

Why Volunteer?

Geoffrey Walker, Hon. Member WOC

Philosophy: Most of us choose to become doctors or para-medical colleagues with the idea of 'helping people', and although with the passage of time this rather idealistic philosophy often becomes 'modified' by the pressures of life, family commitments and other worldly considerations, I believe that many do find deep down inside that our work and way of life becomes a major part of the way we live and think.

We are lucky in orthopaedics to have a virtually bottom-less pit of fascinating clinical material i.e. patients, for whom so much can often be done to maintain if not improve both their function and their quality of life. While in the more developed parts of the world ('the West') the continual stream of technical advances helps us to keep up with the problems of our aging populations; in poorer and less developed areas a very great deal can be done if one follows the basic principles of our specialty and learns to use and to teach with the materials and facilities locally available.

However, I believe it is also important to remember that in the long term more assistance to more patients can be given if visiting volunteer orthopaedic surgeons concentrate on 'teaching the teachers' rather than devoting their time to operating and other service work – fascinating and self-satisfying as this can be. WOC always stresses that training should be 'in their own country', 'on their own patients', and 'with the facilities locally available'.



Not all of us are born good teachers, but with self-discipline and experience teaching is not too hard to do. It is always fascinating and sometimes rewarding, particularly as one's 'students' mature and in turn and in time themselves become teachers. This really epitomises what I believe to be one of the most important tenets of WOC – i.e. 'to work ourselves out of a job', and in fact this has happened in several countries where WOC helped to establish and then assist with an orthopaedic training scheme.



The Practicalities: Enough of this ‘humanistic’ philosophy – and so what does one actually have to do? From the outset it is important to appreciate and to accept the chasm which has developed between ‘developing country’ and ‘western’ orthopaedics. Not only does one encounter many of the problems which in the west were our bread and butter not so long ago, but it is also unlikely that all (indeed ‘any’) of the sophisticated materials taken for granted in the West will be available in many developing countries.

These days how many of our trainees learn how to handle open fractures which arrive days late; or are faced with whole shaft sequestrum osteomyelitis, deformities following polio, severe untreated club feet, huge tumours, or have learned the relatively difficult conservative/orthopaedic management of fractures and deformities using traction of one sort or another? Mention too must be made of the orthopaedic problems of the current HIV/Aids epidemic.



However, road traffic accidents (RTA’s) have become a world wide problem, and in many countries that I visit a high proportion of the often few orthopaedic beds available are filled with patients injured in these events. This may result in an unsatisfactory ‘case mix’ for training purposes, but is often a difficult problem to solve – particularly during the early days of an orthopaedic training scheme, and when our general surgical colleagues are only too anxious to abandon any responsibility for RTA’s

There are likely to be grave shortages of operating time (especially for emergencies), and in one large university hospital that I visit there are no x-ray facilities of any sort for the operating rooms, or of portable machines for use in the wards (but there is a CT scanner!). Even so it is amazing what can be done with a tape measure, and the application of basic orthopaedic tenets – for example ‘Reduce’, ‘Maintain Reduction’, and ‘Treat the Soft Tissues’, etc. Always aiming for ‘FUNCTION’ and particularly the avoidance of stiff joints.

As the late Alan Apley said young surgeons (as well as those not so young) love to operate, and it is constantly necessary to stress that an operation (even when this is necessary) is only one relatively small part of the total management of patients, and that closure of the wound is not the end of the surgeon's responsibilities.

There will be many frustrations that visitors will meet, and a healthy sense of humour helps. It can be difficult to instil our belief that 'doctoring' is a full time activity, and that patients require attention in the evenings, nights and at weekends. But example helps, and one does have to go on trying.

Every training program and its facilities are different, and I suggest that it is helpful for 'first time volunteers' to overlap when possible with an appropriate colleague - there can be quite a 'culture shock'. Young orthopaedic surgeons who are in a UK training program need and appreciate much more supervision, and I am always happy to have one or more with me when I am teaching (currently in Ethiopia and in Laos). I advise visitors not to bring collections of slides of arthroplasty revision surgery.

Oh yes, social life. Living conditions vary enormously, and it is wise to communicate with one or more previous visitors. There are always interesting things to do and to see, and 'The Hash'* helps to keep one reasonably fit.

[*Hash:- refers to social runs that take place in most countries and big cities throughout the world and not to a certain noxious weed: Ed.]

Further information can be obtained either from [WOC UK](#), or directly from me: Geoffrey.Walker@Bigfoot.Com

Good luck – it is, and should be fun!



Small part of club foot clinic in Dhaka Orthopaedic Hospital



Guinea Worm



Pre-operative assessment of post-polio hip fixed flexion



Young orthopaedic patients in Children's Hospital, Chennai