Developing countries and medical progress

SIR,—It was most encouraging to read Beltus Ivo Bejanga's "personal view," the more remarkable because a professor of surgery seemed to be singing the praises of primary health care in rural Africa.¹ Or was he? In the final two paragraphs he began to speak of "transfer of technology" and "collaborative links." Does this mean teaching African surgeons to use the latest Western gadgetry, which in the professor's own words is prone to "frequent breakdown and spare parts are not available." What message is he wishing to convey? Is he wanting to promote disease prevention at primary level and ease the burden of the suffering majority or is he advocating training surgeons in the cities with laser and laparoscope?

A recent World Health Organisation memorandum on the use of intraocular lenses in cataract surgery in developing countries suffers from the same schizophrenic outlook.² The paper begins well. Half the burden of blindness in the world, 90% of which occurs in the developing world, is from cataract, mostly "aging-related." As many as 13 million people need surgery to regain their sight, but because of a lack of trained workers and resources the number of blind people is set to increase. The cheapest and quickest operation for cataract is intracapsular cataract extraction. The resulting aphakia is easily correctable with cheap spectacles. In the developed world ophthalmologists have now converted to extracapsular cataract extraction with intraocular lens implantation, so this is now being seriously considered for the developing countries despite the serious disadvantages of higher cost, increased surgical training, longer operating time, sophisticated equipment, posterior capsular opacification in up to half of cases, and greater risk of infection and inflammation.

What message does this send to our colleagues in Africa, India, and beyond? That "West is best." And if I, as a foreigner, dare to suggest that all this technology is neither necessary nor adapted to the local milieu I am accused by national doctors of wanting to provide a second class service for their compatriots. The uncomfortable reality, however, will be that the "improved" service will be available and affordable for still fewer of those who might benefit, and the number of people blind from cataract will continue to increase. WHO, please note.

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1 Bejanga BI. Developing countries need collaborative links. *BMJ* 1992;304:786. (21 March.)
2 Use of intraocular lenses in cataract surgery in developing countries. *Bull World Health Organ* 1991;69:657-66.

Medical response to disasters overseas

SIR,—Before the staff of the accident and emergency services, stimulated by the reported efforts of the Edinburgh MEDIC 1 team,¹ rally to A D Redmond's call to join a register of civilian mobile support teams² they may wish to deliberate carefully.

Neither the editorial nor the Edinburgh team's report mentions a host country's appeal for help or outlines the support required. How does a team integrate its possible contribution with that of international non-governmental organisations experienced in disaster relief work? The Overseas Development Administration is an agent of the British government, with which host countries

may have discordant relations even in times of disaster. The scope for a constructive contribution may therefore prove limited and integrated action be hampered by non-governmental organisations carefully guarding their neutrality or independence from political wranglings.

Redmond says that "logic demands the inclusion of the armed forces," which exposes at least two problems. Firstly, the forces are logistically unable to mount relief beyond British airports. Secondly, the presence of British forces, irrespective of their logistic competence, will be tolerated only when they are perceived as politically legitimate by a host country and by the British government. Otherwise, the team is an invading force: who will be "complementing and reinforcing" whom when the heavy metal starts to fly?

The success of rapid deployment demands an equally well planned rapid withdrawal if local circumstances deteriorate dangerously. Under whose authority, and within what safety limits, will well intentioned British civilians operate? Working in a military general purpose tent not otherwise identified makes you a military general purpose target.

Managing severe needless injury in children is distressing. Can Parke and colleagues' actions really be reconciled with the need for skilled professional evacuation by helicopter to achieve the necessary ventilation of two small children? If the team's role is to immunise the population at risk of measles its skill input is excessive; alternatively, heroic or unrealistic surgery in which additional lives are jeopardised is not acceptable.

The role and contribution perceived for the civilian mobile support team in the complex matrix of needs and skills produced by natural and manmade disasters remain unclear.

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1 Parke TRJ, Haddock G, Steedman DJ, Pollok AJ, Little K. Response to the Kurdish refugee crisis by the Edinburgh MEDIC 1 team. *BMJ* 1992;304:695-7. (14 March.)
2 Redmond AD. Medical response to disasters overseas. *BMJ* 1992;304:653. (14 March.)

