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DALLAS MEDICAL JOURNAL

THE FUTURE OF CANCER CARE

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What Should I Say?

DCMS 2021 President
Beth Kassanoff-Piper, MD, FACP

One in three people will be diagnosed with some form of cancer during their lifetime. One in eight women will be diagnosed with breast cancer, the second-leading cause of cancer death in women (lung cancer being the first). The chance that a woman will die from breast cancer is about one in 39 (about 2.6%). Thankfully, over the last five to 10 years, the death rate has declined, in part due to better treatments and also due to improved rates of screening. There are currently more than 3.8 million breast cancer survivors in the United States. This number includes women still being treated, as well as those who have completed treatment. These statistics mean that all of us are likely to encounter cancer patients both personally and professionally, no matter our specialty.

I am in a unique position to write about cancer. I am a breast cancer survivor, a primary care physician who diagnoses and manages cancer patients, and a friend to many cancer patients. I also have an incurable, although manageable, cancer (I have chronic myeloid leukemia). We all bring our own personal experiences to the relationships we have with our patients when we see them in their most vulnerable moments. They rely on us to be professional and always have their best interests in mind. Yet, they also need us to be compassionate and supportive. While we don't all have a personal cancer history to draw from when forging a bond with our patients, we all want to foster that supportive relationship.

I, of course, am an advocate for routine breast cancer screening and encourage my patients to stay up to date with their mammograms. A patient a few years ago said to me, "I'll go because you want me to go, but I've always known that I'll never get breast cancer." I was briefly stunned but recovered quickly enough to thank her for agreeing to screening and to say a quick prayer that she was right. Everyone thinks it won't happen to them, until it does.

Our cancer patients are scared. Scared of dying, of surgery, of chemotherapy. We are afraid of being disabled and being unable to care for a husband, parents, and children. We're scared of missing out on seeing our kids grow up. On a deeply personal level, patients are scared of feeling bad, of looking like a cancer patient, and scared of losing part of what makes them a woman. There are so many thoughts swirling around in the head of a cancer patient when difficult choices must be made relatively quickly, while a patient is still in shock from the diagnosis.

How do we as physicians navigate difficult psychological issues surrounding cancer? How do we, as human beings, approach the topics with our friends or family members? How do we help them in their struggle? Clinicians, as well as patients, find it very difficult to talk about cancer. After my diagnosis, I often found myself having to comfort others when telling them I had cancer. I also had to develop a thick skin, because people, including some doctors, don't know what to say to cancer patients. There are some things no one should say to a breast cancer patient, such as, "They are just breasts" or "Hey, you get a free breast lift," or "You've had your kids, you don't need them anymore." Losing one or both breasts is both physically and emotionally painful. Breasts are a huge part of our femininity, and the loss can impact self-image, intimacy, and relationships with others. And to those who think they understand because they have had augmentation, there is a huge difference between augmentation and reconstruction, which involves rebuilding a breast from scratch using implants and/or chunks of tissue from other parts of your body.

Even well-meaning comments such as "stay positive" can have a negative psychological impact. Being told you have cancer starts a grieving process, and we should honor and respect our patients' feelings through this process. Never say to anyone, "Hey, it's not that bad. Smile!" Sometimes it is that bad. And cancer patients don't need the added pressure

of having to constantly portray positivity. For patients with metastatic cancer, hearing "you'll beat this" can be upsetting. "We could all be hit by a bus tomorrow" is especially insensitive. While that may be true, you can be sure that metastatic cancer patients feel the pressure of their finite time every single day. What patients truly need to hear is, "I see you hurting. I'm sorry you are going through this. I am here for you and will do everything I can to help you through this process."

Remember, too, it is not just the physical symptoms of cancer treatment that are difficult, but also the responses of others. People shun you if you look like you have cancer. When I was undergoing chemotherapy, my husband and I went to buy some new furniture. One day I wore my wig and was approached quickly by a salesperson offering to help. The next day, I wore a scarf instead, and salespeople went out of their way to avoid me. If you run into a cancer patient in a hallway or on an elevator, look them in the eye, smile, and say hello! This helps us feel normal.

"Our cancer patients are scared. Scared of dying, of surgery, of chemotherapy. We are afraid of being disabled and being unable to care for a husband, parents, and children."

I chose to notify my patients of my cancer journey to encourage them to get their own cancer screening and to explain my absence while out for surgery. I received a tremendous amount of support, including cards and personal notes, and was placed on prayer lists across the country. I even had some patients pray with me in the office. I chose to wear my wig to the office while I was receiving chemotherapy so that my patients would be able to focus on their own health concerns and not be distracted by mine, and I was told more than once that my hair had never looked better. I got a chuckle from that!

Cancer patients undergoing treatment think about their cancer most of every day, and we welcome conversation that is not cancer-related. Ask about the other things going on in your patients' lives. How are their grandkids? Which college did their son choose? How is the kitchen remodel going? Even after completing treatment, the risk of recurrence lingers in our brains. Many patients have "scanxiety" regarding their follow-up imaging and, if they experience symptoms, such as back pain or shoulder pain, it strikes fear in their hearts. Acknowledge this with your patients so they can express their concerns.

Several months after completing my chemotherapy, I went to a mall department store. It was the first time I went out in public without covering my short, curly stubble. It was so freeing to go bare! As my kids and I walked through the door, a woman working at the men's cologne counter called out to me, "I love your hair! It looks really great." I almost immediately started to cry and, once I pulled myself together, went to thank her and explain what her comments meant to me. She said she had no idea that I hadn't just cut it really short on purpose. It wasn't about hair. It wasn't about looking pretty or even just looking healthy. It was about being more than a cancer patient.

I hope by sharing my experience with you, you can be a little better equipped to give your patients the very best care possible. I am very thankful for the excellent care from my physicians, Dr. Michael Grant, Dr. Paul Pin, Dr. John Pippen, and Dr. Christopher Maisel. I hope I am helping my patients through their journey as well as these outstanding physicians have helped me through mine. **DMJ**

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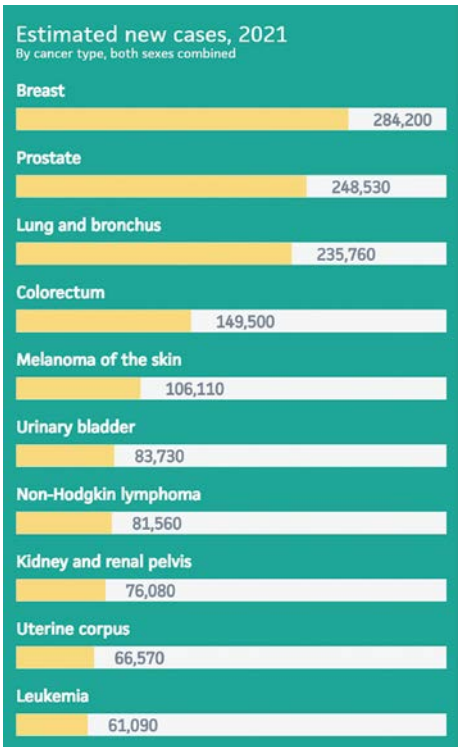
Keeping Focus Amid the Chaos

Jon R. Roth, MS, CAE

As the pandemic waves continue, it is natural, appropriate, and expected that the bulk of our attention would be focused on doing everything we can to stem the tide of illness and death resulting from COVID-19. Our lifetimes will forever be etched with the memories of those in our families, communities, and the profession who have been afflicted by this virus.

However, no matter how deleterious the pandemic has been, we must remember that life and other health care challenges continue to impact those we love. In fact, it is sobering to know that almost exactly twice as many Texans died due to cancer in 2020 than the totality of the COVID-19 outbreak (129,770 compared to 62,323). This is certainly not to imply a judgment that one disease process is more important or impactful than another. If anyone in your family has been affected by either of these diseases, there is no discrimination for the pain and suffering that you may have endured. Rather, I share this realization as a reminder that, while we do everything we can to reduce the impact of COVID-19, we too must continue dedicating resources, research, education, testing, and treatment for all forms of cancer.



Source: American Cancer Society, 2021
cancerstatisticscenter.cancer.org

Sadly, I suspect nearly every family has a story about a loved one touched by some form of cancer. The American Cancer Society has released its annual estimate of new cancer cases for 2021.[1] In Texas, female breast continues to be the leading cancer with a predicted 20,900 cases, followed by lung (15,010), and prostate (14,200). This closely mirrors the predictions for the entire U.S. with lung and prostate being reversed in the national prediction. Of the 133,730 total cancer cases expected in Texas next year, sadly 42,840 people will succumb to their disease. Not surprisingly, as with other populous states, this places Texas third, nationally, behind California and Florida both in new cases and total deaths.

