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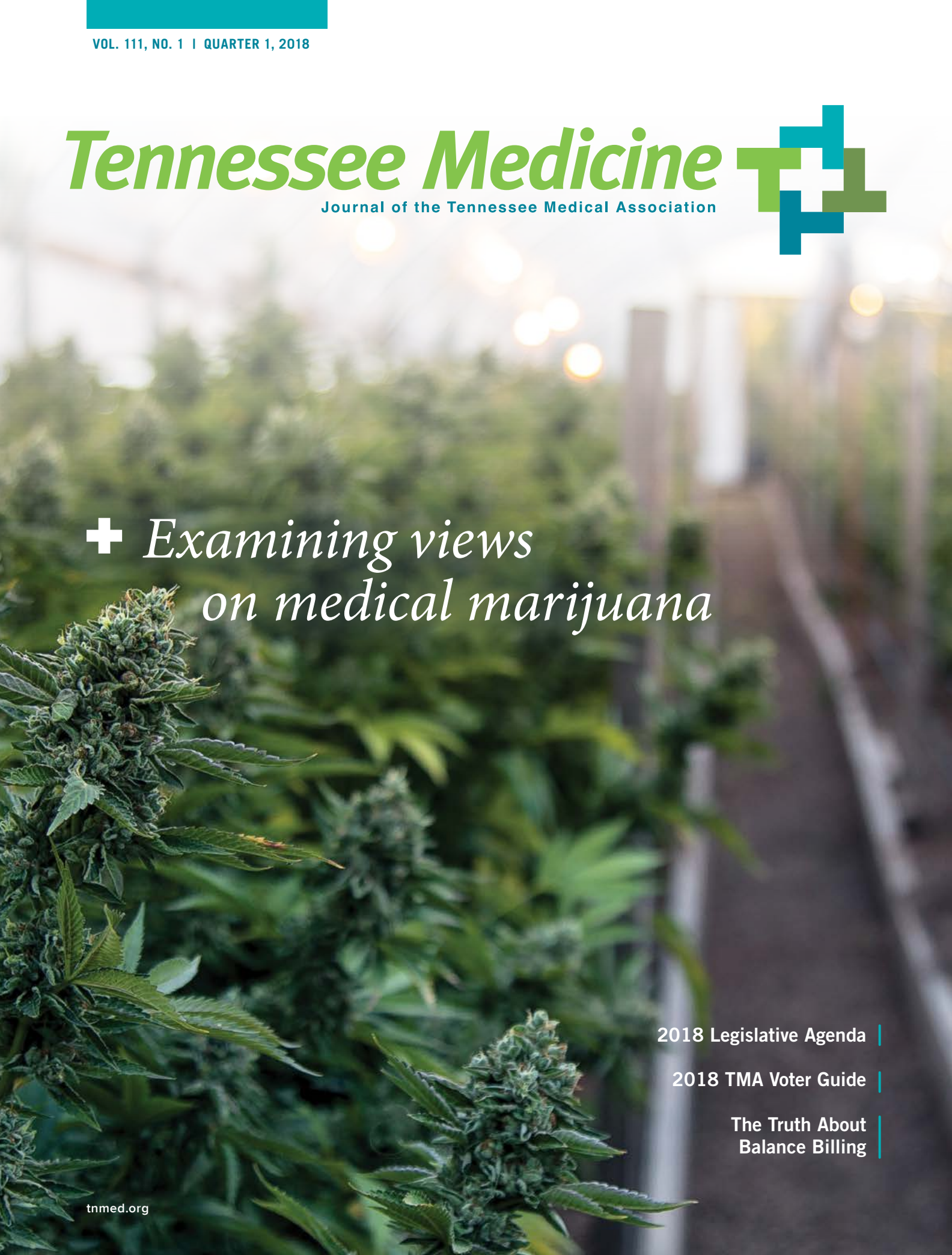

Examining views on medical marijuana

2018 Legislative Agenda

2018 TMA Voter Guide

The Truth About Balance Billing

tnmed.org

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2018 Legislative Agenda

TMA Takes Aim at Episodes of Care, MOC, Balance Billing and More

TMA enters each legislative session with a short list of priority items it hopes to accomplish on behalf of members, followed by a bevy of other issues that physician leaders and staff lobbyists expect to arise.

The legislative package is set after months of deliberation by the TMA Legislative Committee, which considers member requests and sorts through hundreds of pages of research to come up with a recommendation for the TMA Board of Trust. Once session begins, lobbyists carefully review draft bills filed in the state legislature, looking for landmines and making sure lawmakers understand the implications for doctors and patients. Every piece of legislation is carefully examined to determine whether it relates to healthcare and, if so, how it could affect the business of medicine or the delivery of patient care. Ultimately, TMA advocates for or against each bill based on whether the physician members deem it good public policy.

Following are just a few of the highest priority issues for TMA's lobbyists in the second session of the 110th Tennessee General Assembly.

TennCare Episodes of Care

TMA members have grown increasingly frustrated by the state's inconsistent, inaccurate and ineffective episodes of care payment model. Decisions about the program are continually made without physician agreement and in many cases with physician opposition. TMA has long advocated for improvements but the state has not addressed fundamental flaws in the design and implementation of the program.

TMA redoubled its advocacy efforts in late 2017 at the same time it stopped participating in a state grant that funded episodes-related education efforts for physicians and practices. TMA President-Elect Matt Mancini, MD of Knoxville testified in a Senate Health Committee hearing on episodes of care in October 2017. TMA officials followed that meeting with a letter to Sen. Rusty Crowe, Chair of the committee, and reiterated concerns during multiple meetings with state policymakers in late 2017 and January 2018.

Despite TMA's advocacy efforts, significant concerns remain about data collection, data reporting and accuracy, and overall transparency of the episodes of care program. TMA is opposed to further expansion of the initiative until or unless these

Protecting Tennessee's Favorable Medical Liability Climate

TMA claimed an early legislative win for 2018 when it announced in November 2017 that a three-year push to dismantle and replace the state's medical liability system had ended. A Georgia-based group called Patients for Fair Compensation had since 2015 lobbied the Tennessee General Assembly to shift physician liability cases from the civil court system to a government-run administrative system. Doctors raised fundamental concerns about verifying proponents' claims that their plan would save the state money, and preserving medical liability insurance in the event a patient compensation system did not work. The opposing groups could not resolve fundamental issues, and Patients for Fair Compensation assured TMA that it does not plan to introduce any related bills in the 2018 legislative session.

fundamental issues are satisfactorily addressed and tested.

TMA has been given no assurance or confidence that the state is going to address the ongoing fundamental design issues with the program, which we have outlined repeatedly and most recently ranked in priority order at the state's request. TMA will ask the legislature to intervene and needs members to contact their elected officials to educate them on this complicated but important issue.

Learn more about TMA's position and related advocacy work at *tnmed.org/episodes*.

Doctor of Medical Science (or successor name)

Legislation first introduced in 2017 would create a new academic degree for physician assistants. Sponsors filed the updated version of the bill in January. The language is much improved from the 2017 version; it does not give PAs independent practice but requires PAs to collaborate with a supervising physician in a team-based healthcare delivery model. TMA remains opposed to the legislation and is advocating for a different name to avoid patient confusion in a clinical setting.

Balance Billing

TMA wants to protect physicians' rights to balance bill and will continue to fight for a solution to "surprise medical bills" that is fair to all parties, especially physicians and patients. TMA opposes any effort that gives health insurance companies even more undue leverage to force providers to accept unfair contractual terms and proliferates the trend of narrow networks.

See more on this topic on page 14 from Doug Springer, MD and Jonathan Hughes, MD of Kingsport.

Maintenance of Certification

For the second year in a row, TMA will have legislation filed to give physicians relief from the costly, burdensome and in many cases valueless requirement of Maintenance of Certification.

TMA successfully worked for passage of a bill in 2017 that prohibits the state medical boards from requiring MOC for initial licensure or renewal. A task force was also created to further explore MOC as it pertains to hospital and insurance credentialing. TMA hopes the task force will propose a solution to address those issues in 2018. If not, TMA will work with the 2017 bill sponsors (Sen. Richard Briggs, MD of Knoxville and Rep. Ryan Williams of Cookeville) to try to pass a stronger bill to prohibit hospitals and health insurance companies from requiring MOC for physician credentialing or network participation.

