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Together … we are stronger

BY JAMES G. (JIM) BECKNER
Executive Director

PHOTO BY BRUCE HONG

The Delta variant rages, people are dying and choice politicians are putting party above the lives of the people they represent. Meanwhile, hospitals and ERs and ICUs bulge and frontline providers struggle to keep going through what was a totally preventable surge.

I cannot imagine the depths of their fatigue and frustration. Heroes, yes. Invincible, no. Shame on us.

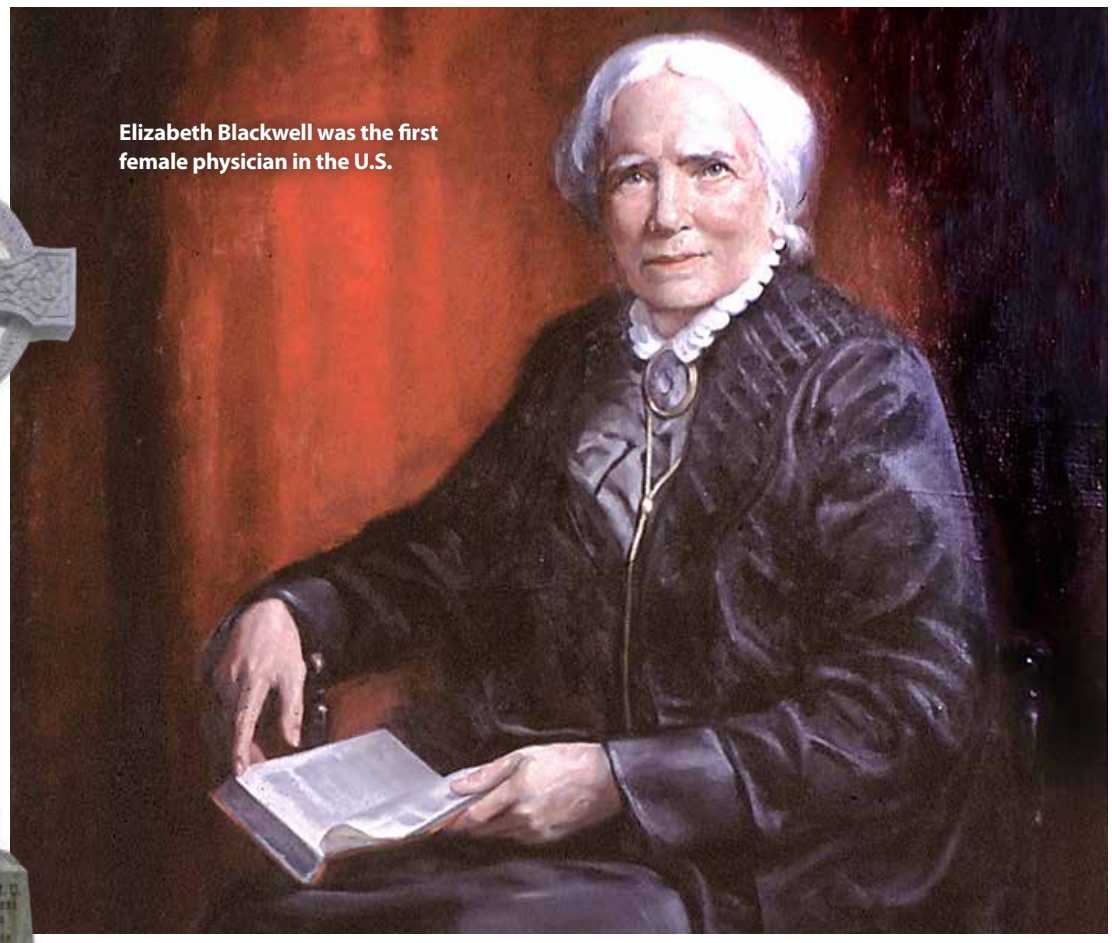
There are times when words fail and thoughts do not come. In those times I often turn to the quietness of the garden or the beauty of music for inspiration and solace. On occasion, I bumble into something that speaks to my core, that voices my heart, that screams my frustration, that plays my vision better than I could ever write. This is one of those times.

Take a moment to sit in front of your computer or iPad (not your phone, it's too small) and Google "together for king and country." What will pop up is a video of the group For King & Country performing "Together," a song written in 2020 in response to COVID. Enlarge it to full screen so you can read the signs that appear throughout. Watch it (a few times), even follow along with the lyrics that show up below it. Let the notes and voices and visuals wash over you.

"Together," continued on page 2

Reflecting on diversity in medicine

BY CAROLYN BURNS, MD



Elizabeth Blackwell was the first female physician in the U.S.

PORTRAIT OF ELIZABETH BLACKWELL BY JOSEPH STANLEY KOZLOWSKI, 1963.

A biography I just completed is on my mind. The book, "The Doctors Blackwell" by Janice P. Nimura, lends some insight into the trials and tribulations of two of the remarkable women who opened up the field of medicine to the "other half."

I've long known that Elizabeth Blackwell was the first female physician in the United States, but I did not fully understand her journey, nor that she was joined by her sister, Emily.

With great courage and insight,

"Reflections," continued on page 2

Mentoring and the future of medicine

BY ISAAC L. WORNOM III, MD, FACS

PHOTO BY ZOE SCHAEFFER

The Richmond Academy of Medicine turned 200 last year. One of the ways an organization makes it to 200 is by nurturing future leaders. This does not happen by accident but requires intentional purpose, work and time. One does not immediately become president of an organization like RAM. There is always a time of prolonged service on the board of directors before that commitment is made. RAM has had the good fortune to be led by many talented men and women over its 200-year history.

How does one end up in medicine? What leads one to become a leader in organized medicine? I think our mentors have a lot to do with the answers to these questions.

I had the good fortune to have several good mentors in my schooling and training. Probably the most important was Maurice J. Jurkiewicz, MD, or Dr. J for short. Dr. J was the chief of plastic surgery at Emory University, where I learned my craft.

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"Reflections," continued from page 1

both sisters sought out their own education from open-minded men in the profession. There were no open doors. Medical education was not well formalized in the 1840s and certainly did not include women on any front. Women typically served as midwives and had little training.

But the pioneering Elizabeth Blackwell systematically searched for places to learn where she would be accepted. Postgraduate education was also an "on your own" affair. She traveled to England and Paris to achieve a majority of her education. Her sister followed in her footsteps a few years later.

While serving in a maternity hospital in Paris, Elizabeth was exposed to purulent ophthalmia from an infant born to a mother with gonorrhea. She lost an eye as a result.

Together, the Blackwell sisters, having managed to obtain a substantial education, gained the admiration of many of their male colleagues. But they were still excluded as faculty in medical schools and in hospitals. Therefore, they started an infirmary in New York for women and, ultimately, decided to open a medical school for women.

This was something they loathed to do as they truly wished to have women accepted alongside men in education. Elizabeth was the driver of advancing the acceptance of women in medicine, while Emily was more interested in providing the best care possible.

