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 problem with regard to communication is that when important changes are imminent, time is required to consider the many concerns. At the same time dissemination of opinions is essential. Final decisions are a matter of the whole society, and a draft record of Minutes is a subject for debate. Therefore the reports in this Newsletter do not have authority; they are transmitted in this Newsletter, in order that the maximum number of those involved can contribute.

At present the draft Minutes of the invited discussion on the notorious "GAP" have been excellently compiled by **Dr Wilson Li**, and circulated among those taking part in the debate. Keith Luk's inspired initiative will bring about changes, largely of emphasis. The subject is huge, and the discussion largely preparatory. Even the very word GAP is not defined. There are irregularities in the stages of

training of would-be surgeons, from undergraduate to postgraduate. Perhaps it cannot or should not be defined. Urgency lies in the fact that the size of the Gap is increasing exponentially. We are in an equivalent position as SURGERY as a whole was, and still is. And yet globally, the need for Total or General Surgery does exist, where the need is huge, but facilities (funds) few.

The word Specialty used to divide Orthopaedics from general surgery. Now it separates the hip from the back, the foot from the leg, the athlete from the labourer and the well equipped from the poorly so! But the width of this separation carries with it the danger of error, for inappropriate reasons.

Prior to the meeting, the SICOT assembly issued a pre-ambling document analysing the global distribution of the care for musculo-skeletal disease (MSKD), as a basis for discussion. This excellent analysis suggests ways in which the financially poorer countries might most usefully be assisted.

One small matter does attract some concern (- possibly an accidental ambiguity?). Quoting the contribution of the AO Socio-Economic Committee, and their many courses of instruction they have mounted in subSaharan Africa, it is stated that *"we need to avoid the oversimplified distinction between non- operative and operative treatment, and assume that the latter is superior."* Perhaps this is too specific; but it will be misunderstood.

The reader's attention is directed towards the current issue of the "**Bone and Joint Journal**" bemoaning the **"Lost Art of Conservative Management of Paediatric Fractures."** (from **James Hunter's** dept. at Queens Medical Centre, Nottingham, UK.

Quoting from reviews of the above, in the same issue:-- “there is nothing quite so dangerous as an orthopaedic surgeon with an idea, a new implant and a biomechanics lab.“ This might apply to much that goes under the spurious title of Research.

So many and varied are the needs and shortages in the LICs (Low Income Countries), that help offered and given must be very carefully tailored to each individual institution. This calls for unwonted flexibility in the visiting tutor.

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There are four separate grades of carer for MSKDs, between each of which a GAP – a different Gap - exists.

1. Practicing orthopaedic surgeons; with differing equipment.

2. General surgeons, without an orthopaedic colleague, so that he (or she) has a commitment to trauma.

3. Newly qualified doctors, contemplating a surgical career;

4. Unqualified orthopaedic assistants – the surgical Clinical Officer.

Each of these calls for a different approach, in his quest for improvement. To satisfy that desire presents the prospect of very great profit, properly earned, as long as it is graded and guided.

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Detailed information about hospital facilities is essential and can be acquired only by personal contact. Some establishments will have quite well staffed and equipped facilities: none will be identical to any other. An experienced

orthopaedic surgeon must visit for several weeks, and actually to take part in the work, in order to appreciate and assess a service in action. Such a visit would report on the following:-

* Review all possible manpower; schools of medicine, physiotherapy and nursing;; training facilities for making splints etc.
* Review of all implants available; their adaptability to local conditions and patterns of disease; their cost and maintenance.
* Tailor the surgical training curricula to local needs.
* Examine the support services – theatre organisation, radiology, laboratory, and rehabilitation.
* Investigate all organisations and individuals, currently engaged in supportive projects, and collaborate (rather than duplicate or compete).

