



Commentary on A Lack of Leadership Often Has “Unintended Results”

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Acknowledgement: Bruce Shepherd, MD, and John Harrison, MD, NSW, Australia (True Leaders)

Abstract:

Leadership has been described as the “process of [social influence](#) in which one person can enlist the aid and [support](#) of others in the accomplishment of a common [task](#)”.^[1] Many have tried to define leadership and the qualities that make a Leader. One

critical factor to recognize is the lack of leadership and the unintended results caused by this lack.

This paper will reflect on my observations and opinions as to current situations and conditions in the orthopaedic health community as a result of a lack of leadership.

Introduction:

A leader is a person who influences a group of people towards a specific result. It is not dependent on title or formal authority. Most cannot define what makes a leader but they say they recognize a Leader when they see one. Some say Leaders are born other say Leaders are defined and groomed by a process, if you have the will, self-study, education, training and experience you can become a Leader.

This is a look at the current conditions. We find the overall orthopaedic health care community and some observations that brought us to these conditions.

This is an account of some of the experiences from my 41 years in this business of orthopaedics. My career started as a Naval Corpsman in 1969 and working continuously in a variety of positions from Corpsman, Orthopaedic Technician, Independent Sales Representative, Associated Distributor, Director of Marketing, V.P. of Sales & Marketing, V.P. Clinical Surgical Development. President & CEO of a Medical Device Company, Executive

Director of a non-profit scientific and education foundation, member of a number of professional societies and founder of a IP development company.

These are my own opinions and do not represent endorsement by the JISRF Board or any other individual or organization.

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Review

The reputation of the orthopaedic surgeon has been tarnished, and the reputation of the orthopaedic device industry has been tarnished. Surgeon fees have declined, sales prices for implants are under attack and eroding, funding for research is down, funding for CME activities are down and health care employee unemployment is up. Patent development costs are up, product development costs are up and regulatory costs for new product introduction is up.

What has put us into this current situation, in my opinion, the lack of Leadership. However, we still have time to turn things around.

Obviously, there was a serious problem as perceived by the United States Attorney's Office (USAO). In New Jersey in March 2005 they issued subpoenas to the five largest orthopaedic devices manufactures (S&N, Stryker, Biomet, J&J & Zimmer). The subpoenas requested consulting contracts, professional service agreements, and remuneration agreements between the respective companies. Subpoenaed were orthopaedic surgeons, orthopaedic surgeons in training, even medical school students using or considering the surgical use of hip or knee joint replacement or reconstruction products made or sold by the companies for the period beginning January 2002 through March 2005. This investigation has been ongoing and other companies have been added to the list. Major R&D projects were put on hold, CME activities were not supported to the same level and the cost of compliance increased significantly. Companies paid fines to avoid prosecution and agreed to supervision by monitors, many surgeon contracts were cancelled. Many of these agreements, although legal by contract law, were now deemed to be against public policy (USAO) which basically supersedes contract law.

Now we find a large group of surgeons faced with declining fees, cancellation of consulting agreements and faced with question of how are they going to supplement their income? The creation of a new business model Physician Owned Distributorships (PODS). On top of all this, the orthopaedic health

care community is now faced with the largest orthopaedic device recall ever "ASR™ MoM Bearings." This could easily cost over two billion dollars to resolve all the potential claims.

This has placed serious concerns about the competence of the device industry, the FDA (all regulatory bodies), and the orthopaedic surgeon community as to their ability to evaluate and determine appropriate technology for their patients. This is all fuel to both the media and the legal community.

So where do we see the leaders within the orthopaedic community? Are they standing up and providing the encouragement to take a stand to help set things right? There is, in my opinion, some promising activity supported by the American Association of Hip and Knee Surgeons "AAHKS." Dr. Richard Santore and the Leadership of AAHKS have stepped up their activity and, every year at their annual meeting, present significant information to the membership at large. I encourage all total joint surgeons to become members and support this group and their activities.

Current Trends

Times are different, we all need to stay involved and participate in the process. One step we can do to reduce legal exposure is full disclosure. As a general rule, if you are afraid to disclose you probably should not be doing what you are doing. Failure to warn can be one of our greatest exposures.