The fact that women are now fully accepted in medical schools and all branches of the medical profession is a powerful tribute to the struggles of the Blackwell sisters. For example, they assisted in the postgraduate education of Rebecca J. Cole, one of the first Black female physicians who, in turn, became a voice against racial bias in public health.

In thinking about the persistence and courage required of these women, I am brought back to the present, where we continue to deal with inequalities in medicine.

The Academy has developed a statement focused on equity and diversity in medicine. This statement aims to keep at the forefront the goals these women fought for more than a century and a half ago: acceptance of all human beings as equal.

Unfortunately, centuries of discrimination and injustice have made this lofty goal even more challenging. It makes one wonder when and how equality is ever going to be achieved. To do so will require all of us to work together as the Blackwell sisters did, individual by individual, so that we all advance together. R

Dr. Burns practices at Virginia Cardiovascular Specialists and serves as RAM's president. She can be reached at caburns01@gmail.com.

Richmond Academy of Medicine:
a statement on equity, diversity and inclusion

The Richmond Academy of Medicine commits to keeping equity, diversity and inclusion as priorities of who we are and what we do.

We believe that all patients deserve a respectful, unbiased, safe and supportive environment in which to seek and receive quality care. Our advocacy is an essential part of the healing process for those in our care.

The Richmond Academy of Medicine shall foster equity, diversity and inclusion within our own organization. Further, we charge our members to do so in their own practices and health systems so that our systems of care reflect the communities we serve.

Many thanks to the members of the RAM Board of Trustees Task Force who produced the statement above:

Dr. Carolyn Burns
Dr. Sidney Jones
Dr. Alice Coombs
Dr. Erica Royal
Dr. Joynita Nicholson
Dr. Quinn Lippmann
Dr. Ranjodh Gill
Dr. Peter Buckley
Dr. Eric Freeman
Mr. Mathew Alexander

"Together," continued from page 1

… If we fall, we will fall together
Take my hand (together)
Come and stand
When we rise
We will rise together
Together (that's right!)
Together we are dangerous
Together with our differences
Together we are bolder, braver, stronger

Together. 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.

"Mentoring," continued from page 1

He influenced me in multiple ways, all positive, and I rarely go to work when I do not think about him and the other fine plastic surgeons he assembled at Emory.

I still remember the day in 1984 when I met Dr. J. I was a third-year resident at the University of Alabama in Birmingham in general surgery. Under the influence of another fine plastic surgeon, Tony Marzoni, MD, at UAB, I had decided to pursue plastic surgery after my general surgery training. At that time there was no match in plastic surgery. Residencies were pursued by word of mouth and reputation.

Leaving the operating room following a day of assisting with four kidney transplants and no sleep, I drove to Atlanta in a pouring rainstorm. My '74 Chevrolet Caprice Classic convertible, which had not been driven in the rain on the interstate for three years, unexpectedly leaked like a sieve. I arrived late, soaking wet, in my interview suit. Fortunately, Dr. J was late, too, and I dried off while talking to his secretary of many years. I have wondered if that hour talking to her is why he offered me a job.

When I walked into his office, I noticed Dumas Malone's six-volume biography of Thomas Jefferson on his desk. The first thing Dr. J did was look me in the eye and say, "Isaac, I see you went to UVA for med school. Have you read these books?"

I had not read them. In fact, I did not even know about them, so I told him that. He said I really needed to read them and talked about how much he admired Jefferson. After he offered me a job, I decided to read them in the two years before arriving at Emory. They are great books. I am not sure he ever asked me about them again, but he was the kind of man who could influence people in that way.

Dr. J's teaching method was collegial and Socratic. The faculty he led at Emory had all trained under him and expected a great deal of those who worked under them. Following his lead, they gave us lots of responsibility. They could get us to rise to the occasion. This was all because of the atmosphere Dr. J had created. He was one of the main reasons I came to VCU to work in academic medicine for 14 years. I knew that transferring knowledge was what he expected of me. I am not the only one he influenced in this way. A generation of young plastic surgeons fell under his spell, too.

Dr. J also was a leader in organized medicine. Among other positions, he served as president of the American College of Surgeons, which was very rare for anyone not practicing general surgery. He expected people he trained to become leaders. He even told us that. In fact, it was part of how he mentored us. We all knew we were to use the knowledge we gained to make the world a better place. It became part of our DNA.

When I became involved in RAM, I had several mentors who as leaders helped me along the way. **Dick Hamrick, MD**, **Carolyn Thomas, MD**, and **Lornel Tompkins, MD**, immediately come to mind. I cannot discount the importance of Deborah Love Yoder – RAM's executive director when I was president – who taught me what a great helper to a leader should be. I am certain every doctor who has served RAM has stories about people who mentored them and those with whom they worked.

You never know when opportunities to mentor may come your way, but keep an eye out for them. When they materialize, jump on them. I have found having a student or resident with me in the office and the operating room to be extremely rewarding. You never know what it may lead to in that person's life journey. I always hope it will lead to them becoming a doctor or a better surgeon.

I recently had to write a description of an internship that a rising senior at VCU will be doing with me this fall as part of the premed curriculum. I taught this student in Sunday School at Second Baptist Church and have known her since middle school. Her internship will cover far more than consultations, post-op follow-ups and surgeries; it will help her gain insight into communications, teamwork and how plastic surgeons must think in relation to their patients.

I think mentoring is a little like gardening. You plant something small or throw out some seeds. It does not happen fast, but slowly the plants grow and mature. Some may wither and die. Some may just sit there. Some grow into beautiful things that give beauty, goodness and nourishment for years to come.

Look for a student or other individual you can mentor. You won't regret it. Neither will the future of medicine. R

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

What to do when the lawyer calls

BY SEAN BYRNE AND LUCIEN ROBERTS

A telephone call from an attorney or paralegal requesting information or assistance from a health care practice or professional is often an unwelcome overture. Providing attorney assistance inevitably takes administrative and clinical staff away from their core functions. And questions are likely to arise about whether the requestor is friend or foe and what assistance or information should or must be provided consistent with patient privacy laws, other legal obligations and principles of reasonable cooperation and professionalism.

Here's a guide to spotting issues as you field and respond to common requests for records and testimony.

Sean Byrne

Lucien Roberts

Record requests

Most practices are well familiar with routine record requests, and the health information team is ready to respond. It is imperative that your process evaluates each request for disclosure of records to ensure it is compliant with state and federal law and then responds with proper disclosure.

The fees that can be charged for record production are specified in Virginia Code for both electronic and paper production. A wrinkle that arises here is what to do if the request for production contains items beyond the standard designated record set for the patient. For example, requests for policies and procedures, scheduling logs, metadata from or about your EHR, patient incident or event investigation, data (even if deidentified) about other patients and the like should raise a concern, and practices are advised to seek advice from their risk management professional and legal counsel.

