Newsletter

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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.

A report on a visit to Addis Ababa, by **Geoffrey Walker, (**minimally edited)

Friday 20th November to Saturday 28th November, 2015, to Addis to attend the 20th Anniversary Meeting of the Surgical Society of Ethiopia and to visit the Orthopaedic Training Project at the Black Lion Hospital.

1. Addis Ababa and Ethiopia:

a) In 1990 when I first arrived in Ethiopia the population was 45 million. It is now about 100 million. In the same period Addis has grown from 2.1 million to 3.4 million.

b) The growth of the economy of Ethiopia is thought locally to be about 12% per annum, but is more probably about 6% pa.

c) The number of cars has increased enormously. There used to be two or three parked in the Black Lion Hospital Compound (BLH). Parking currently has to be carefully controlled by 'wardens'.

d) The ‘middle class’ continues to expand and there are now two 50-bed private orthopaedic hospitals. The planning of an even larger private orthopaedic hospital of seven floors is well in hand.

2. **The Black Lion University Hospital:**

a) The main buildings are still undergoing some restoration and development, mainly of the Radiology Department, which has new sophisticated apparatus.

b) The main Operating Theatres are still not functioning. This means that some general and other surgery is being done in two of the four new theatres in the Orthopaedic/Physiotherapy block.

c) A major enlargement of the current grossly inadequate Accident and Emergency Department, has recently started.

d) The Orthopaedic Department and its 21 bed children’s ward have been supplied with new beds, all with electrical controls, replacing the ‘special’ orthopaedic beds obtained some years ago.

e) There are still problems with the water and electricity supply, which seem to be more severe in the orthopaedic/physio building than in the main part of the Hospital.

3. The Orthopaedic Training Project:

a). The Orthopaedic Trainees: Currently there are seven in the fourth year, 19 in the third year, 27 in the second year and 24 in the first year. A total of 77 – while there are a total of only 72 orthopaedic beds in the BLH. However our trainees also spend time and gain invaluable experience in four other hospitals:- Cure Children’s Hospital, Soddo Christian Hospital, St Paul’s and a new department of Plastics and Accident and Emergency at Alert.

b). General surgical trainees spend time in our department, usually in three separate visits of one, two and three months. There are usually about 10-15 of these trainees in our department at any one time. Currently our Orthopaedic Trainees spend no time in general surgery.

4. The Teaching Staff:

a) Currently these number twelve, although two are currently on sabbatical leave and one may be working in the new Plastic and Trauma Unit at Alert Hospital.

b) Dr **Geletaw Tessema,** a recent graduate from our training project, is the current Department Head. He is a very impressive young orthopaedic surgeon who is striving hard to improve the workings of the training project and is worthy of all the help that he can receive.

c) However, there are problems with the amount of time that our trainers actually spend in the department. It seems that some only spend two days a week actually working in the department and others "disappear" regularly into the private sector. It also appears that there is less clinical activity throughout most of the Hospital in the afternoons. It is perhaps noteworthy that some of our trainers are more keen to operate than others. This is a serious situation which Dr Geletaw is going to have to solve through leadership, the cooperation of his colleagues and his own example.

5. <u>WOC and Other Help with Teaching</u>:

a) Currently this comes from WOC UK, Fintan Shannon from Ireland, Andrew Howard from Canada, Orthopaedic Surgeons from Australia and occasionally from America under the auspices of Orthopaedic Overseas (O.O. the US Region of WOC).

b) What and how to teach? While sophisticated orthopaedic surgery is now being practised at the BLH, in private hospitals and in a few but important hospitals outside Addis, the vast majority of the 100 million Ethiopians receive care for their orthopaedic problems from General Surgeons, General Practitioners and Traditional Healers. It is therefore important that visiting teachers keep this in mind and stress the importance of conservative management, i.e. plaster and traction, as well as discussing more sophisticated techniques (c.f. sections 1a and

c) Unfortunately injured limbs are still being treated with circumferential (i.e unsplit) plasters or traditional splints both of which may result in Volkman's contractures (V i c.) or gangrene. It is best to emphasise the use of padded plaster gutters, i.e. a plaster back splint with sidepieces, never forgetting the danger of joint stiffness. <u>Teaching needs to be 'inter-active'; formal lectures do not seem to be readily absorbed.</u>

6. **Books and other Supplies**:

a) Currently the orthopaedic library at the BLH is only being used as a storeroom for obsolete and broken down pieces of equipment. All the trainees now use electronic means for reading and studying and the many books that have been donated by the British Council and others are slowly deteriorating on book shelves which themselves are also showing major signs of age and disuse.

a) The same applies to Journals. These are virtually never read in printed form so it is a complete waste of time and effort and money to send collections of old Journals to the BLH, or indeed to most other orthopaedic departments in low and middle income countries (LMIC's). Even up-to-date Journals are rarely read; but then the more "up-to-date" they are, the less relevant to "time honoured" tools.

b) Orthopaedic Materials. I am sad to report that since the inception of the Orthopaedic Training Project, virtually no orthopaedic instruments or other materials (apart from plaster) have been supplied by the 'Hospital/Government'. All have been donated from various sources. Private and Mission hospitals make their own arrangements, but there can be problems with 'Customs'.

