Letter to the Editor

I am nearing the end of the Australian Orthopaedic Association Congress, with New Zealand next week, having attended the British meeting a few weeks ago, and spoken extensively with the Presidents of the other English-Speaking Associations over the past six weeks. Only now am I beginning to appreciate how different these organisations are, and how unique the SAOA is. The other Associations are primarily concerned with education and professional standards, while remuneration and political issues are the responsibility of other professional bodies. In contrast, the SAOA is a single body and intensively involved in education, financial, professional and political matters to represent and protect its members interests. This is a respectable achievement for a small Association and we have much to be proud of, not least the *SA Orthopaedic Journal*, our own dedicated orthopaedic showpiece.

My travels have had many highlights, but the British Orthopaedic Association featured some outstanding eponymous lectures which I think are worth summarising.

Colonel Mike Stewart delivered the Robert Jones Lecture, 'Wounds of mind and body' with the theme of battlefield injuries in modern warfare. Few of us appreciate the number of serious mutilating injuries caused by IEDs (informal explosive devices) in both military and civilian patients in the continuing fighting in Afghanistan (and Iraq). With the use of body armour to protect vital organs and modern resuscitation techniques, soldiers survive grossly destructive injuries to multiple limbs and the perineum which would have been fatal only a few decades ago. With such severe wounds, a return to basic principles of repeated debridement, delayed soft tissue cover, and avoidance of internal fixation has been the secret of success. Primary amputation was never performed without obtaining a second opinion, and MESS scores were found invalid for badly contaminated war wounds. External fixators are often difficult to apply to shattered bones, and POP and Thomas splints are used frequently for temporary stabilisation of severely comminuted fractures – I wonder how comfortable our modern registrars would be with this 'obsolete' technology? The reconstruction of these injuries and their subsequent rehabilitation is an enormous challenge. To its credit the British Army is also fighting a political battle to award realistic compensation (often ridiculously low compared to civilian injuries in Britain) while attempting to retain even the badly disabled in army posts, and not simply dumping them on the street as been the military practice for millennia. Interestingly, Mike Stewart worked for a while in Cape Town (he came to play rugby!), and was taught trauma surgery by Johan van der Spuy.

The speaker at the John Charnley Lecture (attended by his widow) was Clive Duncan of Vancouver, with the title 'One step forward or two in reverse?'. He had three messages about infections, periprosthetic fractures, and changes in prosthetic materials. He suggested that after early success treating infected prostheses (4% persistent infections, with no difference between results of 1 or 2 stage revision) we are now losing the battle against resistant organisms. MRSA infections have increased from 10 to 24% in his area, and despite 2 stage revision using antibiotic cement spacers, the rate of persistent infection has increased to 18%. The next problem was the increasing frequency of type B3 periprosthetic fractures. He identified the underlying factors as the increasing age of patients, failure of implant surveillance for loosening, reluctance to perform pre-emptive surgery in the frail and elderly, and failure to recognise impending fractures. The final issue was the complications emerging after changes in implant materials. He noted the emergence of the 'new millennium patient', who is younger, more demanding, assertive, and 'informed' than in the past, with a resulting increase in resurfacing arthroplasty. His unit had reviewed patient (not surgeon) reported outcomes after resurfacing and conventional hip arthroplasty, and found no difference in quality of life, only the dislocation rate. They also found very high serum chromium and cobalt levels in many patients with large head implants, not only resurfacing, and suggested the following indications for revision even if the patient was asymptomatic: silent severe osteolysis; high serum metal ion levels; and a silent pseudotumour. It is obvious that we should start to monitor serum chromium and cobalt levels in our patients.

The Walter Mercer lecture 'Mastery and specialisation: what is a consultant?' was delivered by Prof D Rowley of Edinburgh, and compared the development of an orthopaedic surgeon to that of a craftsman. To a craftsman, work must be more than a way to earn a living: it is a part of his personality, a pleasure in technical expertise and a source of pride. I too believe these are qualities essential to our profession. Traditionally, an apprenticeship, the first stage of craftsman training, took six years, or 10 000 hours, and he suggested that this is also the period required to specialise in surgery. The following stage is that of journeyman, where a qualified craftsman gains practical experience, usually under the guidance of a Master Craftsman, for a further six years; this would be the equivalent of a young specialist. The final stage is the Master Craftsman, a title granted only by peer review, and not always achieved. This would be the equivalent of a specialist being given a Consultant position, and has the responsibility of adding special skills in surgery, education, research or administration. South African hospitals no longer have Consultant posts: they were abolished when private surgeons were no longer allowed to practise in State hospitals, and this was a great loss to training and service delivery. To be made a Consultant was a privilege and matter of pride: Consultants were responsible for the training of many doctors of my generation. In the future when we need the private sector for orthopaedic training, we may well see the return of the Consultant.

I have had much food for thought in the past few weeks, and I hope readers of the journal find these few extracts as stimulating as the lectures were to me.

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