Medical Examiners and Federation of State Medical Boards policy statements are good resources to better understand the finer points of gifts, boundary violations, dual relationships, romantic relationships with an ex-patient, and professional sexual misconduct.

For the physician who has violated a patient’s boundary it is mandatory to get help immediately. The required help will depend upon the type of boundary violation but includes individual and/or group therapy, legal advice, and professional coaching. Although PSM is generally out of the wheelhouse of the TMF-PHP, we can refer to vetted available resources. Please don’t hesitate to call us if you or someone you know is caught up in or even has questions about boundary violations or professional sexual misconduct. You can reach the TMF at 615-467-6411 or online at e-tmf.org.

For assistance or to make a tax deductible contribution to the Physicians Health Program, contact the Tennessee Medical Foundation at 615-467-6411; write to the Tennessee Medical Foundation, 5141 Virginia Way, Ste 110, Brentwood, TN 37027; or visit e-tmf.org to send a confidential email or donate online.
The TMA Group Health Plan experience has exceeded all of our expectations. Though we understand our performance won’t be this good every year, we are almost $300,000 ahead of a fully insured premium equivalent. TMA’s team has done a great job helping us understand the self-funding environment and add cost control measures that will benefit us for years to come.”

Kevin Burris, CEO | Premier Surgical Associates, Knoxville
My PEMBA year proved to me that a dedicated faculty coupled with a well-constructed learning strategy can convert physicians into systems thinkers with fluency in the language of business.”

SAM DAGOGO-JACK, MD, MBA
Director, Division of Endocrinology, Diabetes & Metabolism
University of Tennessee Health Sciences Center in Memphis
TMA Sets 2020 Legislative Agenda

The Tennessee Medical Association, the state’s most influential advocacy organization for doctors and patients, has set its priorities for the 2020 legislative session.

SCOPE OF PRACTICE:
TMA for years has led advocacy efforts to keep Tennessee physicians supervising patient care and prevent inappropriate scope of practice expansion for midlevel healthcare providers. Advance practice nurses and physician assistants have been unsuccessful in their attempts to change state laws to achieve independent practice in Tennessee, and TMA remains steadfast in advocating for policies that improve and strengthen interprofessional relationships, not weaken them. TMA is leading a coalition of medical specialty societies and other healthcare organizations promoting physician-led, team-based healthcare delivery teams as the best model for patient safety and quality of care.

tnmed.org/scopeofpractice

BALANCE BILLING:
While no related bills gained traction in the Tennessee General Assembly during the 2019 session, Congress is considering multiple proposals to protect patients from “surprise medical bills.” TMA continues to educate state and federal lawmakers on health plans’ narrow networks as the root cause of balance billing and advocate for a solution that frees patients from the financial burden of unexpected out-of-network charges while protecting physicians’ rights to choose how they practice and get paid appropriately for services they provide.

tnmed.org/balancebilling

TELEHEALTH:
TMA supported a 2019 bill to ensure telehealth services would be reimbursed at the same rates as in-office visits. The bill did not pass, but it helped advance the conversation about appropriate rules and reimbursement for technology that is critical to improving healthcare access across the state, particularly in rural, underserved areas. TMA will continue advocating for laws, rules and regulations that support telehealth as part of coordinated, integrated healthcare delivery and bring reimbursement on par with comparable in-person services.

TENNESSEE PROFESSIONAL PRIVILEGE TAX:
Prior to adjourning the 2019 session in May, the General Assembly abruptly exempted several professions from paying the state’s professional privilege tax. Doctors are still required to pay the annual tax, along with lawyers, lobbyists and stock brokers. TMA has advocated for reduction or removal of the professional privilege tax for years and will continue working with state lawmakers on possible solutions.

Learn more about TMA’s legislative advocacy at tnmed.org/legislative and follow TMA @tnmed and @tnmedonthehill.
Special interest groups have pushed the Tennessee General Assembly during the past few years to address the issue of “surprise medical bills,” including filing a bill to remove the state’s ban on the corporate practice of medicine. TMA wants to reach a solution — at the state or federal level — that frees patients from the financial burden of unexpected out-of-network charges while protecting physicians’ rights to choose how they practice and get paid appropriately for services they provide.

**OUR PRINCIPLES**

- Hold patients harmless for out-of-network charges without removing Tennessee’s ban on the corporate practice of medicine, prohibiting balance billing or obstructing physicians’ right to be fairly compensated for the services they provide.
- Hold health plans accountable to patients with reasonable network adequacy standards.
- Do not allow insurance companies to set their own reimbursement rates without negotiating with physicians and other healthcare providers.
- Create a fair arbitration process to resolve payment disputes between providers and payers, and keep the patient out of it.

