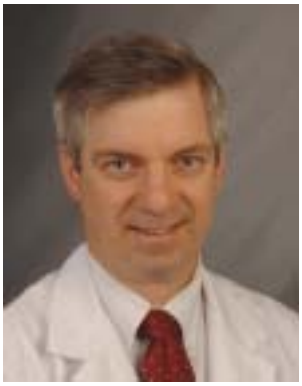
BACKBONE

a publication of the Connecticut Orthopedic Society

Volume 13 ***Summer 2009***

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

(Editor's Note:The following is Dr. Brian Smith's New President's Address to the members at the Society's Annual Meeting on May 29, 2009.)



Good Morning. Honored guests and visiting lecturers and especially my fellow orthopaedic surgeons, it is indeed a privilege to be able to accept the leadership of this wonderful organization, the Connecticut State Orthopedic Society. I am truly honored and look forward to this responsibility in representing the Connecticut State Orthopedic Society.

My background and experience may be somewhat unique compared to recent leaders of our organization. I am in the daily practice and care of children which is different from past Presidents. I also have the exceptional experience of being very actively involved in both of our outstanding orthopedic residency training programs first for 16 years through Newington and Connecticut Children's at the University of Connecticut and for the last year-and-a-half at the Yale University. I can assure you that both programs are superb and the caliber and quality of candidates being educated in both programs is truly extraordinary. I am privileged to be an orthopedic surgeon and this is reinforced to me everyday seeing the phenomenal young students and residents that we attract to our specialty.

As I accept this position, it is with the knowledge that we have significant challenges ahead of us in orthopedics and not specifically just in orthopedics, but in medicine and for our country. These are daunting economic times for our country, our profession of medicine, and our specialty. The only constant now going forward will be change and this is especially so in light of our federal government's intention and the desire of its new leadership to enact significant changes in healthcare. Given the trials that we face, I think it is critically important that we affirm our values and act in a concerted effort to communicate them. The tie that binds orthopaedic surgeons and physicians in general is the fact that we care for patients. Our focus must be our patients as we endeavor to represent ourselves in this ever changing healthcare environment. The fact that we care, that we go to great lengths to support, enhance, and help relieve our patients' ills and illnesses gives us the moral authority and the respect that we have earned in our society. The fact that we care enables us to speak out and support not only our patients, but our profession, and now is the time when we must speak with one voice, a voice that must not be strident but calm, reassuring and confident, qualities that have been rightly attributed to our new President Obama.

I think this challenging time also highlights another value we share, that of commitment. Our commitment to our patients and also to our profession is critically important at this time. Without this commitment, our voice will not be heard whether in the state legislature where we have a number of initiatives working or at the broader national level. In our own state, there are crucially important initiatives that we have started, including most recently a commitment to emergency room care and our responsibilities therein. We wish to speak for all Connecticut Orthopedic Surgeons, but to do that we need to express first our commitment to care for patients that have trauma by emphasizing we are the experts most able to provide this care. We will indicate that in providing this care we need to be supported by our hospitals and potentially by the state itself. The key component that we must continue to stress first and foremost is our commitment to care for these patients.

Again in this challenging time, we must also have our commitment to each other and express this as collegiality. We are small state. As we pursue initiatives and contracting with HMOs, a legislative bill that is under consideration, we must be committed, we must care, but most of all we must be collegial to each other. Yes we have different sub-specialties, we have different specific interests in our practice, maybe different patient populations, but we all share the same goal of providing excellent patient care in the area of musculoskeletal health. Orthopedic surgeons consti-

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Annual Meeting Highlights

Orthopedist of the Year

John Banta, M.D., received the Connecticut Orthopedic Society's highest honor, Orthopedist of the Year, at a luncheon presentation held during the Society's Annual Meeting on May 29, 2009, at the Farmington Marriott in Farmington, Connecticut. He was nominated by his peers for the Society's prestigious honor and his longtime friend and colleague, Dr. Brian Smith, President of the Society, presented him with the award.

Dr. Banta was honored for his many achievements, leadership and commitment to pediatric orthopedics and the development of orthopedic surgeons.

John(Jack) Banta, MD,(center), with his wife, Mrs. Jane Banta, accepts the Orthopedist of the Year award from Society President and Colleague, Brian Smith, MD,(r) at the Annual Meeting on May 29, 2009.

