Allocation of scarce resources in surgery

James P. Waddell, MD*

It is with trepidation that I challenge some of the assertions made by Dr. Gross in his article in this issue (page 421). I concede that policies regarding the procurement and implantation of orthopedic devices are changing rapidly and that the potential for serious problems in orthopedic surgery exists for surgeons who do not get involved with decision-making in their hospitals.

Dr. Gross expresses concern that fiscal constraints may limit the choice of technology, including the choice of orthopedic implants that may be available for patients. He expresses strong reservations about current cost-accounting methods within Canadian hospitals, he challenges hospitals to include surgeons in the fiscal decision-making process and he concludes with a personal description of the hospital in which he works and his frustration in changing the corporate culture of that hospital to include more physician input.

I challenge the assertion Dr. Gross makes that newer and more expensive implants will necessarily give superior results. The orthopedic literature is replete with case studies extolling the virtues of new, improved implants that have turned out to be significantly inferior to the ones they were designed to replace. Based on Dr. Gross's own publications regarding the importance of appropriate controlled trials to monitor the efficacy of newly introduced technology, perhaps no new implants should be introduced except in a trial setting, and the costs of these trials should be borne by the company that wishes to introduce the product.

Quite rightly, Dr. Gross points out that some of the cost of orthopedic implants may be attributed to ongoing follow-up studies, and further monies are expended on educating surgeons on how to use implants effectively and correctly. However, data derived from such company-sponsored follow-up studies is *always* viewed with scepticism by orthopedic surgeons generally (as I well know, having authored such studies). Furthermore, educational efforts by implant manufacturers tend to be directed exclusively to those implants that they manufacture and from which they derive considerable profit.

The ongoing partnership between orthopedic surgery and implant manufacturers is important and should be fostered by the Canadian surgical community. Long-term stable relationships between suppliers, vendors and health care professionals can be seen in relationships not just in surgical specialties (orthopedic surgery, cardiac surgery, ophthalmology, general surgery) but also between pharmaceutical companies and physicians who prescribe their products in a hospital setting.

Surgeons and the hospitals in which they work must develop a strategy to maximize educational events and clinical research and benefit from this relationship. Instead of looking to individual companies to sponsor follow-up studies and educational data, we should request that educational contributions from industry be placed in a central fund to be administered by an organization such as the Canadian Orthopaedic Association (COA) to support worthy projects such as the National Joint Registry, the continuing medical education activities of the COA and the Canadian Orthopaedic Foundation, and to sponsor visiting lecturers and other academic activities. Such financial benefit would then be openly recognized by all members of the surgical community and by the hospitals in which they work.

Dr. Gross notes that in the hospital where he works there is a lack of information and cooperation between the surgical staff and the administration with respect to cost-sharing and cost-containment strategies.

Fortunately, the situation in the hospital where I work is totally different. In order to meet the fiscal restraints imposed by steadily declining revenues in a time of increasing patient demand, this hospital has undergone extensive restructuring, involving all aspects of patient care. Physicians were involved in every step

*Coeditor, Canadian Journal of Surgery

Correspondence to: Dr. James P. Waddell, A.J. Latner Professor and Chairman, Division of Orthopedics, University of Toronto, St. Michael's Hospital, 30 Bond St., Toronto ON M5B 1W8

of those discussions and chaired a number of important committees relating to employee compensation, hours of work, patient flow and operating-room reorganization. As part of this exercise all surgical services now receive a budget, which includes nursing salaries, implant costs, allied health services and radiologic services. Because of their fiscal responsibility, surgeons now participate fully in decision-making processes regarding the allocation of scarce resources within their areas of clinical responsibility — salaries, implants and drugs. I am confident that such responsibility would never have been granted to physicians without the current fiscal situation that Dr. Gross finds so threatening.

Therefore, I conclude as I began: the potential harm to surgical services is great in the current situation of fiscal restraint and hospital disorganization/reorganization. However, the potential for positive change is also great, providing the right combination of physician interest, hospital administration support and industry investment is present and actively promoted.