Are we there yet? 
Not by a long shot!
BY MARK B. MONAHAN, MD

Time sure does fly! Lisa Crutchfield Barth, our fantastic communications director, informed me that this is my final article for Ramifications as your president.

First, I’d like to say what a pleasure it has been to serve Richmond’s medical community. I read once that it is always good to do something outside of your comfort zone, and many aspects of my RAM duties have been just that. It has been a wonderful opportunity of personal growth and learning for me. I appreciate all the thanks and support I have received from many of you.

I am also grateful to hear from you when you disagree with the direction the Academy is taking. Those are some of the most challenging yet rewarding conversations to have, and they help us all to grow and learn from each other. It’s what makes our Academy stronger and more relevant. I am also proud of all the Academy has accomplished in the last two years. Membership remains strong. I believe that is because of the vast variety of programs the Academy supports, from credentialing services that benefit your staff, family social events, networking nights out and legislative advocacy.

“Thankful,” continued on page 3

‘Game of Thrones’ and ‘The Lord of the Rings’
Thoughts about fantasy on a summer day at the beach while escaping from medicine
BY ISAAC L. WORNOM III, MD, FACS

Apart from sports, I don’t watch much TV. That does not mean that I am unaware of popular culture. This awareness comes from many sources, but one is conversations in the operating room and the office.

Contrary to how they are portrayed in pop culture, most ORs and medical offices are not stress-filled incubators where life and death are always hanging in the balance. Certainly at times this may be true, but often, as operations are being performed or patients are being seen, there is casual banter about food, music, TV, movies, family, travel and books — the world we live in apart from our work in medicine.

“Fantasy,” continued on page 3

RAM: something to be thankful for
BY JAMES G. (JIM) BECKNER
Executive Director

What could you do with four and a half extra hours? That’s what RAM saved you recently. Say thank you!

In mid-May I got an email from a local system CMO about a new Department of Medical Assistance Service policy that was burdensome, to say the least. It required every physician who ever signs an LTSS discharge/transfer form to complete a FIVE-HOUR online training session and take a test. The results of that test have to be kept in each physician’s personnel file. The test has to be repeated every three years.

Just for fun, this all had to be completed by July 1.

Just to sign a form.

President Mark Monahan and I immediately began contacting area health system CMOs, practices and others, including DMAS leadership. After much investigation, we discovered that the screening form is almost never completed by physicians, rather by nurses or social workers. Physicians are asked to sign off on the form. Five hours of training and a test … to sign off on a form. Sure.

Following some firm communication from the Academy and others, the training was reduced to two hours. After more advocacy, it was postponed until further investigation. As it stands right now, a 30-minute training and subsequent test is being proposed. RAM is holding strong that perhaps the problem is with the form and not with the physician if it requires training and a test just to sign it!

This advocacy work is just another example of the value RAM adds to your practice and professional life. CMS on
to introducing the Academy to VCU medical students and residents and helping to care for our most vulnerable patients through Access Now. I encourage you all to see what the Academy has to offer and possibly step out of your comfort zone and get involved. I promise you it will be rewarding! As we learned from Drs. Wendy Dean and Simon Talbot this past spring, the practice of medicine is suffering from death by a thousand cuts. A strong Richmond Academy of Medicine, as we learned, has what it takes to provide our medical community solutions to the problems that will continue to plague our profession.

On another note, I turned 50 this year. “Over halfway there” is what I used to tell our kids when we were driving on vacation and they asked how much longer we had to go. I’d use this response even if we had just left Richmond. It usually worked; they would go back to entertaining themselves and I’d keep driving until they asked again.

I use life expectancy tables commonly in my practice when counseling patients about what treatments may be best for their prostate or kidney cancers. This birthday was a big reminder. As I look at my professional life more closely, I am “over halfway there,” too, as a practicing physician.

I thought about this when the Academy recently hosted an event for the incoming medical students. I was reminded that most of them were half my age! It was wonderful to see how proud they were to get into medical school and the excitement in their eyes as they talked about their dream job or specialty.

We hope to inspire some of them to join and get involved in organized medicine. But we also realize that their lives will be busy with school, residency and starting families as all of our lives were at those stages. If you see them at our upcoming events, introduce yourself and have a chat. You’ll be amazed at what they have already accomplished and what they have planned for their futures. Be ready for some questions, too. Many are very interested in learning about and understanding what our lives as physicians have been like and what we envision for the future of medicine.

As the Academy turns 200 this year, I wonder: Are we over halfway there? I don’t think so. I believe we are just getting started! R

Dr. Monahan practices at Virginia Urology and has served as president of the board of trustees of the Richmond Academy of Medicine for the past two years. He can be reached at mmonahan@uro.com.
Would you like to comment on this column, or is there an issue YOU would like to discuss? Please contact Jim at jbeckner@ramdocs.org, by direct dial at (804) 422-4131, by cell at (804) 920-3536 or via the Academy website, ramdocs.org.

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“Thankful,” continued from page 1

cutting-edge topics such as medical marijuana, CBD oil and trauma-informed care in the adult patient exam room are others. Professional networking and creating physician community are further examples, as is aiding with work-life balance. There’s also system advocacy and legal representation.