Be aware, public policy established by the Justice Department is overriding contract law. Ethical standards are being dictated by the Justice Department not by professional societies. The health care field, in particular physicians, can no longer play by the same rules that govern other inventors and developers of technology.

There are now restrictions of payment of royalties, restrictions on stock options, restrictions on ownership, restrictions on travel and entertainment.

Beware, so-called watch dog groups are out there looking for controversy. Also with society facing run away health care cost, the Government and Insurance industry want to downgrade your (surgeon & inventors) activities, education, and experience to “generic.” In this way they can justify keeping fees and implant prices down. If they can state there is do difference in surgeon quality or implant quality then pricing structures can remain flat. This tends to be short sighted and can and will contribute to long-term increase in health care costs.

Negative exposure at all levels of society has put the credibility of private health care at risk, “Doctor bashing” is in vogue.

There are groups that are seeking to shut down the relationship between physicians and industry. One such group is ProPublica, they are tracking the financial ties between doctors and medical companies. It is not hard for some of these groups to take information out of context and present a negative image.

Example of some titles of their reporting:

Emails Show Drug Company Used Third-Party Medical Groups to Influence Regulators, Undercut Rivals

by [Marian Wang](#)

Spending: Shuttle bus ads

[St. Jude, Inc.](#)

[Medtronic](#)

[Boston Scientific](#)

[Boehringer Ingelheim Pharmaceuticals, Inc.](#)



\$50,000

\$50,000

\$50,000

\$12,500

Total: \$162,500

ProPublica, May 25, 2:30 p.m.

Reports Detail More Drug Industry Ties to Medical Societies

by [Nicholas Kusnetz](#)

ProPublica, May 20, 12:58 p.m.

Medical Schools Plug Holes in Conflict-of-Interest Policies

by [Charles Ornstein](#) and [Tracy Weber](#)

ProPublica, May 19, 1:01 p.m.

This kind of scrutiny is not limited to the orthopaedic device industry:

Cardiac Society Draws Bulk of Funding From Stent Makers

by [Charles Ornstein](#)

ProPublica, May 13, 1:27 p.m.

Financial Ties Bind Medical Societies to Drug and Device Makers

by [Charles Ornstein](#) and [Tracy Weber](#)

ProPublica, May 5, 9:48 p.m.

How the Heart Rhythm Society Sells Access

Recent Heart Rhythm Society Annual Conference
May 2011

Spending: Johnson & Johnson exhibit spaces/lounges

\$275,000

[Educational support](#)

\$36,000

[Banner ads](#)

\$25,000

[Newspapers](#)

\$20,000

[Glass clings](#)

\$15,000

...and more...

Total: \$386,750



➤The Heart Rhythm Society's annual conference is a marketing bonanza for drug companies and medical device makers. Last year, firms spent \$5 million festooning the conference with ads and on exhibits, sponsorships or educational grants.

"This style of reporting is not in the best interest on anyone but the special interest so-called watch dog groups that they themselves benefit financially."

McTighe

Many states have moved to pass bills restricting pharmaceutical and device marketing including limiting funding to continuing medical education (CME) activities.

Now some states are concerned that there has been an overreaction and there is a movement to repeal some laws.

Massachusetts House Votes Overwhelmingly to Repeal the Code of Conduct AKA the "Gift" Ban

➤Enacted in 2009, the Massachusetts "gift ban" has been a controversial piece of legislation that has had significant impacts on the pharmaceutical and medical device industry in Massachusetts. After going into effect on July 1, 2009, the Massachusetts (PCOC) required the reporting of payments of more than \$50 made to any health care practitioners by industry. Payments were then published on the states website in late November, 2010.

Violations would carry a penalty of \$5,000.

➤As the [Massachusetts Restaurant Association](#) (MRA) noted, the current **law prohibits** a pharmaceutical or medical device manufacturer agent from **paying for meals** that are offered, consumed, or provided outside of the health care practitioner's office or hospital setting. **These companies are not allowed to hold educational and informational presentations in the restaurants that are surrounding the hospitals.**

➤Accordingly, MRA recognized that the **"misabeled 'gift ban' has been devastating to restaurants and thousands of middle-class employees," in Massachusetts.**

In my 41 years in the orthopaedic health care field and having my share of dinners discussing hip and knee technology, I cannot recall any surgeon using my device as a result of a dinner. In fact, since most hips and knees have good to excellent outcomes, 90-97% results at 15 years, I find the lead time to get a surgeon to change to a new device is about 1-2 years. Maybe I have not taken my surgeons to the right restaurants. *McTighe*

➤Increased cost to all health care companies in the formation of compliance personnel.

