be told before appointment that they will be considered for later part time senior registrar training only in exceptional circumstances.

General recommendations

(1) (i) The college should seek to counsel young graduates by presenting information on the following:

(a) The requirements for general professional training in the various subbranches of general medicine.

(b) The specialties best suited and least suited to part time training, the sessional specialties of dermatology and venereology being the best and the acute specialties the least.

(c) The desirability of continuing full time training until general professional training is complete, unless a career as an associate specialist or in general practice is planned.

(d) The availability of advice on part time training from regional advisers. This information should be made available to graduates at the time of full registration with the General Medical Council.

(ii) This counselling role would with advantage be done in concert with the other colleges, and it should be considered whether an intercollegiate working party on part time training and careers would be helpful.

(Accepted 20 July 1983)

Outside Europe

Working in Afghanistan

CHRIS BLATCHLEY

Five years ago I visited Afghanistan as a tourist. I returned last September as a doctor to help with the emergency medical relief sent to rural areas by the French organisation Médecins sans Frontières. Now the country was at war I had little idea what to expect. Afghan guerilla groups were fighting each other in some areas and, though this did not concern us directly, it might have made it impossible for us to stay; we could not have worked impartially. Because of poor communications and volatile politics we could only assess conditions once we had arrived. Three hundred miles of dirt tracks by jeep led us to the Hazarat mountain region, 150 miles south west of Kabul, inhabited by people descended from Mongolian invaders. We had no direct contact with the Russians as the government controls mostly urban areas and our route avoided these.

I was working with two women doctors and a male nurse in the remote mountains at over 10 000 feet. We lived in one room of traditional mud construction. There was no electricity, and we carried our drinking water from the stream 50 yards away. We worked in one large consulting room, using a curtain to divide the men from the women. Some of the 200 patients a day had walked for eight days to reach us. We had only the simplest diagnostic aids, with no x ray facilities or blood tests, but we did have a remarkably well equipped pharmacy. Some of the medical teams had worked in active war zones and treated trauma, but while I was there my area was largely peaceful.

The medical problems were mainly those seen in a primitive mountain region, influenced by poor hygiene, low incomes, and inadequate diet. It was difficult to estimate how the Russian occupation had changed things. People were poorer because of 100% annual inflation and because sons could no longer work abroad. In my area there were enough people to tend the land

and they grew crops without interference from the Russians. There was only just enough land to support them.

There was a huge gap, however, between the rich and the poor. The richest lived in large spacious houses and kept themselves clean with Palmolive soap, bought from the bazaar. They had simple lavatories, though, which were usually perilously close to streams. They had enough land to support many animals and so ate a lot of meat. They supplemented their diets with the crops that they took as rent from tenant farmers. They had a good life expectancy—many reaching their three score years and ten.

The poorest had to pay half or more of their scanty harvest as rent and had to work the inferior land extremely hard for little return. Their homes were grossly overcrowded. They ate

Some of the Médecins sans Frontières team with their mujahideen escorts.

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The clinic picks up patients by bus.

a poor diet—bread, black tea without sugar, rarely milk, eggs, or green vegetables, and never meat. With a family income that was often only £5 a month they could not afford to buy soap. Florid skin eruptions and tuberculosis were particularly common.

Although we saw no famine, dietary deficiency was common, particularly among children. Many lived on the verge of malnutrition and were easily pushed into it by illness. We often saw merasmic children, sometimes from apparently well to do families. Many children had stunted growth, which made it difficult to gauge their age. People often had no idea of how old they were, making some of their estimates extremely amusing.

Effects of seasonal changes

Disease is endemic, epidemics being a problem of overcrowded refugee camps in Pakistan. Seasonal changes produced an increased incidence of illnesses, particularly when the cause was water borne. The early snows carried intestinal parasites into the streams and we saw a rash of gastrointestinal upset, usually abdominal discomfort rather than frank diarrhoea. In Nawur, a high marshy plateau at 11 000 feet, we saw much malaria in the summer. Three of our team suffered from hepatitis.