RAM’s advocacy on a state and national level has far-reaching effects. National legislation being considered on pharmacy transparency, PBMs and drug pricing came about because of a RAM meeting! What would you do with four and a half extra hours? RENEW YOUR RAM MEMBERSHIP, and continue to make possible everything we do to be the patient’s advocate, the physician’s ally and the community’s partner.

“Fantasy,” continued from page 1

medicine.

As I write this, I am in that world in Duck, N.C. Sometimes you just have to escape.

Over the past year it seemed that the HBO series “Game of Thrones” was on the minds of many people. I have not watched the TV show, but an OR assistant I work with at Mederva was nice enough to lend me her set of five books — George R.R. Martin’s “A Song of Fire and Ice” — upon which this series is based. The series is not finished; he plans to write two more books.

Martin creates a complex fantasy world based on medieval times and mythology. There are so many characters that he lists many of them in the back of each book so readers can see how characters relate to each other.

Several key characters matter the most, however, and that is how Martin tells his story. There is a witty dwarf, a beautiful young queen with three dragons and a bastard son of a king with his own giant wolf whom he raised from a pup … just to name a few. Each chapter is told through one of them — and what a telling it is! There are journeys across seas and deserts and down long rivers. A giant wall of ice, guarded by a special force, separates wilderness from civilization. There are extravagant descriptions of castles, food, clothes, family, sex, battles and death.

I think Martin’s ability to describe what these various characters think and experience in the world he creates is the real strength of his narrative. You find yourself immersed in the characters, rooting for some and despising others. It is hard to stay neutral. Throughout each book is a strong sense of impending doom or triumph for each character. Triumph or death seems random and can occur any time. Through it all, there is never really a good guy or hero. There is only manipulation, war and violence used for power.

While reading “A Song of Fire and Ice,” I could not help but be reminded of other fantasy books I have read. The work that kept coming to mind is “The Lord of the Rings” by J.R.R. Tolkien. I first encountered this work at Hampton High when a good friend told me about “The Hobbit,” a children’s book that serves as intro to the bigger world of “LOTR.”

“The Hobbit” is the story of Bilbo Baggins. He is a kind of miniature person who leaves his quiet home in the Shire, an idyllic place similar to the English countryside, to enter the wider world and battle the dragon Smaug in a quest for gold and fame. During this adventure Bilbo acquires a gold ring in a riddle game from a shrewed-up creature named Gollum. The ring causes the person who wears it to vanish, and Bilbo occasionally uses it for fun. Little does he know the ring’s true meaning.

In the trilogy, “The Lord of the Rings,” the significance of this ring of power is explored in depth.

One ring to rule them all, one ring to find them, one ring to bring them all and in the darkness bend them.

The Lord of Mordor where the Shadows lie.

The Dark Lord Sauron, who made the ring, needs it back to conquer the world of Middle Earth. Sauron is pure evil but has great power. He controls giant armies and manipulates men from afar for his own purposes. There is no good in him.

The ring must be destroyed to save Middle Earth from Sauron. As these books were written in the early 1940s, some think Tolkien saw the land of Mordor and Sauron as representing Nazi Germany, and Middle Earth as our world.

Bilbo’s nephew Frodo is tasked with carrying the ring to Mount Doom in Mordor where it must go to be destroyed. Frodo and his hobbit, elf, dwarf and human companions, as well as the wizard Gandalf, are the good guys and heroes who make up “The Fellowship of the Ring,” the trilogy’s first book. As they journey, they face immense odds and suffer greatly in their quest.

In the world of “The Lord of the Rings,” there is clearly good and evil and a quest to rid the world of evil. Many of the heroes on this quest are hobbits who are not strong in body but are strong in character. Frodo’s lack of a desire for power is what, in the end, gives him the strength to see his quest to completion.

In “Game of Thrones,” death and killing seem to be random and unjust, kind of like a modern-day, first-person shooter video game. In “The Lord of the Rings,” when a character dies it means.

In “GOT,” there is not really good or evil; that world is all about power, the getting and keeping of it. In “LOTR,” power is almost seen as part of the evil. In “GOT” the acquisition of power is the whole point of living. Even characters you often find yourself rooting for use their, physical prowess and noble birth for power, Power, it seems, is all that matters.

What do these works say about our world today? Does life imitate art or does art imitate life? Does “Game of Thrones” show us what is valued most in our world? Can you have power and be good? Does power eventually make one evil? Which is more important, to do good or to have power?

I think these may be questions for next summer.

Dr. Wornom practices at Richmond Plastic Surgeons and is the editor of Ramifications. He can be reached at wornom@richmondplicutsurgeons.com.
An introduction to trauma-informed care

BY SUSAN JONES, MD

When I want to get a fellow physician’s attention, I start talking about the original Adverse Childhood Experiences (ACE) Study, which was conducted 1995-97. A Kaiser Permanente primary care doctor, Vincent Felitti, MD, and a CDC epidemiologist, Robert Anda, MD, surveyed over 17,000 patients who were waiting to see their primary care doctors for routine physicals. Drs. Felitti and Anda inquired if the patients had experienced any of 10 types of childhood trauma during their first 18 years, including physical or emotional neglect; physical, emotional or sexual abuse; witnessing domestic violence toward their mothers; living with a mentally ill or addicted adult; having a family member incarcerated; and experiencing family disruption by separation or divorce. Each of these adversities was worth a point, producing a total ACE score of 0 to 10.

