Contemporary Debates in Orthopedic Trauma OTA Annual Meeting 2013

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Proposition: "Orthopaedic Trauma Fellowship Training is a Necessary Marker of Quality"

a. Pro Argument (10 minutes) – Samir Mehta, MD
b. Con Argument (10 minutes) – Phil Wolinsky, MD
c. Pro Rebuttal (5 minutes) – Manish Sethi, MD
d. Con Rebuttal (5 minutes) – Sam Agnew, MD
e. Open Microphone (15 minutes)

Disclosures

American College of Surgeons Committee on Trauma
Various OTA and AAOS committees
No financial conflicts with this presentation

Real Disclosure

I did an orthopedic trauma fellowship
My partners and I train 2 orthopedic trauma fellows each year
My partners are all fellowship trained
One of my partners- Mark Lee- is chair of the OTA fellowship committee

Literature Search

Key phrases:
Fellowship/ Fellowship training/ Quality/ outcomes
No results

What is "Quality"

Mortality rate?
Infection rate?
Non-union/ malunion rate?
Patient centered outcomes?
Number of cases per day/ time per case?
What metric are we actually talking about?
In any case- We don't measure any of these!

Issues: Metrics

We don't measure any metrics prior to fellowships: Residents come in all shapes

and sizes
We don't measure any metrics after fellowship: Fellows come in all shapes and sizes

Issues: Fellowship Structure

- Fellowships vary widely:
  - Different volume/types of cases
  - Ortho trauma does different types of cases at different places: Peds, Hand
  - Different number of attendings
  - Call responsibility
  - Etc, etc

Issues: Fellowship Education

- Not standardized:
  - Curriculum
  - Educational conferences
  - Operating room dynamics:
    - Here's your OR I'll critique you Monday
    - I wont let you do anything
    - I'll be there and let you do what I think is appropriate

Fellowship Goals?

- Knowledge/procedures those residents did not do a lot of during residency- some examples:
  - Complex peri-articular fractures
  - Pelvis and acetabulum fractures
  - Decision making for fractures attached to patients with multiple system injuries

Issues: Fellowship education:

- We don't know what fellows exposure to "sick" patients and treatment decision-making is
  - We don't collect the data
  - There is no standard curriculum

Procedure Volume

- Documented to correlate with outcomes:
  - Cardiac surgery
  - AAA

Total joints
Major esophagus procedures
Liver transplants

Cardiac Surgery

How "good" or experienced the team is affects outcomes
May or may not be applicable to orthopedic trauma training programs as well
Fellowship setting may affect education

Issues: Case Volumes

The only ACS COT VRC case data that is accurately collected
Number of pelvis and acetabulum cases
No other numbers are reliably reported
Only data that can be used as a "marker" of volume
Varies widely between fellowships
Some grads may have done 0 pelvis/tab during their fellowship

Peri-articular fx;s
We don't collect numbers
We don't know how many folks do
We don't have quality information

Volume

We perhaps could all agree more numbers of case types are good
We don't have good numbers on case types yet
OTA fellowship committee is working hard on this
The one category we do have shows very variable numbers

Other Issues

In past were a few fellowships that were all high volume
Fewer traumatologists who all knew each other
Was easier to check references,
That is no longer the case

The Fellowship Experience may be More Important Than Ever

Jobs have changed:
Solo jobs
Case difficulty may vary widely

No true peer review
Fellowship may be the last time someone is looking over your shoulder

Conclusions

I would like to believe that completing a trauma fellowship program is an indicator of quality
We do not have the data to prove that

Fellowships very widely:

Case volume
Call
Education experience
Etc etc

True Assessment of Quality

Define what we are talking about
Uniform training programs
Know where you start- metrics
Know where you end- metrics
What to do with outliers