Why I still love to practice medicine
by Mark B. Monahan, MD

These days, you read plenty about the stressors on medical practice: EMRs, insurance, malpractice, government regulations and articles suggesting that doctors are part of the problem — not the solution — with medicine in our country. The list goes on.

Speakers at a recent urology conference encouraged physicians to sit back and focus on the things that bring most of us joy in practicing medicine and to minimize those that frustrate and exhaust us.

For me, it is the human interactions and the healing that give me strength. It’s the patient who is grateful that he did not miss his vacation when we got his kidney stone removed urgently. It’s the wife who hugs me after her husband underwent successful removal of a renal cancer. It’s my family who, although disappointed at times that I work long hours, understand that it’s a calling to heal and not just a job.

As for minimizing the stressors, one of the conference speakers said, “For me, it is the human interactions and the healing that give me strength.”
basic scenarios when they come to see us, and each has its own challenges. These are outpatient care or elective surgery, care of a major medical problem such as cancer and, finally, emergency hospital care.

Let’s say our patient is insured with a high-deductible health plan. This situation, short of being uninsured (which is a whole different deal), carries the most financial risk.

First is the outpatient visit to a primary care doctor or to a specialist for elective surgery. If you go to someone in your network, your cost will typically be the contracted fee for the billed CPT code. The insurance company will pay the provider and hospital this fee, and you will be responsible for the deductible. Usually you can get some idea in this environment of what your out-of-pocket cost will be. When a patient comes to my office for a facelift consult, the last thing that is discussed by my cosmetic surgery coordinator is how much the procedure will cost. It seems to me that as physicians we should do this for any elective operation.

However, it doesn’t always happen. For example, I recently heard a fellow MD with a high-deductible health plan complaining of an experience his wife had with an orthopedic surgeon.

The family received a bill for $1,400 for knee X-rays. This was not the professional fee for reading the X-ray but the fee for taking the films. When the MD called about the bill, he was told that the charge was high because the films were done at the hospital and not in an outpatient setting, even though it had been ordered out of one of the health system clinics. This charge was a big surprise.

I recognize that transparency in cost for the treatment of a major diagnosis such as cancer is much more difficult, but it’s especially critical in two areas.

One is out-of-network providers. I know a nurse with breast cancer who needed specialized testing; there’s only one lab in the U.S. that can do it, and it’s out of her insurance company’s network. Despite the test having been preapproved, she received a very large bill and is still trying to get the insurance company to pay.

The second is how certain treatments, such as chemotherapy drugs, are viewed by insurance companies. Some newer drugs may be classified as experimental and may not be covered. These drugs can be very expensive, and patients must know this before treatment is rendered.

And then there’s the third situation, which grabs headlines: emergency hospital care. With a life-threatening condition such as major trauma, heart attack or the birth of a very premature baby, patients and their loved ones just want to save a life. Cost does not enter into the thinking until later. But then it can become a huge issue.

Anyone with one of these conditions and a high-deductible health plan is going to max out their deductible in the first few days of hospital care. Their insurance company then will kick in and cover the rest of their bill. That’s why we buy health insurance.

The major pitfall today for patients in scenario No. 3 is out-of-network providers.

Certain physicians in large hospital systems in central Virginia do not participate in all insurance plans. There are many reasons for this, and often it involves ongoing contract negotiations. Doctors have the right to negotiate these contracts, and these negotiations can influence the financial health of their practice. I have been caught up in some of these negotiations myself, and they can be quite contentious. It becomes unfair to patients, however, when they are caught in the middle.

I recently heard a compelling story from a nurse anesthetist who had a premature baby requiring two months in the neonatal ICU. The baby is now a thriving 4-year-old. A very good outcome, but because the NICU doctors did not participate in the family’s insurance plan, the stay was denied and the family received a bill for $700,000.

No one told them about this lack of participation before the birth (which the family planned for this specific hospital because of the likely need for NICU care). Their financial health was preserved only due to a Virginia law that made the baby eligible for Medicaid because of the 60-day NICU stay. Fortunately, Medicaid ended up paying the entire bill.

Medical care is very expensive and getting more so for most of our patients. We owe it to them to advocate for more transparency in what they may pay for their health care. Doctors should lead the way in this effort. It will never be as easy as getting your hair done, but the situation has to get better than it is now. And you don’t have to leave your doctors a tip!

Dr. Wornom practices at Richmond Plastic Surgeons and is the editor of Ramifications. He can be reached at lwornom@richmondplasticsurgeons.com.
Tovia Smith, MD; John Ward, MD; and Peter Zedler, MD.

Also at the MSV meeting, Dr. Hylton presented the Clarence A. Holland Award to Dr. Butterworth in recognition of his long outstanding efforts in advocacy and education on behalf of the practice of medicine in the Commonwealth.

