Why Workers’ Comp Matters

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The current workers’ compensation system is a medical driven legal compromise, commonly described as the “grand bargain” between employers and labor.

The impact of the workers’ compensation system was clearly stated as long ago as 1982, by Florida District Court of Appeals Judge E.R. Mills, in the case of Singletary v. Mayhew Construction (418 So.2d 1138). According to Judge Mills, “Workers’ Compensation is a very important field of law, if not the most important. It touches more lives than any other field of the law. It involves the payments of huge sums of money. The welfare of human beings, the success of business, and the pocketbooks of consumers are affected daily by it.”

Interacting with the workers’ compensation system

Approximately 30 percent of patients seen at an average orthopaedic practice are workers’ compensation patients. Fractures, back pain, and musculoskeletal pain of undetermined origin are some of the most common kinds of orthopaedic issues treated in these patients.

Although orthopaedists have the most training in treating musculoskeletal conditions, they often lack training in “occupational” considerations. In workers’ compensation cases, the physician is often asked questions regarding causation, diagnosis, treatment, outcome, return-to-work guidelines, and impairment. Although these concepts are familiar to most orthopaedists, interacting with the workers’ compensation system can often increase the demands on the physician through administrative, insurance, legal, and government-based burdens.

Although improvements in the workers’ compensation system could be made, the current state-based system remains the most suitable means of addressing workplace injuries. As physicians, we will probably have little influence on future legislative changes, but we can have an immediate and effective impact on the outcomes and the quality of life for our patients.

Improving outcomes

Similar skills are required to treat and enable an individual to return to activities—whether the individual is an athlete returning to sports or an injured worker returning to work. The expertise of how to determine and report causation, diagnosis, treatment, outcome, return to work, and impairment is available from the Academy. This know-how reduces the “burden” and improves the outcomes.

For this reason, the AAOS annually sponsors a continuing education course on workers’ compensation subjects. This course is designed to provide fresh perspectives and develop skills for treatment options, patient care management, and strategies for handling both nonmedical and medical issues associated with treating workers’ compensation patients.

Learn More

This year, the AAOS course, “Workers’ Compensation and Musculoskeletal Injuries: Improving Outcomes with Back-to-Work, Legal, and Administrative Strategies,” will be held Nov. 4 to 6 in Chicago. It will be preceded by a linked course, “AAOS Expert Witness: Solving the Legal Quagmire of Medical Liability—Methods and Insights.” on Nov. 3. For more information, visit http://www.aaos.org/coursecalendar/.

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dic surgeon shortage. Some have wondered, for instance, whether physicians of the “millennial” generation will be willing to work the longer hours of their mentors. So far, it seems to be too soon to tell.

The AAOS census reports that the percentage of AAOS members performing part-time work has been stable around 11 percent.

In the future, technical improvements and procedural efficiencies may further reduce surgical and hospitalization times for many orthopaedic procedures. Over the last 6 years, the number of procedures performed by the average full-time orthopaedic surgeon has been unchanged at 32 procedures per month. That said, the number of total joint arthroplasty procedures or single-level lumbar fusions the average subspecialist can perform per day seems to have increased since my residency ended in 1998.

Orthopaedic surgery could certainly evolve in other directions that could markedly impact the looming doctor shortage—for example, improved medical management of osteoarthritis, perhaps through stem cell therapies, would have massive effects on surgical rates.

And what of concerns regarding our ability to safely care for patients? Recently, pan-antimicrobial resistant E. coli have been identified in the United States. Worldwide, these bacteria are on the rise. In many ways, the risk-benefit analysis surrounding implant driven, elective orthopaedic surgery requires strong aseptic measures. If our prophylaxis loses effectiveness, what will happen to the rates of surgery?

Access barriers and other hurdles

So far, the plans to prevent a major shortage of orthopaedic surgeons centers on increasing the available training positions. With today’s logic, increasing these positions will increase the number of orthopaedic surgeons because demand for orthopaedic training remains strong. In fact, the number of applicants to orthopaedic surgery residency programs from American medical schools has been gradually increasing, with 287 applications being received in 2015. As one indication of the increasing competitiveness of these positions, the number of applications filed per candidate has increased from 16.6 in 2011 to 21.6 in 2015.

Will orthopaedic surgery continue to appeal to medical students? Since I can’t imagine doing anything else, I would say “yes.” And yet, looking at other specialties may be instructive. Today, shortages in neurology are pervasive. Why? If something is not being paid for, it’s harder to find people willing to do it. An American Academy of Neurology statement concluded that “without fair and stable reimbursement, medical students and residents who have substantial education debt often are forced to seek more financially rewarding specialties than neurology.”

Today, orthopaedic surgery is well compensated, but that compensation remains under considerable threat. Aside from direct cuts to reimbursement, a number of other hurdles could strangle the flow of patients. For example, in some areas, patients are required to see physiatrists before scheduling spine surgery. In my practice, this has increased my efficiency by eliminating most inappropriately patients from my clinic. I work closely with my physical medicine and rehabilitation colleagues, who promptly refer patients for whom surgery is truly indicated. In other settings, interspecialty competition or other access challenges could have marked impacts on a practice’s financial viability.

Looking to the future

I suspect our workforce assessments will need constant revision as the facts on the ground change. Given the long training interval, these projects are critically important. Close partnership with our legislators through our advocacy efforts is also vital. The funding for graduate medical education has to be need-based and more flexible. Most importantly, as orthopaedic surgeons, we owe it to our patients and our profession to fight to preserve access to care.

A longer version of this article and references for the studies cited may be found in the online version available at www.aaos.org.

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