EDITORIAL

Changing world yet business as usual?

The global and local orthopaedic surgical landscape is rapidly changing. We are confronted daily with increasing implant options, intra-operative navigation technology, and a variety of reconstructive techniques with promised technical gains but short on convincing clinical advantage. This was highlighted by Prof Dick van der Jagt's FP Fouche lecture recently in Skukuza. The need for newer and better solutions are further fuelled by the growing elderly population's demand for higher levels of function and quality of life. These co-existing factors are exponentially driving health care cost at an unsustainable rate which is resulting in funders responding with a variety of restrictive and risk-sharing strategies, mostly to the detriment of the solo orthopaedic surgeon.

Despite the changing trends in orthopaedic surgery, our training and subsequent practice organisation has remained the same for as long as I have been around, and probably well before.

Our tried and trusted approach may well no longer be adequate.

Focusing initially on the training, we have had the same College syllabus for at least 20 years. Yes, we focus on the safe reasonable surgeon, but train on a public health based platform for independent practice in a largely clinically uncontrolled private environment where surgeons of any skill level can take on any surgery without peer review.

As with any assessment process, one is only sampling areas of competency. I think we have done well in assessing candidates' theoretical knowledge and clinical assessment skills on basic Orthopaedic Surgery. All surgeons however don't all restrict themselves to practise in their competent areas.

At the Cape Town COMOC in April, there was a poorly attended but excellent Canadian Orthopaedic Association symposium on registrar training and assessment. Here all the global regions presented where they were, and what they were striving for. There was a lot said on competency-based training as opposed to time-based training, the latter being the model that we follow. In SA we assume being in training for 4 years will provide sufficient exposure to the spectrum of orthopaedic pathology, but this is no longer necessarily the case in many of our trauma-skewed training hospitals.

I would like to avoid completing an app-based questionnaire every time my registrar sees an outpatient or performs a procedure, which is where the Australians are heading! What I take from this though are the non-clinical areas of competence that we ignore. They were referred to as foundation competencies and include communication, teamwork, conflict management, professionalism, leadership, organisational skills, advocacy, education and research. Now many of you will see these as obvious skills, self-learnt, and why should we bother – it's all about operating isn't it? These attributes are, however, where we seem to fail once in independent practice. Anyone providing expert opinion in medico-legal matters will identify with this. It is not usually the lack of orthopaedic knowledge that results in the legal matter.

Many of these competencies were previously subconsciously learnt from mentors, both in and out of our medical environment. As our training facilities have increasingly suffered under overwhelming trauma loads and chronic underfunding, many have lost strong and long-serving mentors to rapidly changing junior consultant staff who cannot provide the same osmotically learnt behaviour.

As President of the Orthopaedic Constituent College, I have introduced examination changes on the basis that the assessment process drives learning. For decades we used multiple long questions as our written assessment. This makes it difficult to interrogate these foundation competencies, despite some of them being listed in the syllabus. With a staged approach, we have adopted single best answer multiple choice based on a scenario, a short question paper and only one long question paper. Not only is this a much fairer assessment model, reducing candidates' concern about bias, but it allows us to assess candidates on ethics, professionalism and the like. This will hopefully encourage them to consider these areas during the training phase of their careers at the very least.

The next area of concern is the subsequent private practice organisational structure. For some reason we all train in a team-based, peer-reviewed, load-sharing environment yet many aim for totally independent, solo-based practice. It makes no sense to me that each surgeon has expensively decorated rooms and a contingent of two to three staff members when they are unused for two to three days while they are operating.

We want autonomy but sacrifice a lot for this. Although

we may share calls, our patients are always 'ours' – so you are seldom off. As popular as you are, you have nothing to sell other than some depreciated furniture and outdated IT. Thus you only generate income while working with no capital wealth generation. This also makes negotiation with funders onerous and difficult. As we are repeated told by the SAOA and the legal community, we have to avoid being anti-competitive, i.e. we are not allowed to stand together financially – bizarre but so it is.

We are facing increasing financial headwinds. It started with designated provider status, all based on price not quality of service – short-term strategy at its best. This has now escalated to pressure from a large administrator to shift risk by soliciting bids for total cost arthroplasty models. This forces each surgeon to negotiate with other role players of disproportionate power over opaque costs and profit distribution, blinded by the law to what his peers are charging. Taking the risk of future lower-than-CPI increases and 'partner' pressure to reduce the surgeon's fee out of it, where is this clinician meant to find the time to analyse the model, costs and then administer it? In all likelihood he missed those foundation competencies!

I think it high time that we re-consider our private practice organisational structure. I have seen the benefits of a local general surgical practice with many partners. It allows extracting the benefits of economy of scale, i.e. turnover growth in excess of cost growth, resulting in higher profit. It also allows salaried positions for surgeons within the practice who may or may not become partners. This creates a feasible and respectable private career path for our newly qualified surgeons. This should reduce supplier induced demand, i.e. the temptation to over-service to survive, as they benefit from the overflow of an existing well-established group practice.

With at least cost sharing and possible profit sharing, there is less competition allowing free sharing of skill and knowledge, restoration of in-house clinical meetings, case discussions and local peer review. An entity will be built that has value beyond yourself, giving you something to sell when you retire.

This does come at the price of some loss of autonomy. Not every surgeon can disappear at short notice on a long weekend or school holiday. You will have to answer to your partners/peers as to your practice, implant choices and complications – but this is a good thing. I do not see why the private practice should be so different from the state academic organisational model.

A very real benefit of such re-organisation would be that the group can negotiate with funders and other role players, providing a greater impact than any individual surgeon can. In fact, it could more than likely employ a financially astute negotiator, and it would be legal, freeing the surgeons to do what they do best.

As our world continues to evolve at a rapid rate, it is NOT business as usual.

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