

Michael Roberts ([00:09](#)):

Welcome to the Health Connective Show. I'm Michael Roberts. Today's episode will be hosted by Scott Zeitzer and Lara Wynne. Scott is the company president of Health Connective, and Lara is the co-founder of Gate Science and the Chief Academic Officer at the Journal of Orthopaedic Experience and Innovation, a journal also known as JOEI. And she's also an independent consultant on commercial strategy for orthopedics and pain management. On this podcast, we typically show the medtech company side of marketing the products, or we'll take a look at the technical aspects in creating a product, but we thought it might be helpful to get some insights into the physician's processes for finding and adopting new technologies. Our guest today is Dr. Michael Langworthy. Dr. Langworthy is a leading orthopedic surgeon and Chairman of Orthopedic Surgery at South Coast Health. In his practice, Dr. Langworthy is frequently seeking out new innovations that will improve patient care. In this interview, we will learn more about how some of these new innovations have impacted his practice and how he introduces new technologies to his group.

Scott Zeitzer ([01:11](#)):

We've got with us Dr. Michael Langworthy, and we've got a lot of questions for you, uh, Lara and I do. So, Lara, why don't you start off with the first question and then we'll kind of play off, uh, accordingly and, uh, ramble on.

Lara Wynne ([01:25](#)):

Sounds great. So, I've worked with Dr. Langworthy for many, many years, maybe 20 years at many different companies, and I have always known him as a surgeon who is a real innovator. He gets really excited about new innovations, new technologies. He's always wanting to improve his practice, improve patient care. And I think one of the questions that I would ask is, what are some of the important technologies that you've discovered even more recently, say in the past five years, how have you discovered them, learned about them, and what does it take to start to integrate them into your practice?

Dr. Michael Langworthy ([02:08](#)):

So, being a surgeon, but also being a chairman, there are fiduciary responsibilities that I've got towards my program. And one of the things is, is you've got a storm coming with aging population. You have, uh, CMS insurance carriers that are really tightening up on what we are able to do both conservatively and surgically in the theater of orthopedics, and certainly in adult reconstruction. And then you have a declining reimbursement dollars. So the new technologies should undergo rigorous efficacy, safety, but then they also have to come in and show that they can help with the bottom line economically within patient care. And at the facility, to give you an example, there's a technology called, uh, IlluminOss. And, um, we adopted it probably about 18 months ago. It's a game changer for folks with metastatic cancer to various bones and also for fragility fractures.

Dr. Michael Langworthy ([03:12](#)):

So typically somebody came in with, say, a, a renal cell metastatic lesion to the acetabulum, and the acetabulum's destroyed. And previously I was stuck doing a, a cage, uh, total hip construct, which is probably upwards around, uh, \$30,000 just for the implants. And with this, this new technology where you feed in a dacron balloon under fluoroscopy, you then, uh, inject this balloon with an acrylic material, and then you use a, a, it's like a dental blue light to polymerize the structure and the patient's able to walk out of the hospital with their native hip, and they're able to have, you know, several more years of

pain-free life, which is that, that's a perfect scenario. That's one of the evolving technologies that's, that's come down the pipe recently. So the aging population, we're seeing more arthritis, more fragility fractures, more cancer and things like that. So we're gonna have to get very clever on how to adequately address these patients, both from an efficacy, safety, and economic standpoint. Yeah. And IlluminOss is one of those technologies which is sort of a game changer for, uh, previous fractures and pathology that required, you know, big joint replacements with a big attendant cost.

Scott Zeitzer ([04:34](#)):

It's interesting, uh, doc on that particular product, it's definitely innovative. It's right outta the box. It seems like it's an easier conversation to have with the hospital, say, because you're walking in and going, Hey guys, the implant's 30 grand, this product is less. Uh, was it an easy conversation or no, no, no, no. It was still a hard conversation.

Dr. Michael Langworthy ([05:00](#)):

Yeah, that's an interesting point because we have a value analysis committee. We're a 340B hospital. We serve an underserved area. So literally every anchor we do, every joint, we do every technology. Bring it, we have to bring it there. And you have to make a cognitive argument on why this would be, uh, beneficial. Now, when I brought it in, of course, the, the vendors saying, oh, yeah, you can do this with it, but you sort of have to prove it. And a number of times, we'll do, you know, five or 10 of the cases, and then come back and look at it economically and go, yeah, this is, this has been a, a game changer in regards to clinical outcome. They're still very interested in that. But then also the economics behind utilization and adoption of the technology. So it still goes to your value, uh, value analysis committee and your, your point is well taken. Uh, but you do have to negotiate and present a, a good argument to your, uh, committees at the hospital to adopt this stuff.