He was recognized for his significant contributions and his dedication to the practice of pediatric orthopedic surgery, his commitment to research and as a mentor to orthopedic surgeons and the practice of medicine.

Dr. Banta is currently on the consulting staff of the Newington Department of Pediatric Orthopedics at the Connecticut Children's Medical Center and is a clinical instructor for the Department of Orthopedics' Outpatient Orthopedic Services at Hartford Hospital. His career dedication to children with spina bifida, scoliosis and cerebral palsy is evident in his teaching assignments and committee participation and leadership in related professional societies and research. His passion to the field and compassion for his patients provided an unparalleled example to the many orthopedists that trained with him.

Dr. Banta received his medical degree from Cornell University Medical College and served as Lieutenant Medical Corps in the U.S. Naval Reserve. He is the father of three and resides in West Hartford with his wife, Jane who joined in the awards ceremony.

Yale & UConn Resident Paper Awards

Resident Paper Award Recipients, Yale Resident, Matthew Milewski, MD (left) and UConn Resident Clifford Rios, MD (right) at the Society's Annual Meeting on May 29, 2009.

Residents from each of Connecticut's orthopedic residency programs presented Papers at the Annual Meeting on May 29, 2009. Residents were selected by the heads of each residency program. The following were presented:

UConn - "Anatomic Reconstruction of the Posterolateral Corner of the Knee with Minimum Two Year Follow Up" Presenter: Clifford Rios,MD Authors: Clifford Rios, M.D., Clifford Yang, MD, Robert Arciero, MD, Robin Leger, RN and Mark Cote, PT

Yale - "Distinguishing Lyme Arthritis from Septic Arthritis in Children Presenting with a Joint Effusion" Presenter: Matthew Milewski, MD Authors: Matthew Milewski, MD, Aristides Cruz, Jr., MD, Christopher Miller, BA and Brian Smith, MD

The Society will continue to fund orthopedic residents' memberships in both their county medical association and the Connecticut State Medical Society to foster relationships, communication and commitment to organized medicine.

2009 Honorary Members of Society

Honorary Membership was granted to Rick Illes and Susan Schaffman at the Society's Annual Meeting on May 29, 2009. Honorary membership is conferred by the Board of Directors to any individual who serves or contributes to the advancement of orthopedics in Connecticut.

Mr. Rick Illes accepts his honorary membership at the Annual Meeting on May 29, 2009.

Mr. Illes was recognized for his 20 years of service and dedication to the orthopedic community and noted that the relationships he has developed in Connecticut are an inspiration for him professionally and personally. Dr. Brian Smith (COS President) presented him with his honorary award. Dr. Robert Green (COS Past - President) presented Ms. Schaffman with her award and noted her work with the CT Orthopedic Society.

President's Corner

(cont. from front page)

tute only about 3% of physicians and we must speak in one voice, we must be committed to each other. If you as an on call physician need to transfer a patient to one of the medical centers, please do evaluate the patient, render appropriate emergency care, and then help arrange the transfer by making a phone call to the center and speak to the orthopedist on the receiving end. Yes you may end up speaking to a resident, but again this is in the patient's best interest so it is in our interest too as orthopedic surgeons.

A couple of points regarding healthcare reform:
1) As had been stated by a number of commentators, one cannot have meaningful healthcare reform without meaningful tort reform. We are a designated state in crisis, and coupled with our high tax status, few of the excellent residents we train are interested in staying in Connecticut. Texas had tort reform several years ago, and at one point shortly thereafter, the state office of Medical Licensure actually had to shut down temporarily, it was so overwhelmed with applications for new licenses. The current system serves only the plaintiffs' attorneys well, while adding huge expenses to our individual overhead and nationally in defensive medicine, and is in urgent need of comprehensive reform.

2) Taking out a meniscus, or reconstructing an ACL would seldom present an orthopod with a moral ethical dilemma, but some of our colleagues in medicine have much more agonizing decisions to make in caring for patients that may run against their personal moral code. Healthcare reform must still include conscience protections for those physicians in those cases where they may be otherwise forced to do procedures or make recommendations that are contrary to their personal moral principles, providing other physicians are available to provide appropriate care. Our profession was founded upon Hippocratic principles including the first rule "To do no harm," which should include doing no harm to one's own internal values in practicing medicine.

