The castle of the Knights of St John, Rhodes

and racy wit, kept us entertained and edified with his many talks on topics such as "oracles and healing," "Crete and its palaces," "the colossus of Rhodes," and "the Knights of St John and the Crusades." The Reverend Dr Philip Edgcumbe Hughes discussed "the cult of Asclepieios" and "the church and medicine throughout the ages," and also described the different

monasteries and sketes on the Mount Athos peninsula. Dr Barbara Watterson, an Egyptologist from Liverpool and a lively lady, taught us about "the legacy of Imhotep," "the Egyptian way of death," and many other fascinating topics, while Mr Alfred Evans, our twinkling Scottish botanist from the Royal Botanical Gardens in Edinburgh, not only shared with us some hilarious expeditions of plant spotting in the quiet and wilder countryside but also taught us about herbs and medicine.

And what of our medical colleagues? I certainly shall not forget Surgeon Vice Admiral Sir James Watt's lectures on "medicine at sea," Professor James Robinson on "Hippocrates to Galen," Mr Harvey White on "surgery in perspective," and Sir Christopher Booth on "patients, plagues, and pestilence across Europe." And several passengers, too, contributed ten minute vignettes about various historical passions or hobby horses.

I prefer to draw a veil over my own contributions, but as I write in the library once occupied by Sir William Osler I reflect on the truism that so much of what doctors do today and so many of the precepts and principles on which the proper practice of modern day medicine depends are based on the examples and discoveries of our forebears.

My "swan" in the steps of Hippocrates was a delight from beginning to end. It was a memorable experience which brought to life much of what I knew and did not know about ancient Greek and Egyptian medicine.

"Been to Africa"

Alison Fiander, David Hughes

As the end of our contracts working in a rural hospital in Africa approaches we are asking ourselves questions. Has it been worth it? What have we learnt? Should we recommend it to others?

In many specialties budding registrars feel the necessity to enter a research post or to travel abroad, notably to the United States—the "been to America" syndrome. Until they do their future paths may be blocked. The rationale behind such a period of research is said to be to sharpen the mind and to cultivate a sense of inquiry and critique. Much of the actual research is neither earth shattering nor fulfilling but rather represents clinicians marking time. Traveling to the United States is not always the best alternative either; finding a suitable job may be difficult, defensive medicine may prevent you from doing as much as originally expected, and other frustrations may arise. So what alternatives are left? Might time spent working in a developing country prove worth while? We think so.

The main drawback of our working in such relative isolation is that our practice is unsupervised. The medicine is often very different from that encountered at home. The general standards of medical and nursing care are low, facilities and infrastructure poor, and the size of the problem enormous. We have had periods of feeling alone and helpless, knowing that under different circumstances we might have saved the person before us—life seems cheap at times. We have had to change our attitudes and expectations. Inevitably mistakes have been made and patients have suffered; the responsibility weighs heavily at such times. Poor motivation among the staff, lack of essential supplies, and suffering our own share of tropical diseases have created added frustrations. We know that some will level the argument of unsuper-

vised work and inappropriate medicine, but on the other hand we have benefited in many ways: we have had to rely on and improve our basic skills in examination and have grown more confident and self reliant in our judgments. In addition, we have had to be careful to justify the use of limited resources, and within these limits our technical abilities have improved. Seeing the complications of delayed medical care, rarely seen in Europe today, has brought to life for us the benefits of modern health care, raised patient expectation, and good transportation. Not only have we been tested clinically but we have also had to develop management and administrative skills. We have read with interest the discussions in the *BMJ* concerning the government's white paper—we have had no option but to act as managers and to be aware of costs; we soon learnt that there is no medicine without logistical support. There have been great possibilities for teaching and introducing small changes, though it has paid to be realistic and not to expect to change the world. Added to all this has been the rich experience of seeing patients recover, receiving their gratitude, seeing their smiling faces despite their extreme poverty and their quiet suffering. We have met great acceptance and friendship from the nurses, many of whom have taught us valuable lessons both medically and culturally.

