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SUPPLEMENT

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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Drums begin to beat in the waiting list jungle

SIR,—Dr Maureen Dalziel and Mr J Kerr have heard drums in the waiting list jungle (21 March, p 722), but there is little sign yet that the wood is distinguished from the trees. The vast chopping exercise now on its way will certainly create clearings, but how fast will new growth replace it? Concentrating on variations of supply without closer examination of demand will not produce a lasting solution. Redistribution certainly makes surgery available sooner, at the cost of travel, with some districts even willing to trade off whole groups of patients (such as those requiring abortions) to accommodate others. While that is a tolerable expedient if the whole problem is being faced, it is nevertheless a negation of the principle by which doctors cooperate within their community to meet its needs. The personal contract between the patient, the general practitioner, and the surgeon, seen as one of the benefits of private care, is fading fast in some National Health Service specialties to the point where, being unattainable, it is no longer seen as desirable.

The equilibrium which can exist in some specialties, whereby large waiting lists seldom vary, undoubtedly generates private facilities and the growth of the insurance industry that services them. Timing, rather than privacy or the choice of the surgeon, is probably the most valued commodity offered by the private sector, especially to group industrial and commercial clients. The fact that many surgeons thus gain substantial added income both confirms the true market value of their skills (though there are signs that the insurers are restive) and exposes them to criticism about the time they devote to the NHS.

A waiting list marks the acceptance of responsibility between the events of consultation and admission, and as it broadly distinguishes surgical from medical specialties it is a major cause of tension in the competition for resources. The surgeon who sees his potential contribution severely limited by circumstances beyond his control is rightly disaffected and frustrated. With no clear understanding of who should carry the responsibility between the general practitioner and the hospital for rationing access to treatment, the burden falls on the shoulders of many, from admission clerks to managers.

In view of the growing gap between tomorrow's medicine and today's resources the importance of both cost effectiveness and medical priorities is clear. The fundamental question is how closely the decisions made at consultation reflect the availability of resources. Some new consultants do adapt as is shown by the growth curves of their waiting lists from zero to plateau when the curve of learning about resource realities levels off. Nevertheless, the two basic conditions of surgical facilities geared to the agreed current and changing needs of a specific community and a steady feedback from general to specialist practice about the effectiveness of specialist care remain unfulfilled.

There has been little study of the differences between referral rates of individual general practitioners or groups, though the few contributions have generally been of high quality and show that the outcome of consultation and treatment may be perceived very differently by the general practitioner and the specialist.[1] How far a surgeon may vary the level and quality of care for patients depends on firm trust that his conscience is clear and that he will not be exposed in the courts for the lack of clothes the service does not provide.

Current attacks on filing cabinet waiting lists, mounted with large sums of money thrust into the system at short notice, are more a political than a medical remedy. They encourage temporary purchasing outside the NHS, regardless of the long term consequences. The uncontrolled waiting list is fundamentally a problem of clinical management, and its remedy lies with the individual consultant, or a group, or doctors in the district as a whole. To transfer its management away from doctors to managers is to distance the source from the remedy. But unless there is a new thrust of concern and cooperation from those who originate waiting lists from primary medical care there will be no lasting solution. It is yet another example of a divided health service.

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1 Kamien M. An Australian's impression of general practice in the United Kingdom. *J R Coll Gen Pract* 1987;37:36-8.

SIR,—The analogy drawn by Dr Maureen Dalziel and Mr R Kerr (21 March, p 722) between waiting lists and the travel business is most appropriate.