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 who may not be connected through the "net." It is addressed to all interested in orthopaedic surgery in areas of the world with great need but Limited Resources.

Fresh from the latest Annual SICOT meeting in Dubai (Oct 2012), the next SICOT Conference is already in the process of organisation at the SICOT HQ in Brusselles. The high standard of complex orthopaedics on display at Dubai might generate a reaction this year, when the Indian Organising committee has chosen for its theme, the subtitle for the Congress, - "**Orthopaedics in an Unequal World".**

Hyderabad, India 17-19 October 2013

The closing date for submissions for this meeting is approaching – March 28th 2013. I need hardly say what an opportunity has been offered by the organisers of this meeting, but at the same time there is a responsibility, not just the wave a flag but to influence the course of global Orthoapaedics. Too often papers, read under the auspices of WOC, are auditing lists of hardships endured and intractable but photogenic deformities shown. Extreme trauma has its own pornography. Safety and simplicity are the signals of success. They do not indicate acceptance of the mediocre.

Apposite to this subject was an all day meeting at the Royal College of

Surgeons (Eng) in London, on January 16th 2103, with the title -- **GLOBAL FRONTIERS in SURGERY**. A busy, packed program covered opportunities for surgeons of every specialty to arrange teaching and training visits to areas with limited (or even absent) resources, with two principle objects; firstly to reawaken the long-ago-learned art of managing without packaged and polished equipment; and secondly to teach and train those who have to manage under those circumstances, every day of the year. Such a visits is educational, but that is a two way process. – for the trainee from the West and for the established Consultant. Both will find themselves to have learned much.

Introducing the subject, Council member **Martin Bircher** spoke about the attention given to the subject by the Council (RCS) and the collaboration between the other Royal Colleges. By way of an introductory theme, he projected a photograph of Dr Antonio Socrates, whose premature death in Palawan, was announced in the last Newsletter.

Recently retired Consultants attended the meeting in great numbers (N=242), with Registrars in training and senior students, together with abundant NGO societies (dozens) keen to prove their credentials and offer to fund volunteers. Prominent among the presenters were the Royal Colleges of England and Ireland, MSF, VSO, THET, WOC, COSECSA, CURE, Merlin; also many individual local organisations, all devoted to preaching a fundamental faith – to manage without Management. In a slot titled “Lightening Presentations” every organisation was given a strictly limited period of three minutes to convey the core of their message; and afterwards each had a stall in the main room for follow-up questions. All were extremely busy.

The general themes that emerged from the day included the following;
1. that there is an appalling world-wide imbalance in medical care,
2. there is more to medicine than iatropathic disease.

3. that shortage or lack of equipment does not imply impossibility to treat.
4. that a complete undergraduate program in the UK, does not cover the most pressing of the World's epidemics,
5, that time spent engaged in S-S A (=countries as poor as Sub-Saharan Africa) is a positive item on a student's C.V.

The economics of care with limited resources was honestly analysed; the domestic problems of uprooting families during training, the place for clinical research, the responsibility for consultant cover and a reappraisal of surgical priorities, dominated the discussion. Nor were anaesthesia, prosthetics and rehabilitation ignored. There was a general air of optimism and adventure.

The organisers **Professor Chris Lavy and Mr Martin Bircher** are to be congratulated on a constructive meeting, reviving a real interest in positive medicine rather than defensive damage limitation.

CORRESPONDENCE

James Waddell writes from Canada:-- "I was saddened to see in your newsletter the notice of the death of Antonio Socrates. He was introduced to us at ARTOF through the Jeffrey Hallett, and participated in some of our meetings. He gave a great talk on looking after these terrible fractures in very difficult circumstances and was a real inspiration to people who want to help in these austere environments. On top of all that, of course, he was a thoroughly nice man.

Professor Iain Patel writes from Myanmar. He still finds fund raising extremely difficult in the present economic "resessional' atmosphere Europe!! He presses on because the Burmese Orthopaedic surgeons, who have developed under Alain's tutelage, are good and they now teach the younger generation. He hopes for relief from the global

recession, with revival of the policy which used to provide the major part of his money for his health sector budget.

A message from **Dr Oscar Paz Bueno.** WOC's representative in Honduras, Central America, a country of modest dimensions, into which 8 million citizens are packed, 85% of whom subsist below the official definition of poverty. He writes about hospitals in his country with space for orthopaedic care but virtually no material equipment. He writes "We read your Newsletter recently and take heart from your initiative to help poor countries, such as ourselves, We hope the initiatives of SICOT might raise the level of Orthopedics in our hospitals. We are clear in your concept that the principal idea is not to send money or second hand materials. We are agree with that principle, and would greatly welcome surgical visitors to our hospitals to teach and train through courses to our Orthopaedic Surgeons.