➤Decrease in innovation in significant high technology devices.

➤Decrease in commercial funding for CME Activities.

With respect to the number of CME activities which received commercial support:

- In 2010, 68 activities received commercial support vs. 145 in 2008
- In 2010, 26 of these activities would have been solely supported vs. 48
- In 2010, 42 activities would not have been offered without commercial support vs. almost all 48 programs in 2008.

➤Commercial support is down from ave. of 58% to 28%.

Once commercial support is reduced, schools and centers can no longer support the resources or staff necessary to offer adequate or similar programs to faculty, staff, and surrounding community health care professionals.

If commercial support continues to decline, and the number and kind of CME courses continues to decline, America's leading medical schools and centers will face significant problems training and educating our health care professionals.

With a growing population, and increasing number of elderly and sick, America needs "a workforce of competent health professionals" that can use and learn the best health care practices that effectively cure and prevent disease and promote well-being.

In order to achieve this success, an integrated system of interaction between the medical industry, private practice providers, academics, insurance industry, and, yes, the government need to pull together.

Past practice of greed and corruption should not take away the necessary incentives to encourage collaboration and cooperation between all stake holders.

What is necessary is Leadership at all levels. Complacency has been the most significant problem, we must all strive to stay involved and encourage our colleges to get involved or support those that do.

Sitting back does not help anyone. Get involved and stay involved.

Now lets take a look at "PODS"

Tom Donaldson and I had a stimulating debate on this subject at his recent meeting: Update in Hip and Knee Arthroplasty & Bearing Surfaces
September 7-9, 2011, Mammoth Lakes, CA

Physician Owned Distributorships "Caution is called for"

Fact: They are controversial but are they legal, and if they are, should we be encouraging their use?

I would direct interested readers to a recent article by Douglas W. Jackson, MD, in the September 2011 OrthoSupersite. His article touches on many of the points that we have raised.

First lets look at the controversy. Five U.S. Senators asked the Inspector General of the Department of Health and Human Services to open an investigation into the legalities of physician-owned distributorships. Middleman entities that allow surgeons to profit from the medical devices they use on their patients.

The Senate Finance Committee is concerned on the proliferation of such entities in spine and orthopaedic surgery. The concern has to do with creating "financial incentives for physician investors to use those devices that give them the greatest financial return," they may violate an anti-kickback statute and other federal fraud and abuse laws, the report warns.

Remember the Justice Department has already ruled that it is against public policy for physician inventors to be paid on their inventions used by them on their patients. With that understanding, why would any physician think it would be proper to receive commissions, dividends or any kind of financial payment on product that he sold to his hospital and then used on his own patients? We are not the only ones that think this action is very questionable.

A recent quote by Tom Scully a senior counsel at the law firm Alston & Bird who headed the Medicare program from 2001 to 2004. "You can't possibly think this is OK." "I understand that the docs feel squeezed and want to make more money, but they're racing toward a cliff. This can't possibly hold up."

Some physician owners argue that they have a legal opinion and they are safe. Many lawyers are not sufficiently sophisticated or knowledgeable about the nuances of the Anti Kickback Statute (AKS) to render a reliable opinion. Others are willing to tell their clients what they want to hear.

Who gets in trouble if your legal opinion is wrong? Not the lawyer, you the Physician "investor" are held accountable.



Lets look at the argument for PODs. Physicians say they want to save their hospital money!

The impression “image” for and against

They can save money and cut the fat

What fat? Implant prices are falling!

Surgeon fees are down we need to make more money!

The impression PODs are a kickback

The truth is usually in the middle

Not all PODs are created equal

Which side of the argument do you want to be on?

The only favorable argument for involvement is that they may save money for the hospital. The Justice Department does not care if they save the hospital money. Their primary (AKS) concern raised by PODs comes from the financial incentives received by physician investors to use a particular manufacturers' products, not from an incentive to refer patients to a particular hospital.

Why Take The Risk?

