SPINE SOCIETY OF AUSTRALIA

PRESIDENTS REPORT 2008/09

I have now almost completed my first year as president of the spine society. It has certainly been a busy year, not least because these are challenging times for the spine society and because its potential role is changing. We need to consider carefully if we want change, and if we do change the way the society operates then constitutional reform is required. This clearly needs to be the subject of substantial discussion within the membership. I hope that this discussion can go on over the next 12 months.

The society was formed in 1991 after adopting the rules of the previously existing Facet Club. The Facet Club in turn was formed by a group of orthopaedic surgeons with an interest in the surgical management of spinal conditions. Since then the society has welcomed into its ranks neurosurgeons, basic scientists, and non surgical physicians and our society is much stronger because of this diversity. Our roots however are still surgical. This is relevant because to a greater or lesser degree our parent surgical specialties have, over the years since our inception as a society, been less supportive of spinal surgery and spinal surgical expertise than many would have liked.

As an orthopaedic surgeon I can say with some authority that this has been the case with the Australian Orthopaedic Association. I can say with much less authority that this has at least been the case in the past with the Neurosurgical Society of Australia. The last time the Australian Orthopaedic Association put on a continuing education meeting for orthopaedic surgeons in spine was in 1992. A low point in the relationship with the Australian Orthopaedic Association came in 2003 when the AOA refused a request from the Spine Society of Australia to make CPD points available to orthopaedic surgeons to attend high quality international spinal meetings such as NASS, ISSLS, SRS, and CSRS. Also during this time there was a decline in the number of young training orthopaedic surgeons who had an interest in training in spinal surgery. Simultaneously, I am told, as least in the early period since its inception, the neurosurgical society had concentrated largely on non spinal matters in its annual meetings, whilst at the same time neurosurgeons began to do more spinal surgery. The reason for mentioning this is that the executive of the Spine Society of Australia, and a number of our senior members has become increasingly concerned about education in complex spinal surgical training in Australia.

Societies such as ours do not form unless there is a vacuum to fill and I suspect that for surgeons, at least, spine societies form to fill an unmet need for multi disciplinary knowledge about basic and clinical sciences relevant to the spine. Spine Societies have formed in most developed countries around the world, presumably because there is an international unmet need for this type of cross disciplinary body. One of our reasons for existence is that each surgical group can learn, not only from our non surgical members, but from each other. It seems clear to me, at least, that we are heading towards the creation of a separate discipline of spine surgery in the future. How this should involve the Spine Society of Australia is of course unclear though there remains a potentially important role in this process for a multidisciplinary body of surgeons such as ours. At present there is no other body of orthopaedic and neurosurgically trained spine surgeons in Australia. The society is at a point where we to need to critically evaluate our need to become involved in this process. Our society view on this matter should be the moral one – that patients who need complex spine surgery are better served by having access to surgeons who have had the benefit of both orthopaedic and neurosurgical input into their training. To this end the society supports the RACS initiative in combined post fellowship training in spinal surgery (PFET).

SECTION 2

MATTERS TO DO WITH PROFESSIONAL SPINAL SURGERY

The executive is also aware that there are issues to do with the professional management of matters to do with spinal surgery that are currently not being managed either by the Australian Orthopaedic Association or the Neurosurgical Association. These matters relate to the need for the processing of a number of important applications to the government regulatory process, to do with spine surgery. These include applications for approval of MBS Item numbers for the following technologies:

1) Cervical disc arthroplasty
2) Intra-operative spinal cord and nerve root neural monitoring.
3) Intra-operative x-ray techniques relating to image guided surgery and the introduction of new technology such as intra-operative CT scanning.
4) The need for the MBS schedule to be updated to include well accepted surgical procedures relating to the spine. These include:

    a. Pedicle subtraction and Smith Peterson osteotomy.
    b. Laminoplasty for cervical myelopathy
    c. Update on section covering intradural surgery
    d. There are no doubt others

DIGITAL RADIOLOGY

There has also been the need to lobby for changes to the way that the radiology industry is attempting to introduce digital radiology into spinal surgical practice. In the past the society has polled its membership and demonstrated significant unhappiness with the process, and particularly with the provision of images on CD only, and the poor or absent scout views on digital CT scans and MRIs

