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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between the two. It was in Moti Daman that the Portuguese and the more trustworthy Indian citizens had lived. Entering the walled city was like walking into a different country and an age gone by: cobbled streets; whitewashed, Portuguese inspired villas, bedecked with bougainvillea and standing next to once smart wooden houses now in a state of disrepair; any number of shrines to the Madonna; and three lavish churches made these few square kilometres contrast amazingly with the crowded, dusty, and bustling streets and bazaars of Nani Daman.

We visited one of the churches and had an enlightening discussion with the friendly and knowledgeable parish priest, Father Rodrigues. He told us that although all of the households within the walled city were Roman Catholic, those in Nani Daman were mainly Hindu. We asked him if he knew of any families with Portuguese blood and told him of the blue eyed porter we had talked to. He smiled as he told us that marriages between the Portuguese and the Indians had been forbidden, but yes, there was a lot of Portuguese blood around; to get a family to admit illegitimacy, however, would be difficult. He said that in the 'sixties, when the Portuguese left, some of the Indians from Moti Daman had emigrated to Portugal; most of them, however, had stayed but clung to the Portuguese way of life—that is, they spoke Portuguese, were devout Catholics, and kept to themselves, refusing to mix socially with the Hindu population across the harbour.

Hushed up illegitimacy

We decided that the families in Moti Daman were the ones that we ought to screen for the diseases that we had come to find. To begin with we went to the local

health centre and chatted with the doctor, who had been born in Daman and knew most of the families within the walled city.

"No," he said, "I know of no undiagnosed disorder or funny disease in any of my patients."

Regardless, we searched the dusty admission records of the past 10 years for an entry of what possibly could be one of our Portuguese diseases. . . . Nothing.

We spent the next five days in Moti Daman going from house to house asking about disease. We were overwhelmed by the hospitality offered by even the poorest household. The surnames Colaco and Machado recurred repeatedly, consanguinity was high, and it was not uncommon to see fair hair and light eyes. A blood connection with the Portuguese was always denied (although the people often gossiped in hushed undertones of how the grandmother of the family next door had often visited the Portuguese garrison commander's villa). We did find a large family with 10 members with autosomal recessive retinitis pigmentosa—that was the closest we got to any kind of hereditary disorder. We diagnosed probable pulmonary tuberculosis, malaria, amoebiasis, and one case of leprosy and sent the people with these diseases across to the doctor at the health centre. On our sixth day in Daman we saw the final family—the 450th. We spent our seventh and last day on the beach.

No, we had not found any rare and exotic Portuguese diseases in Daman, but we had learnt much about its people and had found ourselves a private bit of Portugal in India, where time had stood still. Since then we have been back to Moti Daman often, and on the last occasion Joseph, the blue eyed porter, insisted on carrying our bags free of charge.

Medical mishap in Turkey

Christopher Saunders

A fall down a black hole added an interesting (in the sense of a Chinese curse) experience to a cruise round the historical marvels of the Turkish coast. On the dim second floor of a tower in the mediaeval fortress of Anamur are two vaguely visible openings: one is the way down a dark staircase, the other opens into what may have been a disused well or store. Coming down alone I chose the wrong opening and feeling in vain for a step slithered down almost vertical rubble for about 5-6 m. Feeling bruised but, I thought, intact I optimistically contemplated struggling back up the rubble to the glimmer of light at the top—until finding that my left leg gave no support. The only hope was to yell for help; remote voices could be heard above. Shouts aroused no response, and I began to wonder what would happen when the tourists had left: How long before a corpse would be discovered?

Turkish Hercules

After an anxious half hour someone up above realised that my shouts from the depths might not be merely conversational. By good luck the English doctor from the cruise ship was within reach. Getting a rickety ladder and a torch he descended and quickly suspected a fractured femoral neck. Meanwhile, at the top a Turkish Hercules belayed a rope; he and the doctor hauled and pushed me up, with one leg on the ladder. Then, clinging round Hercules' neck, I was got down two narrow and dark staircases and driven in a

car to the ship moored at the small port. My wife, who had prudently refused to come up the tower, had been persuaded to return in the coach to the ship. She knew that I was missing but not what had happened. She was assured that I would be found and brought along later and that everything would be looked after.

The doctor, debating what could be done next, heard of a local hospital and there we drove. Of course, all this happened on a Sunday afternoon and the hospital could do nothing; but a doctor in the town with x ray apparatus was suggested. After more hauling up stairs to his surgery the diagnosis of a fracture was confirmed. The nearest possibility of treatment, we were told, was the university hospital at the provincial capital of Antalya—over 160 km away. Back in the taxi, the English doctor and I were driven to Antalya, the splendour of the Taurus mountain landscape (plus painkillers) slightly alleviating the pain of rounding at speed innumerable hairpin bends.

At the hospital, the first shock at the reception was that the necessary operation could be done but only if £2000, in Turkish cash, could be paid immediately. Surprisingly, this little financial problem was quickly solved: the shipping company's local agent appeared and returned within the hour with a wad of Turkish lire notes drawn somehow from the travel insurance. A Thompson prosthesis would be got by air from Ankara and the operation would be done in two or three days—"no problem" with money on the barrel to ease the hard pressed budget of the hospital. Having said

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