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CORRESPONDENCE

We may shorten letters to the editor unless the authors specifically state that we may not. This is so that we can offer our readers as wide a selection of letters as possible. We receive so many letters each week that we have to omit some of them. Letters must be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

How might we improve surgical services for rural populations in developing countries?

SIR,—The articles by Professor Samiran Nundy (14 July, p 71) and Dr Erik M Nordberg (14 July, p 92) on the severe shortcomings in surgical services in the poorer countries of the world and the article by Dr J Muir Gray (14 July, p 106) referring to the inadequacies in the health service provided in England are closely related. It was the realisation on my return from five years in Africa that there was no longer any place for me as a consultant surgeon in the NHS that helped to crystallise my feelings about doctors' roles in health care. Seven of us who graduated from Liverpool in 1971 turned to a career in surgery after qualifying, and not one to my knowledge has a permanent senior registrar post in general surgery. Yet in Lesotho I was one of only four qualified surgeons in a country of over a million inhabitants.

What sort of system can it be which allows myself and 200 others to be effectively redundant while accepting that surgical services in many countries are desperately short of exactly the same energy and expertise which is presently being wasted in this country?

Furthermore, I would ask Professor Nundy whether he prefers the sight of unsightly lumps and bumps to that of thousands of children dying simply from lack of access to clean water. I was surprised that neither surgical article referred to the enormous possibilities which the education of non-medically qualified people may contribute towards the solution of these ubiquitous, severe, and avoidable (in many cases) problems. There is every advantage to be gained from a surgeon/obstetrician training traditional birth attendants in the villages; in the same manner all doctors working in the poorer countries should spend time and energy educating their communities in ways in which they may increase their access to clean water. It is not enough for surgeons to concern themselves only with the end results of preventable diseases, and it is no longer enough for us as medically orientated individuals to concern ourselves with our own chosen specialty.

While I agree with Professor Nundy and Dr Nordberg, I do not think that the answers they have proposed are likely to work in practice. If any solution is to be found it will have to take into account the meagre resources allocated to health care and surgery. Furthermore, the fact that neither article gave any serious consideration to the preventive aspects of surgical care in rural areas is indicative of a prevailing attitude in surgeons generally. I can illustrate this point more clearly by describing one of the methods we adopted to extend the surgical service provided by our hospital in Lesotho.

Burns cases represent a high proportion of surgical intake in all countries. Most cases arise as a result of preventable accidents in the home. Even if we go out to villages and schools in order to spread the gospel of accident prevention practical problems often prevent the message being acted on. In January this year we used the hospital as the base for a week long course on how to build and use a Lorena stove; this was well attended by various people throughout the local community and within three months we had news that these same stoves were starting to be built even in remote villages. From a preventive, surgical view the advantage of these stoves is that they are completely stable and there is little chance of young children being burnt by them. They are also of great practical advantage to the community—for example, in conserving fuel. The lesson from this is that a high degree of involvement of the local community should be considered an essential part of any plans we may have for trying to improve surgical care in rural areas.

My very first sight of an operating theatre in rural Africa was in 1964 in a mission hospital deep in the southern rain forest of Cameroon. The sight of seven operating tables in full swing was awe inspiring and was made more so when I realised that only two tables were being used by doctors. All others were occupied by clinical officers who had been trained by the doctors to operate under supervision. I believe in the use of non-medically qualified staff to assist with the heavy surgical load. I do not think that we have the right to blame politicians and administrators until we as surgeons and doctors can honestly say that we have at least made some attempt to make better use of resources.

My experience in Africa has shown me the inappropriate nature of much of the surgical teaching in academic institutions, but I fear that the generally conservative nature of those in charge is unlikely to allow change. It is sad that much of the benefit which may have been gained from tertiary education in the industrialised countries has been masked by an