

# *World Orthopaedic Concern*

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Distributed from:-

[laurence.woc@gmail.com](mailto:laurence.woc@gmail.com)

and through Websites:- [www.worldortho.com](http://www.worldortho.com)

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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.*

Thank you for dragging yourselves from televiewing the world’s sporting competitions, displaying feats of astonishing physical achievement, to read this Newsletter. May I be forgiven for introducing a faint aftertaste of discomfort.

The world’s media have plugged our ears with absolutes. The words Olympian and Corinthian are replaced by chauvinistic hyperbole and the cruelly abused words – “Incredible” – “Unbelievable!” The decibels of the commentators have reached levels bordering upon hysteria - the triumph of thiumphalism!

One disquieting feature is the amount of time the cameras spend on the faces of the defeated, close-ups of abject misery. But when it is all over, the facts of life and the problems of its preservation, will persist. Deprivation is in some way bound up with the triumph of the Elite. I read of one gold medallist from the last Games, now begging on the streets of Beijing. I fear to tread in the philosophical footprints of religious leaders, but the poverty of those less gifted and less served than the best, remains our responsibility.

My attention was drawn to a message in the “letters” page of the London Times, today (8/8/12). Three eminent experts deplored the blind donation of billions of dollars to Africa, creating dependency, a hostage to corruption. They quote an American investigation to reveal that two thirds of such Aid is

not traceable into healthcare and impossible to audit. International Aid is suffering from the global economic situation.

Readers of earlier Newsletters will have learned of the governmental support, which Alain Patel had from the French Government, has dried. He writes more recently that he now has to depend entirely on his own fundraising activities, for his work in Burma. Now is surely the time to concentrate on the organisations which fund the voluntary visits of expert teachers to the hospitals and medical schools of the continent. That is real and practical charity. Two good examples are reported in this Newsletter, below.

## **REPORTS ON REGIONAL ACTIVITIES**

### **SOUTH AFRICA**

Treloar/Gauvain Fellowship Report; from Kwa-Zulu

**Laurence Wicks** writes:-

Ngwelezana hospital is situated on the north coast of Kwa-Zulu Natal, South Africa, serving a population of 3 million, with referrals from 13 other district hospitals. The Trauma and Orthopaedic department is never quiet. Run by UK born and trained, surgeon **Paul Rollinson**, for the past 20 years, this chronically under-staffed department has been helped by a trickle of UK doctors passing through its doors over the years.

I started work here on the 1st January 2011 having completed core surgical training the previous year, and with an aim to secure orthopaedic registrar training (ST3) and return to the UK in 2012. I was assisted greatly by Africa Health Placements, (AHP) an organisation helping foreign doctors find placements in rural parts of South Africa ([www.ahp.org.za](http://www.ahp.org.za)).

January is the busiest time of year for South African orthopaedic departments. Over Christmas there are around 1000 deaths on the national roads, the survivors of which fill the wards with multiple injuries, as they patiently wait for their place in the queue for theatre. The summer weather of January brings a hoard of children who have fallen from fruit trees, sustaining arm injuries. The hot and humid climate also seems to increase the rate of pyogenic bone and joint sepsis in children.

In addition to road accidents, wounds from guns and bush knives are common, as are musculoskeletal manifestations of tuberculosis, Blount's disease, and clubbed feet, for which I have helped run a dedicated clinic

treating children by the Ponseti method.

As well as becoming familiar with the mix of clinical conditions, different skills are needed. Plaster casting techniques are quickly acquired; operating the image intensifier in theatre (which has to be learned) becomes routine, together with wound management and skin grafting. Many of these skills are essential to an orthopaedic trainee, but are not emphasised in a purely UK based training programme. Working in this setting does not mean that my methods of treating patients are old fashioned, out-dated, or below par. For example, we have been reconstructing bone defects, using the Masquelet technique. We regularly use an improvised method of topical negative pressure dressings in wound management.

The constant need for an interpreter I found frustrating, and probably more so the nurses upon whom I relied upon so heavily, although they rarely seem to show it. However, my “isiZulu” has progressed dramatically in the last year. I can get through the basics of a history and examination with some assistance. More importantly, grasping some basic understanding of Zulu society, culture and practices has helped my management of patients.

A major difference from Western practice has been the frequent “shifts” of 24 hours at a time. I probably average 70 hours a week here, but despite working far more than would be legal under *European Working Time Directives*, I feel no more tired on a day-to-day basis. Furthermore, continuity of patient care is improved by the lack of regular handovers that have become mandatory with shorter shifts to achieve a 48 hour working week. Whilst I agree that tired overworked doctors might not provide optimal care, I am unconvinced by rigid rules.

