Reid BlackweldeR, M.d., Runs foR the aafP BoaRd of diRectoRs
SEE EDITORIAL ON PAGE 5

Join us in Gatlinburg on October 27-30 for the Tennessee Academy of Family Physicians’ 61st Annual Scientific Assembly!
THERE'S ALWAYS A BETTER WAY. Doesn’t it make sense that checking in at a doctor’s office should be as easy as checking out at a store? Just swipe a credit card and go. We thought so, too. That’s why you’ll find automated check-in kiosks for our clinics at Vanderbilt Health One Hundred Oaks. We’ll also give you a pager to alert you of your appointment. Dine in our food court. Check your email with our free Wi-Fi connection. Or just sit back and relax. Healthcare has never been more comfortable. To learn more about the conveniences at our new facility, visit VanderbiltHealth.com.
TENNESSEE FAMILY PHYSICIAN
AN OFFICIAL PUBLICATION OF THE TENNESSEE ACADEMY OF FAMILY PHYSICIANS

Fall 2009
Vol. 2 Number 3

President’s Corner

Editorial

2009 National Tar Wars Poster Contest

Slate of Nominees for 2010 Officers and Board of Directors

Legislative Report

Members of the 2009 TNAFP Congress of Delegates

Practice Opportunities
It is hard to believe that this is my last President’s Corner to write. I have been privileged to serve two years/terms as your president of our Tennessee Academy. My first term as president was to have belonged to Doctor Chris Graves; I still miss Chris so much. My life would have been easier the past two years if he had been here to share and be the friend that I enjoyed for so many years. Just like the deaths of my father and brother, the hole in my life hasn’t gotten any smaller, I’ve just gotten more adept at not falling in that hole.

As with anyone in leadership, how will my service to the Academy be remembered? I know how I want it to be viewed, but as in all circumstances, time will tell. Did we accomplish the goals we set? Will I be leaving our Academy in better shape than it was before I was installed and served as president?

As you read this article and contemplate my last paragraph, I ask you as an individual member of our Academy how will your service to your Academy be remembered over the past year? Have you left our Academy in better shape at this point than this time last year, or two years or five years ago? What have you done to promote our Academy and fulfill the needs of the Academy and its membership? I say this because it is our responsibility to move this Academy forward as a team. If we rely on the Tennessee AFP president to be the only responsible person for the improvement of our Academy, then we only have one person’s talents and abilities at work.

I challenge each and every member of our Tennessee Academy to view 2010 with a new perspective. As Doctor Scott Holder is installed in October as the 2010 President, it is our collective responsibility to support him and our Academy to reach our goals and to carry our organization to the mountain top. I know he will do a marvelous job as our fearless leader, and I truly look forward to working with my friend.

October will be a busy month. The AAFP Congress of Delegates and Scientific Assembly are being held in Boston during the second week. One of our goals for that week will be getting one of our members, Doctor Reid Blackwelder, elected to the AAFP Board of Directors. I believe he will serve our Academy well and help make our Academy better through his energies and efforts. The educational opportunities offered at the Scientific Program are phenomenal and will challenge each of us and help us grow as physicians.

The last week of October will be the Annual Scientific Assembly of the Tennessee AFP, peak leaf season in Gatlinburg. Great educational opportunities and a fun time for all. And, a great time to renew friendships, make new ones and challenge each other to consider what can we do collectively to make our Tennessee Academy better.

Thank you for the privilege of being your President. You and our Academy will always be in my prayers.

Lee Carter, M.D., Huntingdon
President
looking into television lights. TAFP spent much of the first decade this century dancing around issues in the Legislature over our relationships and interactions with allied professions and chiropractors. Many leaders among us have also learned politics at the knee of the Tennessee Medical Association, and Reid was outside this loop for leadership training. We had learned the importance of testing our candidates before tossing them into the fire of debate and controversy. I wondered whether Reid would find this difficult given his appearance and avant-garde personality. Our Board meetings are pretty tame, but just when you think all’s going great, you get hammered by an issue out of the blue that tests your mettle. I was very wrong to heed my first impressions. Reid has been exactly the kind of leader we had hoped for Tennessee.

Reid came along as expected. His capacity for debate and discussion proved to be considerable. He listens well. He then speaks to the issue with fresh attitude that accounts for what has been said, but then the magic happens— he brings a new thought or vision of the point in question and seeks consensus, all the while attending to the emotions of the opposing sides of the question. I don’t know if it’s an inherited talent or an acquired skill, but I have seen him referee hearings that would render me helpless, and he has been consistently fair, thorough, and thoughtful. What is refreshing is the lack of agenda. I harbored the erroneous suspicion that he would have radical opinions. Nothing could be further from the reality. Reid has talent that disarms us and opens us to fuller discussion and reasoned debate. His reputation for being “not mainstream” is actually the catalyst that encourages us to risk speaking honestly and often healing by choosing Reid for care. He teaches us all something. Look beyond the shell. The value is the core.

He is drawn to teach and has talent for this beyond the usual. Students and residents are changed for the better when they’ve been at Reid’s side. Patients experience health and often healing by choosing Reid for care. He teaches us something good beyond the shell...”