Indoor Tanning

TMA will encourage Tennessee to join 28 other states that have some type of prohibition on dangerous indoor tanning for minors. TMA and other groups in a coalition of advocates, including dermatology and pediatric organizations, will educate lawmakers about the preventable dangers of indoor tanning, such as skin cancer.

Follow TMA's legislative progress at tnmed.org/legislative or on twitter *@tnmed* and *@tnmedonthehill*. ■

TMA CAUTIONS PATIENTS AGAINST WHITE COAT ASSUMPTIONS

"Know Your Provider" Campaign to Help Educate, Clarify Roles on Healthcare Team

TMA has launched a public education campaign to help inform patients about different types of healthcare providers and the role of physicians on the healthcare delivery team. The **Know Your Provider** campaign features online resources to help Tennesseans choose the right provider(s) for their medical situation.

More than 50 percent of people said it was difficult to identify a licensed physician from looking at his or her title, credentials, services offered, and marketing materials, according the most recent T**ruth in Advertising survey from the American Medical Association**. Healthcare providers are required by law to display their professional credentials (e.g. a badge with name and title) when delivering care but do not have to proactively discuss their level of education, training or experience with patients.

As part of the "Know Your Provider" campaign, TMA offers an **online guide** to help Tennesseans understand the different education and training requirements for healthcare providers and make more informed decisions about how they access care. The resource also points users to state-run databases where they can research an individual provider's licensure and disciplinary status.

TMA encourages patients to share resources and participate in the conversation using **#KnowYourProviderTN**.

Leading physicians in TMA maintain that unless a provider volunteers his or her qualifications, patients may not be fully informed—or worse, misinformed—about various healthcare professionals or what their roles should be.

The number of distinctions and scope of practice for some disciplines within the healthcare sector has expanded in recent years to satisfy a growing demand for convenient, cost-effective care, particularly for non-emergent, routine services. But TMA survey data shows that 92 percent of patients still prefer a physician to have primary responsibility for leading and coordinating their healthcare.

Learn more about TMA's Know Your Provider campaign at *tnmed.org/knowyourprovider*.

EDITORIAL:

Another tool to reduce narcotic overdose deaths in Tennessee

By Matthew Hines, MD

Our practices will soon intersect with the therapeutic use of marijuana (cannabis). During the past four years, the reported annual use of marijuana among American adults has doubled from 7% to 14%, while the use by teens has declined. *Is this a good thing?* Remarkably, I think so.

I used to believe the public health hazards of allowing comprehensive medical marijuana programs outweighed benefits. But after many hours of study, I've reached the opposite conclusion: public health benefits predominate.

The criminalization of the substance has resulted in increased expenditure on incarceration rather than effective public health education. In Tennessee, the possession of 1 cannabis plant remains a felony. The cannabis plant is classified by the federal Controlled Substances Act as a Schedule 1 substance, while the psychoactive ingredient (THC), as a 100% pure synthetic substance (Marinol) is classified as Schedule 3. A schedule 3 drug has accepted medical use, while abuse of the drug may lead to moderate or low physical dependence or high psychological dependence. It seems to me an accurate description of the whole plant.

> Many studies have concluded that medicinal cannabis treatment results in a very significant decrease in opioid consumption.

Cannabis has a low potential for addiction. The Institute of Medicine found that fewer than 10% of persons who try cannabis ever met the criteria of drug dependence. By contrast, 32% of tobacco users 23% of heroin users and 15% of alcohol users met those criteria.

The jury is still out on recreational cannabis, but where a properly regulated medical cannabis program exists, it's unreasonable to conclude the program does more harm than good.

A recent interview by the Canadian Broadcasting Company (CBC) with Dr. Larry Wolk, Chief Medical Officer of the Colorado Department of Health, is enlightening. They wanted his expertise, as Canada is moving to treat cannabis similarly to alcohol.

He's not talking about medical cannabis. That program was authorized in 2000, and at the end of 2016, the Colorado medical marijuana registry had approximately 95,000 active patients. Here, Dr. Wolk is describing what's happened in the last three years since Colorado has granted legal access to adults, including the right to grow up to six plants at home.

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EDITORIAL:

A Hospice Doctor Looks at Medical Marijuana

By Greg Phelps, MD

True Story slightly altered to protect privacy.

Some years ago, I had a patient who was dying of ovarian cancer and was suffering from terrible nausea. We had tried everything: Phenergan, Haldol, cocaine addicts such as Reglan, anticholinergics, 5-HT3 agents. Nothing was helping. We started a Phenergan drip, and I went out to the house at the outlying county to meet with the patient and her husband to explore what else we could do. I reviewed all the options we had taken so far. The husband arrived after I did, apologizing that work it held him longer than expected. We discussed the possibility of Marinol which was not in our hospice formulary. The cost of the husband would be close to $900 which he said he didn't have.

"Isn't there *anything else* we could try?" he asked?

"Well, Tennessee is not a medical marijuana state" I started tentatively. "However…"

The husband ruefully shook his head and "No I don't think so, I wouldn't even know where to get it."

"Neither would I. I guess I'd have to ask my kids." I quipped.

The husband walked me out, and we stopped at the back door. He apologized again for being late and making conversation I asked, "so what do you do?"

"Oh, I work for the courthouse. I'm a bailiff for the Sheriff's office."

All I could do was look surprised, and hold up my hands as if to be handcuffed.

"Oh no," he said, "I asked you if there was anything else we could do and you are willing to consider all the possibilities, and I appreciate it." with that he waved me out, and I beat a hasty retreat.

This week as I begin this article, I reflect back on a health care summit I attended for the Coalition to Transform Advanced Care in Washington D.C. The Summit Co-chairs were former US Senators Frist and Daschle. The Summit was about how to improve care for patients in the advanced (and often terminal) stages of illness. It was heavily tilted towards hospice and palliative care.

The first plenary speakers were the authors of **Driving Ms. Norma** who was a 90-year-old diagnosed with uterine cancer. When offered chemotherapy she said," Heck no, I'm 90 years old. I'm hitting the road." Thus did she, her son and daughter-in-law tour of the United States. The speakers described their tour and how as she declined, one of the places they detoured by was Colorado to try medical marijuana. They found that it helped. So much so that Norma asked to go back to the shop and stock up before they moved on.[1]

I am writing this article as a Boarded hospice physician, but I am also a certified addictionologist and treated addicts for over 20 years. In all that time treating addicts, I never once heard an addict say, "Ya know doc, it all started when I first tried marijuana." Not once. But I still hear the concept of marijuana as a "Gateway" drug from time to time even though the concept has largely been debunked. Three of the four past presidents of the US admit to using marijuana (whether they inhaled or not.) As to the fourth and current President, he said he supports medical marijuana "100%." In May of 2017, Donald Trump signed a bill including a continuing rider that forbids the Justice Department from using federal funds to prosecute marijuana businesses. Now, this view is not shared, of course, by the current Attorney General, who would like to rev up prosecution of drug offenses. This becomes a matter of justice.

Harry Anslinger was a veteran of the Bureau Prohibition and became the first head of the Bureau of Narcotics from 1930 to the 1960s. Anslinger's use of statistics was described as "creative." One author characterized his essays on marijuana as "over the top." Wrote Harry, "no one knows when he places a marijuana cigarette to his lips, whether he will become a philosopher, a joyous reveler… Or a murderer." The essay also included the possibilities for young people to rob, rape, murder strangers, police officers and even members of their own families.[2] This portrayal resulted in the 1930s movie Reefer Madness

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CBC: What have you seen since recreational cannabis has been legal in Colorado?

Dr. Wolk: The short answer is we have not seen much. We have not experienced any significant issue as a result of legalization. I think a lot of people think when you legalize you are going from zero to some high-use number, but they forget that even when marijuana is not legal, one in four adults and one in five kids are probably using on a somewhat regular basis. What we've found since legalization is that those numbers haven't changed."

CBC: Do we know if cannabis legalization is leading to higher uses of hard drugs?

Dr. Wolk: We are not seeing those kinds of increases.

CBC: What about drugged driving?

Dr. Wolk: We have actually seen an overall decrease in DUI's since legalization. So, the short answer is: There has been no increase since the legalization of marijuana here.

We need to ask whether cannabis, as a whole plant, has legitimate medical applications. It does. The National Academy of Sciences recently released a report on the topic and noted: "There is substantial evidence that cannabis is an effective treatment for chronic pain in adults."

Cannabis has not been shown to be a gateway to more dangerous substances.

There is strong evidence it acts as a stepping stone away from dependence on opioids, benzodiazepines, and alcohol. This is largely why, in my opinion, regulated cannabis provides a net benefit regarding harm reduction.