Just because something is requested by an attorney does not mean you are obligated to disclose it. And if the process of searching for and compiling the requested information is going to be burdensome (i.e., expensive), you may be entitled to reimbursement for that effort. Finally, a document request may be so broadly worded as to include information that is protected by legal privilege, and attorney action may be needed on your behalf to protect your confidential information.

Deposition requests

In civil litigation a party is generally entitled to take sworn testimony by deposition (before trial) or at trial, from anybody who has factual knowledge about relevant topics. In personal injury, medical malpractice, employment dispute, domestic relations and other lawsuits, people with factual knowledge often include treating health care providers. This testimony is authorized as a limited exception to patient privacy protections. Testimony requests often start with a letter or phone call, sometimes followed by a subpoena. The subpoena is a court order mandating that the witness appear at a given time and place to answer questions, and it can also require the production of documents. It is important to give these requests priority and a response.

Virginia law draws a distinction between information that a practitioner may have acquired in attending, examining or treating the patient in a professional capacity – and opinions that the practitioner might otherwise form afterward or outside the actual treatment relationship. The former – diagnoses, signs and symptoms, observations, evaluations, histories, and treatment

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plans obtained or formulated as contemporaneously documented during the course of treatment together with the facts learned by the practitioner – are fair game and the subject of lawful disclosure to: 1) patients or their counsel with patient consent, or 2) other parties to the litigation, but only with patient consent or, more likely, via formal discovery and trial testimony. In essence, providers can voluntarily speak with a patient's attorney (with proper patient consent) about their care of the patient. But they cannot disclose PHI to other parties in the litigation absent specific legal authorization, which generally occurs via a deposition or court proceeding.

A provider is not obligated to go beyond the body of information identified and provide expert opinions, analysis, observations, compliments or criticisms of care provided by others. Doing so moves the provider over the line from a "treater" to a consulting "expert." Serving as a volunteer consulting expert can be educational, intellectually challenging and lucrative, and it provides an important service to patients and attorneys alike.

Not everybody has the time, interest or stomach for weighing in as a consulting expert in contested litigation, but most who do find it to be rewarding. The medical legal system needs practitioners who are willing to serve as objective analysts, in particular, to combat hired-gun consultants who may be less scrupulous and whose opinions may change to fit the theory of the hiring party.

Fact witness fees

It is well-established that a physician is entitled to a reasonable fee for the time expended reviewing medical records, preparing reports, attending attorney-physician conferences and providing expert testimony. But Virginia law does not define how much can be charged. Reasonableness, in this context, is measured by reference to the physician's compensation for a similar measure of time in ordinary practice and as is usual and customary in the community. It makes good business sense to establish a fair and reasonable fee schedule for this service and to consistently provide it when responding to proper requests for attorney consultation. Virginia law also allows any fact witness to seek reimbursement for mileage, tolls and reasonable attendance fees when summoned to testify.

Expert witness fees

When a provider (or practice administrator) is consulting in a legal case and volunteering to go beyond facts and to offer opinions, a market rate can be set and freely negotiated with the attorney. Rates vary widely from one practice, geographic area and circumstance to another. But there are times where a court might step in – for example, if a physician agrees to consult as an expert witness for the patient and charges the patient $250 an hour but then charges the opposing attorney a flat fee of $4,000 to give a deposition. The attorney requesting the deposition may intervene and ask the court to reduce the proposed fee to a reasonable charge.

Again, reasonableness is in the eye of the beholder (the judge). Factors might include providers' specialties and the value of their time if spent caring for patients and how much of their schedule will be disrupted by the deposition. The circumstances of the deposition – including location, duration, time of day, flexibility of scheduling, remote video or in-person and other convenience versus disruption variables – might be considered by a court when resolving a fee contest.

Phone a friend

Other resources to consider when your antennas go up in response to a legal request include: your HIPPA privacy officer, your in-house or external corporate counsel, your professional liability insurance carrier and its risk management department and – to the extent you have established a relationship with a medical malpractice litigation defense attorney – you can always call that attorney to point you in the right direction.

While in theory, practitioners' fact witness testimony is intended to be confined to the scope of their care as documented in the records, attorneys are often quite skillful at blurring that boundary. Witnesses are always entitled to have their own attorneys. In the setting of a health care practitioner giving fact witness testimony in litigation, having your own attorney can help you:

- potentially avoid the deposition altogether through attorney-attorney communication;
- schedule the deposition or court appearance so as to minimize disruption of your professional and personal time;
- meet and prepare for the deposition to go over the expected topics and questions so as to avoid surprises;
- evaluate practitioners' potential legal exposure so that they do not unwittingly get caught up in the cross fire and become a target; and
- protect and advocate for practitioner witnesses during the testimony if one side or the other seeks to obtain information in the deposition that is outside the legal boundaries of required or permissible fact witness testimony.

In the most recent Virginia General Assembly session, Senate Bill 1446 proposed to set some requirements regarding litigation assistance by practitioners. The proposals included mandatory scheduling of meetings or calls between practitioners and patient attorneys, deposition participation, fee schedules and estimates, and prepayment requirements. While it did not pass out of the judiciary committee and did not become law, the bill highlights the challenges in this area for practitioners and attorneys and hints at potential regulation to come. R

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Drug prices: It's everybody's fault

BY HARRY L. GEWANTER, MD, FAAP, MACR

PHOTO BY JOSHUA COLEMAN

Just like climate change, everyone wants to do something about drug prices. But it seems that nothing ever happens.

Prices, and more importantly costs, continue to rise. And while everyone blames everyone else in the drug manufacturing, supply and distribution systems, they all run happily to the bank. Everyone, that is, except the ultimate payer – the patient.

As we dive into these convoluted issues, we must agree on our definitions.

Each term can have multiple meanings depending on the context, who uses it and why they want to use it to their advantage. To quote Inigo Montoya in "The Princess Bride," "I do not think that word means what you think it means" is the general rule here. Remember that the PBMs and insurers are now frequently single corporate entities. I consider them a single unit.

Harry Gewanter, MD

- **Price** is the list price or the published price of a drug.
- **Cost or net price** is the actual final price after all price concessions from the manufacturers to the pharmacy benefit managers (PBMs), insurers or anyone else involved in the distribution and sale of the medications. Unfortunately, this actual cost is not known because it is considered proprietary data by the PBMs and insurers.
- **Rebates** are the contractually listed monies paid by manufacturers to PBMs, which are supposed to be passed on to their customers.
- **Fees and discounts** are other monies paid to PBMs and insurers to ensure priority placement on formularies that result in total price concessions.

To continue the climate change analogy, trying to create system change over the drug pricing and supply system is much like trying to address climate change. There is more than adequate data demonstrating the problem and suggesting available solutions, but there are also powerful and significant self-interested players blocking any actual interventions.

Everyone within the system can blame everyone else for the problems, and they can all be correct. Each participant can easily and effectively pick data, create false equivalencies and "what about?" scenarios to divert the discussion from themselves and potential solutions.

