RAMIFICATIONS

RICHMOND ACADEMY OF MEDICINE 1820

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Stick a fork in me … I'm DONE!!!

BY JAMES G. (JIM) BECKNER
Executive Director

We're having a plague, flooding, locusts, social unrest and even a real firenado. We're walking the edge of a knife economically. And, just for fun, we're having an election accompanied by some of the most partisan, racist, classist, sexist vitriol I've ever witnessed. I've stopped asking what's next for fear of karma responding, "Hold my beer!"

Almost everyone with whom I speak is exhausted … and it shows. People are tired. They're overloaded, not just with the looming presence of a disease but with all that comes with it. More work, less pay. Clumsy technology. Child care and school. Science vs. partisanship. Profits over patients. Cabin fever. Fear of infection. Store clerks are being shot because they asked someone to wear a mask. Our families, our children, parents, grandparents and loved ones are at risk. Some are sick and some have died.

Tension is thick. Nerves are frayed. Tempers flare. Mouths engage while brains go blank. Rest eludes. At the time when we need community the most, it is harder than ever to achieve. Difficult but not impossible, yet more essential than ever. But how …?

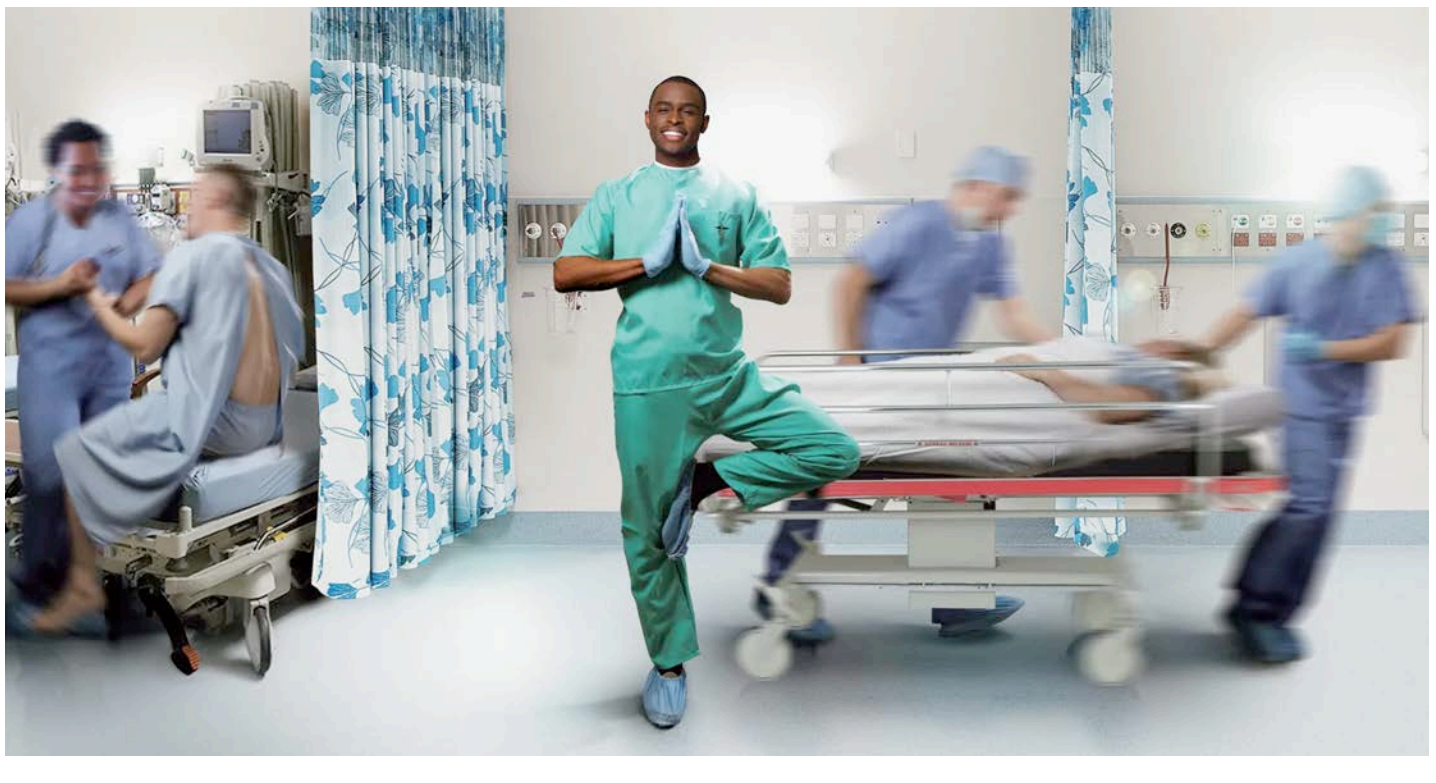
1. Make a point to use your cell phone and **take a picture every day** of something that brings you joy or makes you smile or warms your heart. Start a group to share your images, no comments or explanation needed. Just share a pic every day.
2. **Make a list** of five people whom you haven't heard from lately. Call or text or write a letter and just check in. Chances are you'll both be blessed. When you finish that list, make a new list.
3. **Get outside.** Walk the parking lot for five minutes. Sit on a bench. Walk

"Fork," continued on page 2

Physician burnout:

Have you seen it? What can we do about it?

BY CAROLYN A. BURNS, MD



Amid the COVID-19 pandemic, we in the medical profession must step back and take a good look at ourselves and our colleagues. The pandemic and all of the accompanying changes to our norm have increased our stress and anxiety significantly, possibly leading to burnout.

The many academic reports and studies on physician burnout seemed to become more numerous after the use of electronic medical records was mandated. Some feel that burnout is not a real thing, that rather we are suffering from moral injury.

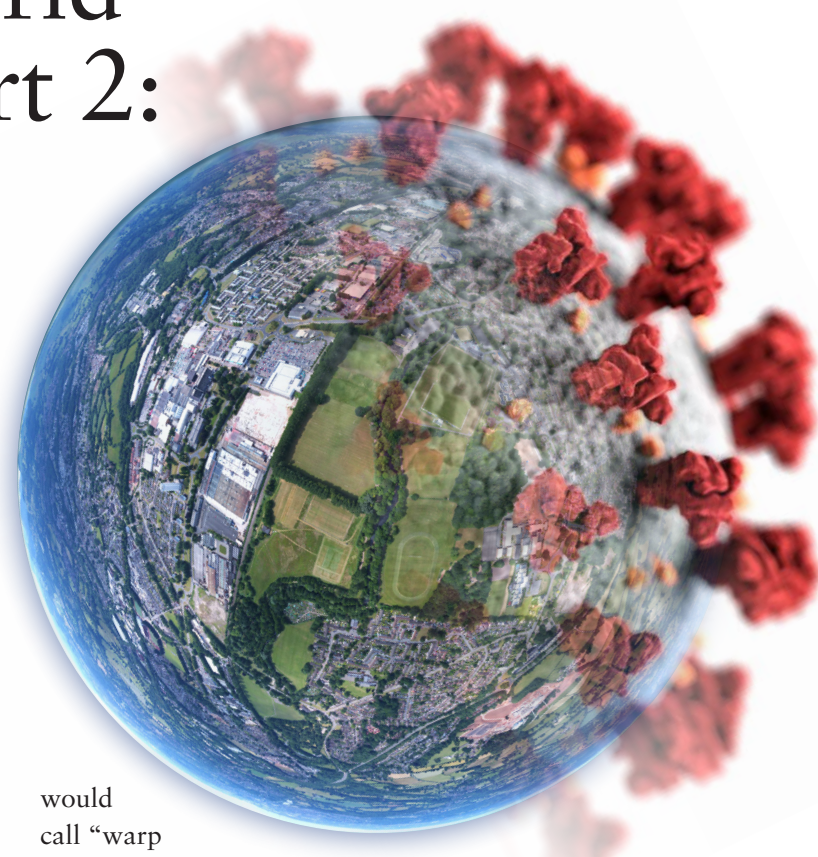
But scholarly evaluation of physicians, both in practice and in training, reports components of burnout among a significant percentage of physicians. First labeled by Freudenberger and then further defined by Maslach, burnout is described as "a chronic stress associated with emotionally intense work demands for which resources are inadequate."