Scott Zeitzer ([06:00](#)):

Yeah, it seems like that was a easier conversation, shall we say? It looked much more straightforward, especially removing conceptually the idea of having to do a major implant.

Lara Wynne ([06:11](#)):

So Michael Langworthy not, not only adopted, not only is Michael Langworthy, you know, an innovator and likes to try new things that he thinks will benefit his patients. He's also been involved in a lot of programs where he's been involved in the development and design of a number of products for, um, United Orthopedics is one, right? And I believe Orthopedic Development and even up

Dr. Michael Langworthy ([06:39](#)):

Yep. Ortho Development, MaxKnee. So these are boutique companies. Max's and United are international companies. So is, Ortho Development, but the, the boutique companies can provide, uh, constructs and services with economic benefit, uh, to the hospital system. So with Ortho Development, it's actually interesting, it's a boutique company out of Utah, but their, their hip stems, their hip construct is the least revised construct, uh, in the United States for the past 10 years. So it turned out to be a very well developed designed, well thought out project, uh, that used, uh, a number of surgeons to participate in the design. And they were able to, uh, scavenge information and intel and longevity data off of multiple implants, consolidate it all into one implant. They don't have a lot of inertia, so they can make rapid changes with a few telephone calls and their guesswork, their planning produced a stem that's the least, uh, hip construct that's the least revised over the past decade now.

Dr. Michael Langworthy ([07:49](#)):

So you're competing with, you know, Stryker and Smith&Nephew and Zimmer. So these boutique companies can be very nimble, and they're providing a niche resource that's turning out to be quite effective, in this case, quite safe. And they're a little bit more economical because they're a little bit less expensive. They're not carrying a big, you know, marketing budget. They haven't done a lot of papers, but it's, it's solid technology. As you know, Lara, I know you've been in the, the space with, uh, pharmaceuticals and there were two technologies that Vin Dasa and, uh, Spitzer out in USC, we just published on the disease burden of osteoarthritis. And, uh, two of those were actually Pacira has come up with technologies that reduce postoperative pain. I know it's near and dear to your heart, but these, these technologies, like a liposomal Marcaine, which took the cell wall, mimicked it, put the Marcaine inside of it, and then you can inject along the nerves and the perineural sheath, and it reduces, uh, patient's pain, it reduces length of staying, uh, stay.

Dr. Michael Langworthy ([08:52](#)):

Zilretta was another one that's a polylactic glycolic acid matrix that leaves triamcinolone for up to five months. So, uh, this is arthritic, arthritis management that the Academy has now come out and said, Hey, long-acting steroids appear to be effective and safe. They're, they don't give that distinction to short-acting steroids, and they don't give it to viscosupplementation. So the, the technology has developed that you would do a localized injection. So the patient no longer has to take Motrin. They don't have to take Tylenol, both of which has attended risk. So Motrin causes more GI bleeds, more deaths than HIV in this country. Acetaminophen or Tylenol is a big cause of liver failure, liver transplants in this country. So targeted technologies that address arthritis and, and knee arthritis is the number one arthritis that we've got in this country, you know, is the, is sort of the way to go if you're looking at efficacy, safety, and a lot of bang for your buck.

Dr. Michael Langworthy ([09:50](#)):

So you have targeted therapies, uh, biologically you have instruments or, uh, uh, joint joints that are being developed that take in consideration the design, the, the polyethylene wear and things like that. Uh, one of the things that's, it's contr-, not really controversial, but robotics has come in and, and really planted the flag in, in orthopedics. Thing is, uh, even with our data, we're not seeing a difference in the patient reported outcomes with robotics versus doing it with traditional technology. And the reason that's important as a chairman, is the average robotic joint is more expensive than doing traditional technology. And, uh, what what may happen in the future is they may be able to adopt aviation sensors that would take into consideration just the body mass index and the height. You no longer have to put pins in and, uh, you'll be able to do, uh, joints with open platform, which would be a, a money saver for a health system interested in using, you know, navigation or robotic technology.

Dr. Michael Langworthy ([10:53](#)):

The robotic technology for orthopedics in the US is very interesting because, uh, the FDA has not approved artificial intelligence, uh, for use with the, with the computer with the robot, which is interesting because we've moved towards joint registries to tell us, are what we're doing, is it, is it being done correctly? Is the outcome good? And you really need to incorporate all the joints and let it layer out. The trouble with AI is all of them are proprietary, so the, they can't communicate with one another and you won't be able to compare, uh, various joints because they can't participate in the registry. Um, if they've been, if they've been done that way.

