



Knee Arthroplasty Surgeons : coping with the pressure of treating patients with high expectations

Emmanuel THIENPONT

From the Department of Orthopedic Surgery, University Hospital Saint Luc, Brussels, Belgium

Total knee arthroplasty (TKA) remains a surgical procedure delivering excellent outcomes for many patients allowing them to return to their previous quality of life. With an increasing demand stimulated by demographics and online knowledge about state of the art health care solutions, the yearly number of implanted TKAs keeps growing (3). Despite of this globally positive message TKA remains a challenging surgery not always delivering results to patients as they expected. It is the type of surgery where the patient is often asking for perfection and complications are not well tolerated (2). This puts a lot of pressure on the shoulders of the knee surgeon who tries to perform as well as he can within the given conditions of his institution. In this knee-dedicated volume of the Acta Orthopaedica Belgica we invited, as guest editor, several authors to extend on the different aspects of medicine influencing a surgeon's result or the perception of his result. Despite of the teamwork, the surgeon will be the only one responsible, facing patients or their family, in case something goes wrong. Joint registry results or patient's feed back about their TKA will only be linked to his name despite of the interaction with many other health care professionals (HCP).

Stuyts *et al* showed in their review paper on the responsibility of the different stakeholders in the prevention of periprosthetic joint infections that the surgeon clearly can't control all factors influencing his personal complication rate (7). Their paper un-

derlines exactly how all team members should understand their role in the success of the procedure and feel involved, despite of their more distant role at first glance. Rosinski *et al* showed how all health care providers don't necessarily have the same attitude towards the patients that they are treating (5). This difference can lead to conflicts within the team, where the more involved and caring HCP doesn't necessarily understands how some direct collaborators can be so disconnected. However their paper helps us comprehend how the remarkable HCP finds motivation and inspiration in his career and life, leading to a higher level of awareness and happiness. Coping with difficult situations and complications is seldom easy. Especially if the patient tries to manipulate the surgeon, not only for a material benefit, well known as workers' compensation, but also for a psychological benefit. Lavand'homme describes in her paper how the different patient personalities interact with their treating HCP and how depending on their personal needs they will continue to explain in detail how the surgical procedure

■ Emmanuel Thienpont.

Department of Orthopedic Surgery, University Hospital Saint Luc, Brussels, Belgium.

Correspondence : Emmanuel Thienpont, Department of Orthopedic Surgery, Avenue Hippocrate 10, 1200 Brussels, Belgium. E-mail : emmanuel.thienpont@uclouvain.be

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was a failure despite of the objective outcome (4). Patient's expectations receive nowadays much more attention and these should be clearly identified before the surgery. Personality traits can play a role in the expression of subjective results if the outcome is evaluated with patient reported outcome measures (PROM). We must all know the type of person lying on the beach in Hawaii with a cocktail in their hand complaining about how the sun is too hot and their drink too cold. The evaluation of a surgeon's result by patient reported outcome measures only could lead to the wrong conclusions about the overall result. Are we asking the right questions? Cobb is looking at the same issue but from a different angle concerning arthroplasty registries, which are being utilized in more and more countries (1). Obviously we should all support a close follow-up of medical devices to identify potential early failures before they had devastating effects on our society leading to human suffering and important health care costs. However as Cobb pointed out in his paper, what are we using as an endpoint and at what moment in life? In a binary system (yes/no) where revision is considered a failure, the register is limiting the options of patient specific treatment both for patients and surgeons. Unrevisable devices will have a 100% survival rate despite very unhappy patients and early death after surgery could be considered as the only guarantee for implant survival success. A register should indeed be flexible enough to evaluate the full outcome for patients and society looking at their postoperative morbidity and mortality, the functional outcome, the percentage of patients with persistent pain using morphine for the rest of their life and the ability of younger patients to return to their economical activity. All this should be offset against the cost of a primary intervention and an eventual revision later on during their life, maybe even after retirement. After all, the value surgeons bring to society by their surgical procedures should be calculated by the outcome divided by the costs of the treatment.

The challenge for this generation of surgeons will be to deliver high quality health care compatible with the expectations of their patients at a price our society can still afford. The increased demand and the exploding costs of new technologies available to everyone at any age should be evaluated critically for their efficiency and cost effectiveness (6).

The papers in this special knee issue of the *Acta Orthopaedica Belgica* give us an overview of the concerns surgeons and patients still have. Many questions remain open and certainly not all the answers are at our disposal today. Clinical research can help us solve those issues to obtain better results for our patients. We can only hope that some of the selected papers will help fulfilling patient expectations and assist surgeons in delivering the outcome they aimed for with their treatment.

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