Newsletter

No 205

May 2017

Distributed from: laurence.woc@gmail.com

Website: 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 interested in orthopaedic surgery, particularly those who work in areas of the world with great need, and very limited resources.

Members of WOC (uk), and others within range, are reminded of the forthcoming **Annual Meeting** of the group, to be held on June 9th/10th 2017. The venue is the Conference Centre of Wrightington Hospital, Hall Lane, Appley, near Wigan, WN6 9EP

The program, provisional at present (might be modified) has the general title of "**Engagement from Trainee to Trainer** ". There will be contributions from trainees (tbc) and four invited guest speakers :-
Dame Sue Bailey FRCPath, Director of Global Health Exchange.
Tony Redmond, Manchester Univ. Founder of UK Med.
Goran Jovic, Plastic surgeon to the Fyspec organisation, Zambia
Shiva Murugasampillay, World Health Org. Geneva.

Other presentations will include Primary Trauma Care instruction and reports from distant regions regarding on-going WOC projects.

Fuller details are available through conference@wocuk.org or <nota4africa@gmail.com>

NIGERIA. (Report following a recent 20-day visit)

Nigeria is so much more than a three week study; only in the third week does one begin to acquire a semblance of understanding; -- one week to be amazed and charmed, one for frustration, and one to learn. It is a useful model of a Nation-state in need of assistance. Nigeria is the largest population unit in Africa, the wealthiest (in the broadest sense) and the most explosive. From without, the West may not be able to help; but it could exacerbate the problems if it is not careful.

The wealth of this country lies in its natural resources, (minerals and water) its rich soil, long hours of sunlight and above all by the energy of its farmers and its well-educated, inventive people. The hydrocarbon deposits (oil and gas) may yet prove to be one of the lesser contributions to the Nation's mineral wealth. Various untapped metal deposits are known to exist but petrochemicals will burn the Country for a long time to come.

The Health problems in Nigeria are essentially organisational and monetary. Of the latter, it is not a matter of too little money, but too ill-controlled and abused. Secreted deposits of cash, like undiscovered gold, have no value; but they do have potential danger. D**r Paul Ofori-Atta**, who provides WOC's view of West Africa, and guides our endeavours, knows it better than any western colleague. He warned this correspondent (so rightly) to avoid politics at all cost, and association with "government."

The population give the impression of a content, rather uncritical people; of a humorous, open hearted, generous, politically naive (but no fault there) and highly literate and eloquent society . Medical visitors may have a problem understanding how the hospitals work and maintain themselves and the citizens of Nigeria. What we (as foreigners) cannot grasp is the rigid adherence to "market force medicine". It is a rich country by any standard, but there are huge "leaks" in the national budget and federal exchequer. The national income from taxes goes entirely to the Civil Service – none to education nor health.!

It is a UK assumption that sufferers from acute illness or sudden injury are due care and attention, irrespective of their capacity to pay for it; and having been started, it would continue. This principle is so fundamental that discussion of the subject founders. Nigerian hospitals, generous in their hospitality to this visitor, are of three main types. The "Federal" (national Nigerian), the "State" (or regional, by each State, rather like the US of A), and there are locally organised hospitals,

mainly the Christian Missionary Churches, - mostly in the south, - fewer in the Islamic north. Each of these separately appeals to its source of funding, but survives on what income it can generate directly from the patient, and the patient's own community.

Fundamentally then, they all depend on charity, and also on the "patience" of their junior doctors. In some States, the junior doctors have not been paid (at all) since last December ! Sporadically the resident doctors feel they can **not** continue. Very recently Government allowed a modified settlement,- to pay a "percentage" of the debt, due to the doctors. . .

Nigeria has had an inaccurate coverage in the Western Press, with a bias on certain striking features. That unintentional pun, has an association with Western experience, of threatened industrial action in the health provision services. Strike action is not unusual in Nigeria, but explicable. The President of the Nigerian Medical Association (NMA), **Dr. Mike Ogirima**, confirmed at a recent meeting, that between 10 and 15,000 Nigerian doctors are now working outside the country. "We cannot continue to have the Nigerian doctors emigrate at this rate; it is unhealthy for any country". The annual wastage is 700. The immediate former 2nd Vice Chairman of the NMA in Lagos State, **Dr. Olusegun Akinwotu**, urged "government and stakeholders to ensure the provision of adequate remuneration for doctors in the country". To the ignorant outsider this seems astonishing. "Remuneration is the single most powerful factor driving Nigerian doctors to emigrate," he said.