Lara Wynne ([11:35](#)):

That's a great point. I think of the Canary device in the Persona knees, Zimmer's Persona knee, but it is proprietary Zimmer, so you can't really compare outcomes across different technologies, different implants. It would really just be

Dr. Michael Langworthy ([11:50](#)):

Right. Different service lines. Yeah. And, and we're gonna need that going forward. We need to be able to compare apples to apples and oranges to oranges to find out if what has been constructed is legitimate, is it making a difference? Does it have long-term survivability? So these are things that, you know, it's kind of the wild west out here in orthopedics right now. Uh, a lot of very innovative technologies coming about with, um, you know, the shrinking economics, uh, in our field. So you're absolutely correct. When we take it to the hospital, you gotta make sure that, you know, it's effective, safe, and it, uh, economically, it's, it's providing a service or a technology that's not in that current space.

Scott Zeitzer ([12:33](#)):

Yes. You know, when you look at the introduction of technology, there's different ways that technology can be introduced to the patient. So one is, uh, the implant itself, uh, it could be the, a new drug or drug combination. And then what we're talking about right now is like, you know, do we add a layer of information technology to it? Do we add a robotic system to it? Uh, Canary is basically, uh, for people who don't know, it's a bluetooth device that is essentially added to the bottom of the tibia, and it allows the orthopedist to get a better idea about how well the patient's doing postoperatively in terms of their movements, et cetera. I know Stryker has a similar product that I think they essentially put on the outside of the, uh, on the leg itself. This does open up a whole different set of conversations about how you measure all of these different outcomes and how you go back, like you said, you know, you're gonna go to your people, you're gonna sit down and you're gonna say, Hey, I think this is safe. I think this is cost effective. We're gonna do a half a dozen of these and we're gonna go measure it. And so that's gonna be interesting about how we measure all of that. Maybe walk us through, you know, I know, uh, Heron's got a product, uh, that you're using, how you kind of took a look at that, how you made a decision in your own head, Hey, this might be interesting. And then walk us through how you introduced that, you know, to the hospital system and measured it, et cetera.

Dr. Michael Langworthy ([14:08](#)):

It, it's actually, uh, Lara is very familiar with this, this, uh, story. So, uh, she knew about the technology, okay. Uh, state of Massachusetts during the height of Covid was no longer allowing inpatient total joint surgery. So we were dead in the water. And, uh, we were just chatting about this. She goes, you know, actually there's a, a technology that's available that you might be interested in. This is the, the, uh, the Zynrelef. It's a dimethyl sulfoxide matrix that leads bupivacaine and, and Mobic for three to four days. So the representative came and, uh, sat down and talked with them, and we were able to, uh, start off with 167 patients that they were well selected. Uh, I, I would do a total hip or a total knee on them, and then we would layer this technology in on their synovium as we were closing.

Dr. Michael Langworthy ([14:58](#)):

And, uh, it, it, uh, basically worked as they advertised. So we saw a dramatic drop in the postoperative pain. So typically postoperative knees, hips are people around 6, 7, 8 on a Wong pain scale. So 10 being the worst, one being no pain. And we noticed that with this technology, it dropped them down to quite mild pain. So we did ERAS protocol. That ERAS protocol includes starting the night before with, with

things like gabapentin, uh, Tylenol day of surgery, mobic cox inhibitor day of surgery, spinal, adductor canal block, and then layering this in. And we were able to move from 30% outpatient to 70% outpatient. So I'm able to kind of gear up and continue doing total joints during Covid when the rest of the nation was really not able to do that. 'cause they were staying overnight. They couldn't do it. So that was one where, uh, I was introduced to technology by, uh, a, a source expert, which is Lara, and then she brought in the Heron people and we were able to, uh, talk with our pharmacy and, uh, get it through P and T for a, a, uh, you know, temporary use.

Dr. Michael Langworthy ([16:12](#)):

That's for about six months. Uh, and I'm, I'm still using it to this day.

Scott Zeitzer ([16:15](#)):

Wow. That's interesting. Lara, how did you find out about it? Well,

Lara Wynne ([16:18](#)):

I had worked, you know, for Pacira, and Michael Langworthy was developing an opioid sparing joint program. So he was using EXPAREL at his hospital and was, uh, you know, I think some, some company came in to consult and said, this is too expensive. And they wanted to remove EXPAREL, uh, from the shelf. So they, they were having to function without EXPAREL at that time. And I said, you know, there's a new product out that would be helpful to you, so you might, you know, I know this is important to you. And he was in a real bind at that time, not being able to perform joints in the inpatient setting during Covid.