Every diagnosis and death related to cancer is a call to action for more research and better predictive tools to reduce morbidity and mortality. Fortunately, investments into cancer screening, prevention, and therapy have resulted in remarkable improvements in five-year relative survival rates. For example, for the three most prevalent forms of cancer in Texas, the survival rates for prostate cancer are 98%, and 90% for female breast cancer. Lung cancers continue to be a challenging cancer with a 20% survival rate.[2] However, as a testament to investing in additional research and technologies that foster early screening and detection, lung cancer survival rates more than double to 56% when the disease is caught early.[3]

Sadly, I suspect nearly every family has a story about a loved one touched by some form of cancer. The American Cancer Society has released its annual estimate of new cancer cases for 2021.

As with cancer and many other disease processes, the acute nature of the COVID-19 pandemic demands that we advocate for strong public health measures to mitigate its impact. Continuing to advocate that our family members, friends, and colleagues take preventive measures like getting vaccinated, wearing masks, and avoiding large indoor gatherings is important to reducing COVID-19's impact at the individual, family, and community levels. We must also continue to support our physicians on the front lines in critical care units, emergency rooms, outpatient clinics, and ICUs who are caring for those who have contracted the virus. Likewise, let's not forget to encourage our family members, friends, and colleagues to keep current on their preventive wellness screenings to stave off other significant diseases, like cancer. **DMJ**

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Jon R. Roth, MS, CAE
DCMS EVP/CEO

What's on the Horizon? Looking Toward the Future of Cancer Care

By **Scott Cheek**, MD, radiation oncologist, and **Scott Paulson**, MD, medical onzcologist, both of Texas Oncology–Baylor Charles A. Sammons Cancer Center

Cancer impacts all of us. Whether you're a physician whose mission it is to care for people with this disease, or you or a loved one have experienced a cancer diagnosis, you understand the toll that cancer takes. Nearly 1.9 million new cancer cases are expected to be diagnosed in 2021, according to the American Cancer Society (ACS).

But one of the most valuable – and dare we say, life-giving – parts of our jobs as physicians is to offer real hope to our patients fighting this complicated disease. After all, more than 16.9 million Americans with a history of invasive cancer were alive as of early 2019, the ACS also reports. These patients currently have no trace of the disease in their body. While this news is encouraging, there is progress to be made in early cancer detection and treatment.

As we look toward the future of cancer care, many new breakthroughs in cancer therapy, screenings, and clinical trials are changing the way we diagnose and treat cancer – ultimately helping our patients live longer, healthier lives. But what advancements, specifically, will have an impact on not only the detection of cancer and survival rate in our patients but their well-being during and after treatment? We see much progress – and potential – in the innovations described below.

The New Era of Radiopharmaceuticals

For more than 100 years, radiation therapy has been a common and effective cancer treatment. While successful at destroying cancer cells, we know traditional radiation therapy can damage healthy cells and deal out a host of side effects.

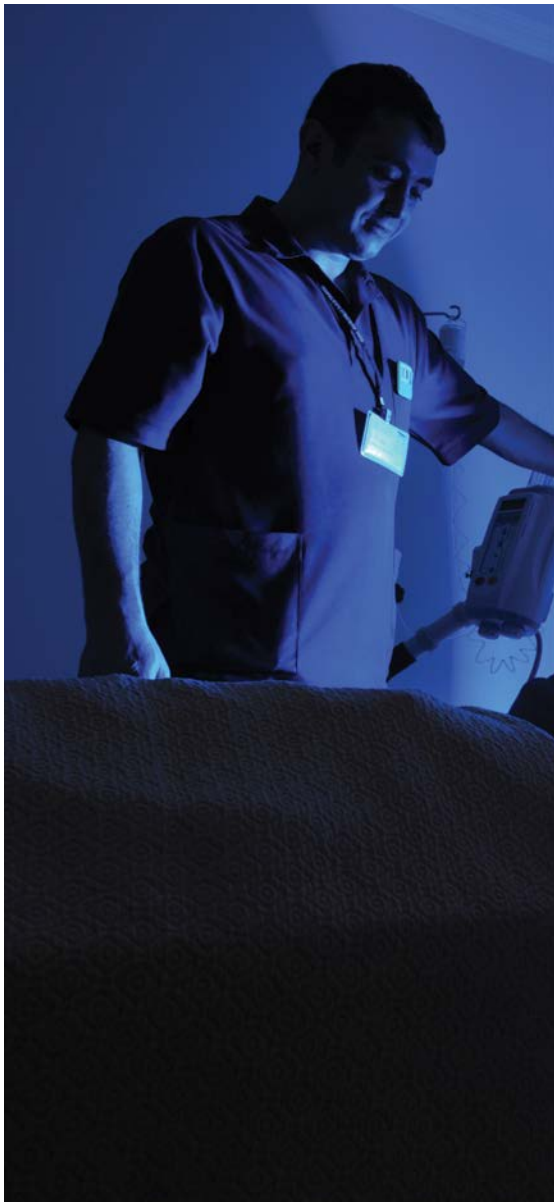
An emerging form of radiation therapy, radiopharmaceuticals deliver radiation specifically to cancer cells in the body while preserving more of the healthy tissue around them. Delivered via IV, radiopharmaceuticals are designed to track and "stick" to a cancer cell. Once this happens, the radioactive compound breaks down on its own, then releases energy to the DNA of the nearby cells, thus killing that cancer cell. The ability for a single radiopharmaceutical to stick to a cancer cell and kill other cancerous cells around it means less radiation is needed in the body, which greatly benefits the patient.

Researchers are gaining more understanding of how radiopharmaceuticals could target specific cancers. In 2018, the FDA approved the use of lutetium Lu 177-dotatate, a radiopharmaceutical, for the treatment of certain neuroendocrine tumors affecting the pancreas or digestive tract. Research released at the American Society of Clinical Oncology (ASCO) annual meeting this year found that radiopharmaceuticals could help men with advanced prostate cancer live longer than those who only receive the standard of care. Also, studies have shown that the use of immunotherapy combined with radiopharmaceuticals has the potential to improve the way tumors respond to certain drugs.

As we look toward the future of cancer care, many new breakthroughs in cancer therapy, screenings, and clinical trials are changing the way we diagnose and treat cancer – ultimately helping our patients live longer, healthier lives.

Emerging Methods of Cancer Screening

Screenings are the most effective way to identify cancers in their earliest



stages – often before patients experience symptoms. For many cancer types, including lung, breast, colorectal, and cervical cancers, advancements in screening and treatment offer promise for earlier detection and more positive outcomes. New, emerging screening methods could change the way we find cancer in its earliest stages.

One of the newest screening methods for lung cancer is the low-dose CT (LDCT) scan. Studies have shown that using the LDCT scan in high-risk patients could save more lives than using chest X-rays. According to the American Cancer Society, unlike chest X-rays, LDCT scans can more accurately find abnormal areas in the lungs that *could* be cancer. In fact, after several years, studies have found that patients who received LDCT scans annually had a 20% lower chance of lung cancer death than those who received chest X-rays.

While breast cancer is the second-deadliest cancer among American women, steady declines in mortality among women in the past 30 years can partially be attributed to early detection of the disease. Today, large-scale research is underway for the use of 3D mammography – also known as digital breast tomosynthesis (DBT) – to screen for cancerous tissue or other abnormalities, and we're seeing promising results. The 3D mammography takes thin "slices" of images of the breast using an X-ray machine and reconstructs the image to look for any cancerous tissue or abnormalities. As more study is completed and its use widens, we're hopeful for the possibilities of 3D mammography in diagnosing breast cancer early and more accurately in women and men.

We know that the earlier cancer is detected through screenings and self-exams, the better chance of successful treatment. But what about finding cancer where there is no available screening test? Multi-cancer early detection blood tests are an area where researchers are making progress. Galleri is one such test, developed by GRAIL, with Texas Oncology participating in the research. It's a multi-cancer early detection test that offers detection for more than 50 types of cancers through a simple, single blood draw. In clinical studies, when the Galleri test detected cancer, its prediction of the cancer signal origin was correct approximately 89% of the time. Multi-cancer early detection tests, including the Galleri test, hold incredible potential in finding more cancers at earlier stages and, ultimately, improving survival rates.

However, these advancements mean nothing if our patients aren't getting screened. As physicians, we share in the responsibility to communicate the importance of cancer screenings and make it easy, approachable, and safe for our patients to take this important step in protecting their health.

Precision Medicine and the Future of Clinical Trials

We're seeing groundbreaking possibilities for the use of precision medicine across the healthcare landscape. For cancer care, precision medicine has the potential to transform how we organize and administer clinical trials.

Clinical trials traditionally organized patients in a central location by similar cancer type. Precision medicine offers the ability to decentralize trials into community-based cancer centers and group patients with a drug therapy that can better target the genetic changes in their tumor identified in genomic testing. We've learned that the same cancer-causing genetic changes may be found in different types of cancer. As a result, patients with unique tumors from one another, but that share the same genetic change, can receive the same drug that targets the change, regardless of the type of cancer. This allows us to target the cancerous cells down to a single-patient level and treat the cancer precisely based on the genetics of their tumor.

Though some cancer centers, including Texas Oncology, are already using precision medicine in this way, it will take time for smaller, community-based cancer centers to adapt and leverage this new clinical trial design. But with more research into genetic changes that drive cancer cells to divide and grow, more patients in the future will be able to receive personalized cancer treatments based upon the genetics of their tumor, all within their own community.

