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.

Pre-script; to convey Seasonal Greetings, universal at this midwinter time of year, for various individual groups. There is a common denominator in all these greetings, -- Good Will to all suffering humanity.

Statisticians tell us that the current era is more peaceful, less ridden by destruction and mayhem and with less polarisation of political extremes; and yet publicity and photography have presented so much that is "in your face !" through the ubiquitous media. In a moment for reflection on the world's present situation, there is an uncomfortable tendency towards horror fatigue. There is no shortage of blood-stained atrocity, either man-made or geological. But the more energy that is deployed in response to

earthquake or hurricane, the more we see how impotent is organised medicine. Experience has proven that the first requirements are manual digging and lifting gear, quickly followed by helicopters and mobile phones.

With journalistic excess, we are either horrified or immured by images of suffering. They are too readily to hand, so easy to transmit, so prone to generate extreme reaction. And the selection of images constitutes a sort of reverse censorship.! The abuse of the media is responsible for much of what is shown on screen. Truth is the victim; and where it truly lies is obscure.

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As reported in the last few Newsletters, plans are advanced for the next International meeting of **SICOT, (December 2017. Cape Town**). Education always has prominence on the program, with attempts to draw distinction between the many differing stages of training, Each is applicable to individual conditions and equipment.

The historic arguments persist, largely because of economic inequalities. Much argument is false. The disagreements rarely relate to quality; but as long as differences exist between levels of staff training and available support for surgery, there will always be inequities. Rarely is the disagreement one purely of biased choice. It is a cynical view that blames the labourer for his lack of tools.

Professor Arindam Banerjee writes:- At the last WOC meeting in Rome - I had an impression that a lot of people have a view that conservative treatment of fractures consumes less resources than Orthopaedic operations. My experience is somewhat different. Once an operation is competently performed at a moderately equipped and clean centre- it is actually easier to the manage the patient. The costs are lower in the long run as rehabilitaion is simpler. The patient suffers less and is back to work quicker. It is sometimes a better solution in poorer economies where beds cannot be blocked indefinitely and where physiotherapy and home outreach programs are over stretched.

Many concerned traumatologists will discuss the pros and cons of the various modes of management for long bone fractures. But in the absence of full sets of tools, there will always be a need for surgical ingenuity. This is why an understanding of the elementary principles of bone and joint healing are the most important foundation upon which to build a service for injured patients.

The time has clearly come for a constructive debate on the details of managing trauma. We have had too many presentations on “Recent Advances” in fracture care. It is as if there are two quite opposite alternative methods – by surgery, or without it.

James Waddell writes on the subject, describing a Group with a broad approach, -- “ the Association for the Rational Treatment of Fractures” – which attempts to put the subject into context and avoid special pleading. He refers to the appropriate role of surgical versus non-surgical management of different fractures, recognizing that low and middle income countries have particular challenges in surgical management of fractures. Waddell writes about identifying those fractures in which surgery is clearly the best option, versus those fractures where surgery is one of several options. The “age-old” debates need no resurrection; they are always with us. In short it is essential that a variety of techniques can be practiced and perfected, and then evaluated in collaboration – not in competition.

The greatest advances in traumatology have been generated by the effects of war. It is over a hundred years since surgeons began seriously to aim towards perfection of recovery from skeletal damage, rather than just the saving of life. This was by no means the origin of surgery, but the wars which beset Europe over the centuries, have shown how heavy weaponry either maims or kills men and wrecks constructive employment.

The inventive science of repair of damage to the locomotor system reached its apogee during the last century, for which we owe gratitude to the anaesthetists and microbiologists. They have made it possible to reconstruct that which could not be repaired, nor function recover. The story of one of its pioneers, William Arbuthnott-Lane (b 1857, d 1943) was

one of fierce antagonism and mediocre medicine. It took longer than Lane's lifetime to reach fruition, in anatomical restoration and perfect rehabilitation, In the process Lane was driven from the profession for, amongst other things, his campaign for a "New Health Society" (or N.H.S.! - in every way the model for the UK.) But the pioneers of the nineteenth century did not anticipate the demands of the twenty-first.! Lane's basic tools are still the standard of every operating theatre's equipment.

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Last week, (December 2016) the General Medical Council (UK) published its report of key findings from their **2016 national training survey**, comprising feedback from 53,000 trainee doctors in UK, revealed that increasingly heavy workloads are interfering with the time for training… "Training must enable the trainees to learn as well as provide the best possible patient care. The Health Service has to make more effort to nurture this valuable resource". (Clare Marx, PRCS, 2016). The paradox here is that in an intimately involved specialty (surgery), training and practice are identical and inseparable. Experience is never acquired in comfort.

"In service" training is stressful. Any different opinion of the experience of a junior doctor, is unreal. To be "Concerned" demands considerable care, which itself imposes stress. Those who chose such an intimately involved specialty as surgery, do so because they are attracted to it, with all its stress, strain and ultimate satisfaction.