Several important findings emerged from this study. Adverse childhood experiences were common. In fact, 64 percent of respondents had experienced at least one type of childhood trauma. ACEs were additive, as the risk of experiencing problems measured in the study increased with each ACE reported.

These problems resulted in outcomes that I didn’t find surprising: The more childhood adversity a person endured, the more likely they were to struggle with tobacco, drug or alcohol addictions, obesity or depression. ACEs also increased the risk of public health problems, such as becoming a victim or perpetrator of violence or contracting a sexually transmitted disease.

However, unexpected findings also emerged. Childhood adversity increased the risk for medical illnesses, as well, including heart disease, diabetes, lung and liver disease, even when controlling for risk factors such as obesity and addictions.

An individual with an ACE score of 4 or more has a 260 percent increased risk of developing COPD compared to one with a score of 0. A female with an ACE score of 4 has a 500 percent increased risk of becoming a victim of domestic violence and a 900 percent increased risk of becoming a victim of rape. A male with an ACE score of 7 has a 4,600 percent increased risk of becoming an intravenous drug abuser.

Perhaps the most astounding finding is that an individual with an ACE score of 6 has, on average, a 20-year shorter life expectancy compared with one who has an ACE score of 0. ACEs dramatically increase the risk of developing seven out of the 10 leading causes of death in the United States.

This study is over 20 years old, but we still haven’t changed the way we practice medicine. We use an illness-focused model that centers on the “chief complaint” and diagnosis code of the appointment. According to the U.S. Department of Health and Human Services, TIC incorporates several basic principles:

1. Realize that trauma is common and has a widespread impact — many of your patients have histories of trauma.
2. Recognize the signs and symptoms of trauma — patients often seek medical attention for symptoms such as depression, anxiety and insomnia related to trauma.
3. Respond by integrating knowledge about trauma into policies, procedures and practice — consider screening for ACEs in medical settings and educating patients about how past trauma can influence their current health.
4. Actively resist retraumatization — create a safe, empathetic environment for patients, providers and staff.

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I recently attended a lecture by Nadine Burke Harris, MD, the surgeon general of California, and texted my husband (Sidney Jones, MD), who is a primary care doctor, a slide about ACEs and their effects. He happened to be in a provider meeting and said that his colleagues were indeed shocked by this information. They asked him, “How do we not know about this?”

It appears that trauma may especially impact the developing human brain. The brains of traumatized children are smaller than those of the nontraumatized, and those children are more likely to be diagnosed with intellectual disabilities. Constant exposure to stress hormones rewires the brain, resulting in the structures that house primitive emotions — such as the amygdala — exhibiting hyper- trophy and overactivity and having fewer connections to the prefrontal cortex, the area of logic, intellect and

ACEs dramatically increase risk for 7 out of 10 leading causes of death

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<td>1. Heart disease</td>
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<td>3. Chronic lower respiratory disease</td>
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<td>6. Alzheimer’s</td>
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<td>7. Diabetes</td>
<td>1.5</td>
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<td>8. Influenza and pneumonia</td>
<td>3.0</td>
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<td>9. Kidney disease</td>
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<tr>
<td>10. Suicide</td>
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The stress response system causes increased risk to the cardiovascular endothelium. Trauma causes epigenetic changes that actually alter DNA and how it is expressed and can lead to premature cell death.

Given the connections between trauma and health, it is clear that trauma should be addressed in medical settings, and the relevance of trauma-informed care should be apparent to physicians. A trauma-informed medical care setting seeks to acknowledge past trauma and prevent retraumatization.

Physicians can offer emotional support and recommend mental health treatment to help their patients recover from past trauma. They can also suggest exercise, mindfulness and smoking cessation as lifestyle changes that can assist in healing. Since insurers are increasingly reimbursing providers based on outcomes, it follows that one of the largest drivers of health outcomes should be addressed in medical settings.

Dr. Jones is an assistant professor of psychiatry in the Division of Child and Adolescent Psychiatry at Virginia Commonwealth University.
Experts? Can I get a witness?

BY SEAN P. BYRNE AND LUCIEN W. ROBERTS III

Ever been sued when you didn’t do anything wrong? If you have ever been sued frivolously, you know the opposing counsel found an “expert” willing to testify that the standard of care was breached. Most expert witnesses are objective and provide an unbiased opinion. However, some find a breach where none exists. Such frauds exist on the fringes of medicine, using their board certification to convince juries that they are indeed experts and are presenting an unbiased opinion. They can make a nice living doing so.

We want to explain the safeguards that are in place to protect you if you are ever sued.

