

An alternative perspective on how to treat Achilles' tendon injuries

To the Editor:

The coverage of Achilles tendon ruptures in a recent CME article (published in August 2009) was surprising to me. As a PA in orthopedics my views could be biased, but I think articles such as this one should have more review and control. I hope subscribers of our association's magazine would never treat an Achilles tendon injury without referring the patient to a musculoskeletal specialist. This tendon injury should not to be taken lightly.

I felt that the author's treatment options were severely outdated and reckless compared to today's approach to an Achilles injury. Specialty bracing and early immobilization for improved vascularization, as well as avoidance of plantar flexion contracture, are light years ahead of strict casting protocols, not to mention fibrin (which, at best, is a historical side note).

I understand that pleasing and/or agreeing with each provider's own perspective and treatment protocols is impossible; but if taken literally, the treatments discussed in this article could limit a patient's potential for full or near-full recovery. Articles that discuss treatments should have the date of the resource material reviewed to avoid the above-mentioned issues.

Scott Wilson, PA-C

Editor's note: The article on Achilles tendon rupture was peer reviewed by PAs working in orthopedics and revised by the author based on the reviews. This occurred before we accepted and published the article and represents our usual practice. It is difficult to say how we could have provided "more review and control." Readers should note also that the references in the article are all quite recent; all but one were published in the past 5 years.

It's just a new name for an old concept

To the Editor:

I read the Clinical Watch article "The PCMH: A model for primary care," published in September 2009. Every time I attend a CME event that touts the benefits of the PCMH (patient-centered medical home), I wonder:

How is this different from the "gatekeeper" mentality of the HMO era? In philosophy or what?

I work in an UC/ED in rural, northern Wisconsin. I'd love for patients to be able to go to their primary care provider. But, it takes at least a week to get an appointment.

I know I have been doing this job for too long because I no longer have even the slightest pretense that the patient will actually follow my advice. So, now I am poorly reimbursed because I won't go home with the patient, fix their meals, and pry their butts off the couch so they can get some exercise.

I'd like to say this sounds good, even great. Unfortunately, it sounds like new verbiage but no real solutions.

Penny Cornelius, PA-C

Health costs reform versus health care reform

To the Editor:

I read the Editorial by Michael Halasy on health care policy and projected reform, "The challenging economics of US health care reform," in the *JAAPA* November issue preview and found it to be thoughtful and insightful.

However, I was surprised and distressed that the focus was on costs and that the human issue, the basic right of the public to health care, was not addressed. Perhaps a sentence of "apologia" might have done the job, considering the focus on policy. A person who writes policy, not thinking of bioethics, might best reread an old basic text on ethics that is hopefully in his or her personal library.

Allow me to introduce myself. I'm a PA with privileges at a city hospital in Bridgeport, Connecticut. I graduated with the second wave of our profession, after the health care policy folks in DC got monies for institutions to train us in 1972. I graduated from Touro College in 1974, after completing a pre-PA program at Rutgers before they started their own PA program. I would day-hop from New Brunswick, New Jersey, to central Brooklyn [New York] for that. And for full disclosure, I'm now on Medicare (only part A because I have health care coverage as a retired Federal civilian, as well as my husband's coverage—he's still working full time as a distant tests and measurements psychologist—and I work part time).

I've been a PA for more than 35 years and you for 9 years, so there is no contest on how many patients I've seen and grieved over. Most of my patients had "health insurance": veterans in VA medical centers for 10 years; active duty military personnel at the Pentagon clinic for 9 years; plus 12+ years in workplace (occupational) medicine in DC, New York, and Connecticut; and several years teaching. I have seen patients who couldn't afford cheap, basic hypertension meds in DC and New York's inner city (Harlem Hospital), civilians in DC whose ear pinna was eaten away with basic cell carcinoma, and retired men on disability who were unable to afford extraction of an infected tooth and inexpensive antibiotics. I've been to Puerto Rico, where there are no PAs but we're working on that. I saw and heard about patients who have take a public car from the hills to a small city for a day-long "appointment." These people bring a bag lunch with them so they won't have to give up their place in "line" and have to consider using their food money to pay for their prescriptions.

During my years at Columbia's School of Public Health in New York City studying for a Master's in environmental and occupational medicine, we grappled with the ethics of allowing companies to continue to spew toxins into the environment versus shutting them down and thereby denying longevity to the working poor who would have *no* salary and *no* health care if/when the plant closed.

Universal health care is not an easy fix, but one we desperately need. I think covering the cost with a slight amount of taxing on those who have food, clothing, shelter, and health care versus closing one's eyes to the haves and have-nots of a basic life expectancy is a small price to pay. It's like the bible story on the widow's mite: she gave from her nondiscretionary income, after all

Next, we will have to tackle the employers who "import" low-wage workers and don't provide health care. We should also look at the government's immigration policies and their enforcement. But that's for another day's discussion.

Maryann Ramos, MPH, PA-C
Legislative Chair, Physician Assistants for Latino Health
Greenwich, Connecticut

Author's reply:

This editorial was borne out of a want to educate people on the costs associated with health care, and the need for reform from an economic perspective. I should preface that by stating that I was an economics major as an undergrad and tend to view the world through an economic lens. There certainly are ethical issues to discuss, but that is likely the topic of an entirely separate article. This article was not intended, nor meant to tackle ethical issues or concerns.

I would caution against thinking of a single payor or universal plan as a sort of panacea. Most countries with single payor systems are also sustaining rapidly escalating health costs. The difference lies in the ability of centralized planning agencies to ration or limit services in order to reduce or keep HCE growth lower. Although several of these countries, the UK and Canada included, are now grappling with cost issues as well.

Personally, I support the Zeke Emanuel/Victor Fuchs plan. Unfortunately, there is going to be a lot of resistance to this.

I do sympathize with patients who cannot get coverage, or get good care. I actually wrote an editorial for *PA Professional* (July/August issue) on rationing of care.

My underlying message is that if we ignore the flawed economics of the current structure, then adding more patients won't help. It's akin to building a third floor addition on top of a house with a crumbling and unstable foundation. You need to fix the foundation first. This is what won't happen. Congress is simply *not* capable of fixing this.

Additionally, the opponents of reform are succeeding in substantially changing the debate, and this is going to lead to a very weak legislative effort. By the time this gets out of the Senate, and into conference, it's going to be pretty watered down.

Lastly, I do support a form of single payor, but *not* universal health care, as I don't think the government should be involved outside of levying taxes. There are some real constitutional issues with a true universal health care system that I don't think can be ignored. This, in addition to most people's distrust of our government, will preclude this from happening.

Michael Halasy, MS, PA-C
Assistant Supervisor PA/NP Group
Department of Emergency Medicine, Mayo Clinic
Rochester, Minnesota