

adherence to teachings which may not be appropriate to the needs of the student's own country.

It would be comforting to know that there was a body responsive to the health needs of the world which could begin to use the vast wealth of experience, materials, and technology for the needs of the large proportion of the world's population. The World Health Organisation can claim credit for some successes, but there is much it could do to improve surgical services to the poorer countries by encouraging more liaison between the rich and the poor nations.

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SIR,—For too long Third World governments have concentrated on providing services for urban populations. One can understand this policy since city dwellers are the most vociferous, literate, and political. Any unrest among them may be a bad omen for these governments. Only in recent years have governments shown any interest in rural populations—especially as regards health care.

Although I agree with Professor Samiran Nundy (14 July, p 71), my worry is that the decision makers may choose the wrong priorities. Instead of concentrating on basic needs they may advocate sophisticated and expensive measures modelled on Western countries.¹ These measures may be a luxury in Third World countries. There is an acute need to develop an infrastructure in primary health care before establishing secondary services.

In terms of achieving common good for large rural populations this is the best way forward. Unfortunately, many of the health care decision makers are preoccupied with the glamorous institutions to which Professor Nundy refers. A drastic change in this attitude is needed to improve the services for the rural populations. The main emphasis has to be on rural health care.

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¹ Ramaiah RS. Clinical epidemiology in the Third World. *Lancet* 1982;ii:220.

SIR,—I have recently been working in a hospital in rural Kenya that was the main health facility for a population of around 200 000. None of the four doctors working there had had a formal training in surgery, but all of us had learnt by experience to deal with common surgical emergencies. Very little cold surgery was undertaken. We did our best with occasional spectacular successes and occasional disasters. I often felt that I was working very close to and maybe beyond the limits of my surgical skill and experience and often regretted that the only way to learn was the hard way.

Undoubtedly the hospital, the doctors, and the patients would benefit from a trained surgeon. Local surgeons are generally not keen to live and work in remote rural areas, preferring the higher salaries and better living standards offered by the bigger towns. In any case their numbers are few compared with the need. Expatriate surgeons, while paying lip service to the wonderful experience to be gained in the developing world, are unwilling to jeopardise their career prospects by working abroad.

I suggest that there is a place for short term attachments to the developing world for surgeons from training centres in the developed world. This must be a sustained and regular commitment from the centre of excellence to the small rural hospital, and the surgeon should be well briefed about the problems he is likely to meet. Surgical care will improve as the longer term doctors are encouraged to increase their surgical skills; the local population will benefit from the establishment of a good quality surgical service; and the surgeon will benefit from the challenge of rural surgery.

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SIR,—Professor Samiran Nundy is right to emphasise that much surgery in the Third World can be competently performed by doctors with a "fairly rudimentary training in surgery." Dr Erik Nordberg also emphasises this (14 July, p 92) by highlighting the importance of three common conditions requiring surgery. My 10 year review of surgery at a rural mission hospital in West Africa¹ showed that hernia repair, laparotomy, and strangulated hernia repair accounted for 58% of general surgical procedures, whereas thyroidectomy, prostatectomy, and mastectomy accounted for less than 0.5% each.¹

Rural government hospitals and mission hospitals are often staffed by young doctors. I am concerned that they should be prepared before reaching these demanding assignments. Certainly such doctors should be ready to learn necessary operative skills—often from "unqualified" medical assistants. When I visited several remote hospitals in Northern Zaire earlier this year I met African nurses who had taken training in surgery and were achieving commendable results. British doctors contemplating service overseas should if at all possible have up to date experience in general surgery, obstetrics, gynaecology, and accident and emergency work.¹ Six months in each of these specialties, even at a junior level, would be a suitable foundation for work in the Third World. "We should like to see it widely accepted in this country that a professional career should normally include a period of work overseas in a developing country."²

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¹ Potter AR. Surgery in an African bush hospital. *Med J Aust* 1982;ii:469-71.

² King M, ed. *Medical care in developing countries*. Oxford: Oxford University Press, 1966.

Surgical waiting lists

SIR,—I learnt a salutary lesson about waiting lists (4 August, p 271) three years ago when I was a junior doctor at St Elsewhere's Hospital in another part of the country. The area health authority (as was) had produced a mountain of official statistics which purported to show a long waiting time for gynaecological operations. Knowing that our unit's practice was to give the patient a date for surgery at the initial consultation, I was at a loss to explain how the waiting list could be so long. I queried the figures with the information office which had produced them, and I was told that the figures were correct. How dare I question them.

Undaunted I pressed on and requested a list of all patients reputed to be waiting longer than six months for a gynaecological operation. A cursory glance through the list of names showed that some women featured as many as three times. One poor woman had been waiting over nine months for an operation to terminate her pregnancy and another had been waiting 15 months.

Taking just one consultant's waiting list as a sample, I examined the case notes of all those patients said to have been on the list for over six months. Most had either had their operation already or had notified their intention of not proceeding with the operation, and yet their names had not been removed from the official waiting list. *Not even one* patient on the list was genuinely waiting for her operation.

As I did not examine in any detail the waiting lists of the other consultants, I cannot say to what extent my findings were representative of the area waiting list as a whole. Doubtless some patients do genuinely wait a long time for an operation. Nevertheless, I strongly suspect that I had uncovered the tip of a large iceberg of spurious statistics.

Some while afterwards these same dubious waiting list statistics were quoted in the House of Commons by one of the local members of parliament in support of one particular cause he was espousing. I do not doubt that he quoted them in good faith. As the question of waiting lists seems to fuel so much angry debate is it not time for us to provide our politicians (both local and national) with valid statistics about which they may then argue at leisure? Valid statistics would no doubt pave the way for a better deployment of our limited health resources, which would in turn help those patients who genuinely do wait a long time for operations.

I propose that we invent a new specialty—that of the medically qualified "consultant queueologist." He could tackle not only surgical waiting lists, but also outpatient waiting lists and clinic waiting times. If he could solve the problems his salary would be money well spent.

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SIR,—I have recently completed a report on waiting lists, and rightly Dr David Morris (4 August, p 271) complains that the official statistics do not give an accurate impression of NHS waiting lists.

The surgical waiting list (including gynaecology) is 96% of the total waiting list; and 78% of that surgical list consists of patients waiting for general surgery, trauma and orthopaedic surgery, ear, nose, and throat surgery, and gynaecological treatment in that order. Furthermore, there is no doubt that numerically, 70% of the current waiting list was inherited in 1948-9 and has hung like a millstone round the neck of the hospital service ever since.

As calculated from data collected individually from each of the 22 administrative districts in the West Midlands region the numbers of patients waiting for general surgery, trauma and orthopaedic surgery, ear, nose, and throat surgery, and gynaecological treatment alone represent work for more than double the number of operating theatres that now exist in the West Midlands. If 17 extra theatres were built in each of the 14 English regions it would