"Burnout," continued on page 2

My, how the world has changed, Part 2:

What is happening to us and how will it end?

BY ISAAC L. WORNOM III, MD, FACS



Central Virginia, so far, has been spared the worst of COVID-19. When I last wrote, there was great uncertainty about what would happen here. That uncertainty remains, but it seems we are now in a position where our health care systems will not be overwhelmed.

With our community pretty much shutting down for two months from mid-March to mid-May, we flattened the curve and we slowed the spread of the virus. That is not necessarily true for the rest of the United States.

COVID-19 is still around, and there is still so much we do not know about the disease. Things we do know are that social distancing, frequent handwashing and face masks are really important to slow the spread. We also know that people with diabetes, obesity and older age are more likely to get sick if they catch it.

We do not understand yet why a few people become critically ill with the virus when their immune system becomes overactive, while others remain asymptomatic or have a mild flu-like illness.

We have no real treatment yet, although there are some drugs that help the critically ill recover. So far, the main treatment is supportive care until the body fights off the virus.

Fortunately, research on a vaccine is moving along at what one of my old heroes, "Star Trek's" Capt. Kirk, would call "warp speed." Large-scale trials of vaccines on patients began in July. There is hope we will have an effective vaccine late in 2020 or early in 2021. This would be a game changer, but many questions remain about efficacy, safety and how the vaccine would be administered. For you other Trekkies out there, my own opinion is that COVID-19 is not the world's Kobayashi Maru (a no-win scenario).

Back in mid-May, the moratorium on elective surgery was lifted by the governor, and health care in Central

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"Burnout," continued from page 1

Perhaps burnout is the result of suffering moral injury, an explanation offered by Dr. Gary Price, president of the Physician Foundation.

Burnout results in:

- Exhaustion (feeling used up at the end of the day)
- Depersonalization (treating patients as objects; being unable to connect)
- Reduced sense of personal accomplishment (feeling of ineffectiveness)

What burnout is not: fatigue, depression or job dissatisfaction.

In multiple studies, burnout affects as many as 40 percent to 50 percent of physicians.

The research tool for assessing burnout is the Maslach Burnout Survey, made applicable to medical professionals. Shorter surveys also have been used, looking at only the emotional exhaustion and depersonalization components.

Traditional thoughts as to why physician burnout is so high have included excessive workloads and work intensity, loss of control or autonomy and, of course, the time spent dealing with EMR requirements and documentation. It is also felt that burnout varies by specialty and type of practice (private practice is noted to be at increased risk of burnout). In addition, females are at greater risk of developing burnout than their male counterparts.

Now we have the added burden of a pandemic that is truly a once-in-a-lifetime health crisis. Physicians on the frontlines of treating patients with COVID-19 have faced many challenges. Initially, it was concern about the availability of PPE and ventilators and the lack of a treatment for the virus. As this plague continues, the stress of working in such an intense environment and the constantly evolving practice paradigm – in addition to the emotional strain felt by everyone as our lives are upended – are certain to add to potential burnout. Depression also has been seen.

What are we, as health care professionals, to do?

First and foremost, we must identify burnout in ourselves and our colleagues. There is help for individuals; significant support and possible adjustments from health care systems and private practices must also play a role. Given the passage of the "safe-haven" bill in the Virginia legislature last year, physicians can seek help and counseling without affecting their licensure.

Much of what is recommended in the literature as mitigation for burnout includes individual efforts at mindfulness, stress management, exercise and self-care. Also, in many cases, institutional and peer support and practice changes are needed.

You can look in the general literature or on YouTube for ideas to develop resilience and foster happiness in your life. I first heard of the "happiness" class at Harvard many years ago but was re-introduced recently during a talk on physician wellness by CJW CEO Dr. William Lunn.

The Positive Psychology class, taught by Tal Ben-Shahar, Ph.D., in 2006, became the most popular class on campus. He has written several books on how to increase one's positivity and happiness. One of his students, Shawn Achor, has become well-known for his contribution to positive psychology. His TED Talk about "The Happiness Advantage" has attracted more than 22 million viewers. The summary of his hypothesis is to train our brains to think more positively, which leads to a more engaged, fulfilled and productive life. Achor suggests five practices per day (which should become habit after three weeks):

- Three gratitudes each day
- Journaling a positive event daily
- Exercise
- Meditation to quiet the mind
- Random acts of kindness

I've been thinking a lot about the increased stress levels in these past months. I too have felt this, though I am not in the ICU caring for COVID patients.

I count myself lucky to work in the health care field. I know this stress has affected my routines and sense of well-being. I suspect many of you have likewise been affected. This is not meant to be negative: We are collectively experiencing stress, anxiety and even burnout, and we need to look after one another.

Through our advocacy, we can help to diminish burnout by changing things that are causing us frustration and feelings of disenfranchisement. I encourage you to look for ways to keep your hearts and minds in a positive frame. R

Dr. Burns practices at Virginia Cardiovascular Specialists and serves as RAM's president. She can be reached at cburns@ramdocs.org.

> "We are collectively experiencing stress, anxiety and even burnout, and we need to look after one another."

"Fork," continued from page 1

the dog. Breathe. Take a walk after dinner. Garden. Golf. Hike. Sit.

4. **Step away from the computer screen.** Literally. It will be there when you come back in five minutes, I promise.
5. **Connect.** Ask your patient a nonmedical question. Check in with your colleagues. Compliment your spouse. Read to your children. FaceTime or Zoom someone who is geographically distant.
6. Start a **virtual cocktail hour** with friends or create a virtual book club.
7. **Share stuff.** Cut flowers for a neighbor or coworkers. Bake or cook and share the fruits of your labor. Buy doughnuts for the office. Put a candy bowl on your desk. Send dinner to a neighbor or a shut-in. Share those extra zucchini!
8. **Engage.** Masks hide so much of our expressions and thereby cut off a large part of our communication. So be effusive. Say thank you to the curbside delivery worker. Wave. Be appreciative.
9. **Create You-Time.** Set aside at least 15 minutes every day and do something only for you. Read, meditate, walk, relax, enjoy a drink, eat a piece of fruit, listen to music. Unplug … literally and figuratively. Leave your cell phone in the other room over dinner.
10. **Count to 10.** When something pushes your buttons, stop. Breathe and count to 10. Ask yourself if what you are about to say or write will benefit the other person or will really make a difference. Type it, then delete it. Pledge to keep at least one partisan comment to yourself every day. Ask if your reaction is more about you or them. Self-examine. Hide THAT one Facebook friend for 30 days.
11. **Commit to doing something on this list or your own ideas every day.** Make a list or put it on a Post-It Note. Mark out time on your calendar. As Nike says, "Just Do It!"

