Newsletter

No 202

March 2017

Distributed from: laurence.woc@gmail.com

Websites : www.worldorthopaedicconcern.org

Linked with: www.worldortho.com (Australasia) www.wocuk.org (UK)

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.

Previous issues of this Newsletter (now into its third hundred) have been filled with statistics demonstrating the depth and breadth of the "Gap" between the well and the poorly equipped Health Services of the world. Every great Association dedicated to the science and art of limb and spinal surgery, has concentrated on our dependence on surgical equipment.

With time a country comes to realise that the health of its work-force is dependant upon physical health, and that the march of technology (particularly in the motor vehicle industry) has been unwittingly responsible for the magnitude of trauma on the roads. It is a sick observation that the world's birth-rate seems able to compensate for these modern killing-fields. . . But the strain on the world's uneven distribution of human resources is a tragedy – by which I imply that it must never be accepted as inevitable as a natural sequel of technological progress.

World orthopaedics is engaged in a race to keep up with Man's headlong dash to be ahead of those whom he takes to be his competitors (– and every

other car on the road). But this attitude is inappropriate to the art and philosophy of medicine; it is uncomfortably common that the Centres of Surgical Excellence, where the care of common conditions is well known and well treated in accordance with time-honoured texts, give scant attention to the ‘commonplace’.

“General Orthopaedics” is thinly described in the modern journals, which are in competition with the “super-sub-specialties”. It is common for Teaching Hospitals to seek and find applicants for their staff who have seen and addressed the problems (like compound fractures of the tibia) to be found in their masses in the under-resourced parts of the world. By contrast, it has become hard to find employment for a surgeon whose training has comprised many years spent “Revising” failed knee joint replacements.! The neglected “Third World” can provide a much broader experience than can western centres of Excellence !

It is noticeable that the pressure to compete, has affected the Great Journals of yesteryear. The clock of progress cannot be put back; nor is that ever to be wished. The achievements of the last century are confirmed in the experience of the 21st, and are to be celebrated appropriately. But the current tragedy is the concept that progress is dependant upon an ability to pay for it. The affluent world has yet to grow up ! We rely upon the purchasing power of others. Economics and morality tend to coincide.

-o0o-

The essential first step in a medical education (which differs from training) is to teach the biology of healing and, simultaneously, inflammation. Anatomy, it seems, has become a dead subject - in every sense. But each of these is becoming lost in the depths of the ‘Gap’, as immediate personal profit exercises its influence on medical education.

All this is irrelevant to modern life; or is it? For whom are the medical schools of affluent societies educating its students? Presumably its own – its clinical medicine is based upon cybernetics, genetic engineering and performance enhancement. Are we producing doctors with skills totally dependant upon expensive equipment?

Perusal of the popular press might suggest otherwise. The world of Orthopaedics expresses great satisfaction with the West African crusade finally to eliminate the scourge of APM. An outbreak of polio in Northern Nigeria reminds us that the world of Virology can still exercise its ability to escape the best efforts of Immunology ! Thirteen countries, simultaneously, will "vaccinate" every child in West Africa !

Acronym of the year **– "D E C"** - the disaster emergency committee

Readers are under some pressure to keep pace with the flood of new acronyms, calling for generosity towards yet another famine in East Africa. The speed and urgency was clearly evident in the voice of the broadcaster; and later a news item announced a record response, to the images of child death. Full marks to the BBC for alacrity.

There is a clash of appeals, testing the western pocket -- Oxfam, MSF, Save the Children, and a myriad of our own choice charities supporting research into MND, Leukaemia, Cancer, HIV, and a variety of Church-based funds – every one worthy, honourable and reliable.

Although not strictly "Orthopaedic", may I make an observation based upon a recent experience? I was in Addis Ababa in 2004, in June. The annual rains always begin in the first week of that month, but they had not shown by June 9th. Anxious predictions had appeared in the lay press in London, declaring a recurrence of Famine.

Speaking to Ethiopian friends in the city, I enquired about contingency plans, should disaster ensue. There were none. My surprize and disappointment was evident. What will happen if …? "You will have to pay again" I was told (identifying myself with the disaster !). He reminded me of the previous drought when the full force of the pop-music industry stimulated a mass philanthropy, and plane-loads of donated foodstuffs swept into Ethiopia. "How do you think our farmers were able to compete with tons of Free Food?. You bankrupted us.!"