And three annual superhero awards went to RAM members: Dr. Deal, Dr. Hazle Konerding and Suzanne Everhart, MD. The overall impact the Richmond Academy of Medicine has on the practice of medicine reaches well beyond the Richmond and surrounding counties. Its presence impacts the entire Commonwealth and, indeed, the nation. RAM members are well-represented at every level of organized medicine — from our local community to a strong presence on the national level at the AMA.

Another ripple on the national front was achieved by RYPE ‘N RVA, RAM’s initiative to foster engagement with the early-career and new to practice in Richmond members. It was recognized by the American Association of Medical Administrators group. One factor in the overall success of the Academy that is often taken for granted is its historical focus on those other than its members, its outward focus on the community at large. The Academy has much to celebrate in the accomplishments of its subsidiaries.

Access Now boasts more than 920 active medical volunteers who cumulatively provided in excess of $40 million in care since its inception to the most vulnerable in our community.

Honoring Choices Virginia, your Academy’s Advance Care Planning initiative, has established 45 active clinic sites across all three local health systems and trained more than 250 health care providers to be certified Advance Care Planning facilitators.

CCVS, your Academy’s nationally accredited credentialing service, continues to partner with local health systems and practices and now is a national company with clients from Washington state to Texas to Florida to New Jersey.

RAM Services Corporation, your medical society management company, serves nine other medical societies, giving your Academy the opportunity to help thousands of doctors across Virginia.

While each of these are outstanding accomplishments, they are not RAM’s greatest achievement. The biggest shout-out goes to our RAM members themselves, who every day dare to do their very best to practice the art and science of medicine, who take the extra time with a patient even though it throws off their schedule, who put in countless uncompensated hours because it’s the right thing to do, who mentor the next generation, who continue to learn and grow, and who fight on the advocacy front, who fight for patient access to care and services. Yes, the real Richmond Academy of Medicine heroes are its members, who every day make Richmond a better place to practice medicine and a better place to receive care.

Thank you for daring, thank you for your courage in action.

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, or via the Academy website, ramdocs.org.

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WINTER 2019

Editor’s note: The Academy had a great showing at the Medical Society of Virginia Annual Meeting in October. Nearly 30 RAM members discussed topics including surprise billing, firearm risk reduction, ways to improve insurance and billing, health care policy and other issues, all aimed at ensuring the best care for patients and protecting the practice of medicine.

Also at the conference, longtime RAM member Richard A. Szucs, MD, was inaugurated as president, and our own Clifford Deal, MD, became president-elect.

The following are excerpts from Dr. Szucs’ inauguration address.

As physicians, we have all been blessed and fortunate to be able to make our living helping people. We are members of an honorable profession created by those who went before us. It is our duty to give back and work to ensure that we provide the same or greater opportunities for those who come after us.

It is important for a leader to create a vision and at times question or challenge the status quo but not to get too far ahead of those they are trying to lead. Often incremental change is preferable to radical change.

I think one of the most important things for a successful leader is building relationships and working towards consensus. It is important to listen as much or more than we talk. I have seen countless examples of a good idea or plan becoming a better or even great idea or plan when others are allowed and encouraged to provide their input.

Although every generation faces challenges, I think it is fair to say the challenges facing physicians have never been greater. The change and pace of change in health care are daunting. The challenges come at us from all sides. While it is easy to think that the obstacles are insurmountable and we cannot make a difference, I would disagree. We must not give in or give up.

Richard A. Szucs, MD

Mark Hylton, MD, left, nominated John Butterworth, MD, for the Clarence A. Holland, MD, Award for outstanding leadership in advocacy. Butterworth was named winner at MSV’s annual meeting.

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The art of medicine
BY LISA CRUTCHFIELD BARTH

Arts and medicine partnerships aren’t new. Perhaps you’ve seen a harpist in an infusion center or noticed an art exhibit hanging in the hospital lobby or heard about patients with Parkinson’s using dance as a therapy. Creative arts therapies have been applied to health issues ranging from PTSD to autism, from medical education.

VCU announced last summer the creation of its Physician-Scientist in Residence Program, tapping RAM member John Nestler, MD, to lead it. With an international reputation for research on polycystic ovary syndrome and insulin resistance, several NIH studies under his belt, and as former chair of VCU’s Department of Internal Medicine, Nestler brings a passion for collaboration and a deep working knowledge of the university’s legacy as well as its current endeavors.

Nestler’s curiosity about arts in medicine was piqued when he heard his wife talking about a TEDxRVA talk featuring Amy Black, a Richmond artist who creates nipple tattoos for women who’ve undergone mastectomies. He began to explore other collaborations between art and medicine and was amazed when he realized how many already were happening at the university.