3) Any new system of healthcare must provide not only coverage for patients, but access as well. My friend David Skaggs at Children's Hospital of Los Angeles did a classic study published a few years ago where his office nurse posed as the mother of a 12 year old patient injured on a family overseas trip with a forearm fracture who needed follow-up. She called 50 orthopedic surgeons' offices in California for an appointment. When she explained that they had Blue Cross insurance, 50 out of 50 offered her son an appointment. When she called back a week later with the same script to the same 50 offices, but this time her insurance was CA Medicaid, she was offered an

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Save the Date
2010 Annual Meeting
May 14, 2010
Farmington, CT

Society News

New Officers to Serve Society

The Connecticut Orthopedic Society elected new officers for 2009- 2011 at its Annual Meeting held at the Marriott Hotel in Farmington, Connecticut on May 29, 2009.

Elected to serve as President of the Society is Avon resident, Brian Smith, M.D. Dr. Smith is an Associate Professor of Orthopedic Surgery at Yale University School of Medicine and Director of Pediatric Orthopedics at Yale-New Haven Children's Hospital. He received his medical degree from Georgetown University and completed his residency in orthopedic surgery at the University. He went on to complete a Fellowship in Pediatric Orthopedic Surgery from the Children's Hospital in Boston and specializes in spine issues of young children and adolescents.

Vice-President (President-Elect) of the Society is William Cimino, MD. Dr. William Cimino will serve as Vice-President/President-Elect of the Society. Dr. Cimino received his medical degree from the University of Nebraska Medical Center and completed his orthopedic surgery residency at the San Francisco Orthopedic Residency Program. He continued his education with a Fellowship in Foot and Ankle Reconstruction at the Hospital for Special Surgery in New York. Dr. Cimino is active in various professional organizations and is in private practice in Fairfield, Connecticut.

Elected to serve as the Society's Secretary/Treasurer is Ross Benthien, MD, of West Hartford, Connecticut. Dr. Benthien is anboard-certified orthopedic surgeon in the Hartford area. He received his medical degree and Master's in Public Health from George Washington University and completed his orthopedic residency at University of Connecticut, where he now serves as Assistant Clinical Professor of Orthopedic Surgery. Dr. Benthien is on the medical staff at Hartford Hospital, Connecticut Children's Medical Center and UConn John Dempsey Hospital.

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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Foundation Contribution

Please join your colleagues in supporting the future training of the next generations of orthopedic surgeons by making a contribution to the Connecticut Orthopedic Foundation. Your tax-deductible gift will help make a difference.

Your Contribution Makes a Difference.

Enclosed is my contribution, made payable to the "Connecticut Orthopedic Foundation, Inc." *(Please Print)*

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I am pleased to support the Connecticut Orthopedic Foundation with a gift of *(check one)*

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Please send to the Connecticut Orthopedic Foundation, 26 Riggs Avenue, West Hartford, CT 06107. Your cancelled check is your receipt. ***Thank you!***

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Sham Peer Review

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

In The Yankee Years, Joe Torre makes the case that the only reason he chose not to come back to New York was that the Yankee executives no longer trusted him. So much of our conduct is based on "trust", a term that embodies the notions of reliance, hope, care, obligation and responsibility. As we are judged by our peers, we presume that these noble functions will provide fair and just treatment. The reality is that it is not always the case.

In a recent article he wrote for the Physician Executive, Dr. John Henry Pffiferling of the Center of Professional Well-Being (with whom I collaborated on a series on Orthopedic Stress) defines peer review as a process intended to protect patients and colleagues from ill, incompetent, unethical, dangerous, and unprofessional practitioners. Peer review may be formally conducted in the hospital setting, regulated by strict legal policies or it can be conducted informally in a group's corporate meetings as partners discipline partners. In most states the business of peer review is not discoverable in a court of law, which is essential to the open and forthright adjudication of these matters without the threat of malpractice and restraint of trade litigation. An unintended consequence is that nondisclosure protects the reviewers from liability for incorrect judgments and/or inappropriate disciplinary actions. In fact the process can be exploited in a number of ways

At the institutional level, high ranking administrators have been guilty of persuading executive committee members to use peer review to silence medical staff opponents. On the practitioner's side, some disruptive physicians use peer review to portray themselves as "victims", and in their fight to avoid professional remedies they perpetuate their denial

By its very nature, peer review is best performed by one's peers because they are most familiar with the standards of behavior and care under which we all labor. This , however, leads to two dilemmas: 1)Peers are by definition competitors, and the action of one peer in one group against another peer in another group may be considered an unethical ploy for commercial gain, and 2) Fears of retribution, retaliation, and isolation may serve as barriers both to participation in the process and to effective judgment. Even within one's own group, consider the high earner who feels his status confers a license to misbehave.