Everyone involved in our current deliberately opaque, complex and interconnected drug supply system contributes to the high costs. No one is innocent.

Scant information

This recent and significant vertical integration of PBMs within insurers is resulting in a greater capture of the revenue associated within the drug supply chain. The consolidation also has made it even more difficult to obtain any valid information regarding the true drug costs at either a systemic or individual level. Since we do know the list prices but not the net prices, more ire and blame are directed at the manufacturers.

While that makes good press and wonderful political slogans, it's not that simple.

I believe the best paradigm to use when one tries to unpack all of this is to look at it through the lens of formulary construction. In an attempt to control costs, PBMs (and countries with universal coverage) resort to limiting availability of various medications. The rationale is that:

a) this will allow for negotiating better prices from the manufacturers, thereby creating more "savings" for their clients; and

b) this will prevent prescribers from being influenced to prescribe higher-priced medications rather than what the formulary constructionists consider the most appropriate and, more importantly, economical choice.

While a) makes sense in an economic model, b) does not comport with how clinicians and patients make treatment decisions. Further, since the PBMs' actual economic data is not available, prescribers and patients are unable to make even a semi-rational decision on the most appropriate and economical choice.

Formularies are constructed by creating various groupings of drugs in tiers that result in differing out-of-pocket payments by patients. These tiers are allegedly based upon the least expensive and most efficacious medications (in that order) as determined by the PBM/insurer.

If one were trying to limit costs, this makes sense. However, there is much at play behind the scenes that does not take into account the specific variations, comorbidities and needs of specific patients.

Once again, I remind you that no one in this process is innocent. Not the PBMs, not the insurers, not the manufacturers, not the wholesalers, not the prescribers, not the patients.

It's all about the formulary

In creating a formulary, the PBM will ask manufacturers for their list price, their best price and what rebate they will provide to the PBM. In addition, the PBM will request various other price concessions, expectations of market volume and other considerations.

In order to be a preferred medication on a top tier, therefore, the manufacturer must agree to a wide variety of price concessions if

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they wish for their medication to be used by patients within the PBM's purview. Given these parameters, the best (list) price does not necessarily make it to the top tier. Rather, the most profitable (net) price comes out on top.

Here's an example of how this works. If a medication's list price is $10,000 and the PBM requests a 50% discount, the net price is $5,000. If a competitor has a new medication that they price at $8,000, the 50% discount results in a lower net price of $4,000, but the PBM loses $1,000 in potential profit. Further, the PBM contracts say they will pass on all rebates to their "customer" (the insurer or company, NOT the patient). It is therefore in their interest to ask for a 5% rebate, but also demand 50% to 60% of the list price in additional fees, discounts and other price concessions if that drug is to be on the formulary. And since all of this is based on both percentages and volume, existing medications with higher prices have an advantage over newer medications or those with lower list prices.

The result is that medications that are most profitable for the PBMs are preferred over medications that may be lower priced.

We need transparency

But the manufacturers are not innocent, either. If they have medication with a large volume and/or a high price, they can threaten to lower or take away their rebates, etc., if one of their newer medications is not made preferred.

PBMs entice their customers (insurers, companies, etc.) by promising lower prices and increased rebates, but do not provide the data to prove that the proposed formulary is the least expensive or even if the customer is receiving all the rebate monies promised. After all, this is proprietary data.

If one adds the vertical integration of the PBMs within insurers along with their ownership of specialty pharmacies, physician practices, pharmacies, data management companies and so on, that means there are many more ways of a company paying itself without revealing the data. This results in PBMs forcing choices upon prescribers and patients through both indirect (higher copays) and direct (offering cash inducements) means.

Since we know the list prices but not the net prices or the actual costs of the medications, prescribers and patients cannot choose what we would consider the most appropriate and economical intervention for their specific situation. I think it would be safe to say that we would do this if we only knew the data. But since this is all "proprietary," all we can do is ask which insurance and PBM the patient has after we've come to a decision and then pick whatever the PBM and insurer has deemed best.

Now that I've likely totally confused and depressed you, I'd like to point out that proposed solutions exist. Of course they all center around transparency, but no one is sufficiently naive to believe that total transparency will occur as there is so much money involved.

On the other hand, if PBMs' price concessions were no longer based upon a percentage of the list price but rather a flat administrative fee (since all they do is administrative activities), that could significantly reduce the administrative burden as well as lower the total costs. Another suggestion would be to have patient copays and so forth based upon the final negotiated net price, as occurs with medical insurance.

Having an open formulary with the final, best price from the manufacturer – which would allow prescribers and patients to know the true cost and therefore make an informed economic decision – is another potential solution. While value-based pricing and payments are currently popular, in my opinion they do not sufficiently include the patient's values and situation to make this system appropriate.

These changes can only occur through societal changes – aka politics. Like the climate change crisis, it will require significant pressure from all sides to impose appropriate systemic changes if there is to be any hope of decreasing the drug costs for our patients and our country. R

Dr. Gewanter is a retired pediatric rheumatologist.

Access Now wins top honors

Access Now, a program of the Richmond Academy of Medicine, earned a 2021 Gold Rating from the National Association of Free and Charitable Clinics Quality Standards Program.

NAFC Quality Standards elements include policies and procedures related to the following areas: administrative, enhanced access and continuity of care, identifying and managing patient population information, planning and managing care, providing self-care support and community resources, tracking and coordinating care, and measuring and improving performance.

Access Now serves thousands of uninsured patients in the Richmond area, connecting them with specialty providers who volunteer their time to ensure that no one goes without care. For more information, visit AccessNowRVA.org.

Medical cannabis: what physicians need to know

BY LISA CRUTCHFIELD BARTH

PHOTO BY GIRL WITH RED HAT

Medical cannabis is legal in Virginia. Dispensaries are open. Patients want it. What do physicians need to know?

The Richmond Academy of Medicine offered answers earlier this year with a trio of programs on the science behind medical cannabis, the ins and outs of recommending it and tips for managing patients.

We can't begin to cover all the information you'll need, but this article aims to give you resources and advice from several RAM members that can help you, should you decide to recommend it for your patients.

"Cannabis use is common, it's prevalent – up to 10 percent of older adults are already using it either medically or recreationally," says **Michael Weissberger, MD,** a VCU Health geriatrician and assistant professor of internal medicine at VCU School of Medicine. "I think it's going to get more common, so asking your patients if they use it is important."

John Daniel, MD, a primary care physician at Virginia Physicians Inc., doesn't approve of legalized marijuana but, he says, "I'm not making the rules. I'm just trying to adjust my practicing for the rules that exist now. I have a lot of patients who do use marijuana, and they were getting it illegally. So if it's going to be legal, at least I can be sure they're getting good quality marijuana."

The structure of Virginia's system

The state's medical cannabis program is regulated by the Board of Pharmacy. Rebecca Gwilt Esq., co-founder and partner at Nixon Gwilt Law, notes that the program includes vertically integrated pharmaceutical processors (locally, that's gLeaf Medical) responsible for cultivation, extraction, processing, product development, packaging, dispensing and delivery. An independent third-party lab must be used to test cannabinoid levels and quality.