Most patients presented with minor aches and pains, particularly in the knees because they sat cross legged or in the back because they worked so hard in the fields. They often had a succession of small complaints, producing them as if from a hat. We needed tact, however, for although some were "trying it on" others would walk for several days to get treatment for perhaps a sore back and would depart stirring trouble among the waiting patients if we sent them away with nothing. We almost had a riot on our hands one day. More stoical Afghans arrived with severe illness, particularly tuberculosis, but would not stay to be treated because they had to get back to their farms.

Clinical cardiovascular disease was usually rheumatic, and I saw several cases of end stage mitral incompetence in young people. Hypertension (>180/110 mm Hg) was also common, though I saw none of the ischaemic sequelae: cigarettes were expensive, and an active life, little stress, and low intake of saturated fat all helped to prevent it. Educated Afghans often asked us to check their blood pressure. I found no evidence of myocardial infarction, but my translator said that strokes occurred in people as young as 40 or 50. I saw none.

People often complained of chronic shortness of breath on exercise, which did not surprise me since at 11 000 feet walking

on the flat tired me. Usually there was nothing obviously pathological, but we saw asthma, and indolent chest infections were common. We had no way to diagnose tuberculosis, and, anyway, we had resources to treat only the severest cases. Dry nocturnal coughs were also prolific, no doubt due to the dusty atmosphere.

Abdominal discomfort was particularly rife and was probably due to intestinal parasites. But I suspect that the speed with which they bolted their food was also an important factor. The Afghans eat from communal dishes—he who eats slowest eats least. Peptic ulceration presented as haematemesis and malaena, or later as anaemia, and was common. Our treatment was limited to alkalis, iron, and vitamins. I saw no obstructions or perforations.

Many came with dysuria, perhaps because a man would dry his penis with soil after micturition. Indolent infection, shown by resolving proteinuria after antibiotics, was common, and sometimes the patient presented with incontinence more reminiscent of the automatic bladder of multiple sclerosis.

Fungal and scabietic infestations frequently presented, especially in the poorer classes. Many people had gritty eyes, though not usually due to trachoma. The trachoma we saw was generally burnt out, and I saw only two cases of blindness due to it. It is a much greater problem on the windy plains to the west. There were many cataracts.

Psychiatric disturbance

Psychiatric disturbance was more often seen among the educated. Some had been tortured in government jails and were grossly disturbed. Many others, who had left the towns to avoid conscription, were afflicted with a sense of helplessness and inability to use the skills that they had learnt at university. The support of the extended family did help to prevent severe neurotic disturbance.

Most of our medical work, even in the active war zones, was civilian. In the Panjshir Valley doctors had to amputate limbs damaged by pencil mines dropped by the Russians. Fortunately, there were none in our area. Simple trauma was treated by the local healers, and we tended to see only the secondary or severe problems. When necessary we used intramuscular ketamine anaesthesia, supplemented with diazepam. We found this adequate, safe, and easy to administer. Diazepam prevented the emergence of delirium, even in a race of people who express their emotions so strongly.

The political instability made it impossible to organise a large preventive medicine programme, but in the more stable

The author draining a litre of pus from a compound fracture of the femur.

Two old Afghans.

areas we were able to set up a BCG immunisation campaign. The Afghans readily accepted this since our reputation had spread widely through the work of the clinics. They trusted us.

Afghans have a varied but surprisingly utilitarian understanding of illness. Islam, with its accent on education, is free of the mysticism of Eastern religions and does not obscure the cause of disease. They were enthusiastic tablet takers, a trait we had to resist. Their compliance was usually good, however, and I was particularly impressed by how the educated patients followed a low salt diet, our regimen for hypertension. We tested compliance before embarking on long courses of treatment—for example, for tuberculosis. The patient had to stay for a week and then return regularly showing us the empty streptomycin phials. We gave lessons on Saturdays on injection technique, though there was one person in most villages who knew how to do this.