Scott Zeitzer ([16:59](#)):

Yeah, this is one of those areas, guys, where getting people together, whether they're just all surgeons, whether they're in the business, so to speak, and just talking can be so helpful, uh, to the outcomes of patients over the long term. So you've got this modality now where you've got, okay, I've got ways to avoid opioids, which we all wanna avoid. You've got some different usages where you're actually looking at the implants themselves, which for a long time, I mean, a total knee was a total knee, a total hip was a total hip, and not many people really thought about it. And then a lot of vendors started coming in and, and like you mentioned, uh, docs, some, uh, some boutique vendors, and then companies like United and Max, et cetera, came on. And how do you make decisions about, let, let's talk about United, their offerings, and how you came to know them better. I know we all knew about them, but how you kind of got introduced to them, how you kind of walked through the process in your own head about this particular company.

Dr. Michael Langworthy ([18:03](#)):

So actually the, the introduction to United came, uh, I was using a major vendor for, uh, a hinge prosthesis. Okay. Those are very expensive up around, you know, \$22 to \$30,000. But, you know, depending on what goes into it. And, um, uh, one of my vendors that I work with goes, Hey, this, this United company seems to be, you know, doing very well with this type of hinge. So I got, got in, um, uh, contact with them, we brought them in. Now we've developed a technique at South Coast where I don't, I don't take the bone away. So we have a periprosthetic distal femur or proximal tibia fracture. And, um, I leave the bone in, we put the, the implant and, uh, the bone grows around it. So that's worked out very, very well.

Scott Zeitzer ([18:57](#)):

And so when you presented that particular device back to the hospital, were they fairly like, you know, hey, it's a hinge prosthesis if I trust you, kind of a conversation and you were able to,

Dr. Michael Langworthy ([19:11](#)):

That was straight economics actually. So that one, one that was several thousand dollars cheaper, and we were able to adopt that technology, uh, you know, quite readily after I've done these cases, United has come to the table now and said, Hey, perhaps, uh, we can design one specifically for trauma. So these hinge prosthesis are typically for, uh, tumor cases, which, so it's not an ideal fracture prosthesis. United has now double down and said, okay, we will, uh, change the technology, uh, with coatings and things like that, which will adopt your surgical technique. And we'll now be able to implant these safely with a high degree of efficacy and better function than, than previously done before. So they're, they're shrinking the components, putting surfaces on that, that the bone will anneal to. And this is gonna be a specifically a, a fracture hinge prosthesis. It's exciting technology.

Dr. Michael Langworthy ([20:09](#)):

As the boomers are now taking over the, you know, the nursing homes and things like that, you're gonna see a lot more of these complex, uh, para or just distal femur, proximal tibia fractures that are catastrophic. And you're seeing courses starting to sprout up now called castraplasty, where they, they talk about, you know, what are we gonna do with these? So you have not only native joints, but periprosthetic joints that need to be addressed. And these smaller companies are addressing this by being nimble, looking at the literature, and then bringing in, uh, clinicians and surgeons and, and industry to, to ideally fill these nicks that have been out there.

Scott Zeitzer ([20:50](#)):

Yeah, you know, you're kind of, you know, like a, you are kind of a cutting edge kind of guy and you are a KOL. Do you kind of talk to other hospitals and hospital systems surgeons, et cetera, about, Hey, this is what's worked for me, and how does that process work? You know, when you're talking to other, uh, people,

Dr. Michael Langworthy ([21:08](#)):

I do a fair amount of, of national international lecturing. So we do talk and people who come in and, you know, take a look at the techniques and stuff. It's been a, you know, good ten year run. I was in Afghanistan in 2012, so since I've gotten back, it's been very, uh, you know, it's a lot of, uh, of commercial and industry contact with organizations that are nimble with very smart people that, and we're trying to stay ahead of what's cooking with CMS. So trying to keep length of stay working on, uh, making sure that people don't come with an backline adverse event. I'll give you an example. I've got a trauma team, an adult reconstruction team in my health system. So if I take a 80-year-old with a, uh, common distal femur fracture and let my trauma individuals plate that, and they will plate it, they'll put a bone graft.