You are healers. The world needs your leadership, your knowledge and your integrity now more than ever. Be generous. R

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.

"World," continued from page 1

Virginia gradually ramped back up. People are going to the doctor again, and operating rooms are again busy with elective surgery.

But your trip to the doctor or hospital is different than it used to be. Waiting rooms are pretty much kept near empty, all staff and patients wear masks and are screened for fevers, and social distancing is practiced except when touching is required for patient care. Telemedicine has remained part of many practices.

Since the ban on elective surgery ended, my own practice has become extremely busy very fast. I don't know if patients know they have time at home to recover, so they are finally having that lift or tuck they always wanted – or perhaps they don't like looking at themselves on Zoom – but many people are seeking out cosmetic surgery. My fellow surgeons and other doctors tell me that is true in other elective specialty areas as well.

Our community has begun to socialize again, albeit in very limited and different ways. Restaurants have much more outdoor dining space, and servers wear masks. Not all establishments have been able to adapt, and many have closed. Places of worship that are meeting in person are doing so outside or socially distanced inside with no hymnals or congregational singing. Weddings and funerals, when they happen, remain small affairs.

> "We have to accept the need for social distancing, masks and frequent handwashing, and we must not let fear of the virus overcome our lives."

In-person professional meetings and educational events have essentially stopped. Business is conducted virtually on Zoom or other internet platforms.

Your own Richmond Academy of Medicine has postponed until next year all the events that were to commemorate our 200th anniversary. Even though we are in Phase 3 in Central Virginia, where gatherings of up to 250 people are allowed, very few people are hosting or attending gatherings of this size.

Fear of catching the virus or spreading it remains prevalent. My daughter, Victoria, was married last month in Richmond. It was a small outside affair where social distancing was practiced in all ways. My brother, Tom, who lives in New York, and his wife Cathy made the heart-wrenching decision not to attend their niece's wedding. They had mostly been around only each other for the past months and were worried about the trip and the event – as well as having to quarantine for two weeks when they returned home. Such is life in the time of COVID-19.

Then there is school. Many colleges had students return to campus with some mix of in-person classrooms and virtual learning. Many tested their students prior to coming to campus or had them quarantine at home for two weeks prior to arrival.

Having college students practice social distancing to prevent spread of COVID-19 is a fascinating social and biologic experiment. As you read this, we will probably be hearing in great detail how it has played out. How this works may be the key to our world returning to normal … or not.

Parents and school systems also faced hard decisions. The conflict was between solid data that shows in-person school is better for children and the potential spread of the virus by children to each other, their families and teachers.

It seems young children are not at high risk for getting sick with the virus. But teachers, especially older ones and those with pre-existing conditions, are. While I am writing this, most of the school systems in Central Virginia have made the decision to start the year completely virtually with no in-person instruction. Most of the parents of young children I talk to are really struggling with the care and education of their children. Families without resources are struggling the most.

I suspect 2020-21 will come to be viewed as a lost year for many children who may well fall behind. I hope I am wrong.

Looking forward into Wornom's crystal ball, where will this end? The tea leaves I am reading say no time soon. I think we are going to percolate in our current situation with COVID-19 for the foreseeable future.

As a community, we are not meant to stay home. We have to accept the need for social distancing, masks and frequent handwashing, and we must not let fear of the virus overcome our lives. The pandemic has taken so much from us.

One of the strongest drives in human beings is the need to gather in social groups. I think we must figure out a way to do that again amid the ongoing presence of COVID-19. I hope we are up to the challenge. R

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

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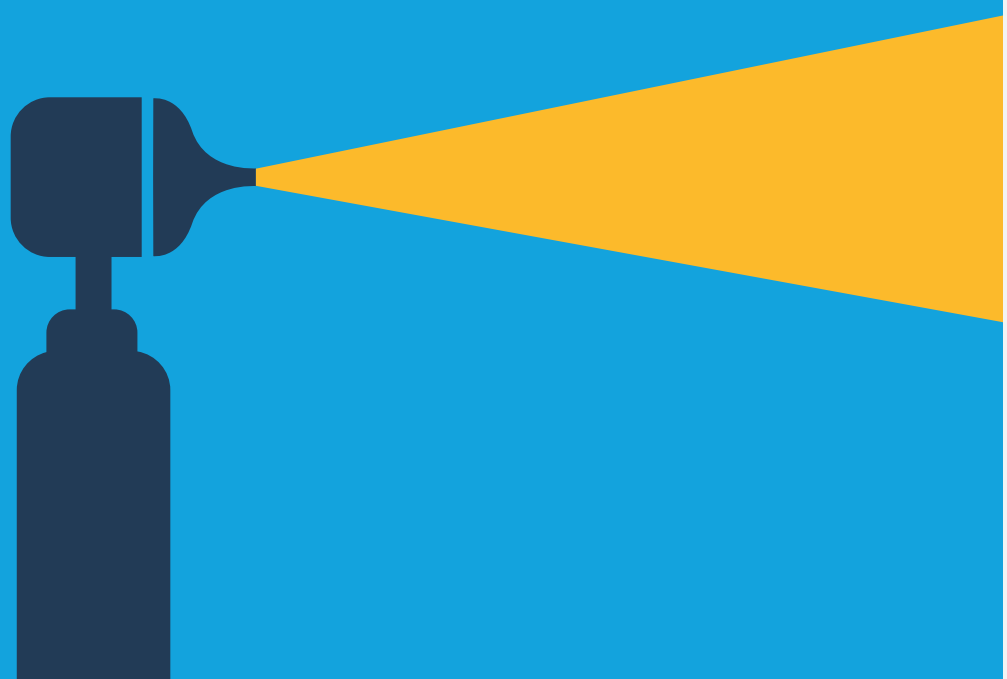

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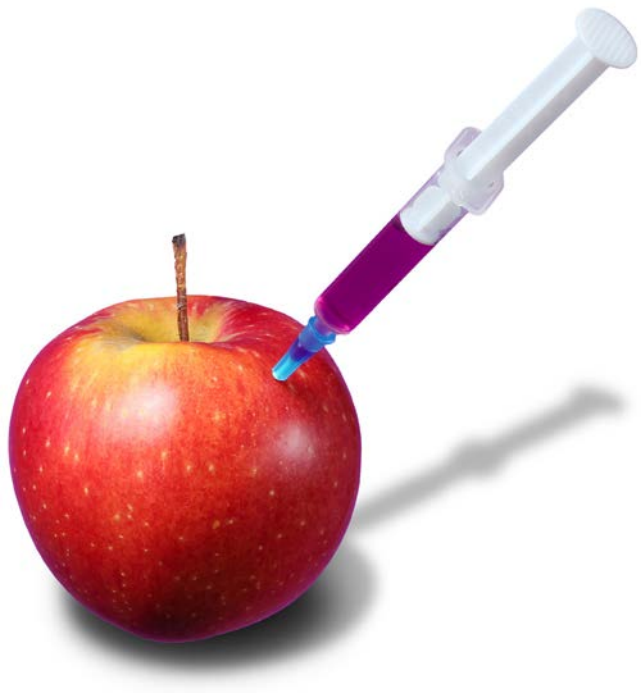
Medical students play a vital role during pandemic

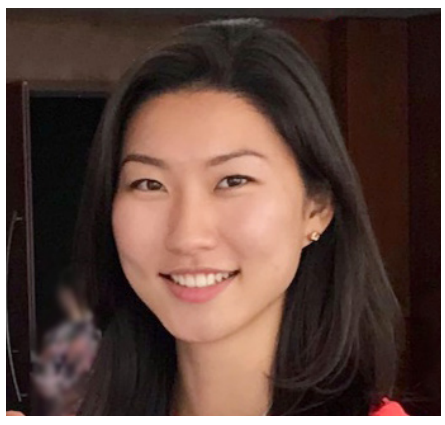
BY ALEX ROBINSON AND JIN K. KIM



Alex Robinson and Jin K. Kim are third-year medical students at VCU School of Medicine. Robinson is the recipient of the Richmond Academy of Medicine Endowed Scholarship.