- Sylvia Griffith Wheeler,
“Kansas Farmer,” 1966, Kansas Magazine

In my dusty collection of Y-2-K memories is the late afternoon dinner meeting between Cathy Dyer, Executive Director of Tennessee AFP, Doctor Reid Blackwelder of the ETSU Department of Family Medicine Faculty and myself in what was the latest incarnation of the Troutdale Restaurant in Johnson City. We were coming off the heels of a long range planning for leadership succession in the spring of 1998. I was looking for east Tennessee talent to move up in the rotation for the Academy to weigh in against a considerable line of middle and west Tennessee politicos. Reid was a puzzle to me then. I knew his pedigree was ideal for Family Medicine leadership. But was this bearded, unique, mind-body academic ready for primetime? We had a great discussion about the challenges of developing leaders who serve both academic and professional societies. And then, Reid surprised me. Yes, he’d been seriously considering leadership service in the TAFP and wanted to throw his hat in the ring.

Now, it’s one thing to be interested in serving and another thing entirely to stand up as the collective voice of Family Medicine for the TAFP to sensitive matters, be they about our politics, our patients, our families, or our colleagues. This is not to be overlooked. Our current national political discussions are polarized beyond repair. We cannot get beyond the positions to the urgent matters at hand. Our leaders set the stage: they direct the terms of the debate. Shall it be open to all? Are we in full consideration of the sides? Do we address the obvious sticking points and the emotions and beliefs that underpin them?

The decade since dinner on a spring evening has changed my mind. Every discussion, meeting and encounter since that time has solidified my respect for him. However, I must warn people not to be misled by his gentle and balanced approach to discussion/debates. He is just as passionate about all other aspects of his life as he is about listening to all sides. He’d rather suffer than tell you that he’s dying on a bicycle just to keep the pace! I’ve learned that his competitive spirit cannot overcome lack of skill on the golf course. He fashions wooden pens by hand with care and pride. He loves his wife, Alex, and his life in Kingsport. He is drawn to teach and has talent for this beyond the usual. Students and residents are changed for the better when they’ve been at Reid’s

Mike Hartsell, M.D., Greeneville
Delegate to the AAFP
Hannah Miller of Jonesborough, Tennessee’s 2009 State Tar Wars Poster Contest winner, along with her parents, Sandi and Robbie Miller, visit with Tennessee’s U.S. Representatives and Senators during the 2009 National Tar Wars Poster Contest in Washington, D.C., in July.
It only takes one hour of your time to teach one Tar Wars class in your local classrooms. Tar Wars is the AAFP’s National pro-health tobacco-free education program and poster contest for fourth and fifth graders to discourage tobacco use among youth. The program uses a community-based approach and provides an opportunity for health care professionals, school personnel and community members to work toward a common goal of discouraging youth tobacco usage.

Your help in teaching Tar Wars in your local classrooms would be appreciated! Teaching Guides for 2009-2010 will be available in September. Contact the Tennessee AFP for a printed copy or access a copy on the TAFP website at: www.tnafp.org. Or, if you have questions, please contact Cathy Dyer, Tennessee Tar Wars Coordinator, at the TAFP office: Toll Free at 1-800-897-5949; Nashville/Brentwood calling area at 615-370-5144; Email at tnafp@bellsouth.net.
There have recently been some questions about the laboratory screening requirements for children enrolled in Head Start. Variation in requirements by local programs had led to differing standards for laboratory screenings across the state. In an attempt to achieve uniformity in screening requirements, the Governor’s Office of Children’s Care Coordination has worked with the Head Start State Collaboration Office and the Tennessee Department of Health to clarify the guidelines for laboratory screening for children enrolled in Head Start.

For purposes of child health screening, Head Start references EPSDT as a standard of well-child care and requires certain diagnostic testing and screening accordingly. Specifically, providers should note the following points (table 1) in order to ensure appropriate testing and to avoid unnecessary testing. A notice with this clarification is being distributed to pediatric providers across the state, as well as to local Head Start program staff. If providers have additional questions, they may contact Dr. Michael Warren, Medical Director of the Governor’s Office of Children’s Care Coordination (michael.d.warren@tn.gov) or Janet Coscarelli, Director of the Head Start State Collaboration Office (janet.coscarelli@tn.gov).

Providers who would like additional information on the Tennessee Childhood Lead Poisoning Program may visit the program Web site at http://health.state.tn.us/lead/index.htm or call 615-741-7353. Additional information about the requirements for health maintenance screening may be found on the AAP Bright Futures Periodicity Schedule, which is the standard for all Medicaid enrollees and the reference for Head Start participants. The schedule may be found at http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%2020101107.pdf

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<th>Lead</th>
<th>Early Head Start (Birth to age three)</th>
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<tr>
<td></td>
<td>• Blood lead level must be obtained at age 12 months and at age 24 months. Providers should document</td>
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<td>that a blood lead level was obtained, note the numeric result and note whether the results were</td>
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<td>normal or abnormal, and note the date of the test. (If test results are abnormal, blood lead level</td>
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<td>must be rechecked—see attached protocol.)</td>
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<td>Head Start</td>
<td>• Blood lead level must be obtained at age 24 months. Risk questionnaire alone is not sufficient.</td>
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<tr>
<td>(Age 3-above)</td>
<td>• Providers should document that a blood lead level was obtained, note the numeric result and note</td>
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<td>whether the results were normal or abnormal, and note the date of the test. (If test results are</td>
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<td>abnormal, blood lead level must be rechecked—see attached sheet.)</td>
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<td>• If the blood lead level was obtained at age 24 months and was normal, no further testing is</td>
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<td>needed unless risk factors are identified during the lead risk assessment.</td>
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<td>• If there is no documentation that a blood lead level was obtained at age 24 months, then a blood</td>
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<td>lead level should be obtained as soon as possible.</td>
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<td>• Providers should ask lead risk questions at every well-child visit between 6-72 months.</td>
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<td>• If the family answers “Yes” or “Don’t Know” to any of these questions, then the provider should</td>
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<td>draw a blood lead level.</td>
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<td></td>
<td>• If the family answers “No” to all the questions, then a blood lead level is not needed.</td>
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| Hemoglobin or Hematocrit | • Based on EPSDT guidelines, hemoglobin (or hematocrit) should be checked at age 12 months. Providers should document that a hemoglobin (or hematocrit) level was obtained, note whether the results were normal or abnormal, and note the date of the test. • Yearly hemoglobin/hematocrit testing is not required unless the provider or family has specific concerns (based on the child’s clinical history or physical exam). |

