

Michael Roberts (00:09):

Welcome to the Health Connective Show. I'm your host Michael Roberts, and I'm joined by our company President Scott Zeitzer. Today we're talking to Patrick Jamnik, the president of Episurf Medical, an orthopedics company out of Sweden. Episurf received FDA approval for their patella femoral system in December, 2022. It's a precision technology that allows certain parts of the knee to be replaced without having to do something as intensive as a partial knee replacement. We wanted to have Patrick on to talk more about the company as well as their approach to customer experience and marketing. So, Patrick, thank you so much for joining us today. We're looking forward to the conversation.

Patrick Jamnik (00:45):

Sure. It's my pleasure.

Michael Roberts (00:46):

Alright, so let's start off, let's, let's talk about Episurf's patellofemoral system and how it's different from other knee products, knee replacement products that are out there on the market.

Patrick Jamnik (00:55):

Sure. So, I mean, at its core Episurf's patellofemoral system, it's a, it's a customized, customized meaning both the trochlear or the femoral implant and the patellar implant. It's a customized implant system to treat arthritis of the anterior or or front of the, the knee. In terms of difference though, I, I think maybe the best way to describe it is a dental analogy that I often make. So if you think about people who have their knee replaced, you know, total knee replacement, that's a super common orthopedic procedure. Around a million of them done per year in the United States. Millions more done around the world. That's sort of like dentures for someone's knee. The surgeon has determined that there are too many structures in the knee or too many teeth to keep the analogy going. Too many structures in the knee that everything needs to come out.

Patrick Jamnik (01:48):

And in this, in the knees case, a centimeter of bone around all three, all three bones, one or two of the cruciate ligaments, both of the meniscus on, on both sides, the surgeon has decided that all needs to come out. Nothing is salvageable, sort of, and the whole knee needs to be replaced. Or in dentures, you know, your whole, your, all of your teeth need to be replaced. If you go to the right a step, I'm sorry, go to the left a step, sort of a step down on the level of invasiveness, there's partial knee replacements. This is more analogous to sort of like a crown on a tooth. So a a surgeon has just determined that there's one area of the knee that is damaged. One of the three compartments, the knee is three separate joints working together. One of those three separate compartments is damaged beyond the point of repair, and therefore that compartment needs to be replaced.

Patrick Jamnik (02:36):

But all the other, everything else in the knee is fine. That's sort of like putting a, a crown on someone's tooth. The dentist has decided that that individual tooth is decayed past the point of repair. So they need to just sort of put a cap on the entire thing. Where we entered the picture today, and, and hopefully more so in the future, is our implants serve as a, maybe the best analogy is sort of like a cavity in someone's tooth. So using a combination and, and for this conversation's purposes, it's the, in the patellofemoral joint, using a combination of a customized and company, company specific MRI protocol. And then taking those, those images and incorporating and using them with modern day manufacturing

and 3D printing of, of implants and instruments, we're able to sort of like take a spot in the patient's knee and kind of fix it like a cavity, like a dentist would fix a cavity, they see a specific area of decay and therefore they're going to sort of drill around and fill that specific area on, on that tooth or, or in this patient's knee. And then leave everything else to, you know, it's still working well, leave it to fight another day. And this is the type of thing that was very, very difficult to do. It's not an idea that is brand new, but we like to think of ourselves as being able to take, you know, sort of an idea that has kind of kicked around orthopedics for a while and bring to it the necessary imaging and manufacturing techniques that sort of like actualize the real idea there.

Michael Roberts ([04:03](#)):

Talk to us a little bit about sort of that ideal patient that you have in mind. 'Cause the first time that I heard about this product, I heard you present on it, and then I sort of, it was less than a week later, I had a buddy of mine that's not quite to where he needs to get like a full nowhere near like full knee replacement kind of level. And I was thinking what was, what was that guy's name? What was that product that they were talking about? I was going back and looking you up, but love to hear it in your words.