Whether it is through a lack of resources, or typically a South African trait, there is a ‘can do’ attitude about the work here that hasn’t always been the feature in hospitals I’ve experienced in the UK. If the department runs short of basic equipment, we make a plan; if a vital service such as radiology or anaesthesia is in meltdown, we make a plan; when water, power, or sterilisation facilities fail, we make a plan. This commitment to keep going no matter what, has impressed me hugely and will always make me think twice when told something is “impossible.”

Other real highs for me have been teaching and research. Despite the constant demands for service provision, there is a regular educational programme, and time is always made to pass on knowledge in the ward, clinic and theatre. There is a wealth of opportunity to start research projects. I have

been helping run a repeat observational study of the effects of HIV status on the outcome of open fractures; prospectively studied management and outcomes of distal femoral physis fractures; and am following up all patients treated using the Masquelet technique.

Aside from work, living on South Africa's northern coast, with the Indian Ocean on my door step, has been paradise. Away from the busy city life I have known for so long in the UK, I have enjoyed spending much more time with my wife and children. On returning to England we will never forget the lessons we have learned, about the joys of simple life and quality family time.

To conclude, this had been the most fruitful chapter of my (so far) short working life. Having worked in an under resourced setting, with frequent frustrations, I am preparing to return to the UK/NHS training with a renewed vigour, but also nostalgia for this hospital and its beautiful setting. The experience has been an invaluable part of my orthopaedic training and I hope I will be able to take further opportunities to step out of a training programme at various intervals and work in the developing world. Indeed I feel that all UK trainees should spend time in such a setting to increase their knowledge base and versatility. Surely this will benefit not only the countries they visit, but also the NHS when they return.

I would like to thank **Dr Paul Rollinson** for his time and dedication in teaching me and many other UK surgical trainees over the years; and I thank World Orthopaedic Concern UK for supporting me through the Treloar Gauvain Fellowship.

Laurence Wicks <[wickslarence@yahoo.com](mailto:wickslarence@yahoo.com)> (now back in UK)

## **MALAWI.**

**James Cameron**, MD, undertook a tour in Malawi under the auspices of Health Volunteers Overseas Here is his report`;-

My role was slightly different as I am still a resident. My time was spent between ward rounds, teaching the OCO's (Orthopaedic Clinical Officers), clinics and operating (in the OR). All my time was spent at Queen Elizabeth Central Hospital which is the main teaching hospital in Blantyre. There was adequate time throughout the week to prepare for the following weeks lectures. There was also time during which I could read about interesting cases I'd seen either in theatre or on the wards. I felt that there was adequate

oversight of my activities but also appropriate independence for my level of training.

There are currently 20 OCO's going through their training. They are approximately half way through their 18 month course. Lectures I gave included basic orthopaedic oncology, crystalline arthropathies, and rheumatoid arthritis. I spent a lot of time discussing x-rays and how to be systematic and thorough when reading them. I also spent time going over cases that were presented in morning reports, to try to reinforce important basic orthopaedic principles. We also did some practical stuff which included learning/practicing how to tie instrument-free knots.

The students are very enthusiastic and eager to learn, always full of questions. (I would be more than happy to discuss the appropriate level at which to pitch formal lectures and slide shows, for any prospective visitor)

**Supplies.** There are some scrubs/hats/gloves/shoe covers/gowns in the flat but you'll never go wrong bringing some more in your bag. There may be other items that HVO asks you to take out to Malawi, depending on the local deficiencies. The greatest need at Queen's right now is a portable X-ray machine for theatre. The present one broke down some time ago and they've been unable to get the necessary spare parts. A functioning machine would help tremendously in the treatment of many fractures, most noticeably hips which are currently treated in traction.

**Living Arrangements** □ I think the flat is more than adequate for the volunteers, without being luxurious. Previous reports have mentioned the ceiling caving in due to bat droppings but this is no longer a problem. Previous reports also discussed how the hot water works etc. so I won't repeat that here. There are also mosquito nets in the main bedrooms which is great. The water is regularly off from 6am to 6pm but there are buckets for storage. Also, there are power "outages" a couple of times a week, but there is an emergency light in the flat. A torch/flashlight is something to consider bringing.

**Internet Access.** The flat is in a hotspot for "Skyband" which is one of the internet providers in Malawi. You can buy access cards from multiple places posted on the Skyband website. Cards vary from 25MB up to 1GB of data. I bought a 500MB card for 5500 Kwacha but I needed to buy more to last me the month. The internet connection is not bad in the flat and you can certainly Skype without difficulty (turn the video off otherwise your data will disappear very quickly). I also left a 50MB card in the flat which the next volunteer will be able to use immediately.

