ETHICS AND ECONOMICS IN SPINE SURGERY

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ATTRIBUTES OF A SPINE SURGEON

- SKILL
- JUDGEMENT
- ETHICS
SKILL

- TRAINING
- EXPERIENCE
- LOSE THE EGO
  - Do it well, do it frequently, or don’t at all
JUDGEMENT

• THE ABILITY TO ASSIMILATE SYMPTOMS/SIGNS/X-RAYS AND MAKE SOUND DECISIONS
• HARD TO TEACH
• NOT SAME AS “SMART”
• MORE THAN KNOWLEDGE
JUDGEMENT

• SURGERY?

• WHAT SURGERY?

• FAILURE OF CONSERVATIVE IS NOT A STAND ALONE INDICATION FOR SURGERY

• FAILURE OF CONSERVATIVE NOT ALWAYS NECESSARY FOR SURGERY
ETHICS

• THE INTENT TO DO THE RIGHT THING
• CAUSALITY
• PATIENTS FIRST/COIs
• ATTENTIVE / METICULOUS
• COST AWARE
ETHICS
Causality

• CAUSALITY OFTEN A CENTRAL QUESTION IN WC/LIABILITY CASE
• PRESENCE OF “ABNORMALITY” DOES NOT = “INJURY”
• MRI SHOWING ONLY “DEGENERATIVE” CHANGES DOES NOT EXCLUDE INJURY
• COI WHEN NO OTHER INSURANCE
• ASSUME ALL UNDER OATH...TELL THE TRUTH...ALWAYS!
ETHICS
Patients First

• CONFLICT OF INTEREST
  • Recognize it
  • Imaging
  • Med equip/spinal implants
  • Ownership in other service lines
  • THE BIG ONE FOR SURGEONS = DO WE OPERATE?
THE BIG ONE

• EVERY PATIENT IS A COI FOR SURGEON
  • Office visits = lose money
    • …and WC > 120% BC
  • Surgery = make a living
    • Ratio of about 1/4 to 1/5
    • >1000 cases/yr not compatible with ethical
ETHICS
Attentive/Meticulous

• NO SUBSTITUTION FOR ATTENTION TO DETAIL
  • Examine the patient
  • Look at your (spine) films

• TAKE YOUR TIME
  • 10-12 cases/day (done well) not possible
ETHICS
Cost Aware

• WHY?
  • It’s not our money
  • Resources are not unlimited
  • All treatments and many diagnostics have risks
• Costs have risen consistently in real dollars and as percent of GDP in US
  
  1980……..9%
  1990……..13%
  2000……..14%
  2011……..17.9% (>\$8600 per capita) – **STABLE X 3 YRS**

• Family plan ins. > $16,000/yr in 2013 (rate of growth has slowed-13.9%-2003, 6.1%-2007, 4%-2013)
<table>
<thead>
<tr>
<th>Category</th>
<th>Cost</th>
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<tbody>
<tr>
<td>Healthcare</td>
<td>16.2%</td>
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<tr>
<td>Housing</td>
<td>10.6%</td>
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<tr>
<td>Food</td>
<td>9.6%</td>
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<tr>
<td>Defense</td>
<td>4.8%</td>
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<tr>
<td>Auto</td>
<td>3.1%</td>
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<tr>
<td>Energy</td>
<td>2.6%</td>
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CMMS and Bureau of Economic Analysis (2007)
RISING COSTS

• Other developed countries
  10-13% Germany, France, Austria, Switzerland
  8-10% Canada, UK, Australia, Norway, Sweden
  5-8% Japan, Finland

MOST ARE GROWING

• General rule: The higher the per capita GDP, the higher the percent spend on healthcare
RISING COSTS

• Hospital care - 31.5% in 2011 (was 30% in 2000)
• Physician component – 20% in 2011 (was 21% in 2000)
• Prescription drugs – 9.7% in 2011
  – Was fastest growing, then slowing, then Mcare D
  – 8.8% in 2000
  – Tiered benefit (generics), OTC’s
RISING COSTS

• WHO PAYS
  – 47% PUBLIC
  – 53% PRIVATE
  – PUBLIC IS GROWING FASTER THAN PRIVATE
    (8.0% CAGR 2003-2007 vs. 6.5%-private ins.)
    • Aging population
    • Medicare D
    • Medicaid-wait until baby boomers are in nursing homes!
• Big difference in public vs. private hosp rates
  – Private = 129% of cost (2005)
  – Medicare = 92% of cost (2005)
  – Medicaid = 87% of cost (2005)
• Big difference in public vs. private spending
  – Private ins = 31% hosp and 29% physician/clinical services
  – Public = 39% hosp and 17% physician/clinical services
  – Out of Pocket = 20% prescriptions, 17% physicians/clinical services, 8% hosp
COST DRIVERS

