

World Orthopaedic Concern

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This Newsletter is circulated through the internet, and is also sent to all known WOC Regional Secretaries, in the hope that they will be able to download and distribute it to those of their members not connected through the “net.” (Any help in forwarding this will be appreciated.)

The principles of modern Orthopaedics have emerged in the developed world over the past hundred years, and taught by the giants of our trade, through dexterity and an understanding of living skeletal tissues. With the simultaneous development of anaesthetics, complex and complicated procedures have become possible. With that has come the need for precision instruments and implants, the complexity of which calls for “high tech” at unlimited cost. The consequence is seen in the dominance of the art of Orthopaedics by cost, and therefore of Big Industry. We cannot criticise this, but whereas the teaching of such surgery has to involve the manufacturers, it must not exclude the people of those areas of the world (the greater part) for whom the cost of modern equipment is just beyond dreams. There must be no quarrel between the “haves” and the “have nots”, but collaboration.

As we approach the XXV Triennial Meeting of **SICOT September 6-9th 2011**, in Prague, Czech Republic. (c.f. website – congress@sicot.com) we have been delighted to read (in a recent SICOT Newsletter) the sterling call for “Globalisation” of orthopaedic training, written by the eminent President of the Asia/Pacific Orthopaedic Association (and past President of the Indian Orthopaedic Assoc) - **Professor H. K.T. Raza**.

If I might summarise, he makes an appeal based upon the need for young orthopaedic surgeons to be trained to an international standard, enabling him (or her) to work anywhere in the world. Because of the lack of orthopaedic Centres of Excellence, in certain countries in the world, he emphasises the need for travel

to gain breadth of experience in new concepts, new equipment, new possibilities. For this he calls for international cooperation, facilitating travelling fellowships and exchange programs, for which he sees SICOT as the most appropriate agent.

We applaud professor Raza's dedication to training. From the point of view of those of us who "plough that field", we see two guiding principles:

1. The teaching and hands-on training (clinical and operative) of the young surgeons, and

2. The provision, maintenance and replacement of expendable equipment.

These two are mutually interdependent. Each is deficient and defective without the other.

We see a weakness in Professor Raza's appeal which might confound the noble aim. The need for funding is of course vital, but the first essential is not in the provision of overseas experience and technical training, but the provision, maintenance and replacement of consumable hardware. For a trainee surgeon from a poor country to visit a foreign Centre of Excellence and learn a new technique with equipment which cannot be provided in his home country, is like training a racing driver from a country with no cars, or a cricketer from where there are no bats. He will be well trained for practice in the West (or the equally affluent parts of the East!) and be almost obliged to stay there. In short – another doctor, lost to his homeland. These are the reasons for WOC's persistence with the principle that surgical training be conducted in the country where the need is, on the local orthopaedic pathology, with the locally available equipment.

ETHIOPIA

Graham Forward writes, following his recent (May 2011) visit to Addis Ababa:- At the Black Lion two small but functional operating rooms have been opened, dedicated to orthopaedics. ADFA (Australian Doctors for Africa) have supplied most of the equipment including the operating tables and I was present for the first operation, an "ex-fix, on a 3A tibia."

The next step is to build two new large orthopaedic theatres on the second floor of the new building, above the orthopedic wards and near the Dept. offices. They have a technical working group consisting of an external consulting architect, the hospital CEO, the hospital engineer and medical technician, an orthopedic rep. and an ADFA advisor, by email. The architects' drawings are being studied by an architect in Perth who does all the theatre design in Western Australia.

This project will cost about \$US300,000, and will be put out to selective tender to

ensure that good quality construction is completed in good time.

The hospital have committed 10% of the construction cost.

We have some ideas about funding, as follows:

10-20% from Ethiopian donors such as Hailie Gabriesellassie and Midroc.

30-40% from overseas orthopedic benefactors such as ADFA, WOC, and individuals from the US, Ireland, Norway, Canada, and others who have visited over the years.

10% from the Australian Embassy in Addis (indicated but not guaranteed)

20-30% from other donors, individual corporate or other Aid organizations.

This project will build orthopaedic capacity at the Black Lion to capitalize on the progress which has been made in the last three years.

On behalf of **Dr Woubalem** and the Dept of Orthopaedic Surgery I ask for comments and invite everyone to find a way to give support at this early stage.