Dr. Michael Langworthy ([22:01](#)):

And it, it turned out those constructs were quite, quite, uh, expensive. And yet 80% of the time they were failing and they were coming back for a second surgery. And I'm like, we, we need to look at that. We need to figure out tactical strategies so that people can have one surgery, they're walking on it the next day, and they're going on about their life. One of the things is, I, I mentioned the boomers a little

while ago, the average age in the US where somebody has their first big medical issues, typically about 63 years of age. So as you get into your seventies and eighties, you don't wanna spend three to six months recovering from a fracture. You want to do something definitive, something that's not gonna get infected or have an adverse event that they can walk on and they can go off and enjoy, uh, those years that they have remaining.

Scott Zeitzer ([22:50](#)):

Yeah. As a 62-year-old, you just made me open my eyes wide on that statement, so thanks doc, I appreciate that. But you're right, I, I am active, uh, I like to stay active and if God forbid something happened, you're right. I don't wanna spend the next year and a half trying to figure out how to fix it. I think that a lot of orthopedic and orthopedic care is going to be adapting accordingly. And I think that the nimble companies out there that are focused on that are gonna be more successful. It's the, it's the plus and minus, you know, the Zimmer Biomet and the Strykers, they're very large, they're very good at what they do, they're fine companies. But yep, there is

Dr. Michael Langworthy ([23:27](#)):

No, and I agree, but there's yep. There's, uh, also small entities out there that produce, uh, excellent results. Now, one of the things, the spaces that we're moving into, we, we talked a little bit about a poster with liposomal marcaine and, and, uh, Zynrelef with Heron, but, um, there's like AlphaGRAFT, which is a type of substance that transports mesenchymal cells directly into the area of fracture or disease. So we're seeing now orthopedics getting into, uh, the manipulation of, uh, biology, biologic proteins as once you get over the age of 40, there's a precipitous drop in poor potential cells. So now there are graphs that are not only synthesize, but harvest it where you can import mesenchymal cells. Now the mesenchymal cells can differentiate into one of eight cell lines. So the trouble is, if I use that, if I take iliac crest bone from a 40-year-old, not, not only do I have the morbidity of where I'm harvesting that graft from, but those cells aren't particularly effective.

Dr. Michael Langworthy ([24:30](#)):

And when you look at iliac crest bone graft from people, you know, 40 to 60, most of those cells are actually dead. So we're seeing this regenerative, uh, wave coming. Stryker was involved this, you know, 20 years ago with, with the BMP7, it was called OP-1 when they went through, it was a wonderful material. I was one of their, their senior, uh, clinical researchers on it. But, uh, they had it set up, they were only doing 4,000 cases a year. They eventually sold the thing to Olympus and went back to Japan. But the ability to manipulate cells, OP-1 was one, BMP2 is, is, uh, infused. We're seeing, uh, this Magellan technology, which we're able to pull blood off, you spin it down and inject those platelets in the management of osteoarthritis. Now the Academy's come out and given it a provisional, okay, TRICARE has said, we will reimburse for it.

Dr. Michael Langworthy ([25:23](#)):

Certain workman's comp programs will reimburse for it, but the ability to pull your cells off, use your own cells to heal or to, uh, help you symptomatically, that's where the space is going next. And, uh, doing it economically, doing it in, in ways that insurance companies can validate that it's effective and safe. Uh, it's gonna open up a lot of doors and it may just move your total knee out for, for two or three years, but if you do that, you may only need one, one knee.

Scott Zeitzer ([25:54](#)):

Yeah. It's huge. You mean, uh, uh, you're absolutely right about that.

Lara Wynne ([25:56](#)):

I was just going to ask if you've had experience using different types of PRP, if you feel more confident in, you know, if there's a, a denser or a higher platelet count, what are your thoughts on that? Or is that something that, that you really haven't, haven't been measuring too closely?

Dr. Michael Langworthy ([26:16](#)):

I think you gave me, uh, Don Buford's contact out of Texas. So I talked to him directly and, uh, he was, he was pretty convinced that you need to get to about 6 billion platelets to make it till it's efficacious. And so we went with that and um, we use a technology that spins it down and we sort of know what the, the density is. He's an interesting cat 'cause he is got his own hematologic lab down there, which is pretty unusual for a, for an orthopedic surgeon. But yeah, it seems to be, you know, the, the cells and when we started this talk, we were talking about efficacy and safety and, and, uh, costs. And, and those are things where you need to, you go through your phase clinical trialing, you figure out what's efficacious and it looks like a high cell density is, is effective. And, uh, helping to modulate that milieu of exci, you know, excitatory amino acids and proteins that are, that are in the knee.