The future of cancer care is bright and promising. Challenges lie ahead, but we will never stop learning from our past and evolving for our future based on what new research and this disease are teaching us. With more breakthroughs come more victories for cancer patients. **DMJ**

Real Concerns with Artificial Intelligence

Legal and Regulatory Considerations in the Use of Artificial Intelligence for Cancer Diagnosis and Treatment

By **Brandon Kulwicki**, Attorney, and **Caitlin Bell-Butterfield**, Law Clerk, Hall, Render, Killian, Heath & Lyman, P.C.

The potential applications of machine learning and artificial intelligence ("AI") to cancer prevention, detection, and treatment are nearly limitless. From targeting lesion detection during colonoscopies,[1] to individualizing breast cancer risk assessments,[2] to optimizing chemotherapy regimens,[3] AI and machine learning have already proven useful in cancer care. And, as partnerships between clinical research stalwarts and tech giants make clear,[4] progress on discovering and building out these applications is only just beginning.

As an increasing number of health care providers integrate these technologies into their practices, however, new legal and regulatory questions emerge. This article provides a brief introduction to these emergent questions: How will AI in cancer care be regulated? How will patient privacy considerations be addressed? And will using new technologies expose providers to heightened levels of liability?

Regulation and Reimbursement

The FDA is racing to keep up with medical-technological developments. In recent years, a new unit dedicated to digital health was created,[5] and the FDA is piloting a streamlined regulatory model for digital health software.[6] Nevertheless, the current regulatory framework lags behind the technology. This regulatory delay can create legal challenges for health care providers eager to adopt promising developments in AI.

As the FDA develops new models for regulating fast-moving AI technology, payors are also playing catch-up. In 2020, the Centers for Medicare & Medicaid Services (CMS) approved the first reimbursement for an AI-augmented health service—Viz.ai, software that identifies signs of a stroke on CT.[7] This groundbreaking rule by CMS opens the door for additional reimbursement for services involving AI.

Privacy

The development of AI relies on vast quantities of data collected from a huge number of patients. This reliance on individuals' health information necessarily raises questions about whether such use of data violates the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and state health privacy laws. These questions have only just begun to play out. Google, which has partnered with a number of health care institutions to

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provide cloud storage and the application of AI and other technologies, has already undergone investigation by the Office of Civil Rights for possible violations of HIPAA.[8] Google also recently succeeded in opposing a class action lawsuit brought against it and its partner, UChicago Medicine, which alleged that patients' personal health information had been shared with Google by the hospital without having been completely de-identified.[9] Use of AI in healthcare also poses unique privacy and security risks on the back end, as the large amounts of data being stored create vulnerabilities to cyberattack.

The growth of AI and big data in health care is straining the margins of HIPAA, which passed when the internet was in its infancy. As more providers integrate AI into practice, and partnerships with tech firms become increasingly commonplace, health privacy law is likely to undergo rapid changes.

Medical Malpractice Lawsuits

AI is imperfect, and algorithms make mistakes. When a provider relies on an inaccurate algorithm to make a diagnostic or treatment decision that results in patient injury, who is liable? Today, AI in cancer care and health care generally is assistive and is intended to be coupled, first and foremost, with clinical judgment. This means that overreliance on AI could be the basis for a medical malpractice claim.[10] The assistive nature of current AI has also meant that courts have been hesitant to use products liability approaches to find the software developer liable for patient harm.[11] As use of AI and machine learning becomes the standard of care, however, this is likely to change. Indeed, it is possible to imagine a near future where a provider adopts liability by failing to follow recommendations produced by an algorithm.

Likewise, hospitals and health systems could be held liable for adopting AI without implementing proper training and protocols, but the same institution could be held liable for failing to adopt AI that had become the standard of care. As AI becomes increasingly standard and reliable, it is even possible that the AI itself could be sued.

These legal issues are sure to be tested in coming years, as integration of AI into everyday clinical practice increases, and as the attitudes of the general public adjust to those changes. Already, a recent study found that potential jurors are sympathetic to clinicians who make use of AI—study participants were less likely to find a physician who accepted the recommendations of AI liable for malpractice than a physician who did not adopt the recommendations of AI.[12]

Conclusion

AI in health care is estimated to become a $36.1 billion market by 2025.[13] The developments wrought by this massive investment are certain to have an important—perhaps game-changing—role in the future of cancer care. The law will likely continue to struggle to maintain pace with technological innovation—but by staying alert to regulatory momentum, privacy considerations, and liability exposure, health care professionals can make wise decisions about integrating AI into their practice. **DMJ**

Our articles and alerts are provided for informational purposes only. For ethical reasons, our attorneys cannot—outside of an attorney-client relationship—answer specific questions that would be legal advice.

Brandon Kulwicki is an attorney and Caitlin Bell-Butterfield is a law clerk with Hall, Render, Killian, Heath & Lyman, P.C., the largest health care-focused law firm in the country. Please visit the Hall Render Blog at http://blogs.hallrender.com/ for more information on topics related to health care law.

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Proton Therapy: The Future of Cancer Care

By **Texas Center for Proton Therapy**

"Proton therapy has been effective in treating a wide variety of tumors, while helping to preserve quality of life for our patients," said Andrew Lee, MD, MPH, medical director, Texas Center for Proton Therapy and the first physician in North America to utilize pencil-beam proton therapy to treat cancerous tumors. In Dr. Lee's practice, patients find precision targeted therapy in the only proton therapy center in the region.

Proton beam therapy is an advanced type of radiation therapy aimed at destroying cancerous cells using accelerated protons. The treatment offers submillimeter precision that delivers high-energy proton beams directly to tumors, minimizing damage to surrounding healthy tissue.

"Pencil-beam scanning enables greater conformality in tumor treatments compared to traditional proton beam therapy, allowing us to reach levels of precision that was not possible even 10 to 15 years ago," Dr. Lee said.

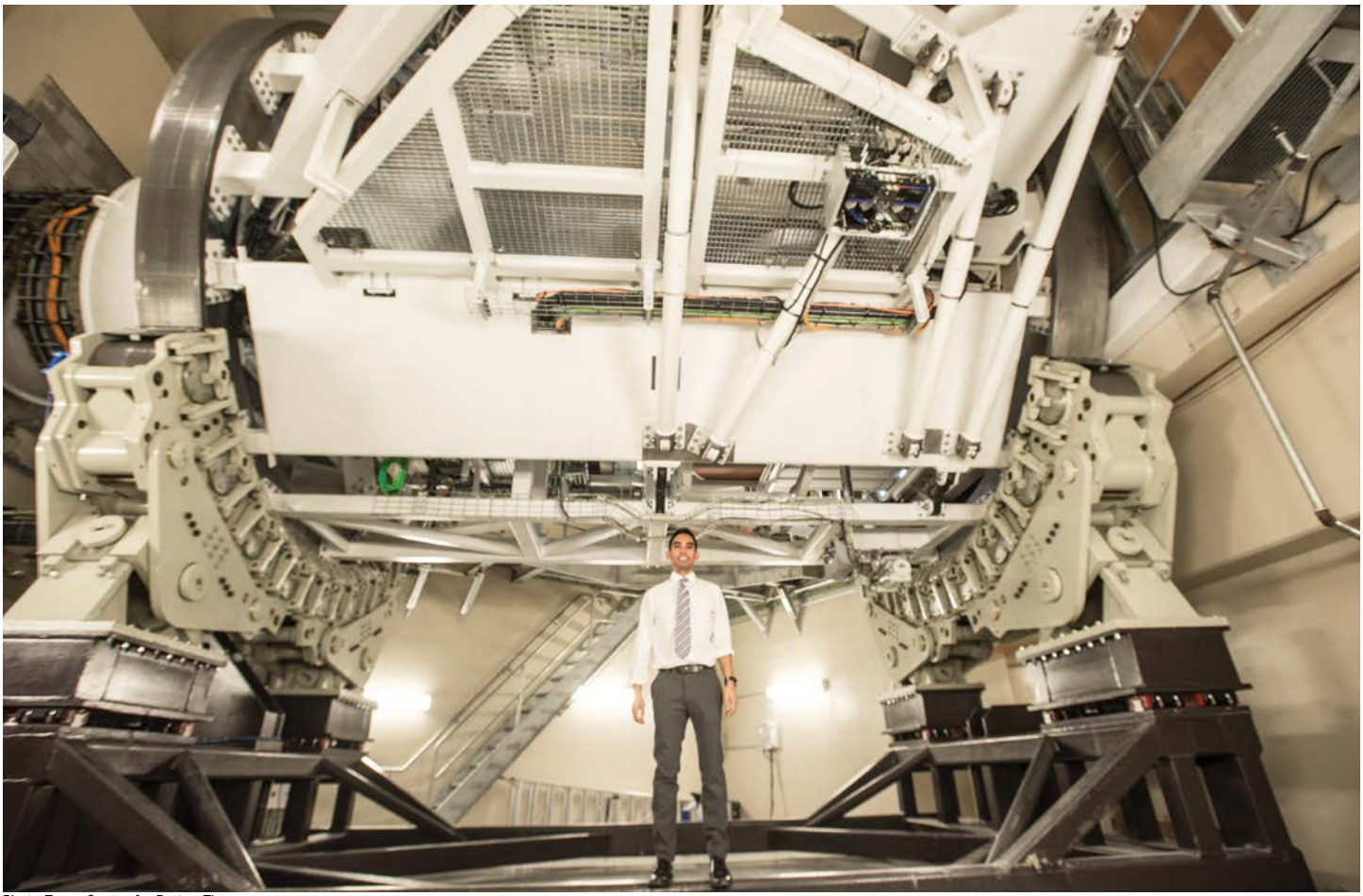
Pencil-beam Scanning in Proton Therapy

All three treatment rooms at Texas Center for Proton Therapy feature spot-scanning proton therapy, known as pencil-beam scanning. Using an ultrafine proton beam with pencil-point precision across each three-dimensional layer of the tumor, the tumor is essentially delicately "painted" with spots of radiation one slice at a time until the entire 3D tumor volume is covered. It's the ideal technology for irregularly shaped tumors near sensitive areas.