As of July 1, telemedicine is allowed in accordance with federal requirements for teleprescribing Schedule II-V controlled substances, says Gwilt. Providers should be aware those rules have shifted during the Public Health Emergency and will change once it ends. Importantly, once the PHE ends, patients will be required to have an in-person meeting prior to a physician being permitted to recommend cannabis via telemedicine.

Richmond-area residents

Michael Weissberger, MD

John Daniel, MD

Adam Blankinship

Rebecca Gwilt

Medical cannabis plants are closely monitored as they grow.

may have noticed a proliferation of signs on the street advertising telehealth consultations – some with a guarantee of money-back if a cannabis recommendation is not obtained.

That worries Daniel. "I'm afraid there are going to be people coming in just drug-seeking. I think it's going to cause either the physician or the patient to have a problem. Physicians are closely monitored for opiate prescribing, and there will be similar oversight for cannabis.

"I think THC should only be given to somebody you know very well, and has had a complete evaluation for their medical condition. Current standard therapies should be tried first. Only then, after discussion with the patient, should the option of medical marijuana be considered. If somebody new came to my office and the first thing they said is that they need opiates or cannabis, I'd be very concerned."

That said, he does consider recommending medical cannabis for established patients with chronic back problems, multiple sclerosis-induced pain or neuropathy, chronic osteoarthritis, cancer pain and other conditions who haven't found relief through alternative methods. "I'm trying to be sure there is good quality control. Flying to California or Colorado to get marijuana won't be required for patients that need it for medical reasons."

There was originally a cap on the number of patients a provider could see, but legislation removed it.

Before you can begin

Before you can respond to patient requests, you must register with the Board of Pharmacy (there's a $50 annual fee). You'll then receive a link to the written certification form to use when recommending medical cannabis to patients.

Once you've been certified, your name will be added to a growing list of Virginia physicians that is published on the Board of Pharmacy website. It's a good bet that patients will find you.

You'll bear similar responsibilities as when prescribing other drugs, including adhering to Prescription Monitoring Program protocol. You'll have to evaluate the patient, perform an in-person examination and make a diagnosis.

Your patients also must register and will have to appear in person at the pharmaceutical processor after obtaining a newly issued written certification (the products may subsequently be delivered). Yes, you may recommend medical cannabis to a minor, but be sure to authorize such use on the written certification form.

RAM members get a safety briefing before a tour of gLeaf's Richmond facility.

Where's the science?

Weissberger notes that cannabis' status as a Schedule I substance at the federal level means there's not been much structured research into its effectiveness. "We do have largely observational studies," he says. "It's not that we have evidence that it doesn't work, it's we don't have evidence at all.

"Most of the resources I use are primary literature for efficacy and best practices from other countries where it's federally legal," he says (such as Canada, European Pain Federation). "There aren't a lot of good peer-reviewed resources."

Daniel says he learned a lot from various seminars and webinars (including RAM's; see links) and reading what studies he could find.

Recommending (not prescribing)

Keep in mind that federal law still prohibits prescriptions of medical marijuana. Doctors in the U.S. cannot "prescribe" medical cannabis, but they can recommend it and issue written certifications.

Daniel says physicians should do extensive research before recommending it to patients. "I think we need to learn about the product itself. Just like any other drug we prescribe. Learn how it works, how the quality is, how it's made and what the side effects are. Pick the right one that's appropriate."

> "Cannabis use is common, it's prevalent – up to 10 percent of older adults are already using it either medically or recreationally."

If you're uncertain about what to recommend, you've got a partner in the dispensing pharmacist (i.e., gLeaf). Each facility is led by a pharmacist-in-charge, and it's the

"Cannabis," continued on page 12

PHOTO BY MIKE VON

Common medical uses

The Virginia Medical Cannabis Coalition notes that Virginia is not a state that requires a certain condition to qualify for medical cannabis. But patients have reported that medical cannabis has helped relieve symptoms of:

- Agitation of Alzheimer's disease
- ALS (amyotrophic lateral sclerosis/Lou Gehrig's disease)
- Anxiety
- Arnold-Chiari malformation
- Arthritis
- Autism
- Cachexia (wasting syndrome)
- Cancer
- Causalgia
- Chronic inflammatory demyelinating polyneuropathy
- Chronic pain
- Crohn's disease
- CRPS (Complex Regional Pain Syndrome Type II)
- Cancer
- Dystonia
- Fibrous dysplasia
- Fibromyalgia
- Glaucoma
- Hepatitis C
- Hydrocephalus
- Hydromyelia
- Insomnia
- Interstitial cystitis
- Lupus
- Migraines
- Multiple sclerosis
- Muscular dystrophy
- Myasthenia gravis
- Myoclonus
- Nail-patella syndrome
- Neurofibromatosis
- Parkinson's disease
- Peripheral neuropathy
- Post-concussion syndrome
- Post-traumatic stress disorder (PTSD)
- Reflex sympathetic dystrophy
- Residual limb pain
- Rheumatoid arthritis
- Seizures (including those characteristic of epilepsy)
- Severe or persistent muscle spasms
- Severe nausea
- Sickle cell anemia
- Sjogren's syndrome
- Spinal cord disease (including but not limited to arachnoiditis)
- Spinal cord injury with objective neurological indication of intractable spasticity
- Spinocerebellar ataxia
- Symptoms from AIDS/HIV
- Syringomyelia
- Tarlov cysts
- Terminal illness with life expectancy of less than one year
- Tourette syndrome
- Traumatic brain injury (TBI)

"Cannabis," continued from page 11

For more information

Check out RAM's webinars on medical cannabis. Visit **ramdocs.org** and click on the YouTube icon.

pharmacist who will ultimately determine dosing, collaborating with you to discuss the patient's course of treatment, medical conditions and other medications.

It's important not to equate recommending medical cannabis with prescribing prescription drugs, says Adam Blankinship, Pharm.D., a pharmacist at gLeaf Medical. "Many cannabis users tend to think of cannabis strains in the same way they think about prescriptions. They want one strain to treat a specific condition the same way that specific medications are used to treat a disease. But this isn't how cannabis works."

Though it's the pharmacist who ultimately determines the best product and dose, physicians can give recommendations and general guidelines, says Weissberger. For example, he says, "Patients with active cardiopulmonary conditions shouldn't be smoking the product and, in general, I keep them away from vaping products. Sometimes I keep them away from products that have a lot of THC because the cognitive and euphoric side effects can be difficult for some patients. But it can be difficult to know what to recommend because the products change so frequently."

Gummies are a popular way of ingesting medical marijuana.

The optimal dose, Blankinship says, is the minimum dose needed for symptom relief without side effects. "Less is more."

You'll want to counsel patients about safety around driving, how it might affect decision-making and about securing the products. Also, you should explain the logistics of obtaining the product and any possible side effects.

