My first 100 days
BY MARK B. MONAHAN, MD

Since assuming the Academy’s presidency in January, I’ve been heartened to receive so many expressions of congratulations and support. So thank you all again. Several members have asked if I have enough time to fulfill all the duties of this position. The answer might surprise you. Yes, I do have the time but only because the fantastic RAM staff is organized and manages to keep the demand on my time to a minimum. Thankfully, staff members are used to dealing with busy physicians and understand the need to keep us informed and on schedule even as we keep practicing medicine.

Still, as I write this column in late March, I’m reminded that our communications team was politely requesting the first draft of this article nearly two weeks ago! Well, I ended up on call, then got sick, and of course I didn’t want to miss one of my children’s school meetings. So now, low and behold, I’m behind schedule. Thank goodness the deadline was a little softer than I thought — and hopefully you are seeing this in print!

I cite this example simply as a way to remind you, the members, that RAM’s experienced staff is also there for you. We want you to be involved and utilize the benefits available as a member. We can make your ability to participate easy as pie as they like to say down here in the South. So please sign up for the social events. Just to give you a sample, in the coming weeks you can enjoy:

- June 6, 6-8 p.m. | RAM Member Networking Social at Tesla Richmond
- June 24, picnic from noon-2 p.m.; gametime, 1:05 p.m. Take me out to the ballgame! Join your RAM colleagues for the annual summer family event — a Sunday afternoon picnic lunch and a Flying Squirrels game.

We also invite you to get involved in one of the many activities designed to meet the needs of our growing and diverse membership. Those activities include:

- RYPE ‘N RVA, RAM’s initiative to engage early career and new-to-Richmond members.

“First,” continued on page 2

What is ‘fake news’? Is the medium the message or is it the mass age?
BY ISAAC L. WORNOM III, MD, FACS

“We got information in the information age But do we know what life is Outside of our convenient Lexus cages”
(from “Gone” by Switchfoot)

How do you get information you trust? This has become a key question in our professional and in our personal lives. We live in a world where we are bombarded by information. It is at our very fingertips through our smartphone connection to the internet. We touch the screen and voila! — pictures, movies, words, sounds appear. The source of this information could be just about anywhere.

When I had a question about a new procedure or idea in plastic surgery I used to go to the medical library to look up journal articles that related to this topic. No more. Now I go to my computer and click on the website of the journal Plastic and Reconstructive Surgery and do a search. I instantly have access to full text articles on the subject I am interested in, often with videos attached. I trust this journal. It has been around a long time, and I know the peer review to have an article published within its pages or on its website is first rate and intense. I suspect pretty much every one of you has a similar source you go to for medical information that you trust.

Unfortunately for our patients attempting to gather information about a disease or the doctor who is treating them, reliable information is sometimes hard to come by. Google searches can lead to websites that are not always accurate, to put it mildly. Instead of providing valid information, these sites may be trying to sell a particular procedure or treatment that may or may not work. Doctor-rating sites are often just complaint departments. There is a whole industry that specializes in enhancing a physician’s online reputation.

Thanks to the last presidential election, the term “fake news” became a key question in our professional and in our personal lives. We live in a world where we are bombarded by information. It is at our very fingertips through our smartphone connection to the internet. We touch the screen and voila! — pictures, movies, words, sounds appear. The source of this information could be just about anywhere.

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Our RYPE ‘N RVA leadership team has been hard at work looking at ways to add programming and foster opportunities to make legislative advocacy more digestible for members new to the advocacy arena.

- Women in Focus: Created in 1997 as a way to promote awareness and understanding of women’s health issues, this subcommittee of RAM is open to all Academy members and meets three times a year for networking and an educational talk. The next WIF program is this fall and will feature a talk on GI-related health.

- Lunch on Tuesdays: This is another program series that meets three times a year for lunch at the Westwood Club. Our final LOT program of 2018 is Oct. 9 and features a talk on Alzheimer’s disease by Dr. Kristin Williams from VCU Health’s Department of Neurology.

If you have questions about how to join our exciting galaxy of RAM groups, please contact Kate Gabriel, our dynamic director of Member Engagement, at (804) 622-8133 or kgabriel@ramdocs.org.

Another frequent question is, “What have you been doing as president?” As I started my two-year tenure in January, we were in the thick of the General Assembly session, with the combined legislative teams of RAM and our partners at the Medical Society of Virginia in full swing. I attended one of the White Coat days, educating legislators about the importance of keeping adequate clinical experience as a licensure requirement for nurse practitioners. I also helped to inform lawmakers on the issues by writing letters. By the end of the 60-day session, I felt we’d scored a number of legislative victories, including:

- Passage of HB 139 which allows physicians in the credentialing review process by a health plan to see patients and retroactively receive payments if they’re ultimately credentialed. Practice executives estimate this policy change could result in substantial increased revenue. Based on conservative analysis, a physician awaiting credentialing could generate $1,000 revenue per day during the credentialing period.

- Defeating a number of potentially damaging liability/malpractice bills. One would have created unlimited liability for damages to families of individuals who have been victims of personal injury. Another bill would have raised the punitive damages cap from $330,000 to $500,000. The punitive damages cap also affects the medical malpractice cap and would have ultimately raised the existing statute and agreement by $510,000. (The current medical malpractice cap is $2.3 million.)

- We also defeated a number of other bills that would have negatively affected the practice of medicine such as extension of Lyme disease test notification, mandatory use of the Electronic Death Registry System and mandatory notification requirements on cadet poisoning in joint replacements.

- On the scope-of-practice front, we opposed and averted legislation that would have created a Doctor of Medical Science (DMS) license and averted an optometry scope bill that would have allowed optometrists to perform surgical procedures.

