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A Frank Chat with my Patients

Appointments

I try to keep my appointment scheduling as realistic as possible – the intent is to see my patients on time. It really bothers me when I know I have patients waiting and am going to be late seeing them.

When I was in medical school, my wife went to an obstetrician with our second child who scheduled all his morning patients at 9 AM and all his afternoon patients at 1 PM. He had them sign in when they arrived and saw them in the order they signed in. The result was that everyone except the first patient had to wait for the doctor, and some waited for hours. When the stacked up patients began comparing notes in the waiting room, they realized they all had the same appointment time. The message this gives is that the doctor's time is really important and everybody else's is unimportant. I consider this to be extremely rude (and wrong). Everybody's time is important.

There are times when I run late -- and, as much as I hate it, I cannot prevent it. Orthopaedic surgery involves treating trauma and fractures, and they are seldom planned events. If I have a long time patient who falls and breaks an arm, I have to fit that patient into to my schedule. Asking them to go to the emergency room (which often takes hours and does not solve the problem), is worse than seeing them quickly and efficiently in the office. Most people would understand that the acute trauma patient shouldn't have to wait until everybody else is seen in order. If you are the patient with the trauma, you would want to be seen sooner than somebody with a longstanding and non-urgent problem. We hope that if you are the one having to wait, you will understand.

Other times, what is scheduled as a simple and quick problem turns out to be very complex and difficult and takes an extraordinary amount of time. Patients often do not know what their problem is when they schedule the appointment, so we try to guess how much time it will take. We often guess wrong. In addition, I believe that no patient should leave until they understand their problem and I answer all their questions. For some patients this is relatively fast. For others, I have to go into great detail and explain things in other ways so they understand. This can take an unusual amount of time.

While I prefer to wait between patients rather than have patients wait for me, it does not always work out, so sometimes patients do have to wait. I hope you understand if it happens to you.

High Volume Surgeons

If you want to go to the orthopaedic surgeon who does the most hip replacements or the most knee replacements or the most of any other surgery, you should go somewhere else. I have been there, done that – and I have no interest in going back.

During the midst of the HMO assault, I realized that I do not enjoy trying to cram in as many patients as I can possibly see. This is usually done to maximize income (which, with the HMO's, was necessary just to meet expenses). I decided that I would rather drive a backhoe than see patients on a schedule that did not allow me to get to know and enjoy them. I quit all the HMO's long before many thought you could survive without HMO patients, and I will never go back to that type of schedule or that kind of volume. I really enjoy taking time with each patient and do not want to be so rushed that I lose that.

Earl Scheib probably does the most auto painting, and MacDonalds probably sells the most meals to the most people, and I have no intention of being the Earl Scheib or the MacDonalds of orthopaedics. I never again want to be getting close to finishing my first surgery while the second room is calling, asking when I will arrive because the patient is already asleep. I do not enjoy that.

I want to do enough of what I do so that I am completely competent, but I also want to take my time and savor what I do. My ego will do just fine if I am not the one who does the most of anything. If you want to go to the orthopaedic surgeon who does the most of anything, it will be somebody else.

Insurance Companies and HMO's

Insurance companies today are in the business of collecting premiums. They are NOT in the business of paying claims. In the 'good old days', the biggest health insurance companies were non-profit and merely collected enough in premiums so they could cover their claims. This is sadly no longer the case.

In what seems to be the least-reported, large scale change in society, most of the non-profit companies have been taken for-profit by the very trustees who were supposed to maintain the non-profit status and viability of the companies. It seems no surprise that those same trustees each reaped millions of dollars in the process.

The result has been a rapid change in the way health insurance operates. Whereas in the past a doctor submitted his bill and was paid for his services (with the insurance company covering the agreed upon 80% and the patient paying the remaining 20%), now the system is so complex that it never seems to work that way. Most of the insurance companies have created their own "usual and customary" fee schedules that have no relationship to the real world. They then pay a percentage of their schedule and leave the patient or the doctor on the hook for the rest.

In addition, the insurance companies have created their own system of accounting that is (by design) so complicated that nobody can understand it. It is hard to question something when

you cannot understand it. Each company does accounting a different way, so even the office billing specialists (and if pressed the insurance companies' own specialists) cannot figure it out.

My participation in PPO and HMO plans

Unfortunately it has become necessary to drop being a participating provider in most of the PPO Health Plans. Due to this escalating practice whereby insurance companies create these artificially low, self-serving "fee schedules" -- and a scheme where they fraudulently take money from one patient's accounts to cover "over payments" that they unilaterally decide that they made (sometimes years in the past), I have been forced to resign as a Preferred Provider in many plans.

The net effect this has on my patients is the services that we provide are paid by the insurance companies as a "out of network" provider. This can have an effect on the percentage of the bill that the insurance will pay and, additionally, in rare cases can affect the amount of the deductible. As an additional insult, it is often necessary to pay the bill at the time of service and then submit the charges to the insurance company to be reimbursed for the services provided.

In an attempt to make this less of a burden on my patients, I can usually discount the charges if the bill is paid in full by cash or check at the time service -- because I do not have to pay the costs of collections. In many cases, this will result in the out of pocket costs that you have to pay to be the same or very close to the same as if I were an "in network" provider.