Meeting a need

Nestler identified a need for a central coordinator of the myriad programs at about the same time he was stepping down as department chair. He made some calls, and thus was born the physician-scientist residency. “I regard myself as a facilitator,” he says. “I can get people together to talk and brainstorm.”

Nestler’s vision is to create new collaborative and synergistic opportunities for trainees and faculty across the School of Medicine and School of the Arts, aka VCUarts.

With 38 VCUarts faculty members working with more than 24 health units, the time for the residency was right, says Sarah Cunningham, PhD, executive director for research and director of the Arts Research Institute. “What we have learned is that there is terrific activity happening, but people aren’t being strategic about it. There are no point people on campuses. We wanted to move existing collaborations to greater sophistication.”

Though he’s not an artist himself, Nestler immersed himself in all things art before the residency officially began in August. Now with offices in the VCUarts’ Pollock Building and in Sanger Hall on the MCV Campus, he seeks ways to enhance the practice of medicine. “I’m a researcher. I want to do what I do in the model of a research project so that we can objectively confirm the value of art in medical teaching and practice.”

He already sees a number of possibilities, such as helping alleviate physician burnout, improving caregiving, increasing community engagement and enhancing medical education, an area close to his heart.

It’s an important mission, says Peter Buckley, MD, dean of VCU’s School of Medicine. “We’re trying to improve patient-physician communication, which is so important. We’re enhancing interpersonal skills and empathy. This really puts our training of doctors more in tune with what patients need.”

“John has expanded partnerships in a way that we couldn’t have done on our own.”

~Sarah Cunningham
people are looking for in a physician: someone who’s not just talented with a stethoscope but well-rounded and holistic.”

In a press release announcing the residency, Buckley said that “the intersection between arts and medicine has the potential to be life-changing.” He credits Dean Shawn Brinker, Cunningham and other VCUarts administrators for their support of the initiative and for encouraging Nestler’s involvement in every department of the school.

A small body of research already shows how incorporating arts into the medical curriculum improves student training. In one study, first-year medical students enrolled in an arts-in-medicine course saw a spike in their capacities for personal reflection, tolerance for ambiguity and personal bias awareness. In addition, the ability to empathize and recognize different ways of thinking increased. Another study used an art intervention to train med students to be more astute observers of radiological images.

Benefits of art in patient care — in some instances — have resulted in shorter patient stays, fewer complications, less need for narcotics and, ultimately, a reduction in costs.

The new VCU residency is proving beneficial for the School of the Arts as well as for the School of Medicine. “We had so much happening that we needed someone from the medical campus to provide us with guidance,” says Cunningham, a former director of arts education at the National Endowment for the Arts.

“The intersection between arts and medicine, said several years ago in an interview, “In improv, like real life, you have no idea how someone is going to respond.”

And VCU has worked with Carnegie Hall program The Lullaby Project, in which expectant mothers in challenging situations (such as correctional facilities and group homes) get the chance to write and record a lullaby to enhance bonding with the newborn through music. Psychiatry professor Susan Kornstein, MD, and Cunningham are working to expand and develop the program, which had a pilot study at VCU.

One of the best-known and most successful collaborations has been VCU’s standardized patient program (Ramifications wrote about this in 2017). In VCU’s state-of-the-art simulation center, many theater faculty and students serve as “patients,” giving medical students a safe place to practice diagnostic and communication skills.

“Students have the opportunity to manage a difficult situation with no risk,” says Buckley. “All this is an effort to reclaim the humanity in medicine, to reach into the arts and technology and to provide a more holistic training.”

A variety of projects

One VCU sculpture graduate worked with associate professor of plastic and reconstructive surgery Jennifer Rhodes, MD, on several projects, some of which have been presented at major conferences in both art and medicine (including the World Society for Simulation Surgery). A recent project involved taking a casting of a woman who had undergone a unilateral mastectomy. Medical residents practicing reconstructive surgery were able to see the curves and folds and to better understand what women see when they look at their bodies.

In 2011, as VCU was preparing for its first-ever separation surgery on 3-year-old conjoined twin girls, VCUarts students were called in to participate with medical providers to ensure success both in and out of the OR. Fashion students created the first clothing designed for (and fully covering) their conjoined bodies, and occupational therapists designed a car seat. A sculpture student created foam models so surgeons could practice on synthetic skin before the operation.

Some medical residents have taken comedy improv classes to increase their listening and communication skills, and a randomized controlled study assessing the effects of improv training on the communication skills of medical students will be conducted this spring. Catherine Grossman, MD, associate professor of internal medicine, said several years ago in an interview, “In improv, like real life, you have no idea how someone is going to respond.”

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Looking to the future

“Once Nestler started talking to VCUarts faculty and administrators, he began to recognize ways to incorporate and expand other projects in the hospitals and the classroom.