Here are a few examples from the literature:

JAMA Internal Medicine noted that states with medical marijuana laws have rates of anticipated opioid-related deaths averaging 25 percent lower than states that don't have such a program. The longer the medical cannabis program was in place, the lower the overdose death rate.

Many studies have concluded that medicinal cannabis treatment results in a very significant decrease in opioid consumption.

For example: The Journal of Drug and Alcohol Dependence published that among injection drug abusers, persons who had used cannabis within the previous 30 days used opioids only about half as often as those who had not used cannabis in the prior month, showing a protective effect from cannabis use. Patients in drug rehabilitation clinics who occasionally used cannabis were more likely to complete treatment and stay off more dangerous drugs.

A study published in International Journal of Drug Policy found that 63% of medical cannabis users substituted cannabis for their prescription drugs, mostly opioids, and anxiety medication, and 25% had reduced their alcohol consumption.

The Journal of Psychopharmacology reported that over 75% of regular opioids users cut their dose once they started cannabis. 72% decreased the use of anti-anxiety medication, 65% cut back on sleep medication, and 42% reduced their use of alcohol.

How are states with established medical cannabis laws proceeding?

In April 2016, the Federation of State Medical Boards published guidelines for cannabis in patient care, and various states are adopting these. The guidelines include the presence of a physician-patient relationship, appropriate patient evaluation, informed and shared decision-making, a written treatment agreement, ongoing monitoring, provisions for consultation and referral, and the maintenance of appropriate medical records.

The Medical Board of California has published an informed consent called a Medical Cannabis Agreement, similar to the chronic pain management agreements with which we're familiar.

When I visited with an Arizona physician who performs medical cannabis evaluations, I learned how she communicates with the dispensary staff. The recommendation sheet she provides specifies the approximate THC and CBD content to dispense.

Several states now require physicians to complete CME on the topic of medical cannabis as a condition of being able to recommend cannabis for a specific medically qualified condition. The upcoming Tennessee legislation will likely contain a similar provision. ■

(Continued from page 7)

which my generation watched in college mainly for its comedic value. Up until the 1930's, marijuana was much more commonly known as cannabis. Anslinger took a page from the Prohibition days and how prohibition tied alcohol to "others" and "otherness." In the run-up to prohibition, various public figures tried to attach alcoholism and drunkenness to African-Americans. To quote Frances Willard: "the grog shop is the Negro's center of power. Better whiskey and more of it is the rallying cry of great dark-faced mobs."[3]

Likewise with cannabis. The name "Marihuana" (as it was spelled then) was popularized by advocates of Prohibition to exploit prejudice against "despised minority groups, especially Mexican immigrants."

Interestingly in both the 1930s and then again in the 1970s with Richard Nixon's "War on Drugs," scientific Commissions were impaneled to provide the medical facts that would backup the politics. In both cases, the LaGuardia Report in the 1930s and the Shafer Commission appointed by Richard Nixon, ended up repudiating the politics. Said the Shafer commission: *"the commission is of the unanimous opinion that marijuana use is not such a grave problem that individuals who smoke marijuana, and possessive for that purpose, should be subject to criminal procedures."* In both cases, politics overrode science and were ignored by the politicians. To this day race and ethnicity play a strong role in the prosecution of drug crimes. In fact, whites and most minorities use marijuana in similar percentages and yet minorities are four times more likely to be arrested for drug possession and are 85% of drug arrests. Under President Bush, the nation's drug czar tried to come after the DEA registrations of physicians who recommended marijuana. This was quickly slapped down by the 9th circuit court in *Conant vs. McCaffrey* where the court said: "the government could not initiate criminal proceedings against a doctor simply for recommending marijuana."

The fact is a LOT of my hospice patients have found benefit from marijuana. I remember one of the first patient's I had after fellowship. An elderly, grizzled mountain dweller in a cabin. He said he'd come into hospice IF, he could still use his marijuana. I felt obligated to point out that marijuana was illegal in the state of Tennessee.

He looked at me, as he snorted mordantly: "What are they gonna do? Kill me?" Here in lies the essential point. Patients in hospice and palliative care by definition, have life-limiting illnesses. If standard treatment was effective, they would not be life limited. That changes the equation from live "forever" to keeping a patient comfortable. Dr. Atul Gawande in the book, "Being Mortal," made the point. "…our most cruel failure in how we treat the sick and aged is the failure to recognize that they have priorities beyond merely being safe and living longer: that the chance to shape one's story is essential to sustaining meaning in life.[5] Once I was comfortable asking a hospice patient, I was surprised how many use marijuana but only admit it when the question is put to them, for fear that we'll refuse care.

> "Penalties against possession of the drug should not be more damaging to an individual in the use of the drug itself."
>
> —President Jimmy Carter

I had a patient who had lung cancer, he was bed bound and declining. He was getting Marinol from the VA, and we had to keep upping his dose to control his nausea. This eventually led to a strange conversation with a VA pharmacist what called to tell me my last prescription had gone past the recognized and recommended upper limit for marinol. (In hospice we love restrictions like these, they give us something to shoot for!) I told the pharmacist the new dose was helping the patient.

"But you don't understand doctor! The patient might die!"

A long pause on my end (fatal overdose by marijuana is rare. In fact, the DEA itself has **no record of fatal marijuana overdoses** according to Politifact).

I replied: "You do know I'm a hospice doctor, the patient has lung cancer and has maybe a week or so to live?"

Pharmacist: "Oh," then in his best Emily (Saturday Night Live) Litella voice "…Nevermind."

So does the stuff work? The feds say no, there isn't the research to show it does. This is a bit of a tautology because the federal government places numerous hurdles in the way of doing research. This keeps research to a minimum. Only one heavily regulated facility at the University of Mississippi is allowed to grow marijuana for medical research. Of note, the palliative medicine blog, Pallimed, "the research literature on marijuana use exclusively in hospice and palliative care populations is quite thin—only 110 articles could be found in a 2015 search." Medical marijuana will not work for every patient. But then nothing does. There is a fascinating website called *www.TheNNT.com* that shows the number needed to treat,

adequately, many medications. It is stunning how many people may take a medication for only one to show benefit. Even with opioids, the NNT is 2.5. But opinion is shifting. Surgeon General under Pres. Obama, Dr. Vivik Murthy, notes that "in some medical situations marijuana can be helpful."

In his book, **"Stoned: A Doctor's Case for Medical Marijuana,"** palliative care physician David Casarett, examines literature and spends time with patients concluding that marijuana is particularly helpful for nausea as well as neuropathic pain and may well help with seizures. He also makes a case for CDB oils which may have more therapeutic benefit than the THC component.

Casarett, also looks at the addiction issue and finds marijuana less addictive (9%) than cocaine (12%) or alcohol (15%). Some heavy use patients may exhibit withdrawal behavior characterized by anxiety and agitation and insomnia. Of course, most of the medications used in hospice and palliative care have habituating or addictive potential including opioids, sedatives, and anti-anxiety medications. When I've had hospice patient's families express concern about addictions I gently pointed out the patient has a fatal illness, and there is "no trip to the Betty Ford Center" at the end.

In 2017, West Virginia became the 29th state in the union to adopt a medical marijuana law. Many states including Tennessee have a "Right to Try" law. These laws are supposed to give terminally ill patients the opportunity to try medications that have passed phase 1 safety trials.

It would seem that this should also include marijuana and its compounds. The Institute of Medicine published a report in1999 the said: "the accumulated data indicate a potential therapeutic value for cannabinoid drugs, particularly for symptoms such as pain relief, control of nausea and vomiting, and appetite stimulation." 90% of the US population supports the concept of medical marijuana. For those physicians opposed to patient's smoking 'anything,' there are a multiplicity of other ways to ingest marijuana, and its by-products that include vaporizers, pills, foodstuffs, transdermal oils, sublingual application, etc.