Pencil-beam scanning capability also is a prerequisite for a proton therapy center to offer **intensity modulated proton therapy (IMPT)**. This type of highly specialized proton therapy delivers a precise dose of protons to often tight spaces through a combination of pencil-beam proton therapy and sophisticated treatment planning algorithms and offers one of the most advanced forms of radiation therapy in the world.

Texas Center for Proton Therapy is one of only a few centers in the country offering pencil-beam scanning with on-board volumetric cone beam CT. With all three treatment rooms capable of pencil-beam scanning, Texas Center for Proton Therapy is the largest pencil-beam proton center in the state.

"This type of therapy is noninvasive, performed as an outpatient, and patients



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Targeting Cancer, Precisely

Photo Texas Center for Proton Therapy

can maintain their current quality of life during and after treatment," Dr. Lee said, emphasizing the benefits of proton therapy as a treatment modality.

Types of Cancer Targeted by Proton Therapy

Proton therapy has effectively treated a wide variety of cancers (whether small or large) in virtually every part of the body. As part of a multidisciplinary treatment regimen, proton therapy has been shown in studies to increase a patient's ability to receive other concurrent or sequential therapies, such as chemotherapy and/or surgery. Proton therapy may also treat tumors in sensitive areas where conventional therapy may not be the best option.

Proton therapy may be used to treat virtually any tumor that is treated with standard radiation, but it is particularly applicable for treating certain cancers, including:

Brain and Spine Tumors

During treatment, a narrow proton beam is guided to focus the highest energy of the beam at the location of the tumor in the brain or spine. While the proton beam is being delivered, it can also be designed to conform to the shape, size, and depth of tumors, limiting excess radiation near surrounding areas of the body.

The accuracy of proton therapy makes it particularly useful in treating:

- Tumors near sensitive areas of the brain, skull base, or spine
- Patients who require postoperative radiation therapy
- Patients who have recurrent brain tumors following treatment
- Select patients, including those with brain metastases, who may be candidates for stereotactic proton therapy

Patients with benign tumors

"Preserving adjacent tissue is of extreme importance," Dr. Lee noted. "Once the proton beam enters the body at the targeted tumor, less radiation is delivered before and after the tumor. After the proton beam hits the tumor, little to no radiation is delivered to nearby tissue."

Breast Cancers

For cancers of this sensitive area of the body near several vital organs, proton therapy can deliver high doses of radiation to destroy cancerous cells while preserving other nearby tissue. This precise treatment minimizes exposure to the heart, lungs, and healthy tissue near the breast and can be used for breast cancer patients even following lumpectomy or mastectomy. Proton therapy may also be used in select cases in which cancer has recurred following surgery and/or radiation or has spread to other parts of the body. We routinely treat breast cancer patients that require radiation to their breast or chest wall as well as the adjacent lymph nodes. Proton therapy allows us to comprehensively treat these cases while minimizing exposure to the underlying heart, lungs, and brachial plexus

Childhood Cancers

While childhood cancers are rare – accounting for less than 1% of all cancer diagnoses – they remain the most common cause of disease-related deaths among children outside the newborn period, according to the American Society of Clinical Oncology. Types of childhood cancer treated with proton therapy include brain and spine tumors, chordoma, craniopharyngioma, ependymoma, Ewing sarcoma, germinoma and other germ cell tumors, lymphoma, medulloblastoma, neuroblastoma, rhabdomyosarcoma, and sarcomas.

"A cancer diagnosis may be one of the most difficult challenges a person will face, and this point is particularly relevant for young patients and their families," Dr. Lee said. "We are uniquely positioned to treat children with cancer and provide the support needed for their families as they


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Texas Center for Proton Therapy specializes in pediatric oncology and uses national protocols developed for children. The center has specialized pediatric equipment pediatric sub-specialists, clinical trials specifically for children, and has a child life specialist on staff to support patients and families.

Gastrointestinal, Genitourinary, and Gynecologic Cancers

Proton therapy is effective in treating many types of gastrointestinal cancers, including esophageal, liver, pancreatic, and stomach cancer. This may also include patients with recurrent or metastatic disease. Patients with genitourinary cancers, including bladder, prostate, and testicular cancer, and women with gynecologic cancers, including cervical, ovarian, and uterine cancers, also find benefit in proton therapy.

For Dr. Lee, the extensive applicability of this treatment method in such a wide variety of cancers, including tiny tumors to rather large volumes, makes proton therapy one of the most unique advancements in cancer care available today. "The breadth of cancers that proton therapy can treat is a contrast to the specific and small areas we can use this therapy, which is a tremendous advantage for our patients and their quality of life."

Head and Neck Cancers

Treating head and neck cancers through highly targeted treatment is essential to maintaining who the patient is and how they proceed through life. Typically, cancers of the head and neck begin in the mucosal surfaces or the tissue lining of organs. Proton therapy's ability to minimize stray radiation exposure may also improve a patient's ability to tolerate concurrent chemotherapy. Head and neck cancers treated with proton therapy include cancers of the:

- Oral cavity
- Nasal cavity
- Paranasal sinuses
- Lymph nodes
- Larynx
- Naso and oropharynx
- Salivary glands
- Periorbital structures
- Lung Cancers

Lung cancer is still responsible for the most cancer-related deaths in both men and women in Texas, with the most common type, non-small cell lung cancer, accounting for approximately 80-85% of lung cancers. Lung cancer can be treated and is often preventable, but today, only 16% of men and 23% of women live more than five years beyond their initial diagnosis. Treatment options for lung cancer vary depending on the stage and type of the cancer. Proton therapy has been shown to be an effective treatment for lung cancers and should be considered, if the patient is a candidate, to preserve as much lung function as possible while improving survival rates. Proton therapy can be used for relatively large tumors with or without concurrent chemotherapy and also small tumors utilizing stereotactic approaches, which may be less than five treatments.

Lymphomas and Sarcomas

Both categories of lymphoma, Hodgkin lymphoma and non-Hodgkin lymphoma, vary in behavior, treatment reaction, and how each spread. However, proton therapy has been shown to be effective in treating both types. This is particularly important in young patients and in those individuals who may have received neoadjuvant chemotherapy.

Cancers of connective tissue, sarcomas, are also treatable via proton therapy. This may be done preoperatively, which is preferred, or postoperatively. Whether they are soft tissue sarcomas, originating from cells of muscle, fat, nerve, fibrous tissue, deep skin tissue, or blood vessels; or bone sarcomas such as osteosarcoma or Ewing sarcoma; proton therapy can provide the precision treatment that can help save patients' lives but also preserve function.

Connecting for Care

Dr. Lee, the physicians and staff at Texas Center for Proton Therapy greatly value the relationships with physicians in the medical community and the opportunity to improve oncologic care in the region.

"We consider the proton therapy treatment we offer to be part of the overall approach to care offered by the patient's care team," Dr. Lee said. "Collaborating with other physicians to improve and save lives together is truly an honor." **DMJ**


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COVID-19 Vaccine Mandates in the Workplace

By **Christie Davis**, Attorney, Hall, Render, Killian, Heath & Lyman, P.C.

As cases of COVID-19 continue to rise across the state, the question of whether COVID-19 vaccines should be mandatory is being considered by employers across all industries. In the health care field, the question is especially relevant given the increased risk of exposure to health care providers, as well as concerns related to patient safety. Federal and state governments, as well as employers in the private sector, are taking varying stances on this issue.

At least seven states have enacted legislation to prohibit or restrict COVID-19 vaccination mandates.[1] On July 29, Texas Governor Greg Abbott issued an executive order prohibiting governmental entities from compelling any individual to be vaccinated against COVID-19.[2] The executive order explicitly overrides a state law that empowers health authorities to implement control measures designed to curb the spread of communicable diseases, including immunizations. While other provisions of the executive order make exceptions for government-owned or -operated hospitals (such as the order's ban on requiring the use of masks), the prohibition on requiring vaccination is without exception. Of note, Governor Abbott's order specifically refers to COVID-19 vaccines that are "administered under an emergency use authorization," and therefore would not operate to bar vaccine mandates among government employees once full approval of one or more COVID-19 vaccines is granted by the U.S. Food and Drug Administration (FDA).