Scott Zeitzer ([27:10](#)):

I haven't read too much on it. Uh, what little I've read, uh, seems to be pointing in that direction. And I, I kind of come back to this whole, no matter if you're having fiduciary responsibility specifically outlined by what you do and the fact that you're chairman, every orthopod has a responsibility when they, you know, when they walk into the operating room and take great care of their patient to come up with a way that's cost effective, et cetera. 'cause they have pressures on them. And I do think that a lot of these conferences where these reports are coming out, where conversations can be had where online journals like JOEI, where you can get a quick, you know, review of, uh, it doesn't have to be 5,000 or 50,000 joints were done, blah, blah, blah. Still important to do, but it's just as important of like, Hey, I did 50 to a hundred and here's what I'm finding out so far. You know, how, how is that all helping you communicate and helping you learn more as well? Uh, uh, and <inaudible>.

Dr. Michael Langworthy ([28:10](#)):

Well, JOEI's very, it occupies a very, very interesting space because it allows very nimble, very lightning analysis and interaction on these emerging technologies. So yeah, if you, if you look at the traditional journals and you need, you know, double blind studies that are, if you look at the Academy of Recommendations, you have the American Academy of Orthopedic Surgeons, American College of Rheumatology, or the, they don't even agree on what they're doing, what their guidelines are. For example, the, the Academy doesn't advocate for the use of visco, yet 80% of orthopedic surgeons use visco. So JOEI holds an important place on doing very real time, uh, communication in regards to what is currently being practiced, what's effective, what's safe, how are we gonna, uh, pay for it. So it's, it really was a spot that needed to be filled. And, you know, JOEI's done a great job in, in filling that spot.

Scott Zeitzer ([29:06](#)):

Yeah, it's funny, uh, uh, it's a very old school thing that's been now made into a new school thing. So what I mean by that is when I, I've been in this business now a long time, uh, Lara, and I'd like to admit almost, I'll say 30 some odd years, almost 40 years. And I remember when we first started, the designer of the hip or the knee, like there'd be a lot of surgeons just kind of walking around and talking about like,

well, what do you do if this happens? 'cause it was so new to do a total knee or a total hip. And JOEI kind of reminds me of that, of like, you know, I'm just started using product X, whatever that is, and this is what I find that's been effective for me and this is what I'm doing. And having that conversation about it, especially now with an online community where you can communicate more openly, I think is really helping energize, uh, the field of orthopedics and medicine overall.

Dr. Michael Langworthy ([30:00](#)):

You know, you do a JOEI article, it is evaluated, you get a response back within a matter of weeks. The last article we did, two and a half years, two and a half years to publish in a peer reviewed journal.

Scott Zeitzer ([30:14](#)):

Yeah. And it's still necessary to do peer reviewed journals. I believe in them, I believe in big studies. I think they're important, but while you're waiting the two and a half years for that to be published, patients need to be taken care of. And so, um, you know, I'm, I'm gonna leave it and end it, uh, here because we could keep talking for another hour about all this. Um, I could spend an hour talking to you about how you made the transition from a fighter pilot in Afghanistan to an orthopedic surgeon. That's a whole different conversation, which we could talk about. But I did find it interesting that we, having an open mind about new technologies, understanding the business side of medicine is hypercritical to your success as an orthopedic surgeon. As much as it is, is like, you know, the skill of your, of your hand and a scalpel.

Dr. Michael Langworthy ([31:02](#)):

Yep. Well, it's gonna be a interesting decade coming up. No doubt about it.

Scott Zeitzer ([31:07](#)):

Very excited about it. Even being the old guy who apparently now has to be worried about falling down and you taking care of me, doc. So I better be

Dr. Michael Langworthy ([31:16](#)):

Alright. Well thank you very much for having me. That was, that was wonderful.

Scott Zeitzer ([31:19](#)):

Thank you, doc. Thank you Lara.

Lara Wynne ([31:21](#)):

Thank you for joining us today

Michael Roberts ([31:23](#)):

In the interview, Dr. Langworthy shared insights into some of the new technologies he has adopted, how they improve patient care and how he introduces them to his practice and other surgeons in his network. Thanks to Scott and Lara for hosting this episode. If you'd like to keep up with Lara, you can find her on LinkedIn. Thank you also to our listeners for joining us for this episode. For more on the Health Connective Show, please visit [hc.show](#) for previous episodes and Health Connective as a company.