Understandably patchy strikes cripple the hospitals. This is not a new phenomenon. It is the longstanding explanation as to why so many of Nigeria's qualified doctors seek to escape from real penury, to other parts of the world, or seek a cranny in the private sector of medicine in the towns and cities. In each type of hospital, the senior professionals are generally excluded from decision-making; nor are they consulted over the provision of medical equipment. This is an unsatisfactory situation, towards which major charities and NGOs are invited to contribute. Appeals against this system are resisted by those who have the privileges and benefits of commercial authority – a situation which might possibly be open to abuse ! This is very far from being a poor country, but its wealth is very poorly distributed.

The followers and participants, such as WOC, but also the major Philanthropic Societies, are regularly approached for equipment, including surgical instruments, X-ray and scanning machinery (CT & MRI), anaesthetic and ITU plant. But such appeals lack reality if the doctors have departed. Those that remain, are not consulted over current needs. The result is uneven provision.

In Nigeria I have observed both paucity and glut; - for example multiple instruments, equipment lacking an electrical connection, a fuse or a plug, athlete's "running" machinery but no physiotherapist, arthroplasty implants but no crutches or splints, no organised ambulance service; and worst of all, patients kept in hospital for months on end, denied treatment because they could not afford their bills so far. In each type of hospital I saw patients totally neglected because they could not pay, becoming progressively disabled, from joint contractures, bed sores, degloved areas of limbs.

This last phenomenon occurs in most types of hospital in Nigeria; but less commonly in the church-based mission establishments. Sadly there is more leverage in an appeal for a new C-arm or scanner (which could bear the name of the donor) than for the patient's unpaid bill to be settled by philanthropy.

Certainly the Nigerian doctor expects proper payment for his (or her) service. He cannot be expected to deprive his own family of their living. It is as if he is presently being driven from the Country. To remain in NIgeria the young graduate doctor must have confidence that the funding authority will pay him his salary, listen to his requests for equipment and most importantly, that government would actively enlarge the support staff for new treatments. The wealth is there. The streets of the major cities are filled with big expensive motor cars in greater numbers than anywhere in sub-Saharan Africa.

On reflection, having visited all three types of hospital, I have the enduring impression, not of pressure on facilities, but of beds lying empty – sometimes whole wards so.! This fundamentally unsatisfactory situation requires explanation. Asked what I thought was the principle requirement for the hospital service, I had to say "patients". But this cannot be the correct image of hospitals throughout the Nation !

In my recent hospitable reception in a southern Nigerian state, the Minister of Health, a most impressive person and a barrister, was only interested in which big charity was funding me and what was I able to offer in the way of

equipment. But the impression is not lack of modern equipment, but of timely surgery, skin grafting etc; for which the patient could not pay, and most of all no physiotherapists geared towards mobility and rehabilitation.

The industry of orthopaedic training is already in advance of the Nigerian society's capacity to make use of its medical schools' production. What is most disappointing is that in this decade, the Nigerian victim of trauma, usually resorts to the traditional healer before the doctor or hospital. This is currently the case in a greater proportion of instances than used to be the case.! In other words the medical profession appears to be loosing ground to the "healers", for the combined reasons of cost and availability. Thus the service of medicine is actually obstructed.

And lastly I was constantly reminded of Professor Rajasekeran's campaign on road rules and abuses, and the accidents that follow from that weapon of mass destruction -- the internal combustion engine. The main roads are not lit at nght, they are undermined by tropical rain, and uncontrolled by either convention or laws. All in all, there is neglect of the highway infrastructure.

-o0o-

By contrast with this impression, based on a brief visit, I was impressed by the general level of knowledge and understanding of medical problems by the young graduates. One of my prepared conference talks in southern Nigeria was on the subject of Trauma, with reference to ATLS. The subject is familiar to Nigerian doctors. Its importance in the training of all manner of surgeons is well understood. But a paucity of anaesthetists and any specialists in the essential internal systems of lung, kidney, heart and intensive care generally, makes ATLS somewhat remote from practicality. They have ATLS Courses in the Federal Hospital I visited, and at least one accredited ATLS trainer. (Possibly the modified system – "Primary Trauma Care" – would be a more practical organisation, being less demanding of very high tech. equipment.)