Additionally, Texas House Bill 4272 was introduced in March 2021. In part, H.B. 4272 prohibits the use of information contained in the Texas Department of State Health Services' (DSHS) immunization registry by an employer in order to fire or refuse to hire any individual "because the individual does not provide any documentation or other proof certifying the individual's COVID-19 vaccination status."[3] Unlike the July 29 executive order, this prohibition is not limited to governmental entities. HB 4272 passed both the House and the Senate in May and currently awaits further action by Governor Abbott.

In contrast, California's Department of Public Health has announced it will require that all healthcare workers "who work in indoor settings where (1) care is provided to patients, or (2) patients have access for any purpose" be fully vaccinated no later than September 30.[4] Exemptions from the vaccination requirement may be made for qualified medical reasons or religious beliefs; however, exempted workers will be required to submit to regular COVID-19 testing (twice weekly for workers in acute health care and long-term care settings, and once weekly for workers in other health care settings) and to wear approved facial coverings (such as N95 masks) at all times while inside the healthcare facility.

At the federal level, the Department of Veterans Affairs (VA) became the first major federal agency to mandate COVID-19

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vaccines when it announced on July 26th that it would require its healthcare personnel to be vaccinated against COVID-19 in order to provide services at Veterans Health Administration facilities.[5] VA personnel have eight weeks to receive the vaccination in order to maintain eligibility.

In the private sector, healthcare facilities in Texas and across the country have begun announcing COVID-19 vaccination requirements for their employees, medical staff, and volunteers. Several major hospitals and health systems in Texas, including Baylor Scott & White Health,[6] Memorial Hermann Health System,[7] and Texas Health Resources,[8] have announced in recent weeks that COVID-19 vaccinations will be mandatory for health care providers and volunteers.

While COVID-19 vaccine mandates are becoming more common, are these mandates legally permissible? The legal basis for mandatory vaccinations dates back to the early 20th century, when the U.S. Supreme Court held that it was within a state's power to implement laws requiring vaccinations.[9] Today, immunization requirements in certain settings, such as schools, are commonplace.[10] Though some states have enacted laws requiring that health care providers be vaccinated, Texas does not currently mandate that providers be vaccinated against any particular disease.[11]

However, Texas regulations do permit healthcare facilities to require that providers be vaccinated – specifically, facilities must have policies that "require covered individuals to receive vaccines for the vaccine preventable diseases specified by the facility based on the level of risk the individual presents to patients by the individual's routine and direct exposure to patients."[12] Per the regulations, a facility's vaccination policy must "include procedures for a covered individual to be exempt from the required vaccines for the medical conditions identified as contraindications or precautions," but other exemptions from the vaccination requirement, such as an exemption for "reasons of conscience, including a religious belief," are discretionary.

In May 2021, the U.S. Equal Employment Opportunity Commission (EEOC) issued updated guidance addressing "frequently asked questions concerning vaccinations in the employment context" related to COVID-19.[13] The EEOC confirmed that federal equal employment opportunity laws do not restrict an employer from requiring COVID-19 vaccination for members of its workforce who are physically present at the employer's facilities, provided that the mandate does not violate the Americans with Disabilities Act (ADA) or Title VII of the Civil Rights Act of 1964. The EEOC guidance noted that "[i]n some circumstances, Title VII and the ADA require an employer to provide reasonable accommodations for employees who, because of a disability or a sincerely held religious belief, practice, or observance, do not get vaccinated for COVID-19" with the exception of instances in which providing such accommodations would create an "undue hardship" on the employer's business.[14] Additionally, the EEOC advised that employers are permitted to offer employees information regarding vaccinations, and in certain cases may even offer incentives to employees for receiving the COVID-19 vaccine.

The EEOC guidance specifically declined to discuss the legal implications of the emergency use authorization (EUA) status of the three current COVID-19 vaccines. However, the U.S. Justice Department's Office of Legal Counsel published an opinion on July 6 regarding the legality of vaccination mandates involving vaccines that are subject to EUAs rather than fully approved by the FDA.[15] Specifically, the opinion explored whether an employer's vaccination mandate would violate the FDA's requirement that recipients of the current COVID-19 vaccines be informed that "[i]t is your choice to receive or not receive [the vaccine]." The Office of Legal Counsel concluded that this notice requirement did not bar entities (either public or private) from requiring vaccinations, "even when the only vaccines available are those authorized under EUAs."

With many health systems only recently instituting COVID-19 vaccination requirements, case law addressing the legality of these mandates is just beginning to emerge. In June 2021, the federal court for the Southern District of Texas dismissed one of the first claims attacking COVID-19 vaccine mandates in the workplace.[16] Houston's Methodist Hospital System was an early adopter of a COVID-19 vaccination mandate, first requiring vaccination by employees beginning in April 2021. A group of employees brought a lawsuit against Houston Methodist, claiming that the hospital's employees were illegally being made to be "human guinea pigs" for the "experimental and dangerous" COVID-19 vaccines. U.S. District Judge Lynn Hughes dismissed the case, noting that the employees did not meet the basic requirements for a wrongful termination claim under Texas law. Judge Hughes also rejected the employees' public policy-based arguments, including the employees' contention that mandates for vaccinations that do not have full FDA approval were unlawful and described the employees' allegation that the COVID-19 vaccine mandate was akin to medical experimentation in Nazi concentration camps as "reprehensible." The court acknowledged the hospital's interest in keeping its "staff, patients, and their families safer" and that Houston Methodist was "trying to do their business of saving lives without giving [the patients] the COVID-19 virus."

With more workplace COVID-19 vaccination requirements being announced, it is likely that more legal challenges will follow. And, while guidance from the EEOC and Justice Department suggests these mandates are legally permissible, local and state governments may seek to create barriers to implementation of COVID-19 vaccination requirements by employers. **DMJ**

This article is educational in nature and is not intended as legal advice. Always consult your legal counsel with specific legal matters. Christie Davis is an attorney with Hall, Render, Killian, Heath & Lyman, P.C., the largest health care-focused law firm in the country.

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Health Care Marketing in 2021: The World Has Changed, Have You?

By **Claire L. Carlo**, President,
The Reds Group Strategic Services, LLC
Contributor: **Tara Ryan**, Director of Marketing, 99 MGMT

Like a wobbly moth emerging from its cocoon, healthcare organizations are spreading their wings and learning to fly again. As a healthcare marketer, are you doing things differently, or are you just rehashing the same old strategies and tactics?

Based on what I'm observing, hearing, and experiencing, I challenge healthcare marketers and practice managers to think about these four statements:

There must be a bona fide reason for in-person visits.

Video and telehealth visits are here to stay. The American public needed a little push to try telemedicine, and the pandemic provided a massive shove. According to research published in Health Affairs, 30.1% of all visits were conducted via telehealth during the COVID-19 period. Although there was an increase in telehealth visits, the overall visit volume dropped by 35% from the pre-COVID-19 period to the COVID-19 period.

There is pent-up demand for healthcare. But if your practice believes that people will automatically revert to in-person visits, you're mistaken. Few people will choose the hassle of parking, sitting in a waiting room, and being exposed to viruses over receiving care in the comfort and convenience of their own home.