Like their physician counterparts, VCU School of Medicine students were pulled into the COVID-19 pandemic this year, a world they never expected to experience. Here are stories from two students who learned a lot about medicine – and about the kind of physicians they want to become.

Jin K. Kim:



Jin K. Kim

"Can you hear and see me OK?" I shouted through my N95 mask and face shield at hundreds of patients in line for their free COVID-19 nasal swabs at a local high school. As a volunteer through the Virginia Medical Reserve Corps, I filled out intake forms for teenagers who should have been at prom and translated for the elderly who didn't speak English. I was limited in how I could help without a medical license and questioned whether I was making a difference from the sidelines.

My doubt quickly changed into confidence as I looked around at my fellow volunteers: teachers, students, retired medical professionals and friendly neighbors. We were united under the unknown of COVID-19 in volunteering ourselves to provide basic care for patients regardless of their citizenship status, language barrier or ability to afford care.

The patients sought reassurance and validation through my words while they waited in line for their test kits. In those moments, my own fears of the pandemic washed away, and I felt empowered by my ability to provide comfort to the patients, no matter my training level. After the preclinical years of didactic learning and months of remote classes due to the pandemic, seeing patients of various backgrounds allowed me to tap back into what brought me into medicine in the first place: to serve the community around me to the best of my abilities.

> "My own fears of the pandemic washed away, and I felt empowered by my ability to provide comfort to the patients, no matter my training level."
>
> – JIN K. KIM

Alex Robinson:

Alex Robinson

"Can you hear and see me OK?" I repeated from my apartment dining room table as I spoke with patients over the phone and while using telehealth software. Over the past few months, I have worked with Richmond physicians who graciously provided mentorship and guidance while allowing me to interview patients remotely, using telephone and video technology, as a third-year medical student. My opening phrase for telehealth encounters allowed me to quickly rule out technical difficulties and started to take on a new meaning as I have repeated it throughout the COVID-19 pandemic.

What about those patients who cannot hear or see me? What about the ones who still cannot participate in a telehealth visit due to a lack of internet access or a day off as an essential worker? What about those who face worsened food insecurities or who cannot get to the pharmacy or hospital safely? We know these barriers to care, and so many others, exist because we treated vulnerable populations before the pandemic. We also know some patients have worse health outcomes due to societal and health inequities that existed long before COVID-19 and have since amplified beyond what we could ever imagine.

While we care for our patients during this global pandemic and period of social and political upheaval, we are faced with the task not only to hear and see our patients through the camera used for telehealth but also to hear and see the circumstances in which our patients live. This includes acknowledging barriers to health care, patient values, goals of care and growing fears and concerns amidst a pandemic.

I am motivated to advocate for patients I have not yet encountered, as they still do not have access to the care they need. For me, this time has been an opportunity to reflect on health disparities, systemic racism and the need to continue to bridge the gap of health care inequity for all patients. As I slowly returned to the clinical environment, my first few shifts in the emergency department continued to remind me that we have quite a long way to go. I am eager to be a part of the future of change in medicine.

Learning and leading through both a global pandemic and a time of social change reminds us as medical students that regardless of the communication medium, we must hear and see our patients as a whole. Behind the computer monitor, masks and face shields, we need to continue to listen to the needs of our patients and communities. As medical students and physicians, we must collaborate through organizations such as the Richmond Academy of Medicine to improve health equity during this pivotal time. Our patients are asking, "Can you hear and see me?"

> "For me, this time has been an opportunity to reflect on health disparities, systemic racism and the need to continue to bridge the gap of health care inequity for all patients."
>
> – ALEX ROBINSON

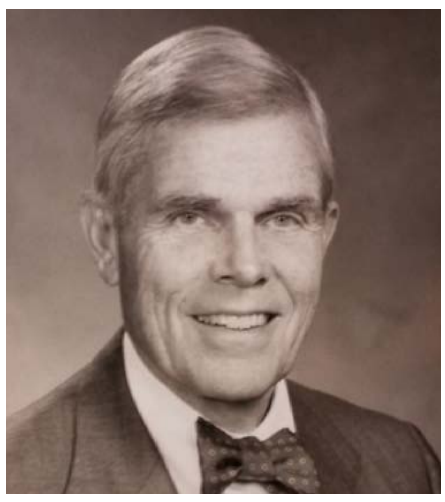
In memoriam

Professionalism

BY SHELTON HORSLEY III, MD

Editor's note: Shelton Horsley passed away in June after a distinguished career as a surgeon and teacher in Richmond. He was a mentor and role model to many. This column appeared in Ramifications in 1995 when Dr. Horsley was president of RAM. His words are as timely today as they were then.

— Isaac L. Wornom III, MD, FACS



J. Shelton Horsley III, MD

Professionalism comprises the conduct, aims or qualities that characterize a profession or a professional person. The doctor-patient relationship is firmly rooted in the ethics of character and virtue. There are several distinguishing characteristics of this professional relationship.

The first is the vulnerability of the patients who seek help. Someone who is sick is not able to pursue life's goals. As such, patients are extremely dependent on the physician.

The second is the inherent inequality of the professional relationship. The physician possesses the knowledge the patient needs to restore health. Therefore, the preponderance of power is in the physician's hands. It is hardly fair to consider this professional relationship as an equitable contract when patients are so dependent on the physician.

Third is the special fiduciary character of the professional relationship. Patients are in a vulnerable state, which forces them to trust the physician. On the other hand, patients are poorly equipped to evaluate the abilities of their physician. However, patients must bare their bodies, souls, personal lives and failings to a relative stranger in order to be helped. Clearly this is the request by the physician to trust him/her to use this information in the patient's best interest.

Fourth, the physician's knowledge is obtained to meet certain fundamental human needs. It should not be wholly proprietary. This is paramount in the training of medical students and house staff, which involves teaching with patients under supervision.

Fifth, the physician is the guardian of the patient's interest and welfare and responsible for the final recommendations and decisions regarding care. The physician must be the patient's advocate.

Finally, the physician is a member of the moral community "whose members share the privileges of special knowledge and together pledge their dedication to use it to advance health."[1]

"The very word profession comes from the Latin *profiteri*, to declare aloud, to accept publicly a special way of life, one that promises that the profession can be trusted to act in other than its own interest."[2]

Business people ask to be trusted, but not at a cost to themselves. *Caveat emptor* must never be the primary principle of our profession. R

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[1] Pellegrino, E.D., Thomasma, D.C., The Virtues in Medical Practice, New York Oxford University Press, 1993. Pages 155-157.
[2] Ibid.