As the point is made elsewhere in this issue, in some cases marijuana and its byproducts may help in avoiding or lowering opioid doses which would be a win in the current opioid crisis. Additional studies in JAMA Internal Medicine found a sharp decline of 25% in opioid overdose deaths in states with medical marijuana laws.[6] Additional studies show declines in Medicare and Medicaid prescription spending in medical marijuana states.[7] I firmly believe the terminal ill patients have the right to any medication that will help them feel better in their final days. At the very least, I would quote Pres. Jimmy Carter in his *Drug Abuse Message to Congress* where he said: *"penalties against possession of the drug should not be more damaging to an individual in the use of the drug itself."* ■

SELECTED RESOURCES:

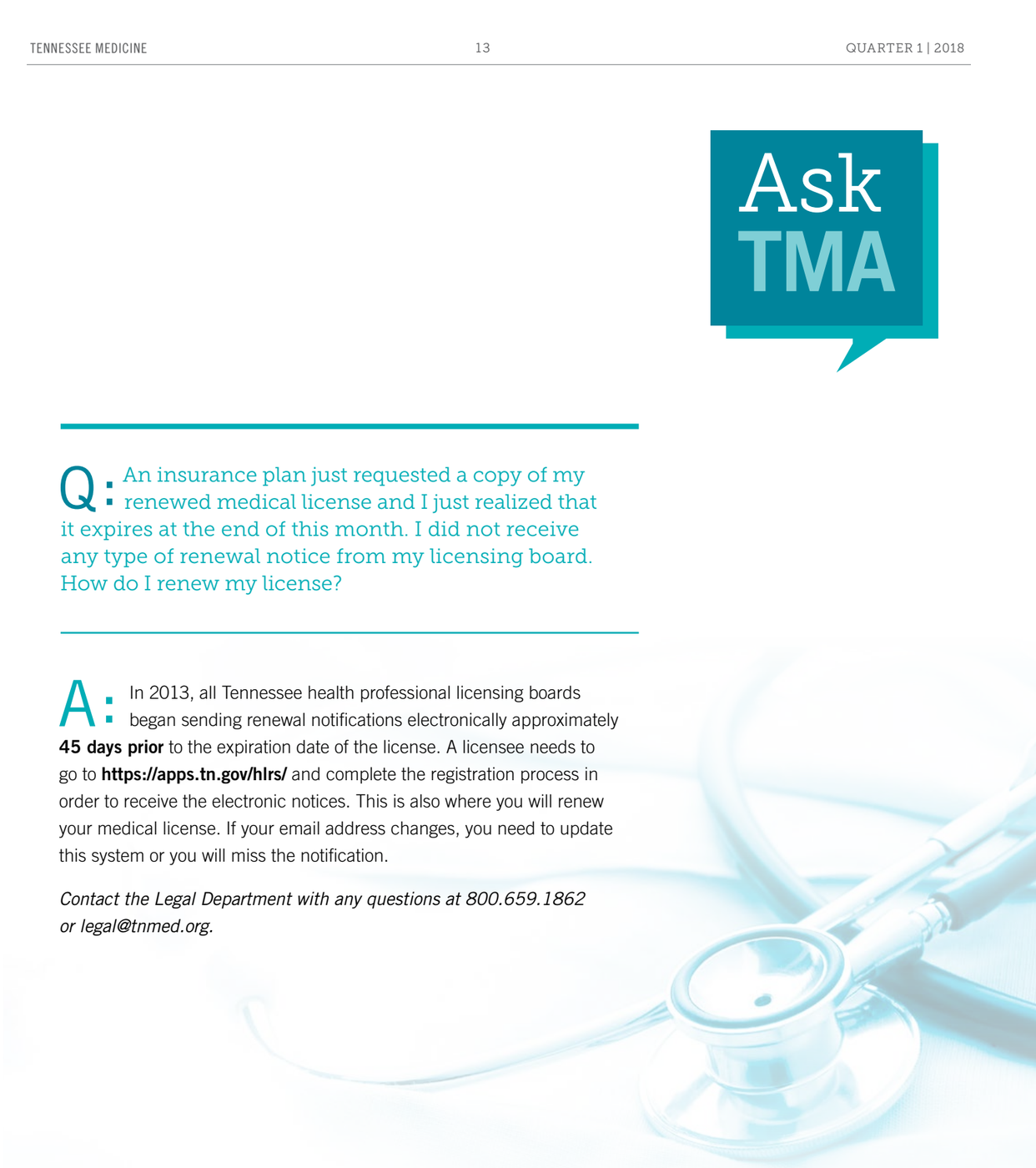
1. Driving Miss Daisy: One Family's Journey Saying "Yes" to Living. Tim Bauerschmidt and Ramie Liddle. HarperCollins 2017.
2. Marijuana: a short history. John Hudak, the Brookings Institution Press, 2016 page 36
3. Last Call: the Rise and Fall of Prohibition. Daniel Okrent. Scribner, 2010 page 42
4. Stoned: a Doctor's Case for Medical Marijuana. David Casarett MD, current& 2015
5. Being Mortal; Dr. Atul Gawande. 2014, Metropolitan Books
6. Medical Cannabis Laws and Opioid Analgesic Overdose Mortality in the United States, 1999-2019. Buchhuber, MA, Saloner B, Cunningham C.C, Barry, CL. Jama Internal Medicine 2014; Oct 174(10) 1668-73.
7. Medical Marijuana Laws Reduce Prescription Medication Use in Medicare Part D. Bradford, A.C, Bradford, W.D., Health Affairs July 2016. pps 1230- 36

Ask TMA

Q: An insurance plan just requested a copy of my renewed medical license and I just realized that it expires at the end of this month. I did not receive any type of renewal notice from my licensing board. How do I renew my license?

A: In 2013, all Tennessee health professional licensing boards began sending renewal notifications electronically approximately **45 days prior** to the expiration date of the license. A licensee needs to go to **https://apps.tn.gov/hlrs/** and complete the registration process in order to receive the electronic notices. This is also where you will renew your medical license. If your email address changes, you need to update this system or you will miss the notification.

Contact the Legal Department with any questions at 800.659.1862 or legal@tnmed.org.



TMA members can "Ask TMA" by emailing **becky.morrissey@tnmed.org** or calling **800.659.1862**. Questions and comments will be answered personally and may appear anonymously in reprint for the benefit of members.

The truth about surprise medical bills,

PART I

Originally published by the Kingsport Times News November 26, 2017

By Douglas Springer, MD and Jonathan Hughes, MD

Your favorite aunt (we will call her Aunt Beatrice for illustrative purposes) goes to the Emergency Department of her local hospital with the sudden onset of abdominal pain. The emergency room physician examines her and orders testing. Labs and a CT scan are performed. The lab work is reviewed by the ER doctor, and the X-ray is read by a radiologist. She is found to have acute appendicitis. The "on call" surgeon is immediately consulted and takes her to the operating room. She is reviewed by the anesthesiologist, who will sedate her for the surgery. The appendix is removed and the specimen is sent to pathology.

Aunt Beatrice is in the hospital for 36 hours and released. She feels confident that her bill will be minimal because she has insurance. She has interacted with health insurance before and expects, at most, that she will owe some reasonable co-pay amount.

This was the case for her visit to the hospital and ER, the labs, the CT scan and the surgeon. Why? Because they were "on the panel" of previously negotiated fees with her health plan. Aunt Beatrice's Explanation of Benefits and bills from the various providers reflect the reasonable co-pays she expected.

But the bills for the ER doctor, radiologist, pathologist and anesthesiologist began arriving 30 days later and totaled $5,000 (a made-up figure, but illustrates the issue). Aunt Beatrice is confused and asks, "How can this be?"

The answer is *balance billing*.

The manner in which medical services are bought and sold in our health care system, including who pays and how much, has become so complex that it can overwhelm the average patient. Even doctors and hospitals have a hard time keeping pace. This complexity results in patients getting a "surprise bill" from a hospital-based doctor or other health care providers, just as Aunt Beatrice did in the above story.

She is not just getting a co-pay bill, but a bill for the full amount of the service provided because the insurance company is not going to pay any part of the bill submitted by the professionals that were "not in network." Aunt Beatrice has no option but to pay the balance owed because of the contracts written by her insurance company. She is not happy!

The health care industry refers to the "surprise billing" scenario as "balance billing," and it can make an otherwise positive clinical experience unnecessarily frustrating and confusing for the patient. Because the insurance company will not pay the providers who make your diagnosis, give you anesthesia, read your X-ray or interpret your pathology specimen, those providers are forced to try to collect the charges directly from you. The amount is typically much higher than what you would have paid "out of pocket" if the insurance policy had covered the various providers.

But why don't insurance companies cover all the providers in the hospital? How did we get to this point? Answer: In their quest to attract more employers and patients to their plan, insurance companies have used "narrow networks" to hold down costs and limit what they pay for services by having a restrictive list of providers and deeply discounted rates, resulting in lower premiums. Buyer beware of these "affordable" plans. You must investigate thoroughly to ensure that the plan offers adequate providers and services because if you go "out of network" you will be responsible for the full amount of the services rendered.