The modern Federal Rules of Evidence lay out the legal concept for expert testimony. Notably, they give trial judges the authority to exclude incorrect or irresponsible experts and evidence. Two additional rules — the general acceptance test and the Daubert test — were incorporated into the Federal Rules of Evidence in 2000 and give “trial judges authority to exclude expert testimony that is based on bad science or faulty reasoning.”

Trial judges, however, don’t go to medical school. They are unlikely to exclude testimony based upon their understanding of the medical nuances of a lawsuit. That’s where you and your attorney can provide objective input and, perhaps, have irresponsible testimony thrown out.

Your defense attorney can discredit a plaintiff’s expert if the expert did not thoroughly review the medical facts of the case and all available relevant information. Experts’ opinions are generally only as good as the facts that they have relied upon. So if an expert has an incomplete or inaccurate understanding of the facts, the admissibility or weight of the opinion can be challenged. Likewise, testimony given under oath in one case often can be located and referenced by attorneys in another case. A “frequent flyer” expert who gives inconsistent and irreconcilable opinions from one case to another will be exposed in the crucible of cross-examination at trial.

The American Medical Association Code of Medical Ethics Opinion 9.7.1 outlines physician obligations to assist fairly in the administration of justice. The AMA guidance empha-
sizes testifying honestly, without bias induced by financial compensation, and only within areas where the physicians have appropriate training and recent, substantive experience and knowledge.

Several professional medical societies have established similar guidelines that build on the AMA’s position. The following excerpt is from the American College of Obstetricians and Gynecologists: “The [physician] testifying as an expert witness must have knowledge and experience about the range of the standard of care and the available scientific evidence for the condition in question during the relevant time and must respond accurately to questions about the range of the standard of care and the available scientific evidence.”

Policing unethical or disingenuous expert testimony presents a challenge for the medical and legal professions. But some professional associations are attempting to tackle that by engaging in review of members’ expert testimony to ensure compliance with good medical practice. In part, the professional associations seek to protect against witnesses who fail to distinguish between medical malpractice (i.e., negligence) and medical maloccurrence (i.e., a bad outcome unrelated to the quality of care provided). Likewise, experts who take unreasonable positions in favor of physician defendants on issues of standard of care or causation may be subject to review and reprimand.

This safeguard comes into play after the conclusion of a trial if a physician reports his/her concerns to the professional society. The society’s ethics committee then reviews the complaint along with de-identified testimony to rule whether the society’s ethical code of conduct has been breached. If the ethics committee feels a breach or potential breach occurred, it may ask for a hearing that both parties may attend. Potential disciplinary actions for inappropriate testimony include published reprimand, suspension, a ban from the professional society and reporting of the plaintiff witness’s misdeed to the National Practitioner Data Bank. If you have concerns about keeping a complaint confidential, check with your professional society to determine whether anonymity is an option.

During our respective careers, we have seen experts who appeared out of touch with the realities of what really happened. Expert testimony review by professional associations may represent an underutilized tactic in holding such experts accountable.

We hope you are never sued frivolously. We have borne witness to the impact of such suits on physicians and their families. But sadly, some of you reading this article will be sued one day and find a not-so-expert expert being paid to take you down. In that case, we hope these safeguards will help. Together — physicians, defense attorneys and practice administrators — we can make a dent in reducing frivolous lawsuits.

Sean P. Byrne is a director at Hancock Daniel, a national health care law firm, where he focuses on medical malpractice defense work. He’s also an adjunct associate professor at the University of Richmond where he teaches courses on trial skills and health care law.

Lucien W. Roberts III, MHA, FAC-MPE, is chief administrator of Gastrointestinal Specialists Inc. During his career, he has stewed in several courtrooms while watching hired guns ignore the facts. He hopes to publish his first book, “Self-Colonoscopy for Dummies,” in 2020, and will donate the profits to efforts toward the deterrence of frivolous lawsuits.

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The American Medical Association Code of Medical Ethics Opinion 9.7.1 outlines physician obligations to assist fairly in the administration of justice.
Limiting expert witness evaluations in cases of traumatic brain injury is unwise

BY NATHAN ZASLER, MD

Although trends are highly variable across jurisdictions, there has been increased propensity by attorneys to limit the scope of medicolegal assessment by physicians and neuropsychologists asked to serve as expert witnesses. These types of strategies are unwise because they limit comprehensiveness, compromise the standard of care/evaluation, and aspects of the forensic evaluation are being made without appreciation for the complexity of brain injury evaluation when questions of causation, apportionment, diagnosis, treatment and prognosis are before the court.