- With a great deal of effort, time and energy on behalf of all parties, we reached a compromise that allows nurse practitioners to practice independently after appropriate clinical training — five full-time clinical years of experience attested to by a physician. Of course, the pesky issue of prior authorization will likely return next year and serves as a reminder that our advocacy planning is already underway.

- RAM’s Legislative Committee was to meet in April and advance a number of issues to the MSV Advocacy Summit late that month. Stay tuned to see what will be included on the 2019 legislative agenda!

And let’s not forget that our very own Dr. Richard Szucs — a former RAM president — will be installed as MSV’s next president at its Oct. 19-21 annual meeting at the Hotel Roanoke. This would be the perfect year to commit to serving as a delegate at this meeting and at the same time support Dr. Szucs at his inauguration!

To learn more about our year-round advocacy on your behalf, please contact Lara Knowles, our talented Program and Legislative Services coordinator, at (804) 622-8137 or lknowles@ramdocs.org.

You’ve no doubt seen Lara’s contact information — along with Kate’s — in some of our regular messages about upcoming member events, including our stellar slate of General Membership meetings this fall, for example, we hope to host Gov. Ralph Northam, a pediatric neurologist himself and a familiar face to many RAM members.

On Sept. 11, Dr. Lynette Charity, a board-certified anesthesiologist with over 35 years of experience and ties to Virginia (she completed some training at EVMS), will be joining us. She will discuss surviving and thriving after a medical liability lawsuit plus offer tips on how to stay inspired throughout medical training and thereafter.

For those of you who heard my inaugural address, you might recall that we’re in the thick of developing a comprehensive strategic plan for your Academy. I promise to keep you informed on the plan’s progress. (If you’d like to catch the highlights of my Jan. 9 speech, please visit Ramdocs.org and see News & Press.)

Finally, rest assured that if you call with questions or concerns, we’ll work hard to gather the appropriate information, formulate a response and communicate as efficiently as possible with everyone concerned.

So join in the advocacy summit, come to the Squirrels outing or take part in any or all of the many activities we have in store for you. All you have to do is sign up and show up. We’ll handle the rest. I look forward to seeing and hearing from you!

Dr. Monahan practices at Virginia Urology and is the president of the board of trustees of the Richmond Academy of Medicine. He can be reached at monahan@uro.com.
news” is everywhere — from Russian bots to Facebook posts from people you know and don’t know to tweets and more tweets. (Full disclosure: I don’t have a Twitter account, but I can’t seem to escape hearing about those who do discussing them on such old-school media as radio and TV.) Facebook and Twitter accounts are even for sale on the “dark web” (whatever that is!) to falsely inflate the apparent popularity of your posts.

Two articles in the March 11 Richmond Times-Dispatch spoke to me about these issues. One article described the speed at which information spreads on Twitter. And guess what? It turns out that lies spread a lot faster than truth — about six times faster, in fact. This was proven in an MIT study. It was not bots doing the spreading either — it was people! The author of this piece said “No matter how you slice it, falsity wins out.”

How sad!
The second article I found fascinating provided the text of a speech delivered at the Times-Dispatch’s “Correspondent of the Day” lunch delivered by Delegate Lee Ware from Powhatan. Ware drew from such diverse thinkers as Plato, Alexis de Tocqueville, George Will and Rene’ Girard to make a strong argument that our public discourse has been corrupted and badly influenced by the mixing of fact and opinion. In his speech he quotes George Will’s column about a RAND Corp. report, “Truth Decay: An Initial Exploration of the Diminishing Role of Facts and Analysis in American Public Life.”

Will writes about the impact of the sheer “volume and velocity of the information flow,” which, combined with Internet-driven “a la carte information menus, erode society’s assumption of a shared set of facts.”

This information overload, Will argues, also deepens our human tendency toward “confirmation bias” and leads to people living in “information silos” and “echo chambers.” This in turn produces political polarization, which in turn “promotes the permeation of partisanship throughout the media landscape.”

“This quote demonstrates how technology and the information flow is changing the way people think so they cannot connect with each other. It is pushing us further and further into our own preconceived or accepted notions and does not allow us to accept or consider other points of view. It can lead us to such polarization that we shout each other down. Just look at what is happening on some college campuses today when certain speakers are not even allowed to express their points of view and are shouted down.”

“Fake,” continued on page 4

It is pushing us further and further into our own preconceived notions and does not allow us to accept or consider other points of view.

“Pandora,” continued from page 1

Physicians dared to speak the bold truth of what they knew was in the best interests of their patients. It certainly wasn’t easy and indeed it took years, but finally Virginia, the tobacco capital of the world, banned smoking from restaurants and other public places. Just ask RAM’s own antismoking warrior, Dr. Walter Lawrence, if it was an easy process!

Or let’s talk immunizations. Who made possible the advances in public health and disease eradication as a result of vaccines? Who drew immunization laws? Again, who led the charge for social and political change for the health and safety of those whom they serve? Medical professionals. And who will keep the “my-Googles-trumps-your-medical-degree” anti-vaxxers at bay?

The medical community, bolstered by science and reason, that’s who.

Seat belts, medical cannabis oil, elder driver evaluation, OSHA regulations, food safety, drug regulation, the opioid epidemic — the list goes on and on. All of these came about (or at the very least were greatly bolstered) because doctors and other health professionals acted on what they knew were the best interests of their patients to make the necessary changes in society, in policy and in law. Just ask Dr. Siobhan Dunnavant or Dr. John O’Donnell about how other legislators constantly turn to them in matters concerning health and patient safety. In all of these instances, the House of Medicine took a reasoned, logical and scientific stand to do the right thing — even when there was plenty of capital (political, philanthropic and corporate) at stake. In every one of these advances, the medical community did not allow itself to be silenced by the extremes nor allow profit to take precedence over principles.