In the fictional case above, how would Aunt Beatrice investigate which providers she should see and request in the middle of an emergency? How is her "on call" doctor supposed to advise her in the middle of an emergency about whether her particular policy includes his/her practice in the "panel of approved providers" or what she would owe as a balance without the help from their office personnel who may not be available to them at the time Aunt Beatrice came into the hospital? How is it reasonably prudent for providers to spend hours of their day digging up these facts?

Insured patients who are treated in the hospital should be confident that their health insurance will cover them. Unfortunately, a growing number of patients are finding out too late that their coverage is far less comprehensive than they had previously understood. Insurers are making unsuspecting patients responsible for huge additional payments.

The Tennessee General Assembly debated this issue in 2016 and 2017. Lawmakers considered legislation that would have required health care providers who are not contracted with the patients' insurance carrier to give an estimate of anticipated charges to patients. The Tennessee Medical Association and its partners — Tennessee Society of Anesthesiology, Tennessee Society of Pathology, Tennessee Radiology Society and Tennessee College of Emergency Physicians — opposed the legislation because it would have created operational slowdowns and more unnecessary administrative hassles for providers without fixing the real problem for patients.

As a result, the legislature created a task force to study the issue in 2017 but never developed any final recommendations.

If it were not for the TMA and its partners, providers would already be forced to comply to unreasonable rules that would force more inefficiencies into a system that already has enough burdens.

PART II

The following was submitted by Dr. Douglas Springer, past president of the Tennessee Medical Association, and Dr. Jonathan Hughes, Sullivan County Medical Society board member. Part 1 of their article, published last week, addressed the issue of "surprise" medical bills.

Originally published by the Kingsport Times News December 3, 2017

Remember Aunt Beatrice and her surprise medical bills? Since insurance companies are intensifying their efforts to narrow networks and force more hospital-based physicians out of network, a fair and equitable solution should be developed to protect unsuspecting patients from paying high, unexpected out-of-pocket charges.

Contract negotiations between physician practices and health insurance companies are usually one-sided, take-it-or-leave-it negotiations in which the insurers have all the leverage. Many providers feel forced to choose between accepting lower than standard fees or not participating in the plans.

The TMA is currently working with various health plans, state legislators and other stakeholders on solutions to prevent this scenario, so patients stop receiving surprise bills. **Here is what can and should be done to solve the issue of "balance billing" from the TMA perspective:**

1. The TMA is advocating for our state government to adopt clear and objective standards for the adequacy of plan networks. This should include adequate access to specialty care, including access to hospital-based physician specialties. State regulators should uphold such standards in approving the various health insurance plans.

2. All persons and entities involved in providing and financing health care have an obligation of transparency to health care consumers. If patients choose a plan based on low premium monthly costs, then it should be made clear about the magnitude of their out-of-pocket expenses and their potential coverage gaps as it would relate to balance billing and care. Thus, insurers must clearly inform their enrollees of the limits of their coverage and prior to elective and non-emergency scheduled procedures, provide enrollees with reasonable and timely access to in-network physicians.

3. The vast majority of physicians want to participate in network with insurance companies. Why? The reasons for agreeing to be in-network are the volume of patients a pracsee, ease/reimbursement of claims. However, they can only do so when insurers negotiate in good faith for fair reimbursement. This cannot be legislated directly but could be influenced as outlined further below.

4. Some insurance companies and state officials want to prohibit balance billing without addressing the real drivers of the problem as noted in points 1 and 2. Holding insurance companies to network adequacy standards and compelling them to offer reasonable reimbursement to hospital-based physicians would solve most of the issues. If this is not done, insurance companies will continue to exclude even more providers and services in "narrow networks" in efforts to control their costs and ultimately transfer the real costs to unsuspecting patients.

5. Patients need a simple and transparent avenue to be able to take their billing grievances to the health insurers and the out-of-network physicians to get their bills amicably resolved for all parties. Our legislature can facilitate putting the type of structure in place.

6. Out-of-network payments should be based on reasonable charges for the same service in the same geographic area utilizing physician charges that are geographically specific, transparent and independent of the control of either insurance companies or doctors. Also by not paying a reasonable fee to out-of-network providers, the insurance companies virtually eliminate access to and deny the potential benefit of these providers.

7. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

Your physician does not want you to get a surprise medical bill. That is why TMA is working diligently on patients' behalf to treat the cause of this problem and not put a Band-Aid on the symptoms. ■

A Marijuana Update from the AMA

By B. W. Ruffner, MD

The AMA has addressed the social and medical challenges of cannabis in four reports over the past fifteen years. This paper will summarize CASPH Report 5, presented at this year's Interim Meeting in November, with two goals in mind. First, our legislature continues to struggle with pressure to make marijuana more available, and our thoughts are important. Second, physicians must respond to patients' inquiries about its use for a variety of conditions. The AMA report updates the current legal status in various states, has a thorough review of the effects of cannabis, both positive and negative, and presents AMA policies.

STATE LAWS ON CANNABIS

Only eight states have approved recreational use of marijuana. Most have done so by referendum. Vermont is the only state to do so by legislation, but the governor vetoed the proposal until further data was available on its ramifications for the health of the state. Some states are attempting to collect data on the benefits and risks, but in most cases, the legal use has only occurred in the past one or two years, so data is scarce. In 2017, 20 state legislatures have introduced bills to legalize marijuana for recreational use.

The National Conference of State Legislators updated their survey of state activity in September.[1] Twenty-nine states, including Tennessee, have legalized medical use of marijuana or cannabinoids, but most restrict its use to carefully defined medical conditions. The update notes that "Some of the common policy questions regarding medical marijuana include how to regulate its recommendation, dispensing, and registration of approved patients. Some state and localities without dispensary regulation are experiencing a boom in new business, in hopes of being approved before presumably stricter regulations are made." Their report also reminds that since marijuana is a Schedule I substance, distribution is a federal offense, so "Medical marijuana prescriptions are more often called 'recommendations' or 'referrals' because of the federal prescription prohibition."

MEDICAL EFFECTS, POSITIVE AND NEGATIVE

An overview of the chemistry of the many components of marijuana may be helpful. Few patients know that not all marijuana is the same. The main desirable component for "recreational" use is tetrahydrocannabinol or THC. The second component with definite medical value is cannabidiol or CBD which is very effective for some causes of pediatric epilepsy. CBD has no euphoric effects. There are many other chemicals in the leaves of cannabis that may be useful. There are two main species, but growers crossbreed plants in hopes of getting varieties with enhanced properties. Where legally sold, products include "Tijuana Gold" and "Tom Cruise Purple." In most cases, the ratio of THC to CBD is the same, but the potency may vary tremendously. In Israel, selective breeding has produced a variety with high concentrations of CBD, but little THC, known at Avidekel.

About 50 years ago, an oncology fellow at the Sloan Kettering Cancer Institute noticed that young adults with Hodgkin's Disease slipped into the restroom before taking their chemotherapy. The patients reluctantly confided to the staff that they had discovered that if they smoked a "joint" beforehand, they had less nausea from their treatment. This discovery led to the development of some compounds, available by prescription, for this purpose. Nabilone (Cesamit) and drobanilol (Marinol) are cannabinoids extracted from, or modified chemically from, marijuana. The drugs are rarely used because other options are more effective and less expensive. Older patients complained of sedation and dysphoria, but younger patients had fewer complaints. These are examples of an ideal process, where compounds are extracted, evaluated in drug trials and approved by the FDA for prescription use.

Report 5 gives a detailed overview of the data. It reviews a National Academy report which attempts to evaluate the significance of the available studies.[2] The AMA report has a four-page table of their findings. For each therapeutic value or risk, they attempt to give a score, from "substantial evidence" to "no or insufficient evidence." A link to the study is available from the TMA. It is important to note that in almost all cases, the studies were conducted with oral, carefully defined products — not on street corner "joints" or "marijuana oil."

Their most significant findings included *chronic pain*. They found "moderate" evidence that chronic neuropathic pain was improved but noted that a report in Annals of Internal Medicine found the evidence unconvincing.[3] There is also evidence that patients receiving opioids for pain require less when supplemented by cannabinoids. *Chemotherapy-Induced nausea*. As noted above a purified product is effective. *Anorexia from HIV* also benefits, as does *spasticity in patients with MS*, and *children with Dravet Syndrome and Lennox-Gastaut Syndrome* (cannabidiol). There is no convincing evidence for use for the post-traumatic syndrome, other seizure disorders, irritable bowel syndrome or for achieving abstinence from other addictive substances.