According to the Board of Pharmacy, no more than 4 ounces of botanical cannabis shall be dispensed for each 30-day period. Any dispensed botanical cannabis is calculated into the total 90-day supply of medical cannabis products that may be obtained by a registered patient.

Right now, medical cannabis is a cash-only transaction (there's an ATM in the lobby of the gLeaf facility). It remains to be seen whether insurance will eventually cover medical cannabis; for now, because of its federal status, lack of FDA approval and the lack of extensive clinical research, insurers aren't eager.

Cannabis plants grow indoors at gLeaf's Manchester facility.

Other considerations

Many national medical groups maintain hardline anti-marijuana stances. The American Medical Association remains opposed to both adult-use and medical marijuana legalization.

Daniel believes physicians need to be sure that medical cannabis doesn't become a problem like opioids. "Take the time to talk to your patients. Don't get fooled."

Concerned about malpractice? You'll want to check your insurance carrier's liability policy language – think "non-FDA approved medications" – says Gwilt.

You're probably already doing a great job of establishing and maintaining a strong practitioner-patient relationship. Keep an eye on changing regulations (RAM will keep you updated), and keep all your records updated.

Not every physician will be comfortable recommending it, but medical cannabis can offer another way to care for your patients. "We already prescribe many medications that have potentially negative side effects, and cannabis is something that has the potential to be helpful," Weissberger says. "It's a practice that more providers could be comfortable doing." R

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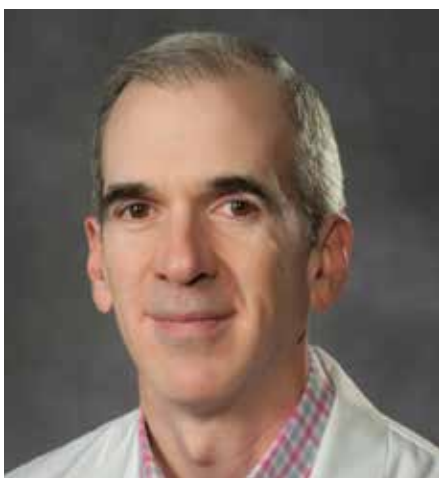
When there's COVID after COVID

BY LISA CRUTCHFIELD BARTH



Wes Shepherd, MD

By now, physicians know that once an acute SARS CoV-2 infection is over, it's not over for many patients. Ten to 30 percent of patients experience what's called long COVID.

The VCU Health Long COVID-19 Clinic, which opened this past summer, gives patients a central place to help manage their symptoms and allows physicians an opportunity for research into the baffling disease. Several dozen similar programs have been created across the country.

While some patients who've ended up hospitalized or on a ventilator may get long COVID, there are many, many others who had a mild case that only later led to debilitating and frustrating symptoms. "It became clear fairly early on that there are plenty of patients who had a COVID illness that was not severe enough to warrant hospitalization and yet they went on to develop all types of long COVID symptoms," says **Wes Shepherd, MD**, a lung specialist in the Medical Respiratory ICU and Interventional Pulmonary Program at VCU Health and professor of pulmonary disease and critical care medicine at VCU School of Medicine, who helped develop the new clinic. "Patients who were critically ill may have long COVID symptoms that overlap with post-intensive care syndrome symptoms as well. There are even cases of long COVID now being described in those who had a COVID infection despite being vaccinated."

VCU Health's clinic serves patients who have tested positive for COVID-19 and have experienced persistent symptoms for more than 12 weeks after their initial diagnosis, says Shepherd. "Patients need to be referred by a health care provider. We know that if we opened the clinic to any COVID patient with any unusual symptoms we would be overwhelmed with the clinical need." The clinic originally opened for VCU patients, but is expanding to admit other area patients this fall.

A lot of patients will have lingering symptoms for three or four weeks, he says, but that doesn't necessarily mean they need the clinic. "Not everyone gets back to normal that quickly. If someone had COVID and was sick enough to be in the ICU

The nonprofit group FAIR Health analyzed the health insurance claims of nearly two million people between February 2020 and February 2021.

Findings include;

- The new ailments affected patients of all ages, including children, and even included patients who were asymptomatic, or experienced no symptoms whatsoever.
- 19% of asymptomatic COVID-19 patients came down with long COVID symptoms, increasing to 27% who had mild or moderate symptoms but were not hospitalized, and 50% of those who were hospitalized.
- Other ailments revealed in the study included intestinal symptoms, heart disorders and mental health issues such as depression and anxiety.

CDC guidance for long COVID

cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/post-covid-index.html

According to the CDC, people with long COVID commonly report different combinations of the following symptoms:

- Difficulty breathing or shortness of breath
- Tiredness or fatigue
- Symptoms that get worse after physical or mental activities
- Difficulty thinking or concentrating (sometimes referred to as "brain fog")
- Cough
- Chest or stomach pain
- Headache
- Fast-beating or pounding heart (also known as heart palpitations)
- Joint or muscle pain
- Pins-and-needles feeling
- Diarrhea
- Sleep problems
- Fever
- Dizziness on standing (lightheadedness)
- Rash
- Mood changes
- Change in smell or taste
- Changes in period cycles

or hospital, had acute lung injury and pneumonia or other complications, and is now eight, 10 or 12 weeks out, that might not be long COVID."

The clinic is structured to be as multidisciplinary as possible, says Shepherd. Since the predominant symptoms of long COVID fall into three systems – heart, lung or neurologic – VCU Health started with pulmonary, cardiology and neurology providers. They're working to soon add a colleague from psychiatry, and hope to expand as needed. For now, the clinic only sees adults, though a pediatric version may be needed in the future.

Patients are triaged and see the providers they need based on symptoms.

"There may not be specific treatments for everybody, but there are definite things, such as heart arrhythmias or lung inflammation, that can be treated," Shepherd says. "The more challenging areas are some of the broader constitutional or systemic symptoms like fatigue or brain fog. We may not have specific therapies."

Shepherd wonders, "Is there just a persistent immune system response from the body that the virus triggers? Or does it lead to an unmasking of other underlying conditions? Some people have a predisposition to other disease such as rheumatoid arthritis or diabetes that could be activated by the immune effects of the virus."

Current studies on long COVID have focused more on describing its prevalence and symptoms. Not many have looked at therapeutic options yet, though Shepherd hopes that VCU Health will secure NIH funding to address that.

> "There are even cases of long COVID now being described in those who had a COVID infection despite being vaccinated."

It's a good bet that the clinic will continue to have the patients to study.

"Three or four months ago, we were having discussions saying maybe we won't even need the clinic in another year or so. Now, obviously with the current Delta variant spike, it's hard to know how long." R

Shopping for professional liability insurance in a 'hard' market

FROM THE MEDICAL SOCIETY OF VIRGINIA INSURANCE AGENCY

The insurance market is cyclical and often characterized as being either a "hard" market or a "soft" market, or in the process of transition from one market to another. Currently the market is transitioning to a hard market from a soft market.