PHILLIPINES

Louis Deliss, who was awarded the 2010 BOA Presidential Medal for his work in support of the British Palawan Trust, writes :-

The **British Palawan Trust** continues to go from strength to strength, as I saw in the three weeks I spent in Palawan in March 2011. The number of patients helped remains huge. We now work through a local NGO called Bahatala Inc. to comply with local rules. There is a Board of Directors in Palawan of which I am a member. The activities are now quite widespread, comprising:-

1. **Rehabilitation.**
 - a. Physiotherapy in Bahatala.
 - b. Manufacture and maintenance of orthoses, prostheses, wheelchairs & modified bicycles
 - c. Provision of Aids to Daily Living for the disabled and injured.
2. **Trauma & Orthopaedics.**
 - a. Treatment of fractures and soft tissue injuries.
 - b. Treatment for congenital deformities, such as club foot.
 - c. and of degenerative conditions, bone and joint infection and tumours
3. **Training.** We have a separate purpose-built Training Centre, dedicated to the instruction of doctors, nurses and village health workers in the principals of Appropriate Orthopaedics. (See Soc's book "*Appropriate Orthopaedics*" for details. This is available to all, from the Trust)

The next excitement is a move. We have been using an old house in the grounds of the Provincial Hospital, but this is now too small and dilapidated (due to age and termites). It is also 'in the way' of new hospital building which has already started. So we must move out.

From the generosity of one donor we have purchased some land not far away and near to our purpose built Training Centre. We now have the plans for a new clinical area and workshops to house all the activities described above. Our architect is working on building permits and finding contractors.

We have launched a Special Appeal, that so far has brought in about one third of the building cost, and are actively seeking the remainder. {details and brochures can be obtained from website.} -- www.britishpalawantrust.org.uk.

GHANA

(From the Journal of HVOUSO.)

Dr. **Peter Trafton**, a semiretired traumatologist from Brown University, is the program director of HVO's Orthopaedics in Ghana. He states, "The new residency program at the Komfo Anokye Teaching Hospital (KATH), in Kumasi, Ghana, is an outgrowth of efforts by AAOS, OTA, and the Paediatric Orthopaedic Society of North America, and efforts that extend back to the year 2000. Known as the African Cooperative Education Program, it was a highly developed project with detailed curricula for orthopaedic education that would eventually be available in many African countries. As the financial crisis hit in 2007, however, it was clear that the program was not going to be fundable to the level of excellence that was desired.

Dr. Trafton, describes the new National Trauma Center, next door to the teaching hospital. **Dick Fisher**, the president of HVO's Orthopedics Overseas, and Dr. **Boachie** worked to obtain approval from the national authorities to establish the residency. The hospital had already hired three German-trained Ghanaian orthopedic trauma surgeons.

Dr. Trafton travelled to Ghana three months ago to volunteer his time and get the lay of the land. "I wanted to try and duplicate what a typical HVO volunteer is going to be doing so that I would understand what was working and what wasn't. The reality of limited imaging is something that volunteers have to be ready to deal with. The hospital has a CT scanner, but because of the expense it is rarely used for anything other than head injuries. Most X-rays are done in miniature so as to reduce the number of films used, and it is unusual to see a comparison view of the contralateral body part. The second most difficult shortage is that of transfusable blood; and the third, all manner of pins and screws and devices for invented fixation.

"The staff surgeons are quite comfortable with external fixation; however they must rely on the more junior doctors to handle the debridement. The goal is to

develop skills within the group. To this end we are recruiting plastic surgeon volunteers to come over and teach. In the meantime, the surgeons are making do without things such as negative pressure wound dressings. They are working on ways to improvise this expensive technology, such as the use of reversed aquarium pumps and locally available adhesive foam.

“If you have a bad intra-articular fracture, for which and might like to have a CT scan, you must proceed without this modern convenience. So what do you do? You may need to work through a wider wound. This lack of imaging reduces your ability to plan the procedure beforehand, something that is an essential part of complex fracture surgery. For those of us who trained many years ago, it is a bit easier... we can think back to a time before CT scans were available.

“American orthopedic surgeons, particularly those with trauma experience, must contribute to the efforts made by Ghanaian surgeons to develop their skills. These individuals are becoming not only the caregivers for future generations, but the teachers for the many surgeons they will need. We can help the short-handed Ghanaian team with teaching and patient care; we can help them develop skills and techniques that will be safe and self-sustaining in their environment. This may mean coping without our more sophisticated techniques until local resources are ready.”

To those who might join the volunteer effort in Ghana, Dr. Trafton says, “I would urge the volunteer to leave his or her high-tech toys and home, and bring basic principles and skills, flexibility, and common sense. While it is always tempting to bring the latest orthopedic gizmos, if what we leave behind is something that is not self-sustaining, we are of no assistance. It is only by helping to develop the technology locally, and by training future orthopedists that our efforts will mean anything. We have to ensure that what we deliver doesn't depend on our ability to provide the answers.” In short ingenuity and invention are the parents of fracture management in the developing world.