There are many concerns about legalized marijuana, however. Colorado data suggest that after legalization, use in ages 35 – 43 has increased, but use among adolescents has not. Colorado has documented a 48% increase in auto fatalities among drivers with positive blood level for cannabinoids. Other states have also noted increases. ACOG has officially discouraged marijuana use during pregnancy and when breastfeeding because of possible effects on neural development. In Colorado, 5.7% of women consumed marijuana during pregnancy and 4.2% when breastfeeding. There is also an increase in the number of low birth weight babies. Smokers have an increased incidence of chronic bronchitis, and there is marginal evidence of an increase in lung and head and neck cancers.

There is strong evidence of "impaired domains of learning, memory, and attention with acute cannabis use" which is obviously a concern with adolescents, and that heavy users are underachievers at school. There is moderate evidence that users become dependent, but states with recreational use document that the risk is not great. One of the most frightening observations is substantial evidence for the development of schizophrenia and other psychoses in some regular users.

AMA POLICY

The Report includes all current AMA policies, including encouragement of continued research on the potential value of cannabis products. They note that the fact that marijuana is a Category I product makes it difficult for researchers to obtain specific strains that might be important, and that there are legal obstacles to studying it. "Our AMA supports research to determine the consequence of long-term cannabis use, especially among youth, adolescents, pregnant women and women who are breastfeeding," and our AMA urges "legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequence of its use." ■

SELECTED RESOURCES:

1. National Conference of State Legislatures. State Medical Marijuana Laws. 2017. http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx
2. The National Academies of Sciences Engineering and Medicine. The health effect of cannabis and cannabinoids: Current state of evidence and recommendations for research. Washington DC. The National Academies Press 2017
3. Nugent SM, Morasco BJ et.al. The Effects of cannabis Among Adults with Chronic Pain and an Overview of General Harms: A Systematic Review Ann Intern Med 2017; 167(5):319-331.

2018 LEADERSHIP ELECTIONS

IT'S ELECTION SEASON!
Use this voter guide to review nominees before casting your ballot online. All election materials are available at **tnmed.org/elections**.

- Voting will be open Feb. 1 – Feb. 28, 2018.
- All active dues-paying members and veteran members as of Dec. 31, 2017, will be eligible to vote in the election.
- All votes must be cast online.
- Every member with an email address in the TMA system will receive an electronic notice with his or her TMA member number, verification of voting region and a link to the ballot.
- Members without active email addresses on file with TMA can access the ballot at **tnmed.org/elections**.
- No login is required to vote, but a valid TMA member number and region number will be required.
- All ballots will include space for write-in votes.
- All ballots must be cast by **5 p.m. CST** on **Wednesday, Feb. 28, 2017**, in order to be counted.
- A runoff election will take place March 21-28, if necessary.

ALL BALLOTS MUST BE CAST ONLINE BY **5 P.M. CST** ON **WEDNESDAY, FEB. 28**, OR THEY WILL NOT BE COUNTED.

For more information: contact Amy Campoli at amy.campoli@tnmed.org or 615.460.1650.

2018 TMA NOMINEES

President-Elect
Elise Denneny, MD,
Knoxville
Jane Siegel, MD,
Nashville

Board of Trustees

Region 2
W. Kirk Stone, MD

Region 4
Rodney P. Lewis, MD

Region 5
James Wilson Cates, Jr., MD

Region 7
Timothy S. Wilson, MD

Judicial Council

Region 1
Justin Monroe, MD

Region 3
Omar Hamada, MD

Region 5
James C. Gray, MD

Region 7
John W. Lacey, III, MD

Meet the Candidates

PRESIDENT-ELECT

Serves as head of the Tennessee Medical Association for the year following the election. Responsibilities include serving as official spokesperson with media, government officials, and other entities. The president-elect will serve one year as president-elect, one year as president and one year as immediate past president.

President-Elect Nominee:

Elise Cheng Denneny, MD, FACS

In 30 years of practicing medicine across every kind of practice setting, I've seen the relevance and impact of organized medicine. It impacts the lives of physicians, patients, families and communities. TMA fights for those interests, along with federal, state and local societies. TMA has great momentum on the back of recent legislative successes. Looking forward, we must leverage that momentum and stand to influence discussion on issues that will define the immediate and long term future. Foremost among these issues are improving clinical workflow and mitigating burnout, better access for patients and reducing payer obstructions, and navigating the transitioning reimbursement landscape. These are pivotal times, and we must present a clear vision as an organization to improve the lives of our patients and colleagues.

City: Knoxville
CMS: Knoxville Academy of Medicine
Specialty: Otolaryngology—Head and Neck Surgery
Medical School: Rush Medical School
Email: elise.denneny@greaterknoxent.com

President-Elect Nominee:

Jane Siegel, MD

Many of you may recognize me as the former Speaker of the House of the Tennessee Medical Association. I have been a TMA member for many years and have participated on various committees including the insurance issues committee, have been involved in the TAG advisory groups and met with legislators on Capitol Hill. There are many important issues that continue to challenge the house of medicine in Tennessee, including the opioid crisis, independent practice by mid-levels and the ever-changing insurance landscape. More and more physicians are choosing to be employed while others band into larger groups. Individual and small practices are seemingly under siege. We need to open lines of communication, listen to the needs of all physicians in Tennessee, understand the diverse nature of our profession and try to come together with common purpose. I will challenge myself to rein in the forces driving us apart and find common ground for which we can work together as a true association.

City: Nashville
CMS: Nashville Academy of Medicine
Specialty: Orthopaedic surgery
Medical School: Vanderbilt University Medical School
Email: siegeljm1@me.com

2018 TMA VOTER GUIDE

TMA BOARD OF TRUSTEES

The TMA Board of Trustees determines the policy and details of management of the association between meetings of the TMA House of Delegates. Trustees carry out the directives given by the House. They serve two-year terms.

Region 2 Nominee:

W. Kirk Stone, MD

My name is W. Kirk Stone, MD. I am a family physician in Union City. I have been a TMA member for more than 20 years. During that time, I have served in several capacities. I was president of my local society for several years. I have served on the judicial council, the IMPACT board, the public health committee, and have been chair of the credentials committee for the last several years. I also served a previous six-year term on the board of trustees. I am completing my current term on the Board and am seeking re-election to another term. I have been very active in my local society as well as statewide functions such as Doctors' Day on the Hill. I look forward to continuing to serve my fellow physicians.

City: Union City
CMS: Northwest Tennessee Academy of Medicine
Specialty: Family Practice
Medical School: University of Mississippi
Email: William.Stone@bmg.md

Region 4 Nominee:

Rodney Lewis, MD

Rodney Lewis, MD graduated Summa Cum Laude with a Bachelor of Science degree in Biology from Emory and Henry College located in Virginia. He received his Doctor of Medicine degree from University of Virginia School of Medicine. Dr. Lewis completed his internal medicine internship and residency at University of Tennessee Baptist Hospital in Nashville. Also, he participated in residencies in ophthalmology at Medical College of Georgia and general surgery and anesthesiology at Vanderbilt University Medical Center. He is a member of the American College of Physicians and has served on the board of the Tennessee Medical Association and the Nashville Academy of Medicine for two years. He has also served as a delegate to the TMA for many years and is an active member of the TMA Membership Committee. Dr. Lewis enjoys spending time with his wife and three children. His hobbies include music, golf, sports, gourmet cooking and reading.

City: Nashville
CMS: Nashville Academy of Medicine
Specialty: Internal Medicine
Medical School: University of Virginia
Email: RLewis@heritagemedical.com

Region 5 Nominee:

James Wilson Cates, Jr., MD

Jamie Cates attended Meharry Medical School and completed his residency training in family practice at the University of Tennessee Medical Center. He is a member of numerous societies including American Academy of Family Practice, Tennessee Academy of Family Practice and the American College of Sports Medicine. His leadership training includes the Executive Physician Harvard Medical School and TMA's Physician Leadership Lab. Dr. Cates served as the 2017 president of the Upper Cumberland Medical Society-TMA.