I believe the Richmond Academy of Medicine should be that space where reasoned, science-based and even daring dialogue takes place on tough issues. We are already talking about issues of obesity, diabetes prevention, substance use disorder, physician burn-out and mental health. Now, as we approach our 200th anniversary in 2020, we’re beginning to speak about issues like gun safety, health disparity and transgender health. Based on my years serving as the Academy’s director, I truly believe that RAM is uniquely positioned to provide a safe space for discussion, a space for reasoned creativity and a space of informed and daring decision-making.

The Academy has a unique history of innovation and of putting the needs of patients and progress above the shouts from the extremes.

So, yes, I went there. If one knows the whole story of Pandora, one knows why it’s so important to this column. When she opened the box, death and many other evils were released into the world. Pandora hastened to close the vessel, but the contents had escaped except for one thing that lay at the bottom: Hope.

RAM: Rising above the extremes to be the patient’s advocate, the physician’s ally, the community’s partner. [1]

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) 622-8131, by cell at (804) 920-3536 or via the Academy website, ramdocs.org.

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Facebook has 2.1 billion users around the world generating annual revenue of $40.6 billion

Source: The New York Times April 12, 2018

“I try to be more widely informed by listening to National Public Radio and, for counterbalance, Rush Limbaugh.”

National Public Radio and, for counterbalance, Rush Limbaugh. You might listen to CNN and Fox News. If you do, you probably get a good dose of bias from both sides.

Third, and most importantly, don’t be afraid to have dialogue with people you disagree with. It is only through mutual trust that different ideas can be brought together. Try really hard to get out of your “convenient Lexus cage.” Or at least be aware that you might be in one.

Dr. Wornom practices at Richmond Plastic Surgeons and is the editor of Ramifications. He can be reached at wornom@richmondplasticsurgeons.com.

“Fake,” continued from page 2

in public forums. In its most extreme form, riots and mob rule may take over the rule of law.

Marshall McLuhan, the great media critic of the 1960s, saw it all coming. In “Understanding Media: The Extensions of Man,” he first put forth the phrase “the medium is the message,” which would later be used to explain the changing media landscape. He then wrote another book which he initially titled “The Medium Is the Message,” but due to a typo from the printer the title came back “The Medium Is the Massage.” He liked the typo better so he stuck with it! He particularly liked the new title because it could be read as “mass age.”

In that book, he posits the theory that how we acquire information is actually more important than what the information is. And he correctly predicted what we’ve seen in various media from TV to the rise of the internet. That is, these changing media actually change how human beings think.

So, what is the answer for what ails us in the “mass age” of the 21st century? I see three possible ways to cut through the clutter. First, be skeptical about what you read and see everywhere. Be aware of your own biases. They can separate you from others. Second, find sources of information you trust. For me it is the newspaper, but I know that is going out of style which I personally think is a real shame. I find myself in good company, though, as one of the top technology writers in the country — The New York Times’ Farhad Manjoo — described his own experiment in going “old school” by turning off his many digital news notifications and unplugging from Twitter and other social networks. The goal, Manjoo wrote, was “to be informed by looking to formats that prized depth and accuracy over speed.”

He happily reported that not only was he “less anxious and less addicted to the news,” but also that he was “more widely informed.”

In my life, I try to be more widely informed by listening to National Public Radio and, for counterbalance, Rush Limbaugh.
One of the smaller rare books, complete with the personal stamp of Dr. Miller along with the RAM logo; below that, the other images — starting with the skeleton seemingly “contemplating” a skull — come from a 16th century anatomy book known as “Fabrica,” written by a Belgian physician, Andreas Vesalius. He was best known for lifting anatomy out of the realm of mysticism and helping it become a more exact science. According to legend, William Shakespeare saw the woodcut of the skeleton and gave him an idea for Hamlet, where Yorick’s skull plays a starring role. The pages and bound copy of Vesalius’ book (whose whole title is ‘De Humani Corporis Fabrica’) complete the images shown here.
RAMgagement UPDATE

The heat is on! RAMgagement race tightens

With summer fast approaching, Year 3 of the Academy’s RAMgage-ment challenge is really heating up! RAMgagement is our way of striking up some friendly competition among members and rewarding our top finishers annually. Kudos to Dr. Mark Hyton with VCU Health’s Department of Anesthesiology for finishing in first place two years running and taking home overnight stays at the Jefferson and Wintergreen Resort. Can anyone stop him in 2018?

As a reminder, earn RAMgage-ment points for each Academy event you attend. Rack up additional points for bringing a new active member with you to an event as your guest and more points when your recruit joins RAM. Shout out to Dr. Irene Foley, Dr. Johnny Wong and to medical student members Annalyn Welp and Malika Gill for recruiting new members this year.

Here’s the Leaderboard as of March 31, showing who is standing in your way of taking home a top-finisher prize in 2018. Please join us for one of our upcoming member events (see RAM calendar) and invite a colleague along to join you. You may just see your name on our next leaderboard!

2018 LEADERBOARD

(As of end of Q-1)

1. Ms. Malika Gill | VCU School of Medicine, medical student
2. Dr. Irene Foley | VCU Health, Department of Internal Medicine
   Dr. Walter Lawrence | VCU Health, Department of Surgery
   Dr. Johnny Wong | Pulmonary Associates of Richmond Inc.
3. Dr. Owen Brodie | (retired)
   Dr. Mark Monahan | Virginia Urology
4. Dr. Joseph S. Galeski, III | Innsbrook Primary Care
   Dr. Ranjodh Gill | VCU Health, Department of Internal Medicine
   Dr. Joseph Haddad | Joseph B. Haddad, MD, FACOG P.C.
   Dr. Demetrios Julius | Sleep Disorders Center of Richmond
   Dr. Thomas Moffatt | Richmond Nephrology Associates (retired)
   Dr. Bobbette Newsome | Commonwealth Radiology P.C.
   Dr. M.C. Pinsker | (retired)
   Dr. Susan Prizzi | Commonwealth Radiology P.C.
   Dr. Joe Rountree | Dermatology Associates of Virginia P.C.
   Dr. Maggie Sigman | Advanced Allergy and Asthma of Virginia
   Dr. Lori Smithson | Commonwealth Radiology P.C.
   Ms. Annalyn Welp | VCU School of Medicine, medical student

All in the family: Student Trustee Malika Gill and father Dr. Ranjodh Gill enjoy a RAM dinner program.
PROUD TO CALL GOOCHLAND HOME

From our brand-new outpatient surgery center to our network of leading-edge physicians to our ongoing sponsorship of community projects, MEDARVA West Creek Surgery Center is making Goochland a stronger community. Visit MEDARVA.com today to learn more.
‘House call on steroids’: Is this the future of medicine?