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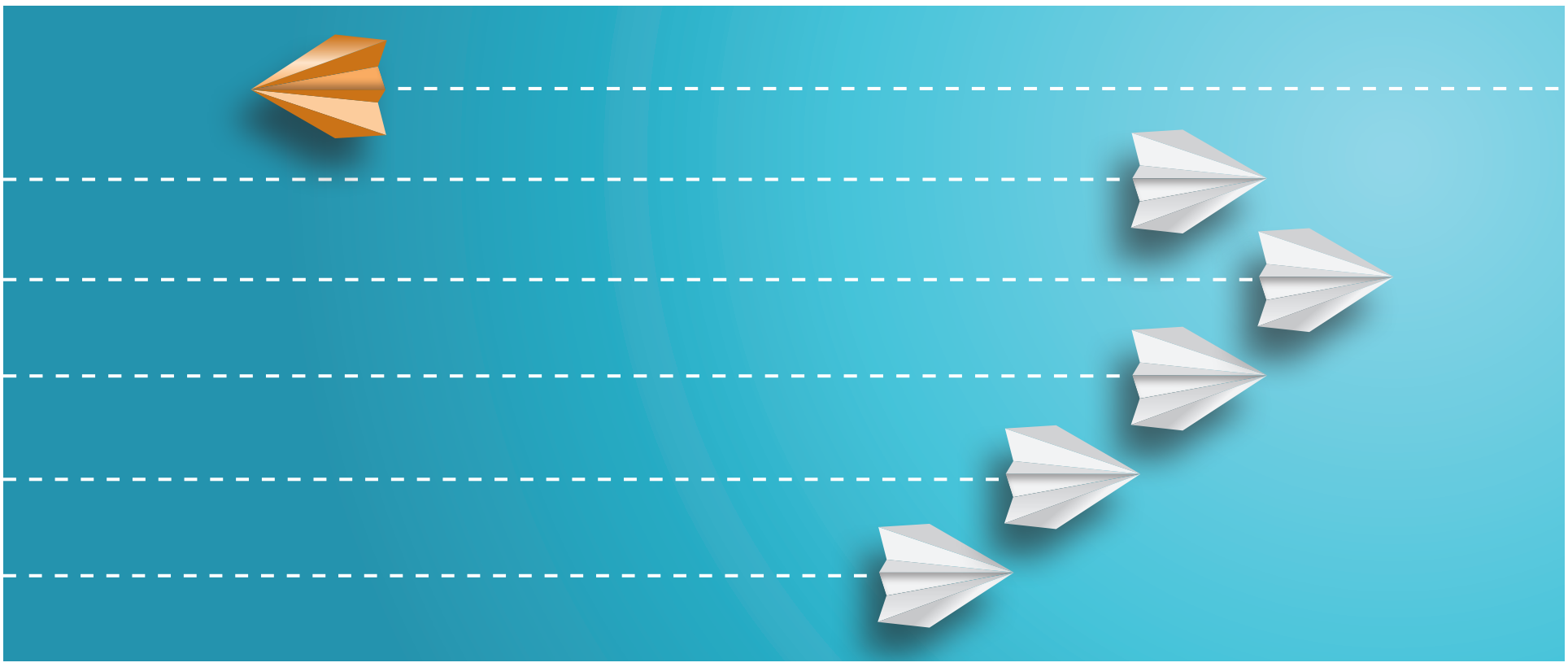
Paradigm shift:

A timely treatment for depression and suicide

BY PATRICK A. OLIVER, MD, FAAEM



Patrick Oliver, MD

In 2019, more than 16 million adults in the United States suffered from Major Depression Disorder – and that was before the COVID-19 pandemic started. Things have only gotten worse; recent data from the U.S. Census Bureau shows that approximately 36 percent of adults reported symptoms of anxiety or depression during the week preceding the survey.

Doctors are at even greater risk. Studies have suggested that suicide rates for male physicians is 40 percent higher than among men in the general population, and that rate skyrockets to 130 percent for female physicians.

Nearly 25 million adults have been taking antidepressants for at least two years, up 60 percent in the past decade. Furthermore, commonly used medications take at least two weeks to reduce symptoms.

Fortunately, an old drug is being used as a new treatment with robust results, when we need it most.

Receiving little fanfare in the times of COVID-19, a national recession and an impending presidential election, the FDA recently approved esketamine (Spravato) nasal spray to treat patients suffering from MDD with acute suicidal ideation or behavior. Multiple studies have shown that ketamine infusions in subanesthestic doses can decrease suicidal symptoms within hours, with effects reaching six weeks of decreased suicidal thoughts from a single 40-minute infusion.

Twenty years ago, Yale University published the first ketamine study that showed a rapid decrease of depression symptoms within hours to days, as opposed to weeks or months with more conventional oral antidepressant medications. While not completely understood mechanistically, ketamine is both an NMDA receptor blocker and an AMPA receptor agonist. National Institutes of Mental Health research has shown that treatment with ketamine infusions has increased glutamate levels and decreased GABA levels in the amygdala, the emotional center of the brain.

This novel approach to this neurobiochemistry of treating depression has also resulted in increased activity of G proteins in the neurons that result in increasing the dendritic spines amongst the neurons, effectively increasing interaction and signaling among the adjacent nerves.

The results are nothing shy of the foundation to a transformative paradigm shift as to how we approach MDD, mood disorders and suicidal thoughts and actions. We're moving from a "talk to someone" approach to a neurobiochemical medicinal approach to rapidly treat the disease process at the molecular level.

These results have shown approximately 70 percent response and 37.5 percent rate of long-term remission, versus placebo, with six infusions of IV ketamine, which is approaching 99 percent bioavailability. When combined with an oral antidepressant, esketamine nasal spray, with approximately 48 percent bioavailability, showed a 37 percent increase in symptom remission above oral antidepressant alone.

Esketamine nasal spray requires eight treatments in the first month, then weekly treatments for the next several months. Alternatively, after initial infusion protocols, booster infusions of ketamine are necessary only on an as-needed basis, with a mode of 30 days.

In 2017, the American Psychiatric Association published a consensus statement on the use of ketamine in the treatment of mood disorders. A year later, Johnson & Johnson's Janssen Pharmaceutica received FDA approval for Spravato to treat MDD, defined as failing two trials of oral antidepressant medication of adequate dosage and duration. On July 31 of this year, the FDA added a second indication for treating MDD with suicidal ideation or behaviors.

Administration of Spravato must be performed under a physician's care in an office or medical facility. Unfortunately, as of this printing, neither Medicare nor Medicaid covers this treatment or its administration. Nor do most commercial insurance companies.

This paradigm shift is timely, as our psychiatric resources are taxed as never before. The nine inpatient psychiatric units in Virginia hospitals have been operating at greater than 90 percent capacity over the past four years and have often been at more than 100 percent capacity. This leads to patients being held in crowded emergency departments around the Commonwealth, awaiting transfer and admission while not getting the care and attention they need. Unfortunately, neither esketamine nasal spray nor ketamine infusions are presently administered in any of these facilities.

