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Keeping up with all specialties

It has been an interesting couple of months since the last issue of *360*, and despite our recessionary times, life feels good. I was astonished to find that we now have subscribers in 33 different countries around the world. Actually, as Editor-in-Chief, that is quite humbling. So for those who have subscribed, thank you. For those who are thinking of doing so, feel free to have a go.

One major attraction of publishing *360* is its multi-subspecialty nature. All of us involved have subspecialty interests – there are so few real generalists remaining – but each of us, thanks to *360*, is finding topics that, in our subspecialty cocoons, we never realised existed. Hip surgeons are becoming knowledgeable about the shoulder, foot surgeons know all about the wrist, even hand surgeons spend time reading about the spine. Recently, a senior surgeon, who had not fixed a fracture for two decades, admitted that our Trauma section in Roundup had fascinated him. At *360* we were delighted to hear this, as a significant reason for creating the journal was to allow a free interchange of ideas between the various subspecialties that make up our large family of orthopaedic surgeons.

For this issue, our flavour is again different, as you might expect. There is an interesting feature article on a possible robotic future for orthopaedic surgery, superbly written by Justin Cobb and Barry Andrews (London, UK). I was very interested by this article, particularly if someone can design a robot that might help a highly pressured editor offload some content. Do you realise that a single issue of *360* contains an astonishing 30 000 words? That is roughly half a paperback novel for us to prepare and edit every eight weeks. Then there is the second feature article from Rob Grimer and Lee Jeys (Birmingham, UK), highlighting the fact that a malignancy of a limb does not always mean amputation. This was certainly an education to me. Interestingly, it appears that none of us yet knows if the modern designs of tumour prosthesis will actually last any longer than their forefathers. No doubt time will tell.

Our Editorial Board, as ever, is proving to be tremendous. They are the eyes and ears of *360*, identifying papers not only from the mainstream journals of which we have all heard, but also from those lesser-known publications whose circulation sometimes number in the tens, rather than the thousands. No holds are barred. Medical, surgical, veterinary, paramedical, anything goes. The key feature is the message. If it is useful to an orthopaedic surgeon then we need to know of it, wherever it may reside. Plenty of our readers write in with their own recommendations as well. Thank you to those who have done so. A high impact factor is all well and good, but we frequently find critical messages in journals whose impact factor would not merit a second glance from the research community. I trust you find our Board's selection of papers interesting, helpful and worthwhile.

Of course, the orthopaedic literature has been filled with an I-hate-metal-on-metal fest for the past few months and a number of those appear in this issue of *360*. A shame, when there are still plenty of satisfied patients out and about with their metal bearing surfaces behaving as they should. It is naturally impossible for anyone to develop an orthopaedic implant or device with a zero chance of failure, which is the reason why post-marketing surveillance is so important. Yet despite this being essential, it is not always as effective as we might like. Certainly, the proportion of high-risk devices being introduced through the FDA's 510(k) pathway, which generally requires little clinical pre-marketing testing, has increased enormously in recent years.[1]

Then there are those papers that do not truly fit into any subspecialty area but are nevertheless fascinating to read. How about iatrogenic nerve injury? Where would we put that? Yet it is extraordinarily common, in whichever branch of medicine you look. In New Zealand, these injuries are the fourth most common cause of treatment injury claims accepted by the country's no-fault compensation scheme.[2]

Specialty hospitals have also been a topic for debate. As a breed, we orthopaedic surgeons seem to like them, but not all would agree, as highlighted by an article from the USA.[3] Critics would say that physician ownership creates a conflict of interest and leads to the overuse of medical care. Certainly, there are some general hospitals that are suffering as a result of unfair specialty practices. Yet real excellence is also possible through specialty hospitals. Take one establishment in Ontario (Canada) for example, which solely undertakes inguinal hernia repair, roughly 20 each day, with the lowest recurrence rate on the planet. How sad it is to see specialist orthopaedic hospitals in so many parts of the world, particularly here in the UK, coming under fire from government when there are so many advantages to remaining specialist. We love our non-orthopaedic colleagues, of course. But we would prefer, at *360* at least, to keep them at arm's length and to see them only on occasion.

So, welcome to issue number 3 of *Bone & Joint 360*, which I trust you will enjoy as much as the previous two. If you do subscribe, you will join a rapidly expanding group of surgeons who want their information in bite-sized chunks. Welcome to the rapid-read revolution.

My very best wishes to you all.

REFERENCES

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3. **Badlani N, Boden S, Phillips F.** Orthopedic specialty hospitals: centers of excellence or greed machines? *Orthopedics* 2012;35:e420-425.