IMPACT OF REGULATION ON ACCESS TO NEW SPINAL TECHNOLOGY

The executive has also been concerned by the apparent slow process of the regulation of access to new surgical technology relating to the spine. Part of the reason for the spine society's existence has been, at least in the past, the fact we have provided a forum at our annual scientific meeting for members to present their results of new and innovative surgical procedures of the spine. This is an important aspect of self regulation. Access to new surgical technology for Australian surgeons is falling substantially behind those in other countries. There appears to be divided opinion amongst our membership with some feeling that more stringent regulation is required to curb the excessive, over enthusiastic uptake of new technology whilst others feel that a less aggressive approach should be taken by government in this regard. I think all agree the process has become slow, cumbersome and difficult to understand and indeed the Australian government has also recognized this because it has announced a review of the health technology assessment process in Australia

THE NEED FOR A PAID SECRETARIAT

Because of all the factors mentioned above and the potential for the executive and other subcommittees to become involved in these issues, the workload of the executive continues to increase. It has simply reached the point of being unsustainable. The society either has to contract and become an organization with the single objective of putting on a high quality scientific meeting every year and not to become involved in these other matters or it needs to expand. If it decides to expand and take on other duties then it simply cannot manage without some form of paid secretariat to provide administrative support.

THE NEED FOR CONSTITUTIONAL REFORM

The society needs to consider as a whole the need for constitutional reform. There are two general reasons for this.

1. The constitution has not been updated (apart from only minor changes) since its inception. Our executive and the make up of our committee structure and, in general, the way we do things needs modernization and reform. The executive has taken advice in this matter from an appropriate lawyer who is experienced in societies of our type and the advice is that constitutions should be updated about every 8 years or so.
2. If the society is to take on more of a role in matters to do with the professional conduct of spine surgery, we need to consider whether this would best be done by creating a

separate organization outside the Spine Society of Australia or, alternatively, to create a new membership category for surgeons within the Spine Society of Australia. This would potentially involve separate funding and a separate fee structure. Any change would need to protect the rights of non surgical members. There are advantages and disadvantages of both options and even the need for this depends on whether the membership feels the society should become involved in these matters.

ACTION ITEMS

The executive has taken the following actions:

1. CONSTITUTIONAL REFORM

The executive held a meeting at the Hyatt in Canberra on the weekend of the 2nd and 3rd of August 2008 for the specific purpose of discussing our constitution. This meeting was held as part of our regular executive meeting. It was agreed that there were two forms of constitutional reform required:

1) The relatively non controversial reforms to do with the modernisation of our structure.
2) Those reforms related to a potential formation of a new membership category.

It was agreed, after having considered how we could become involved in the college of surgeons process of post surgical fellowship training in spine surgery that this process would be much more likely to occur if bodies such as the college of surgeons could deal with a group that solely had surgical membership. It was agreed that options for achieving this should be identified and that possible models developed and presented to the membership for discussion.

At this meeting the society had valuable input from legal counsel (Mr John Kelly) who has significant experience in these matters. It was agreed that a constitutional reform committee be formed with Roy Carey and Professor Kevin Singer as members. This committee has reported at a number of subsequent executive committee meetings and a number of the non controversial constitutional changes have been identified and recorded. It was considered that these changes would produce little comment from the membership. The more difficult problem of producing a separate surgical category within the society has produced substantial discussion. Mr Graeme Brazenor has written a discussion paper on this and the paper has been posted on the website (INSERT LINK HERE). Mr John Kelly (lawyer) has also been commissioned to write a discussion paper that should be available for the members to read at or before the annual general meeting. It has been agreed that there should be a period of 12 months discussion regarding all the options and this should be undertaken through discussion at the annual general meeting and through ongoing discussion within discussion

groups on the website. Furthermore it was proposed that once some form of consensus is achieved, a change of constitution be presented for a vote at the 2010 annual meeting in Christchurch.

2. REGULATORY MATTERS

At the Canberra executive meeting, members of the industry were invited to attend for one session to share problems associated with regulation of new surgical technology. It was clear that a number of these problems are shared between industry and our society. The broad outcomes of that discussion focused on two main points:

1) Industry expected surgeons to have a greater role in applying for new surgical technologies through the MSAC process. This process is, it pointed out, largely an application to provide government funding for new surgical item numbers. In other words this has to do primarily with reimbursement of surgical fees. There is also evidence in the literature that Government, when it set up the MSAC process, thought that most of its applications would come from professional bodies. The MSAC secretariat has subsequently confirmed that it is more than happy to accept submissions from bodies such as the SSA. Industry also felt that it had trouble making appropriate applications without the input of clinicians.
2) Industry also reported significant lack of advance knowledge about the level of evidence that would be required to gain regulatory approval for a new surgical process.