7. Financial Affairs:

a) Dr Geletaw told me that individual departments in the Hospital are not allowed to raise funds, nor entrusted to look after money. All requests for materials, or indeed for 'anything', have to be made to the Faculty. So the orthopaedic department has no means of purchasing small but necessary items, paying for small services or indeed for anything, or for any activity.

8. The Orthopaedic Apartment:

a) No significant further restoration has taken place for the last three years. In fact everything remains in the same condition as I reported after a visit I made in 2012 in company with the relevant and then current Assistant Dean, and a Hospital Administrator. I stayed in the apartment during my recent visit and was not asked to pay any rent.

b) However, Wubitu the maid told Dr Geletaw and me that she had not received any salary since August 2015 – apart from money given to her by the relatively

few who had stayed in the apartment. Dr Geletaw and I discussed the current situation with Wubitu and explained that the question of her future employment would be discussed at the Feb 26th Meeting of WOC UK. (*Deepa please put this on the Agenda.)* Wubitu has given good service for over twenty years and my own feeling is that WOC UK needs to do something about her situation. I need hardly say that our discussion with Wubitu was not one of the high points of my visit.

c) It is probably relevant that the Hospital Administration is not doing very much to look after the two residential blocks which are mainly occupied by residents of other departments. A relatively short while ago the Administration made a major effort to eject these young doctors and their families and this almost produced a "strike". Eventually the Residents were allowed to stay but I have a feeling that the long term future of the two blocks is uncertain. In my opinion it would be very sad to lose our Orthopaedic Apartment which, with a little refurbishment, would continue to be very useful, comfortable and safe for teaching visitors, particularly as it appears that we are not expected to pay for its use**.**

9. Assistance for Visitors:

During my relatively short visit at the end of 2014 I stayed in the apartment and had the services of a young doctor (Dr Mohammed) who had been accepted for, but not yet started his orthopaedic training. He had a car and looked after me very well indeed. If possible I hope that Dr Geletaw and his successors might find further young colleagues to help and generally tend visitors. (The cost of taxis has doubled !)

10. The 20th Anniversary Meeting of the Surgical Society of Ethiopia went well but there were only two orthopaedic papers.

Total separation of Orthopaedics from General Surgery is very unwise as much orthopaedic management will for a long time have to be undertaken in Ethiopia by General Surgeons and General Practitioners. (cf Section 5c).

SUMMARY Suggestions

11. At present Dr Geletaw has three specific requests:-

a) Fellowships (presumably out of Ethiopia) for members of the training staff.
GW recalls the success of sending an Assistant Professor to the training project in Dhaka, Bangladesh.

b) Visits by Orthopaedic Surgeons from other Countries.
GW believes that these need to be by those of us with experience in the use of simple/conservative management, i.e. Plaster and traction and who will make visits of at least three weeks. (cf Section 5c in regard to teaching more sophisticated techniques requiring implants etc.)

c) Whenever possible visitors should bring implants and other orthopaedic materials for the department. Dr Geletaw is confident that he can overcome any 'Custom's Problems'.
GW believes that when possible potential donors should first check with Dr Geletaw the suitability of any materials that they may be able to bring.

(Geoffrey Walker)

CORRESPONDENCE

In appreciation of other correspondence that flows from the Newsletter, we quote the following:-

From **Professor Vijay Kumar Khariwal**,
Artemis Hospital, New Delhi, & Gurgaon, India.

"I read your letter this month in which you have mentioned the various problems of developing nations. You have rightly mentioned various issues regarding these countries. Our problems are very different from those in developed nations (as U.S.A., U.K. etc.). It is true that new technology has to develop, but at the same time there must be no exploitation in the name of technology. A technology which does not last for more than two years is of no use.! And it does not follow that "advanced" technology will give better results; nor even be as good as simple established methods. Must a technique be discarded because everybody is able to do it, everywhere.?

It is the duty of WOC to see that simple methods, along with newer techniques, are taught and demonstrated to give good outcomes, and that a doctor will ethically and legally be right to practice them. The impression given in some courses, sponsored by commercial companies, is that previous methods are out-dated, no longer useful and even wrong to perform in the present age. The young doctor is given the impression that he may be legally blamed for wrongful practice. Therefore a "white paper" should be issued on methods which are simple, and need to be stated that they are scientifically and universally correct.

The prevalent trend, that different companies must have different sets of instruments and implants for the same procedure, needs contradiction.

I suggest that in a scientific session, there should be a paper on problems faced by a young surgeon in a peripheral general hospital, treating poor patients who cannot afford to go to a big hospital, and how he can be helped with simple surgical technique. I myself had worked in rural areas for seven years before moving to a larger centre. The capacity to work with limited resources is an absolute essential.