This last item is important and always difficult. Many colleagues have an individual style and contribute a great deal, while not wishing to be part of any of the philanthropic bodies. They are almost secretive in their endeavours and may go unrecognised and unappreciated. The majority of instructional visits were started by an individual, rather than an organisation. It is hoped that these Newsletters report on them, whenever possible and enable and encourage collaboration. (Relevant reference - NL 123.)

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Regular readers of these pages will recall a report from the last annual SICOT meeting but one, in which a study was made of the appalling road traffic accident statistics from a city in India. CCTV taken from a number of traffic black spots, demonstrated murderous behaviour on the highways, attributable in equal measure to bad roads, terrible driving and unenforced rules of the road.

So dramatic was this finding that the investigator took the Government to task, and then to Court, winning his case and altering the enforcement of the law. Professor **Rajasekaran**, (once President of WOC and now the same of SICOT) has made significant improvement on India's accident statistics, and doubtless saved the lives of many who will forever remain ignorant of their good fortune.!

In Rome, Raja gave a follow-up presentation with even more dramatic pictures from the cross-roads. His message has been widely and effectively publicised. (SICOT 36).

From other Newsletters:-. COSECSA, Overseas. Autumn 2016.

Oxford Orthopaedic Link (COOL) is a health partnership (funded by UK Department for International Development) linking COSECSA and the University of Oxford, led by Professor **Chris Lavy**. It encourages UK surgeons' involvement in building trauma and orthopaedic surgical capacity in Africa. His model of personal, combined, responsibility and training in Malawi deserves imitation.

Annual COSECSA Scientific Conference, and Annual General Meeting, will take place 7th – 9th, December. 2016; in Mombasa Kenya. Thus event will follow closely on the COSECSA Surgical Examination, in the same city. The hosts earnestly hope that as many fellows as possible will be able to be present. Future plans are developing with the collaboration of the International Federation of Surgical Colleges, to arrange the next Course in Emergency Surgery. It is hoped that this will attract a positive response for a grant from UK Government. <rhslane@btinternet.com>

In view of the global activity in regard to LMICs, (described above in the report from Rome) this Mombasa meeting will have much to discuss in order to define and formulate precise requirements. The whole subject of

assistance to Bridge the Gaps in orthopaedic services, depends almost more on the recipient institutions than on the prospective visiting trainer.!

W. O. C. Under "Other Business", at the **AGM** of **WOC** in Rome, there was unanimous approval of a motion to appoint to the **Honorary Fellowship** of WOC, two special members of WOC (and SICOT), namely **Geoffrey F. Walker and Rajasekaran Shanmuganathan**,

Although this decision may require committee confirmation, the AGM decision will be announced at the next SICOT Meeting, in Cape Town, December 2017. *(Until then it remains secret and confidential, so that the recipients can be suitably surprised when the awards are announced !)*

Coincidentally, with the next SICOT meeting, the South African Orthopaedic Association (together with the Trauma Unit in Cape Town and its AO unit) will be mounting an Instructional Trauma Course, organised by **Professor Nicol and Mr Sithombo,** on the few days prior to the SICOT meeting (Dec 2017 – details to follow nearer the date.)

The **AGM of WOC(uk)** was held adjacent to the British Orthopaedic Assoc Meeting in Belfast, September 2016. From the Minutes of the AGM, prominent items from the agenda, included the following:-

Support for the **Black Lion Hospital**, Orthopaedic Department, in Addis continues with an instructional visits from **Sally Tennant, Tony Clayson** and **David Jones.** This is a linked program with the group from Western Australia, (ADfA) reported through **Graham Forward** in NL 123, 127 &c. and ***gforward@iinet.net.au***. This collaboration, also involving the Rift Valley town of Hawassa, has support from the AO Alliance Federation, whose program includes Malawi, Ghana and Myanmar. The Minutes also record the plan for two Ethiopian graduates to take up fellowships at the Queen Elizabeth Hospital in Birmingham, UK.

Paul Afori Atta announces plans for an instructional course to be held in February 2017, in association with the West African College of Surgeons Annual Examination, in Nigeria. (ML)