

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.

This Newsletter likes to recognise awards for achievement, made for Orthopaedic work in the context of practice under "straightened circumstances", under which ingenuity is required in order to "invent", without the facilities available in so-called "centres of excellence". (*vide infra*).

At the present time, Surgeons in the hospitals of the Western World are preoccupied with "standards of practice", comparing and contrasting outcomes judged by clinical outcome data, and displayed in a "League Table" according to (as yet) undefined standards of Excellence. But still the majority of the world is short of any care at all! This clearly gives the impression of unequal standards of comparison.

So great are the differences that comparisons are "odorous". The lack of resources does not, and must not, indicate a lower standard of practice, but a different basis upon which Excellence, which means the best with the available resources, is to be judged. Outcomes depend upon a variety of conditions; some take longer to achieve than others, without however, jeopardising the final outcome.

A different impression is conveyed by the widespread criticism of the Accident and Emergency service in the UK NHS. Figures regarding prompt treatment or delay, feature in the popular UK press as "scandalous." Calls have been made for the permanent presence of senior staff to receive "Casualties", because it is in the management of emergency cases that the reputation of a hospital is made or destroyed. The famous American principles of ATLS, speak of the "Golden Hour", within which life or death is determined. Too often, in the LMIC, accident victims

arrive at the E.R, several days after the injury, and too many are then left in E.R. for even more days.! The first is outside a hospital's control; the second, very much within it. The response to serious injury is the front line of a health service; and a society's reputation depends upon its reaction to Emergencies.

ESSENTIALS in EMERGENCY SERVICE.

Here are illustrative tales of two characters; - John and Paul; -- individualists with totally different contributions to make, and plans to offer, at totally opposite professional positions. They are not typical of WOC, but demonstrate the breadth of WOC's involvement and "Concern".

Paul Barry qualified this year in Medicine, and has been appointed to the Royal Free Hospital in London for his first pre-registration "house job". Without a clear onward plan, he used the six weeks prior to the appointment to broaden his own experience of medicine, (as practiced in a UK Centre of Excellence) in order to see how the other 85% of the world copes. He already had a previous qualification in pharmacology, but lacked the experience of clinical diagnosis without the facilities of scanning upon which modern medicine depends. Through personal contacts he was in touch with the Ireland-based "Medical Missionaries of Mary" and enlisted for six weeks to work in a 200 bed hospital in Masaka, 100kms south of Kampala, Uganda.

So much of what we know as a "Health Service" started in some form of Missionary work - funded (inadequately) from philanthropic donation. The 200 bed hospital is served surgically by a comprehensively General Surgeon, Sister **Maureen Lynch**, who has been in post for 40 years. She provides every aspect of the subject, from fractures, and the "acute abdomen", to obstetrics, and the reparative surgery to close vesical fistulae, many of whose patents had to be helped with money to travel home (from where they so often have been cruelly ostracized).

Paul's initiation was immediate and profound. His knowledge of modern medicine was in no way diminished, but his appreciation of the pathology and basis of treatment was hugely broadened and enhanced. He learned lessons through "hand and eye", the assessment of patients without the medium of a mutual language, and without the pile of faceless request forms, for this or that 'scan', histopathology or genetic profile. He learned the value of observation, of interpreting physical appearances, and immediate first aid. He saw the discipline of cleanliness, quick response to pain, hygiene, wound dressings and domestic

support. Paul returned for his job with a deeper, more intimate understanding of immediate doctoring, without accountancy. His contribution to the work in the hospital was hard to measure but enormously appreciated.

By complete contrast, **John Beavis'** life was radically changed when he was already a fully trained orthopaedic surgeon, appointed Consultant to a busy hospital in Kent. The demands of Traumatology were attractive to an energetic surgeon, but national economics imposed restrictions, obstructing treatment. Beavis suffered the strain of frustration and sought medical advice for severe angina pectoris, brought on more by squabbling committees than long surgical lists. Stenosis of the anterior descending coronary artery was revealed by angiography, and an open bypass operation was performed in 1991. By 1992, the angina returned. Repeat investigations lead to advice that the work of a trauma surgeon was not consistent with many years of life, for him!

Instead of acceptance, Beavis chose to squeeze as much rewarding work as possible into what short time remained to him. He resigned from the Health Service, studied the subject of Medical Care in Catastrophes, at the Worshipful Society of Apothecaries, and was awarded the Society's Diploma for his thesis on the subject. He departed for what became a prolonged sojourn in the besieged, war-torn Bosnian city of Sarajevo. For a skilful surgeon to abandon the very work that gave him symptomatic relief, and pleasure, seemed ridiculous.