For expensive services such as surgeries, my office will certainly bill your insurance company for you—but you need to recognize that the charges for the services are your responsibility (in the unlikely event that your insurance company decides to cheat you and refuse to pay for these reasonable and medically necessary services). We will always get pre-authorization, so this has not been a problem.

I understand that this does place an additional burden on you and I am very sorry that I had to do this. This was necessitated by increasingly unethical insurance company practices. I am unable to continue being a preferred provider with those practices being so commonplace. By getting the insurance companies out of the middle between me and my patients, I rob them of the ability to pull these stunts.

I hope you understand and we will help in every way possible to make this process easier.

Neck and Back Surgery

I am a strong believer that most neck and back problems can be treated nonsurgically. I also believe that there is too much neck and back surgery done in this country. One of the big driving forces behind neck and back surgery is the tremendous amount of money that it generates. The reimbursement rate for hospitals and surgeons is so high relative to other procedures, that there is a tremendous amount of pressure to do a lot of it. This is quite unfortunate.

In other countries where the reimbursement is far lower, the rate of neck and back surgery is far lower. The interesting fact is that their success rate is equal to or better than our success rate for the same problems.

Studies that were done to attempt to show the great results of spine surgery have actually shown that at ten years, there is no statistical difference between patients who had surgery and those that did not for simple disk problems. At one or two years the patients often did better with surgery, but over the long haul, they did not. The spinal cord and spinal nerves have an incredible ability to adapt to problems if they are given enough time.

There are some patients who need spine surgery, but in my experience, the vast majority do not. Before a patient of mine is recommended for any spine surgery, they have to meet my three criteria: 1) They have to have tried – and failed – all forms of nonsurgical treatment, 2) They have to have symptoms that they absolutely CAN NOT live with and, 3) They have to have something that can be fixed surgically. Few patients end up meeting all three criteria.

I do a staged treatment that only advances to the next stage if the prior stage does not work. The first is anti-inflammatories, muscle relaxants, pain pills (if necessary), physical therapy, and time (very important). Most people get better with this treatment alone. If this fails to work, the next stage is slightly more invasive and includes epidural steroid injections, trigger point injections, short course series of oral cortisone and possible alternative treatment options such as acupuncture, chiropractic and meditation. Only if this fails do I consider the next stage -- which is surgical. With an extremely few exceptions, there is no need to rush to surgery.

Another interesting fact is that in most instances there is no need to rush to get an MRI. The high number MRI's that are done in this country is also, to a large extent, driven by big reimbursement. For the most part, I do not need to get an MRI unless I am going to change my treatment plan based on the results. If the symptoms do not warrant invasive treatment, an MRI does not help at all (except to make the patient feel better about what they are doing). For me to initiate treatment, I don't need it, since I am not going to recommend stage two treatment until you have tried and failed stage one treatment anyhow. The initial treatment for a simple back strain is the same as for a low grade disk bulge, so the results of the MRI are academic.

One of the big drawbacks with much of back surgery is that it often is not really fixing the underlying problem. If the problem is one of a disk going bad and losing its shock absorbing capacity -- then bulging out and pressing on a nerve, taking the disk out and fusing that level really does not fix the basic problem. It will take the pressure off the nerve, but it does not restore the shock absorbing capacity of the disk. It also then causes more motion to be shifted to the next level, which can cause it to fail prematurely. Once you then 'fix' the next level, the third level is at still greater risk. It goes on and on. My analogy is treating a problem of gophers in your back yard. We just don't have a good rifle. Our current treatment surgically is to napalm the entire yard. You usually will get the gopher -- but the collateral damage can be severe.

Hopefully the newer method of putting in artificial disks will pass the test of time, but with neck and back problems, there is a 'new' cure every five years – and most fail miserably. They are often resurrected variations on old treatments that have failed miserably in the past and are usually promoted heavily in the media. In the first year there is a lot of interest (and hype) and everybody tries it. In the second year we start to discover some of the problems that take a while to surface. By the third year the problems become much more obvious and by the fourth year most people stop doing it. By the fifth year the 'new' cure hits the papers. Unfortunately, artificial disks have all failed in the past.

In my career I have seen chymopapain injections (Adolph's meat tenderizer – it eats the disk but also like to eat spinal cord and nerves), laser diskectomy (fry it with a laser -- but often fries the nerves nearby), arthroscopic diskectomy (try to look at it when you fry it -- but you can't really see well), automated percutaneous diskectomy (suck and grind it up while looking with an X-Ray –still can't see it well), thermal ablation (heat shrink it -- hope not to heat shrink nerves and spinal cord), and IDET (special way to heat shrink it) to name a few. All were extensively tried and promoted and for the most part failed. I am still taking care of many of the unfortunate victims of these failed treatments.

I will only recommend for my patients (or for my family members for that matter) treatments that have at least passed the five year test. The old fashioned diskectomy and fusion has at least predictably done that – with problems.

Two of my favorite old sayings in orthopaedics are:

- 1) There is no problem with the neck or back – no matter how bad it is – that we can't make worse with surgery.
- 2) The best way to prevent a second neck or back surgery is never to have a first neck or back surgery.