Accreditation of residents

I recently read the editorial in the December issue of the *Canadian Journal of Surgery* (2003; 46: 404–5) and fully agree with all your comments. Current fellowship examinations are antiquated and indeed obsolete in the current environment.

A suggestion I would like to add is to take it one step further: we in teaching centres should come up with a list of the basic set of skills, to be assessed and certified by educators, that all orthopedic residents should have when they finish their residency.

The variety of procedures done nowadays in orthopedic surgery is very broad. It is simply no longer possible that after a 5-year training program, every resident be competent to perform them all. There is enough variability of training that certain residents will have different mixes of skills; these need to be documented by the different training programs. There must be some simple evaluation process that can be put in place so that these individuals can be certified that they know, more than other graduates might, how to do these more subspecialized procedures. Since fulfillment of a secondary postgraduate training fellowship may lead to the acquisition of special skills, some means of recognition of these skills is needed as well.

I think the day is gone that an orthopedic resident passes his or her exams and is qualified for every procedure in *Campbell's* [*Operative Orthopædics*]. This becomes a major problem when young surgeons in their earliest jobs begin applying to do every orthopedic procedure thinkable, even including hemicorpectomies.

Granting privileges to do certain surgical procedures is becoming a complex issue. Here in Hamilton we have tried to break down the different orthopedic procedures into some broad categories, but obviously the system is unperfected. I think we need not only to protect our patients from poorly performed surgery, but also to protect us from ourselves. We sometimes consider ourselves more skilled than we really are.

We in the teaching centres must continue striving to improve surgical education itself, as well as the certification process.

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Tibial plateau fractures

The long-term outcome of tibial plateau fracture remains unclear. Intuitively, one would expect a fracture involving significant damage to the articular cartilage to lead to the late development of post-traumatic osteoarthritis. In my own experience, however, this development has been uncommon. To study this, I reviewed the records of all total knee replacements that I have done over the past 25 years (over 3000).

I found 14 cases of total knee replacement after tibial plateau fractures (6 in women and 8 in men). These patients ranged in age from 44 to 88 years (mean 69 yr). The length of follow-up after total knee replacement was 1–14 years (mean 5 yr).

Of these 14 fractures, 4 were medial tibial plateau fractures. In 4 cases both plateaus were fractured (1 patient required knee fusion, 1 had nonunion and 1 weighed over 159 kg).

Six patients had lateral tibial plateau fracture. In 2 of these there was avascular necrosis of the elevated tibial plateau. In 1 patient, a plateau was elevated twice and there was nonunion. One patient suffered sepsis in the knee. This left 2 uncomplicated lateral tibial plateau fractures, and of these 1 had occurred 37 years before the knee replacement.

Revision of the knee replacement was required in 3 patients: 1 for tibial wear, 1 for a loose tibial component 10 years postoperatively and 1 for undiagnosed pain. The results are currently good or excellent in all patients except the patient with fusion takedown, who gained only 35° of flexion, and the patient with undiagnosed pain.

My study suggests counterintuitively that tibial plateau fractures, especially those of the lateral tibial plateau, seldom progress to total knee replacement unless there are surgical complications.

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SESAP question inaccurate

I would like to bring to your attention an error that has been transmitted through the SESAP question published in the February 2004 issue of *CJS* (*Can J Surg* 2004; 47: 56). The answer suggests that there is no role for the use of corticosteroids in reducing mortality related to acute acute respiratory distress syndrome (ARDS); the supporting reference is a textbook from 1997. I would direct readers to a more recent (though not new) randomized controlled trial of high-dose corticosteroids in ARDS.[1]

To put the data in perspective, Canadian authors have also published a review of the topic.[2]

The correct answer should be B.

The SESAP questions are a good way to incite interest in a topic. However, in our current information explosion it is important for readers to question references, especially textbooks. The current series in *JAMA* of Users' Guides to the Medical Literature is a useful aid in this evaluation. Participation in the online learning tool, Evidence Based Reviews in Surgery, available through the Web site of the Canadian Association of General Surgeons (http://cags.medical.org), can also help surgeons evaluate the evidence and support best practice.

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Outreach multi-beneficial

I read the article by Dr. Mark Burnstein about his experience with surgical outreach clinics with interest. In it he commented that specialist outreach clinics should be a "win–win–win situation." Let me add my enthusiastic endorsement.

The Maritime provinces have a lengthy history with surgical specialists' outreach clinics, particularly in pediatric orthopedics. Such clinics have been a continuous part of our delivery of care for 75 years. I myself have had 30 years' experience with such programs in a variety of centres. The periodic presence of the surgical specialist outside the referral area of major academic centres has many benefits for patients, especially for evaluation and follow-up. The savings to this population in travel and lost work time are huge.

Patients are not the only beneficiaries; surgical trainees, for example, profit from community exposure. Less well defined gains can include connection with patients and with their communities, introducing a more realistic appreciation of the resources (human as well as facility) available there. Contact with community physicians also creates opportunities to undermine the too-common perception of "ivory tower" specialists.

As noted by Dr. Burnstein, these clinics are time-intense and require consultants to be absent from their home institution, where their inability to be on-call adds to the burden on coworkers. But there is really no other downside to community outreach. Full-time equivalents adequate to provide outreach services must be incorporated into human-resources planning in the various disciplines.

Integrating continuing medical education into such outreach programs is an obvious opportunity, and doable. Surgical departments today should consider specialist outreach programs an integral and important element of their educational responsibilities as well as of their services.

Based on our Maritime experience, these programs definitely are a win–win–win situation.

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