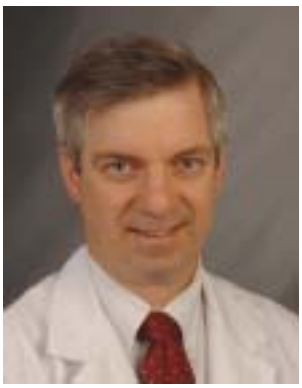
BACKBONE

VOLUME 13 ***a publication of the Connecticut Orthopaedic Society*** ***FALL 2009***

President's Corner *Brian Smith, M.D. - President*



Healthcare reform dominated the news headlines this past summer as changes to the healthcare system that determines our professional lives have been hotly debated in the U.S. Congress and throughout the country. The news media have provided almost a 24/7 saturation coverage of all the various proposals emanating from Congress, the very contentious town hall meetings, addresses by President Barack Obama and analysis of same. It has indeed been a fascinating time for us as orthopaedic surgeons to be observing the potential major changes that may be enacted in healthcare in the United States.This has also been a time when many questions have arisen that remain as yet unanswered. Of paramount importance to us is how exactly will changes that are eventually adopted affect us and our practices? Of even more critical importance is how will any changes impact our patients? Among other questions, will there be a government option? Will there be panels that determine who is entitled to what care? Could for example, patients over 85 be denied the possibility of having joint replacement surgery? And finally, what if anything can we do as active participants in the healthcare system to influence the outcome?

It was also a Summer of profound contradictions leading to much confusion. For example, President Obama talked about how we have a healthcare system that is bankrupting the country and is "a disaster." Yet, between 80% and 85% of the citizens in the country actually like or are satisfied with the health insurance that they have, as reported by Time Magazine. If this is the case, why would potentially radical changes to the healthcare system that in the near future will consume 20% of our Gross National Product be considered when we need to only address the needs of the 10% or 15% that are not adequately served by our current system? Even the amended reform proposal from the Senate Finance Committee indicates additional costs of the program at about $829 billion dollars over 10 years and yet President Obama in his address to the country in early September on primetime television indicated that not one dime would be added to the federal deficit by healthcare reform. Similarly, President Obama refers to Medicare as a model of an efficient health insurance system with low overhead and providing good care for its clients. However, what is left unspoken is the nearly $35 trillion dollars in unfunded mandated support for Medicare in the years ahead which is one of the huge liabilities facing our financing of healthcare in the future. Again, President Obama talks about a system that is competitive and cost sensitive. But, how does that reconcile with adding a government option which many view as anticompetitive and likely to drive insurance companies out of business? A single payer system favored by some would be the antithesis of competition. Many of us wonder how any government run program could ever be successful when we see the likes of the Post Office, Amtrak, and even our own Federal Government.

Finally, the President speaks about potential savings from Medicare and not just the original $500 million that would be cut from the program that angered and greatly concerned many Medicare enrollees. He indicates hundreds of millions of dollars in waste, fraud, and abuse can be captured to pay for the changes in the health plan or as he now has renamed it, Health Insurance Reform. This simply begs the question if there is that much waste, fraud, and abuse now, why hasn't it been stripped out in the past few years, thus potentially saving us from this current dire situation?

What exactly are we as orthopaedic surgeons supposed to do in these times? Recognizing that many of us may have our own strong feelings on what system would be best for our country or even our own practice, I think we can take the values articulated by the leadership in the American

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In Practice *(cont. from page 3)*

Curative vs. Palliative Care

fact is that some conditions do deteriorate over time, just as others may improve. MMI appears to be a moving target, and by this line of reasoning the lady who hangs electrical harnesses in submarines is being continually "cured" with her yearly Botox injection because her MMI has to be renewed on an annual basis- an opinion with which Chairman Mastropietro concurred!

Where problems in Workers' Comp tend to arise are in those workers who cannot be cured, but who, for instance, require a pain pump to remain comfortable at home. I call this "sustenance" because pain management is the quintessential example of palliative care. Although it is not curative treatment in any sense of the word, insurers are often required to pay for it, as Chairman Mastropietro put it, "for humanitarian reasons." He feels no worker who was been injured on the job should have to endure unmitigated suffering. Attorney Passaretti notes that whereas quality of life and amelioration of intractable pain issues are always being debated in workers comp circles, " putting compassion aside, the Workers Compensation Act was specifically designed to eliminate common law pain and suffering in favor of a permanent partial disability model." That is why the AMA's *Guides to the Evaluation of Permanent Impairment* always stress that quoted ratings include the pain and suffering usually associated with that condition. Dr. Marks makes the point that every society has a limit as to how much can be spent on non-curative care, but Attorney Joseph Zeppieri, a former orthopaedic surgeon and COS Board member, insists the patient must always be put first. He feels the Workers' Comp system is only in place to assure that injured workers gets appropriate and reasonable treatment- and that the employer/insurer pays for it.

