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.

Much of this Newsletter relates to the report in Newsletter 183, dated January 2016. That report, from the Black Lion Hospital, Addis Ababa, by Geoffrey Walker, records his latest impressions, and includes references to the history of the BLH Orthopaedic Department. Plainly it is as busy as ever, dealing acutely with every degree of compound injury through the A & E dept., bursting from its insubstantial seams.

The many enthusiastic trainees in Addis (N=77, -- about equivalent to middle grade registrars in the old UK grading) are desperate for night-time supervision of their work on complex fractures. About half the trainees are dedicated to Orthopaedics; the other half to General Surgery, in which capacity they will be responsible for "Trauma" in all the towns of rural Ethiopia.

The senior staff surgeons at the Black Lion have huge pressure on their time and expertise, to be spread between teaching, organising and attending to the demands of the massive trauma load. There is competition for theatre time, anaesthetic service and the queue of emergency cases which should not have to wait at all ! On top of that, are the demands of private patients, screaming for attention, from a booming national economy.

In the well equipped West we have been able to cope with these pressures, with junior staff part-way through well established schemes of surgical education. In the newer establishments, the pressure for service cannot to be denied; their standards of treatment would not be accepted by the well-informed Western public; but the alternatives would be infinitely worse. The idea of medical treatment being a “Charity” has long since been superseded by an educated and demanding public with a clear idea of its rights and its government’s responsibilities. This situation has been a century in its creation. It has now reached the masses in countries without a robust economy to provide, and without the educational base from which the medical profession has to develop.

This “GAP”, so often referred to in these columns, between the “haves and have nots”, receives the attention of each country’s readers of the News media. Until it is seen that “things” are definitely improving in medical care, there will always be an ambition to emigrate to where both medical care and education are “freely” available. The paradox is clear. The provision of a modern standard of care is very expensive, but less expensive than septic complications of modern surgery carried out in imperfect operating theatres; and very much less expensive than war…! The sharp requirement is for mature trainers, to take an active part in their practice; in short to fill that dearth of surgical trainers.

These columns have no wish to create revolution. We have seen too much of that ! ! But simple humanity (if ever simple) calls for a degree of assistance where it is most clearly needed, in the provision of standard “first aid”, the saving of life under threat, and the creation of a surgical profession able to serve its people. The great obstacle to that is the

weight of clinical demand, which supersedes the duty to teach and train the next generation of surgeons.

There is no good being stuffy about Private Practice. It exists and is clearly expanding exponentially. Both the health and wealth of a country will depend on its surgical profession. The most constructive way to help a country (in this position) is by filling that GAP in its training hospitals. What they lack is supervision and *involved guidance.* There is modest call for navigational tools, massive skeletal or vertebral replacement.

There is all the difference in the world between factual knowledge, so well displayed in the modern textbooks, journals and instructional film, contrasted with “hands-on” participation. Impersonal demonstration lacks essential intimacy. The trainee does not learn from lectures but from *guided performance*, which would avoid the errors by which experience is gained. The old saying that you learn from bitter experience, is very expensive in terms of patient morbidity !

Please forgive the repetition of an anecdote, personally witnessed, of an intra-operative complication, in which an eminent surgeon (A) began to loose control of torrential haemorrhage. Colleague (B) offered to help with retraction, but gently took over and solved the problem. Surgeon A expressed his gratitude, and explained, “Such a situation has never happened to me before,” to which surgeon B replied, with just a hint of sympathy – “No; it’s never happened to me either.”

Surgery, if not a science, has many elements of art, which can by-pass science in the hands of the few very gifted graduates. The world appreciates the finest, but they are too few in numbers to fulfil the requirements of the mass of crippled and disabled.

PROGRESS & EXPANSION

It is therefore with a degree of excitement that we announce real progress towards those targets, remembering that what is needed is physical and personal help, and the wherewithal to develop training. Constructive suggestions and positive plans have

emerged from the Management of the Bone and Joint Journal (BJJ -- the renamed (B) edition of the JBJS). Briefly **Rob Marshall**, Chairman of the Board of Management, has expressed the Board's interest in supporting the vigorous training program at the Black Lion Hospital, Addis Ababa. Rob Marshall, has written as follows:-
"I am delighted to report that Council has approved the request for and on behalf of WOC(uk) and the Black Lion Hospital, Addis Ababa. The British Editorial Society of Bone and Joint Surgery will fund the annual project to send six surgeons to Ethiopia during the next year. This will amount to £6000, and in addition we shall also continue to supply free online membership to the Ethiopian trainees, to receive the BJJ.
(*Peter Richardson (manager) will be asked to make the required arrangements for funding and the journal's electronic access.)*

It is planned to provide comprehensive and continuous coverage of the trauma load at the BLH. It is to be set up jointly, by WOC(uk) and Australian Doctors for Africa (ADfA) based on Perth, (by **Graham Forward.)**

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This project fulfils all the highest aims to which WOC aspires, in terms of *training* as opposed to *teaching*. There is relevance to the modern UK National Health Service, which now depends increasingly on Consultants "acting down" in the emergency surgical service.