Some involve using technology to treat patients, such as augmented reality where an operation can be practiced before the patient enters the operating room (a procedure recently used for a complex cardiac procedure at VCU). “These are first-generation things, like a sci-fi movie,” he says.

One initiative that’s particularly exciting to Nestler is expanding a project created by Department of Kinetic Imaging associate professor Semi Ryu, a successful pilot in which senior citizens shared their life stories via avatar.

“There’s scientific literature that reports that people will open up in the absence of a real person in the room,” says Nestler. “Semi heard incredible stories that those people had never told anyone in their lives. I wondered if this could be valuable in the treatment of patients in our palliative care unit.”

Nestler proposed the idea to
Egidio Del Fabbro, MD, associate professor and Palliative Care Endowed Chair, and Danielle Noreika, MD, associate clinical professor and medical director of Inpatient Palliative Services, and made some introductions. Everything clicked. “When we met Semi, we felt an instant connection between her work and ours,” says Del Fabbro. They agreed that the concept of using avatars to allow palliative care patients to express emotions, deep secrets and even family struggles could be beneficial.

“A lot of work suggests that when you’re able to express your emotions, even if they’re negative, it does provide relief,” says Del Fabbro. In addition to Ryu’s work with the elderly, Noreika sees it as a valuable tool for working with younger patients. “Technology is something they’ve already incorporated into their relationships,” she says. “We may find that it’s younger people who connect to it better.”

Buckley finds it somewhat ironic that technology — often accused of dehumanizing medicine — could be what brings back the humanity. “There are amazing technologies that might be helpful in training the very thing you’re worried about: communication skills and empathy.”

Other programs being developed or expanded include musicians performing in the metabolic chamber with Francesco Celi, MD, and music faculty member Susann Klein to study expended energy or repetitive strain injuries, and how to lessen physician burnout through the arts. Nestler is looking at ways to get sculpture students into the operating room for inspiration, or having graphic artists create at the medical center an entire semester’s worth of portfolios focused on medicine, science, disease and dying.

Nestler also assists with projects in the Arts Research Institute, making connections between artists and physicians and medical researchers, and developing research design for proposal development.

That’s something that the VCUArts believes will augment its already highly esteemed research projects. “Artists function with a different kind of methodology than physicians,” says Cunningham. “Physicians in medical research use individual data to make generalized claims, but arts research, the methodology tends to be an exploration of particulars — ideas, materials — that manifests itself through physical material or physical engagement or performative physical — like moving your body in dance.”

“This disjunct between the two disciplines is when you start to really spur questions you never thought of.” That’s the big thing that keeps Nestler excited about the initiative.

Enhancing student learning

Besides making connections and introductions, Nestler, in conjunction with assistant professor of internal medicine Megan Lemay, MD, and the chair of the Department of Art Education, Sara Wilson McKay, PhD, established a medical school elective that premiered this semester for M1s. Medicine, Art and the Humanities incorporates a transdisciplinary approach, bringing together various arts principles and techniques, with the support of arts and medicine faculty members. Modules include improv.

“Medicine,” continued on page 8

Avatars may help palliative care patients share emotions and stories. In the past, they’ve been successfully used with elderly patients.
training, cultural and racial sensitivity that includes a visit to the Black History Museum, creative narrative reflection, functional design and observation skills training at the VMFA. For the latter, art graduate students and medical faculty will lead medical students through various exercises designed to enhance powers of observation and attention to detail. The exercises also focus on the importance of perspective, examine common errors in critical thinking and promote empathy and humanity.

The Physician-Scientist in Residence pilot will be evaluated after its first year to see if and how to continue. But its supporters expect it to lead to more innovative research, better patient care and new ways to educate physicians.

“I think there are so many possibilities,” says Nestler. “Every day brings new ideas for collaborations between the two schools. We’re initiating conversations and finding opportunities.”

He’s certain that the residency will help reclaim empathy and humanity in medicine, while harnessing technology that can enhance the effort.

For Buckley, the program just makes sense in helping to develop the kind of doctors that patients want. Plus, there’s another bonus: “It’s not lost on me,” he says, “that I’m sitting in a building called the James and Frances McGlothlin Medical Education Building, [the result of] a wonderful donation from a couple whose other transformative donation was the new wing of the VMFA. There are so many natural synergies between arts and medicine.”

Contact Lisa Crutchfield Barth, RAM’s Director of Communications & Marketing, lbart@ramdocs.org or (804) 622-8136.

An animated simulation model gives surgical trainees the opportunity to practice breast reconstruction. Models such as this one have evolved from partnerships between arts and medicine.

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Virginia Cancer Institute
The unordered lab test: What to do?