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PHILIPPINES

The Secretary-General of WOC, Professor Deven Taneja recently returned from the Phillipines, where he spoke with Ms Julyn Aguilar, representing Manilla Orthopaedics. The project was to establish a Philippine chapter of WOC. A "foot" has long been in the door of the Palawan Archipeligo, where the reputation of Dr. Socrates has been

described in previous WOC Newsletters. Dr Aguilar is very enthusiastic about the prospect. Their trustees are discussing details and will get back to us.
A country like the Philippines relies on conservative treatment for long bone fractures. Dr Taneja, speaking for the Indian Region, has made an offer of a workshop of surgical instructors, similar to those which he has arranged elsewhere, in the past.
As elsewhere in the unequal world, new projects emerge in places, near and far. But equally fast, new calamities follow each other on a regular basis, leaving behind a residue of chronic disability, begging correction.

In none of them is the work likely to be easy, but the experience of our recently retired colleagues, is of priceless value to those places which are economically neglected. The requirement of surgical technical teachers is less for the new development of orthopaedic practice, but even more so for the time-honored and tested treatments of pre-arthroscope, pre-scanning, pre-navigation surgical correction. The fundamentals of mid-20th century orthopaedics is “old hat”, but fits well the ill-equiped operating facilities of the LMICs. The age of extreme specialization has left behind the masses of neglected fractures and dislocations which, if not attended to in timely fashion, quickly become set in crippling deformity.

MYANMAR

Prof Alain Patel has recently returned from one of his regular visits to Myanmar.
In Yangon he had meetings with several professors of Orthopaedics including **Professor Zaw Way Soe**, Rector of Yangon Medical School. The Centre for Spine surgery, located in Yangon Orthopaedic Hospital, is fully active with up-to-date equipment, benevolently donated from France. Myanmar surgeons are now performing most standard spinal operations. In addition, surgical teams from France come four times a year. All nurses receive training in Paris and sterilisation units and generators have been supplied by AMFA.

During this visit, Professor **Zaw Way Seo** received an honour from the French Government during a ceremony at the French Embassy. A dinner was organised by Profes**sor K Waw Ming** to meet with the 25 nurses from Yangon who trained in Paris.

In Mandalay, the 48th Annual Orthopaedic Meeting was organised and many of the Myanmar's 350 orthopaedic surgeons attended. The topics were most interesting and papers of high standard. I met and discussed with many of the retired professors and surgeons from provincial hospitals where AMFA has been involved. During my stay in Mandalay I visited the Trauma Centres set up since 1997, by AMFA. The two operating theatres (OTs) cope with the many emergency cases every day, helped by a new sterilisation unit and generators, (both AMFA donations.) A new building for emergencies is under construction.

The new Orthopaedic Hospital is running, with nine OTs open and two new clean rooms to open soon. Prof **Maung Mg Hwe** is the professor and four associate professors are in charge of different departments. The hospital beds are full and very many new accident cases arrive each day, many with injuries of the spine. The Myanmar Ministry of Health paying particular attention to the development and quality of teaching. I shall be making a return visit in January. Professor Alain Patel (AMFA)

Nostalgic Corner*.*

With great sadness we announce the death of **Barry Fearn,** (November 2nd 2016). His African connection covered Ethiopia and the Sudan.

The archive of WOC bears many an old soldier. Barry Fearn was a follower of many from that exceptional school, the Oxford Orthopaediic department. As a centre of Surgical excellence he followed the example of predecessors (like **Edgar Sommerville**) whose influence was international – two years in Rangoon (as it was then) and then in Khartoum, maintaining the breadth of orthopaedic concern. This pattern continues to the modern era of **Chris Lavy**. Later Barry resumed teaching surgical anatomy in the department of St Thomas' Hospital. He

followed the pattern of, for example, **Leslie Klenerman** who did the same work in Cambridge. The world's "centres of medical excellence" maintain their reputation not only in their scientific discoveries, but on the quality of their graduates over a long period of time. This valuable facility, (cadaveric dissection) now lost in the western medical schools, gave an opportunity to students with a bent towards surgical practice.

In this age of endoscopy, knowledge of anatomy is missing; and yet it is essential to a general surgical practice. Reports of occasional vascular accidents have occurred in the course of endoscopic gall bladder surgery, only to find that the surgeon had no "experience of the "open" abdomen !

In spite of all the amazing inventions of surgical science, wider demands are regularly made on surgeons throughout the less well-endowed parts of the world. It is not a matter of reinventing the wheel, but of understanding the body and its blood and nerve supply, enabling a surgeon to take corrective steps beyond his narrow specialty. In the third world (70% of it) there is no complimentary specialist to whom to turn. Orthopaedics is more than "hip-ology" or "elbow-ology". It is worth recollecting that peripheral vascular surgery almost became a subset of orthopaedics. Excessive specialisation narrows the mind.

(M.L.)