Newsletter

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Distributed from: laurence.woc@gmail.com

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This Newsletter is circulated through the internet, and through all WOC Regional Secretaries in the hope that they will be able to download and distribute it to those "concerned" who may not be connected through the "Net." It is addressed to all interested in orthopaedic surgery, particularly those who work in areas of the world with great need, and very limited resources.

Amidst the mayhem of terrorism and random slaughter in cities, airliners and football fields, it behoves us to step aside from the front page journalism and assess our reaction. Of course there is none. These victims don't just loose their life – it is violently taken from them. The size of the newsprint headlines is inversely proportional to the distance from the reader. Murder on our street is so much more horrifying than when it happens in most of Africa or South America! Now, it is thrust in our face.

The impotence of emergency services is everywhere demonstrated; lost precious seconds or minutes cannot be found again. The clock never goes back. For all the totally convincing principles of ATLS, they are as dreams compared with a wound to a vital system.

With this in mind, (where it is put everyday by the media) it was realistic to hear on the wireless today, that school children in parts of the UK are to have lessons in **"First Aid". (***This concept was raised on the pages of this Newsletter, Nos 177, 174, and others, regularly*). The only person with an immediate chance to save the life of the Casualty, is the one right next to him in the train, on the road or auditorium, wherever he is when the bomb, tsunami or earthquake erupts.

It is necessary that everyone in a civilised society has learned and developed an automatic reaction to the fallen, as second nature. Without familiarity and teaching, none can know what to do for the obstructed airway or spurting artery. But informed neighbourliness becomes instinctive and spontaneous, germinating from a prompt and accurate analysis of a situation, of which no one should (nor can ever be) insulated. Thus everybody must becomes a "Samaritan."

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Professor **Deven Tanaeja** writes:- in response to the news in NL 179, about the passing of Leslie Klenerman and Frank Horan, both regular readers of this organ, and whose conversation and comments have influenced our messages.

"Very sorry to learn about the sudden and sad demise of our two staunch supporters. *(I pray to the Almighty to grant peace to their departed souls*.)
I knew Professor Leslie (Klenerman) well. He came to Bhopal during a IOACON conference. He even visited my home, and he invited me to Liverpool to give lectures to the M.Ch (Orth.) course students. He was very soft spoken but animated and utterly convincing.
"Super specialization is curiously the trend these days. Newly successful students talk of proceeding into some or other super-specialty. Gone seem to

be the days of General Orthopaedic surgeons. I take pride in my training. I do spine, club foot, joint replacement and of course, trauma. On my first visit to Malawi, I was comfortable because of my background general training. The developing world needs just this type of surgeon."

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The valuable facility of "**Anatomical Dissection**," has been largely lost from preclinical medial school curricula in the so-called "Centres of Excellence". It used to give an opportunity for students to develop a bent towards surgical practice. This fact came to mind at the funeral of the prominent Professor of our Specialty, Leslie Klenerman. He retired from Liverpool, before settling into the department of Anatomy at Cambridge, where he taught Surgical Anatomy for several years, on an ostensible, but very professional basis. At a recent visit to Bulawayo, we saw the dissecting room of the University, still actively engaged.

In this age of endoscopy, knowledge of anatomy is neglected, and yet it is essential to a general surgical practice. In spite of all the amazing inventions of orthopaedic surgery, even wider surgical demands are regularly made on surgeons throughout the less well-endowed parts of the world.

In fact if you think back through the giants of modern surgery, many technical inventions have been made by surgeons, well trained in aspects of general surgery, even in general engineering!. Every country has its own example of that principle. Specialists in a variety of new fields need to collaborate with metallurgists, cyberneticists, geneticists…, but most importantly, with the broadest aspects of **Biology**. Do we suffer from too narrow a training in specialties, too early? Are we in danger of becoming technicians rather than physicians?

The thought rose again yesterday at the funeral of **Frank Horan**, recently the Editor of the British Orthopaedic Journal (once the JBJSb - now the BJJ). In

the customary eulogy, the reputation of that Journal was praised for its firm foundation on surgical practice, ensured by its adherence to General Orthopaedics, through the selection of inspired editors, who never allowed the papers proffered for publication, to be obscure or extreme in specialisation. In this manner the needs of general orthopaedics have been preserved, while at the same time the highest standards of Research have been met. This has been no mean task, in competition with the Specialists. The role of the editor was splendidly filled by Horan whose training was soundly “general”, but his vision, boundless. He realised how his own expertise relied on that of his teachers, principally John Crawford Adams and George Bonney. This example shows the constant thread of influence from teacher to the taught. The call from the LMICs continues to appeal for the greatest need – relating to the commonly occurring conditions and affordable by the under-resourced. Without a firm foundation of general orthopaedics, progress in the form of improvement, founders.

ETHIOPIA.

Laurence Wicks has just completed several weeks in Gondar, Northern Ethiopia, with WOC colleagues **Alwyn Abraham,** a plastic surgeon, **Sunil Thomas** and **Dean Birch** (a plaster technician).