Patrick Jamnik ([04:28](#)):

Yeah, so we were founded by an orthopedic surgeon. It's a Swedish based company. We were founded by an orthopedic surgeon from the Karolinska Institute in Stockholm named Leif Reid. And Leif, when he was in his late fifties, he, he started to develop some early arthritis in his own, in his own knee. Being a surgeon, he was able to sort of self-diagnose pretty quickly and realized like, oh no, I am one of these patients that as a surgeon I always struggled with when they came into my office. So we call them gap patients. Now, a gap patient in our sort of vernacular is patients between the ages of about 40 and 60. It doesn't have to be know, it could be five years on, on either end of the, the spectrum, but in orthopedic terms, kind of middle aged patients. And, and Leif tells the story, I think better than, than I would, but he knew right away that he, he was the type of patient that he was too old.

Patrick Jamnik ([05:22](#)):

He had aged out of the kind of efficacy of a lot of the more biologically oriented products that sports medicine surgeons use. All the times, all sorts of, I won't get into them, but there's a whole variety of groups and gels and pastes and all sorts of different biologically centered products that sports medicine surgeons use. But beyond the age of, let's call it 40, but it's a little bit different than every patient, but beyond the age of about 40, the efficacy of those products starts to really diminish that by the time you're in your late fifties, it's, you know, there's not a lot of real, real good research to, to suggest that they work really, really well on a wide scale. But he also had a knee that was just frankly just not, not damaged enough yet to, to warrant any kind of conventional arthroplasty procedure.

Patrick Jamnik ([06:04](#)):

So he knew he was one of these gap patients that he always struggled with. And he tells a story about how he knew right away if he, the patient came into he, the surgeon's office, the patient would probably be put on this kind of never ending carousel of injections, physical therapy, bracing, sort of just trying one thing, letting it work for a little bit until it just doesn't, and then kind of just moving on to the next thing and hoping it works again. And really all that they're trying to do or all he knew that all he would try to do to treat himself if he saw himself as a surgeon, the conventional treatment plan would be, let's

try a bunch of different things and let's just hope this patient either gets worse or gets older. And if they get worse or older, we've got something in the toolkit.

Patrick Jamnik ([06:47](#)):

But for a 58-year-old who's, who's suffering from this particular condition, we're gonna just try a bunch of things and keep our fingers crossed. So it's those middle age patients that we kind of as a company I think see ourselves really trying to advocate for. There's, there's a variety of reasons of like how we got there, but in, in orthopedics, because most surgeons these days are fellowship trained, five year residency program followed by a a one year fellowship. If you're interested in knee surgery, for example, and you go do a fellowship, you're going to end up in one of two sort of kind of categories. And this is how surgeons define orthopedic surgeons, how they define themselves and how they talk about themselves. And sub-segment themselves. If you're a knee surgeon, you're going to end up doing either a sports medicine fellowship where in that fellowship time you're treating a lot of athletes, especially at higher volume, brand name kinds of centers.

Patrick Jamnik ([07:33](#)):

You're trying to get athletes back to peak athletic conditions. You're doing all sorts of surgeries, ACL repairs, meniscal repairs, these types of things on younger patients, patients in their twenties and thirties and early forties. If you're a knee surgeon and you're not doing a sports medicine fellowship, you're doing a joint replacement fellowship or what's called an adult recon fellowship or an arthroplasty fellowship. And there, especially the types of facilities that have fellowship programs, you're doing either lots of high volume, just like a eight, 10 knee replacements a day, just getting patients in and out throughout the door, or you're doing lots of like revision type of work or, or infection type of work or the, the really, really complicated stuff. And as a result of the way that these fellowship programs have kind of developed over the course of a number of decades, patients in the middle, they just have been sort of left without a real strong kind of surgeon group that advocates for them.

Patrick Jamnik ([08:21](#)):

So depending on where the patient comes from or individual referral patterns can change even from different, like from city to city or or or clinic to clinic in terms of where these patients kind of end up and present into the, the medical system. But they're oftentimes just left with a surgeon, a sports medicine surgeon, trying to sort of make their stuff work later on in life than a lot of their stuff was sort of intended for, or a joint replacement surgeon, just trying to sort of like either get the patient old enough or just do a joint replacement procedure on a patient that was never really intended to, you know, and it doesn't necessarily always have the damage ready for that type of procedure yet. So they've just been sort of left behind historically and hopefully as a company we can play a role for those patients and help kind of advocate on their behalf.