This is an invitation to Ghana, where you will pass on your experience, improve your skills, and leave a valuable footprint. (a.moody@hvousa.org)

LIBYA

Richard Field, Orthopaedic surgeon from Epsom writes from Tataouine Hospital on the Tunisian side of the Libyan border (June 2nd 2011). This small town has been inundated by 270,000 refugees, injured in fighting in the Nafusa mountains. This is more than the peacetime population of the entire region. Patients seem

to be equally from either side of the dispute. He reports (without complaint) of the lack of modern equipment, in spite of the logistic support from Merlin. He has found his few weeks there a lesson in priorities.

And lastly a story, as an example for right minds:

Professor Kenneth Cunningham Rankin, OBE; died 3rd July 2011

Ken Rankin was born in Egypt in 1939. He divided his life between serving in Africa and in Scotland. He did well at school where he was inspired by reading an account of the work of Albert Schweitzer in West Africa. He graduated as a doctor from Edinburgh University in 1963 and continued his surgical training in the same Institution. But travel was always in his blood. He spent a year as surgeon on the S.S.Canberra but in 1967 the lure of Africa proved irresistible. He worked for a year at the Sibasa Rural Hospital in the Limpopo Province of South Africa. The next year found him based at Baragwanath Hospital, Soweto, and he combined this with visits to rural areas in Natal and elsewhere, often helping people displaced by the apartheid regime.

This extra work was organised by the South African Council of Churches. During this time he met a journalist and political activist Joyce Sikakane and the couple became secretly engaged. In 1969 they separately left South Africa but their reunion was delayed by the detention of Joyce under the Apartheid Regime. Ken returned to Scotland where he continued his training until 1971 when he was again in Africa firstly as a Senior Registrar and then Consultant Orthopaedic Surgeon at the University Teaching Hospital, Lusaka. Fortuitously he found Joyce again after her 'release' and exile from South Africa. While in Zambia he took up flying and was a 'flying doctor' on the precursor of Flyspeck. In 1974 Joyce and Ken were married and the following year the couple returned to Scotland where Ken worked as Consultant and University Lecturer in Edinburgh.

By 1977 the family had expanded to five boisterous children, and Ken and Joyce continued to support the Anti-Apartheid movement. But the call to Africa continued and in 1980 they moved to Mozambique; but as a result of their socio-political activities and connections with the African National Congress, Ken and his family moved to Bulawayo, Zimbabwe, in 1982. There he not only worked in orthopaedics but also undertook plastic and maxillofacial procedures. (He even helped with the reconstruction of a leopard's forelimb!)

I (GW) was one of the WOC surgeons to spend time with Ken in his house in Bulawayo, surrounded by several large dogs, his children and a healthy flock of

chickens. These were most enjoyable days, which changed my life through the close association with this 'Master Surgeon'. By 1992 most of their children were being educated in the UK, and Ken and Joyce returned to Scotland to work both in Glasgow and in Lanarkshire. In 1995 they returned to the newly democratic, Rainbow Nation of South Africa, where Ken was appointed Professor in Pretoria University. He continued his teaching activities, and was appointed the Lipmann Kessel Travelling Professor (of World Orthopaedic Concern, UK). He was also elected to the court of examiners of the Edinburgh Royal College and continued as a peripatetic examiner for many African Universities.



In 2002 he was awarded an OBE – for services to Orthopaedics in Africa. When his Professorship in Pretoria ended, he continued to work in the more rural areas of South Africa, always continuing to train surgeons and all grades of health worker. He eventually returned to the UK, but while operating at the New Royal Edinburgh Infirmary, during 2010, he was taken ill with a rapidly progressive acute myeloid leukaemia and sadly died the following year.

I last saw Ken and Joyce at a Global Health Meeting at the Royal Society of Medicine a short while before his death. They were both in good form and we spoke fondly about “the old days”.

The world has lost a truly inspirational surgeon, and I have lost a very good friend.

[Ken Rankin did not often speak of his many achievements, so I am most grateful to his son Kenny (also an orthopaedic surgeon) for much of the information in this obituary. Geoffrey Walker}

CHINA (by complete contrast..)

Alan Giachimo writes:- I am looking for a quality Spine Fellowship for a Chinese Orthopaedic surgeon (English speaking) who is on staff at the biggest teaching hospital in Zhezhang province (city of Wenzhou).

They have an excellent orthopaedic department, which I have regularly visited.

In Ottawa we have had a Chinese orthopedic surgeon as a Fellow for a year each in: Total Joints, Spine ... and this year will be having 3 more, in Tumour, Shoulder, and Trauma.

It would be better if their second Spine Fellowship had a different experience than Ottawa Spine again.

They will fund themselves.

The experience should be good quality and I'm certain the encounter would be a “win/win”. [<giachino@rogers.com>](mailto:giachino@rogers.com)