We have seen all of the following in the context of attorney-requested constraints on medicolegal evaluations in cases involving claimed or documented TBI:

- insisting that no documents are signed during the assessment, including the standard medicolegal evaluation consent form;
- limiting important and necessary parts of the examination including cognitive and behavioral assessments, as well as validity, response bias and effort testing;
- ordering that no “testing” of any kind can be administered;
- insisting that the examiner not ask questions that are not directly related to the subject event; thereby, potentially limiting the expert’s objectivity and ability to comment on apportionment and causality relating to crucial issues that predate or postdate the brain injury;
- forbidding the examiner from asking questions about the actual accident in which the claimed injury occurred;
- disallowing interviews of corroboratory witnesses;
- requesting videotaping during testing, which can adversely affect examinee (and even

Facilitate the best and most scientifically based evaluations without restrictions that compromise thoroughness or results.

often violate ethical codes as well as best practices. Clinicians dedicated to performing high quality, comprehensive work will increasingly decline to conduct such examinations if their ability to provide ethically sound, evidence-based opinions to a reasonable degree of probability are hindered. Decisions that bypass standards of practice and limit essential

limiting total examination time contrary to the examiner’s required/requested assessment time; requesting testing materials prior to the evaluation; requesting copies of copyrighted and/or proprietary materials or raw data in violation of professional ethical codes of conduct as well as copyright law;

Editor’s note: Nathan Zasler, with endorsements from numerous colleagues, has some valuable insights into expert witness evaluations. In this statement, he shares observations and recommendations. For the complete article with references and endorsements, please visit www.ramdocs.org/legaltrends.
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There has been increased propensity by attorneys to limit the scope of medicolegal assessment by physicians and neuropsychologists asked to serve as expert witnesses.

examiner) conduct/performance as well as violate and/or denigrate testing procedures and copyright law;
• requiring that a family member, nurse case manager or other person be in the room during the entire examination to “take notes during the assessment,” despite there being well-accepted evidence that third-party observers may adversely compromise examinee test performance and limit the free flow of information provided to the practitioner conducting the exam.
• limiting acquisition and review of collateral information (including medical, academic, military, criminal/legal, worker’s compensation, etc.)

All parties before our courts should recall Virginia Code 8.01-401.3, adopted from the Federal Rules of Evidence 702, concerning expert witness testimony:
A. In a civil proceeding, if scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified by knowledge, skill, experience, training or education may testify thereto in the form of an opinion or otherwise.
B. No expert or lay witness while testifying in a civil proceeding shall be prohibited from expressing an otherwise admissible opinion or conclusion as to any matter of fact solely because that fact is the ultimate issue or critical to the resolution of the case. However, in no event shall such witness be permitted to express any opinion which constitutes a conclusion of law.

We respectfully make the following five recommendations as related to the aforementioned concerns:
1) Facilitate the best and most scientifically based evaluations without restrictions that compromise thoroughness or results.
2) Encourage evidence-based practice procedures for these types of assessments that optimize the capacity of the expert to provide the most informed opinion on the matters at hand.
3) Adhere to and understand our ethical, practice and professional standards for clinical integrity.
4) Avoid demands that may violate testing protocols or methodology or otherwise compromise the utility of such assessments in future cases.
5) Promote the substantive amount of scientific evidence that supports the critical importance of a thorough history and holistic assessment, collateral information, assessment of bias (whether positive or negative) and performance/symptom validity, as well as the qualification of effort, because these are integral to optimizing our ability as experts to provide medically and neuropsychologically probable opinions in these types of cases.

Our opinions may be challenged as needed in deposition or by courtroom proceedings but should not be compromised by truncating or restricting evaluation scope or content.

Dr. Zasler is medical director of Concussion Care Centre of Virginia Ltd. and Tree of Life Services Inc., and is an affiliate professor, VCU Department of Physical Medicine and Rehabilitation.

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High-deductible health plans: Is it all about the Benjamins?

BY ALICE TOLBERT COOMBS, MD

High-deductible health plans are prevalent in today’s health care landscape. CMS describes a high-deductible health plan as “higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs yourself before the insurance company starts to pay its share (your deductible).”

Pre-tax health saving accounts can be combined with HDHPs, allowing individuals to take advantage of paying for medical expenses (deductible expenses and other out-of-pocket costs) with pre-tax dollars.

While HDHPs are attractive because they accomplish a key goal of acquiring health insurance coverage at a lower premium, patients are challenged by decision-making and misunderstanding of the complexities of out-of-pocket costs. Other OOP costs become conflated. Also, patients can make faulty decisions because OOP cost sometimes functions as a deterrent to obtaining needed care. In HDHPs, the deductible is one of five potential OOP costs for patients. The amount Americans spend on health care is astounding, and it’s growing.

In 2017, the total national health expenditures, defined as total health spending by all sources in the United States, was $3.49 trillion, or 17.9 percent of the gross domestic product. The annual rate of TNHE between 2017 and 2018 increased 3.7 percent. While the overall rate of health care spending has increased in all categories, there is one sector in which the increase is particularly alarming: individual out-of-pocket spending. In 2017, OOP spending was $365 billion, representing 10.5 percent of the TNHE and an increase of 2.6 percent from the preceding year.

With the advent of Affordable Care Act insurance reforms and risk mitigation, the key goal was to increase access to health care insurance coverage. The decrease in the uninsured population since the ACA has been remarkable. As a part of insurance reform and improvement with health care efficiency and utilization, there’s been a major effort to decrease unnecessary and harmful care.

One mechanism for insurance entities is increased beneficiary cost-sharing, the topic of an insightful RAND study by Joseph Newhouse, PhD. But even after decades of evolution and experiment, the health care system has yet to solve the basic challenge of delivering quality health care at an affordable price.