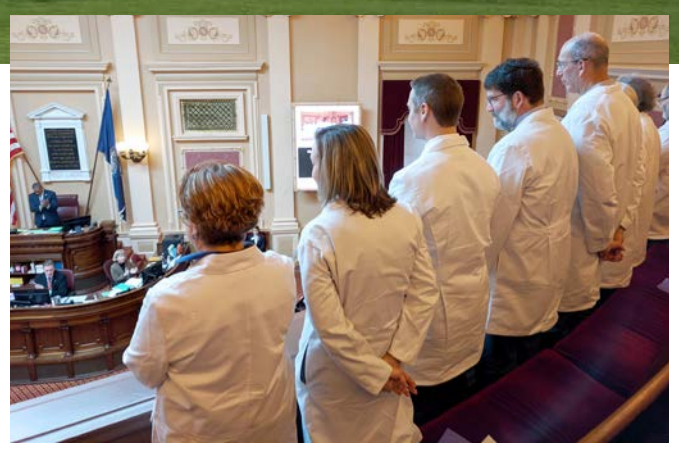
> "We're moving from a 'talk to someone' approach to a neurobiochemical medicinal approach to rapidly treat the disease process at the molecular level."

Given the stresses of life in 2020, it is imperative that we consider this new and promising therapy for improving our treatment of MDD, mood disorders and acute suicidal ideation-afflicted patients. R

Dr. Oliver is the founder and medical director of MindPeace Clinics (mindpeaceclinics.com), which has locations in Arlington, Norfolk and Richmond.

2020: a recap of health care legislation in Virginia

BY JAMES PICKRAL



Each year, RAM members visit the General Assembly to lobby for the House of Medicine.

James Pickral

In the 2019 elections, Democrats garnered the majority of Virginia's House of Delegates as well as its Senate. Democratic leadership was clear that it planned to pursue its top policy priorities right away. And it did exactly that – with the legislature passing bills that brought sweeping reform and a change in policy to most issues.

These included independent redistricting, gun safety measures, an increase in the minimum wage, collective bargaining for state employees, marijuana decriminalization, passage of the Equal Rights Amendment, rolled-back restrictions on reproductive health care services, driving privilege cards for undocumented immigrants, no-excuse absentee voting and many more.

Even with all of the issues debated this year, health care was still a priority. Here are some of the big issues we saw:

SURPRISE BILLING

Legislators were determined to resolve the issue of "surprise billing" for patients who go to an in-network hospital but receive care from an out-of-network provider. The physician community introduced bills identical to a 2018 proposal that applied only to emergency services. The health plans had bills that would have implemented a fee schedule based on the plans' in-network rate or 125 percent of Medicare (whichever is lower) for both emergency AND non-emergency services. We were successful in defeating the health plans' fee schedule, but legislators and patient advocates insisted we address both emergencies and non-emergencies.

A proposal was then offered based on the Washington state model, which applies to emergencies and non-emergencies services at an in-network hospital IF the services involve surgical or ancillary services and are provided by an out-of-network provider. After researching this proposal and discussing with our physician colleagues in Washington, we determined it was a good option for physicians and certainly better than other proposals on the table. The physician community supported this new bill, and the legislature passed it unanimously. The bill contains the following components:

- Providers will be paid a "commercially reasonable amount" that is undefined, so there is no benchmark that can then impact in-network payments.
- For the purposes of arbitration and for determining the "best offers" for the baseball-style arbitration, a data set will be created based on commercial health insurance claims (excluding Medicaid and Medicare) and will be prepared using the All-Payer Claims Database in collaboration with providers and health insurers, for use by providers, facilities, insurers and arbiter. The data set will include:
  - Median in-network allowed amount
  - Median out-of-network allowed amount
  - Median billed charges

The bill includes "baseball-style" independent dispute resolution and takes patients out of the middle of the billing process. It is also a huge win for us in that it doesn't put a benchmark in the Virginia Code and allows the arbiter to consider physician charges when determining a fair payment.

PHARMACY BENEFIT MANAGERS (PBMs)

The General Assembly passed legislation this year, signed into law by the governor, that will require licensure for Pharmacy Benefit Managers under the Bureau of Insurance. PBMs will be regulated and more oversight of their business practices will be provided.

CERTIFICATE OF PUBLIC NEED (COPN)

COPN reform continues to be a hotly debated issue at the General Assembly. The governor and secretary of health and human resources had convened a workgroup to try to find consensus between the different stakeholders but were unable to come up with consensus legislation. However, some of the stakeholders introduced their own bills, including physicians. Legislation would have created an expedited review process for specific projects and amended the charity care conditions to require that certificate holders accept some type of mix of Medicaid, Medicare or Tricare patients. Not surprisingly, the hospitals opposed this and it died in the Senate. The hospital association introduced its own bill consisting of process and administrative reforms. This bill passed the General Assembly and has been signed by the governor. A relevant stakeholders workgroup has been formed to assist in implementation.

PHYSICIAN WELLNESS

Recognizing the importance of promoting physician wellness, the Medical Society of Virginia made it a priority during the 2020 Virginia General Assembly session. We are pleased that the legislation passed unanimously and was signed by the governor. The bill will help address the physician burnout crisis by allowing the creation of a peer-to-peer wellness program among health care providers. Many physicians in Virginia fear seeking help; if a physician has disclosed personal mental health concerns to a coworker or employer, that person is legally required to report the physician to the Board of Medicine.

This new legislation will remove roadblocks to allow for early intervention. The wellness program – modeled after Lawyers Helping Lawyers – will provide confidential support services where physicians can receive 24/7 counseling from peers and behavioral health professionals. The Medical Society of Virginia worked with the Virginia Trial Lawyers Association to ensure that the bill does not jeopardize the state's existing disciplinary process but, rather, allows physicians to receive the support they need, when they need it.

SCOPE OF PRACTICE

As usual, there were multiple bills this year regarding the scope of practice of other health care professionals:

Pharmacists

Legislation was introduced this year that would have expanded the scope of practice for pharmacists and naturopathic providers. As originally introduced, the bill (the Senate side of which was sponsored by Sen. **Siobhan Dunnavant, MD**), would have greatly expanded pharmacists' scope of practice and allow them to provide vaccinations, test for the flu, strep and UTIs and perform other services for which some pharmacists will require additional training. The physician community strongly opposed the bills in that form due to significant patient safety concerns. The patrons worked with the House of Medicine to come up with a compromise that stripped many of the provisions that physicians felt were harmful to patient safety. A workgroup has been formed to take a closer look at the provisions that were removed.

Certified Registered Nurse Anesthetists (CRNAs)

Legislation that would have provided prescriptive authority to CRNAs was introduced this year. The physician community opposed the original form of this bill, although there was overwhelming support among legislators. After working with patrons and the Virginia Association of Nurse Anesthetists, we were able to successfully limit the bill to apply only as part of the periprocedural patient care. The bill also maintained physician supervision of CRNAs, so a supervising physician can choose not to allow the CRNA prescriptive authority. Once the bill was amended, the physician community took a neutral stance. The legislation passed both houses and has been signed into law by the governor.

Naturopaths

The bill (the Senate portion of which was sponsored by Sen. J. Chapman Petersen, MD) would have given naturopathic providers licensure and allowed them the title "naturopathic doctors." These bills were defeated; the Virginia Department of Health Professions will conduct a study on whether licensure is considered necessary.

IMMUNIZATIONS

The physician community had a big victory this session with the passage of a bill that will ensure the list of mandated vaccinations for school entry is science-based and not subject to politics. It brings Virginia's list in line with the current CDC Advisory Committee on Immunization Practices recommendations by adding vaccines for rotavirus, meningitis and hepatitis A as well as HPV for boys. The most important component of the bill is that it allows the state Department of Health to add future vaccinations to the list without approval from the General Assembly.

As we look forward to the 2021 General Assembly session, we are likely to see legislation relating to scope of practice, telemedicine and more reforms of the insurance and pharmaceutical industries. As these issues develop, we will keep you informed. R

James Pickral is a founding partner at Commonwealth Strategy Group.