Dr. Pfifferling has compiled a number of examples of sham peer review with which his organization has had to deal, including:

1) A peer reviewer who instructed staff nurses to watch a particular physician and collect any clinical abnormalities that could be used against him. The targeted physician was a competitor in the same highly specialized field. Fair review or restraint of trade?

2) A hospital CEO who reported a physician as being "disruptive" because he refused to allow the hospital to use shortened half-life, less expensive hospital supplies on his cardiovascular patients. Whose interest was being served- the patients' or the hospital's bottom line?

3) A group of peers who elected not to investigate a surgeon who was well known for her explosive tirades and threats. They claimed "behavior is all relative, and besides, she is a great surgeon." Should a behavioral expert have been consulted?

4) A surgeon who was conned into either giving up his block time or being reported as "disruptive" by more powerful colleagues.

Sham peer review may A) rely on hearsay, manipulated data, fabrication, or delay in order to drive a covertly desired outcome (often the peer review committee is perceived as having "an ax to grind") or B) cast the legitimately disruptive doctor in the victim's role, allowing him to evade responsibility for his errant behavior and the censure, sanctions, or rehabilitation it deserves. In either case it is difficult to prove intentional malicious design.

So how does one go about fixing sham peer review? Dr. Pfifferling's prescription: The first thing one should do is to define professional behavior. This code of professional conduct should be in every set of hospital bylaws and every set of corporate minutes, and annual reappointment should include acknowledgment of the standards set therein. Joint Commission accreditation requires such a code of conduct (under JCAAH standard I.D. 3.10). A consistently applied definition of professional conduct and careful adherence to the protocols and procedures are reviewers' best defense against allegations of inappropriate conclusions and discipline.

Secondly, the allegation must be complete and transparent. The individual's personnel file must be made available to him. The file should also include positive acts of professionalism, as personnel files considered biased and to lack credibility. The file must always be handled in a way to assure confidentiality and privacy, a premise that, according to Dr. Pfifferling, is frequently breached. Occurrence of alleged misconduct has to be well documented, and all witnesses only identified to the committee members (not to the defendant). Remedies already used to try and correct the situation must also be included.

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Annual Meeting Highlights

Thanks to Our Exhibitors

The Connecticut Orthopedic Society gratefully acknowledges the support of the companies who took part in the Annual Meeting on May 29, 2009.

EVENT EXHIBITOR
Stryker Orthopedics

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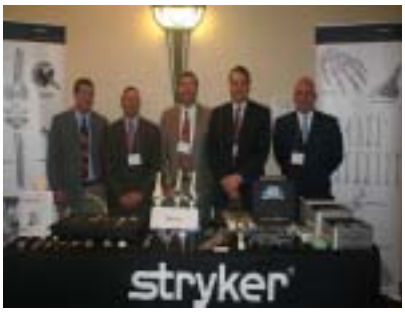

Event Exhibitor, Stryker and company representatives show their products at the Society's Annual Meeting on May 29, 2009.

In Practice *(cont. from page 4)*

Thirdly, the peer review committee should be composed of colleagues who are disinterested and objective. Peers who have prejudices for or against the individual and any competitors , rivals, or parties who have a fiduciary interest in the outcome need to declare these conflicts of interest and to possibly recuse themselves from the judiciary process. The review committee should include people who are qualified (e.g. from the specific medical specialty, if that is what the case calls for, or perhaps a behavioral scientist if disruptive behavior is the issue). In cases where there has been longstanding enmity with a physician, or where the pool of peers from which to form a committee is too small, in an effort to neutralize the possibility of collusion and to promote impartiality and fairness, outside reviewers may have to be recruited.

Enlisting retired physicians, physicians from pertinent medical societies, or even retired administrative law judges have all worked for some communities. Paying for a professional mediator is also possible, but tends to be expensive. When an organization encourages outside data collection to validate or discredit the complaints, collusion is less likely. Membership to the peer review committee should be rotated, with the medical staff voting on the committee members. Where members are elected by the medical staff, prejudice is less likely to occur.

