

EDITORIAL

Having recently experienced a prolonged HOD appointment process, I have been confronted with presenting my vision of Orthopaedic Surgery to local role players. This forced me to 'zoom out' and take a good look at our service provision and training responsibilities.

I realised that we have very little information to plan our orthopaedic service on. Our allocation of resources is largely based on historical factors and political imperatives rather than a basic understanding of need. Many years of financial restriction has also had its toll, resulting in a skewed service platform in the state sector. There is a degree of self-perpetuation due to orthopaedic surgeons incorrectly being seen as, and even starting to believe that we are in fact, trauma surgeons rather than comprehensive musculo-skeletal surgeons.

This led me to investigate the musculo-skeletal burden of disease. This quarter's journal includes my thoughts on this and highlights the dire need for local data. The true extent of musculo-skeletal disease and the requirement for orthopaedic surgery is un- or under-recognised both globally and locally. This is largely due to the fact that we are in the 'quality of life' game, not mortality, which is the frequently reported statistic in health data. It is our responsibility to obtain this data and perform studies that prove the health economic value of orthopaedic procedures. This requires a mind shift on our part, understanding disability adjusted life years (DALYs) and assessing the financial cost of the change due to our surgery.

The other main area of concern is our product – the orthopaedic specialist. We are entrusted by the community to train these young surgeons as specialists for independent practice. There are many challenges with arguably skewed and possibly inadequate training in certain areas due to state practice limitations and the pre-occupation with emergency work.

Is this reducing the quality of our product?

I think the technical shortfalls in some areas such as arthroplasty and arthroscopy are not insurmountable and with public private cooperation can be addressed. Some would argue we should be training for state service and thus the state experience is adequate. I disagree – we are training them to serve the South African community, wherever the community accesses their care. All citizens experience congenital, degenerative and oncological pathology and require elective care. We need to ensure the necessary skill sets are developed and maintained, even if the state health system decides to restrict the availability of this level of care to the general population.

With few state jobs most newly qualified surgeons rapidly enter private practice where there is no supervision and arguably no peer review. This can be dangerous in terms of the surgeons' development.

Although technical expertise is mandatory, these shortfalls can be addressed. What is more concerning is the focus purely on the technical side by surgeons. This led me to consider what in fact a specialist is. Is this someone who simply concentrates on a small section of medicine in an effort to cope – as my GP wife suggests? I hope not.

There does appear to be a tendency for registrars to act like medical officers, focusing on clinical skill acquisition rather than becoming a 'specialist'. With the changes in state reimbursement there is no longer the sacrifice of a lower salary while specialising as compared to working as an MO. This may have changed why doctors choose to specialise and who chooses to specialise.

So what is the difference between a medical officer and a specialist? I believe the desire to develop and improve one's chosen discipline separates us. Being a specialist encourages thinking about each case, ongoing reading and learning, and life-long research. I remember excellent medical officers ripping through the list to play afternoon tennis. The specialist should be living for his list and not in a hurry to go anywhere else. Of course there is balance, but the priority should be the chosen discipline.

With this comes the issue of professionalism. There seems to be a loss of professionalism among us. This may explain some of threats to our status in the community and health care environment. Professionalism is intangible and difficult to explain or teach. Zuckerman¹ deals with this topic well – highlighting the qualities of honesty, integrity, reliability, responsibility, self-improvement, collaboration, self-awareness and altruism. He suggests that professionalism is a developmental process where one progresses from awareness to conduct. He highlights that professionalism encompasses behaviours, attitudes and conduct in their interactions with colleagues, patients and staff.

Our local stresses and high staff turnover with subsequent loss of mentorship negatively impacts on instillation of professionalism in our trainees. As trainers we need to make sure we maintain ours and transfer it by example and explicit education.

Reference

1. Zuckerman J, Holder B, Mercuri J, et al. Teaching Professionalism in Orthopaedic Surgery Residency Programs. *J Bone Joint Surg (Am)* 2012;94:e51(1-7)

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The Editorial Board would like to congratulate Prof Robert Dunn on his appointment as Professor and Head of the Department of Orthopaedics at the University of Cape Town.

Prof RP Gräbe (Editor-in-Chief)