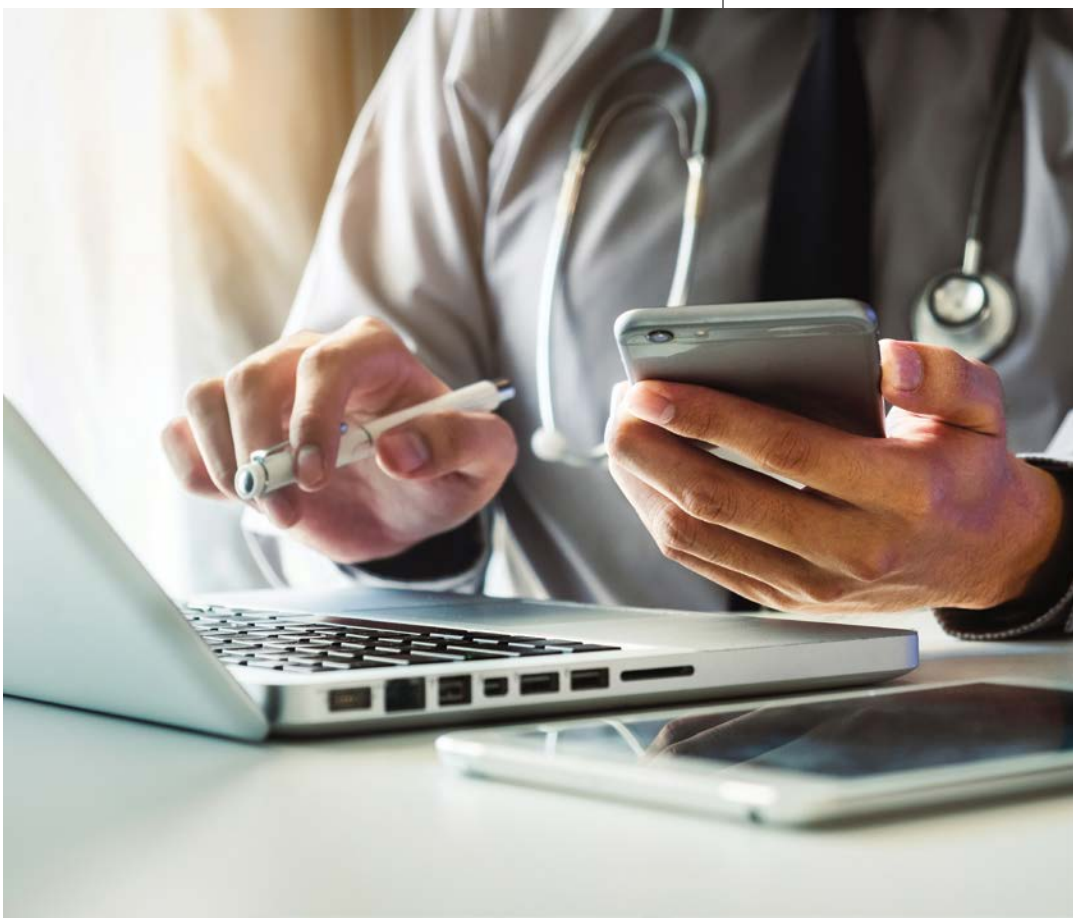
It's time to think creatively about why someone should choose an in-person visit. Here are a few ideas:

- Can you clearly define the advantages of an in-person visit at your practice? If so, write them down and communicate them to your patients in simple terms.
- Are there some symptoms that would be better assessed in person? If so, highlight those to your patients and prospective patients.
- Do not assume that patients know what to expect or will read your website. A personalized email or text message to patients who have not been in your office in 12+ months is a nice way to reconnect with them before they walk through your door. Have you changed your check-in process? Are temperature checks still required? Are masks required—even if you are vaccinated. Can you explain why?
- Is there an easy and convenient way to "bundle" required in-person services (e.g., blood work, other diagnostic tests) with a physician visit? Placing a higher value on patients' time and telling them about it may bring patients back to the office. Thank you, Flo and Progressive Insurance.

Online reputation management is critical to new-patient acquisition.

According to SoftwareAdvice.com, almost three-quarters (71%) of surveyed patients use online reviews as the very first step to finding a new doctor, so your online reputation is often the first impression you make on many potential patients. This research finding is consistent with multiple other studies over the past 10 years, and all point to the same conclusion: Online reviews matter.

Every physician practice manager I talk with still asks the same thing, "Our patients love us, but how do we get more reviews? How do we get rid of the bad reviews?" The simple answer: You use



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It's worth doing your research to determine which service fits the needs of your practice and asking questions like: Do I want a local service? Do I just want reputation management? Am I interested in other add-on services?

The bottom line: People will provide a review if you ask and if you make it super simple for them to do so. Yes, this technology costs money, and, yes, it is worth it.

Physician referral programs are more important than ever.

Most physicians and mid-level providers refer patients to other practices for various medical treatments outside of their scope. They cannot refer to your practice if they do not know you exist.

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Even if providers have established relationships with fellow physicians, there is a need for options. When referring patients, the key considerations for patients are accepted insurances, location or proximity to the patient, treatment options, and provider availability. Patients will consider you if you meet any of these requirements.

With the pandemic scaling down, in-person meetings are making a comeback. Schedule meet- and-greets with specialties that can refer to your practice. If not in person, virtual meet-and-greets work too. Research targeted practices and inform them about how your medical office can best meet the needs of their patients. The main goal is to make sure they know who you are, where you are, what you treat, and how you can help their patients in maintaining quality healthcare. Every practice should have a formal physician referral program as part of its marketing strategy. If you need help, there are firms that specialize in physician-to-physician outreach.

Traditional, digital, or social? Who cares. Your marketing messages are boring.

Let's face it. Millions of social media posts are churned and burned each day—Facebook, TikTok, Instagram, LinkedIn, and Twitter, to name a few, and those are just for "old" folks. Throw in audiences fragmented by hundreds of delivery and channel options—too many to even list examples—and your head starts to spin.

As always, your marketing messages need to be clear, consistent, authentic, and attention- worthy.

The last post-pandemic era was called The Roaring '20s… there was a reason for this. Even though people are craving a fun, fresh perspective, the majority of healthcare ads and posts that I'm seeing are blah, boring, ultra-conservative, and so similar that the only difference is the logo. Effective healthcare marketing must be professional and personal, but it doesn't have to be boring.

Are You Ready to Lead Growth at Your Physician Practice?

My former boss, Greg Daniel, an Emergency Room physician and successful entrepreneur, often said, "If you're not growing, you're dying." If your physician practice isn't growing, challenge yourself to think differently. It's a whole new world for medical marketers and the perfect time to reassess and reimagine your strategy, messaging, and tactics to ensure that you're part of the solution, not part of the problem. Pitter patter, let's get at 'er. **DMJ**

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Editorial: A Call to Action for Physicians to Comment on Federal No Surprises Act

By **Christopher Ryan Cook**, DO, FASA

As a facility-based, solo practitioner in Dallas, I often feel challenged to negotiate a fee schedule with third-party payors that ensures I am able to maintain a viable practice, including a living wage for myself and staff, as well as covering the overhead expenses in my practice. With the passage of the Federal No Surprises Act (NSA) in December 2020, practices like mine could face even greater challenges if the current proposed legislation is adopted without important future congressional amendments and clarifications adopted during the three-part agency rulemaking process. The NSA seeks to establish new and meaningful patient protections from unanticipated out-of-network care for those patients with high-deductible plans and will limit cost-sharing. I believe all physicians support taking the patient out of the middle of disputes between providers and health plans. With passage of the NSA, the federal government has taken a misguided step in accomplishing this goal. Furthermore, as with most legislation, the details that are absent in the legislation are codified through the rulemaking process and are critical for ensuring all parties know exactly how the measure will be implemented.

The oversight agencies, the Centers for Medicare & Medicaid Services (CMS), the Department of Treasury, and Department of Labor, issued an Interim Final Rule (IFR) and requested comments to help inform future rulemaking. Those requests for comment can touch on a range of issues, including the scope of the IFR, the process for obtaining notice and consent, data on urgent care centers, the impact of health-care consolidation on reimbursement rates, how to improve the billing process to identify NSA-related claims, and whether to set a minimum initial payment rate, among other topics.[1]

The IFR for the No Surprises Act Regulation, Part 1, was published in July 2021. One aspect of the proposed rule focused on patient protections against surprise medical bills and determining out-of-network provider payments through a Qualifying Payment Amount (QPA). Because of the way QPA is proposed to be calculated, future payments will not accurately, without intervention, reflect median contracted rates, or the market rate.

Unless changed, the current version of the NSA allows for the median rate provided by the insurer to be calculated as the middle number, or, if there is an even number, then the average of the middle two contracted rates. This formula excludes single contracts, out-of-network median rates, and does not utilize third-party, nonprofit benchmarking entity median rate data. This will heavily skew the dollar amount below the lower of the two benchmarks considered in our Texas informal dispute resolution (IDR) process (50th percentile of FAIR Health allowed). This QPA methodology, as it stands, will create economic hardship for small, medium, and independent practices like mine. Not only would it cost additional dollars and time to request an IDR, but an arbitrator would use benchmarks that are below the lower benchmark currently used in the Texas IDR.

Arbitration requests by provider type

Provider type	Jan-June 2021
Emergency department physician	35,172
Anesthesiologist	8,238
Certified registered nurse anesthetist	1,993
Radiologist	1,749
Surgical assistant	759
Physician assistant	741
Assistant surgeon	686
Neuromonitor	321
Surgeon	169
Hospitalist	117
Nurse practitioner	96
Pathologist	72
Neonatologist	29
Neurologist	10
Other	78
Total	**50,230**

Texas Department of Insurance | tdi.texas.gov

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The cornerstone for Dallas County Medical Society's success is rooted in the physician leaders who selflessly give of their time and talents as volunteers to the organization. In these unprecedented times, DCMS needs physicians from all corners of practice to contribute their time and expertise to the advances of organized medicine in Dallas County. Please consider volunteering for a term beginning January 2022.

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The DCMS Board of Directors is the governing body for the Society charged with overseeing the long-term planning and execution of the organization. The DCMS governance framework is built upon the identification, election, and growth of Directors based on their contributions and competencies in advancing the Society's strategic priorities.

Legislative Affairs Committee
Advocacy is a primary objective and membership benefit of DCMS. Committee members meet with state legislators and federal congressional representatives to educate them about issues of interest to physicians, patients, and organized medicine.

