Broaden your mind, narrow your chances?

SIR,—It was refreshing to read the totally unbiased views of Dr J A Fairclough and S A Spencer on their experiences in Uganda and Papua New Guinea (2 May, p 1454).

This article is a welcome change from the usual "gin and tonic on the patio" viewpoint of a "great white doctor" who gives up the comforts of a suburban semi and the taxes of the first world because of his concern for the natives in the sand and sunshine of the tropical third world. The run-of-the-mill expatriate doctor arrives in a third-world country suffering from a "saviour syndrome." In the process he and his wife become the prey of the local mosquitoes, cockroaches, and dogs, which seem to have an insatiable appetite for the new blood.

At the end of the coveted two tax-free years our Dr Robinson Crusoe yearns for professional satisfaction and returns home, only to find himself unfit socially for the stiff-upper-lip society. A few leave in the first few weeks of arrival because of the absence of cheddar cheese, cornflakes, and draught beer. Of course, it is an intrusion when a foreigner enters any society. The herd mentality of the local community comes to the fore and the newcomer is assumed to be dangerous until his goodwill and reasonable competence are established.

As Drs Fairclough and Spencer rightly point out, a little homework about the country to be visited goes a long way during this initial period of orientation. An early return to one's homeland is usually the result of ignorance about the new country and its social and medical practices. The spectrum of disease, the differential diagnoses, and the order of available investigations are different in every country. Practising only in the developed world makes one's clinical acumen narrow and there is a tendency to rely on a battery of expensive and nowadays often computerised investigations. A short visit to a developing country brings one down to earth.

The time to make such a visit is at an early stage in the career, after experience of rotations through medicine, paediatrics, obstetrics and gynaecology, and casualty. The young doctor should preferably be unattached and unmarried, full of vigour, and willing to mould. If he survives the local charm, he will return home broadened in clinical and social outlook and better equipped to exploit the facilities available in the developed world. As Drs Fairclough and Spencer say, this colourful experience in the third world will always stand him in good stead for the future.

The same remarks more or less apply to a doctor trained in the third world when he visits the developed world. He faces the local aggression until his credibility is established. A period of social and professional adjustment follows. Unfortunately, at the end of his training he becomes so used to the comforts and sophistication of the developed world that he becomes unfit to practise in his homeland.

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SIR,—The personal paper "Broaden your mind, narrow your chances?" (2 May, p 1454) with its complaints of "troublesome insects, intolerable climate, etc" seems unnecessarily petulent. Overseas experience must be of great value to young graduates; they come, however, not for egocentric reasons but to escape for a while the technological rat race, to learn about different cultures (from which they may learn something about their own cultures and attitudes), and to offer practical aid to a third world increasingly ignored by successive British governments.

The experience the graduate gains works both ways—to the advantage of the local population and to his own personal advantage. Medicine in the tropics is not synonymous with "tropical medicine," with its old fashioned image of worms, protozoa, insect cycles, etc. Western diseases—cancers, degenerations, hypertension, and so on—are being increasingly seen; and doctors working overseas have to be skilled in the diagnosis and prognosis of these; treatment can be offered if socially and economically relevant, which at least makes one think very carefully. The British graduate overseas is a learner and a teacher. His role as teacher is the most important—nurses, auxiliaries, students, and young indigenous doctors all have something to learn from him, if he is able to communicate his knowledge; and most learn this art, through necessity, very quickly and adequately.

Doctors back in Britain sitting on appointment committees who fail to appreciate the special qualities which time overseas has produced will forfeit the opportunity of having enthusiastic, questioning, and able junior staff.

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Disability in the developing world

SIR,—While commenting on how little developing countries can afford to spend on health your leading article (21 March, p 928) mentioned in passing that annual expenditure in rural areas of Maharashtra is $0·02 a head. Although your point about low expenditure on health in rural areas in the developing countries is well taken, it is not right to let inaccuracies come into the figures that you quote editorially. Unfortunately, you have not mentioned the source of your figures so I am unable to trace the "Maharashtra State Commission" that you have quoted. Perhaps your readers may be interested to note a few pertinent facts.

Every taluka in Maharashtra, as in other states of India, serves on an average a population of 120 000. At least in Maharashtra State, each taluka has three doctors employed by the government along with at least 20 paramedical staff. The total pay packet of all these people amounts to 120 000 rupees—an expense of about 5p a head a year or $0·12. In addition, there is a lot of expense on petrol and some on drugs. The actual figure of government expenditure is probably nearer $0·2 a head a year. Besides this the population also supports a substantial number of doctors of all persuasions. Total expenditure on health through all these may well be $2 per head in many of the 300 or so talukas.

You will see that even this figure is ridiculously small and is much smaller than the expenditure of the urban communities. It may be of interest to add that despite this small expense the crude death rate as reported in the provisional figures of the recent census (1981) in the state of Maharashtra is 9 per 1000. The figures for the rest of the country are even lower for the expense, while the death rate is not very much higher.

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Overseas doctors: a step forward into chaos?

SIR,—In your leading article (20 June, p 1996) it is stated that: "About one-third of overseas doctors who come to Britain are sponsored by bodies such as the British Council or the World Health Organisation." This surprising statement is taken from a previous article,[1] which says that: "Just over a third of overseas doctors come to Britain on schemes sponsored by the British Council, the Association of Commonwealth Universities, or the World Health Organisation."

The latter statement appears to be derived from the annual report of the General Medical Council,[2] which gives the numbers of doctors granted limited registration for the first time in 1980 as 1682 and states "of this number 1100 had passed the Professional and Linguistic Assessment Board examination and 582 had been exempted from it because they had been officially sponsored or *were granted exemption on other grounds*" (our italics).

Thus your leading article and your article writer appear to have equated the number of overseas doctors coming to Britain sponsored by named official bodies with the number granted limited registration for the first time by exemption from the PLAB Test. We should like to know if this supposition is correct or if another source of this information exists.

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[1] Smith R. *Br Med J* 1981;**282**:1045-7.
[2] General Medical Council. *Annual Report for 1980*. London: GMC, 1981.

**The annual report of the General Medical Council was the source of the information, and further inquiry to the GMC has shown that only 105 of those 583 doctors exempted from the PLAB test were sponsored by named official bodies. We apologise for the error.—ED, *BMJ*.

Management of scientific services and the changing face of the laboratory

SIR,—The correspondence on the organisation and management of scientific services in Scotland (4 July, p 67) and the article by Mr J B Burns (13 June, p 1943) make a timely debate. I agree with Mr Burns's conclusion that a fundamental reappraisal of the provision of laboratory services is needed now.

Professor L G Whitby and his supporters argue that there is now no place for the principal medical laboratory scientific officer (MLSO) with a multidisciplinary managerial role because of the increased specialisation in medical laboratories and because the existence of the post threatens the position of the doctor. This is unsound argument, and its emergence results not from increased specialisation but from the rigid division of laboratory services into departments based upon the four "disciplines."

These "disciplines" are over 50 years old and to base the structure of laboratory services on them is an outdated concept, wasteful of resources and depending for its continuance on conservatism, or the empire-building tendencies of some senior laboratory staff, or