**STATE ADVOCACY**

While no related bills gained traction in the Tennessee General Assembly during the 2019 session, TMA continued to proactively engage other stakeholders, including insurance companies and hospitals, in efforts to reach a solution that is fair to all parties, especially physicians and patients.
TMA continues to educate state lawmakers on health plans’ narrow networks as the root cause of balance billing and advocate for physicians’ rights to be compensated fairly for the services they provide.

**FEDERAL ADVOCACY**

Congress in summer 2019 began considering multiple proposals to protect patients from surprise medical bills. While legislators in both chambers agree that the first priority is protecting patients from unexpected charges for out-of-network care, some of the proposed legislation would amount to price fixing, more leverage for insurance companies and more heavy-handed government interference in the delivery of care.

- H.R. 3502, the *Protecting People from Surprise Medical Bills Act*, co-sponsored by Rep. Phil Roe, MD of Tennessee, is modeled after a successful law in New York and offers the most promising framework for a positive solution.
- The “*No Surprises Act*” currently proposed by the House Energy and Commerce Committee is modeled after a failing California law and would harm physicians without addressing the root cause of balance billing. Sponsors added a provision for an appeals process, but TMA has concerns about other provisions that would be unfavorable to physicians.
- S. 1895, the *Lower Health Care Costs Act* is co-sponsored by Tennessee Senator Lamar Alexander. *TMA leaders visited with Sen. Alexander in June 2019 to express concerns over aspects of the bill that would cause more physicians to be cut from health plan networks, create access issues, and ultimately increase costs for patients. A similar model law is failing in California.*

TMA is working with the American Medical Association, Physicians Advocacy Institute and state and national medical specialty societies to send a uniform message to lawmakers and make sure that Tennessee physicians have a voice in federal policies affecting healthcare in Tennessee.

*tnmed.org/balancebilling*

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**Contact Your Congressmen**

Congress is considering multiple proposals to protect patients from surprise medical bills. Draft legislation is moving through committees in both the House and Senate with different approaches that affect balance billing.

Let them hear from you personally! Your personal contact and opinion may influence final languages as these various bills move toward floor votes in the House and Senate in the coming weeks.

Fortunately, legislators in both chambers agree that the first priority is protecting patients from unexpected charges for out-of-network care, but some of the proposed legislation would amount to price fixing, more leverage for insurance companies and more heavy-handed government interference in the delivery of care.

*tnmed.org/contactyourcongressmen*
New Members

**BLOUNT COUNTY MEDICAL SOCIETY**
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David Irizarry, MD
Kelly Noel Ownby, MD
Nathaniel Runne, MD
Robert Jones, MD

**CHATTANOOGA-HAMILTON COUNTY MEDICAL SOCIETY**
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Brandon Daniel Brown, MD
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Michael Scott Kluska, MD
Rachel Denbo Labovitz, MD
Aditya Mandawat, MD
Michael S. Teuton, MD
Brandon Daniel Brown, MD
Rachel Denbo Labovitz, MD
Aditya Mandawat, MD
Michael S. Teuton, MD
William Roberts Thomas, Jr., MD
Sabrina Uddin, MD

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**CONSOLIDATED MEDICAL ASSEMBLY OF WEST TENNESSEE**
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Carey Wallace Frix, MD
Natasha Gupta, MD

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Marcin Tomasz Gomisiewicz, MD
Jeffry T. King, MD
James M. McCoughlin, MD
Murad G. Salaia, MD
James Edward Shamiyeh, MD

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Jeffry C. Ruff, Jr., DO

**MONTGOMERY COUNTY MEDICAL SOCIETY**
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Giri Prasad Rao Korivi, MD

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Benjamin Sloan Heavrin, MD
Steven M. Hegedus, MD, FACP
Meredith A. McKean, MD