- Expensive technology
  - Often unproven or USED IMPROPERLY
  - Up to 40% of the reason
- New drugs
- Supplier induced demand
  - Physician surplus – 1.53/1000 in 1970 vs. 2.62/1000 in 2000
- Defensive medicine
- Aging population - Medicare
- Industry marketing
  - Pharmaceuticals (Celebrex/Viagra/Cialis/Vioxx/statins)
  - Medicare nebs / motorized wheelchair (we’ll do the paperwork)
- Obesity / diabetes
COST DRIVERS

• HEALTH INSURANCE – public or private
  – PATIENTS ARE SHIELDED FROM REAL COSTS
  – MARKET FORCES ARE THWARTED
- 57 yo DM and HTN fell on school bus steps
- open MRI then visit neurosurgeon who rec: C3/4, C4/5, C5/6, C6/7 ACDF
- SSO 2 ½ wks post injury (3/06)
- c/o severe neck pain > L LBP, L UE N/T/W
- NL motor/sensory exam, 2+ DTR’s, + Hoffmann’s, neck ext = severe neck pain and incr. numb
- MRI (open) = 4 level degenerative looking post disk protrusions with cord compression at 4/5, 5/6
-Rec: x-rays with flex/ext, myelo/CT (\(?\) Include C3/4, C6/7)
-Went back to other surgeon for 4-level ACDF without further w/u 4/06
-2\textsuperscript{nd} SSO re: L-spine 5/07
  -c/o severe neck pain, L UE N/T, severe LBP, L LE N/T, no weakness
  -NL M/S exam, no Hoffmann’s
  -myelo/CT cervical and lumbar – DDD L1/2, L2/3 ant. lipping (evidence of “disk injury” per treating doc), no cord or root at any level
WHAT CAN WE DO?

GONE WILD (cont.)

- My rec: no disko (treating doc opined that L3/4 (NL) was source of pain), no surgery (success approaches “0”), PMMR

- 03/08 L-discography – no concordant pain L2/3, 3/4, 4/5, 5/1

- 03/08 treating doc – “abnormal neurologic exam” = decr. R ankle DTR, absent L ankle DTR, severe lumbar spasms, + SLR = LBP at 20 degrees

- rec: L3/4/5 lami, discectomy, 3/4 and 4/5 interbody fusion with pedicle screws to treat “injuries from the accident in 2006”, re-MRI L-spine
because it calls for speculation.

A. Again, when we present the situation to the patient in terms of risks and benefits of any procedure, in the situation that this lady is present right now, having been through this problem for multiple years, been through a variety of nonoperative treatments, the options basically for her are to continue with pain medication and treat it expectantly or to go ahead and fix it. Overall we’ve had very good success with the treatment of these patients. They have had excellent relief of their back pain. We do functional scales and we do disability scales on all patients as well as pain scales. And over 90 percent of the patients do very well with this approach. There is a small percentage of patients that do worse in terms of not getting relief of their pain or the pain stays the same. Those are patients usually with a nonunion or that do not fuse and require a posterior stabilization procedure.

Q. That percentage is why you put something on the form about the fact that they could be worse.

Correct? I mean, that just makes sense.

A. Well, the real reason is why we try to avoid an operation in the first place, why we do all these nonoperative things first.
SPINE SURGEON GONE WILD

• 65 yo woman s/p total lami of L4 and L5 in 1997 by GCW
• Onset L LE pain one year prior to recent presentation
• Had procedure by neurosurgeon, but never saw that doctor post-op, so presents to our office for eval.
• Has persistant L L4 distr. pain
ETHICS

SPINE SURGEON GONE WILD
ETHICS

GONE WILD (cont.)
GONE WILD (cont.)
- 24 yo F MVA 12/05 – neck, R sh, LBP
- 2/08 c/o neck, R arm to 3,4,5 & LBP
- 3/08 MRI Sh, L/S spine, C spine
  - Shoulder read as NL
ETHICS

GONE WILD (cont.)
ETHICS

GONE WILD (cont.)
GONE WILD (cont.)

- 9/08 – first neurosurgery consultation
- same complaints
- R biceps weak
- hyperreflexia and Hoffmann’s
- MRI = “disk injury”
- MVA caused cervical ruptured disks
- Rx = brief c- traction then myelogram
GONE WILD (cont.)
-10/08 – myelo/CT c-spine
GONE WILD (cont.)

- 11/08 – follow-up with neurosurgeon
- ”disk injury” at C5/6 > C4/5
- rec. C4/5, C5/6 ACDF
- C3/4 may ultimately need to be treated with surgery
GONE WILD (cont.)

- SSO 12/08
- same complaints
- completely NL neuro exam
- no Spurling’s, full C ROM
- MVA causally related to well documented persistent sx
- rec: PMMR and ESI
ETHICS

GONE WILD (cont.)