The conditions in Bosnia have been well reported in the western press. He survived two years under bombardment; and then confronted the aftermath of hundreds of shrapnel wounds. He worked there for a further seven years, without worsening his own cardiac condition.

His experiences in Sarajevo led him to establish a charity, called I.D.E.A.L.S, (International Disaster and Emergency Aid with Long-Term Support) dedicated to providing relief to victims of man-made and natural catastrophes, and to see through to their rehabilitation. IDEALS became involved in reconstructive work in Pakistan following its major Earthquake, and in Sri Lanka and Tamil Nadu, after the 2004 tsunami. Their work on open fractures and crushed limbs included support to regenerate the economy of communities, rebuilding a local school for deaf and blind children, with a new water supply. Various businesses assisted, supplying cattle, fishing equipment, materials for building, even a deep sea trawler was replaced, allowing a crew of 10 to be employed again and their

families supported - about 100 people. Not only has he given freely of his time and expertise, but he personally funded much of this work.

Beavis and like-minded colleagues introduced a tailor-made system of training for immediate and post-traumatic care, known as Primary Trauma Care (PTC). Supported with a grant from the Tropical Health & Educational Trust (**THET**) IDEALS established a training programme for surgeons and nurses, including many from Gaza, to work at Kings College Hospital, London (KCH) as Limb Reconstruction Fellows (LRCF). India too now has a thriving PTC community with hundreds of trained personnel.

Having turned turns his attention to Gaza, in the company of **Sir Terence English**, IDEALS have set up “MAP” (Medical Aid to Palestinians). Last year Beavis convened a conference in Gaza on Trauma Care, to high-light the need to translate the same organisation of trauma management (PTC) to Gaza. The team comprised **Sir Terence English, Graeme Groom FRCS, Eamon McCoy, FRCA MD, Sarah Phillips FRCS, Alastair Wilson FRCS, Dr Andy Ferguson MB FFCM DH&TM and John Beavis**. His PTC work in Gaza has produced a total of 40 doctors and nurses have been trained, and 16 have remained as Instructors in Gaza. Dr Andy Ferguson has tabled a pilot project for a Mobile Medical Clinic in **Southern Lebanon**, which, if successful, could be greatly expanded, pending funding.

All staff of the Mobile Clinic, like a “Field Ambulance,” will be thoroughly trained prior to deployment. There will be regular, standardised data collection, with the collated information used to monitor trends, respond to possible epidemics, evaluate the effectiveness of interventions and ensure appropriate resource allocation. It will use WHO/government-approved protocols for the diagnosis and treatment of priority conditions.

Beavis was appointed **Hunterian Professor at the Royal College of Surgeons** (England, in 2000) for his surgical work and for establishing and teaching in Disability Resource Centres for “Primary Trauma” (UK).

In 2012 **John Beavis** was given the **Sternberg Active Life Award**, made annually in the memory of **Sir Sigmund Sternberg**, the philanthropist and founder of the “Three Faiths Forum”, together with “the Times” (of UK). The award is made annually in recognition of an outstanding contribution to society, specifically dedicated to the provision of relief to victims of natural and man-made catastrophes, throughout the world.

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Herein lies the distinction between Traumatology and reconstructive Orthopaedics. Few surgeons have the opportunity to follow through in both specialties. Surgical support previously given, has been directly proportional to the glare of publicity, and when the press moves on, so do many of the volunteers.

Perhaps a diagnostic error (*in regard to his own cardiac condition*) has benefitted many in the developing world. Beavis still has some chest pain, but no squabbling colleagues or administrators to meet in committee rooms !

It is typical that some (*may I say*) "maverick" individuals choose to work in isolation, shunning organized philanthropy. Unlike the "parachute surgeons", Beavis became totally absorbed in each destroyed community, taking part in every aspect of their recovery, far beyond surgery, even beyond medicine. Although many Emergency surgeons are "ships that pass in the night", without authority or responsibility, many retain profound commitment to a community.

These experiences do not suit everyone, and are not possible for most. Referring to the last Newsletter, these are the situations that MSF regularly copes with, by virtue of the organisation and financial backing of a worldwide Nobel-awarded Institution. But there are too many of these catastrophes. Perhaps there always were so many, but the wide world of international journalism brings every calamity to the attention of the viewing public. As the dust settles, and the dead are buried, the problem fades from the television screens. Traumatology fades into Orthopaedics. Reconstruction takes much more time and creates no drama.
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World Orthopaedic Concern attempts to address the latter, encouraging training, by supporting the surgical profession at each stricken scene. We see two goals - 1. the more equitable distribution of the instruments of health care in our speciality, and 2. the wider application of technical knowledge. But even more important is the spread of humanitarian management, not of the fracture, but of the patient; and that does not cost money!

(M. Laurence