Scott Zeitzer ([09:03](#)):

Yeah, I've worked with a lot of orthopedic surgeons over the years and there is a lament for that gap. You, you're just kind of saying like, I don't know, I'm gonna help 'em with their pain as much as possible, but they're just too young for a total joint replacement and there's a lot of different things they can do to bide their time and you hope that they just feel better. Right? Or to your point, Hey man, when you're old enough, I'll take care of you in the meantime, suck it up. You know? Yeah.

Patrick Jamnik ([09:30](#)):

And this is,

Scott Zeitzer ([09:30](#)):

They're not happy about it.

Patrick Jamnik ([09:32](#)):

Not only in just what you see in terms of ages of patients getting joint replacements. I, I've been in orthopedics for almost 20 years now, and even when I started mm-hmm. <affirmative>

Patrick Jamnik ([09:42](#)):

Barely anybody under the age of 70 would get their knee replaced. Almost everybody was, was 70 or older. And then before too long, 65 was the new 70 and then 60 was the new 65. And then 55 was the new, the new 60. Now if someone has, you know, if they have arthritis all over their knee, they need to have their knee replaced. There's nothing that EPs surf or anybody else will be able to do to help them. But the idea that we can just replace everybody's knees as they, you know, regardless of what age they are, because the materials are better and the materials are better than they were a couple of generations ago. But the idea that you, that need everyone's knees can just be replaced at a younger age. That in large national studies, I'm thinking of the British Joint Replacement Registry, that that data is not reflected. The younger the patients are at the time of their index arthroplasty procedure, the worse off that they, that they do.

Patrick Jamnik ([10:29](#)):

So not in terms of long term where the oldest patients have sort of passed away out of follow up, but at basically from day one, you can pick your interval three years, five years, the 50 year olds do worse than the 55 year olds do, worse than the 60 year olds do, worse than the 65 year olds and so on and, and so on and so on. So there, there is a good reason or, or there does seem to be scientific evidence to if someone is able to be pushed out and have that index arthroplasty procedure delayed, to have it delayed as long as as possible because it's not that Episurf could play a role to prevent all knee replacements from ever happening. That's not at all what we're suggesting, but I do think we can play a role in the younger patients right now who are receiving knee replacements who don't necessarily need to based on their damage. If we can push those out or, or, or if, if those patients can be pushed out further, they're gonna be really, really thankful in their eighties when, when it's time for a revision and they're, you know, they have another, a whole other host of comorbidities and wound healing issues and poor bone quality, that's just a much, much tougher surgery for someone later in life to go through.

Michael Roberts ([11:26](#)):

You guys did start off in Europe. Is this idea catching on more, there, is this more of a, like a thing that surgeons reach for in their bag now that the, that the product's been out there longer?

Patrick Jamnik ([11:36](#)):

We, I mean of course we're, we're we're seeing growth, growth all over the world. Europe is no no exception. Germany in particular, I think the biggest difference sometimes between the mindset, and this is not, it varies of course from country to country a little bit, but I described earlier how niche, or in Europe it's much more common that someone would be a knee surgeon and they handle all host of knee problems from not, maybe not pediatrics, but, but some sort of age 18 through the rest of their life, a surgeon would be just a knee surgeon. They wouldn't do sort of sports medicine or joint

replacement. So in the US if you are a knee replacement surgeon, you are much more likely to replace hips than you are to scope knees. And that's just a little bit different in, in Europe. In Europe you'll get more, I am a knee surgeon, I'm a hip surgeon, I'm a shoulder surgeon.

Patrick Jamnik ([12:22](#)):

In the US there tends to be much more sort of cross anatomy or cross anatomic specialization based almost more on patient age and types of injuries rather than specific locations or, or joints throughout the body. So I do think there's a little bit more of education and sort of like company-surgeon fit kind of matching that we have to do because we're, we're going around the country right now and, and there is no, we get asked sometimes like, is this a sports product? Is this a joint product? And the answer is both or neither really, depending on who it is that you are, that you're talking to. There's not a consistent referral pattern sometimes. And and I always say, you know, at East Side Orthopedics 50 year olds get funneled into the sports surgeon, but at West Side Orthopedics, 50 year olds might get funneled into the arthroplasty surgeon, and neither is really right or wrong.