We have been in a soft market cycle for around 15 years. A soft market results when companies are profitable. It is characterized by falling prices and less stringent underwriting guidelines. Additional companies may decide to enter the medical professional liability arena, and so the availability of professional liability insurance increases. Companies will then fight for market-share through price reductions and broader policy forms.

Eventually, rates will be driven down to the point where companies are no longer seeing the same level of profit or they are no longer making a profit. Thus, a hard market is marked by insurance companies losing profitability, characterized by:

- Claims frequency and/or severity increases, and existing rates are unable to sustain losses.
- Underwriting standards become more stringent as companies seek to reduce claims.
- Rate increases are implemented.
- Some companies will leave the PL market, resulting in reduced availability of insurance.
- Policy coverage may be scaled back or eliminated.

Virginia physicians saw stable or reducing professional liability premiums from around 2006 until recently. Most carriers did not take base rate increases (despite offering higher limits each year to comply with the Virginia cap). However, within the past couple of years we have seen prices begin to increase again.

It is very tempting, when prices are rising, to move professional liability insurance to a company that offers a lower price. A lower premium may be tempting, but it is never advisable to move PL insurance based on price alone and without considering a number of other important factors.

Some of these other factors include:

- **The stability of the insurance company.** Determine how long the insurance company has been in business and how long it has been writing malpractice insurance in Virginia. Find out the insurer's A.M. Best financial rating as well as its outlook (positive, stable or negative). A.M. Best Co. is an organization that specializes in providing ratings, news and financial data for the insurance industry.
- **Claims handling.** How does the claims process work? What is the company's position regarding nuisance or frivolous claims? How do these claims affect the premium? Is there support for a physician going through a suit? If you have previous experience with a defense attorney, you may want to see if that attorney also works with the new carrier.
- **Years insured with current company:** Always consider the number of years you have been insured with the current company. Is there enough of a price difference with a new carrier to forgo an established relationship with the current carrier? (When renewal pricing is decided, underwriters often consider how much total premium has been paid over the years as compared to the total amount paid or reserved for losses.)
- **Policy coverage:** Differences in policy coverage may be the reason for a lower price. Here are a few things to look for in a claims-made insurance policy:

1) Is a separate limit provided, or available, for a corporate entity?
2) How do the policy exclusions compare?
3) Is prior acts coverage provided for all individuals and the corporation?
4) Is a free "tail" (or extended reporting endorsement) available, and under what conditions?
5) Are there other coverage features that some policies offer and some do not? For example, carriers offer varying limits for cyber liability, billing errors and omissions or loyalty programs to their insureds.
6) What patient safety/risk management services does the company offer? Is there a cost to participate and do programs earn a premium discount?
7) Does the policy state that the reporting of a claim is triggered by an "incident," or is it based upon a "written demand"? (Understanding how this can impact coverage is very important.)

MSVIA not only helps with professional liability, it can help health care-related businesses with other insurance needs such as property, general liability, cyber liability, crime, employment practices, directors and officers, commercial auto and other coverage through nationally known companies.

MSVIA is a wholly owned entity of the Medical Society of Virginia. While MSV works hard to advocate for all physicians across Virginia, the MSV Insurance Agency also offers personalized services and education to protect you and your practice. R

The Medical Society of Virginia Insurance Agency is a sustaining partner of the Richmond Academy of Medicine.

Medical Society of Virginia Insurance Agency

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Website: MSVIA.org

Five questions for …

Michael Martin, MD, FAAP | President, Virginia Chapter of the American Academy of Pediatrics

Michael Martin, MD

What role does VA-AAP play in promoting COVID vaccinations?

We began 2021 with high hopes as a vaccine for COVID-19 emerged and found its way into the arms of health care providers in January and February. But with that hope came more challenges and the clarity that COVID-19 would not be going away.

Organizations like the Virginia Chapter of the American Academy of Pediatrics would need to continue to pivot and modify strategic plans to address the current crisis and the inevitable and sometimes unexpected developments that accompanied it.

Achieving high immunization rates in children and adults remains a core value of the VA-AAP. Early this year, the chapter successfully advocated for its members to be among the first groups to receive COVID-19 vaccines. Through social media, provider education and even op-eds, the VA-AAP has broadened its advocacy to get all eligible persons, particularly those 12 to 18 years of age, vaccinated against this vicious and elusive virus.

Early in the pandemic, the chapter also identified plummeting rates of routine vaccination in children and quickly got to work helping raise awareness of this issue. Even now, given that rates are still lower than pre-pandemic times, the VA-AAP recently launched a campaign – which included targeted social media messaging – to continue to encourage families to get caught up on immunizations and well checkups.

How are you addressing children's mental health issues?

As the year progressed, we witnessed escalating mental health disorders in children at rates never seen before. Thankfully, through the Virginia Mental Access Program, initially funded by the VA-AAP, work continued to educate primary care providers to directly provide mental health care to their patients. It also continued to work to provide the support and coordination of care needed to ensure children receive the emotional and mental help they need through these dark times. The VA-AAP helped secure further funding for the program, which has now expanded to cover every region of our Commonwealth.

What kind of advocacy initiatives are you undertaking?

The chapter's advocacy and legislative efforts since the beginning of the pandemic have been nothing short of ambitious. Even now, new legislation goes into effect that expands and strengthens vaccine requirements in school-aged children. Our Legislative Committee successfully sponsored and advocated needed change to the Virginia Immunization Information System and worked to lay the groundwork for undocumented children to receive needed medical care. And the Virginia Immunization Coalition, ImmunizeVA, had a successful first year, in part due to leadership provided by the chapter.

> "The chapter's advocacy and legislative efforts since the beginning of the pandemic have been nothing short of ambitious."

School reopening has been a hot topic. What have you done to ensure children's safety?

And what could be more important than the education of our children? The VA-AAP built an active task force with pediatric leaders from across the state that partnered with representation from Virginia's Department of Education and Department of Health. The task force successfully advocated for the safe reopening of schools and now provides continued guidance in securing the safety of children on buses and in schools in relation to the COVID-19 surge. Members have worked with superintendents, spoken with school boards and presented virtual town halls throughout the state for pediatricians and school staff.

How has RAM Services Corp. helped you?

All these efforts require infrastructure, planning and staff support. The Richmond Academy of Medicine Services Corp. has provided these and more to VA-AAP. Whether it be planning of virtual or hybrid meetings, modifications to our financial plans or even finding new ways to reach out to membership, RAMSC has been there to support not only the chapter but the children of our state during the pandemic. This year, the chapter's membership grew when most organizations experienced a decline in membership. And despite a pandemic, the VA-AAP is bigger and stronger thanks to the support of RAMSC. R

Dr. Martin is a pediatrician and owner at Einstein Pediatrics in Vienna.

Events

FLYING SQUIRRELS

RAM members enjoyed a family social at The Diamond in August. The game was followed by fireworks.

RAM members came out in June for our first in-person social event of the year at Topgolf Richmond.

