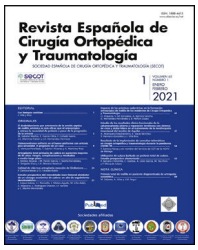
Revista Española de Cirugía Ortopédica y Traumatología 65 (2021) 237–238

Revista Española de Cirugía Ortopédica y Traumatología

www.elsevier.es/rot



EDITORIAL

New Nomenclature: a long and tortuous road☆

Nuevo Nomenclator: un largo y tortuoso camino

For many historians, 1989 was a year when events accelerated. These events included the death of Ayatollah Khomeini, the Tiananmen massacre, the defeat of Augusto Pinochet, and the fall of the Berlin Wall, which heralded the dissolution of the Soviet Union. And if that were not enough, the World Wide Web was born that year, which today it would seem impossible to live without. That was 32 years ago and, to put it in perspective, traumatologists have graduated who were not even born when all this was happening. In April 1989, the Collegiate Medical Organisation of Spain (OMC) published the ''Terminological Classification of Medical Techniques and Procedures'' (for use by health insurance companies).[1] According to the foreword it was intended as ''a first step in the organisation of the liberalised part of public healthcare''. Its authors considered it not to be ''a closed work, but a first edition whose dynamism and updating in successive editions will rely on the constant spirit of collaboration of the Scientific Societies of the medical specialities''.

Since then, this classification, the ''Nomenclature'', has been widely used and its use has expanded not only in free insurance companies, but also in the field of work, sports and even traffic accidents. Of course, it is unrealistic to look at today's world through the eyes of 1989, and attempting to confine such a dynamic and extensive speciality as today's orthopaedic and trauma surgery to the limits of what was done then would seem foolish.

However, for various reasons, it has never been updated. The reasons (and let's put them in order according to our own personal criteria, adding or subtracting those we wish) could be listed to include the indoctrination of a collective accustomed to high social standing, which would make any type of protest to improve their conditions not very appropriate; the traditional lack of initiative on the part of doctors in anything other than the direct practice of their profession; the historical disunity of the collective; the lack of a culture of association among a large proportion of doctors, who in many cases are accustomed to seeing their colleagues as enemies rather than competitors, without realising that the real enemies are others; the lack of business education among doctors, added to the convenience of using familiar terminology which, although obsolete, provided a comfortable framework, like the armchair in your home that you are so used to that, 32 years later, you do not see as old, worn and tarnished, and which you do not notice has become uncomfortable because it is part of your everyday life; the Scientific Societies having become comfortable, more accustomed to looking only towards the public practice of the profession; the lack of a defined leadership to propose changes, due to the effort, involvement and time that this work would entail; the lack of interest on the part of the OMC, dedicated to other less mundane matters, accompanied by the lack of interest on the part of insurers... In short, everything has conspired to ensure that orthopaedic and trauma surgery nomenclature has not been updated in 32 years.

The 2017 survey showed that at least a third of SECOT members work, either part-time or full-time, in a private practice setting, and although SECOT's own statutes prevent it from participating in claims related to the professional scope of traumatology practice, there is no doubt that the definition of the specialty's own acts falls squarely within SECOT's remit.

In 2017, a group of orthopaedic surgeons proposed by the OMC and SECOT came up with a new nomenclature, which was no easy task and took many hours of work. At the first meeting in the OMC headquarters with the representatives of the different health insurance companies, their intention to boycott any significant change and to control the process was so obvious that we left the table, making it clear that we would not tolerate their interference in a purely medical area; the definition and classification of medical acts into difficulty groups. When things had settled down, we held three more meetings. Before each meeting, the insurers were sent the proposals we intended to discuss, but noth-

☆ Please cite this article as: Arriaza Loureda R. Nuevo Nomenclator: un largo y tortuoso camino. Rev Esp Cir Ortop Traumatol. 2021. https://doi.org/10.1016/j.recot.2021.05.001

ing effective was ever achieved. Sometimes because ''they had not had time to study them'', and sometimes because they considered them ''unacceptable'' because it would be disruptive for them to adapt their IT systems to new procedural codes, or because of the possible economic cost of raising the difficulty group of a process. This we were told by representatives of an insurance company that systematically has annual profits in excess of 300 million euros! In the end, tired of spending time and effort on a task destined to fail, we abandoned the whole charade.

In 2019, the Private Care Committee of the OMC conducted a survey among many practitioners and published a report stating ''Private medical practice is no longer free under current market conditions. Insurance companies have changed the classical model of private medical care and, in addition to their insurance work, have gained an increasingly prominent presence in healthcare work, largely at the cost of undermining the ability of private medical practitioners to compete''.[2]

The initial position of the OMC was to attempt to change the nomenclature of 5 specialties every year, leaving the most complex to last, given the difficulty of the process. With luck, the updated orthopaedic and trauma surgery nomenclature could be a reality by 2030. Can anyone imagine what it would have meant to be forced to restrict the orthopaedic and trauma surgery of 2000 (to use a round number) to the criteria of 1959? Furthermore, and as if this were not enough, medical fees have been frozen since before 2000, meaning that what insurers paid on average for a consultation before the Euro was adopted remains virtually unchanged. Following the example of other specialities, such as ophthalmology,[3] the idea of updating the nomenclature was driven under the direct responsibility of the orthopaedic surgeons, for it to be presented and approved by the OMC. The nomenclature of 2017 was taken as a basis and, after multiple working meetings throughout 2020, a new proposal for the nomenclature was drawn up.

Thanks to work that I believe is considered impeccable by everyone, the new version of the nomenclature was drawn up using three objective criteria to calculate the degree of difficulty of each process. Firstly, the time, difficulty (effort) and resources (investment) deployed to achieve the training and level of professional development necessary to perform the professional act with skill, agility, and safety. Secondly, the level of responsibility taken on by the practitioner in carrying it out, as an expression of the degree to which a complication of the surgical act may result in loss of structure and/or function of a limb or the patient; and finally, the average time that the medical or surgical act requires, not counting the time between cleaning or staff breaks. The inclusion of this last factor adds consistency to the difference in process fees between subspecialties. For an understanding of its possible impact, suffice it to say that 118 new codes were introduced, 174 were maintained (sometimes changing their name for a more current one), and 45 acts were removed because they were obsolete or belonged to the scope of other specialties. Some modifiers were introduced, which would be added to the main procedure, such as the use of navigators or robotic surgery in an intervention, as a way of anticipating a future that is already with us.

References

1. Clasificación Terminológica de Actos y Técnicas Médicas (Para Uso de la Entidades de Seguro Libre de Enfermedad). Consejo General de los Colegios de Médicos de España; 1989.
2. Condiciones de competencia en el mercado del ejercicio libre de la medicina. Informe de Resultados. Consejo General de los Colegios de Médicos de España. Junio 2019.
3. Gegúndez-Fernández JA, Piñero-Bustamante A, Benítez-del-Castillo JM, García-Feijoo J, Muñoz-Negrete FJ, Figueroa MS, et al. Nuevo nomenclátor estandarizado en oftalmología: Criterios e indicadores cuantitativos de baremación de actos médicos. Arch Soc Esp Oftalm. 2020;95:591–602, http://dx.doi.org/10.1016/j.oftal.2020.07.019.

R. Arriaza Loureda
Arriaza y Asociados Medical Institute, Traumatology
Member of the Board of Directors of UNIPROMEL, Spain
E-mail address: arriazarafael@gmail.com