Whereas the Commission is not averse to pain management, Chairman Mastropietro lists three problems that make the Commission's work difficult: 1) pain management lacks a standard of care and best practices guideline, 2) there is often no end point to these therapies (the old chiropractic problem), and 3) the overutilization of narcotics often renders workers unable to return to work even though they may have recovered sufficient physical capacity to do so.

The curative model of medicine is what was taught to us when we went to medical school and can easily dominate our approach to the biomechanical sciences of medicine. Fortunately vigorous reform of medical education has been changing that perspective and we are now being exposed to other models of medical care that emphasize our involvement in the total care of our patients and that teach us how to marshal all the available resources to achieve that. The **AAOS's Communications Workshop** is a good example.

ANNOUNCEMENT

E-Delivery of BackBone

Beginning with the Winter 2010 edition, the Society's publication, *BACKBONE* will no longer be printed and mailed to members. The Society's Board of Directors voted to eliminate the cost of printing and mailing and opted for members to receive the publication via email and online at the Society's website www.csms.org

The Society looks forward to continuing its' timely communications with members in a cost-saving and environmentally friendly manner.

If you currently receive email correspondence from the Society you will receive the first e-publication of Backbone with an option to opt in or out to to receive future issues.

If you do NOT receive email correspondence from the Society and would like to receive Backbone, please send your full name and email address to Susan Schaffman, email: sasshops@aol.com to be placed on the Society's email list serve.

Any questions, please contact the Administrative Office at 860-561-5205. Thank you.

Society News

Communication Workshop with CMIC Premium Credit

The AAOS Communications Workshop that Dr. Ripps mentions in his article has been offered by the Connecticut Orthopaedic Society at various locations throughout the State and has trained over 60 orthopaedic surgeons to become better communicators.

In addition, the workshop, which is sponsored by CMIC, offers a 2.5% premium credit for your 2010 renewal for all attendees who are CMIC insured.

The next Workshop will be held on Saturday, November 21, 2009 from 10:00 a.m. - 2:30 p.m., at the Water's Edge Resort in Westbrook, CT. The fee for COS members is $100.00 and space is very limited. For more information and registration details, please contact Susan Schaffman at 860-690-1146 or email your request to sasshops@aol.com.

President's Corner

(cont. from front page)

Academy of Orthopaedic Surgeons and promote them to our patients, friends, and colleagues. These include preserving access to specialty care for all patients. We in orthopaedics are uniquely poised in many respects as the primary care physicians of the musculoskeletal system even though some of us have evolved to specialized tertiary level surgeons. Our primary focus and concern must still reside with our patients' best interests and enabling them to have access to specialty care and orthopaedic surgery must be preserved in any changes.

I think we all can agree that the current system is dysfunctional in many ways. We realize that private insurance executives in some cases earn literally tens of millions of dollars, an unconscionable amount that literally comes from patients' and families' health insurance premiums. Our own Past President of the Connecticut Orthopaedic Society, Dr. Michael Marks, has advocated for insurance reforms that would make all of these companies mutual type insurance companies owned by their members. Certainly, in theory, this would likely make the insurance companies much more responsive to the patient's needs while at the same time lessening their extreme profit motive.

Despite its flaws, our healthcare system is the most dynamic, creative, and inventive system in the world. The advances in some of the hi-tech, high-level specialty care available in our country are virtually unparalleled elsewhere in the world. Preserving this incentive, ingenuity and creativity must somehow be maintained in any reform proposals. A single payer government system does not strike me as being a responsive dynamic system. From my own personal experience, when my mother was ill in the recent past and required IV antibiotics, Medicare would not pay for home IV therapy, but would pay for her to stay in the hospital and receive the antibiotics. Who knows how long it would it take to change that aspect of Medicare, a concept that literally defies logic?

One way to stay involved and influence the system is to respond with support for the efforts of our own Academy in representing our interests in Washington. Recently, Academy president Dr. Joseph Zuckerman mailed us an appeal for additional emergency support to help lobby Congress. It seems perhaps uniquely American that the only way to get your voice really heard is to pay money to sit at the table, but we need to be at that table and our voices must be heard.

Mark Your 2010 Calendar

Upcoming Events Not to Miss

Orthopedic Coding Course

Thursday, March 11, 2010
9 a.m. - 3 p.m.
Farmington Marriott

2010 Annual Meeting

Friday, May 14, 2010
8 a.m. - 4 p.m.
Farmington Marriott

Although, we represent about only 3% of all physicians in the country, we do have two orthopaedic surgeons serving in Congress. Senator John Barrasso from Wyoming and U.S. Congressman Tom Price from Georgia are orthopaedic surgeons who have practiced many years and I believe are still members of our academy. Certainly, they know our practice issues first hand and may well be worth your consideration and support.