Patrick Jamnik ([13:07](#)):

It's just sort of local habits that have come up. So, so we're either the on the, the long kind of continuum of care, the sort of spectrum. We're either sort of the last sports medicine company or the first joint replacement company along the way. And, and that's just a, you know, that that's just a, you have to approach each surgeon category a little bit differently based on their own backgrounds and and interests. But that's maybe, you know, a difference that we don't see as much in, in Europe. 'cause if you're a surgeon that handles a whole variety of knee problems from age 18 on, it's a little bit more obvious sometimes where we fit in the, in the care continuum.

Michael Roberts ([13:39](#)):

Sure, sure. Right on. So let's talk some about the technology that's going into this. 'Cause it, it does seem like a lot of things have kind of caught up to where this vision could go, right? Like in terms of like what you're hoping for. So one of the things that, that I saw online was your company has this damage marking report and you mentioned that a little bit based off the imaging. Tell us more about that, like how it helps surgeons plan for surgery, but then also like sort of like how your company is offering that and making that a part of like the services that are, that are out there for surgeons.

Patrick Jamnik ([14:08](#)):

Sure. So yeah, everything we, we make, uh, is customized. So we don't have a single instrument tray around the world. We don't have a single warehouse of equipment anywhere around the world. But in order to make customized implants, surgeons need to know what it is that they're looking at and what it is that our implants would look like and and, and how they would kind of work and interact in the patient's joint in, in this case, the, the knee. What we're trying to do with the damage marking reports is hopefully help surgeons with patient selection, with their own patient selection process. Industry in general is very, very good at when the phone rings and it's a doctor on the other end of the phone answering the call and the doctor says, Hey, I need this equipment at this hospital next Tuesday for this procedure.

Patrick Jamnik ([14:54](#)):

And industry is very good. They spring into action. There's all sorts of herculean kind of logistical things that take place and there's late night FedEx pickups and all of these types of things. But the industry is

very good at sort of arranging all the equipment and getting everything there and then making, you know, helping make the case go as well as, as it possibly can. What we are not privy to oftentimes is all of the kind of mental work that the surgeon may have done before they ever even picked up the, the phone trying to determine what was the actual right procedure for that patient. Now if you're a joint replacement surgeon and it's like, well, I replace knees and I replace hips, well there are some intricacies in terms of how they may plan to do the surgery, but ultimately the, the equipment with some, barring some real knees that are really deformed, the equipment is oftentimes very, very routine and, and and consistent.

Patrick Jamnik ([15:40](#)):

But like what I'll call all this sort of stuff in the middle, that's a CR description. But all this stuff between kind of conventional arthroscopic surgery and a joint replacement, a lot of it, it does work, but patient selection is paramount. You read all this published literature, you go to the conferences, you hear doctors on the podium talk and they stress patient selection over and over and over again that this works well in the right patients and, and this is not just Episurf, this is all sorts of other things. So what we're aiming to do with these damage marking reports is hopefully help the surgeons with their own patient selection process. We want them to feel that if we are the choice, that by the time they make it to the operating room, they have chosen the right procedure, we wanna give them the confidence or hopefully aid in their confidence that they have chosen the right procedure for an individual patient.

Patrick Jamnik ([16:28](#)):

And because our implants are designed to kind of work in harmony with the rest of the, the native bony and soft tissue structures in the knee, it's important that surgeons know where they would fit and what the rest of the knee will look like after our implants are in there. Because we're leaving a lot of things, we're leaving as many things as possible to live on for, for another day. So it's not common, but it does happen from time to time. And we knew this going into it and we kind of almost encourage it because we don't want our products going in the wrong patients that are, they're not well suited for. It does happen from time to time that we will take receipt of images or have some images that are uploaded to us. We will do a damage marking report back for a surgeon and they'll say, wow, thanks.

Patrick Jamnik ([17:09](#)):

Patient didn't describe this in terms of like, they had pain here, the physical exam didn't necessarily show anything, but here's basically the, the knee is a lot more damaged than I was expecting and therefore I do need to do sort of the next procedure down the line. So thank you because I, this saved me from either having to make a difficult intraoperative decision in a high stress environment like the, OR where you don't wanna have to make too many, you wanna minimize your decision making, or this saved me from just doing flat out just doing the wrong procedure and having a, a, a problematic, you know, sort of maybe potentially an unhappy patient down the line. So for these middle aged patients, we do think that any role that we can play as a company towards helping surgeons in their their own patient selection process, we're gonna make sure that our products are going into the right patients, we're gonna make sure that surgeons have confidence in using them. And even for the cases that we don't sort of get quote unquote along the way, hopefully we're building a lot of, we're building a lot of credibility along the way.