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RAM Calendar

Please note that these dates and events may change as we work to ensure the safety of our members.

DATE	MEETING/LOCATION/TIME
October 27, 2020 Tuesday	Webinar: *Who's Caring For the Caregivers in This COVID Pandemic?* *6 p.m.* Wendy Dean, MD, will speak about how the COVID-19 pandemic is affecting physicians – and what we can do about it.
November 10, 2020 Tuesday	Webinar: *The Health Effects of Climate Damage* *6 p.m.* Join Michael S. Donnenberg, MD, senior associate dean for research and research training and professor of Internal Medicine at the VCU School of Medicine, to learn how greenhouse gases contribute to rising temperatures, why greenhouse gases are increasing, how rising temperatures impact human health in Richmond and what you can do about it for your patients, yourself and family, your community and the planet.
December 13, 2020 Sunday	*RAM Family Night at the GardenFest of Lights* 1800 Lakeside Ave., Richmond, VA 23228 *5-8 p.m.* $20 per family Get into the holiday spirit at the GardenFest of Lights at Lewis Ginter Botanical Garden. Tour the gardens and visit with your family in this most festive setting! Thanks to CCVS for sponsoring.

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!

2021 is the new 2020

Well … you may have noticed that 2020 didn't turn out quite the way we planned.

We're looking forward to 2021, as RAM will belatedly celebrate our 200th anniversary. You can bet that our 201st anniversary will be even better!

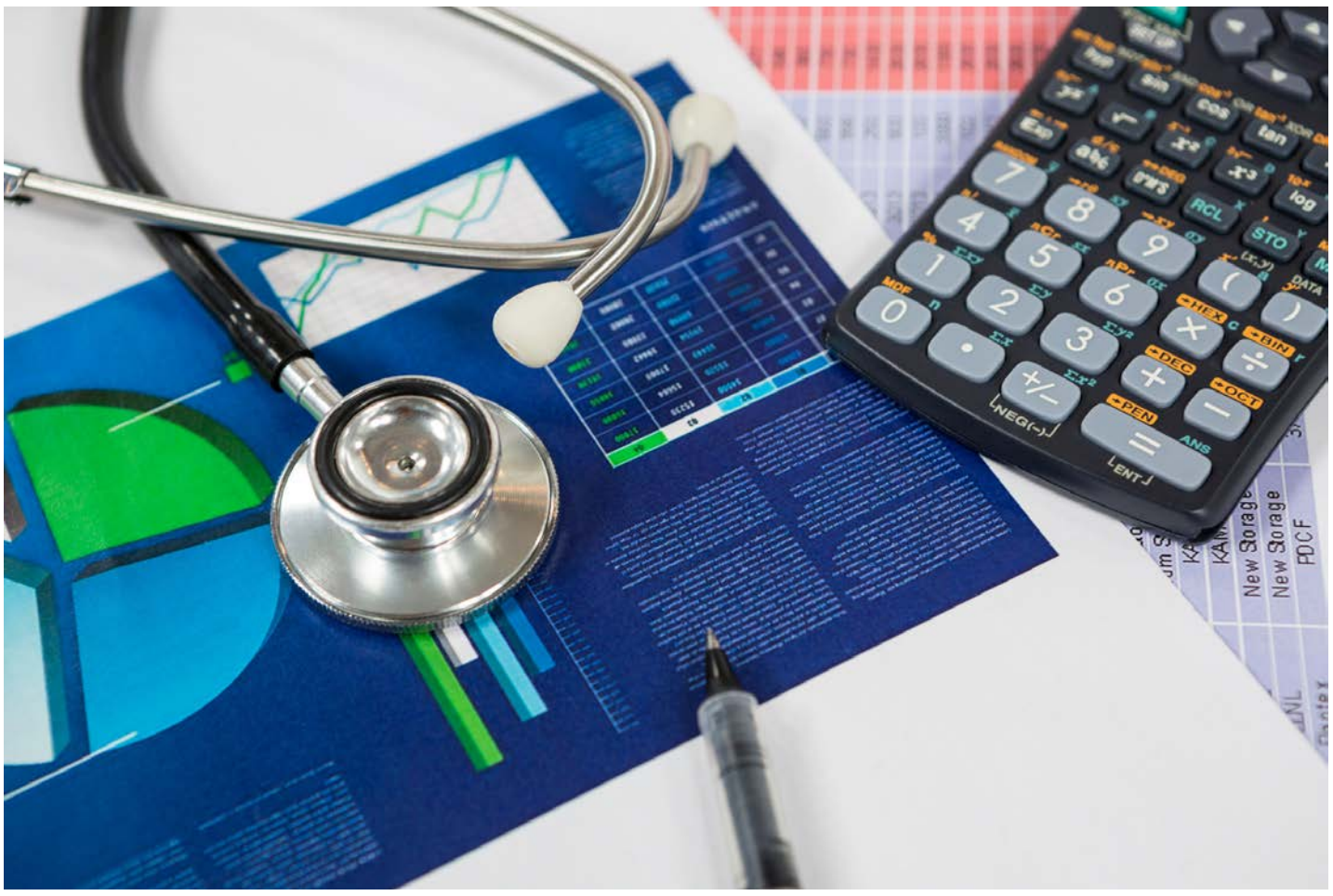
From our first meeting by candlelight in 1820, Academy physicians have been the patient's advocate, the physician's ally and the community's partner. We're hoping to celebrate throughout 2021 with events rescheduled from earlier this year.

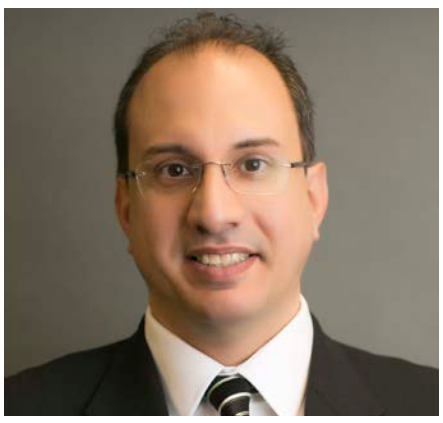
Look for a video presentation on the history of the Academy, a look at the future of health care with renowned medical futurist Daniel Kraft, MD, and of course, the gala celebration.

We'll keep you updated!

Business of medicine, a new language

BY DAVID GALPERN, MD





David Galpern, MD

The business of medicine is not taught in medical school. But it should be.

It is not taught in residency or fellowship. But it should be.

I am here to shed some light on some basic concepts to help you run your business.

The business of medicine is spoken in a language. Like any language, you should know or learn the vocabulary. Once you understand the vocabulary, you should practice it by talking to your fellow physicians. As with meetings on clinical issues, your knowledge and understanding will only grow by talking to your peers. And as your knowledge grows, so will your bottom line.

When we make life-saving decisions, we are expected to shy away from the finance side and do what's best for our patients. That is paramount, but remember that this is how we support our families. You should make sure that you are getting every dollar or RVU you have earned.