The AKS carries both criminal and civil penalties, including fines of up to \$50,000 per violation, damages of three times the amount of remuneration paid, and imprisonment for up to five years. Violations also may result in exclusion from Medicare, Medicaid and other government health care programs.

When it comes to this type of investment surgeons should consider the way they think about new hip and knee technology. What are the risks and what are the benefits long term, not short term. There are more than enough examples in the public media that have demonstrated very negative consequences for these types of activities.

Facts to consider

Government workers that perform these audits make considerably less money than the physicians under review.

Have you ever gone through an IRS audit and won?

Why would you want to exposure yourself to this?

You are not only putting yourself at risk you are exposing the health care industry and your colleagues!

In my opinion, if a physician wants to get into the medical distribution business he should do it outside his community, this reduces any risk of influence on his behalf. *McTighe*

Now lets look at another troubling potential concern. Insurance carriers having more of a say in determining health care technologies. Many of us already think the health care industry is too involved in medical decision making. These companies are, for the most part, for-profit and even the non profit organizations need to make money to stay in business. Tom Donaldson and I know first hand about non profits since we both run our own foundations. They don't run on good intentions they need money just like any business entity.

Insurance companies are already challenging reimbursement for new technology.

In the United States we are faced with hospitals by passing surgeons and dealing directly with implant companies on bids and contracts. Since increasingly more surgeons are becoming employees, they have less authority on technology selection at their institution. We are now seeing the CEO, CFO and Purchasing Managers receiving significant financial compensation if they are successful in getting reduced pricing in place. Often these decisions are contrary to the wishes and desires of the surgical staff. Who is responsible for the selection of technology if something goes wrong? Does the orthopaedic surgeon have an indemnification clause in place and has he warned the patient as to the selection process of the technology used during their case?

We are starting to see in South American the surgeon being removed even farther from the decision making process. There is a growing trend for device companies to be negotiating directly with the insurance carrier. So as the patient sees their surgeon, they present their insurance card, and the surgeon and hospital can only use what is directed by the insurance carrier.

Where is the Leadership that is allowing this to happen? Some larger device companies are partial this process, they can "bundle" products together and not have to worry about maintaining advanced technology. They are not selling advance technology they are selling commodities.

Here is a recent news release and, on face value, can be very misleading:

Orthopedics This Week (National Trade), October 3, 2011

"Insurers Making Own Hips & Knees?"

http://ryortho.com/largeJoints.php?news=1471_Insurers-Making-Own-Hips-and-Knees

By Biloine W. Young

Three Australian health insurers have teamed up to develop less expensive generic hip and knee replacements. Company executives believe this will eventually cut their growing prostheses costs by \$1 billion a year. The developers are basing the design of the generic hips on older products and selling them for 20% to 25% less than rival hips—a saving of around \$2,480 per device.

The three health funds, Medibank Private, BUPA and Australian Unity have provided 90% of the capital funding for the new prostheses company, called Joint Research, to develop the generic hip and knee replacements.

Medibank Private Managing Director, George Saviddes says the number of hip and knee replacements will increase in coming years as the population of those older than 65 doubles while the number of people older than 85 quadruples. He expects that, in the next generation, people will be using an average of three of these devices in their lifetimes. "When you add those three things together, it's looking like a very steep curve. But we have an opportunity to do something about it," he says.

Saviddes calculates that if out-of-patent equivalent joint replacements can gain one-third of the market, his health fund will save \$100 million a year. Within ten years the three health funds could be saving \$1 billion a year which would help keep insurance premium costs under control.

The Australian health safety watchdog, the Therapeutic Goods Administration, has approved two of Joint Research's generic hip devices. One is cemented and the other is cementless. The cemented generic hip is based on the off-patent Exeter hip which was developed more than **40 years ago**. Joint replacement registries show it has one of the best long-term histories of clinical success. Since the hips went on sale in August, Joint Research has sold 250.

First it sounds like the insurance carries have an active role in this company. This group also has some private surgeon investment money. It is my understanding that the surgeon investors are not involved with the intent to be paid on product that they implant in their own patients. However some of these surgeons have received severe media criticism and they wish they never got involved. Also it is my understanding that past management went through some of the initial investment with little performance to show for it. Lesson learned here is if it sounds too good or too easy it usually is not a good idea.