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Arvind Reddy Ankreddypalli, MD
Allen Ardeastani, MD
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Joseph Patrick Blankinship, Jr., MD
Aaron E. Bond, MD
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Charles E. Brown, MD
Chamell Cain, DO
Fatima Sufiyans Chaudhry, MD
Harris Luther Cohen, MD, FACR
Gunjan Dokania, MD
John Francis Eck, MD
David E. Fingerhut, MD
Kathleen Forbes, MD, MSHM, CPE, FAAFP
Elizabeth Hinds Gilless, MD
Amber L. Graham, MD
Poonam Lata Gut, MD
Stephen Michael Huddleston, MD
Kelechi Uzoma Iwuji, MD
John Lynn Jefferies, Jr., MD
Fnu Kaweeta, MD
Samira Mujtaba Khan, MD
Scott Wood Kirsch, MD
Michael David Koplon, MD
Aneel Kumar, MD
Joe Thomas Lequerica, MD
George Orville Maish, MD
Tabitha Manero Marek, MD
Vamsee Krishna Mupparaju, MD
Egunmwendia Iguodala Ogbeide, MD
Yasmina Pokharel, MD
Tina Puthalon Kunnath, MD
Rebekah Kay Hofstra Shappley, MD
Scott Eric Strome, MD, FACS
Ellis Tavin, MD
Latomya B. Washington, MD

**WILLIAMSON COUNTY MEDICAL SOCIETY**
R. Scott Frankenfield, MD
Jessica Littman Mather, MD
Craig A. Ternovits, MD
In Memoriam

Charles M Alderson, MD | age 88
Died January 16, 2019. Graduate of University of Tennessee College of Medicine. Member of Memphis Medical Society.

John Hutchins Alexander, MD | age 87
Died March 9, 2019. Graduate of University of Colorado School of Medicine. Member of Stones River Academy of Medicine.

Thomas Richard Benning, MD | age 73
Died August 1, 2018. Graduate of University of Tennessee College of Medicine. Member of Nashville Academy of Medicine.

Geoffrey Berry, MD | age 91
Died May 7, 2019. Graduate of University of Leeds School of Medicine. Member of Nashville Academy of Medicine.

Lynn French Blake, MD | age 85
Died April 15, 2019. Graduate of University of Tennessee College of Medicine. Member of Knoxville Academy of Medicine.

Charles Robert Clark, MD | age 79
Died July 5, 2019. Graduate of Bowman Gray School of Medicine at Wake Forest University. Member of Chattanooga-Hamilton County Medical Society.

Jill F. Chambers, MD | age 70
Died January 17, 2019. Graduate of University of Alabama School of Medicine. Member of Nashville Academy of Medicine.

Charles C. Congdon, MD | age 98
Died February 10, 2019. Graduate of University of Michigan Medical School. Member of Knoxville Academy of Medicine.

Paul Charles Gomez, MD | age 81
Died May 25, 2019. Graduate of St Thomas Hospital Medical School at University of London. Member of Nashville Academy of Medicine.

Fred T. Grogan, MD | age 89
Died June 13, 2019. Graduate of University of Tennessee College of Medicine. Member of The Memphis Medical Society.

Robert Allen Hardin, MD | age 88
Died April 28, 2019. Graduate of Vanderbilt University School of Medicine. Member of Nashville Academy of Medicine.

Rowland Speck Hawkins, MD | age 77
Died March 14, 2019. Graduate of University of Tennessee College of Medicine. Member of Nashville Academy of Medicine.

George W. Holcomb, Jr., MD | age 97
Died June 29, 2019. Graduate of Vanderbilt University School of Medicine. Member of Nashville Academy of Medicine.

Cecil Byron Howard, MD | age 91
Died April 16, 2019. Graduate of Vanderbilt University School of Medicine. Member of Blount County Medical Society.

Paul Nicholas Jacquin, MD | age 74
Died February 19, 2019. University of Illinois College of Medicine graduate. Member of Upper Cumberland Medical Society.

David Nando Jones, MD | age 75
Died December 21, 2018. University of Tennessee College of Medicine Graduate. Member of Nashville Academy of Medicine.

O. Thomas Johns, Jr., MD | age 72
Died April 2, 2019. Graduate of University of Tennessee College of Medicine. Member of Stones River Academy of Medicine.

James Woodfin Kennedy, MD | age 58
Died April 15, 2019. Graduate of University of Alabama School of Medicine. Member of Chattanooga-Hamilton County Medical Society.

Perry McCallen, MD | age 84
Died March 3, 2019. Graduate of University of Tennessee College of Medicine. Member of Knoxville Academy of Medicine.

John H. Moore, III, MD | age 91
Died May 13, 2019. Graduate of University of Pittsburgh School of Medicine. Member of Sullivan County Medical Society.

Lawrence James Pass, MD | age 67
Died June 19, 2019. Graduate of Northwestern University School of Medicine. Member of Nashville Academy of Medicine.

Toivo Rist, MD | age 72
Died January 1, 2019. Graduate of Medical College of Georgia. Member of Knoxville Academy of Medicine.

N. Lynne Taylor, FACP, MD | age 64
Died February 14, 2019. Graduate of University of Tennessee College of Medicine. Member of Knoxville Academy of Medicine.