Scott Zeitzer ([18:04](#)):

Yep. A lot of trust with the surgeon that you're trying to get them lined up correctly, et cetera. The, the process itself, I'm just guessing there's a lot involved in trying to figure out like, like how do you match up with the MRI systems that are out there? You've gotta sync up with quite a few different systems out there. Is that done through markers, et cetera or anything else?

Patrick Jamnik ([18:27](#)):

There's a company specific protocol that we have and we have a number of different protocols to kind of match all of the, at least most in the United States, almost, almost entirely all of the commonly used machine manufacturers. So we have a GE protocol, we have a Siemens protocol, we have a Philips protocol, even for the, the rare machine that is not one of those three. They can usually take one of those and it's close enough that they can work with it. The MRI that we're, that patients are receiving in the knee at least, of ours, it's sort of a conventional diagnostic MRI plus a couple minute 3D set of sequences, and the 3D set of sequences is what we really sort of need to not only really do the damaged marketing report, but really do the implant design part to see things of course in, in multiple dimensions.

Patrick Jamnik ([19:12](#)):

So it's a pretty simple protocol for the, the facilities to, to follow. Of course, once they do it one time, it's saved and programmed into their machine. So it's not, you know, there's not a, a lengthy build or, or anything like that ahead of time. And, and we have a number of facilities that when the first patient arrives, they just scan the patient, you know, they're just reading the protocol and sort of programming it live on the fly. So generally speaking it is, it is simple enough that we don't get too much pushback on the, on the, on the imaging part of anything.

Scott Zeitzer ([19:37](#)):

And that data, is that stored up in the cloud in some sort of HIPAA compliant matter?

Patrick Jamnik ([19:43](#)):

Yeah, there's a whole, um, I'm not the best person to, to speak to all the technical nuances, but Sure. But HIPAA compliant yes. Stored in the cloud, yes. Anonymized before anybody from the company. You know, we, everything automatically is anonymized to a, of course, a specific system of, of patient identification and case case identification. So our, our engineering team and, and everyone aside from the physician, there's different, our system that we use, our kind of order management system, there's different, different people have different logins and stuff, and what the surgeons can see and enter is different from what the imaging folks can see and enter is different from what our, our engineers or our sales teams can, can see and enter. And there's all sorts of different, you know, layers of anonymity built into that.

Scott Zeitzer ([20:21](#)):

That's excellent.

Michael Roberts ([20:22](#)):

Yeah. One thing we're we're, I actually recorded an episode earlier today. We were just talking about the whole processes around like patient privacy and like how much, you know, information gets exchanged. And one thing that one marketer that I follow says like, "Always thank God for the Germans because they're always gonna make sure that everything's private." And so, you know, European in



general, like, we're gonna make sure that everybody's private, staying private the way that it's supposed to. So already off to a good start coming from a European company.

Patrick Jamnik ([20:49](#)):

Yeah, we took, I mean we took us the same system that we had used in Europe and we didn't need to, there was no new privacy layers or anything, anything like that. Everything that was, was built for the, the European market has worked flawlessly in the US as well.

Scott Zeitzer ([21:00](#)):

Yeah. When you develop for EU, you know, HIPAA compliance, like I I, there is no, it's not really called HIPAA over there obviously, but patient security and patient privacy based on EU protocols certainly will be HIPAA compliant here in the United States.

Michael Roberts ([21:15](#)):

So one of the things I also wanted to focus on, again, poking around the site some more, you know, Episurf does really focus a lot on this kind of customer experience. You've got a platform that you show off on the website called MyFidelity, it's an order management system. You can upload the data, communicate with the team. Is this just kind of part of this process or how does that fit along with the pieces you've kind of already described?