Don't delay . . . plan today

Overall, the experience has been a positive one and we feel that it has broadened our outlook and that we have matured. If you are tempted we would certainly encourage you to consider a similar period and would like to offer some words of advice. Don't leave it too late—one to two years' planning may be required. We

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Br Med J 1989;299:1591-2

found it much more difficult than we expected to find suitable jobs and suggest that you seek advice from those consultants or other experts who have worked abroad or are involved in developing health care. Other useful information can be obtained from those organisations concerned with health issues in developing countries—for example, the Institute of Child Health, the International Centre for Eye Health, the colleges, and the Christian Medical Fellowship. You must decide whether you want to work with a non-governmental organisation, a missionary organisation, or a government. You may want to consider joining a continuing research programme, a university department perhaps on an exchange, or otherwise opt for a district general hospital, as we did. There are many possibilities, but make sure of the requirements demanded by the medical council of the country that you intend to go to. We would recommend that you go after obtaining your postgraduate exams, when you have some experience to offer and can choose to work as a “specialist.” The length of your stay is important: too long and you risk being forgotten; too short and you help nobody. We think that a two year contract provides an acceptable balance. Undoubtedly you will want to find appropriate literature, but remember to cater for the unexpected, which disregards the strict divisions between specialties, and to take books

of an appropriate standard to equip you for teaching.

Once abroad expect a period of upheaval as adjustments to the different facilities, expectations, and lifestyle take place. Keep links with home and receive journals—to keep abreast of new developments and the political situation—and consider taking journals such as *Tropical Doctor* and *Africa Health*. Even if you are not research oriented try to publish something; you will have observations to make that may prove useful to others. Research itself may be difficult if the conditions are primitive, the workload heavy, or the statistics unreliable. Keep a record of your work, including a log book of your operations; this will help to answer those queries about what you spent your time doing.

We hope that if and when we become reintegrated we will be able to keep our links with medicine in developing countries and the friends that we have made. There is great need, and if a period spent working as we have done was more readily accepted then maybe more would take up this option—it would not suit everybody though. Hopefully, this will increase awareness, foster links, and narrow the gulf that currently exists.

Our time in Ghana has provided us with a rich personal and professional experience that we wouldn't consider swapping for a year spent with a laboratory rat.

In quest of Portuguese diseases

M H Bhatt, V P Misra

Unbridled enthusiasm, often in the absence of planning and direction, is perhaps a quality that junior house staff all over the world have in large measure. We most certainly had a great deal of it in 1986. We had heard a lecture by a visiting neurologist from the United States in which he gave a dramatic account of how he had seen families in the Azores with Machado-Joseph disease (a form of inherited spinocerebellar degeneration) and had traced their lineage back to Portugal, where the disease is seen commonly. Some research in the medical library showed us that this was not the only disease exported by the Portuguese. Autosomal dominant familial amyloid neuropathy type I, which is endemic in northern Portugal, has also been seen in the Kyushu area of Japan (where an early Portuguese trading post was established) and in Brazil (which has strong historical links with Portugal).

But what really fired our imagination and fanned our

enthusiasm was that we in Bombay were a mere 160 km away from places that had been Portuguese colonies for more than three centuries. We were naively confident that if the Portuguese had spread their genes and their diseases in Japan they would have done the same in the west coast of India. We chose Daman. Pouring over a map and a history book, we learnt that it lay 100 km north of Bombay and, along with Goa and Diu, had been a Portuguese colony from the sixteenth century right up until 1963. These three cities had been isolated politically and culturally from their neighbours, who were British and later governed by the Indians. In 1986 Daman had an area of 73 km² and a population of 49 000.

A different age and country

Without further delay we arranged a week's leave, packed a neurological examination kit, and set off for Daman in search of these Portuguese diseases, the discovery of which we were sure would be an important contribution to medicine. Our train pulled into Daman station, and a porter ran up to ask if we had any bags in the brake van. We couldn't believe what we saw—a porter with ginger hair and blue eyes. We had to pay him his portage fee before he agreed to sit down with us on the bench on the platform and answer our questions about his ancestry.

“No,” he said firmly, “no Portuguese blood in my family.”

“Where do your red hair and blue eyes come from then?” we asked.

He told us that he had better things to do than talk to us about hair and eyes.

The next day we explored the city. It was divided clearly by a tongue of sea into the densely populated Nani Daman and the walled part of the city or Moti (grand) Daman. A long bridge spanned the water

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The Portuguese influence in Goa is evident in the Church of St Anna at Tallanli. (From “Goa” by Antony Hutt)

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