Uncontrollable health care cost is emblematic in the U.S. health delivery system. Alice Tolbert Coombs, MD

Different Types of Out-of-Pocket

| Premiums   | The amount you pay to your health insurance carrier each month to maintain health insurance |
| Deductible | A fixed amount of money depending on your plan that you will pay prior to the insurance company payments kicking in |
| Co-pay     | A fixed amount of money you pay up front for a procedure or clinic visit, drug coverage or health encounter |
| Co-insurance | A portion of your medical bill that you pay for your service or procedure after you hit your deductible. An example: Your insurance would pay for 80% for your procedure after you reach your deductible; you would be responsible for 20% |
| Fees for out-of-network provider | The medical care you receive from your in-network doctors/providers is covered (somewhat); however, out-of-network providers may not be covered OR charge you large fees. Some out-of-network services may be covered by 50% or less of the actual patient charges |

Fees for out-of-network provider

Prostate Cancer Awareness

KNOW THE FACTS!

- Affects 1 in 9 men
- 2nd leading cause of cancer related deaths
- Most common non-skin cancer in men

Discussions about prostate cancer screening should begin at age 40 and include all family cancers.

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system, and the underperforming health care statistics relative to other developed countries are well-known. Our next steps must address health care policy strategy that results in improved access and better health care outcomes at a lower cost. Essential to this process is the impact that health system reform has both on physicians’ ability to deliver care and patients’ health care literacy and empowerment.

Patient decision-making is key to receive ongoing care at the right time and in the right setting. The reality is that a person can make decisions based on just saving money when health care literacy is absent. This health care literacy gap transcends cultures.

Physicians are no less impacted by patient decision-making because their performance is interwoven with their ability to see patients at the right time and monitor patient compliance/adherence. Yes, this means that if the signal of an extraordinarily high deductible or co-pay is attached, it is correlated with utilization. Of low-income adults with multiple co-morbid conditions who participate in employer-sponsor insurance with HDHPs, nearly half, namely 46.9 percent, have OOP cost that is more than 20 percent of family disposable income.

As providers, our hope and focus is to deliver patient-centered, efficient and appropriate just-in-time care. So if the system is increasingly promoting the HDHP, what must accompany these plans is a robust health care literacy and empowerment skillset.

Low-income families are 50 percent more likely than higher-income families to report cost-related delayed or forgone care. The study shows lower income patients are more likely than higher income to ask their physicians about a $100 blood test or a $1,000 screening colonoscopy subject to the plan’s deductible.

Increasing co-payments from $5 to $10 per prescription is associated with decreased use of effective medication among individuals with chronic diseases. Physicians who “touch patients” should be engaged in this process of health care policy development. Physicians are being evaluated on quality and outcomes over which, because of some scenarios, patients have little control.

Implementing a tailored approach to cost-sharing can decrease inappropriate utilization while promoting care that is focused on research-proven care. Patients need ongoing health care literacy training to understand the role of HDHPs and health care decision-making. Patient education and training in time-sensitive care, such as acute myocardial infarction and cerebrovascular accident, need to be prioritized. Cost-sharing should be minimized or not be used to disincentivize essential high-yield interventions that produce long-term and immediate improvement health outcomes.

Data analysis, including risk adjustment and transparency in conjunction with open source innovations, allows health systems and providers to improve based on real-time assessment.

As we transform our health care delivery system, it is important to promote innovation and transformation that improve patient outcomes and optimize physicians’ ability to care for their patients. R

Dr. Coombs is an associate professor in the Department of Anesthesiology, Division of Critical Care, in the VCU School of Medicine. She also practices with the Department of Anesthesiology at VCU Health.

HDHPs have specific annual IRS benchmarks:

For 2020, the IRS defines a high-deductible health plan as any plan with a deductible of at least $1,400 for an individual or $2,800 for a family. An HDHP’s total yearly out-of-pocket expenses (including deductibles, copayments and coinsurance) can’t be more than $6,900 for an individual or $13,800 for a family. (This limit doesn’t apply to out-of-network services.)