BY RODNEY K. ADAMS AND JENNIFER BRENNAN

In sorting through accumulated e-mails and lab results on a Monday morning, you find an abnormal lab value. You don’t recognize the name as one of your primary care patients. The lab report does not indicate whether the patient or another physician has been notified.

What should you do?

Unfortunately, this scenario is all too common. If you have not requested or authorized lab tests and do not have a relationship with the patient, you are not legally obligated to act on the result.

However, you may feel a moral responsibility to notify the lab or facility that you are not the treating physician. But sometimes, it’s more complicated than that. If an abnormal lab value appears for a test you did not order — and because the law isn’t entirely clear — the burden might be on you to prove a lack of liability.

Consider these scenarios

If the lab was drawn in the ED and no physician-patient relationship existed, then you, the receiving physician, would not be obligated to act on the results. But if the abnormality puts a patient in a dangerous position, the ethically better choice — a noted order — would be to follow up with the ED to assure that the results go directly to the patient or the ordering physician.

In other words, while the ordering physician (such as one in the ED) would be obligated to follow up, this does not absolve you, the PCP, of all responsibility.

According to law, a doctor is not immune from liability if “the physician has reason to know that in order to manage the specific mental or physical condition of the patient, review of or action on the pending results is needed.” Virginia courts have not interpreted what this means. So it would not be surprising for a judge or jury to decide that you do have an obligation to act on an abnormal test as part of the overall care of your patient even if the patient didn’t come in for an appointment. The courts have not addressed the situation of a patient who intends to follow up with you from the ED but has not yet.

“Test,” continued on page 10

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South Hill Internal Medicine and Critical Care
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South Hill, Virginia 23870
(434) 447-2898

mcvphysicians.vcu.edu
When an abnormal lab result is received, whether you have ever seen the patient can make all the difference.

If a screening lab was drawn at a community event, it’s unlikely you would be liable for not notifying the individual of an abnormal result unless you have an existing physician-patient relationship or the patient asked for a consult.

If a consulting physician ordered the lab, it is a good bet that the consultant would be liable for not acting on abnormal results. However, this may not absolve the referring physician. It is not beyond the realm of possibilities that the abnormal results will be sent to you, the PCP. In that case, it is best to be proactive in responding to the results of any test you receive.

PCPs often find, much to their frustration, that a consultant has assumed that the PCP will manage the patient. Of course, it is preferable that both referring and consulting physicians are clear as to who is managing which conditions. Neither the physicians nor the patient will benefit from lab results that have fallen through the cracks.

If another provider ordered a lab study with which you are not familiar, that is beyond your scope of practice or for which you have no reason to believe that you are intended to notify the patient then you would have no liability for not reacting to the test result.

Just be forthright with the patient if you don’t know how to interpret the study and promptly refer your patient back to the consultant who ordered the test. Be sure to clearly communicate with the specialist that he or she needs to address the lab result. For example, an alternative medicine practitioner may order a study that is not commonly used by physicians. You could create liability for yourself if you attempted to interpret a study beyond your scope of practice.

The bottom line? When an abnormal lab result is received, whether you have ever seen the patient can make all the difference. If yes, it is better for you to follow up with the patient. If the results are abnormal enough to cause concern — even if you haven’t seen the patient — it is also advised that you notify him or her of the results.

Most important is that patients — whether yours or not — receive good care.

Rodney K. Adams, Esq., teaches health law at the University of Richmond Law School and the VCU Department of Health Administration. Jennifer Brennan is a third-year law student at the University of Richmond Law School.
RAM calendar

March 27, 2019
RAM Member Networking Social
Canon & Draw, 1529 W. Main St.
6–8 p.m.
Stop by on your way home to enjoy bites and beverages and to network with your RAM friends and colleagues. Open to all RAM members and a guest.

April 9, 2019
RAM Membership Meeting
Speakers: Wendy Dean, MD, and Simon Talbot, MD
Topic: Physicians aren’t “burning out.” They’re suffering from moral injury.
University of Richmond, Jepson Alumni Center
5:30 p.m. cocktails, 6:15 p.m. dinner, 7:15 p.m. presentation
Moral injury is often mischaracterized, portrayed as just burnout among physicians. But there’s a lot of more to it. Without understanding the difference between burnout and moral injury, physicians and patients will suffer the consequences of the stress involved in practicing medicine today.

May 4, 2019
RAMAF Physicians Got Fashion Show
The Hippodrome, 526 N 2nd St.
7 p.m.
Don’t miss the RAM Alliance Foundation’s Physicians Got Fashion Show fundraising event! Cheer on our very own local physicians as they strut their stuff on the catwalk to support local health-related beneficiaries including Access Now.

May 16, 2019
RAM Member Networking Social
Branch Museum of Architecture and Design
2501 Monument Ave.
6–8 p.m.
Stop by on your way home to enjoy bites and beverages and to network with your RAM friends and colleagues. Open to all RAM members and a guest.