City: Cookeville
CMS: Upper Cumberland Medical Society
Specialty: Family Practice
Medical School: MeHarry Medical School
Email: jamiecatesmd@yahoo.com

Region 7 Nominee:

Timothy S. Wilson, MD

I have been a delegate for the TMA House of Delegates for five years. I have been on several organized medicine boards including the Knoxville Academy of Medicine and the Southeastern Society of Plastic and Reconstructive Surgeons, and have served on numerous committees with the American Society for Aesthetic Plastic Surgery. I am Chief of Staff-elect at Parkwest Hospital in Knoxville and am currently President-elect to the Knoxville Academy of Medicine. I believe in and fully support the mission of the TMA and am willing to work to protect the rights of both patients and physicians.

City: Knoxville
CMS: Knoxville Academy of Medicine
Specialty: Plastic Surgery
Medical School: University of Tennessee
Email: tswmd@aol.com

TMA JUDICIAL COUNCIL

The Judicial Council meets annually, or more often if necessary, to investigate alleged improper conduct and oversee formal disciplinary action against members or component medical societies. Councilors also assist component medical societies in maintaining viability in the region. Each region has one councilor serving on the Judicial Council. Councilors serve two-year terms.

Region 1 Nominee:

Justin Monroe, MD

Currently serving as TMA Judicial Council since 2016, and Memphis Medical Society Delegate since 2009. Participated in John Ingram Leadership Institute in 2012 and the John Ingram Leadership College in 2011 and 2012. Board certified in both general and colorectal surgery. Fellow of the American College of Surgeons and a member of the American Society of Colon and Rectal Surgeons.

City: Memphis
CMS: The Memphis Medical Society
Specialty: Colorectal Surgeon
Medical School: University of Tennessee at Memphis
Email: drjmonroe@yahoo.com

Region 3 Nominee:

Omar Hamada, MD, MBA

Dr. Omar Hamada is a proven leader in and out of the TMA. He has been a member for more than 20 years, is a 2011 graduate of the Physician Leadership College, and has served in several capacities within TMA, including the Judicial Council, the IMPACT Board, and as an Ex-Officio Member of the Board of Trustees. He has a medical degree from the University of Tennessee and is Board Certified in Obstetrics and Gynecology, Family Medicine, and is Board Eligible in Sports Medicine. He has an MBA from Vanderbilt's Owen School. Omar has valuable experience in the academic, corporate, pharmaceutical, and military environments. He is a veteran of the United States Army's Special Forces (Airborne).

City: Brentwood
CMS: Williamson County Medical Society
Specialty: Obstetrics and Gynecology
Medical School: University of Tennessee Center for Health Science
Email: olhamada@gmail.com

Region 5 Nominee:

James C. Gray MD

My goal during my first term on the Judicial Council was to give physicians in all 14 counties of the Upper Cumberland Development District (UCDD) an opportunity to participate in a TMA Component medical society. Putnam County Medical Society was the only remaining active society in the UCDD. We petitioned the HOD and successfully changed the name from Putnam to the Upper Cumberland Medical Society (UCMS-TMA). The UCMS-TMA has now been chartered and we strive to serve physicians in all counties in the UCDD that do not have a component medical society. The Upper Cumberland's representation in the TMA House of Delegates has grown from 2 (< 100 members) to 3 (>100 members). If re-elected, I plan to focus on sustainable growth of the TMA in Upper Cumberland the next two years. I believe this will be accomplished as we offer physicians even in the smallest counties peer support and an opportunity for physician leadership through membership in their TMA component medical society.

City: Cookeville
CMS: Upper Cumberland Medical Society
Specialty: Obstetrics and Gynecology
Medical School: Medical College of Georgia
Email: jimgray2@outlook.com

Region 7 Nominee:

John W. Lacey, III, MD

I am a past president of the Knoxville Academy of Medicine and recently retired from The University of Tennessee Medical Center Knoxville where I served as the Chief Medical Officer/Senior Vice President since 1998. Throughout my 40 years of practicing medicine, I have dedicated much time and energy to supporting the medical profession and improving community wellness. To this end, I have served as chair of the TN Governor's Health Task Force, Chair of the United Way Annual Giving Campaign, and as the volunteer medical director/founder of Knoxville Area Project Access (KAPA). KAPA is a program of the Knoxville Academy of Medicine Foundation and has coordinated more than $210 million in care for more than 25,000 uninsured East Tennesseans since 2006.

City: Knoxville
CMS: Knoxville Academy of Medicine
Specialty: Internal Medicine
Medical School: University of Tennessee
Email: jlacey@utmck.edu

FOR THE RECORD

New Members

BLOUNT COUNTY MEDICAL SOCIETY

Michael Todd Damron, MD
Mahdi Mphammad Budayr, MD
Michael P. Bunch, MD
Irina Chelnokova, MD
Julie Ann Corcoran, DO
Michael D Floyd, MD, FACP
Kevin McCoy James, MD
Yaw Otchere-Boateng, MD
Michael C. Prostko, MD
Jack T. Roberts, Jr., MD, FACP
Koovapudi Jayaram Shankar, MD
Deaver Timothy Shattuck, MD
Nicole M. Soto, MD
Laura Elizabeth Yount, MD

BRADLEY COUNTY MEDICAL SOCIETY

William Russell May, Jr., MD

CHATTANOOGA-HAMILTON COUNTY MEDICAL SOCIETY

Radhika Mayank Shah, MD
Maikel Elia Botros, MD
Gregg A. Willis, MD
Robert H. Mitchell, MD
Roza Adamczyk, MD
Aaron Kristopher Blakeney, MD
William John Fritsch, Jr., MD
Jonathan L. Humberd, DO
Ramses Luis Vega-Casasnovas, MD
Paula J. Stewart, MD
Keith D. Bohman, MD
Maribeth Banks Hamrick Bosshardt, MD
Wesley Lane Davis, MD
Jason Hideo Horinouchi, MD
Yuvraj Kalra, MD
Alexandra Martin, MD
Christina Rebecca Parkhurst, MD
Billy D. Worley, MD, MPH

KNOXVILLE ACADEMY OF MEDICINE

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Marc A. Campbell, DO
J. Trent Ellenburg, DO
Blake A. Moore, MD
William R. Oliver, MD
Maya Aravind Raiman, MD
Joseph B. Thurman, MD
Dennis R. Van Dorp, MD
Allison Babelay Johnsen, MD

NASHVILLE ACADEMY OF MEDICINE

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Nathan R. Belt, MD
Meredith A. Brown, MD
Adam J. Canter, MD
Amy L. Douglas-McVay, MD
Farhad Firoozbakhsh, MD
Roland W. Gray, MD
Scott A. Harshman, MD
Nazek Shabayek, MD
Edward Brooks Weller, II, MD
Michael E. Aberra, MD
Makarem Abu Limon, MD
Rabie Ibrahim Adam-Eldien, MD
Sameer Aggarwal, MD
Otis S. Apau, MD
Vagan Arutiunian, MD
Ni Aung, MD
Allen Avedian, MD
Chinye Azuh-Showole, MD
Justin Matthew Bachmann, MD
Ayodeji O. Balogun, MD
Erik Benitez, MD
Philip A. Brooks, MD
Cedrina Calder, MD
Orville C Campbell, MD
David Thanh Duong, MD
Ogonna Eze, MD
Celia Ezidiegwu, MD
Naima Farah, MD
Ghino L. Francois, MD
Dillobar Gelfond, MD
Abel H. Gimisso, MD
Xuan-Lan M. Griffith, MD, MPH
Osakhuemen W. Ihenyen, MD
Paschal Ike, MD
Diseiye F. Iyebote, MD
Rose Izuchi, MD
Lachaundra Latrice Johnson, MD
Huong Thi Thu Le, MD
Stephen Lee, MD
Chenai Saaku Nettey, MD
Chinenye M. Okukpon, MD
Mina Ossei, MD
Rita Patrick, MD
Rene Hulet Powell, DO
Kourtnei M. Robinson, MD
Todd A. Rubin, MD
Hanyuan Shi, MD
Joseph S. Simon, MD
Muthu Vel Sivasankaran, MD
Nicole Stephens, MD
Benjamin E. Studdard, MD
Yihan Wang, MD
Keith F. Watson, MD
Summer A. Williams, MD
Berhanu Zegeye, MD

P. Livingston Brien, MD
Curtis L. Baysinger, MD

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Ben Hunter Butler, MD
Erika Lachelle Crawford, MD
Suzanne Elizabeth Glover, MD
Anjeli K. Wilson, MD

SULLIVAN COUNTY MEDICAL SOCIETY

Manoj Srinath, MD

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Amit Sai Bhakoo, MD
Jeremy Scott Avila, MD
Maher Ghawji, MD
Raza Ur-Rehman Hashmi, MD

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Robert Anthony Comparin, MD
Arthur Judson Nash, Jr., MD

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Elizabeth Anne Lawson, MD
John F Robertson, III, MD
Nigel I. Dsouza, MD
Kenneth B. Lewoczko, MD
Timothy P. Zajonc, Jr., MD

In Memoriam

Allen F. Anderson, MD | age 67
Died November 12, 2017. Graduate of University of Tennessee College of Medicine. Member of Nashville Academy of Medicine.