Source: CMS.GOV
## RAM calendar

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<tr>
<th>DATE</th>
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| November 12, 2019 | RAM Membership Meeting  
Leslie A. Kimball, PhD, LCP, Assistant Professor of Psychiatry, Licensed Clinical Psychologist, Virginia Treatment Center for Children  
“Trauma-informed care for the adult patient” University of Richmond Jepson Alumni Center  
442 Westhampton Way, Richmond 23173  
5:30 p.m. cocktails, 6:15 p.m. dinner,  
7 p.m. presentation  
Leslie A. Kimball will help members understand trauma, its impact on the brain and at-risk health behaviors, and building individual and community resilience. |
| November 19, 2019 | Advocacy and Ales  
Urban Roost in Scott’s Addition  
3023 W. Marshall St., Richmond 23230  
6-8 p.m.  
RAM members and advocacy veterans will break down what legislative advocacy means in the realm of medicine, recent successes as well as current battles and easy ways you can be involved. |
| December 3, 2019 | RAM Legislator Breakfast  
Bon Secours St. Mary’s Hospital  
5801 Bremo Road, Richmond 23226  
7 a.m.  
It’s important to know your elected leaders and to take every opportunity to meet with them. Please join us for breakfast and speak with your local legislators. |
| December 4, 2019 | RAM Legislator Reception  
Virginia Urology  
9101 Stony Point Drive, Richmond 23235  
6:30-7:30 p.m.  
It’s important to know your elected leaders and to take every opportunity to meet with them. Please join us for a reception and a chance to speak with local legislators. |
| December 8, 2019 | RAM Winter Family Event  
Lewis Ginter Botanical Garden  
1800 Lakeside Avenue, Richmond 23228  
5-8 p.m.  
Get into the holiday spirit with GardenFest of Lights at Lewis Ginter Botanical Garden. We’ll have a room reserved for you and your family to enjoy refreshments and holiday cheer with your RAM friends and colleagues before and after touring the gardens aglow with lights. |
| January 21, 2020 | RAM Presidential Inauguration and Board Installation  
President: Carolyn Burns, MD, Virginia Cardiovascular Specialists  
University of Richmond Jepson Alumni Center  
442 Westhampton Way, Richmond 23173  
5:30 p.m. cocktails, 6:15 p.m. dinner,  
7 p.m. presentation  
Mingle and network with your colleagues over cocktails and dinner, and hear Dr. Burns’ inaugural address as she begins her two-year term as RAM president! |
| January 16  
January 24  
February 17 | Lobby Days at the General Assembly  
Virginia’s lawmakers need to hear from you. Mark your calendar for our White Coats on Call days at the 2020 General Assembly. Details coming soon. |

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**For other event photos, check out RAM’s Facebook page.**

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**Should you have questions about any of our upcoming meetings, please call the Academy at (804) 643-6631. Do you have a colleague interested in becoming a RAM member? Bring him or her along to the next RAM event!**

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**RAM members and their families enjoy our Summer Family Fun event with the Flying Squirrels.**

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**Students from the VCU School of Medicine were introduced to the Academy at an event in August.**

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**RAM President Mark Monahan, MD, greets new medical residents at a summer social.**
2019 RAMgagement update

Who will top the leader board this year? Only a few months remain. Our friendly RAMgagement competition awards points to members for attending various events, bringing potential members as guests and for recruiting new members. Top finishers each year are announced at our January meeting and take home great prizes (as well as bragging rights).

Check out the list of upcoming member events — then invite a colleague to attend with you. You’ll be on your way up the leaderboard!

We’ll publish the winners in the Winter 2020 issue of Ramifications!

When it comes to helping grow your practice, or keeping your everyday operations running smoothly, our bankers are dedicated to getting things just right for you. That’s because we’re the sweet spot between a big bank and a small one – so you get the services you need, with the service you need, too.

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Her medical illustrations helped generations of physicians

BY WARREN KOONTZ, MD

You might not know her name, but you probably know her work. Her influence on physicians—including many RAM members—was great.

Helen Lorraine was a medical illustrator whose work appeared in numerous books, articles and exhibits throughout her career. Born in 1892, she was educated in Richmond’s public and private schools, studied at the Art Club and the Art Center of Richmond, then moved to Baltimore. There, she studied in the fledgling Art as Applied to Medicine program at Johns Hopkins University under the tutelage of Max Brödel, who was considered the leading expert in the field of medical illustration.

After graduation, Lorraine returned to Richmond. Always fascinated by medical illustration, she spent $25 for the use of a cadaver in MCV’s Department of Pathology to expand her study of human anatomy. She could do dissection only in summer, when the medical school was closed, as women were not allowed in the dissecting rooms at that time.

Securing a job as medical illustrator at St. Elizabeth’s Hospital in Richmond, Lorraine worked there until 1945. She later became a full-time freelance illustrator for doctors in the United States and abroad.

Lorraine produced more than 1,000 works for physicians in the Richmond area. As her fame grew, her detailed illustrations were exhibited at many medical meetings. She was a charter member of the Association of Medical Illustrators and was the first editor of the journal Graphics. Her work is represented in the permanent collections of the College of Physicians of Philadelphia and the Countway Library of Medicine at Harvard University.

She died in 1984 and is buried in Riverview Cemetery.

Dr. Koontz is a retired urologist and former president of RAM. He currently serves on the Vision 2020 history committee.
I got a terrible infection! The surgery center was so inefficient! The location was so inconvenient! There was nowhere to park!

Visit medarva.com to learn more about what sets our great nursing staff apart from the rest.

The whole process was very organized. The staff, nurses, doctors. Caring, polite and extremely efficient. May they continue to be blessed with good health and patience to deal with "old folks." — Laura P.

Excellent facility and excellent staff. I would recommend SPSC to anyone needing the type of eye surgery that they provide. Please recognize nurse Megan. — Tabbie T.

Medarva.com

My nurse was the BEST! I think her name is Judy. — Craig F.

Dr. Sandhu is the best. He is the most compassionate doctor I have ever had. He explains everything and I never feel rushed. The whole staff was wonderful. My husband was amazed. Please recognize Janet. — Gwen B.

