

NEWSLETTER



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An International Society for Orthopaedic Education and Care in Developing Countries

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Perhaps the magic number 100 is sufficient reason and excuse for WOC to embark upon some form of reappraisal and reassessment. The membership of the organisation is so different in every part of the world, that it behoves us to identify common objectives and to learn from successes and failures, to emphasise the positive and avoid the negative. It is hoped that this Newsletter might begin the process.

I remain disappointed that the dissemination of the Newsletter, through ordinary mail, has not yet been arranged (funded), so we rely upon the various regional secretaries to circulate their remote members, from the internet downloaded copy. But it is painfully clear that the former flow of correspondence, generated by the mailed Newsletter, has dried up since the "net" is our only means of communication. Sadly the result is that our items of news are predominantly from those whom the editor actually rings or meets. This pattern reveals the fact that the UK members of WOC have self-selected certain areas of the world into which to put their effort. WOC is after all, a collection of individuals doing their own thing, generally under with the "blessing" of their own national region of WOC. No part of WOC has executive power, but offers an umbrella of approval, useful if not essential for certain spheres of activity. WOC does not employ, nor itself train, but through communication, it facilitates.

World wide statistics (WHO) have quantified the extent of musculo-skeletal pathology, responsible for significant disability, much resulting in dependence on help from family or tribe. Our planet houses a total of 355 million disabled, including 190 million with O.A and 16.5 million with R.A. The U.S. Center for Disease Control and Prevention quotes 21.6% of the US population, (46.4 million) who suffer from reduced activity because of medically diagnosed arthritis. Faced with such precise statistics, the average reader of these pages can only raise an impotent eyebrow, shrug the figures into a deep frown and, with a profound sigh, get on with his or her work.

Unlike WHO, WOC is involved with the day-to-day assistance of each individual patient. Those orthopaedic surgeons who live and work in the developing world, have the care of those patients; those of us who make teaching visits, inevitably brief, have a duty to convey technical information (passing on tricks and warning of dangers) to those who shoulder the burden of the statistics quoted above. That capacity (duty) is unique to those of us who have been trained in the management of the conditions prevalent in the developing world. We do not, nor can we, accept the responsibility for global economics, nor politics, nor preventative measures outside the narrow field of our speciality.

Examples of achievements, with the above criteria, are described below. They are individual pieces of work, not organisational administration, because WOC does not have power, only enthusiasm.

CAMBODIA

Three years ago this project was stimulated by several factors; much orthopaedic pathology and an increasing number of victims of road accidents required treatment. Dr. **Duong Bunn**, Head Surgeon of the Unit, and several motivated Cambodian surgeons, had recently return to Pnom Phen, from overseas training. The orthopaedic ward and theatres and the nursing staff were in great need of support and assistance. An enthusiastic hospital chief executive, **Prof. Teng Soeun**, wanted change; an Australian Surgeon, **Tim Keenan**, was prepared to contribute time and expertise; a nearby NGO hospital, Sihanouk Hospital Center of Hope [SHCH], was prepared to develop a partnership with Tim and **Dalton Boot** to improve the Unit.

The ethos was to help key Cambodians decide the changes they wanted and then to bring in the finance, expertise and training to make this happen (in collaboration with the Cambodian Ministry of Health - MoH).

In the last three years this approach has born fruit in the following areas;

1. Equipment provision for the wards and theatre – and a system of monitoring usage;
2. Improvements in nurse training in theatre and the wards - **Mary Wood**, a UK Sister, trained the nurses for nine months, and two senior Cambodian nurses have continued the program.
3. Wards and theatres were refurbished, with funds set aside for maintenance.
4. Funds were also set aside to develop subspecialty training in polio and skeletal reconstruction, for a trainee to attend a course in India.

This “pump priming” initiative has been met by a gratifying response from the MoH, which has increased its financial and general support for the Unit. The Orthopaedic Society has been helped to run monthly Clinical Meetings, and a “Spine Club” has been instituted. The SHCH Hospital has helped with equipment and personnel, from a grant of \$60,000 (USAID.) Since then many agencies, including WOC UK, have donated a further \$70,000. The use of an experienced fund raiser has been successful in identifying which donors to approach and how to present an application.