As a result of this meeting the Executive agreed that the Society would be an applicant to MSAC for cervical disc replacement with industry supplying a supportive role. Opinion was sought from Mr John Kelly (legal counsel) regarding the society's constitutional ability to do this and he felt that this was well covered under the aims of our constitution, specifically, under aim A in the constitution that specifies 'To form an educational organisation dedicated to the exchange of ideas and dissemination of scientific and clinical knowledge concerning spinal disease and disorder.' This was interpreted as a general role of 'informing' government about new spinal technology. The society subsequently had a pre application telephone conference with the Medical Services Advisory Committee MSAC who is very supportive of receiving an application from the spine society in this matter.

Since that time the executive has put quite a bit of time into preparing this application and reached a stage where it could go no further. The main hurdle was our inability to provide the requested cost effectiveness analysis of cervical disc arthroplasty. A significant amount of hospital cost data has been obtained though the analysis needs to be performed by a professional health economist. Industry has agreed to take over this role and to hire an independent health economist to perform this analysis based on the information that the spine society has provided. The executive has agreed that all claims made in this application to government will need to be approved as reasonable and

that the application is a suitable one for the government to obtain from a professional body and that of necessity this may be somewhat different to an application made by industry. All claims will need to be unanimously approved by the executive and it has been agreed that myself, (Peter McCombe, President) and William Sears (Treasurer) will not be involved in any vote in this process as they have declared a potential conflict of interest in this matter.

A decision has also been made, as regards the society's general approach to the government regulatory process, that we should put on a major seminar at our annual general meeting and that this should form the focal point to stimulate debate in this matter. To this end the annual general meeting will contain a major seminar entitled, 'The use and potential misuse of evidence based medicine in the regulation of new surgical technology'. The seminar will be professionally hosted by the well respected journalist, Dr Norman Swan and the proceedings will be filmed and a DVD of the seminar will be made available.

The executive notes that there are ongoing matters to do with the need for some professional body to submit MSAC applications for intra-operative neural monitoring, for intra-operative image guided surgery and for laminoplasty, spinal osteotomy and spinal cord tumour resection. With the resources available, the society cannot manage this without paid secretarial support. It is noted that there maybe other bodies, such as the NSA or the Australian Society of Orthopaedic Surgeons, who may wish to take on this role and the society would be happy to co-operate in this matter. In the event that Spine Society of Australia needs to make these applications, adequate resources will need to be made available by some means or another.

3. DIGITAL RADIOLOGY

Both I and Graeme Brazenor (vice president and secretary) have been part of a college of surgeons working party on digital imaging (the Digital Imaging Working Party of the Royal Australasian College of Surgeons). This came about because of an SSA submission to the Department of Health and Aging, regarding its review into the introduction of digital radiology into Australia. This, in turn, resulted from the society writing letters of concern, and complaint, regarding frustration with the unilateral introduction of the provision of spinal radiology on poor quality CD's, with poor quality include software. Of particular concern also, was that of poor quality or absence of scout views on digital radiology images. This made it impossible for surgeons to determine both the level and or the side of features seen on imaging. The society expressed particular concern that this could lead to wrong level surgery or a wrong diagnosis because of misinterpretation of segmental levels. Similar concerns were also raised by the AOA and the NSA. As a result of this I attended a meeting at the Royal Australasian College of Surgeons in Melbourne on 12 th June 2008. This was also attended by the AOA, NSA, AMA and RANZCR (the Royal Australian and New Zealand College of Radiologists)

and the ADIA (Australian diagnostic imaging association). From that meeting two things emerged; firstly a consensus statement that surgical members may wish to read. This is available for review on the society's website (search under digital radiology consensus statement). Secondly, the digital imaging working party was formed. Both Graeme Brazenor and I have sat on that committee and it has met a number of times. The discussion has been slow and convoluted in process. There have however been agreements made regarding draft guidelines for minimal standards for hardware such as monitors and software and for viewing software. A 'diagnostic quality image' is defined as an image of the same quality as a radiologist would use to provide a report. Of significance importance is the fact that the RANZCR has taken the society's concern about scout views seriously and has improved on our suggested guidelines for the provision of scout views. These guidelines are likely to be ratified soon by the college of radiologists and be co branded by the RACS as well as by the SSA. These draft guidelines will be available, when complete, for perusal on the society's website. Of concern is that whilst guidelines for all of these matters are to be published there is little that attempts to enforce compliance with these guidelines, particularly with public hospitals. It is hoped that surgical members, however, will be better armed with these guidelines, to deal with local suppliers of spinal images. This work continues and the college of surgeons is likely to continue with a separate surgical working party, on the surgical use of radiology and that this is to include matters of access to intra-operative radiology, such as image guided surgery and the sustainable roll out of digital technology within surgical practices in a way that is not dictated by radiology industry and that is acceptable to surgeons.