June 15, 2019
RAM Summer Family Event at The Diamond
The Diamond
5:30–7:30 p.m., picnic buffet
6:05 p.m., game begins
Join us for an evening baseball game at The Diamond. Enjoy a picnic dinner, a visit from Nutsy and Nutasha, balloon creations and fireworks at the conclusion of the game!

RAM events

Welcome, new RAM trustees
RAM is pleased to have three new trustees on our Board this year. They are:

- Alice Coombs, MD
- Quinn Lippmann, MD
- Dawncherrie Walker, MD

2018 Top Finishers

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</tr>
<tr>
<td>16. Dr. J. Latane Ware</td>
<td>95</td>
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For other event photos, check out RAM’s Facebook page.

RAMgagement

We’ve talked the points, and the results of our 2018 RAMgagement Competition are in!

Topping our leaderboard with 145 points in 2018 was Owen Brodie, MD, moving up to the gold medal spot after finishing in second place last year. Finishing a very close second behind him was Walter Lawrence, MD, with 140 total points. Rounding out the medaling spots with 125 points was Hazle Konerding, MD. See the side panel for our 2018 top finishers.

The good news is that the competition started fresh again in January with a clean slate, so it’s anyone’s game to lead the pack in 2019. Remember, you rack up RAMgagement points for each RAM member event you attend. But the fastest way to tally up those points is to refer your friends. You’ll earn points for bringing a potential member as your guest to a member event (and extra points if that friend joins RAM). So go ahead and invite your colleagues to join you at our next events. When you do, it’s a win-win: They’ll thank you for the opportunity to get more connected with our medical community, and you’ll be on your way up the leaderboard for 2019!

Check out our list of coming RAM programs and RSVP now. We look forward to another friendly competition in the year ahead!

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!
Your RYPE ‘N RVA leadership team has lots of great ideas in store for 2019! The team is planning ways to provide resources (personal and professional) for our early-career and new-to-Richmond RAM members while keeping members engaged and connected with one another.

Look for more RYPE-focused social networking event opportunities (that are also family/kid-friendly), casual “meet-up” events to mingle and learn more about business of medicine-related topics that impact your practice, and a repeat of the Advocacy and Ales event in the fall. The group also will be looking into a RAM community service activity for members and their families.

Keep an eye out for these opportunities and make 2019 your year to become more involved! R

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‘One bad apple’

BY TIFFANY LONG

Most courts have recognized that a hospital has the duty to credential each physician on its medical staff.

While this response is accurate, it doesn’t do much to relieve frustrations or explain the importance and necessity of thoroughly vetting each applicant who wishes to treat patients in our community hospitals. I get it; the credentialing process can be lengthy and tedious. It is easy to overlook the value of ensuring that each provider who is approved to see patients is qualified and competent to do so.

We live in an extremely litigious society. Most courts have recognized that a hospital has the duty to credential each physician on its medical staff. A part of this process is ensuring each member is qualified and competent to perform the privileges granted. Failure to do so can leave the hospital directly responsible to the patient in the case of harm or injury caused by an unqualified or incompetent physician.

I think most of us understand that hospitals have a duty to investigate each applicant. The frustration comes from not understanding why each element is important.

Recently, while credentialing a physician assistant, we were unable to obtain references from any of the five individuals listed. After calling them directly, we discovered references weren’t responding because of competency and ethical issues involving the applicant. In another situation, we discovered from a professional reference that the applicant suffered from an anxiety disorder and had issues respecting boundaries.

While these individual situations may or may not have been a deterrent in granting hospital privileges, the hospitals did want to investigate further. In both situations, the applicant had not disclosed any of this information on the application.

Professional references

Let’s start with professional references. Uncompleted professional reference forms tend to be the items that frequently hold up a credentialing file. Physicians are busy, and it is hard to find time to complete and return. However, we glean a lot of good information from reference documents. It would be safe to assume that an individual would list only providers who are sure to give a glowing reference. Most times this is true. But as with everything in life, it is the bad apple that spoils the bunch.

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Hospital affiliations

Another frustration we often hear deals with verifying hospital affiliations. The purpose is twofold here. We are attempting to identify gaps in work history that may not have been listed on the application. Also, we are attempting to identify any adverse issues that may have occurred at the physician’s previous employment.

Recently, during the verification process, a CCVS coordinator discovered a discrepancy between the physician’s application and the affiliation dates verified by a hospital. On further investigation, we learned that the physician had been incarcerated...
for nearly a year. Again, the hospital wanted to review the circumstances in greater depth.