| Urinalysis | • Based on EPSDT guidelines, urinalysis is not required for participation in Head Start. • If the provider or family has specific concerns (based on the child’s clinical history or physical exam), then a urinalysis may be obtained. |
Pain from lumbar spinal stenosis had robbed him of his will, his joy, and his passion for golf. A minimally invasive procedure changed everything.

Inserted through a small incision in the lower back, this implant may safely relieve pressure on spinal nerves.

THE X•STOP® SPACER
for symptoms of lumbar spinal stenosis

“I got my life back.”
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X-STOP SPACER RECIPIENT

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Visit XSTOPSPACER.com

IMPORTANT SAFETY INFORMATION

Indications for Use: The X-STOP® Interspinous Process Decompression (IPD®) System is indicated for treatment of patients aged 50 or older suffering from neurogenic intermittent claudication secondary to a confirmed diagnosis of lumbar spinal stenosis (with X-Ray, MRI and/or CT evidence of thickened ligamentum flavum, narrowed lateral recess and/or central canal narrowing). The X-STOP is indicated for those patients with moderately impaired physical function who experience relief in flexion from their symptoms of leg/buttock/groin pain, with or without back pain, and have undergone a regimen of at least 6 months of non-operative treatment. The X-STOP may be implanted at one or two lumbar levels in patients in whom operative treatment is indicated at no more than two levels.

Contraindications: The device is contraindicated in patients with: an allergy to titanium or titanium alloy; spinal anatomy or disease that would prevent implantation of the device or cause the device to be unstable in situ, such as significant instability of the lumbar spine, e.g., isometric spondylolisthesis or degenerative spondylolisthesis greater than grade 1, (on a scale of 1 to 4), an unstable segment at the affected level(s), acute fracture of the spinous process or pars interarticularis and significant scoliosis; Cobb angle greater than 25 degrees; cauda equina syndrome defined as neural compression causing neurogenic bowel or bladder dysfunction; diagnosis of severe osteoporosis, defined as bone mineral density (from DEXA scan or some comparable study) in the spine or hip that is more than 2.5 SD below the mean of adult normals in the presence of one or more fragility fractures; and active systemic infection or infection localized to the site of implantation.

Warnings: The X-STOP implant must be placed in the concavity between the spinous processes. Posterior positioning of the implant may result in dislodgement. If correct placement of the implant cannot be achieved due to variant anatomy, the surgeon should consider aborting the procedure because incorrect placement may result in device dislodgement, particularly if the patient experiences a traumatic event. Radiological evidence of stenosis must be correlated with the patient’s symptoms before the device can be confirmed; if the spinous processes at the affected level are not distracted in flexion, the X-STOP system may not be indicated; the safety and effectiveness of the X-STOP device has not been studied in patients with the following conditions: axial back pain without leg, buttock or groin pain, symptomatic lumbar spinal stenosis at more than 2 levels, prior lumbar spine surgery, significant peripheral neuropathy, acute denervation secondary to radiculopathy, Paget’s disease, vertebral metastases, morbid obesity, pregnancy, a fixed motor deficit, angina, active rheumatoid arthritis, peripheral vascular disease and advanced diabetes or any other systemic disease that may affect the patient’s ability to walk; surgeons should not implant the X-STOP implant until receiving adequate training regarding surgical technique because inadequate training may result in poor patient outcomes and/or increased rates of adverse events; and a stress fracture of the spinous process may occur if strenuous physical activity is resumed too soon postoperatively.

Potential Adverse Events: The following potential adverse events may occur as a result of interspinous process decompression with the X-STOP system: some of these adverse events were reported in the Pivotal Clinical Trial. X-STOP system related: implant dislodgement/migration; implant not positioned correctly; fracture of the spinous process; additional surgery, which could include removal of the X-STOP implant; foreign body reaction; mechanical failure of the device, failure of the device/procedure to improve symptoms and/or function. Surgery Related: reactions to anesthesia; myocardial infarction; infection; blood vessel damage/bleeding; deep vein thrombosis; hematoma; pneumonia; neurological system compromise; stroke; nerve injury or spinal cord damage; paraplegia; thrombus formation; wound dehiscence or delayed healing; pain/discomfort at the operative site; and death.