"As SICOT representative I am my colleagues find it not possible to attend SICOT meeting because of the elevated travel expenses to far Countries in Europe and Asia. If SICOT is really interested to help us, please pass on this appeal, and reply to <Oscarpazbueso@gmail.com> "
(SICOT National Representative in Honduras)

Orthopaedic Traveling Fellowships

Applications for 2013 **HVO Orthopaedics Traveling Fellowships** are being accepted. This Fellowship will provide funding for senior orthopaedic residents (4th or 5th year) to volunteer at an active HVO Orthopaedic project for a period of at least four weeks. Four fellowships are available in 2013. Visit the HVO Fellowship webpage to learn more or "e" to n.kelly@hvousa.org. Applications are due in by April 20, 2013.

In our attempt to rationalize the organisation of “hands-on” assistance, a select committee has drawn up a general framework for projects which require financial support. The essence of these plans is Training, although it must be acknowledged that the need is for In-Service guided practice. The following is an abbreviation of a proposed submission.

WOC Principles:

WOC’s concern and involvement in surgical education and training are exercised at several levels, depending upon the local circumstances, in medical manpower and equipment. Our proposal is for surgical instruction in the following four categories:-

1. In the absence of almost **all** facilities, instruction might be given (with cooperation) to any to whom the patient, with an injury or musculoskeletal disease, has traditionally turned. This might for example, be nurses or teachers in the rural community, the Clinical Officers (so successfully developed by Ed BlaIr, in Malawi), or more probable than any, the traditional healers. Where local politics allow, teaching and training to a level slightly above “First Aid” can be offered, with emphasis on that which is safe and unlikely to make things worse. This will include splintage, with a mind to preservation of both the circulation and nerve function to distal parts of a limb. The standard of teaching would be equivalent to that appropriate to undergraduate medical students.

2. The second category is the young qualified doctors, who might be attracted to the possibility of pursuing a career in orthopaedics. For these the basic science of tissue repair, physical examination, musculo-skeletal pathology, fracture reduction with splintage or traction, are the building blocks of such a career. It must be born in mind that those who serve sub-saharan Africa,

and like places, have to be able to deal with clinics of 60 patients at a time. Therefore the technique of physical examination has to be streamlined to essentials, often needing short-cuts when compared with classical western instruction. *(There is an important difference between a large clinic and an oral interrogation for a Surgical Mastership.)* The most valuable and informative moment is when the patient walks towards the doctor's desk and his mode of gait is clearly to be seen.

3. The third level calls for "hands-on" training for standard orthopaedic surgical procedures, and their complications (-- avoidance and salvage) to be carried out with assistance in the under-resourced community. This will be set against the background of the biomechanics of structural skeletal repair and replacement. It is the area in which experience is gained and hard lessons learned, but its provision depends on established sterile surgical technique. There is also a place for highly specialised surgery (difficult by virtue of anatomical complexity, rather than hardware) to be tackled in host hospitals, particularly if groups of similar pathology can be collected together in advance.

4. The last and by no means least important, is special training for those selected as being proficient in the fundamentals, to be sent to special centres where particular techniques are regularly in use on types of patient comparable with those common in the trainee's home country. But it is equally important that attendance at these courses should be confined to those who, in their own country, would be able to make use of such special training in his practice. In other words plans must be appropriate to prospects in their home hospital - that relevant equipment will be available and will be regularly serviced with spare parts. It is not in the interest of the home hospital that one of its trainees becomes proficient in surgery which is inappropriate or not available, at home.

The first three categories call for visiting teachers to the place of limited resource, so that every part is relevant to the community, and contributes to the local service. The forth category calls for national organisation at not too great a distance from the home hospital, for example the training centres in Egypt, India and possibly Russia, and others yet to be selected and supervised.

With regard to the expense of the above categories, the first three will call for some support towards the cost of travelling to the deprived area. And most of all they depend on the numbers of potential host institutions making the necessary invitations and arrangements. Local accommodation is not expensive, sometimes free, at the invitation of the host hospital. It has been suggested that in return for tuition, given freely, 50% of travelling expanses would be sufficient encouragement. Volunteer visits depend absolutely upon personal invitation and therefore local appreciation of the value of these visits.

The quality of the visitors may be an unknown to the host hospital at their first visit. It will therefore be the responsibility of the parent organisation that a volunteer knows exactly what is required, that he is willing and able to provide it and that two referees be prepared to vouch for his or her competence.

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In the last edition of this newsletter, there is an announcement which is open to misinterpretation. Under the heading or “Orthopedics Overseas” we announced Dr Gary Anderson’s new venture in reviving **OREF**, a research and service organisation for places of Low Income. We may have conveyed the impression that he was new Chairman of O.O. (rather than or OREF). That is not the case Dr Fisher remains the energetic lead of O.O. ..

(M. Laurence)