They also state part of their product selection process is to use product-off-patent that has been around 40 years. Well, I have been in this field for 41 years. It is my opinion that hip and knee total joint surgery has been the most significant procedure development in modern times however, there is not a 40 year old hip or knee that is as good as our current technology. If this statement were true it would be remarkable to say the least.

I had a 1965 Ford Mustang and although it was a good car and one I enjoyed immensely it does not meet the standards of today's cars. I still have a 1978 Honda 750 motorcycle. It is still a fun bike and safe but it does not have the features of today's cross country motorcycles.

The aerospace industry has evolved, manufacturing technologies have advanced, medicine, biologics have advanced, electronics have advanced. Does anyone really think that total joint devices from forty years ago are better than current technology. Lets look at the profile of the typical total joint patient. Today's patient expects and demands more. The life style and activity level is much higher than the patient profile from forty years ago. We can and are building better devices than what was produced in the past. We can also make these device last longer and do less tissue damage so real health care cost associated with revision surgery came come down.

This makes me wonder about the real issue Leadership!

Individuals can effect significant change. We just experience the passing of one of the most significant leaders in recent history, Steve Jobs, Founder, Leader and innovator of Apple products. Here was a man that never said lets except 40 year old technology. He demanded the best and brightest to rise to this call and he defined features and benefits. He made industry more productive he made society more productive and he did not worry about building the least expensive product. He knew the best method would be costly but would, in the long run, out produce the "me too" products and pay for themselves.



The following is going to highlight two orthopaedic surgeons that have demonstrated their leadership to protect not only their chosen profession but the larger calling of their profession, to protect their patients.

Dr. Bruce Shepherd and Dr. John Harrison both of Sydney Australia and both past Presidents of the Australia Orthopaedic Association.

Bruce Shepherd first came to my attention in 1987 at the AAOS Annual Meeting. My dear friend and the Founder of JISRF, Professor Charles O. Bechtol, was attending a dinner I was hosting for our S-Rom Total Hip Study Group Members. Dr. Bechtol and Dr. Shepherd became fast friends, it the beginning of a wonderful 25 year relationship. Bruce was, and still is, larger than life. Not only was he committed to the advancement of total joint technology, he was also very concern with the movement of the Australian health care system into a medicare movement.

Bruce has been described as a lone figure arguing that Medicare was the beginning of the nationalization of the medical profession with a resultant explosion in medical costs. Bruce has continued to campaign against government controlled health system with its waste and lack of empathy for patients.

The sign of this Leader was to create organizations and put himself at the head to get these organizations off the ground. Some of these were the Shepherd Centre for Deaf Children and Their Parents, The Forum for Deaf Education, The Australian Doctors Fund, The Australian Society Of Orthopaedic Surgeons and the Council of Medical Procedural Specialists. Other organizations which he paid a significant role as President were The Australian Orthopaedic Association, The New South Wales Branch of the Australian Medical Association and the Federal Australian Medical Association.

To this day, Bruce Shepherd has managed to preserve a reasonable amount of clinical freedom for the medical professional.



A quite moment shared with Allen Turnbull and Bruce. Allen refers to Bruce as his father of orthopaedics.

The Shepherd Centre, NSW, Australia

The Shepherd Centre was founded in 1970 by Dr Bruce Shepherd AM and his late wife Annette. Both of their children were born profoundly deaf and at that time there was no suitable program in Australia for teaching deaf children to speak.



Bruce and a couple of his students from the Centre.



The Australian Gang celebrating Bruce's 75th B'day. Left to right: Allen Turnbull, Bill Walter, Bruce, me, Warwick Bruce, John Harrison and John Ireland below center. All great men with a common denominator, their love and respect for Bruce Shepherd.

2010 marked the 40th anniversary of the Shepherd Centre. The Shepherd Centre has helped over 1,500 children for over 40 years. 70% of children enroll in The Shepherd Centre program before they are 12 months old.

Bruce's first Charnley Hip June 1, 1970 at Auburn Hospital.



Bruce went on to perform several thousand THA over his career. But that first one stand out in his memory.

Bruce began his leadership in CME activities by being asked by the AOA in the late 1970s to chair a course on joint replacement. He invited Sir John Charnley from England and Mark Coventry, Chief of Surgery at the Mayo Clinic. This lead Bruce and John Harrison to an overseas orthopaedic tour.