In point of fact the rain started two days later. I offer this as a warning not to refrain from life-saving charity; but to urge attention to the ill-effects of indiscriminate distribution, while the farmlands reverted to sand, and farms were ruined.

It is not easy to separate charity from economics; nor should we. To benefit the poor will benefit all. Guarded and guided charity can convert an impoverished community into a purchasing one. Money is nothing if it is not mobile.

-o0o-

.

GHANA; A model to establish and sustain the elements of Trauma and Orthopaedic Services (*from the Ghana Regional Health Service*)
Dr Korpisah J, FWACS (*Medical Director, St.. Antony's Hospital, Dzodze, Ghana.) and* Dr Rompa P, M (*Prinz Hendriklan20, 1404 Bussum NL)*

The inadequacy of access to all essential surgical treatment in the developing countries is a well known fact. The situation is even worse in the area of Trauma and Orthopaedics, doubled by the frequency of road traffic accidents (RTA) and the prevalence of numerous local bone-setters who have a tendency to venture into conditions well beyond their capability. The reasons for this deficit can be summarised as a lack of skilled personnel, lack of necessary infrastructure and the inability of patients to pay the cost of surgical care. For none of these is there a quick solution.

The value of donor organizations, individuals, and especially International surgeons in "bridging this gap", cannot be over-emphasized. We present the experience of a Dutch Orthopaedic shoemaker who noticed that orthotic services did not exist in Ghana at the time when he arrived. He decided to establish such a service at the most deprived but strategic parts in Ghana. He engaged the services of an experienced expatriate orthopaedic surgeon, purposefully to encourage and train the local doctors. Two were given scholarships to study orthopaedics and trauma, a

third was encouraged to enter the Ghana postgraduate training program. Having acquired the necessary skilled personnel, they established the necessary, basic infrastructure for orthopaedics and trauma services, into three district hospitals. The necessary equipment was acquired through the help of donor agencies, and their own personal efforts.

The National Health Insurance Scheme was established in Ghana 2003, and this has since gone a long way to provide access to surgery, easing the major barrier to surgical care. Since 2009, three O T Cs (Orthopaedic Treatment Centres -- in effect, Centres of Rehabilitation) have been established, manned by local specialists offering services not only in corrective orthopaedic surgery, but trauma and other conditions calling for prompt attention and on-going supervision.

Meanwhile the expatriate surgeon still visits regularly to support and consolidate the skills of the local doctors. These centres have transformed the prospects of severe conditions, (e.g. amputees and paraplegics &c) who previously never mobilised but were abandoned to fade away. To make the project sustainable, willing local specialists must be trained and resourced in order to provide prompt, essential and affordable care to the local people. <http.acov.org/index_en.html>

It is clear that the value of donor organizations, individuals, and especially International surgeons in “bridging this gap”, cannot be over-emphasized. It is also clear that that value is to be measured from close continuous personal commitment – not from salesmanship or display.

-o0o-

From Professor **Thami Benzacour,** Morocco

“It give me great pleasure to announce for next year, the 2nd SICOT Trainees Meeting (STM) in Morocco, following the successful pattern of previous Conventions with the ECM.

* This next STM is planned to be held on the first day of the National Orthopaedic Association Congress SMACOT (about 20th April 2018). *The*

dates and venue (in Morocco) will be confirmed next month.

* I will also keep you informed of the topics and our chosen invited SICOT Speakers, to whom we will offer accommodation.

* As in 1995, and in order to attract young trainees to SICOT, I am requesting 10 prizes of 200 Euros each, for the best talks and posters.

Thami Benzacour

Medical Aid International

A message from the director, **Tim Beacon**, for the benefit of the many who have profited from the help he has been able to provide. Mr Beacon has established an organisation whereby classic surgical equipment, surplus to modern requirement, can be recycled, while the newest inventions are struggling to pass the tests of time. He writes:-

"Equipment donated as charity from the developed world is frequently faulty or unsuitable for the local environments. Trained biomedical engineers are thin on the ground, so broken equipment goes unrepaired and Healthcare professionals may lack the training and expertise to use equipment to its full. Medical Aid International is able to provide personalized solutions to these issues, tailored to each individual project. This process often acts as a catalyst to enhance medical practice across the developing world."

Unit 3, Firs Farm Stagsden Bedfordshire MK43 8TB <info@medaid.co.uk>