Travelling Fellowship Review

Nick Aresti

ExecSumm:

I was delighted to be awarded a BOA / Zimmer travelling fellowship, which led me to Texas during July. It came about following a chance meeting of David Ring and Kevin Bozic whilst in Boston in 2014. Both had just been recruited to Dell Medical School to develop a value-based healthcare system.

This provided me with a fantastic opportunity to meet and observe someone who has helped drive our understanding of elbow pathology, particularly of trauma, and also see first-hand what the new wave of value-based medicine and integrated practice units practically means.

The most striking features of my time in Austin, was their clinics. Surgeons were another team member. Dieticians, psychologists, physiotherapists and occupational therapists all had an input. A large proportion of the population served were not US citizens and spoke little English. There was therefore a huge drive to meet all healthcare needs at one appointment and limit the lead for follow ups. It’s not uncommon for fractures to be fixed in a little theatre adjacent to clinic. Almost every patient was enrolled in one of more research study, and the use of outcome scores was very impressive.

I also had the opportunity to visit Stephen Burkhart – the Godfather of shoulder arthroscopy. I was able to watch him both in clinic and in theatre and enjoyed a dinner with him in his favourite restaurant. This all happened in the week that he announced his retirement: not doubt a huge loss to the shoulder community!

I had a fantastic time visiting the units in Texas, and I hope to bring back some great ways of working to my consultant post.

**Full report**

I was fortunate enough to head to Texas for a travelling fellowship, courtesy of a BOA / Zimmer award. I have a keen interest in upper limb surgery and having spent a year as the National Medical Director’s Fellow, I am also interested in healthcare policy, regulation and organisational change.

Whilst on a course in Boston I met David Ring and Kevin Bozic. The former was a professor of orthopaedic surgery at Harvard Medical School and chief of hand surgery at Massachusetts General Hospital, and the latter a professor and vice chair of orthopaedic surgery at the University of California San Francisco (UCSF) and faculty of the Philip R. Lee Institute for Health Policy Studies. Both were recruited to Dell Medical School and UT Health in Austin, which has born out of the ‘Value Based Healthcare’ and ‘Integrated Care Systems’ pioneered by Michael Porter’s group at Harvard. Visiting these surgeons therefore provided me with the opportunity to better understand the clinical and non-clinical area of orthopaedics I see myself working in. Once I had decided to travel to Texas, I reached out to Stephen Burkhart, the ‘God-father’ of shoulder surgery, who is based in San Antonio, not far from the US-Mexico border. I was fortunate enough to be able to combine visits to both units.

I made the trip out in July 2019 and was hosted by Prakash Jayakumar – a former British orthopaedic trainee and Harkness fellow, and now the Assistant Professor of Surgery & Perioperative Care at Dell Medical School at the University of Texas.

My time in Austin was fascinating. I spent time in clinic and ‘OR’ with the surgeons, where the pathologies and procedures are not dissimilar from that done in the UK. The area I was most impressed by was the set-up of the clinics. The whole hospital has been built around an integrated (or multi-disciplinary in the UK) approach to patient care. Alongside surgeons in clinic, physiotherapists, occupational therapists, psychologists, dieticians and pharmacists also work. Before a patient is seen, the team assess referrals and highlight those who will need input from the various team members. Those overweight will see the dietician, those who have chronic pain and somatization, the psychologist, and so on. Issues with health insurance and language barriers in part drives the need to ensure that all healthcare needs are met during a single consultation. Whilst our healthcare system differs, we too have issues with variations in access to healthcare and services, particularly in areas of social deprivation and in groups in whom English is not well spoken. I believe we have a lot to learn from this type of set up, and whilst many units in the UK have similarly integrated set ups, we have some way to go to match that which is offered in Austin.

I was also impressed by the use of outcome scores. Every patient was served with a set of outcome questionnaires via a tablet which they filled out whilst waiting to be seen. Researchers (often medical students taking time out of their studies to work on the unit) diligently inputted the data onto a designated platform, and the data was used to drive the decision-making process and the perceived benefit of intervention. There was a large number of native Spanish speakers with limited English, often uninsured and without the appropriate identification papers. This did not stop their treatment or the use of outcome scores. In fact, most were also available in Spanish and most of the staff spoke the language, and if not, there were of course interpreters on hand to provide assistance.

The final aspect of UT Austin that impressed me was the value placed on research and academia. Almost every patient was enrolled in one or more of the studies run out of the unit. In fact, when the team prepared the clinic before it began, the senior surgeons were unhappy if a patient had not been enrolled into a study and went about rectifying it if they were not. Smaller clinics and units in the periphery (akin to DGH’s) were familiar with the studies, and almost all fed into the multi-sited studies. I got the impression that the local healthcare ecosystem assumed all patients were research opportunities unless proven otherwise. This positive academic culture ensured that clinicians were far more critical of their own practice, often questioning the value of what they do for patients.

During my time in Texas, I made the short trip over to see Dr Burkhart. He is one of the pioneers of shoulder arthroscopy and regarded as one of the leaders in the field. Despite his status, he works tremendously hard and for example has done the most SCR’s in the USA. He has an engineering background and actually invented many of the products we use today. He has had at times over 350 international visitors a year, so of course once I found a route in to see him, I jumped at the opportunity. I spent a few days with him both in clinic and in theatre, alongside a Brazilian and a Taiwanese surgeon. His surgical skill was of course exemplary and he made the most complex procedures seem easy. I did notice however, the tendency to perform multiple procedures in one sitting. All rotator cuff repairs for example were treated with an ACJ excision, and many partial cuff tears that would perhaps be simply debrided in the UK, were repaired. He ran a very efficient operation, and I think it was in part due to having had the same scrub nurse for many years: someone who would even know the length of suture he would like for the different parts of his SCR’s! In a bizarre turn of events he announced his decision to retire from his role whilst I was with him, which perhaps made our conversations particularly philosophical and reflective. It was a real honour to meet the man who has taught us much of what we know in shoulder arthroscopy.

I had a fantastic experience travelling to Texas for my fellowship. Whilst I found the operations I witnessed interesting, I believe I learnt a lot about the setup of American orthopaedic services, and how they are applying the concept of integrated working to their patient care. Of course, there are big differences between our health care systems, but we have a lot we can teach each other to improve the care of all patients, whatever continent they reside on.

In closing, I would like to reiterate my gratitude and thanks to the BOA and Zimmer for this fantastic opportunity.

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