Perhaps we should change the paradigm altogether and uphold a more administrative model, like worker's comp? Regardless of the merits of the case, the committee concept is often perceived as the large group ganging up on the small doctor. In the worker's comp model there would be representatives of the hospital on one side and of the defendant physician on the other, each pleading his case before an impartial "Commissioner". Experts would be consulted. The Commission's conclusions would then have to be endorsed by the hospital's Executive Committee.

Fourthly, there needs to be an accepted set of procedures for rules of evidence, there needs to be a requirement of accountability for all witnesses, and there needs to be a clear, descriptive definition of egregious behavior.

The four essential features of a quality peer review system are objectivity, fairness, prompt responsiveness, and cybernetics (has a feedback loop for upgrading). Since nothing is so demoralizing as justice gone awry, these measures are important parts of the foundation of any sound organization. Is your peer review trustworthy?

President's Corner

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appointment by only one office. As talk about Sustinet and coverage become more widespread and are considered by our legislature, we need to add to the discussion support of adequate reimbursement so that these patients have both coverage and access to care.

Finally the "R" word or rationing is also being raised in some circles. Obama recently questioned whether his own grandmother should have had a total hip in her last months when she was "terminal." Clearly we need to be part of the discussion if rationing is part of the new picture of healthcare in the future to insure we are there to advocate for our patients.

As we go forward this next year or two, I anticipate being available, being accessible, and trying to do my best to serve your needs as an organization and as a group of orthopedic surgeons. I certainly look forward to this challenge and this responsibility and thank you for the opportunity to serve.

2009 Legislative News

The 2009 Connecticut Legislative Session has ended however, legislators and the Governor continue to work on the state's budget, a yeoman's task in light of the current economic situation. During the regular session, many health care concerns were raised and debated including universal coverage, transparency and standards and fairness in contracting to name a few.

As of press time, **Senate Bill 47, An Act Concerning Health Care Provider Contracts**, was unanimously passed in the Senate and the House approved the bill with a wide majority and is awaiting the signature of the Governor. As with any legislation, this Bill was amended more than 6 times before the final language was submitted and approved. The final language can be found at:
www.cga.ct.gov/2009/AMD/2009SB-00047-R00SA-AMD.htm

The CT Orthopedic Society's leadership met with legislators, physician representatives from other specialty societies and the State Medical Society to discuss the bill's language and its impact on physician contracting and negotiations. In the final days of the Session,

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2009 Legislative News

(cont. from page 2)

the Society's leadership agreed not to endorse the final language on the legislative table. The decision was based on variables that may create future contract negotiation issues.

The bill will limit changes to once a year by insurers to make changes to the provider fee schedules, with six exceptions they can use when needed. SB 47 prohibits insurers from making recoupment more than 18 months from the date of receipt of the clean claim with five exceptions. Physicians will be able to access fees for **all** CPT and HCPCS codes applicable to the provider specialty and insurers will provide access via internet or other electronic/digital format to their policies and procedures.

The Society encourages all it's members to review the final language, which will go into effect January 1, 2010, and notify the Society if you and your practice have concerns or questions about the insurer's adaptation practices when negotiating under this new law.

Other bills that passed and are waiting for Governor approval include, AN ACT ESTABLISHING THE CONNECTICUT HEALTHCARE PARTNERSHIP, which opens up the state's health insurance to nonprofit agencies, small businesses and municipalities and SUSTINET HEALTH which creates a new public authority to develop a self-insured health care plan to cover the state's uninsured.

A final legislative summary will be available on the Society's website, www.ctortho.org. For questions and/or more information, please contact Susan Schaffman, Executive Director at 860-690-1146 or via email at sasshops@aol.com.

Annual Meeting Photo Highlights

This year's Meeting featured guest speakers, Seth Greenwald, MD (upper left), Keith Lawhorn, MD (upper right) Javad Parvizi, MD (middle right) David Helfet, MD (lower right) and Judith Baumhauer, MD (lower left).

During the luncheon, the Society was pleased to host Congressman Chris Murphy(top) and Secretary of State Susan Bysciewicz(bottom), who discussed key state and federal initiatives pertaining to health care reform.