Dr. Laskoski did a great job. I have experienced no pain. The staff were courteous, friendly, and helpful. Thanks for making this easy. — Fred P.

From beginning to end, could not have been better. Thank you. My assessment - must be a great place to work. — Charlie B.

Very impressed with the facility. Dr. and nurses were very friendly and made sure I was as comfortable as possible. Please recognize nurse Leslie. — Rebecca T.

Detailed drawings like this helped physicians and medical students alike.
Since 2013, the number of United States consumers tracking their health data with wearable technology has doubled. And that number continues to rise: During the third quarter of 2018, the wearables market saw a nearly 60 percent increase in earnings over the prior year.

Wearables bring promise, but they also might pose real risks for patient safety and physician liability.

Benefits
Promoters of wearable technology believe wearables will drive the transition to intelligent care, whereby physicians have access to more data, allowing them to identify actionable components. Florence Comite, MD, a New York endocrinologist who describes wearables as “almost like magic,” uses data from wearables to tailor her interventions for patients with chronic conditions.

Wearables can help patients take action, too. In one recent study, diabetes patients using wearable apps showed randomized controlled trial results comparable or superior to patients taking diabetes medications.

Promoters of such digital strategies hope that they will encourage healthy behaviors while requiring fewer office visits purely for monitoring purposes, thereby reducing health care costs while improving patient experience and engagement.

Some apps promote healthy behaviors with gamification. Harvard professor Ichiro Kawachi, PhD, wrote in JAMA Internal Medicine that this is “an opportunity for clinicians to turn health promotion into an engaging, fulfilling and fun activity.” Sponsors hope that gamification can promote accountability, responsibility and mindfulness about activity and health conditions.

Skepticism
It is too soon to say whether wearables actually will increase healthy behaviors and/or reduce office visits, thus lowering health care costs. Some studies have found that wearable devices offer no advantage over other forms of goal tracking or social support in helping people meet their health and fitness goals. A 2016 study from the University of Pittsburgh found that “young adults who used fitness trackers in the study lost less weight than those in a control
specific responsibilities for monitoring and protecting patient data vary by location.

- Lack of data security — and liability for physicians: Wearables are subject to cyberattack. In addition to presenting obvious risks to patient safety, this may also present liability risks to physicians, who may be expected to notify patients of recalls issued for their wearables.

**Next steps**

As more and more physicians are accepting — or requesting — their patients’ data from wearables, questions include: How can we tell when data from wearables is accurate? When it’s actionable? When it’s secure?

Certainly, physicians interacting with data from wearables should independently confirm that data before changing a patient’s care and should securely store data from wearables.

Miranda Felde is vice president, patient safety and risk management, at The Doctors Company in Napa, California.

**Possible risks**

Though each device has its pros and cons, all wearables generate concerns for physicians, including:

- Poor data quality: Data from wearables may or may not be reliable enough for medical use.
- Data fixation: Patients may fixate on one number — steps per day, for instance — at the expense of other health variables such as diet, sleep habits and so forth.
- Lack of interoperability with electronic health records: If a patient’s wearable cannot stream data to the patient’s EHR, then how can the physician’s practice securely acquire the data?
- Data saturation: Physicians receiving patient data from wearables risk being soaked by a data fire hose. Physicians need a plan and a process to determine which measurements are relevant for a given patient.
- Unclear physician responsibilities for collecting, monitoring and protecting data: HIPAA applies to patient data collected by physicians, but differing state laws mean that a physician’s
As RAM gears up for its bicentennial next year, one of its partners is having an anniversary of its own. The Medical Society of Virginia Insurance Agency has served thousands of physicians and has returned significant financial resources to organized medicine in the Commonwealth. This year, the agency is celebrating 20 years not only as a premiere insurance agency but as an advocate for Virginia physicians.

Profits from the agency are invested into MSV, directly supporting Virginia’s physicians. The agency is the largest source of non-dues revenue for MSV and the only agency governed by a board of physicians and practice managers. As a result, the insurance carriers that MSVIA represents have products and policy endorsements that are designed specifically to meet the needs and exposures found in the health care business setting.

The MSVIA was founded on a need to offer physicians advice, service and programs superior to what was available in the general marketplace. Through the vision and hard work of MSV’s physician leaders, the agency opened its doors on Sept. 30, 1999.

Once up and running, a succession of MSV physicians, led by Woodbridge physician Craig Hensle, MD, volunteered countless hours to ensure the insurance agency was dedicated to endorsing quality programs that would provide significant service to Virginia’s physicians.

Today, MSVIA offers a wide range of products to assist both MSV members and nonmembers. It represents companies that are all highly rated by AM Best to offer professional liability, property and casualty, as well as life, health and employee benefits. MSVIA remains ready to help physicians with their insurance needs and is excited to be celebrating 20 years of dedication and service to Virginia’s physicians.

MSVIA is also proud of the fact that it has been the exclusive insurance agency partner of RAM for the past 11 years and continues to be a trusted resource for all RAM members. We look forward to many more successful years together!

Dustin Beekman is director of business development at MSVIA. He can be reached at dbeekman@msvia.org.