

## Conclusions

My conclusion is that for the severely mentally handicapped a residential complex of about 70 places on one site is the best solution, provided the residents are in small groups of six or eight so that each will have their own home unit where they eat most of their meals and a small staff dedicated to that unit as far as possible. Most units will need to be in pairs, so that night staff can be shared when possible. There should be sufficient single rooms. Although I am not convinced that all patients need single rooms, disturbed behaviour is likely to be much less if each mobile adult has his own personal belongings, including furniture he has bought and paid for himself and in which he can take a pride. These considerations apply less to the very small number of the most severely handicapped who are unable to move without assistance and require virtually total care. Small units in the community have an important complementary role, but few of the most severely handicapped adults will be able to integrate with their neighbours in the community and their isolation is therefore much greater than if they are part of a larger complex.

Day activities are essential, both on site and off site. Thus the day activity complex on site should be available to the mentally handicapped living elsewhere who would benefit from these facilities, and, similarly, those residents who would benefit by attending day centres in the community should be able to do so. The whole emphasis should be on small homely residences with as wide a variety of activities as possible on the campus and outside it.

I thank the many people who have helped with this paper and especially those I met in Sweden who gave so freely of their time. While the conclusions are my own, they are based on discussions with a large number of colleagues to whom I am grateful, especially Dr Karl Grunewald, who organised my visit. I also thank the special trustees of King's College Hospital for a grant to cover my expenses.

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# Letter from . . . Zambia

## Land of scarcity

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Some 20 miles from Chipata the road to Msoro leaves the Great East Road and turns north. Half a mile (0.8 km) further on the tar gives place to dirt, and from then on the way runs across the Zambian plateau; past beobabs and mangos, through the "fly gate" where a man solemnly circumambulates the vehicle tapping with a butterfly net to trap any travelling tsetse, down a lush little valley, and finally to the river. Traces of a bridge remain, but that was once upon a time. Now packs are hoisted on to the head, I grasp my skirt and lift it high, and we wade through the opaque, tepid water. For us, doctor, driver, and a few returning patients, there is another Land Rover to carry us to the village, with its vast desolate church, decaying mission houses, and rural health centre.

### Rural health centres

The rural health centres, together with their satellite clinics, form the substructure of the Zambian health service. In this sparsely populated part of the country where mechanical transport of any kind is scarce and expensive, and horses, because of the tsetse, unknown, it is the only feasible system. The centres are staffed mostly by medical assistants, men with a fairly high level of education who then undergo a three-year training, after which they work under supervision for a time before being appointed to their own domain. As government employees they are likely to be moved from time to time, but most stay in the area for some years and therefore get to know it well. Like all graduates they vary in quality and the interest they bring to the job. Their besetting sins are a tendency to regard any criticism, however mild, as evidence of racism and polypharmacy. Doctors visit them regularly, and in the intervals patients are referred direct, the accompanying letters brightening many a busy outpatient clinic. "The diarrhoea has been defeated, but the condition continues to lower." Msoro is in the capable hands of Mr Jackson Banda, a quietly spoken man of middle age. In some respects my ward rounds and outpatient sessions were redundant, for those needing further treatment had already been selected. So we returned with a panophthalmitis (the result of a

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neglected scratch) a postmalarial anaemic baby, and a textbook Burkitt's lymphoma.

Medical assistants are also employed in the larger hospitals, for it is a sad and inevitable fact (undreamed of by that ivory tower theorist, Beveridge) that the greater the medical provision and the more familiar it becomes the greater is the demand. When I first went to the Transkei only seven years ago the routine question asked of anyone sick enough was: "Will he/she come/allow the baby to come into hospital?" and in a large proportion of cases the answer was "no." With a gradual increase in confidence patients were brought earlier, the chances of cure improved, mortality dropped, and with it the old name "House of Death." Here "bedi" is never refused, which is to the good. Not so greatly welcomed is the flooding of outpatient clinics with the fit young complaining of "sneezing for one day" or "abdominal pain since this morning." Their appearance is not surprising, for the most exciting thing that happens in the village is a lorry pulling in for petrol, and the hospital provides a club atmosphere with the chance, often gratified, of witnessing the arrival of an "emergency." They must, nevertheless, be sorted, as concealed in the laughing chattering throng may be the young man with advanced tuberculosis or the grossly anaemic baby sleeping quietly on its mother's back.

### "Take no thought for the morrow"

The training received by medical assistants is based on the Western concept of disease and techniques for its relief. The benefits of this are clear for all to see—abscesses (often of alarming size) drained, fractures manipulated or internally fixed, the spectacular antibiotic-mediated recoveries, and the slower but no less satisfactory response to antituberculous drugs. Unfortunately, Western-trained doctors often bring with them the arrogant assumption attributed to a former Master of Balliol: "If I don't know it, it isn't knowledge." A critical glance at their own country might convince them that as the old devils of infectious disease, protracted suppuration, some malignancies, and a motley collection of conditions, such as diabetes, have

been conquered others have taken their place, and the net balance of dis-ease in the population is much the same. Whether the conditions that now bring the public in large numbers to their practitioners should be classed as illness or unhappiness is a matter of argument, but they do not obtain here, or in any other part of rural Africa I have visited. It may be the strict adherence to the doctrine "take no thought for the morrow" (the characteristic that most maddens Europeans), it may be the social rituals and customs developed in any group whose members are forced to live in close proximity to each other, or it may be the acceptability of short dramatic psychotic episodes acting as a safety valve. All these factors have their parallels in pre-twentieth century Europe, before anxiety neuroses had us all by the throat.

