BACKBONE

a publication of the Connecticut Orthopedic Society

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President's Corner *Robert Biondino M.D. - President*

Boomers and Benefits

If you received this issue, the evil empire is golfing, the ghosts in the house of Ruth have moved next door and the Cubs have finally gotten rid of some old goat. Speaking of old goats, I read in Orthopedics Today that Dr. Doug Jackson has addressed Social Security and the retiring orthopedist. Apparently 5% of current practicing orthopedist are 70 years old or older. In our State, many have heard me say that the average age is 55.7 years for orthopedists. Most work because they enjoy it. Others because they or family members have made poor decisions and they cannot quit. We all want a healthy life after 65, the nation's workforce has gotten appreciably older. Part of Dr. Jackson's concern is that Congress spends our Social Security money and gives us an I.O.U. He looks at Social Security as a taxation. Since this is not a new revelation for most of us, I briefly point out that we all pay 6.2% of our first $102,000 earned. If the government chooses to tax greater income earnings or target those who make more, it is safe to state that another form of income redistribution will have to appear.

I did have a bias with the article. We need only to look back to Ronald Reagan and the future Federal Reserve Chief (Greenspan) in the early 1980's. At that time, their recommendation was that the wealthiest retirees pay partial taxes on their Social Security benefits and in 1984, this was passed. But ten years later, the Clinton Administration struck and there was another increase. The figures were simple. Reagan had taken a married couple ($32,000) and then using 50% of Social Security benefits, added in all traditional pension plans, interest or dividends and any employment tax. When added together, anything over $32,000 produced a .50 tax per dollar until 50% of the Social Security was taxed. In 1994, the upper limits did go up to $44,000 per couple, but now 85% of Social Security benefits plus any other monetary benefits would be taxed. The figure was now .85 per dollar. For every additional dollar taken from your pension plan, another .85 of your Social Security would be taxed. This makes upper income producers in life see an effective tax rate of 46%. Their $1 of pension plan, became $1.85 of taxable income.

So, when Dr. Jackson states "to make matters worse, you will most likely be taxed at a higher rate when you withdraw funds from your retirement plan", he should say you will definitely be taxed at a higher rate. When he notes that most of us will benefit very little from Social Security, he really should not be surprised.

What does trouble me and surprise me is his slant on Senator Obama and a bias toward taxation. Nonpolitically, I would say that a noted economist, Peter Orszag, has clearly proposed a twofold attack on our failing Social Security. Reducing the benefits over time by 8.6% and raising payroll taxes to 7.1% by 2055. This is proposed in the obvious presence of life expectancy rising and retirement ages increasing. Our government is more than happy with the latter and has actually encouraged it by extending the time for Social Security. We already have a tax then on the "wealthy".

Dr. Jackson continues by indicating that Senator McCain has given no details for Social Security reforms. Rather he speaks on the campaign trail in generalities. Dr. Jackson, that means he wants to "fix" the system by benefit cuts. We have come to appreciate that Republicans cut benefits and Democrats increase taxes. So both candidates are saying don't be surprised if taxpayers find that their payments are really not based on their contributions to Social Security. However, the bias in Orthope-

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President's Corner

dics Today ignores how we got to this situation. It

(cont. from front page)

Boomers and Benefits

ignores Reagan and Clinton directives. It panders to the crowd within us who resent "recent arrivals" to our country. It actually ignores a solution to the problem. We do have access to Roth IRA's or Roth 401(k)'s. Lo and behold, Roth withdrawals do not count as income. While actively in practice, the time to avoid the losses and the bipartisan tax losses is while we are working. As we begin to downsize, selling the large house and the profits that are derived is not considered income for either Social Security taxation or even Medicare "means testing". The next Administration, McCain or Obama, will do damage to our savings as they both will simply have to. Under Bush, our credit rating is in jeopardy and may be down graded if the national debt is not controlled.

Now that I have reached the age of entitlement, I recognize Medicare isn't free either. The monthly premiums for Medicare B have risen from $42 a month in 2000 to almost $100 in 2008. Economists have stated that Social Security and Medicare are almost $43 trillion dollars in deficit. Medicare will and must demand more out of pocket costs. With the new drug coverage plan, simply raising the payroll tax will no longer help. The plan is paid for by general government revenue. Expect that one or all of the following will have to be increased: income tax, state tax, capitol gains and dividend taxes. Under Bush, higher income retirees have had to pay more for Part B since last year.