SIR,—A D Redmond briefly alludes to the beneficial role of public health doctors in saving lives after a major disaster.¹ After a disaster the refugee population needs immediate health care. This is much broader than the traditional medical response, which is to treat the sick. Although refugees' ill health may result from the disaster itself or from endemic disease, the biggest risk to health comes from the overcrowded, insanitary conditions of the refugee camp. This is reflected in the camp hospital disease statistics presented by T R J Parke and colleagues, which show the major diagnostic categories to be preventable illnesses of an infectious nature caused most probably by contaminated water, poor food, and inadequate shelter.²

Providing clean water, shelter, adequate food, and immunisation (mainly against measles) can have a major impact in reducing morbidity and mortality in the refugee community. Services must be designed to maintain and protect the health of the refugees. The understanding of infection control, environmental health matters, epidemiology, and health service delivery is invaluable in the immediate and ongoing refugee situations and compliments the health care effort. Training in public health medicine imparts this knowledge; experience imparts the skills.

A register of suitably experienced public health physicians, along with other public health staff, who could be relied on to respond in an emergency involving refugees would be a valuable addition to our nation's preparedness to respond to an emergency relief effort. Their expertise could benefit not only the refugees themselves but could

also reduce the impact of the refugee community on the host community.

Response to a disaster must be immediate. Not only must suitably experienced individuals be readily identified through a register but there must also be a mechanism and willingness within the NHS to enable their deployment. Time is of the essence if loss of life and illness are to be minimised.

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1 Redmond AD. Medical response to disasters overseas. *BMJ* 1992;304:653. (14 March.)
2 Parke TRJ, Haddock G, Steedman DJ, Pollok AJ, Little K. Response to the Kurdish refugee crisis by the Edinburgh MEDIC 1 team. *BMJ* 1992;304:695-7. (14 March.)

Response to the Kurdish refugee crisis

SIR,—I take issue with Christian Hegardt's suggestion¹ that the work of teams like the Edinburgh MEDIC 1 team with the Kurdish refugees² was misguided and inappropriate.

I also worked with a relief team in a Kurdish refugee camp and visited the hospital and refugee camp in Zakhu probably some two weeks before the MEDIC 1 team arrived. My primary role was to work in the river valley refugee camp at Cukurca high in the mountains on the border between Iraq and Turkey. This work was in a tented field hospital caring for the refugees before their organised transfer back to the structured camp at Zakhu in the "safe haven."

We supported the work of the Kurdish doctors. On our arrival we found them exhausted, lacking equipment, and greatly dispirited. By supplying equipment, enthusiasm, and support we were able to get them back on their feet caring for their own people. In one case, removing a Kurdish doctor's ingrowing toenail enabled him to function normally again.

Our experience of treating refugees at 3600 m in the mountains was similar to that of the MEDIC 1 team. When our work was complete and the refugees had been moved to Zakhu our team was withdrawn and surplus drugs and equipment donated to the Overseas Development Organisation. Rehabilitation of the Kurdish doctors was a vital part of our work.

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1 Hegardt C. Dealing with disasters. *BMJ* 1992;304:986. (11 April.)
2 Parke TRJ, Haddock G, Steedman DJ, Pollok AJ, Little K. Response to the Kurdish refugee crisis by the Edinburgh MEDIC 1 team. *BMJ* 1992;304:695-7. (14 March.)
3 Hines KC. Field hospital for Kurdish refugees. *Journal of the British Association for Immediate Care* 1992;15:11-3.

First among women

SIR,—I am writing to put the record straight about "the world's first woman doctor." She was Peseshet, who lived and practised medicine in ancient Egypt during the Old Kingdom, the IVth dynasty (2620-2560 BC).

Medical education in ancient Egypt was tightly regulated. There was a hierarchy of doctors, with the chief physician of the land responsible directly to the vizier (prime minister) of the time.

Peseshet held the title of "lady director of lady physicians," which indicates that there were other qualified lady physicians. On her stele (figure) we read: "She having reached a very good old age and possessing honour before the great god." One of her duties was to look after the king's mother.

Peseshet's stele was found in the tomb of her son, Akhet-Hetep, in Giza. Both her son and