Sea of change

BY PETER A. ZEDLER, MD

Shortly after my election as president of the Richmond Academy, one of our members, a friend, jokingly wished me “lots of luck.” He reminded me that health care over the next few years is in for a rocky ride. I have to admit over the next couple of weeks I had a few sleepless nights. I knew that there are many changes coming in health care, highlighted by the start of the Affordable Care Act. I was aware that the Academy, now 2,300 strong, is made up of physicians, midlevel providers and administrators who come from the full political spectrum and from all practice styles. We are made up of independent, employed and academic doctors. All have opinions and we all know our own opinions are the right ones!

How does a group this diverse, this “herd of cats,” maintain a sense of identity as we enter a sea of change? In 2014, that sea appears to be the largest ecosystem on earth. At the federal level, we navigate the Affordable Care Act. We can agree that increased coverage for those without insurance is a positive change. How we get there and whether it is a success is another question altogether. The accompanying rules and regulations seem to add credence to the saying that “sometimes the treatment is worse than the disease.”

A number of Academy members started the year by visiting the state legislature where we met with Lt. Gov. Ralph Northam, a fellow physician, and with our local legislators. In conjunction with our friends at MSV, we did have some success getting our legislative priorities communicated. It was clear, however, that the “Big Enchilada” was, and is, what to do about Medicaid. What is going to happen to those 400,000 Virginia patients who fall in the gap between current Medicaid and the benefits of the Affordable Care Act? This decision affects physicians, hospitals, taxpayers and, most of all, patients. Again, this is political football, with our members on each side of the scrimmage line.

Earlier this month we heard from Rick Mayes as well as three of our own about the changing landscape of health care over the next couple of years. It’s clear that for the foreseeable future, physicians must keep adapting to a shifting landscape, even one where a discount retailer may be calling—or ordering—the shots.

The price is…?

BY CHIP JONES

At our March General Membership Meeting, University of Richmond health policy economist Rick Mayes sparked a lively panel discussion by reviewing national trends that showed what he called “an evaporation of smaller practices.” The percentage of independent practices has plummeted from 57 percent in 2000 to 33 percent in 2013. And by 2020, Mayes predicted, “Less than 20 percent of physicians will be independents.”

“If physicians aren’t selling out to hospitals, they’re more and more going to larger practices.”

One reason for this trend is that the overall rate of health care expenditure growth in the U.S. has slowed from 6.5 percent for most of the past decade to just around 3.6 percent since 2009, making it harder to operate, much less expand, a practice. In other words, while expenses have continued to increase, revenue growth has slowed.

Along with this trend comes another source of “downward pressure on pricing”: the Affordable Care Act, said Mayes. With more price transparency either required by law or simply expected by consumers, Mayes said, “This could be one of those awkward moments when people know what individual doctors are paid... This started in California, but is gaining momentum across the country.

The spread of high-deductible health insurance plans is also “creating a tremendous push-back by patients who don’t want to pay” deductibles of more than $3,000 per year. It’s no wonder, then, that some patients delay or reject medical treatment.

Mayes noted that Wal-Mart is contracting with health systems known for innovative practices—such as the Cleveland Clinic, the Geisinger Health System in Pennsylvania and Kaiser Permanente in California.

It’s clear that for the foreseeable future, physicians must keep adapting to a shifting landscape, even one where a discount retailer may be calling—or ordering—the shots.

The making of doctors: looking back, looking forward

BY ISAAC L. WORNOM III, MD, FACS

This issue of Ramifications focuses on changes in medical education that are occurring all over the United States and right here at home in Richmond at Virginia Commonwealth University. The combination of a new building and, more importantly, a new curriculum is transforming how students are educated to become medical doctors here in our city. I have read through communications sent out by my medical school just up the road that the same changes are happening at the University of Virginia.

In reading Lisa Crutchfield’s article on the new curriculum at VCU’s School of Medicine (page 4), I was struck by the radical change that has occurred during the first two years of medical school in particular. Gone are the days of dark lecture halls where first and second year students sat for hours while lectures on biochemistry, anatomy and physiology were delivered, notes taken, and after-class study focused on the memorization of large numbers of facts. It’s all changed! What does this mean for the future of medical education? It’s clear that there is a need to change the way we teach students, and that means change. How we get there and whether it is a success is another question altogether. The accompanying rules and regulations seem to add credence to the saying that “sometimes the treatment is worse than the disease.”

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health reform. The future of health care will result in changing relationships. Will the rise of mega-groups, hospital ACOS or physician associations be worth the effort? Will they provide better care or will they serve only to further divide the medical community? Will all the new rules and regulations make us better, or force some to leave the profession?

While this may seem like the never-ending wish list, I think there is a reason for encouragement. I am speaking about two items of good news! Things that all members of the Academy, as physicians and others involved in caring for patients, can feel good about.

Last year, the Board of Trustees of the Academy approved dedication of time and treasure to develop a program of advance life care planning for the Richmond community. Earlier this year, all three Richmond health systems—Bon Secours Richmond, HCA Virginia and the VCU Health System—joined our effort. This program, long overdue, will help patients and their families understand the choices of end of life care planning and reassure patients that both family and healthcare providers will respect their wishes. Whether we are the patient or the doctor, I am confident that this is a program worthy of our support and of which we can be proud.

In early March, the VCU Health System Authority Board voiced its support for discussions with organizations, including Bon Secours and the Pediatricians Associated to Care for Kids (PACKids), for the development of a free-standing, independently operated children’s hospital. This significant action shows willingness on the behalf of the health system to be a partner, not owner, of a tremendous community resource.