In the end I think it is incumbent on all of us as orthopaedic surgeons to be engaged, active and participate in the debate whatever our own personal values and beliefs may be. Our current healthcare insurance system is not perfect and reform is necessary. Ideally, we would like to see a system where health insurance provides true and meaningful access to care, not just coverage without adequate reimbursement for services rendered. Whether such a system can evolve from a single payer, the United States Government, or involves modifications of our current system to include more individual responsibility remains to be determined. Whatever the outcome in this debate, I urge you all as orthopedic surgeons to speak up, be a voice of reason, and provide the leadership that our patients deserve.

The Backbone is a publication of the **Connecticut Orthopedic Society.** *Comments and suggestions should be directed to:* **Susan Schaffman,** *Executive Director*
26 Riggs Avenue, West Hartford, CT 06107
(860) 561-5205 phone
email: sasshops@aol.com

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2009 Board Members

Curative vs. Palliative Care

BackBone Contributing Editor - Ron Ripps, M.D., Danbury, CT

(Editor's Note: Beginning with the next issue, Winter 2010, Dr. Ripps will no longer be a regular contributor to the new, online newsletter. The Society greatly appreciates all of the time and consideration he gave as contributing editor of Backbone.)

When I started to wrestle with the concepts of "curative " and "palliative" care on the Ethics Committee of my hospital, all I knew was that palliative care was not the same thing as hospice.

According to a series of articles published in *JAMA* in 1997, "curative" refers to a misguided and antiquated model of medical education and thinking wherein the only goal is to eradicate the cause of disease. Although this is a noble goal, there are other equally important goals: like prevention, relieving suffering, restoring function, and caring for those who can't be cured. Insurance companies love the curative model because therapies can be denied if they are not "medically indicated". Treatments that are patient specific or that address quality of life issues are seen as less important. Curative is the purest scientific approach to disease and discounts the value of communicative skills and patient understanding. In a highly mechanical science such as orthopedics, where "cures" are coldly assessed on two dimensional x-rays, the curative model may easily prevail.

"Palliative" was considered alternative to traditional medical thinking and represented the more global, holistic approach of modern medicine that concerns itself with addressing the symptoms and the effects of a disease as well as the disease per se. The World Health Organization defines palliative care as "active total care of patients whose disease is not responsive to curative treatment." Palliative care neither seeks the goal of a cure nor the goal of death with dignity. Rather, palliative care considers the subjective experience of illness and strives for the relief of pain and other symptoms. The palliative model deems comfort a legitimate goal of medicine.

The differences between the two models are readily apparent and manifold. In the curative model patients are plugged into categorical cubby holes and filed away. In the palliative model, treatment is ongoing and individually tailored to meet each patient's needs- psychological, cultural, ethical and spiritual- a world with which the average orthopaedist is unfamiliar. But that's OK. The palliative model acknowledges that none of us are capable of meeting all our patient's needs and promotes the team approach.

In the medical arena curative and palliative are often considered polar terms. They represent the opposite extremes in the spectrum of patient care, but, as orthopaedist Dr. Michael Mark, MBA, pointed out, in the trenches we practice a continuum of care from the one extreme to the other- always "shades of gray." The point is that curative has a very positive connotation: a favorable outcome, perhaps a perfect result, or a restoration to one's prior state of well-being; and palliative has an implied negativity: like easing the descent of a dying patient. It is also important to note that the setting where patients interact with us will often determine the nature of the care. The emergency room, for instance, is the realm of the curative model. The doctor's office, on the other hand, is the best setting for the palliative model- and that's where 85% of all patient care occurs.

I had always looked at curative vs palliative in terms of the workers comp setting, where curative treatment is compensated and palliative treatment is not. According to the Chairman of the Connecticut Workers' Compensation Commission, Mr. John Mastropietro, all treatment up to the point of maximal medical improvement (MMI) is considered curative, and all treatment after MMI is considered palliative. Case law indicates that most of the time insurance companies are required to pay for the former, but not for the latter.

Here too we are usually looking at shades of gray. For example, take the woman who hangs electrical harnesses in submarines and whose myofascial pain syndrome requires a Botox injection in the trapezius every year to keep her working. That is not curative treatment, but it isn't palliative either. I regard that as "maintenance" because it maintains the worker's productivity, and I think maintenance is something that should be compensated, even though it isn't curative. Attorney Joseph Passaretti, Jr., of Montstream & May, LLP, says that although there is no statute to that effect, a Compensation Review Board opinion (Bowen vs Stanadyne, Inc., 2 Conn. Workers' Comp. Rev. Op. 60,232 CRD-1-83(June 19,1984)) directs the Commission to seek a "nexus between the worker's ability to work at the level she is and the care she is receiving." Attorney Guy DePaul of Jones, Damia, Kaufman, Borofsky, and DePaul, LLC, states the test is "if but for the continued care the worker would not return to the work force"- then that care should be compensated.