Patrick Jamnik ([21:37](#)):

Sure. So it's a one-stop shop in terms of all of our order management capabilities. So I touched on this earlier. We create logins and passwords for surgeons or, or their, you know, their staff, their schedulers sometimes within their office. We create logins and passwords for surgeons. We create logins and passwords for imaging representatives, MRI techs and we create logins and passwords for our sales personnel. And we, we sort of link the sales personnel to the appropriate surgeon customers that they have. Overall, I would describe MyFidelity as part of what we're aiming for as kind of a, as pleasant of a user experience as possible. Anytime you're, you're dealing with custom implants, there's a lot of back and forth that can, that can happen and, and you never want to there to be any questioning of sort of, where are we at or what's next or, or how long does something take?

Patrick Jamnik ([22:31](#)):

And, and in the medical world, this is something we have struggled with historically. I mean like pizza companies for example, you know, like I can order a pizza on Domino's and I can see like, oh there's the guy putting the pepperonis on the pizza right now. But, but it used to be in the medical world, it's like you'd place an order for a custom implant and it's like, okay, let's just keep our fingers crossed that a box shows up. It's in six weeks. But I can, you know, on a, on a pizza, you know, I can order a pizza, I can follow the driver from leaving the store right to my right to my house on a, on an app. So we're aiming to create as positive of a, of an overall kind of experience as we can. And that's something, as a small company, there's many of things, many things that are, we are disadvantaged by just relative to to size.

Patrick Jamnik ([23:06](#)):

But the vibes, for lack of a better way to put it, the vibes around the company, when someone is ready to, to order a product from us, we are in quite a bit of control of over that. So we better be doing a good job at that. There's a couple of other things that I, that are just sort of coming to to mind as we talk about this customer experience that we try to work with. One is an easy approval process. Surgeons



need to approve the, the products, but I've been a part of at different companies throughout the course of my career and different types of custom produced things, the surgeon would have to go in and log in, but they would have to like log in from a desktop because the software only worked in a way that like they only could do it from a, you know, a desktop.

Patrick Jamnik ([23:43](#)):

So they try to get a surgeon who's busy either seeing patients or operating be like, Hey, I need you to go to your office and then go in and log in and I know you forget your password, but just click on the reset password, then go check your email, we'll send you a new password and you know, all of this just to click a green box. That's kind of a pain for them to do. So we try to make our approval process as easy and as as painless as possible for the surgeons. And then another thing that might be sort of specific to our MRI type of technology is I mentioned the 3D, the 3D part of the MRI earlier. That's a bit unique. It's not unique that it's not terribly difficult for them to do, but it's not very commonly done as part of a normal diagnostic MRI that are ordered, you know, where there's millions of them ordered per year.

Patrick Jamnik ([24:23](#)):

So especially as we are getting going with new surgeons, it's a common question, I just had this in a surgeon discussion two hours ago was, okay, what happens if, I get how we'll handle the 10th patient where I see them and I can come in and I can order your specific MRI, but what happens if somebody comes in and it's 'cause people come in sometimes and they get referred in and they sort of show up with an MRI in their hand that had been ordered either by, you know, primary care physician or a PA or someone like that. What happens if they just show up with an MRI and we say, well two things. One, we cannot probably take that MRI and make it all the way to the OR with that MRI, but first of all you can upload those images to us. We can have our engineers take and screen and look at everything, kind of screen it for contraindications, give you a sense of like, is this, or is this not a good case to proceed?

Patrick Jamnik ([25:12](#)):

We don't want people unnecessarily going back and having more imaging done. If it looks like a good case to proceed, on the first one, we'll pay for them to get re-scanned. It might sound crazy like why are you paying for, for MRIs? Almost every facility has a cash rate that's considerably lower than what they tend to pay insurance companies. And honestly it's a very small price to pay to pay for the first MRI to get everything going while you're kind of like ramping up with a new customer. Companies spend, they'll spend twice as much in a FedEx charge to send a box to somewhere else across the country tomorrow. But, uh, for us to, you know, pay for one MRI to get a new customer going, it's a small price to pay in the sort of lifetime value of a, of a customer. But that's all designed, all of these things are really centered around creating a, as easy and as sort of productive and, and just frankly happy of a customer experience as, as we possibly can.