BY LISA CRUTCHFIELD

A few minutes before 9 a.m., DispatchHealth medical technician Lindsay Spain sorts through cases of medical supplies, makes sure she’s got what she needs and then loads everything into the back of a Nissan Rogue. She and physician assistant Carrie Clemens are heading out to see their first patient, a woman with back pain. Once that’s done, there’s a patient experiencing nausea and vomiting. By the end of a typical day, they’ll have seen six medical technicians and ER physicians, offers on-demand urgent care anywhere. The 5-year-old company likes to tout itself as delivering a “house call on steroids,” and given the capability packed into its small cars, it’s a fair description. On this morning, for example, the team loads everything from EKG machines to IVs for rehydration to steroids, in preparation for whatever it encounters.

DispatchHealth says its care model can improve access to acute care medicine, reduce hospital readmissions, free up emergency departments for more critical work and offer savings (in time and money) to patients. And, at least in Richmond, it seems to be making good on its promise.

Why here? Why now?
Like many other players in today’s economy, DispatchHealth has seized on the convenience factor.

House calls certainly aren’t a new idea, but now there’s urgent care in the home. And, instead of seeing physicians, patients are visited by advanced practice providers with virtual support from physicians — who, in turn, can increase access (especially for patients with no way to get to the hospital) to health care.

Richmond is one of five cities where Denver-based DispatchHealth currently operates. Introduced in November as part of a partnership with Bon Secours Richmond, its goal is to be in 10 cities by the end of 2018.

Caregivers go to homes, offices, senior living communities — or wherever — providing both on-call urgent care and, as part of the relationship with Bon Secours, follow-up care for patients recently discharged from the hospital.

For all its seeming efficiencies, this new model has raised concerns and questions among physicians. What kind of way is this to practice medicine? Just who are these providers caring for my patients? And what kind of care are they giving?

Carlton Stadler, MD
DispatchHealth’s medical director and an emergency room physician at Bon Secours Memorial Regional Hospital, says it all comes down to access. Is this the future of medicine?

“A lot times, what a physician needs is for someone to put eyes on patients in the home and tell us what they see.”

— Dr. Carlton Stadler, DispatchHealth Medical Director

‘House call on steroids’

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Is this the future of medicine?
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Medical Center, has heard such questions from fellow physicians. He says he understands them, but the program’s intent is to work collaboratively to fill gaps in care. “One of the first things we say is we are simply borrowing your patients. We are a value-based extension of the care that their own physicians are providing. And we’ll even do it under their direction,” Stadler explains.

“A lot of times, what a physician needs is for someone to put eyes on patients in the home and tell us what they see.” Because, he notes, as a physician you don’t know what you don’t know. That patient who keeps falling … you don’t know her living room is an obstacle course of throw rugs, or you haven’t seen the patient’s clowder of cats underfoot or other impediments to safety and daily activities.

“Bon Secours saw value in getting to patients in their homes, where there’s an abundance of social determinants,” says Stadler. “We can see what their living situation is like, what their resources are, what their social capabilities are. It helps prevent readmissions and keeps patients from having unnecessary visits to the emergency department. It helps ensure that we are bridging these gaps between care, which is a unique niche and needed for patients.”

Susan Coombes, associate professor of management, VCU School of Business, sees a possible upside to mobile medicine. “If they can provide what they say they can provide and do it well — and because we are a culture that craves convenience above many other options — it could be a really good thing.”

Some Richmond physicians may remain a bit skeptical, but national entities have taken notice. In late 2017, the AARP Foundation and Rock Health named DispatchHealth as the winner of the 2017 Aging in Place $50K Challenge, a competition for entrepreneurs with solutions that help vulnerable older adults remain in their homes and communities.

Forbes magazine also sang its praises. “DispatchHealth has begun to disrupt the health care industry, much like other emerging companies have upended the norm in their own niche,” Forbes said. “Millennials are likely to get behind their mission as they look to craft their lives from convenience and the ability to save money.”

And, in another sign of our times, ride-sharing companies Uber and Lyft have plunged into the healthcare business, seeing a big opportunity in ferrying the 3.6 million people who miss medical appointments each year to their doctors’ offices, the Washington Post reported in March.

“Steroids,” continued on page 10

With the rise in antibiotic-resistant bacteria, at any given time one in 25 patients in the U.S. is battling an infection acquired in the hospital, at a cost of $10 billion annually for the five most common infections.

Centers for Disease Control and Prevention

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Centers for Disease Control and Prevention
“Steroids,” continued from page 9

So what’s the business model?
The DispatchHealth concept has taken off, with a recent influx of $31 million in growth capital funding and the company plans to expand rapidly. In addition to adding new markets, it’s exploring ways to use technology to offer services like telemedicine.

“We live in an on-demand culture,” CEO Mark Prather told Forbes. “Our service aligns well with millennial expectations and the shift toward consumer-directed healthcare.”