VCU brings to the table recognized pediatric medical education, acknowledged research breadth and support, steady supply of well-trained pediatricians, and the experience needed to offer tertiary care for children with serious or chronic conditions.

The community brings to the table a broad and deep network of well-respected pediatricians, specialists and subspecialists who daily treat thousands of infants and children. These doctors understand parental preferences, and have the pediatric understanding and passion to envision what a facility focused exclusively on children can achieve. The community also brings to the table strong, determined and willing philanthropic support that is essential for the success of this enterprise.

The VCU Medical Center’s support for an independent governing board for a new children’s hospital moved this vision one step closer to reality.

We have the opportunity to help promote this endeavor by encouraging thoughtful collaboration by so many talented individuals, both VCU and the community pediatricians deserve our support and encouragement for the actions each has taken for the sake of children’s health. As Gandhi put it, “You must be part of the change you wish to see in the world.” Perhaps the single most important element of our support begins when we are open to laying down old perspectives, embracing new ideas, and holding clear and present the vision of a better Richmond for all children.

I do not know how our state’s or our nation’s attempt at healthcare reform will turn out. Nevertheless, I do know we have two opportunities to improve how health care is delivered in our community—the advance care initiative and the children’s hospital initiative. We need to come together to recognize, support and celebrate those efforts that make care better for all.

Dr. Bob Bennett: Electrifying Access Now

By Chip Jones

Dr. Robert M. Bennett is widely known for helping start the Goochland Free Clinic in 1999. But what’s less well-known is his behind-the-scenes role in helping to develop an electronic medical referral system for the uninsured population of the greater Richmond area.

More than a decade later, Dr. Bennett’s early work with a group of engineering students is much appreciated by the Academy’s charity care program, Access Now. Known as a “free clinic without walls,” more than 900 specialists from RAM, along with mid-level providers, provide uninsured patients with access to care in nearly 40 specialties.

Access Now also is supported by Bon Secours Virginia, HCA Virginia and a number of generous grants from area foundations, including the Virginia Health Care Foundation, Jenkins Foundation and Richmond Memorial Health Foundation.

Bennett’s invaluable work on electronic medical records for the uninsured began 10 years ago up the road in Charlottesville, where he was mentoring a group of senior engineering students at the University of Virginia.

Earlier, in 1998, Bennett had taken an extended sabattical as a cardiologist in Richmond. At the time, he recalls, “I wanted to put my two loves together—engineering and medicine.”

“One of my professors used to dock me a letter grade because he knew I was going to medical school,” Bennett ruefully recalled. So it was that after retiring from private practice, he earned a master’s degree in systems engineering at UVa. in 2002.

After he began teaching there, he recognized the untapped potential of taking systems engineering concepts and using them to improve health care delivery.

“I was practicing then the same way as when I graduated from medical school in 1972… Your processes were still pen and paper—the same way it was in 1950.”

Prescriptions were written on pads, records were kept in folders and referrals were sent by fax. So when a fellow UVa. professor challenged Bennett to design a new “Bennett,” continued on page 3
facts to eventually be regurgitated on tests. This has been replaced by team learning, early exposure to patients and an emphasis on interdisciplinary care.

For most of us practicing medicine here in Central Virginia, I suspect those dark lecture halls do not hold fond memories. For one could not wait to get out of them and into my third year of medical school when I would actually get to see patients. I don’t remember much about the Krebs cycle but I remember with clarity the occasional “clinical correlation” during my first year of med school when a real patient would actually appear in the lecture hall with his/her doctor. I can tell you all the details about the urologist, Darracott Vaughan, and the patient with renal cell carcinoma he brought in to talk to us about the illness and its treatment and how it impacted life and family and what was done to fight the disease. If the new changes are bringing more of this type of experience, I am sure the students are happier, and I would guess the anatomy and physiology facts they learn are applied to clinical situations earlier.

When I started to see patients during my third year of med school I did not really think the dark lecture halls had prepared me very well for what was expected of me. I was really uncomfortable at first on the ward and remembering being very unsure of myself. I did, however, have lots of knowledge of anatomy and physiology and various diseases, and over my third year of medical school the clinical skills that would serve me well for the rest of my career slowly began to develop. These skills developed by watching good doctors work and emulating them and continuing to study and think about the patients I saw and their illnesses using the facts learned the first two years. My sense is that one of the goals of the new curriculum is to develop those skills sooner.

For me personally, however, it was in surgical residency that my growth and development as a physician took off. Part of that was the immense amount of time I was required to be at the hospital then; like many in my generation I pretty much lived here during residency. More than that, though, it was the first time I felt true responsibility for what was happening to my patients. With responsibility came emotional involvement and caring. With caring came the intense learning that imprints your brain with things you never forget. These experiences emphasize what the great Dr. Francis Peabody said in his famous lecture at Harvard Medical School in 1925, “For the secret of the care of the patient is in caring for the patient.”

In addition to the changes in medical school, one of the biggest changes in the past 10 years has been the installation of an 80-hour workweek for residents—a far cry from the 100-hour-plus workweeks many of us survived. This change was done primarily in the name of patient safety so exhausted doctors who could potentially make more mistakes would not be caring for patients when they were tired. One of the potential problems with this change in graduate medical education, which is undoubtedly here to stay, is that residents will not have the same opportunity as those of us from the past did to see patients all the way through the acute stage of their illness because they have to go home. This may slow their acceptance of responsibility which is the key to the most intense learning.

