World Orthopaedic Concern

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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 not connected through the "net." It is addressed to all those interested in orthopaedic surgery in Areas of the World with Limited Resources, but with maximum need.

Musicians, artists and writers never retire. Many orthopaedic surgeons are equally fascinated by their life's work and have no wish to stop it. This is but one of the many frustrations which confront some – not all, of our colleagues. From the opposite side, there is a desperate need in those parts of the world with limited resources, to be taught and trained to perform elementary orthopaedic treatments – not to be talked at, with proud statistics, but guided, with "hands on".

In this Newsletter we offer the impressions of three different sorts of surgical visitor; 1. the post-mature and most experienced; 2. the young fully trained Western Specialist; and 3. the prequalification medical student. Each has an important contribution to make, and each has much to learn and re-learn.

1. None has greater experience than **Malcolm Swann;** (maverick individualist, resident sub-Saharan.) He writes:-

"Prospective surgical travellers to the Low-Income parts of the world, often ask what are the surgical problems that have to be faced. Naturally the visitor seeks advice and reassurance on how to manage the conditions with which he might be familiar. What is hard to convey is practical advice because of its very nature, trauma is unpredictable, and each surgeon's chosen instruments will certainly not be to hand.

“Modern orthopaedics has become progressively specialised. The first task is for the visitor to put himself backwards in time to the period of his youthful training, to the basic techniques, to avoid and then to deal with, the complication of infection.

“He must accept the prevalence of imperfect outcomes and to be ever conscious that he will leave behind problems of his own making. The visitor must be a surgical generalist, not only in orthopaedics. He has to convey, not the brilliance of modern orthopaedics, but the efficacy and safety of classical orthopaedics.

“I am just completing four years with Cure International in Zambia, having been with them previously for two years in Malawi (with **Chris Lavy**) and one year in Ethiopia. I just got back from a stint on Mercy Ships in Togo. I mention this as it covers my African experience plus two years in Kano, Nigeria as a Registrar (long ago). In fact I am a fully paid up member and supporter of WOC, but have not called upon their funds and have always organized my own arrangements.

“My perspective is working in a full time job here in Lusaka and not as a short term medical visitor, for it is as such the WOC is probably mainly interested. However I may be able to give some useful information.

“I should emphasize to the doubtful that although there is some lack of sophistication in terms of home comforts or European culture, living in Africa particularly in the cities is quite a civilized experience. There are of course mosquitoes, electricity failures, lack of equipment and no MRI (imagine !). Food is abundant and adequate. Potatoes and tomatoes grow like anywhere else and mangoes and avocados are abundant in season. It is a healthy environment and anyone coming for a while should bring the wife and kids. There are direct flights, London/Lusaka, three times a week by BA.

“I am persuaded that with British Orthopods tending to retire early, many might still wish to fill their remaining active years. I also feel that thanks to BUPA , PPP. Etc., some may have a good financial base to help fund a visit without the need to call on WOC funds.

“My present position as a volunteer is Medical Director of the Beit Cure hospital in Zambia. This is a Christian Missionary organization which directs its clinical activity to physically disabled children. CURE has a number of

hospitals in Africa but here in Zambia we deal with Orthopaedics and Neurosurgery with on-site staff. We have a visiting ENT surgeon, (Irish),a plastic surgeon (US), a spinal surgeon, (UK) and a foot surgeon (Italian). They are all volunteers or sponsored.

“Most pathology can often be described as gross before it presents to us and visitors may be unfamiliar with the conditions or their remedy. This is especially important in an environment where life expectancy is about 37yrs, educational facilities are lacking and the chances of employment are poor even for the able. I have spent long hours time cancelling or modifying surgical procedures proposed by visiting colleagues.!

“Our visiting short term volunteer specialists have been several times and now come twice a year, so they hit the ground running. These include ENT and plastics. The aftercare of their cases can be managed by the local team. Short term visits from spinal surgeons have left us some problems, and I am now of the opinion that visitors involved in major surgery must be prepared to stay for more than a week after they have concluded their operations.

“I feel that any visiting surgeon who feels that they want to operate must come for at least three months for the first visit (and preferably longer) and take part in the general clinical activity and decision making; **not** making their first appearance already gowned in the theatre. There is no place for the parachute surgeon, who lands for a short period, operates and promptly leaves.

“The Zambian Medical Council requires temporary registration for visitors who take part in clinical activity on his own behalf, and this takes quite a while to organize. It took me five visits to get when I first came here. (*I have now got full registration but I also need an annually renewable license to practice, issued here*).