So here’s how it works: Patients request services via phone, website or mobile app. (Since 70 percent of Richmond patients are seniors, most requests are by phone.) They’re screened by clinicians in the company’s Clinical Support Center using a risk stratification tool to ensure DispatchHealth can adequately treat the complaint; if not, patients are directed to call 911 for immediate care or to call their regular provider. DispatchHealth then sends a nurse practitioner or physician assistant plus a medical technician out to the service location, usually arriving within an hour. All care is monitored for safety.

Among the equipment:
- CLIA-certified lab for point-of-care lab tests, temperature-monitored for safety
- Advanced formulary of oral and IV medications, including narcotics
- IV fluids
- Rapid infectious disease tests
- 12-lead EKG machine
- Nebulizer treatments, urinary catheters, sutures, staples, splinting materials
- WiFi and computers to transfer patient data

DispatchHealth works with mobile imaging companies and freestanding imaging centers to coordinate imaging studies when necessary.

Providers typically spend 45-60 minutes per patient. Maybe once or twice a week, the providers will see patients who will escalate to the ER, says Spain, who’s been a certified EMT for about four years.

The patient’s primary care provider and other care team members get a detailed report of the visit the same day. That report includes assessments of the home and medication compliance.

Mark Ryan, MD, a family physician in Richmond, has mixed feelings about urgent care in the home. “The primary care physician may not know there was an encounter at all until the communication from DispatchHealth comes in. As long as DispatchHealth is communicating with the PCP, there’s less risk, but there still is a risk of care fragmentation.” He’d prefer that DispatchHealth consult him before — not after — its provider sees his patients but realizes that “this approval step would undercut DispatchHealth’s business model.”

Whenever there’s a question about a patient’s condition, DispatchHealth will consult the primary care physician or subspecialist, says Stadler. And the care model, he says, didn’t raise any red flags when he considered joining the company. “Really, the only part that was in question was the malpractice insurance. But yes, DispatchHealth carries it. And yes, DispatchHealth carries the same malpractice insurance as if providers were in a clinical setting.

And yes, DispatchHealth uses experienced providers who are certified in emergency medicine and urgent care. Part of their training — before they’re active — is taking part in an intensive training program.

It’s worth noting as well that they’re full-time employees with benefits and not contractors. A nurse
practitioner or physician assistant always is paired with a medical technician, for their safety as well as better patient care.

Carrie Clemens has been a physician assistant since 2004, working for 12 years in emergency medicine and a few more in vascular surgery. She says she loves DispatchHealth’s care model and being able to spend more time with patients. “This is a necessity for so many people. They can’t get out. Many have no other options for care.”

But still ...

VCU’s Coombes understands the convenience factor but still has a few concerns as a potential patient. “Do you really want strangers coming into your home — and doing things to your body?” she wonders. “Who’s going to guarantee that they’re able to — or will — do what they’re supposed to do? What if they don’t catch a deeper-seated medical condition? There are certain efficiencies in hospitals where you can turn to someone and ask what they think. Will this be as efficient as brick-and-mortar context?”

Stadler, who reviews every patient chart every day, says that the caregivers are well-screened and well-trained, and the vehicles they drive carry supplies that give them greater capability than most urgent care facilities.

But he understands the concerns. “In medicine, there’s a lot of comfort in the known mechanisms and algorithms for how we do things. If I have a patient who comes into the emergency room for chest pains, I know the pattern of the orders that I’m putting in, and I trust that everything is getting done that way. Those mechanisms and algorithms exist in every specialty. When you interrupt that and introduce a change in medicine, there’s always a little bit of reticence and skepticism and scrutiny. And that’s something that we remain open to and we welcome to refine our model.”

Stadler thinks DispatchHealth is the wave of the future. “When you look with the patient’s perspective and needs in mind, it takes the selfishness out of anybody’s practice. This is all about the patient to get the right care in the right place at the right time. “There’s never a time when you can have a provider sitting at the bedside of a patient for an hour or more. We rarely have the luxury in clinical medicine to spend this amount of time with a patient face to face, treating their acute medical problem. It certainly doesn’t happen in my emergency room. It’s hard to argue with that.”

Lisa Crutchfield is a freelance writer in Richmond.

In 2017, DispatchHealth treated more than 10,000 patients in their homes, saving an estimated $25 million in unnecessary 911 transports, ER visits and hospitalizations. In 2018, the company expects to treat 55,000 patients and save more than $80 million.

DispatchHealth
I’ll start this article with a confession. I did not like social media. Actually, my first Facebook page was started by a good friend during a visit to her dorm at Georgia Tech during our freshmen year in college. Since I had not started it, I had no vested interest in using my Facebook page. Plus, I had no time to “play.” After all, I was going to be a doctor one day! So I allowed my Facebook page to remain minimally active except for a few rare posts through the years — college graduation, my wedding, match day and med school graduation.

I would have none of it. I had more important things to do — like reading medical journals and focusing on daily human interaction.

I continued my personal and professional resistance to social media until late 2014. After completing 26 years of formal education and training (which included a chief resident year because I’m an overachiever), I was officially tired. My medical school and residency years also included getting married (MS2) and having a baby (PGY3). And although I was finally about to start the medical career I’d worked my whole life for, I was on the verge of burnout.

But I did what a majority of well-trained medical professionals do. I ignored those feelings and kept working at the expense of my self-care. Finally at the end of 2014, I could ignore the warning flags no more. I was 40 pounds overweight and officially had obesity due to stress-eating and not prioritizing the healthy lifestyle I was advocating every day to my patients.

Finally, I realized that I would never shed my extra pounds unless I addressed my root problem: stress control. As a new mom and an attending physician, I had allowed both of those demanding roles to consume my whole life — leaving little room for the kind of creative outlets I needed to relieve my high level of stress.

At the encouragement of my best friend, Dr. Leslie Nwoke (@HeartWorkDoc), I tried using Twitter for weight-loss support. Now with an open mind, I was pleasantly surprised to find I actually liked Twitter! I also found that it was useful not only in my personal life but in my professional practice of medicine. I found that though Twitter is sometimes maligned, the social media service connected me with like-minded professionals and offered perspectives from individuals in different fields. Another pleasant benefit was hearing patient voices that would otherwise be filtered in the traditional medical setting.