During the 1980s, Bruce took on the Australian Government with regards to their overreaching in trying to control the orthopaedic surgeon.

By 1984 Bruce and a number of colleagues were successful in getting roughly 500 doctors to resign from the public hospitals. This grew to over 1,500 by 1985. In the end the Government agreed to repeal legislation controlling doctor's fees for private patients in public hospitals and elsewhere. In addition, the Government agreed to establish a Medial Services Committee. The committee would be composed entirely of medical officers and would be consulted by the Health Minster concerning all changes relevant to medical practice in public hospitals.

Our orthopaedic surgical societies can learn by reviewing these recent struggles in Australia.

Bruce went on to serve as President of the Australian Orthopaedic Association. On May 25, 1997 we performed our first S-Rom® total hip arthroplasty together at Baulkham Hills Hospital. Bruce was instrumental in establishing training of the S-Rom system and that hip still enjoys significant success Down Under.

Bruce was instrumental in my career as was John Harrison and all the orthopaedic gang. Bruce was a co-inventor with me on a proximal modular stem and we received patents back in 1997.



(Modular Prothesis: Co-Inventors: Timothy McTighe, Bruce Shepherd et al., Number: 5,653,765.)

Bruce was very instrumental in the success of the S-Rom® and overall success of Joint Medical Products Corporation. Many changes to instruments and implants came about because of the surgical / clinical input from Dr. Shepherd. In the 1980s, under contract law companies could establish a royalty agreement to a surgeon for his contributions even if he was not part of the original creation of that device. I offered Bruce a royalty contract because I felt his contributions were significant. He replied "Tim I like the S-Rom and use it because of its merit, I don't want to be accused of using it because of a contract."

He also wanted no payment on his contribution to the patent on our Modular Prosthesis. He was and is a man of true character and knows the overall responsibility he had to use the best possible technology for his patients. This is not to say he does not enjoy investing and making money, Bruce is a capitalist and we both have made some investments together, and made money. However, he never got caught up into the fray of royalties of consulting fees. He was always a surgeon first, politician second and investor was last on his list.

John Harrison

John became another strong leader following in the footsteps of Bruce Shepherd. John was another friendship brought about by my relationship with Professor Bechtol and Bruce Shepherd.

This relationship also goes back to the 1980s, I have watched John support Bruce in his political fights and also in his commitment to continuing education and the advancement of orthopaedics.

John started his medical career at the Royal North Shore Hospital Sydney in 1970 and still practices at Baulkham Hills Hospital in NSW, Australia. Since 1987, when I started traveling to Australia, I've had the pleasure of being in that country about twenty times in the last twenty-four years. I don't ever recall a trip where I did not see and spend some time with John.

John has always been interested in sports, his two loves of water polo and Rugby. John was a goalie for the National Australian Water Polo team at the 1968 Mexico Olympics.



Once again, John helped out with the 2004 Olympics for three months as Honorary Manager and Doctor with the Australian Men's Water Polo team, pre Olympic competitions in the United States and Europe. He was also an honorary official at the 2004 Athens Olympiad.

John still enjoys getting into the water and competing, 2009 World Games both in the water and having a discussion with one of the officials.



John rose to the President of the Australian Orthopaedic Association in 2005. To my pleasure that was the same year I was invited to become an Affiliate Member of the AOA.

John and his lovely spouse Deb visiting in 2005 before the AAOS meeting in Washington, D.C.





My wife Cathy and I celebrating with John at one of the many B'Tie functions during his Presidency.



John was taking this picture at the combined AOA & NZOA in New Zealand that year. We were lucky to have Dr. Robert Bourne (President COA) and his wife, and dear friend Sam and Mary, with Debbie, Cathy and myself.

I point out some of these photos and activities because of the overreaction from the Justice Department Probe and the restrictions that are being placed on the health care community. This professional community is having unfair burdens placed on its many members and contributors to a better humanity. Doctors, nurses, scientists and industry colleagues are professionals that work unbelievable hours and often are never compensated for some of those hours. You become friends with mutual professional goals to make a difference. This is a difficult way of life and, yes, there are many



benefits that come to professional successful individuals. We socialize together, what is wrong with that. Even at social functions you can't get a group of surgeons together that some of the talk doesn't come back to medicine. "I have that infected hip how are you treating your patients?"