Note: Medication or additional surgery may be necessary to correct some of these potential adverse events.
SLATE OF NOMINEES FOR 2010
OFFICERS AND BOARD OF DIRECTORS

PRESIDENT-ELECT:
R. Wesley Dean, M.D., Powell

VICE PRESIDENT:
Gregg Mitchell, M.D., Jackson

SECRETARY-TREASURER:
Kim Howerton, M.D., Jackson

SPEAKER OF THE CONGRESS:
B. Alan Wallstedt, M.D., Brentwood

VICE SPEAKER OF THE CONGRESS:
Lang Smith, M.D., Columbia

DELEGATE TO A.A.F.P.:
Timothy Linder, M.D., Selmer

ALTERNATE DELEGATE TO A.A.F.P.:
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ALTERNATE DIRECTOR:
Tom Avonda, M.D., Johnson City

DISTRICT 3 - DIRECTOR:
Mary Bean, M.D., Chattanooga

ALTERNATE DIRECTOR:
Allen Sherwood, M.D., Ooltewah

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Stephanie Gafford, M.D., Fayetteville

ALTERNATE DIRECTOR:
J. Lynn Williams, M.D., Decherd

DISTRICT 7 - DIRECTOR:
Joey Hensley, M.D., Hohenwald

ALTERNATE DIRECTOR:
Gabe Polk, D.O., Waynesboro

DISTRICT 9 - DIRECTOR:
Walter Fletcher, M.D., Martin

ALTERNATE DIRECTOR:
Susan Lowry, M.D., Martin

WOMEN – DIRECTOR:
Doreen Feldhouse, M.D., Dyersburg

ALTERNATE DIRECTOR:
Mary Huff, M.D., Sweetwater

DISTRICT 11 – RESIDENTS:
Jason Myatt, M.D., UT Jackson
Remi Switalski, M.D., ETSU Kingsport

The Resident receiving the largest number of votes at the Tennessee AFP Congress will serve as director, and the resident receiving the second largest number of votes will serve as alternate director.

STUDENT - BOARD REPRESENTATIVE:
Susan Goggans, Nashville (Meharry)

ALTERNATE REPRESENTATIVE:
Carol Logan, Nashville (Vanderbilt)

RESOLUTIONS RECEIVED FOR INTRODUCTION TO THE 2009 CONGRESS OF DELEGATES

At the time of publication of this journal, no Resolutions for the 2009 Tennessee Academy of Family Physicians’ Congress of Delegates had been received.
TO: All Medicare Providers -

The CERT review process is now strictly enforcing a long standing rule that requires a legible signature on all clinic notes, orders and other documentation (e.g. procedure notes) used to substantiate a claim billed to Medicare. Section 1833(e) of the Social Security Act states that contractors must be able to identify the provider who performed the service in order to pay. CMS defines a legible signature or electronic signature as the appropriate ways of identification.

Failure to have a written or electronic signature on these items will result in a denial regardless of the medical necessity.

All Medicare providers billing Medicare for service shall ensure that their signature is attached to these documents. Each provider should immediately put into place a protocol to assure these items are signed within a reasonable time frame, usually 48-72 hours after the encounter but certainly before the claim is submitted.

If a physician written signature is not legible, and many are not, please include a signature sheet with any submissions to the CERT carrier or the RAC carrier. This sheet should include the physician’s written signature and his/her legible printed or typed name. If others have made entries on the items submitted it is recommended that they be included in this signature sheet. Scrawled illegible initials will not suffice, but clear, legible initials accompanying a typed or printed name will usually be acceptable with the initials noted on the signature sheet.

Electronic signatures should clearly show that the item has been electronically signed and include a date and if possible a time.

Providers should act quickly to adhere to this Medicare Program requirement to prevent unnecessary denials or delays in payment for appropriate services.

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TENNESSEE AFP’S 61st ANNUAL SCIENTIFIC ASSEMBLY
October 27-30, 2009; Gatlinburg Convention Center

We hope to see you in Gatlinburg the last week of October! If you have not received your assembly program/registration brochure please contact the TAFP office, or you can access the brochure on the TAFP website at: www.tnafp.org.

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A RESOURCE TO PARENTS IN RECOGNIZING EARLY SIGNS OF AUTISM

Because you, the family physicians, are an essential provider of health care for children, you can play a key role in helping parents be aware of the early signs of autism spectrum disorders (ASD).

You are a valuable resource to parents! They look to you for information on their child, and they trust you.

You can help families learn about the milestones of development and watch for early signs of autism or other concerns by ordering free materials to give to parents.

1. Please order the free “Learn the Signs. Act Early” Healthcare Provider Resource Kit and Milestone Checklist from the Centers for Disease Control and Prevention (CDC). The Kit includes informational cards and stand, fact sheets, posters, and a growth chart. All materials are English on one side and Spanish on the reverse.

Order the Kit at the CDC Learn the Signs. Act Early http://www.cdc.gov/ncbddd/autism/ActEarly.

Another valuable resource is Tennessee’s Early Intervention System (TEIS). TEIS provides funding for child (0-2) developmental assessments and physical, occupational, and speech therapy based on an Individualized Family Plan. For more information: http://www.state.tn.us/education/speced/TEIS/ Central office: (615) 741-3537 and (800) 852-7157.

Tennessee Disability Pathfinder, a free statewide information and referral service, has a list of Tennessee autism resources: http://familypathfinder.org Phone: (800) 640-4636 CDC Act Early materials. For more information: CDC website link: http://www.cdc.gov/ncbddd/actearly/ccp/index.html.