Medical staff professionals take pride in knowing their efforts have a direct impact on patient safety. By thoroughly reviewing an applicant’s information, we can uncover information that can potentially cause harm to a member of our community. The vision of the National Association of Medical Staff Services is to “ensure health care quality and patient safety.” The primary way we achieve this is through a systematic and rigorous credentialing process.

We get it: Organizing the paperwork — and turning it all in — can seem cumbersome and even overwhelming. But it’s an essential part of being a physician and knowing that you’re part of a community that values and ensures the best quality for all patients. R

Tiffany Long is the associate director for Centralized Credentials Verification Service (CCVS).
Physicians aren’t ‘burning out.’
They’re suffering from moral injury

BY SIMON G. TALBOT, MD, AND WENDY DEAN, MD

Physicians on the front lines of health care today are sometimes described as going to battle. It’s an apt metaphor. Physicians, like combat soldiers, often face a profound and unrecognized threat to their well-being: moral injury.

Moral injury is frequently mischaracterized. In combat veterans it is diagnosed as post-traumatic stress; among physicians, it’s portrayed as burnout. But without understanding the critical difference between burnout and moral injury, the wounds will never heal and physicians and patients alike will continue to suffer the consequences.

EDITOR’S NOTE:
Dr. Talbot and Dr. Dean will speak at RAM’s general meeting on April 9. This article is excerpted from one that appeared in STAT’s first opinion column in July 2018.

Physicians aren’t ‘burning out.’

Burnout is a constellation of symptoms that include exhaustion, cynicism and decreased productivity.

Burnout is a constellation of symptoms that include exhaustion, cynicism and decreased productivity. More than half of physicians report at least one of these. But the concept of burnout resonates poorly with physicians. It suggests a failure of resourcefulness and resilience, traits that most physicians have finely honed during decades of intense training and demanding work. Even at the Mayo Clinic, which has been tracking, investigating and addressing burnout for more than a decade, one-third of physicians report its symptoms.

We believe that burnout is itself a symptom of something larger: our broken health care system. The increasingly complex web of providers’ highly conflicted allegiances — to patients, to self and to employers — and its attendant moral injury may be driving the health care ecosystem to a tipping point and causing the collapse of resilience.

The term “moral injury” was first used to describe soldiers’ responses to their actions in war. It represents “perpetrating, failing to prevent, bearing witness to or learning about acts that transgress deeply held moral beliefs and expectations.” Journalist Diane Silver describes it as “a deep soul wound that pierces a person’s identity, sense of morality and relationship to society.”

The moral injury of health care is not the offense of killing another human in the context of war. It is being unable to provide high-quality care and healing in the context of health care.

Most physicians enter medicine following a calling rather than a career path. They go into the field with a desire to help people. Many approach it with almost religious zeal, enduring lost sleep, lost years of young adulthood, huge opportunity costs, family strain, financial instability, disregard for personal health and a multitude of other challenges. Each hurdle offers a lesson in endurance in the service of one’s goal which, starting in the third year of medical school, is sharply focused on ensuring the best care for one’s patients. Failing to consistently meet patients’ needs has a profound impact on physician well-being — this is the crux of consequent moral injury.

In an increasingly business-oriented and profit-driven health care environment, physicians must consider a multitude of factors other than their patients’ best interests when deciding on treatment.

Patient satisfaction scores and provider rating and review sites can give patients more information about choosing a physician, a hospital or a health care system. But they can also silence physicians from providing necessary but unwelcome advice to patients and can lead to overtreatment to keep some patients satisfied. Business practices may drive providers to refer patients within their own systems, even knowing that doing so will delay care or that their equipment or staffing is suboptimal.

Navigating an ethical path among such intensely competing drivers is emotionally and morally exhausting. Continually being caught between the Hippocratic Oath, a decade of training and the realities of making a profit from people at their sickest and most vulnerable is an untenable and unreasonable demand.

Routinely experiencing the suffering, anguish and loss of being unable to

“Physicians,” continued on page 16
Physicians deliver the care that patients need is deeply painful. These routine, incessant betrayals of patient care and trust are examples of “death by a thousand cuts.” Any one of them, delivered alone, might heal. But repeated on a daily basis, they coalesce into the moral injury of health care.

Physicians are smart, tough, durable, resourceful people. If there were a way to MacGyver themselves out of this situation by working harder, smarter or differently, they would have done it already. Many physicians contemplate leaving health care altogether, but most do not for a variety of reasons: little cross-training for alternative careers, debt and a commitment to their calling. And so they stay — wounded, disengaged and increasingly hopeless.

In order to ensure that compassionate, engaged, highly skilled physicians are leading patient care, executives in the health care system must recognize and then acknowledge that this is not physician burnout. The simple solution of establishing physician wellness programs or hiring corporate wellness officers won’t solve the problem.