There is no doubt that surgical performance is taught most effectively by those with great experience, and are still actively engaged in the subject. This does not mean that retired surgeons have little value; but the most valuable are those *able fully to participate*. The word "fully" is important. The relationship between trainer and trainee is both intimate and authoritarian. Both are in the process of learning, but in different ways.

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Already much assistance is given to the assessment of programs of surgical training. – an essential requirement, -- but there is concern as to whether surgical skill can be tested without scrutinised performance; or can a single interview assess skill. Can a visiting external examiner licence a surgeon, unseen?

Active Participation

The above proposal for Addis Ababa, gives WOC the security to plan ahead in a constructive way. There will be regular reports from the BLH on progress, and BJJ will receive acknowledgment of its pivotal contribution.

At each visit it is planned that there will be a “special interest” component, at the request of local host hospital, but the visitors will take an active role in the general trauma workload, providing hands-on assistance for trainees. Currently there are many trainees without consultant supervision (a situation which may not be resolved until the current group of residents have completed their training). The first bursary has already been accepted by **Tony Clayson** (from Manchester) and the second is due to be taken up by **Deepa Bose** (from Birmingham) in May 2016.

WOC(uk) has asked if BJJ would thereafter, share the cost of 12 surgeons over the following year along the lines described, and this has been agreed. It was thought that £1000 each would be enough to cover a flight plus most of their accommodation costs.

This most welcome gesture will require the active collaboration of the Orthopaedic department of BLH and probably the use of the in-house accommodation. This arrangement will be greatly appreciated by Geoffrey Walker who has invested so

much time and energy in that department over several decades.

Recognition and Honours.

Over the years it has been the tradition that some signal of appreciation and reward should be made to surgeons who have made a remarkable and prolonged contribution to the orthopaedic care of disabled with skeletal deformity – not necessarily surgical. . . The first such awards were made in the name of (and to honour the memory of) one of the founding members of WOC, namely **Arthur Eyre-Brooke.** Now we have two.!

In the Newsletter No 103, appears the obituary of **Shri T K Shanmugasundaram,** who died in 2008. Your attention is drawn to his memory by Professor Rajasekaran Shanmuganathan, who wrote movingly in that Newsletter (available through the website). He and TKS's many students and admirers have set up a new award, first formally awarded to **Professor Deven Taneja**, at the 36th SICOT convention, in Guangzhou, 2015. It will be awarded irregularly for particular merit in parts of the world where the principles of WOC are followed assiduously. At the same time the memory of **Arthur Eyre-Brook** (A E-B) will also be recalled, perhaps alternating with the TKS medal, according to the decision of the generous donors. Each award will be made through WOC, usually to be announced at one of their Annual General Meetings. The most recent recipients of the A E-B were awarded in Hong Kong to **Professors Ron Huckstep** and **Geoffrey Walker,** for their prolonged service, respectively to Uganda and to Ethiopia. Separate lists of all the recipients are being collected, for publication in these pages, soon.

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And finally the next (WOC) AGM will be announced soon, but certainly it will coincide with the 37th SICOT meeting, due in September 2016, in Rome. More details will follow, but the Instructional Symposium, organised to take place on the day before the main meeting, will address the particular problems of managing the common but

serious, diseases and deformities in the absence of sophisticated instrumentation.

These subjects touch on basic affordable systems, and present remarkable ingenuity.

SICOT ’37 - - September 8-10.. Instructional Course by WOC, (probably 7th September, 2016

-- draft program --

1. **Osteogenesis**; Embryo to Fracture. **Mike Laurence**

2 **Service** with **Training,** with limited Resources; **Anil Jain**

3. **Injury to the child’s arm** - Wrist to elbow. **Fergal Monsell** (tbc)

4. **Problems** confronting the **Young Surgeon,** **Vijay Khariwal**

5. **Plating** vs **Nailing** in limb fractures. Changes in implant design in relation to surgical infrastructure. **Arindam Bannergee**

6. **Paediatric Problems**. Aspirations for the Third World, **David Jones**

(M. Laurence)