This message has been provided by the Tennessee Act Early Team, Public Awareness Workgroup, with leadership from the Vanderbilt Kennedy Center and University of Tennessee Boling Center UCEDD and LEND Programs.

Questions? jan.rosemergy@vanderbilt.edu; phone: 615-322-8238
Fight Cough & Cold with

NOTUSS PE

Antitussive • Decongestant

NDC # 24839-343-16

Codeine Phosphate ........... 10 mg / 5 mL
Phenylephrine HCl ............ 10 mg / 5 mL

Temporary relief of symptoms due to the common cold, hay fever (allergic rhinitis) or other upper respiratory allergies:
• cough due to minor throat and bronchial irritation
• nasal congestion

DOSAGE & ADMINISTRATION
Adults and children over 12 years of age – 1 teaspoonful (5 mL) every 4 hours, not to exceed 6 teaspoonfuls in a 24 hour period.
Children 6 to 12 years of age – ½ teaspoonful (2.5 mL) every 4 hours, not to exceed 3 teaspoonfuls in a 24 hour period.

Notuss® PE Features and Benefits
• Safe and trusted active ingredients
• Cotton Candy Flavor syrup
• Dye free, Sugar free, Alcohol free, and Gluten free

Wholesalers Item Numbers
Amerisource Bergen 819-839
Cardinal 4237665
McKesson 1170752
Although several bills of healthcare interest were passed and signed by the Governor, 2009 proved to be a quiet year for the Tennessee State Legislature. Three bills of importance to all physicians, including family physicians, are summarized below.


This legislation gives good-faith immunity to a healthcare provider who volunteers to provide services without remuneration at clinics organized by sponsoring organizations which charge a patient based on sliding scale.

2. Medical Malpractice Revisions.

Although no sweeping reforms were passed, the Tennessee Medical Association and the Tennessee Trial Lawyers Association worked out an agreement to make some changes to the medical malpractice law including:

- Establish a clear, more definitive notification process and reduce chances that the notice will be served on a physician in an embarrassing situation. This is a provision not currently in state law but will get information to defense counsel sooner and more economically.

- Require that the plaintiff sign a HIPPA release for health care records of any provider listed in the notice and that the release be included with the notification, a provision not currently in state law but will get information to defense counsel sooner and less expensively.

- In exchange for clarifying that the statute limitations and statute of repose will be extended an additional 120 days, the plaintiff’s Certificate of Good Faith must be included with the claim if and when it is filed. This is designed to eliminate any delays in the plaintiff responding to defense motion for summary judgment and place another requirement that if not met by the plaintiff could result in the case being dismissed.


In the spring of this year, physicians received aggressive communications from a private company based in Franklin, Tennessee demanding immediate remuneration of alleged overpayments and improper billing on behalf of two self-insured business entities in the state. Letters from this company demanded that physicians take action within 15 days either by paying the demanded amount to them or submitting copies of medical records or other documentation to the company “sufficient to justify your billing.” An amendment was attached to an existing health insurance bill late in the legislative year which effectively stopped this aggressive practice.

The “Healthy Menu Act,” a bill supported by the Tennessee Academy of Family Physicians, did not pass the Legislature. It received a considerable amount of discussion and debate including involvement from the Governor’s office. The ‘Healthy Menu Act,’ was primarily written and supported by the Tennessee Department of Health. It would have required restaurants display nutritional information on their menu.

The restaurant industry opposed this legislation stating that the cost involved with compliance would be prohibitive. In addition, an opposing bill was passed by the State Senate which would prohibit Tennessee counties and municipalities from requiring restaurants to provide nutritional information to their customers. Governor Bredeson refused to sign this bill, insuring that the “Healthy Menu Act” will be reintroduced in the next legislative session.

Members of the Tennessee Academy of Family Physicians have continued to be actively involved with health issues at the state level. In addition to the TNAFP Annual Legislative/Practice Enhancement Seminar in March, members of the Academy serve each Tuesday at the Tennessee Legislature as “Doctor of the Day.” On this day, many major committees meet, including the House Healthcare Committee and the Senate General Welfare Committee, at which the family physician serving as Doctor of the Day is recognized. Because of our committed involvement, representation of the TNAFP is now an integral part of several state administrative committees and work groups.

The Tennessee AFP to-date has not taken a position on healthcare reform. With the current proposed national legislation exceeding a thousand pages in length, we would be wise not to hastily support or reject the bill. Tennessee is represented by two Republican Senators, and most of the Congressmen from the opposing party consider themselves “Blue Dog Democrats.” Even though no formal position has been taken by the TNAFP, our goals have remained fairly constant that: 1) the patient centered medical home is the future model for health care, 2) every American should have a personal physician for their medical home, and 3) work force issues need to be addressed to ensure an adequate number of primary care physicians.