-45 yo frontal MVA with facial/dental injuries and neck pain 10/05
-MRI (open) 3/06
GONE WILD (cont.)

- Neurosurgery consult 01/07
- Documents hyperreflexia and rec C5/6 ACDF
GONE WILD (cont.)

-SSO 4/07

-c/o midline and B para/traps spread to low back, no UE pain, + N/T hands

-wife reports that pt. “unable to move” for 2wks due to pain post ESI, 1 ½ ppd

-NL M/S exam, 2+ DTR’s, no clonus, Hoffmann’s, no increase in pain or N/T with extension

-Rec: myelo/CT +/- discogram
ETHICS

GONE WILD (cont.)
GONE WILD (cont.)

-Rec:
  - no surgery for stenosis/cord
  - discogram for 1-level DDD and persistent axial neck pain
  - angry protest from treating doc

-Discogram = 10/10 concordant at 4/5, 5/6, 6/7

-P3 scores = ave. anxiety for pain pt, high depression and somatization scores
GONE WILD (cont.)
- 42 yo man, previous L4/5 ALIF at age 23 post-MVA
- MVA 12/05
ETHICS

GONE WILD (cont.)

-MRI 3/06
GONE WILD (cont.)
- 8/06 – 90% LBP, 10% B leg pain
- 2/07 – neurosurgery consult
  - ”disk injury” at L4/5
  - degenerative changes read by radiologist are actually “changes of injury”
- 3/07 – Discogram – no concordant pain at 3/4 or 5/1 and CT = solid fusion
GONE WILD (cont.)

- 5/07 – treating doc now says that L5/S1 disk was damaged in MVA
  - rec. myelo/CT and surgery
- 5/07 – Myelo/CT = no root compression and solid fusion at 4/5
- 6/07 – L5/S1 PLIF and L4-S1 screws
  - H&P references concordant pain at 5/1 (untrue)
Specifically with regards to Dr. Davis’s opinions in the last paragraph that the surgery performed was not indicated – I would note that Dr. Davis has NEVER agreed with any recommendation that I have made for surgery. He has constantly slandered me in endless medical reports of any patients that I have seen that are sent to him for a second opinion.

I would say that Dr. Davis is biased against me – and cannot honestly offer a fair opinion about any medical treatments that I have provided.

In this way, I feel like his “expert opinion report” is simply bombastic and nonobjective – in this way serves nobody’s interest, neither yours nor the defenses.
ETHICS

• 2009 – case went to trial
• Jury verdict-surgery was unnecessary and cut award by > 50% b/c most of pain and suffering was from surgery, not original injury
Neurosurgery Clinic on September 1, 2006. He is complaining of right foot numbness. He is having no back pain. He said the numbness began in 2005. He becomes sweaty and fatigued very easily. The intensity is 0 on a 10-scale, and he says it is numb constantly. It is in the right foot, and it occasionally burns from the knee to the calf with driving. It is alleviated by wearing shoes. It is aggravated by driving and going barefooted.

On physical examination, ambulates with normal station and gait. He does have an occasional limp. He is alert, oriented, and pleasant. He has good overall muscle strength, 5/5 in the lower muscle groups. He has good strength with dorsiflexion. His reflexes are symmetrical and within normal limits. He continues his sensation to pinprick and light touch is preserved.

A CT scan of the lumbar spine reveals L5-S1 disc space narrowing and posterolateral osteophyte formation. There is mild bilateral foraminal narrowing at the L5-S1. There is also a mildly bulging annulus with flattening of the anterior thecal sac at L5-S1.

At this time we will order a lumbar discogram and CT scan. He will follow up in the clinic with us after the studies.

We appreciate the opportunity to participate in the care of. We will keep you informed of his progress.

Sincerely,
WHAT CAN WE DO?

- **GOOD CARE = GOOD ECONOMICS**
  - Doctor with sound skill, judgment, and ethics saves you a fortune

- **UTILIZATION, UTILIZATION, UTILIZATION-NOT REIMBURSEMENT**
  - Fees are a blip compared to total cost
  - ACDF = about $30K total (doc and hosp)
  - You can double what you are paying doc and still save about 40%
UTILIZATION!

- 100 PATIENTS
- SURGEON A OPERATES ON ½
  - Total cost = $1.5 million
- SURGEON B OPERATES ON ¼
  - Total cost = $750K
- DOUBLE WHAT YOU PAY SURGEON B TO $20K
  - Total cost = $1.0 million (still save 33%)
WHAT CAN BE DONE?

• AVOID UNETHICAL OUTLIERS
  • SSO’s, IME’s, record reviews
  • Preferred doctor panels

• CASE MANAGERS

• OPEN MRI

• NERVE CONDUCTIONS
We've got your back
... and your neck.

SURGERY
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