Scott Zeitzer ([26:02](#)):

It's interesting with the orthopods and with anything, it's like you don't want surprises and you're setting very good expectations with your software, and essentially you're, from what you're saying, they come in with the RI it's like your team will vet it. Yeah, yeah, this looks like it's possible. I'm not sure if it's gonna be, but it's possible. So let's go pay for the MRI in this particular case and let's see if this is gonna work, and this is what you'll need kind of a conversation.

Patrick Jamnik ([26:29](#)):

Exactly.

Scott Zeitzer ([26:31](#)):

Yeah, that's great.

Michael Roberts ([26:31](#)):

Yeah, ideally the technology's supposed to smooth everything over and supposed to make lives, people's lives easier, but it can just as often be an impediment as it can actually be something that helps <laugh>. So it's, it's great that you guys are thinking through.

Patrick Jamnik ([26:45](#)):

Especially when it comes to custom made devices. I mean surgeons, especially United States surgeons, and this is another sort of trans-Atlantic difference to some degree, United States surgeons are, are very used to and to placing a call to an implant rep and asking for something and then hanging up and just, and then everything just sort of shows up a day or a week later. Right. And there's a million things that happen in the background that just sort of happen. The reps act as these wonder miracle workers of, of lining all of this different stuff up and getting, they need 20 trays in total and, and they're, I'm, I'm, I live in Texas, so, but it's like, you know, they, they live in Texas and they, so five trays come in from Georgia tomorrow and then five more come in from California and then five more come in from from Minnesota and then they, they're there at FedEx and they, they do so much stuff behind the scenes, but when it's a custom made device, the surgeons, they do have to just be a little bit more involved in the process than just calling a rep.

Patrick Jamnik ([27:36](#)):

And then the rep shows up with 300 boxes sitting outside the OR and five of the 300 will get used and 295 of them will get sent off to somewhere else. There is a little bit more, now there's, there's hopefully less interoperative sort of stress and decision making that has to take place. But there is more, just a little bit more, but there is just a little bit more preoperative work or communication or back and forth that has to be done. So sort of the, we wanna minimize the annoyance that we, we can to customers because we realize there's some above zero level of annoyance of just, just asking for a custom device.

Michael Roberts ([28:06](#)):

Let me hit on one more thing before we wrap up for today. So one of the things that, that immediately stood out to me beyond the fact that, hey, I have a, a friend that could potentially use <laugh>, this type of product, but when I, when I heard you present the first time, was talking about just the ability of a, a small company to be able to get online, to be able to be on LinkedIn and to be able to interact with people in a different way. And specifically you were talking about distributors and how you were able to kind of like have that kind of direct connection. I'd love to hear more about that. Maybe I think you presented earlier maybe this year, or was it end of last year? I don't recall, but, you know, how has that process continued to play out for you? How is LinkedIn helping you get Episurf out there on a bigger level?

Patrick Jamnik ([28:49](#)):

Sure. So as a small company in a number of pretty obvious ways, you are disadvantaged by size. Hopefully you can, what what you decide to do, you can do quickly, but you can't do everything of course. And you have to be very cautious and thoughtful in your marketing efforts in particular because

you'll get spent into oblivion if you try to just be sort of a, a smaller version of a big company and just think, well, big companies do this and this and this, therefore we'll just do all of those, those things as, as well. It will not work out for you to just do things like the big companies do. I, I'm thinking in particular of a, of a big meeting like AAOS okay, those booths that the big companies have, they cost hundreds of thousands if not millions of dollars. You know, they, a decade's worth of marketing budget in a small company goes into one, a big company can pull off a booth in, in one meeting.

Patrick Jamnik ([29:40](#)):

When you go to a lot of those bigger meetings, for example, the smaller companies only have the budget for smaller stuff. And okay, you're back in the, you're back in the corner. The other, the other companies are at, you know, location A1 and you're at Q92 all the way in the, in the, the, the back in the corner. That, that tends to be a, you know, it's a poor use of marketing budget in, in my mind. What you can do though with places like LinkedIn is it just levels things to a much greater degree. And it oftentimes probably gives smaller companies an advantage. Not just, not just evens a disadvantage because one smaller companies, you have to be thoughtful of how you basically don't speak about product claims or don't get yourself in any sort of, anything that would run up against a, an inadvertent product claim or anything that would trigger a, a problem in your quality system or, or you know, anything that on the sort of regulatory front.