At first I just “lurked” on Twitter. That is, I read posts without alerting anyone to my presence by commenting or liking the content. Over time I realized I wanted to contribute to the discussions. Initially, I used Twitter primarily to contribute to the discussions.

I found that though Twitter is sometimes maligned, the social media service connected me with like-minded professionals and offered perspectives from individuals in different fields.
for accountability on my weight-loss journey. I would tweet that I was going to exercise or eat healthfully and post when I did (or when I didn’t). My posts mirrored the comprehensive and holistic nature of my weight-loss journey that involved my faith, family, friends, fitness and healthy food. Apparently this formula resonates with others because as of this spring, more than 3,700 people are following me on Twitter. I truly feel as if I am making an impact on their lives by providing motivation and evidence-based medical information. Moreover, my use of Twitter and Facebook has allowed me to control my online reputation. I have several new patients who have selected me as their physician after “meeting” me on social media — further confirmation that our ways of meeting, interacting and connecting with each other have changed forever.

While my three years of social media activity have by no means made me an expert, I have learned several valuable lessons through my experience. I hope these are useful to other physicians who are apprehensive about using social media but who also recognize that it holds potential for their practices and careers.

Getting started in social media
Will you be using it for professional reasons?
There should always be a level of professionalism for physicians and healthcare providers. Do not share anything on social media that you will later regret. Once information is posted someone can easily take a screenshot which can be shared even if you delete the post. It’s best to think before you post.

Social media can be useful for networking with colleagues and other professionals, gathering current medical and other information. It is also beneficial for business promotion, branding and/or establishing expert status.

Will you be using social media for personal use?
Social media can be a good creative outlet and useful for making social connections.
Once you get comfortable with using social media, you can delve deeper into it by answering such questions as:

Will you be creating content?
If so what’s your message?
Based on your answers to those questions the next step is choosing which social media platforms you want to focus on. After all, there are now 37 platforms worldwide!

True, as doctors or other healthcare providers we clearly don’t have time to juggle all these platforms. Fortunately, you don’t have to be active on all of them. I’ve found that each platform has a different culture.

Dr. Kevin Pho, the leading physician social media expert, spoke at last September’s General Membership meeting. This leading voice for using social media in medicine advises physicians to start their professional social media profile by creating/updating their LinkedIn and/or Doximity profile. His book, “Establishing, Managing, and Protecting Your Online Reputation: A Social Media Guide for Physicians and Medical Practices,” is a detailed guide to using social media in health care.

Overall, using social media has been an enriching experience in my professional and personal life. And I think it’s safe to say it’s not a fad. I can attest to the fact that if it’s used effectively, social media can be a valuable tool in every physician’s toolbox. But like any tool, the key is understanding what you’re trying to fix or build. Then you’ll know how to choose the right tools to achieve that goal.

As Dr. Pho says, “As physicians we have possibilities available to use we haven’t even conceived. Don’t box yourself in.” So step out of the box, give social media a try. You may find it’s a personal and professional asset.

Dr. Gonsahn-Bollie practices Internal Medicine & Obesity Medicine at Bon Secours West End Internal Medicine. Follow her on Twitter @FITTMD or visit drsylviagbollie.com.
Hospital alert: What’s in your bylaws?  
(Four red flags signaling complications for your medical practice)

BY ELIZABETH “LIBBY” SNELSON

Medical staff bylaws lay the groundwork for medical staff operations, covering everything from who can join, to who can vote, to who can take care of patients in that hospital. Good medical staff bylaws keep everyone working well toward the same goal: quality care. But missteps and misdirection can create problem provisions that will complicate your practice and disrupt your professional life. Watch out for:

**Data Bank reporting triggers**

Physicians have worked under the threat of being reported to the National Practitioner Data Bank for nearly 30 years. Hospitals are still required to report their actions restricting doctors’ medical staff membership and privileges for more than 30 days, based on patient care concerns or any “surrender” of privileges or membership during an investigation or to avoid one.

Recent Data Bank changes exacerbate the threat. Now, hospitals are expected to report any interruption of practice — such as a leave of absence or a choice to drop a privilege — as a “surrender” if an investigation is underway. Since the Data Bank legislation does not mandate notice of an investigation, a physician may well have no idea she is being investigated when she takes leave to recover from surgery, only to find herself in the Data Bank.

The report would be required even if the investigation were swiftly resolved to find no problems or if it were unrelated to the privilege being relinquished. The information reported may have nothing to do with any patient care concerns whatsoever, serving no purpose as a record of the doctor’s professional competence or conduct. If medical staff bylaws do not provide clear parameters for what is and is not a “surrender” or what constitutes an investigation or do not mandate full disclosure when a member is under investigation before any “surrender” is effective, then the bylaws are operating to report more physicians.

**Systemwide bylaws**

Medical staff bylaws can be complicated, and medical staff bylaws that apply to multiple hospitals in the form of hospital systemwide bylaws can multiply the complexity. System rules, and the documents in which they are embodied, are created elsewhere, reflecting the priorities and profit expectations of a corporate structure having little familiarity with the community in which this single cog of a hospital exists.

So while uniformity may make for administrative efficiency, one size rarely fits all. Systemwide rules typically include systemwide disclosures so that a restriction imposed by one hospital in the system is shared and enforced in all system hospitals, clinics and other facilities, even if the basis for the action would not have resulted in a restriction anywhere else in the system. Medical staff bylaws might directly state that any restriction in any one facility will be spread throughout the system or might enable a systemwide effect by allowing application of system policies. This is the case even though the medical staff does not get to vote on them or even get notice of the policy’s adoption until it is enforced against its members.