Charles Ball, M.D., Columbia  
Chair, Committee on Legislation & Governmental Affairs
MEMBERS OF THE 2009 TNAFP CONGRESS OF DELEGATES

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Vice Speaker: Lang Smith, M.D., Columbia

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James Holt, M.D., Johnson City
Danny Lewis, M.D., Greeneville

Charles Leonard, M.D., Talbott
Jose Malagon, M.D., Clinton

Mary Huff, M.D., Sweetwater
W. Jeff Kemp, M.D., Chattanooga
Allen Sherwood, M.D., Ooltewah

Kenneth Dale Beaty, M.D., Livingston
Chet Gentry, M.D., Cookeville
Tersa Lively, D.O., Crossville

Christopher Gafford, M.D., Fayetteville
Diane Petrilla, M.D., Sewanee
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Omar Hamada, M.D., Brentwood
T. Michael Helton, M.D., Smyrna
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D. Gabriel Polk, D.O., Waynesboro

Ryan Bartz, D.O., Selmer
Michael Revelle, M.D., Jackson
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Stephanie Dunagan, M.D., Paris
Doreen Feldhouse, M.D., Dyersburg
Susan Lowry, M.D., Martin

W. Clay Jackson, M.D., Covington
Gregory Laurence, M.D., Germantown
Perry Rothrock, M.D., Memphis

Elizabeth Denby Close, M.D., Chattanooga
D. Brent Hatcher, D.O., Jackson
Robert W. Silmon Jr., M.D., Kingsport

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DISTRICT 2 (Tennessee Valley Chapter)
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R. Wesley Dean, M.D., Powell
Joanne Filchock, M.D., Knoxville

DISTRICT 3 (Chris Graves Chapter)
Stephen Adams, M.D., Chattanooga
Donald Zeigler, M.D., Hixson
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Thomas A. Jenkins, M.D., Cookeville
Ernest Jones, M.D., Carthage

DISTRICT 5 (Nathan Bedford Forrest Chapter)
Stephanie Gafford, M.D., Fayetteville
T. Scott Holder, M.D., Winchester
J. Lynn Williams, M.D., Decherd

DISTRICT 6 (Andrew Jackson Chapter)
George Lanny Holmes, M.D., Nashville
Ruth Stewart, M.D., Nashville
Rodger Wallace, M.D., Nashville

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Penny Mediate, M.D., Lawrenceburg
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Gregg Mitchell, M.D., Jackson
Kellie Wallace Wilding, M.D., Jackson

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William Kirk Stone, M.D., Union City
Douglas Scott Summers, M.D., Paris

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Gloria Burns, M.D., Cordova
Shelia Thomas, M.D., Memphis

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Szekim Pang, M.D., Memphis
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Call for Resolutions

Deadline for receipt of Resolutions for publication to membership is July 1.

Tennesse Academy of Family Physicians (TNAFP)

Leaders on the Move

Information for Members

- Congratulations to Meharry Family Medicine Interest Group for receiving the AAFP’s 2009 Program of Excellence Award in the categories of Community Service and First Time Applicant.

- Congratulations to ETSU’s Family Medicine Group for receiving the AAFP’s 2009 Program of Excellence Award for overall excellence.

- The U.S. Centers for Disease Control and Prevention (CDC) recommends the following: *Return to the full Hib immunization series, including a booster dose for all children over 12 months of age; *Implement a phased approach to immunize toddlers whose booster dose was previously deferred.

  Please refer to the CDC guidelines at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5824a5.htm.

- On September 1, 2009, Tennessee Part B Medicare claims will be processed by the new A/B MAC Contractor (Part A and Part B Medicare Administrative Contractor) Cahaba GBA. As part of this transition, CMS has assigned contractor number 10302 for the processing of claims submitted on or after August 29, 2009, and submitted to Cahaba GBA. Providers should make sure that their systems are updated to transmit electronic claims to Cahaba GBA and with the new contractor number (10302).

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PROPOSED AMENDMENTS TO THE TNAFP CONSTITUTION & BYLAWS FOR CONSIDERATION BY THE 2009 CONGRESS OF DELEGATES

Bylaws Amendment 1-2009: Reciprocity Agreements Between the ABFM and Foreign Colleges of Family Medicine or General Practice

TO AMEND THE BYLAWS of the Tennessee Academy of Family Physicians in Chapter I, Section 2(A), second paragraph to keep the Tennessee AFP Bylaws consistent with the American AAFP Bylaws by adding a new statement.

Reads At Present

Chapter I, Section 2(A)
Physicians first applying for active membership after December 31, 1988, must have satisfactorily completed a three-year family medicine residency program approved by the Accreditation Council on Graduate Medical Education; or must have completed a family medicine residency program approved by the College of Family Physicians of Canada, must be board certified by the College of Family Physicians of Canada and must be employed exclusively within the United States; or must have satisfactorily completed either (1) one year of a rotating general or family medicine internship approved by the American Osteopathic Association plus two years of a general or family medicine residency program approved by the American Osteopathic Association, or (2) three years of a general or family medicine residency program approved by the American Osteopathic Association.

As Proposed

Chapter I, Section 2(A)
Physicians first applying for active membership after December 31, 1988, (1) must have satisfactorily completed a three-year family medicine residency program approved by the Accreditation Council on Graduate Medical Education; or (2) must have completed a family medicine residency program approved by the College of Family Physicians of Canada, must be board certified by the College of Family Physicians of Canada and must be employed exclusively within the United States; or (3) must be Board certified by the American Board of Family Medicine pursuant to a reciprocity agreement between the American Board of Family Medicine and a foreign professional association of family medicine or general practice; or (4) must have satisfactorily completed either (1) one year of a rotating general or family medicine residency program approved by the American Osteopathic Association, or (2) three years of a general or family medicine residency program approved by the American Osteopathic Association.

