Journal of Orthopaedic Experience & Innovation
Clinical, Economic, and Innovative Orthopaedic Experience

Savoie, MD, Felix "Buddy." 2025. ""In My Experience...The Arthroscopic Journey of a Lifetime"." *Journal of Orthopaedic Experience & Innovation* 6 (1). https://doi.org/10.60118/001c.124810.

Editorial

"In My Experience...The Arthroscopic Journey of a Lifetime"

Felix "Buddy" Savoie, MD, MD[a]

Keywords: shoulder surgery, arthroscopy, elbow surgery

https://doi.org/10.60118/001c.124810

Journal of Orthopaedic Experience & Innovation

Vol. 6, Issue 1, 2025

The author discusses his career originating at the start of shoulder and elbow arthroscopy to the present.

I'm Dr. Buddy Savoie. I have been so fortunate and blessed to have been part of shoulder and elbow arthroscopy almost from the beginning. I trained with the most remarkable surgeon, Dick Caspari, in Richmond, Virginia, who actually pioneered much of the early techniques in shoulder arthroscopy. I was also blessed to meet and interact with many of the pioneers of arthroscopy and shoulder surgery in the US , including Lanny Johnson, Bob Jackson and Rich Hawkins. In the elbow with Bernie Morrey, Terry Whipple, Gary Poehling, Shawn O'Driscoll and many others that make me feel like I've been in arthroscopy since the ground floor.

We started looking in the shoulder and the elbow via arthroscopy, but we actually didn't have any way to pass suture or repair anything; . We didn't have any devices. We were just looking and cleaning things up. And then new instruments were developed, including innovative devices like the suture punch, and Mitek anchors, and all the different things that have helped. And over the years, sort of kept trying new things and I'd always start off a new technique and do 10 of something and see if it worked. And if it worked, we'd continue, and if it didn't work, we kind of take the patients and try something else. So, started off on the shoulder, just kind of looking in and then developing techniques. Each time we go to the cadaver lab and figure out how to do things better and safely and then design some instruments, ask a company to make them for me, and then we would make things work out. Then it got more and more easy and effective, and sometimes it was just Blind luck to keep pushing the envelope of what could and couldn't be done.

And in the old days, there would be meeting like the Nottage course where then it would be Steve Snyder, Steve Burkhart, Gene Wolfe, and and many others, where we would put on a shoulder course. During the teaching, you'd have a cadaver lab. Then after the participants would leave,

a Dr. Felix Savoie grew up in South Louisiana on a sugar cane farm. He was really bad at farming, so he was moved to the welding shop, which he enjoyed. Dr. Savoie was fortunate to have great mentors throughout his life, long before mentorship was considered a "thing." His first mentors were his father and grandfather. He also had great coaches in sports, including Bucky Mistretta and Bill Vice in football, and Shelby Robert in baseball. In addition, Dr. Savoie was mentored by physicians such as his Uncle Jon Savoie, Jim Hughes, Frazier Ward, Dick Caspari, Terry Whipple, Rick Myers, Rich Hawkins, Bernie Morrey, and Bob Cofield. Dr. Savoie practiced in Mississippi for 25 years, and after Hurricane Katrina hit New Orleans, he returned home to join one of the greatest leaders in their profession, Dr. Raoul Rodriguez. Together, they worked to help rebuild the city and the Tulane Orthopaedic Program. Dr. Savoie considered it a great calling from the Lord to participate in this wonderful mission. Dr. Savoie has been so blessed with family and friends, and he has had the opportunity to serve the profession as president of the Louisiana Orthopaedic Association, AANA, ASES, and AAOS. He is currently still in practice in New Orleans with Tulane University.

Visit Dr. Felix Savoie

Connect with Dr. Felix Savoie on LinkedIn

Conflicts of Interest Statement for Dr. Felix Savoie

Visit the Open Payments Data Page for Dr. Felix Savoie

we'd all group around a cadaver and share stories of what we did and what we didn't do, and what might have worked. I was always the guy that got to do the operation, only because I had quick hands and took direction well; . So, Craig Morgan would say, 'Sometimes you do this, Buddy, go make this happen here,' and I'll get to do that. That sort of evolved into new methods how you develop new techniques and how do you teach.