**Board takeovers**

Medical staff self-governance has been the basis for preserving professionalism in hospitals practically since the concept of accreditation was invented. All medical staff bylaws include procedures describing how the medical staff governs and leads itself. But check that “elections” provision carefully — does the medical staff actually get to choose its leadership?

Nothing in federal or state law, or in Joint Commission or other accreditation standards, calls for the hospital board to play any role in medical staff elections of officers, department chiefs or medical staff committee members. Medical staff bylaws should not either.

Medical staff leadership needs to maintain sufficient independence to be able to account for the quality of care provided.

Medical staff leadership needs to maintain sufficient independence to be able to account for the quality of care provided. If the board controls the leadership, accountability is compromised. Look for bylaws requirements that subject medical staff leadership nominations or elections to “hospital board approval” — which, obviously, the board can withhold from physicians who do not match the hospital’s preferences in appearance, affiliation, politics or subspecialty.

Some bylaws even allow the board to control the medical staff’s
decision to un-elect its leaders by subjecting any medical staff recall vote to “hospital board approval.” More devious — harder to spot in the depths of the bylaws — is the one-two punch of provisions that, in one section, permit the board to remove the medical staff’s officers (for no reason whatsoever or for the broad reason of hospital preferences and interests) and, in a subsequent section, permit the hospital board to name new officers after removal.

Bottom line: Medical staff bylaws should not cede medical staff governance to the hospital board.

Hospital politics and policies

Hospitals are highly regulated and highly scrutinized as care providers, Medicare participants, accredited entities, employers, businesses and, in many cases, charitable entities. To meet its legal obligations, the typical hospital appropriately generates pages and pages of policies, many of which are based on an employment relationship. While hospital employment of physicians continues to increase, most physicians are not covered by the employment relationship, so a hospital policy that is enforced through an employment-based sanction does not fit physicians. The hospital cannot fire physicians who are not its employees.

Therefore, if the medical staff bylaws require the medical staff to comply with hospital policies, almost invariably a clash is created. Further, disciplinary measures that are not conducted under the medical staff procedures are outside of the peer review protections that could otherwise apply. Add to that the complication of Data Bank reporting (see “Data Bank reporting triggers”) and systemwide hospital policies (see “Systemwide bylaws”) and you can expect to suffer unnecessary and unintended consequences. Medical staff bylaws should not incorporate or apply hospital policies.

So look for these red flags, and don’t forget that the fine print could yield additional problems. Make sure your medical staff bylaws work for you.

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Four lessons from a young doctor

BY TOVIA SMITH, MD

My real continuing education is my patients — they walk through my door every day, ready to challenge me to be the best for them.

It’s not often that you can say your first “real job” was in the place you were born. It took me a while to return — college, medical school, residency and fellowship training — but in 2014, I started working at the same medical practice where my mother brought me into the world in 1980.

At Virginia Women’s Center, I’m a urogynecologist — that means I help women who have disorders of the pelvic floor or urinary tract and may need surgery. Over the past three years, working with many great patients has taught me many valuable lessons.

The first one starts with something as simple sounding as taking a patient history. This used to be a time-consuming process, but in the data-driven world that doctors work in today, I have to remind myself to slow down and listen — really listen — to my patients.

When you see your doctor, you often begin by providing a medical history, in which you’re asked to describe your health and why you’re seeking care. As a doctor, I could be tempted to lead the conversation with “yes/no” questions to get as much data as soon as possible. But this would be shortchanging my patients. It takes discipline to stop posing questions and instead make eye contact — and to let my patient do the talking. These moments help develop trust, which is one of the most powerful elements of the patient-doctor relationship. If the patient trusts me and gives me the chance, most often she’ll tell me exactly what I need to know to understand how to help her.

I once had a patient who suffered from an overactive bladder. After we met and talked for a while, it became clear to me that something else was bothering her. It turned out that her mother had a history of bladder cancer that caused immense suffering. “Could I have bladder cancer, too?” my patient asked.

I reviewed her lab results, which didn’t point toward cancer. I explained that screening for bladder cancer wasn’t indicated, and that such screening actually carried its own risks.

After we talked some more, my patient and her husband agreed that while we definitely would treat her overactive bladder, there was no reason to overreact with unnecessary testing.

Much of medicine falls into such gray zones. I thought the best thing to do was to discuss the situation with my patient, let her see all sides of the argument and bring in her husband so everyone would be on the same page. I think she appreciated my honesty, as well as my concern for her emotional and physical well-being.

But could I be sure that I did the right thing? I think about my father, a practicing cardiologist with an unparalleled work ethic. He always taught me that showing up, putting one foot in front of the other and remaining levelheaded can get you through tough times, and that doing so takes courage.

So that’s my second lesson. No matter what job you hold, having mentors to guide you and give you courage is imperative. In addition to my father, I was blessed to learn from female surgeons who offered fantastic care to patients and maintained some work-life balance. It was one of my mentors at the University of Virginia who persuaded me to pursue an OB/GYN residency and seek a postgraduate fellowship in urogynecology. She and others helped nurture my own commitment to patient care.

Looking back, medical school instilled in me not only knowledge and work ethic but a commitment to lifelong learning, which is a third lesson. Doctors must feel responsible for expanding their knowledge, and my real continuing education is my patients — they walk through my door every day, ready to challenge me to be the best for them.

That leads to a final lesson, one that might sound simple but really isn’t: keeping the focus on the patient.

Doctors today are constantly rushed and face many expectations that have little to do with our actual time with patients. In this era of corporate medicine, we deal with technology, facilities, medical records and compliance with state and national accreditation guidelines. So on any given day, I not only see my patients, but I must document extensively, participate in billing and manage staffing. Despite these responsibilities, I will never go wrong in putting the needs of my patient first.