Finally, I think the new emphasis on interdisciplinary team care in medical school is long overdue and will yield great dividends in the future. I am writing this while at the annual meeting of the American Cleft Palate — Craniofacial Association. ACFA, which is 71 years old this year, was founded on the principle that children with cleft lip and palate should be cared for by a team of surgical, speech and dental specialists who talk to each other. This organization was ahead of its time. For many diseases we treat, such as cancer, heart disease, debilitating neurologic conditions and cardiovascular disease, the same principles apply. Often teams of various doctors, nurses, social workers and other health care personnel who talk to each other are rendering care together for the good of the patient.

The sooner new medical students learn to function in a collaborative way, the better for all of us. It will be very exciting going forward to see how these changes in medical education impact the finished product. For one I am hopeful the physicians of tomorrow will be bright, collaborative, responsible, caring doctors who spend time talking to their patients and rendering excellent care.

“Bennett,” continued from page 2

course that would apply information technology to medical records, the proverbial light bulb went off.

Several years before the creation of Access Now by the Richmond Academy of Medicine in 2007, Bennett and his team approached the RAM board with a project proposal “to design an electronic medical referral system for the indigent population in Richmond, Virginia, which will facilitate specialist health care for the uninsured and underinsured,” according to a paper written by the UNA team.

The project was enthusiastically backed by RAM’s board of trustees, and RAM put his team in touch with area free clinics, including Cross-

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A fresh framework:

VCU has a new curriculum that fits its ultramodern medical education building

BY LISA CRUTCHFIELD

“It is easier to move a cemetery than to change a curriculum,” Woodrow Wilson observed while serving as president of Princeton University.

It’s definitely not easy, but sometimes it’s necessary, and so Virginia Commonwealth University’s School of Medicine introduced its most significant curriculum change in more than 30 years this past fall.

The change is aimed at getting medical students into clinical areas earlier, to work as part of teams and to be ready to face the challenges of 21st-century medicine. It’s a fairly radical change from the old curriculum, which relied on large-group lectures the first two years and lots of memorization. That model was more than 100 years old, reflecting recommendations in a 1910 report by Abraham Flexner, an American educator who never attended medical school but nevertheless was tapped by the Carnegie Foundation to study medical education.

Today, educators believe that developing problem-solving skills, teamwork and early exposure to clinical situations better prepare future doctors for residency and ultimately practice. “It’s about creating an active curriculum,” notes Jerome F. Strauss III, MD, PhD., dean of the VCU School of Medicine. It’s also about maintaining accreditation, and VCU—faced with pending accreditation requirements—decided to act. The school opted to go above and beyond minimum requirements, however, seeking to develop the most comprehensive medical education possible.

Tasked with leading the curriculum change was Isaac K. Wood, MD, senior associate dean for Medical Education and Student Affairs. Wood scoured the country looking at curricula. “We could not find anything that we felt consistently fit our needs. So we had to come up with something new.”

VCU’s new curriculum—student-centered, clinically relevant and competency-based—was developed with the input of more than 200

25,000 square feet
Amount of dedicated space for human simulation training on two floors of the new center.
Virginia Commonwealth University’s School of Medicine introduced its most significant curriculum change in more than 30 years this past fall. The new curriculum stresses the importance of working in teams, which is aided by large, u-shaped tables.

faculty members and students. And—an added bonus—its debut coincided with the opening of a state-of-the-art medical education building, designed especially to enhance the curriculum.

The new curriculum came about from a “backwards design,” said Susan DiGiovanni, MD, assistant dean for Medical Education, who supervises first- and second-year students. “We started out by thinking about what we want our graduates to look like when they walk out the door.

“We listed a lot of knowledge, skills and attitudes,” she said. “A lot of this has to do with professionalism and communication and empathy and respect and things that are as important as just knowing which medication to use.

“And from there, we designed our curriculum.” It was a laborious process, said Wood. “We had to sit down and dissect every old course and every lesson and every topic and figure out where in the new curriculum they fit together.

“Our goal was to graduate students who were much more advanced than their peers from other medical schools when they started their internship.”

The traditional 2+2 curriculum (two years of preclinical followed by two years of clinical) changed to something more akin to a 1.5+2.5 model. The first year remains what most physicians remember: biochemistry, anatomy, histology, etc., and now the second year is taught by organ system, first teaching the normal and then the abnormal. As part of this new integrated curriculum, students can begin working in the hospital during the second year.

At the core is the Practice of Clinical Medicine (PCM) course, designed to integrate basic principles into clinical scenarios. M1 students don’t spend all their time in lecture halls; instead, they’re thrust into situations requiring hands-on practice. “We had a boot camp the first week,” said DiGiovanni. “Students saw a standardized patient scenarios. M1 students don’t spend all their time in lecture halls; instead, they’re thrust into situations requiring hands-on practice. “We had a boot camp the first week,” said DiGiovanni.

“Students saw a standardized patient and were making a diagnosis in their first week of medical school.”

During the school year, students alternate between small groups and standardized patient scenarios. “Students might learn the normal anatomy of the back and shoulders one day and then the next, orthopedic surgeons might be showing them how to treat a sprain,” said DiGiovanni.

“Framework,” continued on page 6

Memories of Med School

L. RANDOLPH CISHOLM, MD
Department of Anesthesiology
VCU School of Medicine

I graduated from Eastern Virginia Medical School in 1977 where a new school emphasis was placed on the psychological aspects of medicine. Students were placed in patient care situations early in our school year learning how to talk with patients even though we did not have any idea what we were doing. The school wanted us to learn how to listen and interact. Courses were small, consisting of 35 students.