Here are some tips:

- We should all review the CPT code description to make sure we are billing accordingly. When I reviewed it, I was shocked to see what was not included in some of the codes. This meant I had to bill additional codes to properly record and get reimbursed for ALL of my work.
- Undercoding can be just as dangerous as overcoding. Many physicians have told me they would rather get paid a little less than worry about an audit. The issue comes up that if you undercode a visit, that can be seen as a kickback to the patient. That is as dangerous, if not more so, than overcoding.
- A great way to learn some basic vocabulary is to take CMEs designed to teach you the business of medicine. I have taken a few at my society's annual meeting and enjoyed talking and practicing the language.
- You are responsible for your coding in the eyes of CMS. We all use coders and rely on their expertise. However, if you are audited and there is an issue, you will not be able to say, "my coder chose that code." Since you are responsible for your codes, you should verify that they are correct.

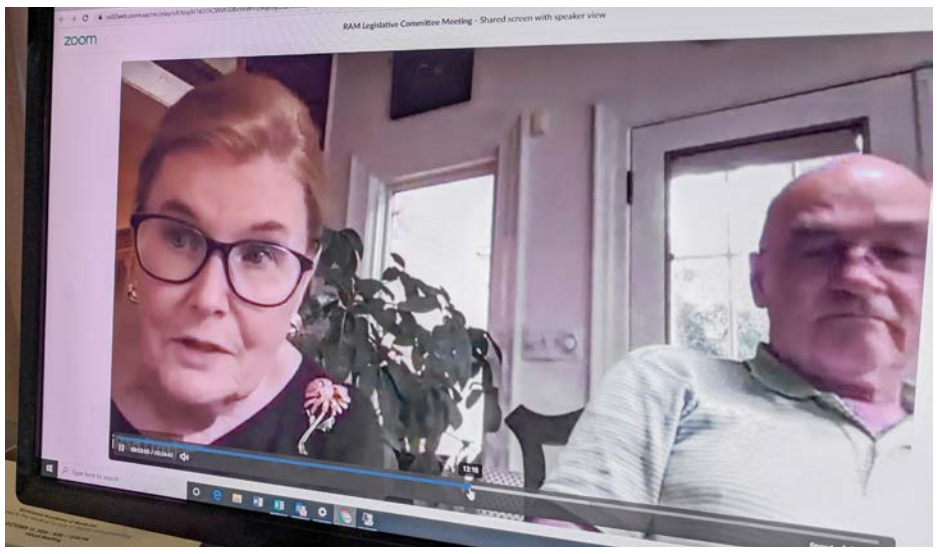
Just like any language, you won't become fluent overnight. But with attention and practice, you'll find that your business runs smoother and you'll gain more revenue – and more satisfaction – from your work. R

Dr. Galpern is a board-certified hand and upper-extremity surgeon who is the founder and medical director of the Comprehensive Hand Surgery Center.

Events

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!

RAM's Women in Focus group managed an in-person meeting before the pandemic shut down such events.

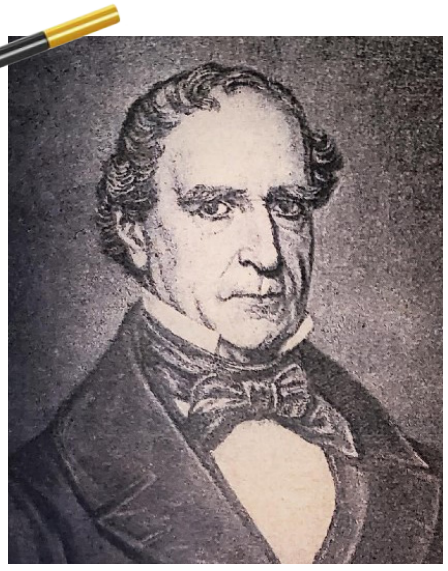


Drs. Hazle and Karsten Konerding participate in a virtual Legislative Committee meeting.

Virginia Secretary of Health and Human Resources Daniel Carey, MD, speaks to RAM members on a webinar in July.

A medical hat trick

BY WARREN KOONTZ, MD



Beverley Wellford

Hunter Holmes McGuire

Percy Wootton

A hat trick, according to Merriam-Webster Dictionary, is "a series of three victories, successes or related accomplishments." One well-known hat trick is a single player scoring three goals during a hockey game.

Members of the Richmond Academy of Medicine have performed a few medical hat tricks during our 200-year history: Three Richmond physicians served as president of RAM, the Medical Society of Virginia and the American Medical Association.

Changing times, changing names

Our Academy has existed since 1820, but we've had a few name changes over the years. Here's a timeline to clarify any confusion.

1820 Medical Society of Virginia established by 17 Richmond and Manchester physicians

1852 MSV became a statewide organization

1852 Medico-Chirurgical Society of Richmond established

1881 Richmond Medical and Surgical Society established (as rival to Medico-Chirurgical Society)

1890 Richmond Academy of Medicine and Surgery (merger of the two rival societies)

1900 Richmond Academy of Medicine (RAM)

Beverley Randolph Wellford

Born in 1797 in Fredericksburg, Beverley Randolph Wellford received his medical degree from the University of Maryland in 1816. He first practiced with his father, Dr. Robert Wellford, in Fredericksburg, but later moved to Richmond to become the chair of Materia Medica and Therapeutics at the Medical College of Virginia. He was the first president of the newly formed state society (which took the name Medical Society of Virginia after RAM's predecessor discarded the name). That year, 1852, the American Medical Association met in Richmond and Wellford was elected president of the organization. During this time, he was also president of Medico-Chirurgical Society of Richmond. During the Civil War, he oversaw a hospital in Richmond. Wellford died in 1870 and is buried in Hollywood Cemetery.

Hunter Holmes McGuire

Hunter Holmes McGuire was born in 1835 in Winchester to a prominent eye surgeon. He received his medical degree at Winchester Medical College in 1855. When the Civil War started, he joined the Winchester Rifles as a private but soon was made brigade surgeon and ordered to report to Gen. Thomas "Stonewall" Jackson, whom he treated twice for gunshot wounds (the second wound led to the general's death). After the war, McGuire returned to Richmond, where he joined the faculty at MCV. However, he later branched out to found his own institution, the University College of Medicine. He was a founder of the Medico-Chirurgical Society of Richmond and served as its president in 1881. He also became president of MSV in 1881 and president of the AMA in 1893. McGuire died in 1900, but his name is familiar to Richmonders; the Hunter Holmes McGuire Veterans Administration Hospital is named in his honor, and a statue of him was placed on the capitol grounds in 1904. He is buried in Hollywood Cemetery.

	RAM	MSV	AMA
Dr. Beverley R. Wellford	1852*	1851-52	1852-53
Dr. Hunter Holmes McGuire	1881-82**	1881-82	1893-94
Dr. Percy Wootton	1976-77	1981-82	1997-98

** Medico-Chirurgical Society of Richmond*
*** Richmond Medical and Surgical Society*

Warren Koontz, MD

Percy Wootton

Percy Wootton was born on a farm in Nottoway in 1932. Wootton received his undergraduate degree from Lynchburg College (now the University of Lynchburg) in 1953 and earned his medical degree at MCV in 1957. Following an internship, he served in the U.S. Navy as chief of the medical service at Naval Operating Base (now Naval Station Norfolk). Wootton returned to MCV for residency training in internal medicine under Dr. W.T. Thompson (who served as RAM's president in 1972). This was followed by a fellowship in cardiology under Dr. Reno Porter. Wootton became interested in organized medicine early in his career, a calling fortified by an inspirational speech made by MSV President James D. Hagood at his MCV graduation. Wootton served as president of RAM in 1976, MSV in 1981 and the AMA in 1997. RAM members will know that he rarely misses a meeting! R

Dr. Koontz is a retired urologist and former president of RAM.

Richmond Academy of Medicine
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