Trauma is one of the last bastions of general medicine and requires experts of a wide field of expertise, currently confined to the larger Medical Institutions in Nigeria. The concept of a "Trauma Centre" (or Accident Unit) might be constructively considered only when the basis for every branch of emergency care can be provided. I am informed that there are three hospitals especially

for Orthopaedics – Kano in the northern region, Lagos in the south-west and Enugo in the south-east. These have begun to form themselves towards fracture work; although concern is expressed that life-threatening “Trauma” calls for numerous collaborative specialties.

This writer has his own bias. He was once an anaesthetist for more than two years, but has been out of that specialty for so long as to know how much things have moved forward, pharmacologically. Indeed it is a truism that any practical facility, unused, inevitably degenerates. This underlines the importance of siting a Trauma Unit where it is already demonstrably necessary in terms of numbers of patients. And in turn, such work will only be done where doctors actually are, and patients can afford to be treated. Only through a significant flow of patients will a department grow and thrive. Indeed Trauma Units in Western societies have grown organically, through the dedication of individuals, keen to collaborate. It is very unlikely that the victims of accidents will ever be able to pay their individual bills, but the Country, clearly could.

Relief from this overall situation is far from simple. Monetary donation alone will not cure it. Many so-called Centres of Excellence in the developed world, have foundered on the logistics of this “New Specialty”, for which speed of transportation is a key part. The will to “care” for the victims of Trauma is a national and humanitarian duty, for which every citizen has to contribute. The poor, present in profusion, demonstrate personal generosity which has to be translated to the Community through National commitments to care for the disabled. No such organisation evolves spontaneously. But it is a drain on the well-being of the whole Country. International “wealth”, from outside the Country, will hesitate to donate to such a rich country, within which huge illicit caches of paper money are periodically unearthed, and commercial fraud is almost endemic.

Financial difficulties must be firmly settled before an accident service can start. This calls for a national commitment to healthcare, and funding, which will have to be measured in billions. It will make a substantial demand for expertise not available in Nigeria - but certainly available in the Nigerian diaspora.! The total support and involvement of both the Ministry of Health and the Nigerian Medical Profession is fundamental; but will not be possible in the light of the situation referred to by the Nigerian Medical Association (above).

-o0o-

Much more profound study is required to obtain a reliable picture. The first impressions sketched here, raise questions worthy of initial planning. (More will follow). If interest in a Service for Trauma were to be confirmed, there are (at least) two essential pre-requisites:-

1. An efficient country-wide Ambulance Service, with secure roads to provide speedy access to each "Centre". (Helicopter transportation might be considered, -- given a secure economic base, which is not beyond the capacity of this gifted country.)

2. Experts in each life-essential medical specialty, to lead, teach and instruct its staff, in the complex collaboration so essential to the concept of "Trauma". (This latter is an area in which WOC – or a related Society - might be able to provide instructional advisers.)

-o0o-

-o0o-

-o0o-

STP. (Sustainability)

The President of the Royal College of Surgeons, Ms **Clare Marx,** recently wrote in the BMJ that "STPs are currently the only game in town looking at how the (UK) NHS can be made sustainable." Miss Marx stated that STPs provide "an opportunity to look radically at how and where surgical and medical care are provided" and, whilst challenging the bad ones and championing the good ones, we should give STPs a chance. *(or in the Universal wording - **Sustainable Development Plans**.)*

The current "**Bulletin** of the Royal College of Surgeons" contains a discussion document on the place of General Surgery in a modern western society. It is dominated by the need for quick and accurate diagnosis of abdominal injury, and is

conscious of the value of physical signs, wherever expensive scanning equipment is lacking.

WOC is in the unenviable (but correct) situation of offering tangible training, based on the experience of 50 years of trauma pathology, by which those of us “long in the tooth” can make value-judgments of the efficacy of classic fracture management, preferably without expensive, breakable tools. Regrettably the numbers of us who were trained in General Orthopaedics is shrinking, through natural wastage.

ERRATA Occasionally pure carelessness finds its way into these pages. I offer profound apology for referring to the late **Professor Ronald Garst**, with the Christian name of Richard. An error for which there is no excuse. It has been corrected in the archive. (Thank you, John Walsh)

(M. Laurence)