JOHN F. BUTTERWORTH IV, MD
Department of Anesthesiology
VCU School of Medicine

I attended MCV between 1975-1979. We spent most of the first two years seated in two classrooms in Senger Hall. It’s a wonder that we did not develop decubitus ulcers.

AARON S. ROSENBERG, DO
Chief Medical Officer Virginia Medicaid/Medicare Program
Senior Medical Director National Medicare

When I attended medical school in the late 1990s, the initial two years were primarily lecture-based learning. The entire class of over 100 students attended the same lectures. The lectures were primarily driven by Microsoft PowerPoint slides.

JULIE KERR, MD
Commonwealth Ear Nose and Throat Specialists

I missed one lecture in the first two years. It was helpful to hear what the professors focused on, and courses ranged from biochemistry to anatomy to military medical history. I then completed clinical training for medical school in the next two years at the Uniformed Services University. I most recall lots of note taking, putting together powerpoint presentations that I saved on those old square hard discs for computers, and quite a few of my professors/proctors. This was mixed in with my Army training as a physician with field training exercises that included care of simulated battle injuries in simulated combat zones, and summer experiences with 18D (Special Forces Medics) and Apache Pilots.

USU prepped us to handle extreme circumstances for patient care. I’ve go back and do it again in a heartbeat.

SARAH G. WINKS, MD
Third-Year Resident, VCU Medical Center, Department of Radiology

For the class of 2010, traditional lectures were supplemented with small group experiences, including an early introduction to clinical medicine through the Foundations of Clinical Medicine course.
“Studies have shown that students can better retain information this way.”

The lessons of the first two years of the old model now are concentrated into 18 months, as the new curriculum eliminated many redundancies. “Not much has changed in what they’re learning,” said Michael Ryan, MD, assistant dean for Clinical Medical Education, who oversees third- and fourth-year students. “What’s changed is how they’re learning it.”

“Nowadays, doctors are part of interdisciplinary teams, and a big part of the new focus is learning how to communicate across the disciplines,” he said.

That interdisciplinary approach is one of the things that sets VCU apart, said Wood. Another is the focus on patient safety, such an important consideration that VCU recently hired Gene N. Peterson, MD, Ph.D., as associate dean for patient safety and quality care in the School of Medicine and chief safety and quality officer for the VCU Health System. It’s a dual role that incorporates the realms of clinical work, academics and research, reflecting medicine’s increased awareness and focus on safety.

Another feature of the curriculum is the work students undertake in the 25,000-square-foot Center for Human Simulation and Patient Safety, which features high-tech mannequins to simulate procedures from childbirth to colonoscopy, as well as live standardized “patients,” often drawn from VCU’s Department of Theatre.

Small groups of students interview a standardized patient, work through the case using specialized computer programs and “order” physical examinations and laboratory tests. Those exams and tests are measured in time and money, which students must justify. From that, they’re expected to make a diagnosis. “They’re getting feedback in practical material from the moment they get here,” said Wood.

The curriculum change reflects changes in how today’s physicians are treating patients, said Ryan. “Naturally, there have been changes in medicine in the past 100 years. When the [old] model was constructed, most people were dying of acute life-threatening infectious diseases such as pneumonia or tuberculosis, and so on. It’s shifted, and now people are dying of chronic diseases such as diabetes and hypertension. So the framework of training students had to shift.”

In addition, some specialties, such as radiology, anesthesiology and emergency medicine, were underrepresented in the traditional model. “Every student might not need to know how to read an X-ray or CAT scan,” said Ryan. “But they need to know when to order it, the pros and cons, and the indications.”

At the same time Wood and other faculty members were developing the

Today, educators believe that developing problem-solving skills, teamwork and early exposure to clinical situations better prepare future doctors for residency and ultimately practice.

An end to “silos”

The collaborative nature of 21st century medicine marks a shift away from the “silos” that have often separated medical students from peers in related health professions.
new curriculum, the $158.6 million James W. and Frances G. McGlothlin Medical Education Center was going up on campus between Main and West hospitals. The curriculum planning committee was able to integrate components of the new courses into the physical space of the 12-story, 200,000-square-foot facility.

School of Medicine technology experts created a computer system to complement the new curriculum and even some of the desks were designed to foster the team approach to learning.

Early reaction to this year’s crop of M1 students has many faculty members convinced of the strength of the new curriculum, said DiGiovanni. “The faculty has commented on how mature the students’ notes are.”

Schools that have had similar curriculums in place for several years, such as Case Western Reserve, have published data showing that board scores have risen and students have reported being much better prepared for residencies than their cohorts, she said.

VCU’s curriculum, Wood believes, is unique in the nation, going above and beyond all licensure and accreditation standards.

“Framework,” continued on page 8

McGlothlin MEC honored

Designed by I.M. Pei’s architectural firm, the James W. and Frances G. McGlothlin Medical Education Center was honored last year by an educational planning & design organization, American School & University, in the category of specialized facilities.

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A time to be cherished
BY SHIKHA GUPTA

By nature, human beings are storytellers. The sharing of stories and experiences has long-served as the backbone of knowledge and information transmission, and despite the advent of dramatic technological changes, the oral passage of advice and history from teacher to student remains a constant. As one of a very small (but growing) cohort of medical student members of the Richmond Academy of Medicine, I am privileged to be one of two student trustees on the Academy's board. I'm no stranger to being on the receiving end of advice, nostalgia, and stories from practicing and retired physicians.

These exchanges range from cautionary tales of the perceived rising opportunity cost of practicing medicine in the wake of a rapidly changing healthcare climate to starry-eyed recollections of first surgical experiences and notable patient encounters. One motif, however, weaves a ubiquitous thread through all of these physician-student interactions: Medical school is a unique, once-in-a-lifetime opportunity for self-discovery, personal and academic growth, and exploration of the capacity and limitations of the relationship between medicine and the human experience. It is, despite its great challenges and seemingly endless demands, a time to be cherished.