What we need is leadership willing to acknowledge the human costs and moral injury of multiple competing allegiances. We need leadership that has the courage to confront and minimize those competing demands. Physicians must be treated with respect, autonomy and have the authority to make rational, safe, evidence-based and financially responsible decisions. Top-down authoritarian mandates on medical practice are degrading and ultimately ineffective.

We need leaders who recognize that caring for their physicians results in thoughtful, compassionate care for patients, which ultimately is good business. Senior doctors whose knowledge and skills transcend the next business cycle should be treated with loyalty and not as a replaceable, depreciating asset.

We also need patients to ask what is best for their care and then to demand that their insurer or hospital or health care system provide it — the digital mammogram, the experienced surgeon, the timely transfer, the visit without the distraction of the electronic health record — without the best interest of the business entity (insurer, hospital, health care system or physician) overriding what is best for the patient.

A truly free market of insurers and providers, one without financial obligations being pushed to providers, would allow for self-regulation and patient-driven care. These goals should be aimed at creating a win-win where the wellness of patients correlates with the wellness of providers. In this way we can avoid the ongoing moral injury associated with the business of health care.

Dr. Talbot is a reconstructive plastic surgeon at Brigham and Women’s Hospital and associate professor of surgery at Harvard Medical School. Dr. Dean is a psychiatrist, vice president of business development and senior medical officer at the Henry M. Jackson Foundation for the Advancement of Military Medicine.

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Cybersecurity insurance for medical practices — the basics

More medical practices are purchasing — or at least considering — an insurance policy to cover the substantial costs of a data breach. Medical malpractice policies often provide basic coverage for this threat. But many practices find their risks have grown to the point where they are looking to a stand-alone cybersecurity policy to better meet their needs.

Here’s an overview of what your practice can expect from a cybersecurity policy.

Coverages are typically split into two types — first-party and third-party.

First-party coverage addresses the costs and expenses your practice incurs from a data security or privacy breach event, such as the following scenarios:

- A physician comes to the office and logs in to the computer, but the screen goes blank and a message pops up claiming to have hijacked the data and demanding payment to get it back. The “extortion threat” section of a cybersecurity policy may assist with this type of breach. Professional experts hired by the carrier will contact the cyber criminals to attempt to get the data released, including possibly paying the ransom. The business interruption section of a cyber policy may provide reimbursement of lost profits during your downtime.

- A physician discovers her system has been hacked and worries that her patients’ personal health information may have been compromised. If you discover your system has been hacked, your carrier can provide data breach response services to work with your IT staff to ascertain what happened. If patient records are compromised, the data recovery and restoration section of your coverage could reimburse you to unencrypt, recover, restore, recreate or recollect data.

- The CEO of a company sends an e-mail to the CFO instructing the movement of funds into an account. The CFO makes the transfer, only to discover that the CEO’s e-mail was a spear phishing attack in which the email address was a clever fake, and those funds are long gone. Your coverage’s cybercrime section may cover the cost of the funds that were transferred. Employees who click on such phishing links could compromise your system. This section of your policy may also assist in those situations.

Third-party coverage provides protection from claims made against you by outside parties. Examples of such claims follow.

- It would not be unusual to have claims brought by regulatory agencies, such as the U.S. Department of Health and Human Services in the case of an alleged HIPAA violation involving a breach of patient records. Cybersecurity coverage for regulatory fines and penalties may allow for payment of fines on your behalf.

- If your practice accepts credit card payments and is not PCI-compliant (adhering to all the Payment Card Industry Data Security Standards), you could be subject to fines from the credit card companies. Policies with payment card industry coverage may provide payment for those fines.

- Some patients may bring claims against you for violating applicable privacy laws. The data security and privacy section of your cybersecurity policy may help in providing a defense and make payment to these claimants, if necessary.

- If you maintain a website or social media platforms, you might have a claim brought against you if someone believes your site or media content is defamatory or reveals private information about them. The cyber media section of a cybersecurity policy may provide coverage in this case.


David J. Eismont, ARM, is senior director of business development, The Doctors Company.
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RAM gears up for 2020

In 2020, the Richmond Academy of Medicine will begin a yearlong celebration of our bicentennial. We’ve come a long way since 1820, when 17 Richmond and Manchester physicians formed our organization and elected Dr. James McClurg our first president. By the time we incorporated in 1824, membership had grown to 24. Fast forward, and today our membership numbers top 2,500.

Over the centuries, RAM members have worked together to improve the practice of medicine and patient care (except perhaps, when two members, Dr. Branch T. Archer and Dr. Ottway Crump, disagreed on the best course of care for a patient, leading to a fatal duel sometime around 1840). During 2019, we’ll be looking back at some of RAM’s historic highlights, plus we’ll be looking ahead to 2020, with many exciting events capped off by a gala. Stay tuned for more information!

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