

ROBERT HUBE

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SUMMARY

Professor Robert Hube's trajectory from the former German Democratic Republic to the leadership of the European Knee Society reflects a career defined by clinical volume and educational rigor. His formative experiences in South Africa and Pittsburgh established a commitment to surgical efficiency, now realized through over 1,200 annual arthroplasties at Munich's OCM clinic. As a mentor and incoming president of the German endoprosthesis working group, Hube advocates for structured sub-specialization and independent postgraduate training to advance international orthopedic standards.

Robert Hube is one of the leading surgeons of the OCM clinic in Munich and a very busy knee and hip arthroplasty surgeons performing more than 1.200 cases personally per year. He is the local host for the upcoming EKS open meeting 2022 in Munich and incoming president of the German endoprosthesis working group (AE). He talks about his career which started in the former Democratic Republic of Germany (DDR), training in Durban, South Africa and fellowship in Pittsburgh US. He also shares with us how to develop an efficient environment to allow high volume surgery. He is Professor for Orthopedics at the Univ Clinic Charite and tells us why he is dedicated to training and education.

You are the local host for the upcoming EKS Open Meeting in Munich. What is the focus of this conference?

Since we can't cover the entire subject and we wanted to focus on innovations to some extent, the focus this year is Optimising Primary Knee Arthroplasty. We are trying to illuminate new developments in knee endoprosthesis, such as kinematic alignment, artificial intelligence and similar procedures. Obviously, this is alongside technique reviews for the audience and tips and tricks.

What represents the European Knee Society and what does it mean for you personally?

The European Knee Society follows the model of the American Knee Society and is a European Association of Orthopaedic Surgeons who deal with knee surgery for the arthritic knee. Its focus is on knee endoprosthesis although it also deals with osteotomies but does not cover orthopaedic sports medicine, which is covered by other societies in Europe. EKS tries to establish itself as a society to advance European knee surgery for the arthritic knee and ultimately bringing together different opinions from key opinion leaders but acting independent of individual companies.

How do you envisage the future role of the EKS compared to EFORT or other sub-specialty societies in Europe?

That depends to some extent on the EKS itself, how attractive and agile it acts, what it offers to its members or potential members, and how it maintains its attractiveness for surgeons interested in the arthritic knee. If we are being honest, there is always a certain element of competition- well, competition has a very negative connotation - with other societies in order to build attractiveness for our members.

There is an option for EKS junior membership and also an EKS fellowship program. Would you advise a young aspiring knee surgeon to try and gain EKS junior membership and why?

I definitely would, because you can quite simply significantly expand your horizon with this membership. You see opinions from other countries and ultimately see not only your own microcosm or national macrocosm. It provides the opportunity for the young surgeon to build networks for their own career at an international level, broaden the horizon, see other opinions, organise shadowing opportunities and potentially participate in fellowships. Obviously, this is not possible nationally in this form, at least it is limited.

Compared to the past, where it was only possible to travel to the States if you wanted to see or contribute to something new, we now have the opportunity in Europe with EFORT and the sub-specialty societies to discover new things or to present them. Do we have enough here in Europe or do we need to continue our efforts to improve?

We do need to continue to make efforts to improve. In many European countries the expertise is large enough to provide comprehensive training, further education and an opportunity for an exchange of experiences. Nevertheless, it is better to have also links to other countries such as the US, where in terms of clinical research much is efficient organized and established. This is an opportunity for the EKS to introduce young colleagues to these clinical projects or to the simple question: How do I get published? This might work so well at a national level and ultimately this makes their international career.

You grew up in the former German Democratic Republic, how did you get to be a Doctor?

My background is in competitive sports and I wanted to simply study Sports Science. That wasn't possible due to my Scheuermann's disease or at least it was in doubt whether it was possible. Then my thinking led me towards Sports Medicine which finally brought me to Orthopaedics.

You studied medicine at the famous Charite Clinic in East Berlin, but you spent part of your training in Durban South Africa. How did that come?

We actually wanted to have adventures and to get out somewhere abroad. English is the only language that we spoke to some extent, and we wanted to go somewhere sunny and ideally, wanted to surf. Australia and New Zealand, I believe, wanted us to pay 400 Dollars a month and I didn't had that as a student. South Africa did it for free, so we went to Capetown and Stellenbosch but no one wanted us there and then we got to Durban, the King Edward Hospital. It was a wonderful time for me, because I could obviously do a lot, such as inserting chest drains, central venous catheters or assisting at births. I was able to do all manner of things that none of the local students in Germany had seen. For me these practical opportunities were great and alongside with the leisure activities this was one of the best times of my life.

What brought you to Halle to undertake your orthopaedic training there?