With regard to the future, admissions to the ward in the last year have increased by 23% and operations by 68%. There is now a need to expand the size of the ward and the number of theatres, in a sustainable manner. Grant money is being sort for this development. There is much still to do before the unit is independent in a manner that complies with the economic situation, but there has already been a gratifying improvement in morale and confidence, a direct result of the demonstration of continuing outside support.

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SOUTHERN AFRICA

A good example of sometimes illogical arrangements, is the investment of funded energy in the Eastern Cape, in the Republic of **South Africa**. A British “senior” surgeon, **Ken Rankin**, has settled there in the town of **Mphatha** where he practices a priceless, basic orthopaedic service to a grossly impoverished area. He was well known in the UK and so senior trainees visit his unit and benefit as much from the experience, as do the indigenous population of Mphatha. Now in general, South Africa does not really belong to the Developing World, (except in so far as we all do); but the personal links between, on the one hand, Rankin with the UK, and on the other, Rankin with the Eastern Cape, are extremely valuable. Doubtless when a WOC Region is created in South Africa, generated by and based upon the South African Orthopaedic Association, an even better service will be organised. Every regional group has its favoured connection; sometimes they change hands as it were, but the links are never “cast in stone” and there is no sense of regional “responsibility or ownership”!

BANGLADESH

The Newsletter from the Impact Foundation carries news of the continuing progress of the Lifeline Express and the Boat of Life, which respectively serve Northern India’s Rail Network and the delta South of Dhaka, Bangladesh, on those mobile but parked Hospital Vehicles! **David Jameison Evans and John Lourie** provide the Orthopaedic aspects of those carriages and boats. {www.impact.org.uk} And between times John has given back-up service at the Sihanouk Hope Hospital in Cambodia (above.)

NIGERIA

Dr. Kabir Abubakar, the Medical Director, writes from the National Orthopaedic Hospital, **Dala-Kano**, Northern Nigeria, which approaches its fiftieth year. It was set up in 1959, largely at the instigation of **Frank Bryson**, with regular consultant and registrar rotations from the RNOH in London. Among the visiting staff have been **Ginger Wilson, Robin Denham, Chris Colton, Geoffrey Walker and Lorden Trickey**. To this day it remains the only source of orthopaedic treatment for 60 million people in the Northern Province. The hospital comprises 180 beds in seven wards, seeing 14,600 patients last year and performing nearly 700 major orthopaedic procedures; it runs a Resident Training scheme and a school for Orthopaedic Nurses and Plaster Technicians. Such success breeds its own problems. The eight consultant surgeons are desperately pressed with demands for modern techniques in back, knee and hand surgery. What the hospital lacks in equipment, it makes up for in care and ingenuity, but they are indeed ready for modern instrumentation. {md@orthopaedicdala.org}

ETHIOPIA

Sally Tennant, who specialises in feet and children’s orthopaedics, has recently undertaken an extensive Instructional Course in the Ponseti and other techniques for the treatment of Club Foot, at the **Black Lion Hospital in Addis Ababa**. She reports on the continued enthusiasm among the young doctors in training, and describes the difficulties under which teaching continues. This was one of the earliest teaching hospitals in East Africa and it has a long history of regular visits from orthopaedic surgeons from the US and UK. At this, her most recent teaching visit, Sally reports on the moral (although not financial) support from the charity CURE, who gave their encouragement, and flags. Sally remains anxious about the trainees and pleads that western visitors are sorely needed to maintain the level of instruction, while at the same time realising that visitors cannot, and should not, simply supply sporadic service.

The current Bulletin of the **Royal College of Surgeons of England** (May 2007) contains a substantial report following visits to Ethiopia by the **President, Mr. Bernard Ribeiro**, and by Mr. Gordon Williams, a urologist at the Hammersmith Hospital from where he is to retire to live in Ethiopia. He made the comment that “It is an unfortunate fact that many doctors trained in Africa leave in search of better opportunities in developed countries.” He goes on to comment on the part to be played in the rural areas by trained but medically un-

qualified care workers.

The article in the Bulletin goes on to draw the comparison with the work in Malawi, describing **Chris Lavy's** ten year period. Chris had only planned a short visit 12 years ago, but the scenes of desperate need caused him to stay. "We saw children with legs so bowed that their buttocks touched their ankles, and spines so twisted that their chest and pelvis faced in different directions." Basic maintenance lead, eventually, to the development of a new hospital and the training of OCOs (Orthopaedic Clinical Officers) to provide basic safe care of fractures, for which they have become the "backbone" of the country's trauma service. Linkage with neighbouring countries lead to the formation of the College of Surgeons of East Africa.