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 10, 2021 Sunday	*RAM Fall Family Event at Lloyd Family Farms* 12204 Pinhook Road, Rockville, VA 23146 *2-5 p.m.* Come get your pumpkins and enjoy an autumn afternoon on the farm at RAM's 2021 Fall Family Event!
October 12, 2021 Tuesday	*Lunch on Tuesdays* Virtual *12:30-1:30 p.m.* Peter Buckley, MD, dean of Virginia Commonwealth University School of Medicine, and executive vice president for medical affairs, VCU Health, will speak on *COVID-19 and Healthcare's Resilience: Learning and Leading*.
October 23, 2021 Saturday	*MSV Annual Meeting* Virtual At MSV's Annual Meeting, delegates vote on resolutions that address health care policy in Virginia.
November 13, 2021 Saturday	*Women in Focus* Virtual Dr. Shilpa Johri from Pulmonary Associates of Richmond will be our featured speaker.
November 16, 2021 Tuesday	*RAM General Membership Meeting* Speaker TBA. Stay tuned for details!
December 5, 2021 Sunday	*RAM Winter Family Event* Lewis Ginter Botanical Garden 1800 Lakeside Ave., Richmond, VA 23228 *5-8 p.m.* Get into the holiday spirit with GardenFest of Lights at Lewis Ginter Botanical Garden. We'll have a room reserved for you and your family to enjoy refreshments and holiday cheer with your RAM friends and colleagues before and after touring the gardens aglow with lights.
January 18, 2022 Tuesday	*RAM Presidential Inauguration and Board Installation* Location TBA *5:30 p.m. cocktails; 6:15 p.m. dinner; 7 p.m. installation of officers and inauguration* Mingle and network with your colleagues over cocktails and dinner, and hear Dr. Sidney Jones' inaugural address as he begins his two-year term as RAM president.

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!

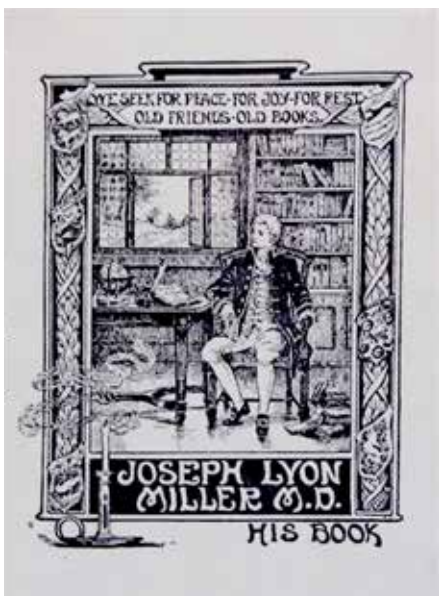
The Academy's Loving Lunches RVA program returned, thanks to a grant from Chick-fil-A.

A new home for the Miller Collection

BY LISA CRUTCHFIELD BARTH

One of the Academy's most cherished assets has a new home – and it's going to be very close to its old home.

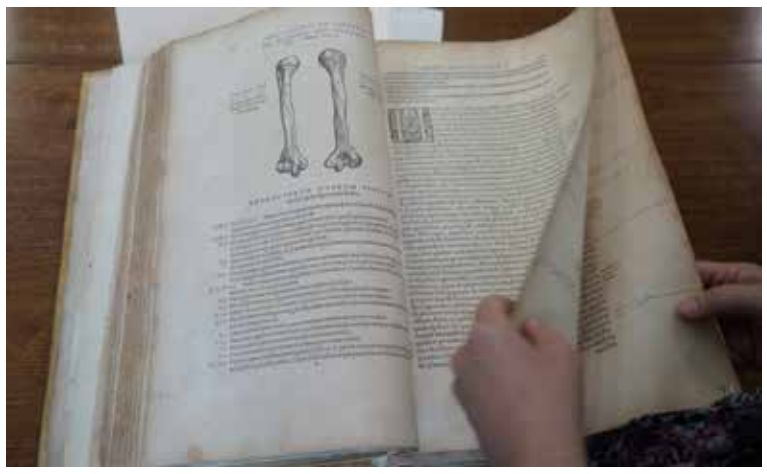
The Joseph Lyon Miller Collection, a treasure trove of more than 3,500 rare books, manuscripts, prints, lithographs and silhouettes, was gifted to RAM by Joseph Miller, MD, an alumnus of the University College of Medicine (a school that merged with the Medical College of Virginia) and practicing physician in Thomas, West Virginia. A condition of the gift was that the Academy provide a suitable library building in Richmond with space to properly house such a rare collection. That led to RAM's first permanent facility



A bookmark from Joseph Lyon Miller's collection.

at 1200 E. Clay St., built alongside the library on the MCV Campus that opened in 1932, a great example of a public-private partnership that benefited both parties.

"The collection is what led the Academy to build our building," says **Wyatt Beazley, MD**, a former RAM president, avid historian and member of the committee that oversaw its sale. "And the building gave us stability and a place to meet. In part, I think the Academy is what it is today because of that gift."



The collection comprises thousands of books, manuscripts, lithographs and other materials.

Still, Beazley notes, the collection was housed for decades in that building, which had minimal climate control and security. About 15 years ago, the Academy sold the building; the proceeds were invested, allowing it to create programs such as Access Now, CCVS, Honoring Choices Virginia, Loving Lunches RVA and the 200th anniversary gala.

But even before that sale, RAM members had recognized the need to better preserve the collection and struck a deal with the Virginia Historical Society (now the Virginia Museum of History & Culture) to house much of it in its facility on Arthur Ashe Boulevard. The historical society announced several years ago that its focus was evolving and that the collection needed to find a new home.

Joseph Lyon Miller's collection spurred the Academy to build its first home on the MCV campus.

RAM's Board of Trustees prioritized keeping the collection together while still honoring the board's fiduciary duty to members, forming a committee to find the best solution. The committee, chaired by **Hazle Konerding, MD**, looked into selling the collection at auction. But there was no guarantee that it would stay intact. When VCU Libraries expressed interest, it seemed like a win-win situation.

After many months of negotiations, a deal was struck to sell the collection to VCU and house

VCU Libraries staff welcomed the Miller Collection.

it in the university's Health Sciences Library. According to Teresa L. Knott, associate dean, VCU Libraries, and director, VCU Health Sciences Library, "Our team is delighted to welcome the Miller Collection back to the corner of 12th and Clay."

She went on to say, "It is especially important because our health sciences special collections were built around the Miller Collection since the collection was

Valuable books were wrapped in archival paper before the transfer.

once readily accessible through the double doors connecting RAM and the library." When fully transferred, the collection will be available to students, faculty, and the community. Knott notes, "We look forward to sharing this gem with the community."

The sale, says Konerding, means that members will continue to have access to the collection and that the Academy has the funds to continue to create innovative programs to help physicians and patients.

"What I like about this is that we're doing what Joseph Lyons Miller would have wanted," says Beazley. R

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