Orthopaedic Trauma challenges and opportunities in North America

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Last week, I flew back from a congress on 'controversies in Orthopaedics'. The faculty was as impressive as the French Alps location; Thierry Judet, Alain Masquelet, Yves Catonne, Philippe Beaufils to name a few, were all discussing their respective topics of predilection. I was surprised to see that only a handful of controversies mentioned were related to orthopaedic trauma. One evening, at dinner, I asked Masquelet and Judet their thoughts on the organisation of orthopaedic trauma in France. The response was unanimous; there was little 'organisation' of trauma the way we know it in the USA. For a traumatologist, this sounded like if Lionel Messi stated that he was no longer interested in football to a Barcelona fan. Trauma was not centralised, a handful of surgeons were willing to dedicate their careers to it and trainees performed the majority of cases at night or during weekends. It is clear that in most countries I had the chance to visit, this was more the rule than the exception. It is hard to argue against the fact that the US model of trauma care is the gold standard for both patients and surgeons. Centralisation of care increases the volume of cases in one institution and the expertise of the surgeons who work within it, it allows the development of streamlined management guidelines and treatment algorithms, and enables the development of clinical research through clinical trials. The job of an orthopaedic traumatologist is valued by both peers and society. It is, in my opinion, the model that countries seeking better trauma outcomes should follow. However, orthopaedic trauma care in the USA is now facing a number of challenges that are in part, the result of a de-centralisation of care points combined to an increased popularity of the specialty both for trainees and decision makers. With the newly set up trauma system in the UK (described in this month's feature) it is perhaps pertinent to reflect a little on some of the challenges now facing the US trauma system.

THE COMPETITION IS RISING

Our city of Denver, with just over 800 000 people has three Level I trauma centers and may have a fourth one soon. It seems that the financial incentives to treat patients with severe traumatic injuries have surpassed the common sense to manage these victims in centralised centers of excellence where trauma is a culture and a way of life. This trend of seeking Level I accreditation is only diluting the expertise and having a negative impact on our patients' outcomes. Lower reimbursements in elective surgery, novel healthcare models and incentives have shifted the attention of surgeons and stakeholders towards trauma care. As a consequence, competition between surgeons, once owned by sports, spine or joint specialists has pushed trauma surgeons and their hospitals to market their services aggressively to the community and outreach centers.

POSSIBLE IMPACT OF 'OBAMACARE'

The recent implementation of 'Obamacare' may ultimately benefit the so called 'safety net hospitals'. For decades, hospitals such as Denver Health Medical Center, Hannepin Medical County and a few others have prided themselves in taking care of the indigent, un-and-under-insured patients. The financial burden combined with the complexity of cases and patients presenting to these institutions has rendered the mission hard to maintain over time. As an orthopaedic trauma surgeon in a safety net hospital, in addition to the high energy 120 pelvic and acetabular fractures per year, we take care of complicated delayed presentations of osteomyelitis, non-unions and mal-unions in patients that are often immune-compromised and that have rarely obtained medical care at all. Once treated, the follow up of these socially/medically/professionally emarginated individuals is often nonexistent. To date, patients with private insurances ensured that our institution stayed financially afloat. Since January 2014, theoretically, the rate of uninsured patients should diminish and help these safety net institutions stay in the black while allowing the newly insured patients to have an easier access to preventative medicine and general basic care.

HOW IS OUR SPECIALTY SEEN BY RESIDENTS?

Orthopaedic trauma as a specialty has never been as popular amongst residents. A few weeks ago, the fellowship interviews took place at our institution and choosing one amongst the Harvard, Yale and various Ivy League University residents was a real challenge. The salaries of orthopaedic trauma surgeons, quality of life and workload are now matched with other previously more attractive sub specialties. Trauma is now attracting some of the brightest orthopaedic residents.

WE MUST STAY OPEN-MINDED AND COLLABORATE

Towards the end of our dinner, I told Alain Masquelet how honored I was to meet him and spend an evening talking. I acknowledged that his induced membrane technique was starting to be used in most US centers and that publications on results had started to flourish. He replied: "I have been doing this technique for 30 years and submitted abstracts to the American Academy over 30 years ago." I was only invited to talk about it at the AAOS 2014. To succeed and help our patients, we must stay open minded, travel and meet likely minded international individuals to exchange ideas and concepts.

The US system whilst currently arguably the envy of the world faces some severe financial and logistical challenges. With an increasing push towards care for the severely injured, trauma systems must evolve on both sides of the Atlantic in such a way that they are able to care for the majorly injured without neglecting the elderly and fragility trauma. This latter group represents a great challenge for our future, both in terms of absolute number of patients and complexity of care. We must remember that a comprehensive and developed trauma system must address both patient groups.