Dr. Michael Saffir, Board member of COS, Chairman of the CSMS Workers' Comp Committee, and member of the State's Dept. of Workers Comp Medical Advisory Panel, notes that Maximal Medical Improvement is not necessarily a permanent end point. California and some other states try to make it so by calling it "permanent and stationary", but the

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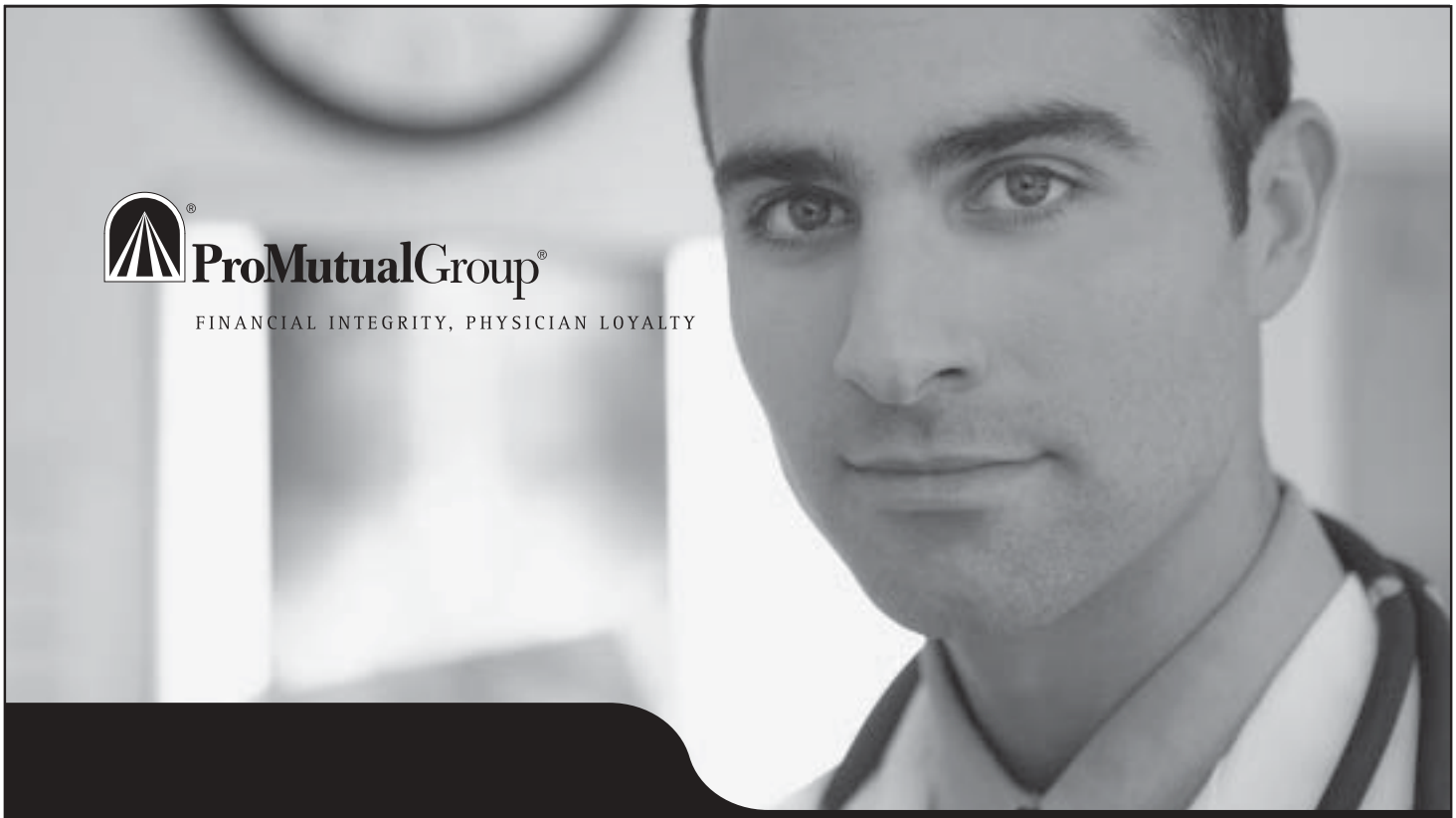

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