The President of the R.C.S. **Mr Bernard Ribeiro**, has recently met with **Lord Crisp**, author of the report "**Global Health Partnerships**" to discuss the role of the College in encouraging health education and training in Africa. They plan to establish a register of surgeons prepared to work and teach in developing countries. Professor Lavy expresses his appreciation of the Presidential visits and acknowledges the support, both physical and financial, of the College and the major charity, Beit CURE, in the development in Blantyre. He hopes that the College "will encourage UK surgeons to make teaching and service visits... to appraise and accredit time spent overseas and support research. While we have made great progress in Malawi, there are still only four orthopaedic surgeons for 12 million people." Mr. Williams echoes these emotions, adding "Working in Africa is an incredibly rewarding experience. There must be hundreds of surgeons who are retired or have holiday to take. They could come out and teach on a regular or irregular basis and take a look at this stunningly beautiful continent." Chris adds "I recommend that all UK doctors spend some time in the developing world so that they can ground themselves in the realities of what is happening on our planet." {["e" bulletin@rcseng.ac.uk](mailto:e@bulletin@rcseng.ac.uk)}

ZAMBIA

John Jellis sends his regular reports on the FLYSPEC Service he continues to give to the remote areas of Zambia. As senior surgeon and pilot he has completed thirty "flying" visits to Chilonga, Kalene Hill, Katete and Chitokoloki; 14 visits were made by road. John's report includes a map of Zambia showing the towns and villages visited. It is like the chart a big innings at cricket! His list of surgical procedures is huge and varied. Although it is generally conservative in regard to implants, it is radical in extent, including tumours, infections, congenital deformity and trauma, both new and old fractures, requiring bone grafts and fixation. His service remains essentially dependant upon external funding, much from the Netherlands. {["e" medorth@zamnet.zm](mailto:e@medorth@zamnet.zm)}

MALAWI

Jim Harrison reports from **Blantyre**, where the new hospital is up and running. They retain the regular service from **Richard Brueton** and the training link with occasional registrar visits and regular professorial visits from **Chris Lavy**, who is now firmly entrenched in Oxford.

PHILIPPINES

Louis Deliss writes as from the **Palawan Trust**, on whose behalf **Socrates** has extended his repertoire to include some modern surgical procedures. He recently attended a course on the Club Foot technique of Dr. Ponseti, held in Helsinki. His Palawan staff has increased to include a colleague trained in Manilla. In May of this year he has visited W.H.O. in Geneva to receive the **Sasakawa Health Prize** for 2007. This prestigious award comes from the Trust of the Japanese Philanthropist, and bears his name. It is awarded for "**Outstanding Innovative Work**" in the field of Health and was presented in the course of the Sixtieth World Health Assembly.

CORRESPONDENCE

This office is delighted to hear from **Ron Huckstep** (Sydney, ex-Uganda) who has clearly recovered to full energy and productivity. His Website continues to carry news and newsletters from WOC, and he sends a reprint from "Clinical Orthopaedics and Related Research" (CORR), March 2007. Ron has always written with absolute relevance to Developing World problems. This essay addresses the common problem of **Neglected Joint injuries**, resulting in chronic contracture. His experience in the management of these conditions is extensive and his warnings and advice are soundly based. He refers to that most valuable tool, the tenotome (or an old cataract knife!). He illustrates the technique of release of the tendo calcaneus by dividing it at two levels. (*Your editor has often done it at five levels!*) The whole article is on pages 58 – 64 in Volume 456 of CORR.

From time to time we get requests that appropriate articles like this should be collected into a journal form to be available specifically for centres with which WOC collaborates. Indeed a set of Professor Huckstep's publications constitute a prototype for such a venture, and many are always available on his website (below). The major orthopaedic journals are usually happy to give permission that their publications be reproduced. {www.worldortho.com} {rlh333@optusnet.com.au}

AFTERWORD

This Newsletter, No 100, is disseminated by way of the Internet, with the hope and prayer that it be further distributed, from each Regional Secretary, to those regional members who might not have access to the net; and a further prayer that some future source be found to fund surface mailing. To this end, please distribute to any and all who might take an interest in the work of WOC, and see in it a cause worth being seen to support.

Mike Laurence