# 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*

**Strengthening emergency and essential surgical care** and anaesthesia as a component of Universal Health Coverage. This global title was the subject of the **70th World Health Assembly,** held last week in Geneva. An agenda was set for Sustainable Development with goals to be achieved by 2030, implementing resolution WHA68.15.

The proceedings of this meeting will be reported by D**r Shiva Muragasampillay**, who convened the above meeting, when he addresses the WOC(uk) Summer Meeting at Wrightington Hospital on June 10th 2017.

**IBADAN**, Nigeria

The College of Surgeons of **West Africa (WACS)** held the annual (Part ll) Exam in Orthopaedic Surgery at the University College Hospital, Ibadan, on 24th April 2017.

The following announcement is to be welcomed as sensible and constructive in the cause of appropriate training for the Health Services of sub-Saharan Africa. Clearly surgical qualifications must emphasise manual dexterity; but above all accurate diagnosis of acute presentations. Examinations must be linked to the specific needs of countries with limited facilities, and their particular pathology.

It has long been clear that surgeons in training must be trained and examined in the land of the trainees' commitment, and requirement. In the remote rural setting, practical operative skill is very much more crucial and 'general' than can ever be acquired in training settings in the centres of excellence in the "West". Throughout Africa, a surgeon will often be called upon to undertake surgery which he has never done before; and will have no time to wait for the "scan".! The breadth of experience will therefore be more important that the "small print".

**ANNOUNCEMENT,** from **the** W.A.C.S College website.

- Effective from October 2017, the **Faculty of Surgery** plan to discontinue the Part I surgical fellowship examination. In its place, the Faculty will now conduct a Membership examination, differing from the old Part I examination, in two areas:

(a) There is a compulsory requirement for 3 months rural surgery rotation for candidates to be eligible to sit the exam.

(b) The operation "log" requirement for the Membership Examination is higher than that required for Part I examination. Membership candidates must clock 150% of the operation log book requirement of Part I candidates, before they are allowed sit for the membership Examination.

- With effect from October 2017, attendance at the Basic Surgical

Skill course will be mandatory before candidates can apply to take the exam.

- The Faculty of Surgery will be introducing the system of "Objective Structured Clinical Exams (**OSCE**) in the Membership examination. In preparation for this system, there will be training for the candidates for the OSCE format during the forthcoming integrated revision course in surgery, conducted at the University of Ilorin Teaching Hospital, Ilorin, Kwara State in September 2017.

- Another training course will be conducted for candidates in Accra between August 2017 and February 2018. All candidates who wish to sit the membership exams in 2018 are advised to make use of these opportunities to get a proper orientation on the structure of the OSCE system.

- Prof. **Emmanuel R. Ezeome** Faculty Chairman.
  <info@wacscoac.org>

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Every national government is beset by the demands and plans for medical care or its population, compounded by the astronomical increases in the cost of medical science's discoveries and inventions. No nation in the world is able to meet the costs of every medical invention and discovery for every one of its citizens. Although we avoid the use of this term, medical treatment has to be rationed!

We are in the age of the paramedic, the anciliary medical assistant, the clinical officer or carefully trained but (medically) unqualified. The possibilities of treatment, particularly in the case of traumatic injury, depend absolutely on the dimension of **TIME**. Viewed in reverse, delay totally alters the list of possibilities, making the difference between salvage or sacrifice – preservation or amputation. It is the single

essential feature in the preamble for **ATLS**; and yet it is the least controllable element.

The last issue of this epistle (NL) dwelt at length (too long?) on Accident Emergency services, but it is worth repeating for emphasis, the importance of Transportation. The efficiency of trauma work relies on the carriage of “casualties” quickly to where they can be treated. The “golden hour” divides life from death. I recall being asked (in Nepal) what single thing a government might do to benefit the situation, in a very remote part of the world. I opted for road building, whereby the casualty might be conveyed. Too often a bumpy road not only delays therapy, but itself constitutes a second “injury”. New roads were built. My next visit saw many, much more serious injuries, attributable to higher speed !! The “Western” ambulance has almost become a mobile operating theatre, certainly in regard to breathing and bleeding,

As more and more media coverage makes everyone acutely aware of disasters, there is more reason for every schoolchild to have the basic principles of “first aid” taught at school. For this the ambulance paramedics are the ideal instructors, while not forgetting that medical students are in urgent need of practical experience. How many of us hesitate to answer the call for ”a doctor”, from an audience or at a sporting event? From such small beginnings grows a community ethos of unthinking care, with roots as deep as mutual defence of society, “threatened by evil spirits”.

Each step in the ladder of care contributes to the overall image of self-preservation, or family protection. National personality is built on those community values.

**ZIMBABWE**

(-- a letter written to **Dr Noel Zulu**, Masvingo District Hospital, Matebeleland; from **Dr Ton Schlosser**.)

”We (**Carroll Tseng**, Mike Laurence, **Yaya Malango** and I) visited you

at your clinic in **Masvingo**, on behalf of World Orthopaedic Concern, with a view to supporting your work (and probably learning from it) and to identify possible entries for us to help support trauma and orthopaedic care in your country.
We were much impressed by your management of complex conditions in your department with a limited resources. We decided internally to give you some priority in our actions.

Our findings and advice were discussed at several national and international meetings, but not until the combined SICOT-WOC meeting in Rome (Sept 2016), for which we invited Dr.**Shiva Murugasampillay**, **Matthew Wazara and Georg Vera**, was much real progress made. (I apologise for the delay.)

Recently a joint project proposal has been adopted by the Ministry of Health and Child Welfare in collaboration with the Surgical and Orthopaedic Society of Zimbabwe. SICOT & WOC have now received an official invitation from Mr S. **Makarawo** – Principal Director, Curative Services, to support this plan.

(We will be discussing these proposals further next week in Geneva-Switzerland, at the World Health Assembly and within SICOT & WOC). Ahead of the outcome from these deliberations, I am happy to confirm that you will be the first to have a visiting surgeon from Europe, in the context of this project.

**Dr Peter Claes** (living in Belgium and working in The Netherlands) is a general & trauma-surgeon (which I think is more useful for you then an exclusively orthopaedic surgeon). He has been working in the outback of Australia for 7 years and has experience in limited resources areas (Kenya, Rwanda, Congo and recently in Burkina Faso).
Peter intends to travel to Zimbabwe this coming August, and is prepared to work with you initially for 10-14 days. I advised him to start his trip meeting **Matthew Wazara and George Vera** in Harare and after that travel to your clinic. After two weeks, his wife and daughter will join him

in Masvingo, with the intention of attaching some touristic country-touring to his stay.
(Peter's wife is a general practitioner and interested to do also some medical work. So, any suggestion from your side would be welcome!
email: <pam.claes@telenet.be>) from Ton Schlosser

**UGANDA**

HVO's Orthopaedic project in Uganda is seeking orthopaedic volunteers to work with the Ugandan residents. **Dr. Kajja** in his role as department chair, is calling for orthopaedic volunteers to work with residents at Mulago hospital. The project also has need of additional training for residents and physicians in spine surgery, hand, reconstructive surgery, paediatrics and arthroscopic surgery.

The number of roadside accidents in Uganda is very high with the second highest rate of road accidents in Africa, per head and per km, (after Ethiopia -- according to the World Health Organization's Global Status Report on Road Safety, 2013.)

With a growing population of more than 37 million, (doubly loaded by refugees from their northern border) Uganda has a continuing need for trained orthopaedic surgeons at Mulago Hospital.
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M. Laurence