Paradoxically, there are probably more Afghan doctors in the richer parts of the mountains now than there were before the revolution because they, like many of the educated élite, have been driven from urban areas by the threat of conscription. But this care does not help the poorer Afghan, since even if he can pay the 40 pence consultation charge he cannot afford the full course of drugs, should they be available.

Reliance on traditional healers

Since the closure of government clinics in 1979 Western medicine for most Afghans has consisted of bottles of penicillin/streptomycin mixture, available at the bazaar and self administered on a pro re nata basis for almost everything. Fortunately, such preparations are out of the reach of most pockets. For everyone else in the mountains the main medical help is from the traditional healers. Some of these were more ingenious and competent than I had expected. They work well alongside the few Western trained Afghan doctors and charge little—sometimes nothing to poor families—because their work carries much religious merit.

The hakim, or herbalist, is a true specialist, full time and literate, who has often spent 10 years acting under supervision. Afghans regard him in much the way that we regard pharmacists. He understands that bacteria cause illness and does not claim to be able to treat all diseases. He will refer tuberculosis and rheumatic fever in particular to Western trained doctors.

The shikastaband, or bone setter, on the other hand, is usually an illiterate trader or farmer, who has picked up his technique by trial and error. There is one in most villages. After he has reduced the fracture he will coat the region with egg before splinting it. Afghans preferred to take their broken limbs to

him rather than to us. The bone setter most needed our help when treating compound fractures as he had no antibiotics. On one occasion he had reduced and splinted a compound midshaft fracture of the femur, and when he removed the splints at 40 days the fracture had united surprisingly well, but we had to drain almost a litre of osteomyelitic pus.

The dai is the local midwife and is usually a widow without other income. She has had no formal training but is often very experienced. Usually we were called to see only postnatal problems, particularly haemorrhage.

The dalak is barber, blood letter, tooth puller, and circumciser and doubles as town crier. He uses primitive moxibustion, applying hot coals to the skin to produce burns at the site of the pain, and almost everybody carried scars from this treatment.

I find it difficult to evaluate our work. Most was curative. I would like to see more preventive work, particularly to support and train these traditional healers. But you have to show them that you have something to offer and the clinics did this. I returned to England with my scepticism assuaged. There is much more to do in Afghanistan, Médecins sans Frontières's most difficult mission, but I was impressed by the work we did.

Médecins sans Frontières

Médecins sans Frontières has no direct counterpart in England. It was set up in 1971 to provide quick and effective care to "victims of natural catastrophes and war, without discrimination, operating with the strictest neutrality and complete independence. . . ." It sends people to disaster zones with remarkable speed. Its particular characteristic is that it will send trained medical staff to parts of the developing world where conventional relief organisations do not go. It sends to war zones to work alongside rebel or guerilla forces. But Médecins sans Frontières has no political allegiance. One of its members told me, "The left consider us to be the right, and the right consider us to be the left." It has posted medical staff to many places including Beirut, Honduras, Ghana, Kurdistan, and Eritrea.

I came back from Afghanistan convinced of the need for something similar in this country. Medical Action has been launched with the help of a few volunteers. Its aim will be to send trained medical volunteers for six months to a year to places that would otherwise receive little or no medical aid. For more information please send a stamped addressed envelope to Medical Action, 3 Park Square West, London NW1.

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Clinical curio: seat belt tinea

A 45 year old man developed an eruption on the front of the right shoulder. The eruption had been gradually extending for two to three months, and at presentation was a 10 cm diameter red scaling area with a well defined edge. The diagnosis was made easier by the fact that he had apparent tinea of the feet and also in the perianal area. As expected, scrapings showed *Trichophyton rubrum*.

The patient suspected that the trouble was due to the fact that he had been wearing his seat belt more regularly, and the site of the eruption was exactly where it pressed against the body; it also produced chafing. Wristwatch tinea is well recognised but often missed; its development in the skin beneath the watch is thought to be partly due to the increased moisture and chafing at the site and is usually caused by *Trichophyton rubrum* but occasionally by *Epidermophyton floccosum*. It would seem that this opportunist organism is keeping up with recent legislation!—ROBERT P WARIN, consultant dermatologist, Bristol.