The four years spent within the walls, both real and imaginary, of medical school offer an incubatory time period for student doctors to bridge the gap between our former, non-medical lives and our future lives as capital P Physicians. To some extent, medical students are insulated from the "real world," which gives us the opportunity to devote the time and energy necessary to excel academically in a competitive medical school, but renders us mostly useless in conversations about current events, pop culture, and general knowledge outside the field of medicine. (Medical students, on the whole, are not great candidates for trivia teams.) As has been the tradition for centuries, the art and science of undergraduate medical education revolves largely around consuming, digesting, and regurgitating vast amounts of information in small periods of time.

Despite being a great champion of tradition, however, the VCU School of Medicine is challenging the adequacy of the status quo of traditional undergraduate medical education on nearly every front. The current first year members of the Class of 2017 are in the thick of the inaugural year of a brand-new medical curriculum that condenses the typical four preclinical semesters into three, providing earlier, longer exposure to clinical clerkships for MCV students.

Dr. Chris Woleben, associate dean for Student Affairs and MCV alumnus, acknowledges that the implementation of the new curriculum has had its share of growing pains, but points out that "VCU is leading the pack in ingenuity and innovation in undergraduate medical education. We are creating an educational system that lends itself to a longitudinal, integra-

It is a well-kept secret that medical school is, at various times, awe-inspiring, transformative, and (believe it or not) fun.
The number of VCU medical students matched into primary care fields, including Internal Medicine (31), Pediatrics (14) and Family Medicine (13).

“Cherished,” continued from page 9

tive, technology-driven understanding of medicine that will provide our students with a distinct advantage as practicing physicians.”

To complement the new curriculum, the architecturally inventive and academically advanced McGlothlin Medical Education Center (MMEC), the new (and vastly improved) home of the medical school, opened its doors in March 2013. The 12-story, 200,000-square-foot building boasts four floors of “Learning Neighborhoods” designed to facilitate the transition from a primarily lecture-based curriculum to an active, team-based learning model structured by clinical cases. The state-of-the-art LEED-certified building also houses the two-story Center for Human Simulation and Patient Safety, which provides students, residents, and faculty alike with unparalleled access to realistic clinical simulations, patient mannequins, and standardized patient encounters.

As a member of the last class of MCV students being educated in the style of the “traditional” curriculum, I have to admit that I approached these changes with a distinct sense of trepidation. The administration wanted us to interact with fellow students, read textbooks instead of pre-prepared outlines, and (horror of horrors) actually show up to class. The 75 percent of my class comprising the pajama-clad cohort of “home studiers” shook its fist and voiced its vehement disapproval of any curriculum that required leaving home study spaces (read: beds). We were dubious about listening to faculty members address us face-to-face in real time rather than listening to lecture recordings at double speed later. Shake our fists as we might, it quickly became clear that the curriculum was changing with or without us, so our only option was to go along for the ride.

Though it was a distinctly bumpy ride at times, it was incredibly refreshing to leave the confines of the lecture hall to tackle clinical cases in teams of my peers. The opportunity to directly apply my hard-earned medical knowledge to clinical scenarios in a group setting tested my capacity for creative thinking, peer teaching, and, of course, rapid-fire Googling. I walked away from “new curriculum” courses with not only a deeper, more thorough understanding of the material, but with a distinct sense of accomplishment at the ownership I was (politely) forced to take over my own education. The marriage of the new medical school building and curriculum is seamless, and the thousands of hours of strategy sessions poured into its development are apparent in every detail, from the inclusion of social spaces on each floor to the selection of lecture hall chairs that lend themselves to hours of comfortable studying to the whiteboard walls throughout the building.

To me, the most notable feature of the rapidly evolving climate of change and development that is almost palpable in its intensity on the MCV campus is the willingness and desire of the faculty and administration to incorporate the student perspective into the decision-making process. All students are encouraged to take advantage of our deans’ open-door policies to make suggestions and voice concerns, and elected student representatives serve as a streamlined conduit for information exchange between the student body and the administration. Kunal Kapoor, president of the Class of 2017, says, “What strikes me the most is that the administrators are not only very down-to-earth, but also express a genuine interest in making sure we succeed.”

On a personal note, I have spent the past year transforming MCV into the closest approximation of

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Hogwarts (the fictional wizardry school in the Harry Potter book series) that I can. The student body is divided into four societies that competed to earn points for their houses all year in a tournament composed of a series of community service, academic, athletic, and spirit events, culminating in the inaugural Strauss Cup Society Field Day, named for Dr. Jerome Strauss III, who began his tenure as dean of the medical school in 2005. The event received unprecedented support from the entire school, and it functioned as an opportunity for students, faculty, administrators and their families to come together for a day of camaraderie, school spirit, friendly competition, and the opportunity to see some of our favorite professors and student leaders in the dunk tank.

It is a well-kept secret that medical school is, at various times, awe-inspiring, transformative, and (believe it or not) fun. My motivation for devoting the time and energy required to organize these events is two-fold. First, MCV is on the cusp of becoming one of the premier medical education institutions in the nation, and it is time to forge a series of new traditions at this school that represent the diversity of backgrounds, interests, and personalities of our student body. The development of the societies and the Strauss Cup Tournament is a tradition that is equalizing and accessible to all members of the MCV family. Second, when I look back on my time as a medical student 10 years from now, I expect that I will have forgotten the names of the enzymes in the Krebs cycle, and the memories of the stress of studying for exams will have faded with time, but I hope to look fondly back on the time I spent becoming the person I will be as a practicing physician.