So how will I know if I did the right thing? Maybe I won’t always know. But by leaning on my mentors and embracing new lessons — and really listening to my patients and placing their needs first — I have a fighting chance in the challenging but exceedingly rewarding profession of medicine.

Dr. Smith practices at Virginia Women’s Center. She can be reached at Tsmith@vwcenter.com. This article first appeared in the June/July 2017 edition of “Discover Richmond” in the Richmond Times-Dispatch. It is reprinted here with the newspaper’s permission.
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Study shows nurse practitioners and physicians face similar liability risks

BY DAVID B. TROXEL, MD, MEDICAL DIRECTOR, THE DOCTORS COMPANY

We analyzed 67 claims against nurse practitioners (NPs) that closed over a six-year period from January 2011 through December 2016. These written demands for payment arose in family medicine (FM) and internal medicine (IM) practices. To provide context, we compared the NP claims with 1,358 FM and IM claims that closed during the same time period. If a claim was against both the FM or IM physician and the NP, we eliminated it from this study to avoid counting the same claim twice.

We included cases that closed within the study’s time frame regardless of how the claim or suit was resolved. This approach helped us to better understand what motivates patients to pursue claims and to gain a broader overview of the system failures and processes that resulted in patient harm.

Our approach to studying these malpractice claims began by reviewing plaintiffs’/patients’ allegations, giving us insights into the perspectives and motivations for filing claims and lawsuits. We then looked at patients’ injuries to understand the full scope of harm. Physician and nurse practitioner experts for both the plaintiffs/patients and the defendants/nurse practitioners/physicians reviewed claims and conducted medical record reviews. Our clinical analysts drew from these sources to gain an accurate and unbiased understanding of the events that lead to actual patient injuries.

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Nurse practitioner or physician reviewers evaluated each claim to determine whether the standard of care was met. The factors that contributed to claims included clinical judgment, patient factors, communication, clinical systems, clinical environments and documentation.

Our team studied all aspects of the claims and, using benchmarked data, identified risk mitigation strategies that nurse practitioners and their physician partners can use to decrease the risks of injury, thereby improving the quality of care.

Limitations: We did not take the following state differences in NP scope of practice (SOP) into consideration because the number of claims in each category would likely lack statistical significance:

- In 23 states and Washington, D.C., NPs have full authority to practice independently. They can evaluate, diagnose, and manage treatment — including ordering and managing medications.
- In 15 states, NPs have reduced practice authority that requires a regulated collaboration agreement with a physician.
- In 12 states, NPs have restricted practice authority that necessitates supervision, delegation or team management by a physician.

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Most common patient allegations

When NPs worked in FM and IM practices, the three most common claim allegations against NPs accounted for 88 percent of their total claim allegations. The top three allegations in claims filed against FMs and IMs accounted for 89 percent of their total claim allegations.

The diagnosis-and medication-related allegation percentages were similar for both NPs and primary care physicians, while medical treatment-related allegations were more common for primary care physicians.

The adoption of the electronic health record (EHR) has negatively affected physician satisfaction and practice workflow. As a consequence, physicians are increasingly using medical scribes to untether themselves from their EHRs, enhance efficiency and reduce burnout. Patient satisfaction also increases with the use of scribes due to improved physician-patient interactions during office visits. A growing body of evidence indicates that NPs provide similar benefits; i.e., they provide high-quality patient care, with patient satisfaction scores similar to those of physicians — which allows physicians to see more patients and focus on those with complex management or diagnostic problems.

Increasingly, the growing need for primary care services will be filled by NPs, not primary care physicians. Subject to individual state regulatory guidelines, NPs may take patient histories; conduct physical examinations; order, supervise, perform and interpret diagnostic and laboratory testing; prescribe pharmacological agents; and render treatment. In 2017, there were approximately 234,000 licensed NPs in the United States, with 86.6 percent certified in primary care and 95.8 percent prescribing medications.1

Approximately 8,000 new primary care physicians enter practice each year. By 2020, it is estimated that about 8,500 will retire annually. As the number of primary care physicians declines, their services will increasingly be provided by NPs. An estimated 23,000 new NPs completed their academic programs in 2015 – 2016.1

It is projected that by 2025, physicians will represent 60 percent of the family practice workforce, and NPs will represent 29 percent (almost one-third).2

For these reasons, it is appropriate to review NP medical malpractice

“Risks,” continued on page 20
“Risks,” continued from page 19

claims and compare them with those of primary care physicians to see if any unique NP risk management issues need to be analyzed. Although this NP claims analysis is statistically limited by the relatively small number of NP claims, it shows that diagnosis-related and medication-related allegations are similar for NPs and primary care physicians — as are the final diagnoses in claims with diagnosis-related allegations.

Medical treatment-related allegations are more frequent for FM and IM, while patient assessment issues, patient injury contributing factors, patient injury–related diagnoses and injury severity are similar. The key differences are that NPs have lower claims frequency, and their medication-related and medical treatment-related claims have lower indemnity payments. The indemnity payments for diagnosis-related claims are similar for NPs and physicians.

An allegation of failure or delay in obtaining a specialty consultation or referral often occurred when an NP managed a complication that was beyond his or her expertise or SOP. The alleged failure to perform an adequate patient assessment often occurred when an NP relied on the medical history or diagnosis in a previous medical record rather than performing a new, comprehensive exam.

Many NP malpractice claims can be traced to clinical and administrative factors:

- Failure to adhere to SOP. Inadequate physician supervision.
- Absence of written protocols.
- Deviation from written protocols.
- Failure or delay in seeking physician collaboration or referral.

Many of these factors can be remedied if physicians are clear about the nurse practice laws and regulations within their state and they support the NP in providing care within the SOP. The quality program within the practice should monitor the practice of the NP to ensure compliance with the laws and regulations of that state.

References


David B. Troxel, MD, is Medical Director of The Doctors Company

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