Lastly recognition must be given to people who encourage methods which benefit the majority of humanity. People who have actually served in rural areas should be encouraged and honoured. Today one will talk of locking plate but will condemn plaster of Paris casts even for Colle's fracture!
<vijay_khariwal@yahoo.com>

From Central Africa. **Dr Naddumba** writes, to acknowledge receipt of the Newsletter:

"Thank you very much; I am particularly interested in the epidemiological survey you refer to, which will take care of the emerging epidemics affecting our orthopaedic practice. Trauma is still the biggest problem in our region, and probably will remain so indefinitely. I shall always be grateful to **Prof. Ron Huckstep** for his service to Uganda, especially with regard to poliomyelitis, which is "no more" in this country, thanks to his dedication and inspiration.
Dr Naddumba EK Senior Consultant Orthopaedic Surgeon, Uganda."

(*Although our attention is directed towards the specialty of orthopaedics, colleagues who work in sub-Saharan Africa will be very conscious of the ambience of infectious epidemics. E-bola has no definitive musculoskeletal complications, but the threat of communicable disease pervades every aspect of medical and surgical care, and makes operations even more dangerous.)*

From Geneva, on behalf of WHO, from where **Dr Sivakumaran Murugasampiay** (Shiva) writes to say:-
"I greatly appreciate and thank you for your Newsletters. They keep us focused on prioritization of Orthopaedics and maintain communication."
Shiva was pivotal in our exploration of the situation regarding the orthopaedic service in Zimbabwe, on behalf of which he speaks. He did much to facilitate the recent visit to Zimbabwe, and it is hoped for further visits in support the burgeoning service in that country. It is sincerely wished that our visit was the first of several to identify and activate the prospect of supportive collaboration.

From a distant outpost of orthopaedic endeavor, we hear from **Dr Oscar Paz Bueso,** --
"I am from Honduras, Central America, and I am receiving the Newsletters that you are sending every month, during the past two years.
Unfortunately in poor countries of Latin America, I had never read any notice about our region. Your information is centralized on Africa and Asia, countries that are also in poverty.
The SICOT participation in our country is very small, and there are no incentives to "grow up" in this part of the world.
We will be very happy if the newsletter talk in a future time about Central American Orthopaedics. We wish that SICOT take a real participation in this region of the world. Due to the bad economic situation in our country it is very difficult for us travel and participate in SICOT Meetings in Europe and Asia.
Oscar Paz Bueso MD. Honduras, Central America

(*I pass this on in the hope of a sympathetic reader, (possibly HVO), not so much that it might be made possible for Dr Bueso to attend great meetings, -- which are*

opportunities for display rather than tuition, - but that attention be given to his plight, and a physical visit might follow.)

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SICOT announces its program for its forthcoming **37th** Annual Meeting in Rome, **7-10th September, 2016**. Preparations are advanced, at least in regard to the pre-meeting course of Instructional Lectures, which this year will include a comprehensive program designed for the management of orthopaedic problems on the assumption that modern complicated equipment might not be available - in other words there will be a whole session concentrating on Pathology, basic Mechanics and Biology, rather than on cybernetics, electronics and metallurgy.

PUBLICATION

Many books have been written on the subject of conservative fracture management, classically Charnley's 1950 "Closed Treatment of Common Fractures". But this and many of the same vintage rested on a particular orthopaedic ethos, namely that fundamental surgical requirements were on hand. Few came from Africa itself. They presented the conservative side of a choice.

But the **African Othopaedic Research Foundation, Nairobi,** has produced "**AORF Textbook of Orthopaedics** edited by **John Ating'a, Vincent Mutiso and Fred Otsyeno**. [Acrodile Pub. Nairobi. www.acrodile.co.ke]. Of course it rests on its predecessors to a great extent, but it differs in that it is based on the conditions which reflect the experience of the LMICs. Clearly Kenya has centres of excellence where the most modern surgical work is being done, and done well, but there are also some of the most impoverished places, where the need lies.

There are some stylistic and grammatical “errors”, but I (for one) would not alter a single one of them. They are its strength.! This book clearly comes from Africa, not from England, 65 years ago.

Such a huge work, taking on such a wide coverage of the whole of orthopaedics and traumatology in its 330 pages, is subject to abbreviation and compression. Much of the information is in the form of lists and tables (even tables of tables); but the instruction between headings is practical and clearly based on African experience. I liked particularly the chapters headed “Clinical Evaluation”, “The Limping Child” and “Splints, Casts and Traction”. These cover the real difficulties of practice in the LMICs; and the coverage of clubfoot is pragmatic, logical and clear.

The copy I have seen was published in India, in 2014. The only small disappointment was the pictorial reproduction of clinical cases, which was poor by any standard. But the style does not depend on them. Indeed most text-books tend to become dominated by conditions that are photogenic, and therefore the most florid examples are shown. They are the easiest to recognise (and the most obvious).

Every medical centre devoted to musculo-skeletal conditions should have this fine, inexpensive text for reference. It is a tribute to African Surgical Education.

(M. Laurence)