And so, as we started a fellowship and started teaching all these cadaver courses and all these new techniques. I was very fortunate to be part of the organizing committee at the Orthopaedic Learning Center and help set up the platform, basically, with Jim Esch, Howard Sweeney and Dick Caspari. Wonderful folks like Rick Angelo, Rick Ryu, Nick Sgaglione and Jeff Abrams really refined how we teach courses. I actually ran the OLC for about 5 years for AANA when the academy was busy with other areas and let AANA run things and AANA let me design courses. I was so fortunate to have great friends and colleagues to help put this teaching program together.

I think the topic I was asked to discuss was was, arthroscopy and how do you push the envelope, and then how do you teach that to people. I think one of the cardinal things is that it starts with an understanding of anatomy and that it's a real patient that you are trying to get better. Maybe what we did in the past was always good, but maybe we can improve on that. And then how do you translate the desire for improvement and excellent care to someone who wants to learn.

The hardest part for the younger surgeons is to really try to think three-dimensionally when you're looking at a two-dimensional screen. So, you have to keep in mind where the nerves are, where the bones are, where the cartilage, ligaments, all the normal and damaged structures s are. So, you can teach them sort of have this three-dimensional image of what's going on, then I think that's one of the exciting things, and we'll get to that later, about the future. I think the future is exciting , not just artificial intelligence, but all the different imaging they'll be able to do and kind of look around and see what's happening.

But for now, the way that I teach is we do an indication of what we're going to do and tell them ahead of time. It's up to them to look at the images. It's not my job to teach them to prepare but to demand that when we get in there they are ready for the case. What I do then is basically give them a time limit on how much they get to work before I take over. Essentially, what I do, the way I developed this, is I had my nurse time me on different procedures. So, they don't get to do the whole thing from beginning to end unless they're very efficient, and hopefully we get them there. But what I will do is say, 'Okay, we're going to put an anterior labral anchor in.' It takes me roughly a minute and a half to put an anchor in and pass my stitches. Then we triple that time. So, now we're at four and a half minutes. We'll say, 'Okay, so you are going to get to work. And we're going to let you put the anchor in.' I'll help their hand move a little bit, which is great. 'And I want you to pass the stitch, and I want you to go through the steps.' We'll give them four and a half minutes to do that. The first time you tell them that you have four and a half minutes, they're in total panic and they get nothing done because they're trying to rush. You tell them 'Calm down. Just be efficient with your movements,' and then all of a sudden, they get it done in the four minutes. Then they train a little bit longer, and we give them other things to do, and then we'll come back to that. They'll knock it out in a minute. They did it really well, and you kind of look at it, and you remember, you couldn't finish this just a month ago, and now they have it. That way, the patient's not paying for extra time, they are being well taken care of and we are making sure everything goes well. And they're trying to understand the importance of being efficient with your movements.

That reminds me of a time when my mentor , Dr. Dick Caspari, came down, and I actually fixed his shoulder when he tore his rotator cuff. It was very interesting. So, he came down, he stayed at my house, he and his wife, Judy. We took him to surgery. We fixed his shoulder, had a lot of cases to do afterwards, and then took him home. The first thing he said is, 'Let's pop the video in and see how you did.' So, unexpectedly, because this was before MRI scans, when I put the scope in there was a tear in the biceps. I knew what my physical exam showed, and I was a bit uncertain about what to do about his biceps. So, when I put the scope in, you could see there was a tear in the biceps, and I was going to have to do something about it. So, it's not a problem, we put a stitch in it. But I put my shaver in, and I went around the biceps once, and I was uncertain that I was really going to do this, and I went over it a second time. He slapped me on the shoulder and said, 'Why'd you do that?' And I went, 'I wasn't sure'. He said, 'You knew when you put the scope in, you were going to have to tenodese the biceps.' That was an inefficient move to do it twice. I went, 'Yes sir.' I mean, at that point, I'd probably done 15,000 shoulders already in my career, but he was 100% right. So, you never quit learning. And he said, 'You knew and 'The only reason you did that is because it was me.' And I said, 'Yes, that's correct. Because you are you. You are the best shoulder arthroscopist ever in the history of the world.' It was funny. So, we fixed his biceps and his rotator cuff his biceps. He did great. He passed away a few years later, but he's great man, great guy.

It was really funny that you still learn all the time. So, now as we as we embrace new things, the reverse shoulder, SCR and the balloon, patches and all these other things, part of the deal is when people bring stuff, we want to make sure it is both better and more efficient. And so, consistently, and I never charged companies for this. I didn't patent things. I just wanted to make better instruments to make the procedures more efficient. So, my buddy Steve Burkhart, he would design all this stuff, and he would patent it. So, he did really well financially.