The point of this commentary about Leadership is we need to demonstrate to our younger colleagues that they need to be part of the system. We need to encourage and acknowledge those who are willing to stand and be heard. We are not all Leaders so we need to support and foster leaders. We need to challenge decisions that place undue risk on our patients, colleagues and our profession.

Where is the proof that the government, or for that matter the legal profession, has a better track record on standards of behavior than the medical profession? At least the medical profession has a code of DO NO HARM.

The legal profession teaches there is merit in **frivolous activity**.

I challenge our Professional Societies to establish guidelines on Physician Owned Distributorship and not to wait again for the legislature branch of government or the Justice Department to make decisions that should be down at a local professional level.

We can learn by example from around the world. That is why I bring attention again to the current events within the Australian Orthopaedic Association. They have become a Leader in their Joint Registry and now are leading once again to control more of their profession.

I have great respect for the Australian Orthopaedic Association and believe they are currently demonstrating the necessary Leadership to have more control and reduce outside influences on their profession. I encourage all to follow their journey as a model of involvement.



AOA–RACS Relationship

Preface

I believe that the time has come for orthopaedic surgeons to determine their own professional future. Orthopaedic surgeons, represented by AOA, are ideally placed to make decisions about their own training and education program and manage the program without inappropriate red tape or intervention from others outside the orthopaedic profession.

Our current arrangements with the Royal Australasian College of Surgeons (RACS) where the final say lies with RACS committees and the RACS Council in a rigid system does not allow for this kind of self-determination. Our attempts to resolve this situation with RACS are revealing the potential for solutions, which may be satisfactory for all parties.

Within this framework, I believe that it is both professionally and legally possible for AOA to determine the nature of training, education and credentialing of specialist orthopaedic surgeons without leaving the RACS family of specialist and general surgeons. That for many members may be the most desirable position.

The information uncovered through AOA's Due Diligence process tells us that such autonomy,

through direct Australian Medical Council (AMC) accreditation, does not have to result in separation from RACS, although it would lead to a different kind of relationship—one based on cooperation rather than authority. However, RACS believes that direct accreditation is tantamount to separation and that is their current position.

My job as President of AOA is to lead the further growth of our specialty and to work to get the best possible outcomes for our profession. I do not believe that it is in our best interests for things to stay as they are.

We also acknowledge the aspirations of others and have met with the leaders of the other RACS surgical

It was pleasing to be able to have direct dialogue with RACS on this important matter at the meeting of AOA and RACS Council Executive members which occurred on 7 September 2011 and a program of continuing dialogue is expected to continue. That meeting was positive and professional and clarified our respective positions. Although seeking AMC accreditation remains on the Board's agenda as one of a range of options, it was mutually satisfying to find both AOA and RACS agreeing to explore sensible alternatives that aim to meet the needs of both institutions.

For the past three months, since the Due Diligence process was completed, we have been actively seeking the views of members on our options for change. Many of you have sent in letters and submissions, the majority of which are now reproduced in this publication. We have presented a number of options and discussed them with many of you at Branch meetings and conferences, and we will continue to consult widely throughout September.

As you know, the Board will meet at the beginning of October to consider the matter and your preferences will play a big part in our deliberations.

We are gauging members' views through a plebiscite (first mooted by me at the Queensland Annual General Meeting a year ago) that is open not only to full voting members but also to associate members



and to registrar affiliates. We are not simply interested in the numbers, but also in the spread of views across the membership. For the first time, younger members have the opportunity to make a significant difference to their own future.

Our profession is a broad church and I expect that views will differ. Professionals do what is best for those in their care ahead of themselves, and I do expect you to put the best interests of your profession ahead of personal feelings or fears.

I urge you to participate in the plebiscite. The decision about direct accreditation and our future relationship with RACS is not yet made, despite rumors to the contrary. Please think carefully and make your views known to the Board through this plebiscite. Your responses are fundamental to the journey ahead.

Bill Cumberland AOA President

Note: Lead by **Bruce Shepherd**, John Harrison, Allen Turnbull and many others were all calling for a separation from the Royal Australasian College of Surgeons (RACS) and called for a vote at the AOA meeting in 2008. Again, Bruce has taken on controversial roles and history has shown him to be right on target.

Does this ring true today?