“The University Teaching Hospital (UTH) in Lusaka now has a good nucleus of Zambian surgeons, some of whom have had additional training in South Africa. Activities are limited by lack of money, equipment and facilities. This is similar to that which I experienced at the Black Lion in Addis and also the teaching hospital in Malawi. In Lusaka the initial management of trauma is done by the general surgeons . There are a number of orthopaedic trainees working for the F.Med.- local specialist exam,- and adequate teaching should be available from the in-house staff. They have an AO course for both conservative and

operative management of fractures. We have a joint venture with them running Ponseti courses for club feet.

“The lack of beds precludes long term admissions such as traction for femoral fractures; but lack of equipment such as the Sign nail, limits the ability to fix fractures, although there are some K nails, plates and external fixators. Of course all young orthopods want to operate, but although the idea of conservative treatment may be good, it is also boring. The orthopaedic department has two teams with four full time consultants, plus **Prof Mulla**, who is busy as Dean, plus two others, by name **Makasa** and **Sonkwe,** who have just passed their exams, and two orthopods in surgical training. It is not therefore man-power which is required at the teaching hospital but resources, and this priority is for a dedicated emergency trauma theatre with all the equipment for 2010.

"There is a massive need to promote and support an Orthopaedic Clinical Officer programme in this country. This has been so successful under Chris Lavy in Malawi. The pathology and population density is comparable in the two countries. The **Flyspec** programme with **John Jellis** is an excellent and fascinating way for a volunteer to help in this environment. Mainly it is hands-on assistance but short flying stops preclude a teaching course. I did this myself in 2001 and it still includes helping at the Zambian Italian Orthopaedic hospital, and some teaching at UTH.

<u>Finally this is a summary of hints for visitors.</u>

1. Expect to stay a sufficient time to learn the African ropes, and contribute.

2. Be aware that the locals know more about the pathology and its treatment than the visitor.

3 That Lusaka is a safe and pleasant place to live (as is Blantyre).

4. Explore other organizations such as Cure, Medicines sans Frontiers, THET. Mercy Ships, Governments and Missions, (I saw an advertisement for Uganda on <doctors.net>).

5. Plaster of Paris does not last well in the wet season in the bush

6. Victoria Falls is mind blowing, and the game parks great (Choose the season)

7. Make plans well in advance. (Medical Registration. Visa, can be got on arrival. Bring variable clothing, and Malaria prophylaxis.)

Malcolm Swann, Lusaka <swannm@doctors.org.uk>

***2*. Dr. Lana Kang** is a specialist Hand and upper limb Surgeon at the Hospital for Special Surgery, NYC. She writes after a visit to the Black Lion, and other hospitals, in Addis, 2012.

"When I arrived to the Black Lion hospital, I got my first glimpse of the living and working conditions in Ethiopia. I was introduced to a typical room for 8 patient beds. Nursing assistance was very limited; typically, two of these rooms were assigned to a single nurse. Within these hospital rooms, I noticed sinks that were not working. Where would I wash my hands in-between patients? Antiseptics were available in the nursing carts. At subsequent hospital rounds, I wondered why all those sinks were placed in the patient rooms if none were to provide running water. Bedside care depended on family members, who changed the bedding, and were the ones who physically went to the hospital pharmacy to buy all of the medications, including any intravenous antibiotics.

"In Ethiopia, I realized the joy of just being a doctor. The rote and ineffective distractions, the static that comes with our bloated and complicated system back home were irrelevant. Don't get me wrong; there are many struggles in Ethiopia but they are different. They are fundamental, short-term and visible. Rather than asking, will your insurance not authorize or approve this, I find myself asking: "How do we control bleeding without electro-cautery? What happens if the electricity goes out and there is no backup? Do we have the right instruments and orthopedic implants?"

"As I asked these questions in real-time, I was and remain inspired - that there are individuals and organizations that specifically address these basic needs outside of the US. In preparing for my sabbatical, I received guidance from my mentor, **Peter Trafton** and a few AAOS leaders, such as **Bill Stetson**. And, of course, I did my homework. I learned about SIGN, and with the help of its president, **Dr. Lewis Zirkle**, I contacted orthopaedic surgeons at the Black Lion Hospital who made going there as easy as it is now true. In addition, I learned of *Hemaclear of the World*, co-founded by our very own Dr **David**

Helfet, MD. *Hemaclear* donated several boxes of tourniquets (all of which I was able to pack in my suitcase!) These tourniquets came in handy in a few of the ancillary operating rooms where electricity was unreliable.