**Money.** Credit cards are off little use; most shops/restaurants simply don't accept them. I have no experience with travellers checks in Malawi so I can't comment, except that I don't think they're used much at all. I would suggest bringing over some US \$ cash and then using a debit card to withdraw money from an ATM machine either in town (on Victoria Avenue) or at Chichiri Mall. The money was devalued while I was there so the black market for US \$ faded. The current bank exchange rate is about 250 Kwacha to \$1US. I have an ING Direct account and was charged \$1.60 per transaction (I could withdraw as much as 40,000 Kwacha at a time). Fuel is now one of the most expensive things.

I had trips to Mt. Mulanje, the Zomba plateau, Majete Game Reserve and to Lake Malawi. They were all very enjoyable and showcased the amazing diversity this small landlocked country has to offer.

**Suggestions.** If there is going to be more than one HVO volunteer in the flat at any one time, I think it helpful to put those volunteers in contact with each other, in advance by distributing their email addresses. I think this would make the initial experience in Malawi much easier. The car works well but could certainly do with new front tires as well as a general service. I would be more than willing to contribute to these maintenance costs as it was great to have access to the car while in Malawi.

**Summary:** I had a really good experience in Malawi I learned a tremendous amount about orthopaedic care where resources are limited and I admire those practicing there for their dedication and resourcefulness. I don't know where **Dr. Mkandawire** finds the hours in the day to do all he does, and **Chris Nugulube** is truly dedicated to the OCO program. Working with and teaching the OCO's was a highlight for me and I hope that they found the lectures I prepared useful and applicable to their future practice.

James Cameron MD [zimcam81@gmail.com](mailto:zimcam81@gmail.com)

**MALAWI.** The **Dr. Edward Blair Memorial Fellowship** for Young Professionals in Orthopaedics at *Queen Elizabeth Central Hospital, Blantyre, Malaw;* organised through HVO USA (address below). Applications for the 2012-2013 **Dr. Edward Blair Memorial Fellowship for Young Professionals in Orthopaedics** are now being accepted. Established by **Richard and Mary Kemme**, this Fellowship will provide funding for an

orthopaedic surgeon who has recently completed his/her residency training to volunteer at the Queen Elizabeth Central Hospital in Blantyre, Malawi under the supervision of **Dr. Nyengo Mkandawire** for a period of three months.

The successful applicant will be exposed to a wide range of surgical pathologies not commonly seen in the United States. He/she will learn to communicate effectively with people from different cultures and will be exposed to the realities and constraints of delivering health care in a resource-scarce environment. The recipient will be challenged to be flexible, to adapt to different circumstances and to hone their decision-making skills. The recipient will be asked to submit a report within one month of returning home.

The applicant must be a US or Canadian citizen who has completed his/her orthopaedic residency training at an ABOS recognized program. Applicants must apply prior to starting practice or undertaking additional training.

Funding will be available to defray expenses related to airfare and lodging, as well as food and incidentals. Interested applicants should send the following documents (in MS Word or PDF format):

1. One page letter highlighting previous experience and motivation for seeking fellowship.
2. Current CV.
3. Letter of recommendation from the director of the residency program or the chair of the department. This letter should address the applicant's suitability for this Fellowship (ability to teach, to be flexible, etc.)

Applications should be addressed to **Nancy Kelly**, HVO Executive Director, and sent to [info@hvousa.org](mailto:info@hvousa.org). Please reference the "Dr. Edward Blair Memorial Fellowship" in the subject line.

Electronic submission is mandatory. Applications must be received by close of business on August 31, 2012.

### BOA Program – Annual Meeting in Manchester 2012

(UK Fellows should place the following in their diaries.

WOC has a Dedicated Session, on the last afternoon of the Annual Congress of the **British Orthopaedic Association. September, 14<sup>th</sup> 2012**, Manchester. (Check the program in case of alteration. .)

The program will include papers on the following subjects:-

1400 Trauma management in the East, Central & Southern Africa. –  
“DFID Initiative”

1415 Crush fracture of the os calcis treated by  
reduction, achieved simply through release of the deforming force.

1430 Orthopaedics & Anaesthesia - a combined effort in Malawi.

1450 Cooperative Orthotic & Prosthetic Enterprise (COPE) Rehab. in  
Laos.

to be followed at 1510 by a selection of “free papers”.

M. Laurence