Whatever the reason for the different range of disease, of one thing there can be no doubt. Zambian patients are never in the foreseeable future going to be able to call on the services of a doctor for a little chat about their marital problems and depart with 100 tablets of the latest tranquilliser. It is becoming very difficult to maintain even essential services (we currently have no gauze for dressings in the wards and very little in the theatre). In these circumstances, and they are to some extent those of the whole of the developing world, all resources will have to be mobilised. The Chinese and Indians have successfully married traditional and modern medicine, and there seems no reason why such a union should not be consummated in Africa, but to do so will require a fundamental change of attitude on the part of some doctors.

The morning's work over we lunched off Nsima (the staple food, a stiff maize porridge and chicken) in Mr Banda's solidly built house overlooking the river, beyond which, he assured us, elephant and leopard are frequently seen, and we discussed the local African medicines. Clearly here was a fund of untapped knowledge, but untapped it had to remain, for there was a clinic also to visit. Before leaving I was introduced to his eldest son, an intelligent young man now boarding at one of the best secondary schools in the country and heading for university. It would be nice to think that one day he might qualify in medicine and return to work in his home area.

### *Is there any safe medical treatment for prostatism that may postpone surgery?*

The common symptom complex attributed to obstruction to bladder outflow due to benign prostatic hypertrophy, so called prostatism, may fluctuate considerably. To evaluate the efficacy of any medication designed to improve these symptoms requires the use of double-blind controlled trials. At a symposium held by the section of urology of the Royal Society of Medicine the problem was reviewed.<sup>1</sup> The main interest centred on the evaluation of various hormonal agents. At that time no agent studied was any better than placebo. The wider use of bladder pressure/flow studies in patients with outflow obstruction has shown that associated bladder instability is common and may in fact contribute to the urinary symptom complex. Emepronium bromide (Cetiprin) may suppress these uninhibited contractions of the bladder and improve the bladder's function.<sup>2</sup> Such medication, however, in patients with established bladder outflow obstruction cannot be recommended and may make matters worse.

Of current interest is the application of alpha-adrenergic blockade with phenoxybenzamine in patients with benign prostatic hypertrophy. This treatment is based on the assumption that in addition to the purely mechanical obstruction by the prostate there may be a coexistent dynamic obstructive factor related to the degree of stimulation of the many alpha-adrenergic receptors in the region of the neck of the bladder, the prostate, and its capsule. Evidence in support of this concept, pioneered by Caine, is accumulating. Caine *et al*, in Jerusalem, have reported considerable experience in the use of phenoxybenzamine in a review of its use in 200 patients with benign prostatic hypertrophy.<sup>3</sup> They concluded that 80% had symptomatic improvement, and reported that 30% had side effects, mainly dizziness, requiring cessation of treatment in 10%. In a double-blind

controlled trial Abrams<sup>4</sup> confirmed an overall symptomatic improvement in those patients treated with phenoxybenzamine, 10 mg twice daily, as against placebo. In addition there was a reduction in the measured proximal urethral pressure profile in the treated group. N B Waterfall (unpublished observations) using video cine cystourethrography, has shown an increase in the diameter of the bladder neck in 17 of 20 patients with bladder outflow obstruction studied after one month of phenoxybenzamine, 10 mg every night. In both of these studies dizziness was the commonest side effect from the drug.

It seems therefore that phenoxybenzamine, in a dose of 10 mg daily or twice daily, can help in treating patients with symptoms attributable to bladder outflow obstruction. The presence of cerebrovascular disease or a recent myocardial infarction are both contraindications to taking phenoxybenzamine and severe side effects from sympathetic blockade can be expected in roughly 30% of patients treated. Phenoxybenzamine does not treat the enlarged prostate itself but may afford some symptomatic relief in patients with proved bladder outflow obstruction awaiting surgery. It is important to recognise that the urinary symptoms caused by an invasive carcinoma of the bladder, cancer of the prostate, and bacterial prostatitis are among the more common urological conditions not infrequently ascribed to "prostatism." A full urological assessment is mandatory to determine the cause of the patients' symptoms before any decision can be made regarding therapy with phenoxybenzamine.—J C GINGELL, consultant urologist, Bristol.

<sup>1</sup> Pills for the benign prostate. *Proc R Soc Med* 1972;65:125-31. (Series of papers.)

<sup>2</sup> Anonymous. Cetiprin in patients with prostatism. *Br Med J* 1978;i:1485.

<sup>3</sup> Caine M, Perlberg S, Shapiro A. Phenoxybenzamine for benign prostatic obstruction. *Urology* 1981;17:542-6.

<sup>4</sup> Abrams PJ, Shah PJR, Stone R, Choa RG. Bladder outflow obstruction treated with phenoxybenzamine. *Br J Urol* (in press).