“This team welds well, complimenting each other in terms of experience and skill. At least five severe ‘open tibiae’ presented themselves – a common week’s work. Tomorrow we shall review the wounds and plan combined “ortho-plastic” management of each case. The local surgeons, both Orthopaedic and General, will lead the surgery, while we assist, advise and supervise. The Leicester collaboration is now established in the most fruitful system of cooperation and instruction.”

This Gondar plan looks remarkably like the training for the practice of “general orthopaedics,” not easily found in the Western Centres of Orthopaedic Excellence. There has never been a time at which the problems of those on whom doors have been shut, have been more prominently aired. Perhaps the impression is spreading that Surgical Science has reached the point at which advances and inventions probe the unknown and unrecognisable - into the realms of great rarity and vanishing obscurity. Are we called to develop the brilliant therapy for that which has yet to occur, reaching out to be the first surgeon waiting for the first case, . . . of something?

From other points of view, the problems of the sufferer from what we believe to be surgical disease, are either personal and pathetic, or global and economic. If the latter, there is a possibility of the problem being addressed. But too often once the matter is placed before the “great and the good”, it is submerged beneath verbiage and inaction. To air a problem, too often dooms it. When the titles of WHO or UNESCO or UN are attached, it is assumed that it will be “on the table”, awaiting action, but frequently it has been filed, out of sight. It may appear that too often we repeat ourselves for a message to be conveyed. The “conservative” mind-set requires time to adjust to innovation, and TIME and accurate note-keeping are essential for a reliable audit.

FIGHTING GLOBAL POVERTY

The International **New York Times (NYT, September 25th, 2015)** bore an important essay with the title – “**How can Surgery Fight Global Poverty”.** That week the UN had adopted 17 proposals as goals, in order “to combat inequalities within and among countries - to build peaceful, just and inclusive societies.” All the appropriate words are there, but little has flowed from them – yet. The lack of appropriate hospital Infrastructure – electricity, sterilisation,

suction, oxygen, anaesthesia, are the building blocks of surgical intervention -- and yet too many ill-quipped hospitals ask for endoscopes, lazars and navigational tools, before the basic tools have been provided.

We, the fortunate many in the West, have developed surgical expertise, often through “trial and error” on the backs of the “guinea pigs” of neglect. Those “pilot studies” do not have to be repeated; the surgical wheel needs no reinvention.

The article, invited by the **NYT** (Internat), comes from the program on **Global Surgery and Social Change** (Harvard Medical School) - in the names of **Drs Mark Shrine and John Meara.** They quote surgery as “the neglected stepchild of global public health” and contrast it with less personal, less intimate, but more simple essential -- that surgery requires trained people to deliver it; and that will require a massive manpower investment, and the time to train it.

These points emphasise the fact that surgery does actually work, although it can just as easily do harm if misapplied or erroneously performed. So the need is not to advertise its efficacy, but to provide the workers to apply it.

Shrine and Meara end their essay with the paragraph :- “For the patient, deformity is a personal issue; for the developing nation, an economic one; for the world, a Moral one – the question of Equity. . . .To achieve global development, world leaders must create systems to provide safe, affordable and timely surgery for those in constant need of it.

POST-GRADUATE COURSE IN ORTHOPAEDIC SURGERY

The **“19th P.G. Instructional Course”** for those students preparing for the Masters degree or Diplomate of the Indian National Board of Examination in Orthopaedics.

This four day course: – **dates: 21st to 24th Jan 2016**. The **venue** is

Arihant Hospital & Research Centre, 283- A, Gumasta Nagar, Indore – 452009 (India).

The participating faculty is drawn from the National level, organized by Orthopaedic Research & Education Foundation, India, in collaboration with the Indian Orthopaedic Association, Centre for Science and Society, Indore, the National Board of Examinations (Ministry of Health, India), the Orthopaedic Association of SAARC Countries **(OASAC),** and finally, **World Orthopaedic Concern (WOC)** is to be one of the contributing partners of this course.

The content of the course includes lectures, demonstrations and discussions on clinical cases. There will also be '*viva voce'* interrogations on pathology, surgical technique, external fixation and standard equipment for cast bracing.

The **object** of this course is to prepare the candidate for the examination, both in theory and practice.

Eligibility – All trainees are invited to apply, who have been registered for the above course in any Hospital in India, or abroad.
Space is limited, so the first 100 will be accepted.
Registration fee is Rs. 5000/- IR (Indian Rupees). This includes Registration Kit, Lunches, Banquet, Tea / Coffee.
For accommodation – Details will be provided on application (v.i.)
Accounts details, below:
State Bank of India, Gumasta Nagar Branch, Indore, India
Account No: 63027689615
IFSC code: SBIN0030416
Course director: Dr. Deven Taneja
Contact: Meghna, Secretary to Dr. Taneja - <pgcourse@gmail.com> and Dr. Keshav Goel - + 91 7724973453

(M. Laurence)