Patrick Jamnik ([30:34](#)):

But as a smaller company, you can act and project with a normal voice that the big companies just cannot do on a corporate level. Their reps can do it on a local level for sure, and they do it with their individual customers, not on the internet, but sort of in face-to-face conversation. But on the corporate level you just can't. And, and it's not even a criticism of those, those big companies. They have to, the way that they're set up, they, they have to act in a certain manner. So for a large orthopedic company, pick any of them, doesn't matter which one, you know, for them to make posts on LinkedIn, that's going through five layers of lawyers and everyone has their say so in it. And what might've been an interesting message ahead of time has been, you know, kind of watered down to we care about getting motion back in patients.

Patrick Jamnik ([31:14](#)):

It's like, well, okay, congratulations everybody, everybody has the same, the same type of message, but at a smaller company you can just act with a little bit more personality. And where that really, I think matters, it's, it's easy to think like, oh great, we can just like market directly to surgeons and they're just gonna come, come flocking. That happens a little bit, but it's, that's not where like the strongest benefits are to me. Yes, there are some surgeons on, on LinkedIn, but it is still is a very small percentage of the overall surgeon pool. There's, there's plenty that are active, but there's an even smaller, an even smaller group that are like really active. So you can definitely help your company with kind of general awareness types of things on places like, like LinkedIn. Where we have found it particularly advantageous is in the acquisition or or the beginning, acting as sort of a kickstart of relationships with distributors.

Patrick Jamnik ([32:04](#)):

Like many smaller companies, you don't have the funding or the, the funds to just like, well there's 50 states, or you know, let's go hire, let's go hire reps in 50, you know, the 50 largest markets you don't have the money to to do that. So you use third party distributors. And this is a very common, sort of common thing in or in orthopedics, but there are lots of distributors on LinkedIn. They are looking for

different companies to work with. I think they know just as well as the companies know that it's a good, it's a good way for them to present themselves to the distributors. The distributors know that the companies are looking for them, so they're quite active as well. And we've had so many inquiries that, or relationships that we, that are now sort of contracted distributors of ours that are doing great in the field.

Patrick Jamnik ([32:47](#)):

That started because of a LinkedIn post that either the company made or I made from my own personal page, or it was a referral from a distributor who got in touch with us the first time because of that mechanism. I, I, I'd have to go back and look at our, our full list, but I bet 80% of our existing distributors and, and we're, we're over 30 now around the country. I bet over 80% of them, there's some LinkedIn connection, you know, it might be two or three levels, levels of separation, but there's, there's some LinkedIn connection to almost all of them because they are, and they are fairly well connected to each other. They don't know all, everybody doesn't know everybody, but almost all independent distributors have a handful of friends of that do the same thing in different locations around the, around the country.

Patrick Jamnik ([33:27](#)):

And if you can be a good partner to, to one of them, they oftentimes after that relationship is up and, and running productively, they're oftentimes happy to help out and, and make an introduction to someone else around the country. So it's just that we've used and we've used LinkedIn unintentionally, there was no, like, I didn't sit in some master strategy meeting three years ago and say, here's what we're going to do. We're going to just, you know, have LinkedIn posts that are interesting and there, and we're, and we're gonna build our sales network with, with that as a primary catalyst. But it is something that we have, we have definitely latched onto as we've seen the positive effects of it.

Michael Roberts ([33:58](#)):

That's awesome. Well, great, Patrick, thank you so much for, for joining us. I, I appreciate you letting me, keeping you on the show for a little bit longer to go through some of these questions. This is really interesting. It's interesting from what the product you have to how you're supporting your customers and then just how, how the company is, is getting out there and getting the word out there. So again, thank you so much for joining us today.

Patrick Jamnik ([34:18](#)):

You bet. My pleasure. Thanks for having me.

Michael Roberts ([34:22](#)):

In our interview, Patrick shared insights into Episurf's product and offerings, how they support their customers and how he uses LinkedIn to connect with others in the industry. To learn more about what Patrick and his company does, check out [Episurf.com](https://www.episurf.com). Thank you to our listeners for joining us this episode. For more on the Health Connective show, please visit [hc.show](https://www.hc.show) for previous episodes and Health Connective as a company.