Membership / Member Services Committee
This committee reviews DCMS member services and strategizes enhanced membership benefits. It proposes membership events and other tactics to enhance membership recruitment and retention.

Socioeconomics Committee
This committee studies, recommends, and implements services valuable to members in operating their medical practices. Areas of interest include: health system transformation; value-based contracting; payer policy and coding changes; and coordination with the TMA Socioeconomics Division and Council.

DCMS Delegation to TMA House of Delegates
The TMA House of Delegates is the policy-making body for organized medicine in Texas. Dallas County physician representatives join physicians from across Texas annually to consider resolutions regarding changes to TMA policies and also to conduct the elections for TMA elective offices.

Communications Committee
This Committee oversees the communication strategies between DCMS and its members. It provides feedback on communication tactics and identifies new tools for disseminating information to members.

Community Emergency Response Committee (CERC)
In a public health emergency, the DCMS CERC has partnered with the Dallas County Health and Human Services Department to engage medical volunteers to strengthen public health, improve emergency response, and build community resiliency.

Dallas County Physicians PAC
Dallas County Physicians PAC is the DCMS political action committee and gives Dallas physicians a voice in Dallas County political races. Committee members meet with candidates to educate them about important issues in medicine and make decisions regarding political contributions to candidates.

Nominating Committee
Committee members are elected to serve on the Nominating Committee and are charged with identifying and slating candidates for elective positions within DCMS. The committee also oversees the elections process and reviewing bylaws.

Women in Medicine Forum
This forum focuses on issues and opportunities for women physicians in the areas of academia, private practice, health system employment, public health, and medical education.

Physician Wellness Committee
This committee offers structure and support, as well as serving as an advocate for impaired physicians. The committee meets with physicians in recovery and helps them chart their path back to practice.

Ad hoc Committees / Task Forces
If you are not sure where you would like to serve, consider adding your name to our list of Ad hoc committee volunteers. These assignments are short-term projects that DCMS requests in response to a specific need.

To sign up to serve your profession through DCMS, please visit:

https://fs25.formsite.com/z5r8vL/iaewrazdae/index.html

DCMS DALLAS COUNTY MEDICAL SOCIETY

STAY CONNECTED WITH DCMS

Additional Information

Annual Subscription Rates

Members	$12
Nonmembers	$36
Overseas	$50

Information for Authors

Dallas medical professionals look to the Dallas Medical Journal and its community of peer contributors as a valued resource for Dallas County medical information. Our goal is to provide insights on various topics, including patient advocacy, legislative issues, current industry standards, practice management, physician wellness, and more.

The Dallas Medical Journal selectively accepts articles from industry professionals that meet our editorial guidelines. We always seek original, informative articles that ultimately will be a useful source to give our professional readers a broad yet unique reading experience.

If you are interested in submitting an article for consideration, or have additional submission questions, please email Pamela Lowery at **pamela@dallas-cms.org**.

There is still time to ensure that the agencies understand the physician's perspective on the implementation of this legislation. TMA and five specialty societies have taken the first step by submitting comments for the NSA Part 1 IFR on September 7, 2021. The TMA and specialty society comments provide an in-depth description of the QPA methodology issue and provide recommendations on how to create a fairer IDR process.[2]

The NSA Part 2 is slated to be published soon, and this regulation should provide more detail on the IDR process, transparency measures, and price comparison tools, as well as air ambulances and enforcement. Although this IFR includes many strong consumer and patient protections, the agencies acknowledge that the true impact of the NSA on overall market dynamics—such as premiums and network negotiations—cannot be assessed until we have rules on the IDR process. The IFRs on these forthcoming rules are "interrelated," and the agencies expect to include additional analysis of the NSA's broader market impacts in future regulations.[1]

Rules on other NSA provisions in Part 3, including insurance card requirements, continuity of care, provider network directions, and prohibition on gag clauses, may not be published until next year.

As members of DCMS, we can have an impact by using the open comment period for all three parts of the NSA IFR. We need to be strategic and clear on our requests and use our collective voices to address the issues in the NSA IFR before final adoption. Please read the proposed rules and submit your comments before these regulations are finalized. We must vocalize our concerns to ensure that the regulation is changed to ensure patient protections are maintained and viable practices are possible. **DMJ**

Dr. Christopher Cook is a private practice anesthesiologist in Dallas/Fort Worth, currently serving as Chair of Communications for the Texas Society of Anesthesiologists. He is the former editor of the TSA Bulletin. An active member of DCMS since 2010, he currently serves as a member of the DCMS Socioeconomics Committee and as a DCMS delegate in the TMA House of Delegates.

The views, information, or opinions expressed in this editorial are solely those of the individual(s) involved and do not necessarily represent those of Dallas County Medical Society (DCMS), its employees, or the Board of Directors. DCMS makes no representations as to the accuracy, completeness, or correctness of any information provided herein and is not responsible for its content.

Submit your comments on the Interim Final Rules during the open comment periods:
Regulations.gov OR contact your Congressman at house.gov and express your concerns.

References:

1. https://www.healthaffairs.org/do/10.1377/hblog20210706.903518/full/

2. TMA No Surprises Act Article and Comment Letter (see upcoming link)

3. TSA No Surprises Act Comment Letter https://drive.google.com/file/d/1Rplv3e6c0Sg8YSiOsVmUoqNbxK9VdWUt/view

4. ASA No Surprises Act Article and Comment Letter https://www.asahq.org/advocacy-and-asapac/fda-and-washington-alerts/washington-alerts/2021/09/asa-provides-feedback-on-first-set-of-federal-rules-for-no-surprises-act

CONTINUING MEDICAL EDUCATION

PSYCH ADVICE FOR THE PEDIATRIC PRIMARY CARE PROVIDER

Course Directors: Sabrina Browne, MD and Mili Khandheria, MD

Psych Advice for the Pediatric Primary Care Provider aims increase children's access to mental health care by increasing primary care providers' knowledge and comfort in managing behavioral health concerns.

This series will increase children's access to mental health care by increasing primary care providers' knowledge and comfort in managing behavioral health concerns. Pediatricians and their medical team will learn ways to assess and make simple diagnoses for common behavior/mental health concerns in children and adolescents. Tools learned in this educational series will lessen referrals to mental health practitioners for simple behavioral concerns and decrease the frequency of Emergency Department referrals.

DATE	TOPIC	SPEAKER
10/13/2021	Assessing and Responding to Nonsuicidal Self-Injury	Nicholas J. Westers, Psy.D., ABPP

- Explain key characteristics of nonsuicidal self-injury (NSSI) behavior that may increase the risk for future suicide attempt
- Recall at least 3 important questions to ask individuals who engage in NSSI
- Discuss strategies for providing brief, targeted counsel/advice to individuals who engage in NSSI

2nd Wednesday of every month at 12:30 | **Sessions** will be held **via live web broadcasts**

To Register and for more information please visit childrens.com/learn

Who should attend: Pediatricians, family practice physicians, pediatric specialists, pediatric nurses, nurse practitioners and physician assistants who wish to update their knowledge on mental health and behavioral health in pediatric care.

Accreditation: The Children's Health is accredited by the Texas Medical Association to provide continuing medical education for physicians.
Credit Designation (CME): The Children's Health designates this live activity for a maximum of *1 AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
CNE Statement: Children's Health Clinical Operation is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.

Texas Medical Association CME Accreditation With Commendation

children's health Children's Medical Center | UT Southwestern Medical Center

CME20129_(16397)

DALLAS COUNTY MEDICAL SOCIETY

Membership Anniversaries 2021

Join us in celebrating DCMS members who have reached a milestone in their membership with the Society! All of our members are special to us, but each year we take time to highlight those who reach a five-year membership anniversary benchmark. Thank you for your commitment to the Society and for all you do to keep our communities safe and healthy!