That was through personal contacts. I did want to stay in Berlin, Professor Zippel held the chair for Orthopaedics in Berlin, but he did not had any junior positions at the time. I did want to stay at the university, and he had connections to Halle and Professor Hein where I did my training and got a position.

At the end of your training you did a fellowship in Pittsburgh. How did you get there and what was your experience?

Professor Sotereanos was my professor in Pittsburgh. I attended in Bern one of those Chaos Congress meetings, which was still en vogue at the time. My boss and our senior physician weren't able to attend so I was sent there since I was somehow the go-to person for anything computing in the clinic. I met this American Professor who was relatively young at the time, and no one knew him or me. There was this pioneering spirit at the Chaos meetings and the first targets for the application were obvious and we didn't know anyone, and nobody talked to us. We simply stood about together for three days and then he asked me whether I wouldn't like to join him for one year. He probably just wanted to be nice to me, but I was immediately very obnoxious.

I was very fortunate to be working there with an institutional licence which allowed to perform surgery. For me it was very fortunate that the fellows and residents operated everything which is not always the case in the US. I think I performed 450 endoprosthesis and trauma interventions under supervision and I learnt how to operate there. Honestly, in a lot of our departments you just watch a lot during your training, but you learn many things after obtaining your specialist doctor qualification.

Did you discover your preference for hip and knee arthroplasty at that time or did that emerge later?

That happened during my fellowship, because there was an endoprosthesis specialist who had just taken over the Pittsburgh division for reconstruction, and perhaps it was a coincidence that he was an endoprosthesis specialist. So this is how I ended up with endoprosthesis, via this fellowship which transpired by chance from the meeting during the coffee break in Bern where we originally met. After all, life is a series of coincidences, you simply have to take up the chances as they are offered to you. There are many moments in life when you can decide. What to do? Turn one way or the other?

In 2003 you changed to the OCM (Orthopädische Chirurgie München) in Munich. Can you briefly explain how OCM developed and what position it has today?

OCM was a merger of two major practices in Munich that were already operating very successfully. They were looking for a second joint arthroplasty specialist to ensure there is a back-up. I had been demonstrating unicompartmental knee joint replacements for a company and that's how we got talking. I found The OCM very attractive, and they made me an offer to join them as a partner. I decided to go to Munich, to leave the University, which wasn't easy for me either, because I am still very fond of the university, but in retrospect that was a very good decision that I haven't regretted for a single day. Obviously, it's also fun to develop something like OCM. At that time we were operating in 2-3 theatres and now we operate in 9-10 and we have managed to attract further specialists with good national/international reputation. We now have 15 focus certificates for leading surgeons in their field which obviously is a little inflationary but if you want to classify the orthopaedic units in Germany we have the most certificates. We are now looking back on a very successful situation, without being arrogant, and whilst it is always easier to grow, we now have to ensure that we maintain quality and to share this with the next generation.

Are you generally a fan of sub-specialities? Since you are an education clinic also, what should an ideal training situation entail in your opinion?

There I am torn a little. On the one hand, sub-specialisation is essential in my opinion to maintain a high level of treatment quality. There is no doubt about that. This is because the specialisation has significantly increased compared to our teachers and our teachers' teachers and one can no longer do everything. You can't be brilliant at operating everything and be great with all. Perhaps others can, I am not able to do that.

On the other hand, we simply have the problem that the sub-specialisation happens very early with many surgeons, and this is ultimately at the expense of the breadth of training. I don't know if that is all that beneficial, but I think it can't be stopped and this development will continue and the situation where you generally do everything, that will certainly disappear in future. There is then the problem in rural areas, where there is no specialisation available and hospital has a broad treatment remit, take care of primary treatment and to deal with everything. I am not entirely clear what the solution is for that in the large countries like Germany. However, in the cities the sub-specialisation with highly specialised focus will continue to go in this direction and that is the right way under quality-of-care aspects.

You are one of the most experienced hip and knee surgeons in Europe performing about 1200 surgeries per year personally. Could you please briefly describe your schedule that ensures to manage this enormous volume?

My working day starts at half past six in the morning, because clinic start to happen at 7 a.m. and this way I simply have half an hour in the office where I am very efficient. The morning meeting is from 7 a.m. to 7.20 a.m., then I go to theatre and usually I make the first cut at a quarter to 8 and I usually operate from 8 a.m. to around 2 p.m. I then usually do the ward rounds and attend to my outpatient clinic or other clinic meetings, etc. At least that is what my schedule looks like on the days when I am present at the OCM and not on the road somewhere, attending talks, conferences or society meetings. In the theatre we have a very efficient set-up. We worked for a long time to achieve this, which is certainly simply not transferrable to any other venue. It takes an awful lot of effort, to get to a position where you can rely on this willingness to perform from positively motivated and happy staff. This skill must be transferred to anaesthesia, assistants, scrub nurses, OR technicians and hospital nursing staff to be able to operate with the same amount of detail, somewhat efficiently. But this is feasible, and people can come and see this at our site for themselves. It is worth for a visit, and it is surprising, how effective one can work with a high level of staff satisfaction. In the past, when somebody would have told me during my university days that it is possible to work like that, I would have told them it's simply not physically feasible.