OUTSTANDING STUDENT IN FAMILY MEDICINE

AWARD WINNERS

Katina Gordon, Meharry
Andrew McComick, ETSU
Zachariah Overby, UT
Tennessee AFP members attended the American Academy of Family Physicians’ 2009 Family Medicine Congressional Visit in Washington, D.C., on May 20-21. Attendees learned how to practice real-world advocacy, learned understanding of family medicine’s national legislative issues, visited with Tennessee Congressional offices and heard from members of President Obama’s administration.

TNAFP members participate in AAFP D.C. Legislative visits - L to R: Jim King, M.D.; Samantha McLerran, M.D.; Charles Ball, M.D.; Charles Leonard, M.D.; Jolaine Beal, M.D.; Barton Chase, M.D.

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Tennessee’s Newborn Hearing Screening recognizes the important role family physicians/pediatricians play in meeting the 1-3-6 Challenge. Universal Newborn Hearing Screening (UNHS) has been instituted throughout the US for the purpose of preventing the significant negative effects of hearing loss on cognitive, language, speech, auditory, social-emotional, and academic development of infants and children. In Tennessee, the Newborn Hearing Screening Pediatric Audiology Assessment and Amplification Guidelines recommend all high-risk babies be re-evaluated every six months until age five, regardless of passing the initial hearing screen.

WHY IS EARLY INTERVENTION IMPORTANT?
There is little advantage to early identification and early amplification without appropriate early intervention follow-up. According to the Joint Committee on Infant Hearing (JCIH) 2007, by six (6) months of age, infants and their families should receive appropriate intervention from healthcare and educational professionals with expertise in pediatric hearing loss and deafness.

Children experiencing hearing loss are limited in their incidental learning as compared to their hearing peers due to lack of or limited auditory input. Regardless of the type and degree of hearing loss, whether minimal or significant, unilateral or bilateral, conductive or sensorineural, individualized intervention should be designed to meet the needs of the child and the family. Appropriate early intervention is based on a family centered approach where families learn in partnership with qualified providers as they maximize their child’s use of their hearing aid/cochlear implant to develop listening skills, learn strategies to promote the development of effective communication and language skills, and literacy skills, all of which are precursors to the development of good academic skills.

WHAT IS QUALITY EARLY INTERVENTION?
Early intervention is a term “used to describe any type of habilitative, rehabilitative, or educational program provided to children with hearing loss. The key component to providing quality early intervention services is the expertise of the provider specific to hearing loss.” (JCIH, 2007)
Qualifications of early interventionists in the field of pediatric hearing and communication:
- Professional training in pediatric education of the hearing impaired
- Professional training in parent–infant education and family support (adult learning, grief cycle, effective communication)
- Specialized training in development of audition, communication, speech, and language
- Certification/Licensure: Education of the Deaf, Audiology, Speech/Language Pathology.

Effective intervention is a blend between the parents and qualified providers. Parents are the child’s primary teachers during the preschool years. Components of effective early intervention should include the following:
- Providing information about hearing, amplification, and current hearing technology
- Facilitating the use of sensory aids (hearing aids, bone conduction hearing aid, frequency modulated systems, cochlear implants)
- Presenting communications options (Auditory/Oral, Cued Speech, Signed English, American Sign Language) – knowledgeable of each option and presented in an unbiased manner
- Supporting the family and their child in learning and using the family’s chosen communication mode(s)
- Teaching the family strategies to help their child develop listening skills, communication, language, and literacy skills
- Accessing resources: parent-to-parent contacts, meeting adults who are deaf or hard of hearing
- Providing guidance in the areas of cognition, language and communication development as the child matures and prepares to transition to preschool.

Collaboration of the early intervention team members is imperative for the child with hearing loss to be successful. Early intervention team members include the following:
- Family
- Physician
- Audiologist
WHAT CAN THE PCP DO TO HELP PARENTS?
A Parent Perspective…
Camille and Rich Keck are the proud parents of twin 9 year old boys, both with hearing losses. The boys were born prematurely and identified through newborn hearing screening. Jonathan has a very significant hearing loss, is a cochlear implant user and attends the Tennessee School for the Deaf. Kyle has a milder hearing loss, wears hearing aids and is fully mainstreamed in his local elementary school program. Camille believes so strongly in early intervention and parent support, that she now serves as one of three regional Newborn Hearing Parent Consultants through a program provided by Family Voices of Tennessee and the Tennessee Department of Health's Newborn Hearing Screening program. They offer parent to parent support to families of newly identified children with hearing loss across the State of Tennessee. Camille shares her perspective…” After the diagnosis, some ways the PCP can help parents like me would be:

1. Help me connect with other parents who have walked in my shoes. I want to learn from other parents who have successfully parented children with hearing loss.
2. Help me connect with appropriate early intervention service programs and providers knowledgeable about working with young children with hearing loss and their families.
3. Help me know that communication with my child is the key element to success, regardless of how communication occurs—talking, listening, singing, signing, cueing, gesturing, touching, etc.
4. Help me feel comfortable asking questions to all those on my child’s team; help me learn to be an advocate for my child.
5. Help me connect with successful role models having hearing loss, regardless of communication modality or listening technology used by each person.
6. Help me understand that this is a journey and that I do not have to make all the decisions immediately … we can add new technologies and methods of helping my child succeed as we go.”

To contact Camille or the Family Voices Newborn Hearing Parent Consultant program call 1 - 888-643-7811 or email familyvoices@tndisability.org.