50 Years

- James Atkins, MD
- Martin Cohen, MD
- Kenneth Cooper, MD
- Joseph Pflanzer, MD
- Leslie Secrest, MD
- Joseph Viroslav, MD

45 Years

- James Burrell III, MD
- Allan Devilleneuve, MD
- Ted Fogwell, MD
- John Guedalia, MD
- John Haley, MD
- Paul Handel, MD
- Charles Johnston II, MD
- Richard Johnston, MD
- Diane Klein, MD
- M. Alan Menter, MD
- James Passmore, MD
- Thomas Russell, MD
- Malladi Sastry, MD
- Gene Wyll, MD

40 Years

- Antoine Albert, MD
- Drew Alexander, MD
- Robert Baird, MD
- William Burns II, MD
- Paul Anderson, MD
- Jeffrey Caruth, MD
- Bruce Cheatham, MD
- Amy Coffey, MD
- Robert Cohen, MD
- John DePasse, MD
- Shashi Dharma, MD
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- Russell McDonald, MD
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- Hien Nguyen-Ngo, MD
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- Peter Ray, MD
- Dennis Raymond, MD
- William Shutze, MD
- Michel Stephan, MD
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- George Thorne Jr., MD
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- Timothy Valek, MD
- Geoffrey Walker, MD
- David Walters, MD
- Steven Wilkofsky, MD
- Ellen Wilson, MD

35 Years

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- Richard Berlando, MD
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- Robert Bossard, MD
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- A. Jay Burns, MD
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- Bruce Zik, MD

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- George Zoys, MD

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- Sarah Scott, MD
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- Maurice Syrquin, MD
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- Philippe Zimmern, MD
- Neil Zucker, DO

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- Maria Perez, MD
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- William Pinson, MD
- Christian Royer, MD
- Nisarg Shah, MD
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- Matt Siskowski, MD
- Ramsey Stone, MD
- Chris Stutz, MD
- Timothy Sullivan, MD
- Carlos Taboada, MD
- John Tan, MD
- Cealee Thomas, MD
- Emilia Thomas, MD
- Felicia Tillman, MD
- Joseph Vineyard, MD
- John Wallace, MD
- Angela Walker, MD
- Susan Watts, MD
- Cynthia Woerz, MD

15 Years

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- Samuel Ahn, MD
- Jamak Almasi, DO
- Karin Anderson, MD
- Robert Antonetti, MD
- Amal Aqul, MD
- Nicholas Arizpe, MD
- Ronald Aycock, MD
- MacArthur Baker, MD
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- Michelle Bassichis, MD
- Paul Bauer, MD
- William Beaujon, MD
- Christopher Bloom, MD
- Benjamin Blow, MD
- Bryant Boren III, MD
- Matthew Brooker, DO
- Christopher Brown, MD
- Melissa Burch, MD
- Micah Burch, MD
- Elizabeth Carroll, MD
- Arun Chandrakantan, MD
- Jacob Chemmalakuzhy, MD
- Lee Chen, MD
- Conrad Cheung, MD
- Christopher Clarke, MD
- Andrew Clavenna, MD
- Gates Colbert, MD
- Rebecca Collins, MD
- Steven Davidoff, MD
- Joseph Dieber, MD
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- Rosechelle Ruggiero, MD
- Mauricio Salicru, MD
- Shelby Salmon, MD
- Eric Schmitt, MD
- Anjali Shah, MD
- Samip Sheth, DO
- Paul Skluzacek, MD
- Bryan Skulpoonkitti, DO
- Ashwani Srivastava, MD
- Jesse Stewart, MD
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- Rebecca Vasquez, MD
- Melissa Villegas, DO
- Dat Vo, MD
- Kevin Walters, MD
- Drew Weiner, MD
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- Bryan Yelverton, MD
- John Yordy, MD
- Amy Young, MD
- Christopher Young, MD
- Xin Jin Zhou, MD

10 Years

- Muhanned Abu-Hijleh, MD
- Richard Adams, MD
- Chinenye Akaluso, MD
- Mohammed Aleem, DO
- Pintu Amratlal, MD
- Lakshmi Ananthakrishnan, MD
- Padma Anne, MD
- Christopher Ball, MD
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- Maria Bano, MD
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- Carlos Cardenas, MD
- Adam Carter, MD
- Winston Chan, MD
- Roohi Cheema, MD
- David Cheng, MD
- Ryan Cheung, DO
- Shweta Chowdhury, MD
- Joshua Clayton, MD

- Quanita Crable, MD
- James Cutrell, MD
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- Adeel Ijaz, MD
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- Don Le, DO
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- Lyndsay Massey, MD
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- Kyle McMenamy, MD
- Angela Young-Achong Mejia, MD
- Todd Moen, MD
- Hashim Mohmand, MD
- Megan Morris, MD
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- Shawna Nesbitt, MD
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- Surendranath Veeram Reddy, MD
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Editorial: We Do Harm

Sobriety Restrictions for Hepatitis C Treatment are Dangerous and Unnecessary Barriers to Health Care

By **Whitney Stuard**, **Tori Pierce**, **Tanooha Veeramachaneni**, **Brittany Wagner**, **Brianna Marschke**, **Makenzie Stuard**, **Chandana Golla**, and **Emmanuella Oduguwa**

Medical students throughout the country are currently training to be the physicians of tomorrow, but what is often forgotten is the health care system in which they are learning to serve a system that obstructs a physician's ability to provide their patients with the best care. How can medical students say they stand for fairness and equity when the health care system perpetuates injustice, which restricts their ability to treat all their patients equally.?[1] This question comes up when medical students reflect on how the health care system treats those with hepatitis C patients who use injection drugs, or in over 13 states, how the health care system seeks to not treat these patients.

Hepatitis C is an infectious disease that can be passed through blood and can become chronic, leading to liver damage, cirrhosis, cancer, or even death when left untreated. The annual incidence of hepatitis C virus (HCV) infection in the United States has tripled in the last decade, due primarily to a rise in injection drug use, and affects 50% of all people who use injection drugs (PWID).[2,3,4,5,6,7,8] HCV can be prevented with early diagnosis and treatment using direct-acting antivirals (DAAs), which cure over 95% of those with HCV.[11,12,13,14] Despite PWID's high susceptibility to HCV, intervention and treatment of HCV using DAAs is often restricted by state policies that impose arbitrary abstinence periods on prospective patients with HCV. Some Medicaid groups require abstinence from alcohol and substance use for up to six months prior to receiving any DAA therapy.[5,15,16] This means physicians are often unable to treat their patients solely because of their substance use disorder, and this completely destroys the physician's ability to "do no harm." Because many patients cannot refrain from illegal drug use for long enough to treat and eliminate HCV early, these required periods of abstinence, also known as sobriety restrictions, go against the Social Security Act, since they result in "denial of access to effective, clinically appropriate, and medically necessary treatments using DAA drugs for beneficiaries with chronic HCV infections."[17,18,19,20]

Not only does federal law oppose the use of barriers like sobriety restrictions, but these policies are rooted only in bias rather than informed medical opinion. Alcohol and injectable drugs have no impact on the effectiveness of the DAA treatment. In fact, those with substance use disorders have the same HCV cure rates as those without substance use disorders, demonstrate high adherence to treatment, and even experience low six-month reinfection rates.[6,8,21] State laws requiring abstinence greatly limit those who receive hepatitis C treatment and most likely lead to higher costs later for the state as the patient becomes sicker over time.

Individuals across the United States are being impacted by these policies. As of 2020, 26% of state Medicaid programs maintain sobriety restrictions for patients expecting to receive lifesaving HCV therapy.[22,23,24,25,26,27] A lot of people who are supportive of sobriety restrictions argue that

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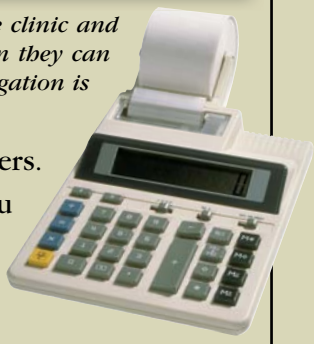

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it would not be cost-effective to treat patients who inject drugs because they believe these patients will get hepatitis C again. However, countries that began treating PWID have found transmission of HCV reduced overall.[28] Some states have shortened the periods of time individuals need to abstain from drugs before receiving treatments. However, a sobriety restriction in any form as it relates to HCV punishes both the patient and those who are trying to provide treatment. If states continue to use barriers to access HCV treatment like sobriety restrictions, it is projected that 320,000 HCV patients will die, 157,000 will develop liver cancer, and 203,000 will develop cirrhosis over the next 35 years.[9,10]

Medical professionals are in favor of ending these sobriety restrictions in order to once again provide equal care to all their patients. State medical associations like the Texas Medical Association have taken a stance of opposition to these sobriety restrictions. Furthermore, the American Medical Association's Medical Student Section stood against sobriety restrictions in this year's conference and will be bringing this topic to the American Medical Association's House of Delegates in the near future. Until these barriers to care are lifted across the board, future physicians will be unable to fulfill their mission of "do no harm." DMJ

All authors are either medical students or law students with the United States. Whitney Stuard is executive editor of the Medical Student Press, and the author of the legislation put forward to both the Texas Medical Association and American Medical Association to Oppose Sobriety Restrictions for HCV Treatment.

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Nexus Practice Solutions provides tailor-made practice management services to physicians, including Revenue Cycle Management, Financial Management, Operations Management, and Consulting Services. We are passionate about helping physicians dedicate more of their time to their passion – caring for their patients. We also believe that practice management is not one size fits all. That is why we customize our service offering to each individual client, so that each physician practice gets the exact level of support needed. We work hard to understand the needs and strategic goals of each client practice and work in partnership with them to achieve those goals. Our mission is to allow every physician practice, no matter how small, access to a level of management and strategic planning typically only seen in large organizations.

We have been in business since 2013, with over 30 years of combined practice management experience between the two owners. We joined the Circle of Friends program as a way to connect with physicians in the Dallas/Fort Worth area who might benefit from working with us. We also enjoy the opportunity DCMS provides us to hear how the physician community in DFW is meeting the challenges of the ever-changing healthcare industry. We look forward to participating in future events!

This gem of wisdom describes what is truly most valuable in life. The people we love; their life, health and happiness and our ability to take care of them.

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