When I eventually transition from the role of student and recipient of knowledge to that of teacher and storyteller, I will tell future aspiring physicians about the years I spent at MCV with pride, both in the quality of the education I received and in the role my peers and I played in helping to shape this institution into what it will one day be. I feel privileged to have the opportunity to learn the tools of my future trade here, and I make a concerted effort each day to cherish this uninterrupted time for personal growth and the development of the collection of skills, experiences, and advice from which I will draw and pass along to my own students as a practicing physician. Even as the field of medicine faces a challenging uncertain path in the years to come, the future for MCV students is bright and we will meet the challenges ahead armed with the knowledge that we received an excellent, well-rounded undergraduate medical education.

Shikha Gupta is in her second year at VCU Medical School. She can be reached at guptas9@mymail.vcu.edu.

VCU’s medical students had good success matching into other specialties, including Anesthesiology (21), Obstetrics and Gynecology (15), Emergency Medicine (14), General Surgery (10), Diagnostic Radiology (8) and Orthopedic Surgery (8).
In his first tour of duty in 1989, Cliff Deal had no time to think before leaving for his first combat deployment. As part of the U.S. Army’s 82nd Airborne Division heading into Iraq during Operation Desert Storm, Deal said, “We were the alert battalion for the entire United States. They called on a Sunday night, and I didn’t come back to the U.S. for eight months.”

With his Washington & Lee roommate also answering the call to battle, they ran out of the house in Fayetteville, N.C., where they were stationed at the time. “You could see the trail of our various clothing items. … You put on your uniform and ran out the door.”

He was a freshly-minted Army lieutenant at the time. Today, Dr. Clifford L. Deal III is a surgeon at Richmond Surgical and a board member of RAM. In a recent interview, he shared his experiences from 2013 during a four-month-long deployment as a combat surgeon in Afghanistan. As he operated in a forward operating base in a remote part of eastern Afghanistan, he survived a firefight with a rogue Afghan soldier that took place dangerously close to his operating room; he was later awarded a Combat Action Badge.

Deal was in the thick of a complex, often troubled military action, which led to severe precautions in his OR. After a number of attacks by Afghan soldiers on American forces, whenever American doctors operated on non-NATO personnel they were closely guarded by an American soldier with a drawn M16 automatic rifle.

Deal’s surgical team also had to use metal-detecting wands on every patient to ensure no bombs or weapons were sneaked into the OR. Soldiers from Taliban units were blindfolded as they were taken off helicopters and carried on stretchers. “It’s not your normal medicine,” Deal observed.
He was well-prepared to deal with the “fog of war” from his early experiences during Desert Storm. Back in 1989, after a long flight to Saudi Arabia, he and fellow soldiers were amped up as they landed at a military base, dressed in full combat gear. When the plane dropped its ramp and the soldiers disembarked, “We were pointing our weapons out of the back of the plane, and there’s an Air Force guy with a Walkman on who says, ‘Yo! What’s up?’”

His part of the 82nd Airborne was attached to a French light armor division and in this joint military operation to drive Saddam Hussein out of Kuwait, the joint forces attacked Iraq’s western flank. As they encountered Iraq units in this desert territory, he recalled, “It was either total destruction or total surrender. … Resistance was fairly light.”

After four years of active duty service, Deal left the Army to enter the Medical College of Virginia where he studied to become a surgeon. But he remained in the U.S. Army Reserve, assigned to a combat surgical team. Based in Minnesota, the 945th typically is activated for nine months at a time—this includes medics and nurses—while doctors usually have 90-day rotations, with another month to prepare. “If you’re in private practice, you can imagine the overhead you have,” he explains.

He began preparing for his latest Reserve tour duty last August. It would last through December. First, he went to Fort Benning, Ga., where he had to qualify with his Beretta 9mm pistol—which he did, just missing expert by one point. (“I practiced before I went down there,” he noted.) Then he flew to Kuwait—arriving in 115-degree heat. He experienced a bit of déjà vu, thinking about his arrival 23 years before that in Saudi Arabia, but this time he flew commercial, and marveled at the amount of security, with bomb-sniffing dogs and other precautions. Another big difference was the nature of today’s combat surgery: During Desert Storm, with ground transportation available in Iraq and Kuwait, medical teams could operate behind the lines and injured troops could be driven to them.

In Afghanistan, though, roadside bombs and the remote locations of American troops battling Taliban forces made ground travel deadly. So Deal found minimal movement on the ground and air transport more commonplace.

His Afghan duty had two distinct parts:

- Steep toll of war
- The Kay Janney Investment Group

Since the U.S. launched military operations in Afghanistan in 2001, followed by those in Iraq, U.S. service members have paid a steep price. This count was compiled Feb. 1, 2014, by the Wounded Warrior Project:

- **6,795** Dead
- **51,876** Wounded
- **320,000** Traumatic brain injuries
- **400,000** with PTSD

Whereas whenever American doctors operated on non-NATO personnel they were closely guarded by a U.S. soldier with a drawn M16 automatic rifle.

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phases—one filled with action, the other not so much. The slow part came first when he was sent to the huge American base at Kandahar in the southeastern region. First built by the United States in the 1960s, the air base later was occupied by the Soviets after their 1979 invasion, and then was rebuilt by the United States after it invaded in late 2001 during Operation Enduring Freedom. Today, Kandahar is the country’s second main international airport and can handle up to 200 military aircraft.