Forrest Tompkins, MD | age 87
Died September 27, 2018. Graduate of Temple University School of Medicine. Member of Knoxville Academy of Medicine.

Leslie E. Traughber, Jr., MD | age 96
Died October 27, 2018. Graduate of University of Tennessee College of Medicine. Member of Nashville Academy of Medicine.

Thomas Moore Webster, MD | age 80
Died February 7, 2019. Graduate of George Washington School of Medicine. Member of Greene County Medical Society.

Robert Roger Young, Jr., MD | age 82
Died February 10, 2019. Graduate of University of Tennessee College of Medicine. Member of Northwest Tennessee Academy of Medicine.
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New Data Shows Continued Decline in Opioid Prescriptions in Tennessee

A report released in June shows a 13.3% decrease in opioid prescriptions in Tennessee between 2017 and 2018, and a 32.3% drop in the five-year period since 2013. According to the data, Tennessee performed slightly better than the national average during the most recent 12-month period and is on par with other states for the five-year downward trend.

More state-by-state data from the American Medical Association Opioid Task Force also showed a dramatic increase in the number of queries to Tennessee’s Controlled Substance Monitoring Database, rising from 8.6 million in 2017 to 11.4 million in 2018. The CSMD is used to identify and address overprescribing and prevent patients from “doctor shopping” for prescriptions.

According to the AMA report, CSMD queries in Tennessee have increased every year since 2014, when state officials reported 5 million queries. Nearly 51,000 physicians and other healthcare providers are now registered to use the Tennessee CSMD, up from about 39,000 in 2014.

“Our focus in the Tennessee medical community for the past several years has been — and continues to be — controlling what we can control with opioid prescribing and getting better at non-opioid pain management. We continue to focus on appropriate opioid reduction while creating best team-led practices to address pain.

This data affirms that we are moving the needle in the right direction and progressing in areas where physicians can make a real difference fighting the epidemic,” said Elise C. Dennen, MD, a Knoxville otolaryngologist and 2019-2020 President.

TMA was the catalyst to changing the prescribing educational requirements for Tennessee physicians and has educated thousands of healthcare providers on safe and proper opioid prescribing since 2012. The Association has also led the way on important public policies and other initiatives. TMA helped pass the original law implementing the CSMD and was the first state medical society in the U.S. to support mandated controlled substance database lookups by prescribers.

The Tennessee General Assembly in 2018-2019 passed some of the most comprehensive and restrictive laws in the U.S. regulating initial opioid supply. TMA worked with the legislature to make sure the laws help reduce opioid supply without over-regulating the practice of medicine or unreasonably obstructing patients from accessing legitimate, effective pain management.

TMA offers a number of proprietary opioid and pain management resources for doctors and other prescribers at tnmed.org/opioids.
INSTRUCTIONS FOR AUTHORS

Manuscript Preparation
Electronic manuscripts should be submitted to the Editor, David G. Gerkin, MD, via email at communications@tnmed.org. A cover letter should identify one author as correspondent and should include his/her complete address, phone, and e-mail. Manuscripts, as well as legends, tables, and references, must be typed, double-spaced on 8-1/2 x 11 in. white paper/Word document. Pages should be numbered. The transmittal letter should identify the format used. If there are photos, e-mail them separately in TIF, JPG or PDF format along with the article; photos and illustrations must be high resolution files, at least 300 dpi.

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References
References should be limited to 15 for all papers. All references must be cited in the text in numerically consecutive order, not alphabetically. Personal communications and unpublished data should be included only within the text. The following data should be typed on a separate sheet at the end of the paper: names of first three authors (last name first initial[s] with no commas or periods) followed by et al., complete title of article cited, name of journal abbreviated according to Index Medicus, volume number, first and last pages, and year of publication. Example: Olsen JH, Boice JE, Seersholm N, et al.: Cancer in parents of children with cancer. N Engl J Med 333:1594-1599, 1995.

Illustrated Material
Illustrations should accompany the emailed article in a JPG, TIF, JPG or PDF format; files must be high resolution, at least 300 dpi. Photos must be identified with the author’s name, the figure number, and the word “top,” and must be accompanied by descriptive legends typed at the end of the paper. Tables should be typed on separate sheets, be numbered, and have adequately descriptive titles. Each illustration and table must be cited in numerically consecutive order in the text. Materials taken from other sources must be accompanied by a written statement from both the author and publisher giving Tennessee Medicine permission to reproduce them. Photos of identifiable patients should be accompanied by a signed release.

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