Finally, my apologies to the Connecticut Orthopedic Society readers, I should never have reacted to Dr. Jackson's commentaries (Orthopedics Today ,September 2008). The last eight years have left me shaking my head. Maybe next month the commentary will address a real issue. Why is the Bush Administration sided with the insurance industry? Why does the Department of Justice only single out physicians and physician groups to bring suits against?

The reality is that none of us expected to benefit from Social Security in our income bracket but I think most of us thought the government would protect free-enterprise and the practice of medicine. This Administration has treated physicians as well as they treat offshore detainees. I really believe we need to look critically at how little help medicine and doctors have received over the past eight years from our government and how little we can expect in the future.

Workers' Compensation

(Editor's Note: The following is information regarding updates to Workers' Compensation in Connecticut.)

Electronic Filing of First Reports of Injury Mandated January 1, 2009

Effective January 1, 2009, the Workers' Compensation Commission is instituting a policy that all First Reports of Injury filed pursuant to § 31-316 must be transmitted electronically to the Chairman's Office.

Prior to the effective date of the above policy, the Workers' Compensation Commission has accepted both electronic and hard copy submissions of First Reports of Injury. However, recognizing that business communications are now largely accomplished through electronic transfers, the Workers' Compensation Commission is mandating that First Reports of Injury be filed electronically with the Chairman's office. We believe this step will help reduce costs and will expedite the forwarding of information that may be necessary for claims processing. This will also allow us to better meet the mandate of Public Act 08-03, the new statute requiring notification of claim filing information. Access to web based filing is an available alternative for low volume submitters.

2008-2009 Weekly Benefits Rate Tables Effective October 1, 2008

Tables for determining the workers' compensation benefits for Connecticut workers injured between October 1, 2008 through September 30, 2009 are now available. These tables can be obtained from:

Rapid Print and Copy
139 Center Street, P.O. Box 1926
Bristol, CT 06010
Phone: (860) 584-8218 FAX: (860) 584-8219
E-mail: rapidprintncopy@aol.com

The cost for the tables are:**$18.97** *(includes sales tax)* if picked up and **$25.33** *(including sales tax and shipping)* if ordered by mail. Payment should accompany mail orders.

For your convenience, these tables are posted on the Workers' Compensation website at: http://wcc.state.ct.us/download/acrobat/Benefit-Rate-Table-2008-2009.pdf

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The Backbone is a publication of the **Connecticut Orthopedic Society.** *Comments and suggestions should be directed to:* **Susan Schaffman,** *Executive Director*
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Workers' Compensation

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Revised Professional Guide for Attorneys, Physicians and Other Health Care Practitioners; Guidelines for Cooperation - Effective October 1, 2008

1.Where appropriate, photocopy charges for physicians will increase to 65 cents per page;

2.Deposition fees will increase to $500 per hour;

3.Fees for Formal Hearing Testimony for the Treating Physician will increase to $550 per hour;

4.Fees for Formal Hearing Testimony for the Employer/ Respondent's Examiner will increase to $650 per hour.

For your convenience, copies may be downloaded from the Workers' Compensation website at: http:// wcc.state.ct.us/download/acrobat/proguide.pdf

Save the Date
2009 Annual Meeting
May 29, 2009
Farmington, CT

Connecticut ORTHOPEDIC Society

Administrative Office
26 Riggs Avenue
West Hartford, CT 06107

CONFLICTS OF INTEREST
by Contributing Editor, Ron Ripps, M.D., Danbury, CT.

Does the logo pen in the doctor's hand dictate the written prescription?

In the last issue of the *Back Bone* I commented that expunging the notion that doctors and pharmaceutical companies have an unholy alliance would make the state more attractive to young doctors. It became apparent that there was much confusion among physicians (myself included) and reps about what actually constitutes "conflict of interest" and what doctors and drug/device companies are legally and ethically allowed to do. Noted health law authority Elliott Pollack, of Pullman & Comley, LLC., sent me an informative article on *Conflict of Interest* that was composed by Fulbright scholar Mahnu Davar, JD, MA, and which was published this year in the *Journal of Legal Medicine*.