While the base’s size and scope is impressive, Deal often found himself twiddling his thumbs over a seven-week period in Kandahar. “Our mission was to be the theater reserve,” which meant his team would help with any surgical work that couldn’t be done by the Navy medical staff on the base.

With 20 people on his forward surgical team—four surgeons, two certified registered nurse anesthetists (CRNAs), plus more than a dozen medics and other nurses—Deal said, “We as a team needed to be performing our mission to jell.”

The second phase began nearly two months into his deployment when he took half his team into a mountainous valley in eastern Afghanistan called Qalat, which means "fortress" in Arabic. In Army parlance it was FOB (forward operating base) Apache, and serves as head-quarters of the 3rd Brigade, 1st Infantry Division—also known as “The Big Red One.”

“You could hear outgoing fire,” Deal recalled, “there was a howitzer about 100 meters from my tent firing at Taliban.” The enemy forces usually were operating 3 to 4 miles away in the surrounding mountains.

Deal had little time to watch the artillery fire, though, since his team started operating right away. As part of the ongoing downsizing taking place with the American forces, his 10-person team replaced a Navy medical team that was three times the size of Deal’s operating unit.

“In our first 48 hours there we operated almost nonstop,” typically on Afghan troops who’d been shot or severely wounded by improvised explosive devices. “Honestly, we wondered how we were going to keep up at that pace.”

Operating on little or no sleep, they managed to save as many lives as possible—including those of the Taliban wounded who also were brought in. “At Apache, I had a flimsy building, but it had a modern anesthesia machine, and a modern OR table.”

He was asked to compare the surgery he performed in the battlefield to his work in Richmond, particularly when he serves as a trauma surgeon at VCU. (Deal practices breast and general surgery at Henrico Doctors’ Hospital, where he serves as department chairman.)

“The difference between there and here is that you are really skinny on people,” that is, “you’re alone” in combat. “It’s just me, an orthopedic surgeon and a CRNA. … At VCU I’m used to bringing the attending, while supervising surgical residents, so I know how to oversee care of several injuries at the same time.”

At FOB Apache, “I had to do the same thing with three medics,” each of whom served as a trauma team leader. His time on call at VCU’s trauma unit has proven to be invaluable to his work as a combat surgeon. “Continuing to do that while I practice saved me while I was in Afghanistan and absolutely led to the saving of some lives, because I had that experience.”

Whenever trauma occurs, the first job is to stop the bleeding. In Richmond, “most people are shot with low velocity weapons,” such as pistols, “causing a lot less damage.” In Afghanistan, the wounds come from high-velocity assault rifles, so “if you get hit in the leg it will almost take your leg off.”

Typically, after stopping the bleeding, the next job is to control any contamination in the wound, and if necessary, evacuate the soldier to the next highest level of treatment, usually by helicopter back to Kandahar for U.S. troops, or to Afghan facilities for their troops. While the U.S. offers its wounded soldiers and Marines “the best prosthetics that money can buy,” it’s not the same for Afghan soldiers. For those who became paraplegics, for example, “That’s often a death sentence, because they don’t have any support.” The same principle applies to burn victims in Afghanistan versus Americans who receive treatment back in the States.

Asked about the stress level of his three months of combat duty, his pulse rate jumped the most one day when he heard gunfire outside his OR: An Afghan guard was firing on U.S. troops. For the first and only time during his deployment, Deal grabbed his pistol and prepared to defend himself and his OR.

He fired no shots, however, and was soon operating on one of the American soldiers who’d been shot in the incident. The soldier was mortally wounded, however.

Deal grows emotional as he recalls his return to the U.S., landing in Portsmouth, N.H. “Practically the whole town was there,” he says.

Since he deployed as an individual, there was not much official fanfare on the return home, which made the New Hampshire welcome reception especially meaningful. The Pease Greeters [as Pease International Airport] have been welcoming home troops 24/7 since the start of the desert wars. Looking back on the conflicted nature of the American military mission in Afghanistan, and the overall lack of awareness of the war today in the U.S, he said, “Going over and coming back, it’s like it doesn’t exist. There’s such a disconnect.”

Nonetheless, he feels strongly that this is a war worth fighting as a means of clearing out the terrorist haven that Afghanistan had become before 9/11 when the U.S. drove al-Qaeda’s leadership, including Osama bin Laden, into hiding.

Asked whether he suffered extreme stress, he said, that unlike combat troops, “I wasn’t kicking down doors every day.” For those soldiers, “That’s a whole other order of magnitude of what I experienced. I wasn’t in immediate fear for my personal safety most of the time.”

Trying to explain his thought process in the combat zone, he concluded, “It’s like you’re worried about walking in a bad neighborhood where you shouldn’t be.”

Are physicians protecting ALL of their income?

BY MATTHEW D. BROTHERTON, AIF, CLTC

Matt Brotherton is president of 1752 Financial. He can be reached at (804) 283-1920 or mbrotherton@1752solutions.com

It is important to complete a thorough review of ALL of your disability policies in order to make sure it is protecting all of your income.

Do you have enough disability insurance?

Most of us understand the need for long term disability coverage, but the bigger question is... Is it enough? Typically, coverage maxes out at about 60% or 70% of gross (pretax) earnings. This is enough to let you plan for mortgage payments and keep the refrigerator stocked. But, if like many people, you get physician’s disability coverage as part of your benefits package at work, watch out. Nine times out of ten, if you are currently covered by a Group Disability Policy, your practice will pay your disability insurance policy with pretax dollars. This means your benefit payouts will be taxed as income and you will likely receive considerably less than you had planned for. Your payouts will be reduced by a third or more (depending on your tax bracket), cutting the benefit to about 40% of your pretax salary, rather than the 60%-70% you expected.