"I made friends with some amazing doctors from around the world. I am so thankful that my first day Dr. Michael Laurence was there to generously and graciously share his perspectives as an outsider and an experienced volunteer. He is an orthopedic surgeon from London committed to working overseas and a major contributor of World Orthopaedic Concern (www.worldortho.com)

"It was especially refreshing to meet a select number of talented residents who were impressively well-read and as polished as the best of our own residents in the United States. I am excited that one distinguished star senior resident of Addis Ababa, **Dr. Samuel Hailu** who happens also to be a big fan of HSS, will be visiting with us this fall. I am ecstatic that, so soon after my trip to Ethiopia, I am able to host and help sponsor his academic travels.

"I look back on my sabbatical and smile for once thinking that my time away seemed very long. While I once had worries about leaving my patients behind, I soon learned that my wonderfully caring patients would be the first to cheer me on in my journey; and they continue to do so. I am uplifted and grateful that when I do share some of the most special moments of the trip, all my friends, patients and colleagues are so very happy for me. My trip has grounded me, nourished me, and made me a better doctor and surgeon. Looking back, it went by so fast. I miss the enrichment that I received, and so I plan to do it again, and again. <lanakangmd@gmail.com>

3. **Rebecca Newhouse**, a 4th Year Medical Student, University of Birmingham, UK, visited the Black Lion Hospital, Addis, in August 2012.

"This August, I was a visitor to the Orthopaedic Department of the Black Lion Hospital. On my first visit to Ethiopia, I really didn't know what to expect.

"On arrival I was struck by the welcoming faces, the beauty of the mountains beyond the city and the hustle and bustle of the roads - acting as a thoroughfare for vehicles, pedestrians and animals alike. I had to adjust to the different calendar and time, and the "intermittency" of the water and electricity!

“My experience in the hospital was varied and exciting: I was involved in ward rounds, clinics, theatres and classroom teaching. On the wards I found the resilience of the patients remarkable, with pathological conditions far more devastating and advanced than I’d ever encountered at home. On just the first round of my visit I saw a teenage boy with a vast fungating osteosarcoma, and many patients with limbs in traction awaiting operations that could be weeks away. The wards were basic and consisted of little more than the patients’ beds and blankets. Clinics, with multiple doctors all consulting in one wide open-plan space. The waiting room overflowed with patients and familes, some having travelled hundreds of kilometres to reach the hospital. I’ve never been in a setting with such an abundance of clinical signs; a it enabled me to learn much more about pathology. It was also a valuable lesson in the importance of a good history and examination, as many investigations commonly used in the UK were not available. Theatres were a really enjoyable way to get involved with the doctors’ work; the most unforgettable case being the amputation of a man’s deeply infected leg. I am very thankful to all the residents being so helpful and the teaching they kindly gave to me.

“I took the opportunity during my visit to experience some Ethiopian culture, much to my enjoyment. The local “injera”, and music and dancing of the different ethnic groups were particular highlights. The coffee was delicious - and will be sorely missed on returning to Birmingham. Once a week I joined the “Hash run”, which was a great way to see the Ethiopian countryside and meet a cross section of the citizens of Addis. I was also able to visit the Yordanos Hospital, built by **Dr Worku Mekonnen** (one of the early graduates of the Orthopaedic Training Project) where I saw an unforgettable collection of pathology. I had the opportunity to visit the **Hamlin Fistula Hospital**, a refuge for women with childbirth injuries to have most complicated repair surgery. They came from all over Ethiopia, and returned home cured. I found the experience particularly memorable for me.

“I would like to thank the staff at the Black Lion Hospital and Professor Geoffrey Walker who kindly invited me to join him for this unforgettable three week visit from which I have learnt so much and gained such enriching experience.”

AFTERTHOUGHT

The latter two impressions above give some ides of the infectious enthusiasm, always generated by Africa. Nothing is more communicable than the excitement of the totally new experience, nor so enriching. Their message is the seed-corn of future endeavours by the multitude of NGO's engaged in Global medicine. By contrast Malcolm's memoir conveys the experience of two decades, and the wisdom of one who has seen it all, and done it.

He is unlikely to attend WOC's principle platform, their clinical session at SICOT in November, in Dubai. But such large meetings are a vital means of communicating and practical planning. To exchange ideas personally, and commit to visiting trips, is essential both to learn how the other half (no, three quarters) lives, and to convey lines of practical research inapplicable to high tech. modern practice.

More details and our program will be in the next Newsletter; please note the date in your diary now. **The 33rd Annual Meeting of SICOT; November 28-30th 2012, at the Dubai World Trade Centre.**

M. Laurence