Davar's major concern has to do with *required* education now mandated by licensing and accreditation boards. His thesis is that when the profit motive is introduced into otherwise objective continued medical education (CME), ethical problems arise. What is implied is that this consideration should also apply to *any* seminars physicians attend with the expectation that they will hear an unbiased, factual presentation. In 2003, pharmaceutical/device company sponsorship accounted for 90% of the $1 billion spent annually on CME. Industry also pays a substantial amount of funding for fellowships (GME), Orthopedics included. In 2006 drug makers spent $6.7 billion on detailing to include $4.8 billion on direct-to-consumer advertising and $463 million on journal ads.

According to Davar, there were three degrees of sponsorship by which drug/device companies have been involved in CME: the Strong Participation, the Gifts and Services participation, and the Mere participation. In every instance speakers are required to disclose any financial or other ties they may have with the company.

Strong participation involved seminars where the vendor did not just sponsor the event, but also controlled the choice of speakers and the topics presented. Typically companies chose speakers who used and endorsed their products (e.g. "script tracking" and surgical usage were monitored). Companies referred to these speakers as *thought leaders* and favored educated and respected health care professionals, some of whom may have had financial arrangements with the company. Ethicists worried about the Strong Participation because attendees might only get one side of the story, rather than a balanced and unbiased approach to the health products discussed.

The second type of sponsorship was the Gifts and Services participation. In this model the company provided an educational grant and nominal gifts and food for attendees. The company sponsor did not directly or solely control the selection of the speakers or the CME topics being presented. Often the selection of CME content was shared by the company and the cosponsor (a hospital, university center, or medical society). Typically notepads, pens, key chains and other branded items that contain the company logo were given as gifts. On 7/10/08 The Pharmaceutical Research and Manufacturers of America (PhRMA) revised their 2002 code. In keeping with the AMA's ethical guidelines, drug/device companies may spend no more than $100 per attendee. Branded gifts (e.g. pens, mugs and calendars) are no longer acceptable-nor are tickets to sporting or entertainment events, travel and lodging subsidies, and sham consulting and advisory arrangements.

The third type of sponsorship is the Mere Participation, wherein the drug/device company gives funding to an institution to hold a seminar with unrestricted content and with little acknowledgement of the drug company's name. Recognition of sponsorship is permissible, but *not* the extent that the seminar is prominently branded by the company. With this model, funding for CME education, payment for bone fide consulting arrangements, fair market value remuneration for speaker training, and funding of scholarships remain permissible. Anatomic models and educational materials are also allowed.

Whether real or perceived, the notion is that drug/device companies provide sponsorship for the purpose of influencing the prescribing behavior of the physician attendees. Because physicians attend these seminars in anticipation of digesting pure CME content, it is considered unethical to skew that CME material for any corporate interest. Davar's thesis essentially hinges on the concept that any favor, no matter how small or insignificant, evokes an obligatory sense of reciprocity in the recipient. Ethicists argue that physicians owe a duty to their patients to remain utterly impartial. Whereas it is difficult to prove (and unlikely) that a physician's prescribing patterns are altered by the company pen in his hand, all other things being equal (cost, efficacy, safety, etc.) the physician will likely select the drug or implant favored by a well-known and respected *thought leader*.

All that having been said, Davar acknowledges that a total ban on drug/device company participation would have devastating consequences on continuing

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education in this country. The amount, variety, and accessibility of CME would be curtailed. Physicians, all of whom have time management problems, would be faced with the choice of either spending time on patient care or seeking and satisfying CME requirements. Only the best-funded and largest medical centers and universities would be able to host CME without the additional support of industry. Seminars present a great opportunity for companies to promote good will, and at a time when the public is decrying rising prices and diminished accessibility to the newest technologies, pharmaceutical/device manufacturers feel good will is of paramount importance. Companies also fear that without these seminars, their drugs/devices may be improperly prescribed or used, which exposes them to litigation.

Although Davar promotes the Mere Participation model as being the only ethically permissible way for drug/device companies to participate, he concedes that pharmaceutical/device companies have no altruistic duty to educate physicians with no expectation of anything in return. He recommends review boards populated by salaried physicians to serve as ethical policemen in the administration of CME grants. He states that in that way CME will not be subject to further government regulation (how many times have we heard that before?). New oversight on device manufacturers has already been imposed by the Department of Justice (the Physicians Payment Sunshine Act of 2007).