Private Medicine Under Siege.

"At the present time throughout _____ the private hospital system is threatened by the recent denial of proper rebates to patients undergoing private treatment by Medicare. As a consequence doctors who work in the private system are threatened. General Practitioners in all areas are struggling because there are too many and they are under-rewarded. It is the stated intention of the Federal Government that they set up a salaried service in competition to general practice and by the same unfair subsidization that now occurs in the hospital sector will be able to squeeze private general practitioners. I fear that this may occur to such a degree that these doctors in desperation will

seek salaried employment by the State. Is the federal A.M.A. doing anything about this?

This is part of a reply letter from Bruce Shepherd to the Australian Medical Association September 1987 when the Federal AMA accused Dr. Bruce Shepherd, President Elect of the N.S.W. Branch of the AMA of destabilizing the A.M.A.

Being a Leader is often very difficult and at the time not very rewarding. Another area of Leadership by Bruce was the Medical Indemnity Crisis.

"At the close of 2000 Australia's largest medical indemnity insurer, UMP, concerned about its depleting reserves and future liabilities, put a pay up call on its doctor members equivalent to an extra 100% of their 2000 premium. For Obstetricians and orthopaedic surgeons, this was the equivalent of \$44k extra in insurance costs."

"Seeing no resolution to the problem, the Chairman of the Australian Doctor's Fund and former AMA President, Bruce Shepherd, spoke publicly regarding the personal toll litigation was having on his colleagues. "The threat and experience of unjustified litigation is something that many doctors never recover from, and the patients become the losers'.

"We hear a lot about the cost of medical treatment, but there is a deafening silence when it comes to the staggering cost of defensive medicine driven by the fear of litigation" - (BDS 03/26/02)

Bruce Shepherd has not been publicly recognized for his contributions to Tort Law reform but those around and students of this Leader know and can affirm his influence. *Stephen Milgate, 11/18/09 & Tim McTighe*

Bruce did not wage these fights alone but he is credited with being the Leader that went up against the Health Ministers of the Hawke Labor Government that was trying to nationalize the medical profession.

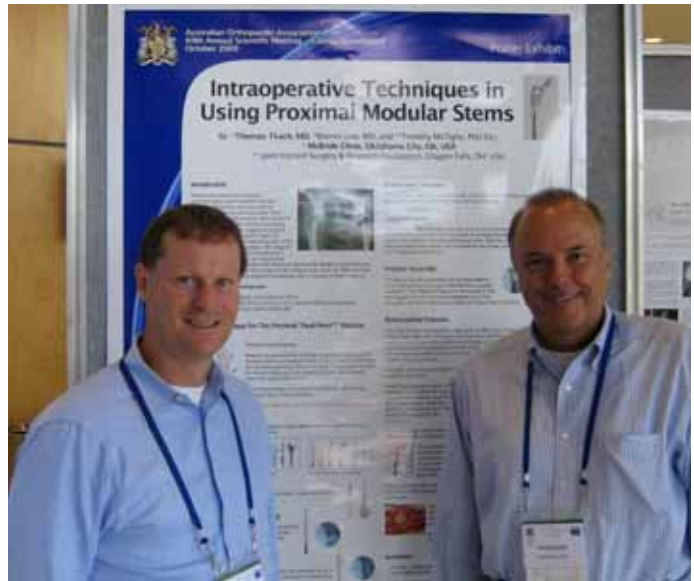
I consider myself a student and friend of Bruce Shepherd. He has influence many aspects of my life

and I continue to learn by reflecting on his actions and character.

Bruce presently resides in Bowral, in the Southern Highlands of New South Wales with his wife, Jennifer.

Bruce's story is one of triumph, of sadness, of achievement and failures; achievements that have lead to Australia being pre-eminent in the care of deaf children throughout the world and an achievement that has maintained an independent medical profession in Australia giving a service at least equal to any other country in the world.

Make a trip to go and visit one of the great places in this world and tie your trip into a visit during the Australian Orthopaedic Association annual meeting. You will never regret the experience.



Tom Tkach and myself presenting a poster on Intraoperative techniques for a proximal modular THA Stem.



During the 2009 AOA meeting a stop off at the Sydney Opera House.

A small traveling group from the States: Ron Emes, myself, Tom Tkach and Brad Vaughn.

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