To some extent you took "The American Way" with sub-specialisation and high efficiency. OCM is privately run but treat all patients, why doesn't everyone do that in Germany?

Well, I believe that we don't like to deal with these simple daily matters, to make small adjustments. If I reflect on my professional life, then the actual changes were simply a matter of tweaking the little things here and there. I think that many people don't like to deal with that, but this is the only way to make it work. I can paint a big picture, but I must fill this picture with life, including the areas of management, controlling and the basics of the daily routine. I have to be a good example and mustn't leave people waiting. Ultimately it is the sum of small things that produce results and need people to bring them to life. Obviously, you can also impose structures

by pushing from the bottom up or from the top down or you can lift from bottom to the top but being a leader of people in daily routine is something that takes a lot of work. Many of us are reluctant, I believe, or don't have the ability or the inclination, even though everyone wants to work more effectively, but it's simply not easy. To transform a company or a surgical theatre in this aspect requires a lot of work but I concede it can also be fun. You do good work and it's fun to work with the people and I believe it's a major advantage. And if it wasn't fun and I didn't enjoy doing it, then the whole thing wouldn't work like that.

In the public system, a surgeon who completes two or three interventions each day, gets the same salary as someone who completes six per day. Is it not also linked to the payment system or is it pure and simply a matter of convincing and motivating?

For surgeons it doesn't matter that much because most surgeons have a certain pride in their own work and want to do that themselves including the implementation. In terms of anaesthesia, it is certainly useful if the anaesthetist participates in the volume. At OCM anaesthetists are being paid per case, and I believe this is a major benefit which is not different to anywhere else. With this model motivation is somehow directly proportional to the implemented volume in the operating theatre. Ultimately you are not dependent on Good Will from the pleasant coworking department.

When did you make the decision to also starting a scientific career?

Well, at my time at the University in Halle I of course started and completed a PhD. I then became an assistant professorship in orthopaedics at the Charité in Berlin during my time at OCM. I was always interested in science and delivering lectures and finally you end up in a certain track and it is obviously fun to research things and to engage with them at an academic level. And I also saw that the more I dealt with science, the more I improved in clinical practice. If you follow up certain things, especially in clinical trials and reviews, then you do find that your own appraisal, how you regard your own work, is not always proportional to the objective results. I believe it is not a bad idea for self-reflection to review your own practice and I believe it is also a major benefit for clinical work. And it is also fun, once you familiarise yourself with the matter, and then involve young people and guide them. At the time, I was the young person who was being guided. I always found it a very positive experience—the fact that I was being looked after.

What were your scientific role models or mentors during your career?

It was definitely my former boss, Professor Hein, but also the senior physician Professor Reichel at Halle, who led me in this direction. Ultimately it was my fellowship in the US, with my boss who did nearly everything in terms of surgery by explaining why he did it and each time confronting me with three or four complications and explained to me the main reason why we are doing this. I was extremely impressed by his theoretical and clinical knowledge where every step during the surgery could be justified with objective results. At that time this was much more pronounced in the US, at least in my experience that I gained before in Germany. It wasn't the case that they were better surgeons, but they were simply better able to justify things with objective facts, publications and data.

Is it possible that this fellowship in Pittsburgh formed the foundation for your ambition to not just become a good surgeon but also a good trainer and teacher?

One hundred percent. For me that was a pivotal point in Pittsburgh and there was another colleague close before retirement who was training me and told me: "Robert, whenever we have

residents here, I don't just want to turn them into better surgeons but also into better people." This might be a little pretentious, but I found this one line very memorable, and I thought about it a lot. I believe that as a leader, when you care about the younger people, you can do a lot and show them the right way, if you take an interest in them.

What is your expectation for the future for the younger colleagues, that they really get the opportunity to receive good training in the way that you were lucky to achieve for yourself?

This is a very good question that I can't answer exhaustively. I think I had a situation where I take pleasure in training, but this was very dependent on individuals, and that obviously doesn't solve the broader problem. We must create structures and control mechanisms and incentives for clinicians to train staff. When it comes to things like teaching, research or whatever, there must be clear approaches and control mechanisms for postgraduate educations that ultimately force us to train our assistants, otherwise, there will be no improvement in training across the board. Then there are people like me who enjoy this intrinsically, but that is simply a personal characteristic that is not commonplace. At a wider level we ultimately must force people - yes force is the right word in my opinion - to train people. Ultimately that only works with incentives in the way that they exist in other areas.