Harkening back to the beginning of this article, Davar's ethical threshold applies only to required CME. Dr. Gary Friedlaender, Chairman of the Department of Orthopedics at Yale, points out that the distinction between what education is and is not required is confusing, since physicians who need and who don't need CME sit side by side and take the same course and should have the same expectations with respect to the purity of the imparted material. Davar's exception for "private education" is really referring to advertising. Pharmaceutical/device companies- like lawyers and physicians- are allowed that prerogative. So, Davar writes, "Events that raise the level of awareness of a particular drug or therapy will always be useful to physicians, and when such events are not subject to accreditation, drug/device companies are free to manage speakers, content, gifts, and services however they please."

Dr. Friedlaender rebuts, "It is the responsibility of the physician, not the company, to behave in an ethical manner. This means the physician should always avoid biased presentation and to reject gifts given for the sake of a sales pitch."

In conclusion, industrial sponsorship for CME may continue, but not in the same form as in the past. Medical educators and professional societies, who depend on industry for financial support, are now in discussion with pharmaceutical/device manufacturers about ways of allowing arms-length sponsorship for GME/CME and research. Although the industry's first obligation is to its shareholders, they are nonetheless legitimately concerned with public health, and teaching physicians about the nature and use of their products is essential to their success. As long as doctors and drug/device companies continue to collaborate to minimize speaker control and content, the disseminated material should remain untainted by corporate bias. But let us not forget that our interdependence is historic and necessary: our mutual responsibilities to expose each other to new concepts and to help each other develop better products for better outcomes.

A vendor recently told me that at 3AM in the morning in the operating room there are only two people who are passionately concerned with the outcome of the patient on the table, and whose livelihood and reputation depend on a good result. They are not the scrub tech, circulating nurse, anesthetist, residents, or interns. They are not the experts, the marketers, or the ethicists. They are the surgeon and the device rep.

In the *AMA News*, they quote one physician who asks, "[After all the pens mugs, and key chains are tossed] and we stop congratulating ourselves, what's going to be the difference for our patients?"

Medical practices need to develop an Identity Theft Prevention Program by November 1, 2008.

Last month, many in the healthcare industry learned that a 2007 amendment to the Fair and Accurate Credit Transactions Act of 2003 (FACTA) will affect them. Originally, FACTA applied primarily to businesses operating in the financial industries; however, the Federal Trade Commission (FTC) determined that the new 2007 Identity Theft Red Flag Regulations and Guidelines do extend to the healthcare industry. 'Red Flag" applies to any business or organization that does not receive full payment at the time of service or product purchase, and where there may exist an ongoing relationship with the purchaser. This means that orthopaedic practices and other healthcare entities must make a good faith effort to develop and implement a written Identity Theft Prevention Program by November 1, 2008. The elements and scope of an Identity Theft Prevention Program are identified in the article, "Identity Theft Red Flag Regulations and Guidelines: What the new regulations mean for medical practices," found on the AAOS Practice Management Center in the compliance section.

Health Information Solutions for Orthopedic Practices Workshop

Sponsored by the Connecticut Orthopedic Society

Wednesday, November 19, 2008

6:00 p.m. Registration & Dinner Buffet
6:30 - 8:30 p.m. Program

Farmington Marriott Hotel
15 Farm Springs Road
Farmington, CT 06032
(exit 37 off I-84)

This workshop will provide you and your staff with the latest in Health Information Technology with a focus on EMR solutions and digital x-ray equipment for your orthopedic practice.

Your Society has assembled some of the leaders in the EMR and Digital field to present the latest technology to inform you and help your office with its' electronic transformation.

Don't miss the opportunity to ask questions of the physician panelists who are currently using EMR packages in their practice.

Companies and Topics of Discussion include:

- **Allscript**
  Inform, Connect & Transform
- **GE Medical Systems Information**
  Virtual Officeware
- **SRS Software**
  Automating Clinical Workflow
- **FUJI Film**
  Digital X-rays:Increase Productivity
- **Physician Panel**
  The Positive and the Pitfalls of EMR

Company Representatives will be available to show you first hand what they and their products can do for your practice.

Reply using the form below and mail to:

COS Administrative Office
c/o Susan Schaffman
26 Riggs Avenue, West Hartford, CT 06107
Fax (860)561-5514 or email to sasshops@aol.com

YES, Please register me(us) for the Health Information Solutions workshop on Wednesday evening, November 19, 2008. (There is no fee for members and/or their office staff to attend.)

Name_____

Name_____

Practice_____

Address_____

City_____ Zip_____

Telephone_____ Fax_____

Email Address_____

Questions? Call Susan Schaffman (860)561-5205 or email: sasshops@aol.com.