4. POST FELLOWSHIP EDUCATION & TRAINING (PEFET)

I attended a meeting in Melbourne on the 29th August 2008 at the Royal Australasian College of Surgeons that was attended by the Australian Orthopaedic Association and the Neurosurgical Society of Australia and the Royal Australasian College of Surgeons. Graeme Brazenor (vice president and secretary) also attended this meeting. A subsequent meeting by teleconference was held on the 31st March 2009. Consensus has been slow and difficult to achieve on this matter though I believe that all parties have continued talking and it is now clear that both the Australian Orthopaedic Association and the Neurosurgical Society of Australia are keen to be involved in some form of co-operative post fellowship education and training in spinal surgery that would involve both orthopaedic and neurosurgical input. How the SSA can be involved in this is unclear. If the society can be involved we are keen to do so, though a prerequisite for this would be some resolution of our issues to do with the provision of administrative support.

The SSA has also offered to be involved, and indeed has offered assistance to the AOA, in a review of the orthopaedic surgical pre fellowship curriculum in spinal surgery. This has been offered with a view to dovetail into any post fellowship education and training curriculum. The AOA is keen to

cooperate in this regard and negotiations currently continue. A similar offer has been made to the NSA. The NSA however feels that it has substantially improved it's curriculum in spine surgery in recent years and assistance is not required.

5. RELATIONSHIP WITH THE AUSTRALIAN ORTHOPAEDIC ASSOCIATION

I have had a number of extremely fruitful discussions with the Australian Orthopaedic Association chief executive officer (Mr Ian Burgess) and also with Dr John North (past president of the AOA) and Dr John Batten (current president of the AOA). I am happy to report that there is a new spirit of cooperation that is present within the AOA regarding spine surgery. The AOA now recognizes the need to engage and support cross disciplinary specialties, such as the spine society. I have had a number of significant discussions with Mr Ian Burgess about the nature of the spine society, its needs and problems. We have agreed as part of this process to have an AOA sponsored, 'Fundamentals in Spine Surgery' programme to be a trial and potential showcase for a new way of providing continuing education to surgeons, and indeed non surgeons, who have interests in conditions of the spine. By having this meeting immediately before our annual general meeting, we have been able to effect a more efficient use of international guest speakers. The AOA has agreed to co-sponsor the 'Fundamentals in Spine Surgery' meeting to the extent of $15,000 and this arrangement has also benefitted the members in general as this provides funding for an extra guest speaker for our main scientific meeting.

6. POTENTIAL FOR ADMINISTRATIVE SUPPORT

The SSA held an executive meeting in Sydney at the offices of the Australian Orthopaedic Association on the 7th February 2009. Following that meeting we had a further meeting with office bearers of the AOA to explore ways of co-operating and obtaining some administrative assistance. What was discussed were ways in which a co-operative approach could be taken where the AOA might provide some form of administrative assistance using existing office processes within the AOA to support our society. The concept is one in which the AOA office would takeover a number of the administrative tasks of the spine society. Such tasks would include bookkeeping, accounting, website content updating, general secretarial support and the possibility of contributing, in part, to conference organization. The concept being explored is that the value of these services would be defined on a commercial basis and the spine society would consider funding part of this from our revenue and that the AOA would fund some of it through its own revenue. The society would also agree to provide ongoing assistance with educational support for spine surgical training for registrars. At the time of writing negotiations have not been completed in this regard, though I am hopeful that a satisfactory outcome can be achieved. The intent is that this process would solely involve an administrative arrangement. It would not involve any change in identity of the Society or create problems dealing with non orthopaedic members of our society.

CONCLUSION

The society is going through a period of change. It is time to modernise our constitution and decide what our future directions are. Spine surgery, at least in my view, is heading towards becoming a separate specialty of its own in the future and the society needs to decide whether getting involved in this is a role for our society. We can either contract our activities and only focus on providing a high quality annual scientific meeting or we can expand our role to be ready for what the future may hold. I encourage debate among the membership about these important matters over the next twelve months with a view to a formal vote on any constitutional change that may be required at our 2010 scientific meeting in Christchurch.

Dr Peter McCombe
President
14 April 2009