John M. Bryan, MD | age 86
Died November 10, 2017. Graduate of University of Tennessee College of Medicine. Member of Bradley County Medical Society.

Robert L. Chironna, MD | age 65
Died December 14, 2017. Graduate of New York Medical College. Knoxville Academy of Medicine Member.

Bennett Young Cowan, MD | age 94
Died December 2, 2011. Graduate of Harvard Medical School. Member of Sullivan County Medical Society.

Donald Baker Gibson MD | age 85
Died August 21, 2015. Graduate of Medical College of South Carolina. Member of Bradley County Medical Society.

Robert Morris Glasgow, MD | age 84
Died October 5, 2017. Graduate of University of Tennessee College of Medicine. Member of Sullivan County Medical Society.

Charles Newman Hatfield, MD | age 84
Died December 19, 2017. Graduate of University of Tennessee College of Medicine. Member of Blount County Medical Society.

Inga Marie Himelright | age 60
Died December 31, 2017. Graduate of University of South Florida College of Medicine. Member of Knoxville Academy of Medicine.

Melvin M. Kraus, MD | age 93
Died November 20, 2017. Graduate of University of Tennessee College of Medicine. Member of Memphis Medical Society

Dee Lamar Metcalf, III, MD | age 74
Died January 24, 2018. Graduate of University of Tennessee College of Medicine. Member of Greene County Medical Society.

J. Pervis Milnor, Jr., MD, FACP | age 99
Died November 13, 2017. Graduate of University of Tennessee College of Medicine. Member of Memphis Medical Society.

Charles E. Morton, III, MD | age 70
Died December 7, 2017. Graduate of University of Tennessee College of Medicine. Member of Nashville Academy of Medicine.

Roy B. Parsons, MD | age 88
Died November 20, 2016. Graduate of Loma Linda University School of Medicine. Member of Knoxville Academy of Medicine.

Thurman L Pedigo MD | age 81
Died July 23, 2017. Graduate of University of Tennessee College of Medicine. Member of Nashville Academy of Medicine.

William Emil Rentrop | age 92
Died October 9, 2017. Graduate of University of Tennessee College of Medicine. Member of Memphis Medical Society.

Robert M. Roy, MD | age 93
Died October 6, 2017. Graduate of Vanderbilt University School of Medicine. Member of Nashville Academy of Medicine.

Robert Joseph Smith, MD | age 83
Died December 15, 2014. Graduate of University of Tennessee College of Medicine graduate. Member of Consolidated Medical Assembly of West Tennessee.

W. Shaen Sutherland, MD | age 89
Died September 28, 2017. Graduate of Loma Linda University School of Medicine. Dormant Medical Society Member.

Donald W. Tansil, MD | age 75
Died September 30, 2017. Graduate of University of Tennessee College of Medicine. Member of Upper Cumberland Medical Society.

William H Tucker, MD | age 81
Died November 4, 2017. Graduate of University of Tennessee College of Medicine. Member of Northwest TN Academy of Medicine.

Physician Burnout

Don't Wait to Ask For Help

By Michael Baron, MD, MPH TMF Medical Director

Forty years ago, the Tennessee Medical Foundation's Physician's Health Program was just getting started, and the problem of Physician Burnout had not yet been described. At the current time, burnout among physicians and other health professionals is not only well described, but is pervasive.

Physician Burnout is a problem of national importance because it not only impacts the physician, it impacts the quality of care the physician provides. Burnout is a syndrome characterized by a high degree of emotional exhaustion, cynicism, and a low sense of personal accomplishment related to work.

TMF Adapts to Changing Physician Needs

In 1978, the Tennessee Medical Association established a committee offering professional assistance to physicians suffering from alcoholism and drug addiction. The next year the TMA's Impaired Physician Peer Review Committee was born, being only the fourth state physician health program in the country. In 1992, the TMA transferred oversight of the program to the Tennessee Medical Foundation, a 501(c)3 organization. Five years later the name Physician's Health Program replaced the Impaired Physician's Program. Now, 20 years later, the Tennessee Medical Foundation Physician's Health Program (TMF-PHP) is once again making changes to meet the needs of Tennessee's physicians. That current need has to do with Physician Burnout.

For the first 25 years of the TMF-PHP's existence most of our new identifications had a substance use diagnosis. That majority has now decreased to about 50 percent. The once-predictable referral patterns are rapidly changing to reflect the impact that changing pressures are having on physicians. Physicians are now being referred to the TMF-PHP with increasing frequency for behavioral problems including boundary violations, disruptive behavior, and for being "distressed."

What is a Distressed Physician?

The distressed physician is a coined term that really implies burnout. The distressed physician is not keeping their medical records current; they are short or inappropriate with staff, peers, and even patients. Their efficiency has declined, which means they are seeing fewer patients per day. Something has happened to their smile and bedside manner; they have lost enjoyment and no longer get pleasure from going to work and being a doctor.

What is the source of this level of distress — this loss of passion, energy, and purpose?

The problems facing today's physicians are more complex than ever. Financial restraints, quality metrics, reimbursement structures, and institutional governance are just a few of the external confines that make us shudder. Add MOC, ACA, and EHR, and we get OMG. We are required to navigate an ever-expanding knowledge base, all while dealing with excessive workload, regulatory requirements, clerical inefficiency, meaningful use, and a loss of autonomy. It is estimated that for every hour of clinical work, primary care physicians now spend two hours on clerical work or other EHR-related tasks.

Physicians have maintained responsibility but with loss of control — a situation that is almost guaranteed to be unfeasible and induce despondency. Is anyone surprised that burnout has become an issue for practicing physicians?

The first large study of burnout among U.S. physicians was in 2011. That and subsequent studies have found that more than 50 percent of physicians have substantial symptoms of burnout; physicians working in the trenches of primary care have the highest incidence. Burnout is nearly twice as prevalent in the physician workforce as in non-medical matched cohorts.

What's the Solution?

Physician burnout has become widely recognized and of national importance, but there is still little information on how to address this problem. The evidence indicates that changes at the national, state, organizational, and individual levels can make a difference. However, progress is unlikely to occur at these grand levels until there is a coordinated effort to remedy the complex causes. Given the dysfunction ingrained in these layers above the individual physician, there is little chance that meaningful change can occur quickly. That leaves the individual physician to implement tactics and strategies that will help prevent, treat, protect, or reverse burnout.

The TMF-PHP is working to develop resources, personnel, and strategies to help the individual physician with burnout; resilience building, mindfulness-based stress reduction, and preventive mental health services are steps we are pursuing. We need your support to provide these resources. As always, if you, a colleague, friend, or significant other have burnout, please don't wait — contact the TMF-PHP for help. Your call is confidential.

We all have a vested interest in addressing physician burnout before it becomes something more serious. A healthy physician provides better care.

TMF TENNESSEE MEDICAL FOUNDATION

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.

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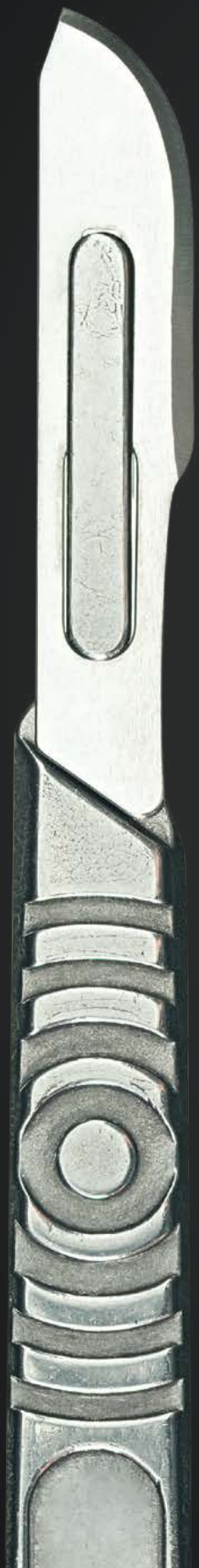

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