I followed a different path, neither better or worse, just different, where companies would bring in new equipment and I would tell them, 'I'll look at your instruments. I'll change your technique. I'll make it better. But if you bring a toy that I like, I'm keeping it.' So, I thought that was pretty fair. And they would go, 'Well, no, it's not ready.' I said, 'I don't care if it's ready or not. If I like it, I can keep it. I'll

sterilize it. When you finish it, you can bring me another one, and I'll give you the original one back.' But right now, so that was a pretty fair deal. It saved them a lot of money, and patients got a lot of good stuff. So, then when you go back to teaching, and part of the deal is if you look over my career, a lot of times I would publish something, and then it would be would not be mainstream, and it would be, 'Oh, he's just crazy.' And then all of a sudden, 7, 8, 9, 10 years later, all of a sudden people are coming back to it, and it becomes something that we actually do routinely.

When I first got into the Shoulder and Elbow Society, the first paper I talked about was arthroscopic management of multidirectional instability. This is like 1992. Nobody did this. I mean, they were barely scoping shoulders. So, it was not met with a lot of positivity. Joe Iannotti was the moderator. I had all these negative comments, and we finished. The nicest thing anybody said about the paper was Russ Warren said, 'You know, Buddy, I don't think you quite understand the patient you're dealing with.' And I went, 'Okay, you know, thank you.' I just kept saying thank you, thank you, thank you. Then Joe said, 'Do you have anything to say back after all these comments?' And I went, 'Yeah. In 10 years, you guys can all be doing it this way because it's that much better'. And sure enough, 10 years later, they were all doing it that way. The same thing happened a year or so later with arthroscopic release of the elbows. The first guy to do that and first guy to deal with an arthritic elbow arthroscopically. All these things just happen because you kind of look at patients and you go, 'You have to have a better way.' And the better way sometimes involves equipment, sometimes in fishbowls, what you can do. So, like at a recent meeting, they wanted me to talk about arthroscopic management of glenoid fractures. I do a lot of elbow fractures arthroscopically because if you can do it, it's better. If you can't do it, then it's waste of your time to go scope in. But at least you learn a little bit and you look and there's some tips. I think it was pretty well received. You know, and then you do things on the far edge of it.

Giuseppe Porcellini is a friend from Bologna, he came to visit and I happened to do an arthroscopic shoulder arthrodesis when he was there. He thought that was amazing. So, he went back home and he did about 15 of them and he combined our study and we published it in Arthroscopy,: arthroscopic shoulder arthrodesis. The comment from the editor was that if you really want to traipse out on the far limb of what potentially could be done, it's that. Giuseppe is a superb surgeon and he was able to do this quite well, but its not for everyone. I think somebody has to keep pushing the limit of what can and can't be done. And then we have to be able to teach it. So not everyone can learn these things, but most people can if you just take them and show them how to do it. A prime example of that is my partner, Mike O'Brien, he's a fantastic surgeon. When he finished his fellowship with Gerry Williams and Matt Ramsey, he was so well trained, he came in and then we start talking about elbows and he came and scrubbed and we did an arthroscopic post-lateral reconstruction and repair the elbow. He went, 'it can't be that easy.' And I went, 'No, no. It's just two things.' So, he did one. He said, 'I had trouble visualization, so I had to open it.' And I said, 'We got an inflow from the front.' He did that and he's never opened another one since. I mean, and he's a great surgeon. He did a great job. And it's just showing people little tricks. Because we're building skill sets now. It's just incredible. And then all of this new stuff about computer training and 3D imaging and now you can 3D print a model so you can look at it and then you have Google Glasses and you have augmented reality. I mean, the future is so great for education and you'll be able to practice it and you'll be able to build in complications and where things are. You'll see what nerves are. I think some of the stuff we learn just by cadaver and by repetition, they're going to learn just on computer. It's just fantastic. So, you know, old people tend to think that the future is not bright. I think the future is going to be unbelievably great in terms of education. I'm very excited. Even if I can't be a part of it, I want to watch it. I think it's going to be wonderful. That's my journey.

Submitted: October 15, 2024 EST. Accepted: October 15, 2024 EST. Published: February 03, 2025 EST.