To give an example, if you are making 100K, your disability policy will likely cover about 65% of your salary, or 65K (if this isn’t the case for you, it’s time to update your disability policy!). If this is paid with pretax dollars, your benefit will drop to about 44K after taxes. So instead of 65% coverage, you are really looking at 44%, a precipitous $20,000 drop in income. That could leave the fridge pretty bare. The same scenario applies for any disability insurance for which you pay using pretax dollars.

The other side of the coin is paying for your disability insurance with post-tax income. If the coverage is paid by you personally, you won’t be taxed on the benefits. The same holds true if you pay with after-tax dollars through payroll deduction.

What to do?

Once you realize you don’t have enough coverage, it’s time to review your policy. You need to perform a thorough analysis to determine your maximum potential benefit depending on your current disability policy portfolio. Let’s say you are maxed out at your highest potential benefit. If that benefit, or even a portion of that benefit is pretax, we can supplement your Group Disability Policy with individual, non-cancelable disability coverage at an affordable discounted price. There are also a number of other reasons you would benefit from a simple disability insurance policy review.

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We relentlessly defend, protect, and reward the practice of good medicine.
An EMR-related claim

BY DAVID B. TROXEL, MD

On April 23, a 58-year-old female presented to the medical group’s Dr. A with symptoms of a urinary tract infection (UTI). In the electronic medical record (EMR)—an early EMR system considered dated by today’s standards—he documented the presence of a 2 cm left upper lobe thyroid mass and recommended a thyroid ultrasound (US).

On May 1, the patient’s US exam demonstrated a 2.3 cm mass in the left thyroid lobe. The differential diagnosis included a neoplasm, and a radioactive iodine uptake (RAIU) test was recommended. The US report was not available until May 10.

On May 5, the patient saw Dr. A for follow-up of her UTI. The US report was not yet available, so the EMR included no reference to the US study. His physical exam note stated, “The neck/thyroid is supple, without adenopathy or enlarged thyroid.” It was later assumed that this note was an EMR default setting for the history and physical (H&P) that Dr. A did not notice and then override to reflect the presence of the thyroid mass. On May 8, the patient called the group, requesting the results of the thyroid US. Staff advised that the US results were pending.

A note in the EMR dated May 10 stated, “Patient was seen by Dr. A, and an US on May 1 revealed a 2.3 cm left thyroid mass; a nuclear medicine scan to exclude neoplasm was recommended. EMR will have US report scanned.” The note also stated that Dr. B was the “rendering provider” (even though he was out-of-state on this date) and confirmed that someone in the group received the US report. Despite the instruction, the US report was not scanned into the EMR. In addition, there was no EMR documentation that the patient was advised to have a RAIU—and no indication of any attempt to schedule one.

On February 22 of the following year, the patient saw the group’s Dr. B for diarrhea and recent weight loss. On examination, he noted the solitary left thyroid nodule. He ordered a TSH and free T3/T4 and stated he would consider a thyroid US if these tests were normal. The patient didn’t mention that she’d had a thyroid US 10 months earlier. Dr. B subsequently stated that when the EMR was later printed, a section titled “Diagnostics History” appeared and documented, “US exam of head and neck ordered April 23.” He said that the patient’s diagnostics history did not appear on the computer screen when he made his note on this visit because “he did not know that he had to click on a drop-down menu to view it.” Therefore, during the patient’s February 22 visit, Dr. B was unaware of the patient’s US the previous year.

On March 16, the patient was seen by the group’s Dr. C to discuss her thyroid function test results (which were normal). The EMR entry noted “nontoxic uninodular goiter; etiology uncertain.” The patient mentioned the prior US study, but the May 1 US report was not in the EMR. Again, the Diagnostics History section did not appear on the screen, because Dr. C was also unaware that she had to click on a drop-down menu to see it. Dr. C ordered a thyroid US, which the patient had on March 24. The thyroid mass had increased in size from 2.3 to 4.1 cm, and the RAIU was ordered.

After numerous efforts to obtain authorization for the RAIU study, it was performed on June 30 (three months after being urgently requested) and showed a “photopenic mass in the left thyroid.” The possibility of ma-
Issues in this case included the physician(s)-patient communication. Fundamentally, it resulted from poor communication, which contributed to this claim, which delayed in diagnosis that resulted in this claim might have been prevented.

### Discussion

#### 1. The Autopopulation of Data Fields

The autopopulation of data fields is fundamental in creating liability. It was later discovered that some EMRs auto-populate fields as a default in the H&P; entering erroneous information into the EMR can create liability.

#### 2. Computer-assisted documentation

Computer-assisted documentation produces structured progress notes which often contain redundant information, making it easy to overlook significant clinical information. Communication with on-call and consulting physicians may be compromised. In this case, because Drs. B and C did not know how to view the Diagnostics History section, they were unaware of the prior US. Whether this resulted from faulty software design is unknown. Vendor contracts may attempt to shift liability for faulty software onto the physician. Read all contracts carefully.

#### 3. The May 10 Note

It was later discovered that some of the group’s EMR problems involved difficulty accessing entry and progress notes from prior visits. The notes could be locked rendering them inaccessible to subsequent physicians. However, if left unlocked, the name of the physician making the subsequent entry would be added to the unlocked prior note. This situation probably explains why the May 10 note stated that Dr. B was the rendering provider when he was out-of-state.

### Authors

David B. Troxel, MD, is a medical director of the Board of Governors of The Doctors Company.

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