WHAT CAN THE PCP DO TO HELP THE NEWLY IDENTIFIED INFANT OR TODDLER WITH HEARING LOSS?
• Communicate with the TN Department of Health's Newborn Hearing program, if and when an infant or toddler is identified with a hearing loss (please report the results of the hearing screening or audiological evaluation) at (615) 262-6160.
• Feel free to call Mark Gaylord, M.D., TCAAP Newborn Hearing Champion, at (865)305-9300.
• Follow the AAP algorithm and rule out medical causes and genetic diseases to make the appropriate medical referrals, i.e.: genetics, ear, nose and throat, ophthalmologist. (Guidelines for Pediatric Medical Home Providers)
• Refer the child/family to the TN Department of Education, Tennessee Early Intervention System (TEIS): 1(800) 852-7157. TEIS must contact the family within five days from date of referral. Families will receive Service Coordination, a developmental evaluation, a family assessment and the option to create of an Individual Family Service Plan (IFSP).
• Participate as a member of the child's IFSP team.
• Provide the parent with the resource list. Help them with referrals as needed or requested.
• Refer to the parent-to-parent program: Family Voices/Department of Health's Newborn Hearing Parent Consultant program: 1(888) 643-7811.
• Ask questions related to hearing loss in young children by contacting the UT Center on Deafness Newborn Hearing program: (865) 974-4147 or 1(866) 961-2397; Julie Beeler (865) 765-3586

Families of newly identified children with hearing loss appreciate your guidance in helping them obtain appropriate intervention contacts and services for their children. It will make a world of difference in the future success of any child with a hearing loss.

Mary Franks, M.A. Deaf Educator, SKI*HI National Trainer
Susie McCamy, M.S. Deaf Educator, Newborn Hearing Program @ UT Center on Deafness Tracy Duncan, M.Ed. / M.Ed., Parent-Infant Deaf Educator / SKI*HI National Trainer

Contributors to this article: Camille Keck, Parent Consultant; Julie Beeler, MA UT Center on Deafness Newborn Hearing Pediatric Audiologist; Jacque Cundall, RN, Newborn Hearing Screening Program Director, Tennessee Department of Health.

More Information for the Family
Physician:
Early Hearing Detection and Intervention Programs (EHDI) - (435) 797-3584; Email: ncham.helpdesk@usu.edu; www.infanthearing.com
National Institute on Deafness and Other Communication Disorders (NIDCD, NIH) - www.nidcd.nih.gov/health/hearing
Center for Disease Control and Prevention (CDC) - www.cdc.gov/nchbddd/edhi
TN Department of Health / Newborn Hearing Screening - (615) 262-6160; http://health.state.tn.us/NBS/hearing.htm
TN Department of Health / Children's Special Services - (615) 741-0361; http://health.state.tn.us/MCH/css.htm

More Information for the Parent:
(Family-friendly websites where you can learn more about hearing loss and what to do.)
Communicate with Your Child - www.communicatewithyourchild.org
Boys Town - www.babyhearing.org
Hands and Voices - www.handsandvoices.org
If you are looking for a partner or a practice location, send information preferably by email to: tnafp@bellsouth.net; or by snail mail to: TAFP, 500 Wilson Pike Circle, Suite 212, Brentwood, TN 37027; or by fax to: 615-370-5199. Information for practice opportunities will be accepted only from TAFP members and will be placed in the Tennessee Family Physician at no charge. You are required to include your name, address and/or telephone number and/or fax number and/or email address as contact concerning opportunities will be made directly between interested parties and not through the TAFP. Information will be placed in four (4) editions unless the TAFP is notified otherwise. Deadline for the next issue (winter 2009) is October 19, 2009.

Cherokee Health Systems is currently seeking full-time physicians to join our team of professionals. We provide a full array of health care services, including medical, dental and behavioral health. Cherokee Health Systems has 21 offices located in East Tennessee. We currently have openings in Knoxville and the surrounding counties. Excellent package includes competitive salary and benefit. No on-call, no inpatient work and weekends off. Most sites are eligible for loan repayment through National Health Service Corps federal program. To learn more about this opportunity, please contact Medical Director Ken Mays, M.D., at 865-207-6826.


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The Department of Family and Community Medicine at Meharry Medical College is currently seeking a Board-certified Family physician to serve as full-time faculty. The position includes faculty appointments at Meharry Medical College and Vanderbilt University at the level of Assistant or Associate Professor depending on experience and qualifications. Previous academic experience, practice of non-operative obstetrics, clinical experience, or fellowship training is desired. Nashville is an excellent community and offers many amenities. The Department has eighteen Family Medicine Residents and also administers Preventive and Occupational Medicine Residency Programs. Contact: Roger Zoorob, MD, MPH, FAAFP, Meharry-Vanderbilt Professor and Chair, Department of Family Medicine, 1005 Dr. B. Todd, Jr. Boulevard, Nashville, Tennessee 37208; Office Phone: (615) 327-6572; email: rzoorob@mmc.edu.

Wesley Eastridge, M.D. is recruiting a partner to practice with him in Gate City, VA just outside of Kingsport, TN. This is a small county seat community only 20 minutes from our two hospitals inside Kingsport. We are seeking a conscientious and motivated Board-certified family physician to join our practice. Call Holly Wheeler at (423) 239-8508 or email Holly_Wheeler@wellmont.org.

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- **Lexington**, Henderson County Community Hospital
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- **McKenzie**, McKenzie Regional Hospital
- **Morristown**, Lakeway Regional Hospital
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