You were involved in a political career when you became member of the board of the German Endoprosthesis working group (AE) and you are also the Incoming President of AE. Can you briefly explain what AE is?

The AE was a merger of interested trauma and orthopaedic surgeons in the 1990s, to achieve improvements in the training and education for endoprosthesis surgery. I have to be a little careful not to hurt anyone's feelings, but it is the largest specialist society in Germany. These days we conduct more than 50 courses at the postgraduate level covering endoprosthesis surgery for hips, knees but also shoulder, elbow and ankle joints. I think that the AE has developed very well but you do have to take care that once you have turned into a very strong organisation, you don't rest on your laurels but you have ultimately stay up to date and develop new systems and stay with the times to remain attractive including for younger members. We see that endoprosthetic surgery are no longer as attractive for younger colleagues as orthopaedic sports medicine seems to be.

You are also a founding member and former president of the German Knee Society. Why was it necessary to form a separate German Knee Society in addition to the existing German subspecialty societies.?

That really is a good question: Do we need that? Obviously, everyone who is not involved says we don't need it, but we simply wanted to reflect the knee in its entirety. We will tend to see more knee, hip, foot and ankle and shoulder surgeons who ultimately deal with all the individual anatomical structure, and it is probably better for the understanding of the individual regions better than someone like me, who ultimately only performs endoprosthesis surgery which is at the end of food chain and may tend to neglect joint sparing options due to a lack of reflection of the situation. In these 10 years of German Knee Society, I have benefitted a lot from this because I left the endoprosthesis bubble and gained a lot of food for thought from people who perform more osteotomies or more trauma surgery or access techniques. I learnt a lot about things that I hadn't previously encountered.

You are also a member of the AO Recon Education Committee. What is the AO Recon and their aims in relation to training?

It is also a future driver of the AO to provide a broader offering, even though there is a certain overlap between topics, such as periprosthetic fractures. The question is: who is supposed to deliver that? A trauma surgeon specialised in fractures or highly specialised orthopaedic surgeons. And the AO also founded or spun off a new branch approximately 10 years ago to be able to offer further education and training in this area with their network that is not tied to commercial companies. For me, this was also positive to have the opportunity to have international interactions, because you will always encounter new perspectives, because you meet new people, new colleagues, including from other companies, etc. who approach things differently. It is sensible to have platforms that are independent and not tied to specific companies and that deliver education not tied to commercial interests. Obviously, this always has its limitations, because everyone receives some sort of support, but relatively more independent than pure company-driven training, and this takes us back to the European Knee Society, both ultimately have the aim to deliver postgraduate education that is not tied to company interests. I believe that this is important because training is the be-all and end-all, and if we check our registries: where are our sources for error? There the surgeon is certainly the error source number 1 and not the implant. Even if we don't like to say that.

You are very busy, how do you manage your work-life balance? What are your hobbies and your private time management?

That is a very good question. In the first instance, I have a problem with the term work-life balance, because my work is obviously my life, or a major part of my life and I really do have a lot of fun at work, so that I reject this term for me personally, if I may be so polemic. But obviously I also have children and family and you lose time with them if you spend long hours at work. For this reason, it is extremely important in my opinion, even if I am sounding polemic, that I am spending quality time with my children. I try to do that as well as I can, even if it's not always ideal but I do make an effort. I still play tennis twice a week, very early on the weekends so that I can then make breakfast and don't lose time with my family and one evening in the week I still have a physical outlet. If you are in a position where you are working hard you have to accept, life is a series of compromises.

The last question. What would you advise a young colleague who asks you: What is most important to ensure that I become a good orthopaedic surgeon?

I think that the key question is primarily the attitude of the individual. I think it is extremely difficult to become a good surgeon in a reasonable amount of time. The question is always: how much time do I want to invest in my profession? But otherwise, if that is a given, I would always start out at a major clinic because you get to see more and different things. I would also try to get involved in scientific research early on, simply to expand my opportunities and to be more attractive to the labour market. I would always try to do as much as possible outside of my own clinic, whether it is shadowing opportunities, courses, fellowships, if possible, simply to broaden the horizon and see what others are doing. That ultimately means designing the training as broadly as possible and gaining a lot of experience abroad, because self-reflection builds character, when you see that other things, different concepts also bring similar results or better results than your own, compared to a situation where you stay in one hospital for 6 years or so. I believe that is very important.

Thank you very much Professor Hube for the interview and the personal insight in your career.