for the obese, non-ketotic diabetic their anorectic action may be valuable when combined with dietary restriction, and, secondly, they are occasionally helpful as additional hypoglycaemic treatment in patients who have an inadequate response to carbohydrate restriction and a sulphonylurea alone. Their main danger is of precipitating lactic acidemia, and they are particularly apt to do so in renal and liver diseases and hypoxic states. Epidemiological studies indicate that phenformin is much more likely to provoke lactic acidemia than metformin, and I have now stopped using the former completely. I must emphasise that in the obese diabetic, diet alone should be the first treatment—weight reduction is vital.

Certain drugs may interact with oral hypoglycaemic agents. Beta-blockers, which may potentiate hypoglycaemia, may also mask hypoglycaemic symptoms and signs, and this interaction is obviously important with this patient. I would suggest therefore that you monitor his treatment particularly carefully, but there is no reason to stop his propranolol. Phenybutazone,

azapropazone, and clofibrate may also potentiate the hypoglycaemic effect of sulphonylureas.

Two final points. One, when he has been stabilised on an appropriate regimen, I suggest that you continue to monitor his progress at regular intervals for an indefinite period: you may find that his control deteriorates, or perhaps that he can stop drug treatment. Secondly, I never myself persevere with diet, sulphonylureas, and biguanides if it is obvious that a patient is not being controlled—in these cases I start insulin unless age and circumstances make this impracticable.

Postscript

The patient failed to respond satisfactorily to a "sugar-free" diet alone, but with the addition of glibenclamide, 5 mg daily, his weight is now steady. His urine is free from glucose, and random blood sugar concentrations are within normal limits.

Letter from . . . Brunei

A whiff of frangipani

JEAN LAWRIE

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I have just turned off the air-conditioning to listen to a faint fetal heart. The electric fan stirs the pile of detailed notes on the patient's seven other pregnancies, the carbon paper I use when referring cases for ultrasound scans flutters to the floor. The trim health sister in spotless white helps the patient to rearrange her gaily coloured clothes; the nurse translates for me; and we discuss the need for more iron, for worm treatment, for hospital confinement, and for a better diet. The patient wraps her sarong expertly and walks with dignity to see the sister, arrangements are made for transport to take her for her blood tests in the hospital, and for the midwife to visit her next week to check on that elusive fetal heart.

All in the day's work

Outside, there is a large brilliant crimson hibiscus, a banana tree, and a waft of frangipani scent. Today I shall see 40 of the 100 patients attending the clinic. This rural clinic is a substantial wooden house on stilts, with spacious waiting room and good consulting facilities, and a staff of sisters, nurses, midwife, and clerk. Tomorrow I shall climb into a helicopter to visit a clinic way up a fast-flowing river in the jungle—where the patients will come by boat, or walk through the jungle expertly balancing on narrow log bridges. Yesterday I was in the water village on stilts where 30 000 people live and where many are born and die, go to school, shop, and see the doctor.

This evening there will be a clinical meeting in the hospital attended by doctors, technicians, nurses, and other health staff.

We may have a lecture from a visiting British consultant doing a locum job here.

The pathologist will finish his work for the day and his computerised record cards will be filed for distribution. He will hope to complete plans to get one of the technicians further training in Britain or elsewhere. The radiologist usually joins the group going to the meeting. He will have had a busy day visiting a second hospital 50 miles away, and he will be thinking cheerfully of the plans he and his wife are making to go water skiing and sailing at the weekend. Friends tried to make him play golf at a glorious course near the sea, others tempted him with tennis and squash, but the boat won. As we talk, we remember we are all due for our six-monthly cholera jabs and muse on the cholera- and malaria-free state of the country and the efficient immunisation programme organised for children by the Medical Officer of Health. As a result, the country is full of healthy young people. I admire the vigorous football played everywhere in 85° F.

Over tea and curry puffs before the meeting, talk will probably move from the topic of the new hospital—due to open in a few years' time—to the need for a second school doctor to help with the big task of identifying and measuring disabilities, to advise on what special facilities should be provided and the need for a paediatrician for preschool child care. Clinical problems will then be presented and discussed: sometimes they will include rarities such as the Wolff-Parkinson-White syndrome or "salaam" attacks that were first found by general duty doctors in their big hospital outpatient clinics (reminiscent of pre-NHS casualty departments, and urban general practitioner surgeries).

Blend of ancient and modern

When the meeting is over, we will leave the old complex of wooden shingled bungalows which make up the 300-bed hospital full of patients receiving modern medical care and relatives waiting and watching. Cascades of water from the

torrential rain of late afternoon rush through the storm drains. A vast crimson cloud will spread over an eau-de-Nil Western sky. We will motor home as darkness quickly falls and the jungle noises tune up outside the garden. The *BMJ* may come with the post and the local daily papers.

Perhaps evening television will show us more of Britain's snow and ice—there will be world news pictures, but tonight we shall also have a repeat showing of the magnificent local ceremony of signing the treaty of friendship with Britain. Immaculate troops paraded as the handsome young sultan drove up in a Rolls-Royce and a colourful blend of ancient and modern

rituals ushered in a new era for this State. Helped by the camera, the mind's eye roves over distant jungle-covered hills with great mountains beyond—wide rivers in muddy spate after recent rains; the extensive riverine group of villages built in the water on stilts; the harbour; the market stalls of bright clothes, flowers, cakes, fruit, and vegetables bordering the great grassy central square of the town; the padang; and, dominating all, the magnificent golden-domed mosque.

Can you guess where I am? This is Brunei in Borneo, 5° north of the equator (not in the typhoon belt), a country that is looking for British doctors. Does anyone wish to join us?

MATERIA NON MEDICA

Auschwitz

For a small town Auschwitz (Oswiecim in Polish) has a railway network resembling that of any capital European city. It was built by the Nazis to transport prisoners to Auschwitz from all over Europe.

I recently visited Auschwitz with my mother and a team from Yorkshire Television. My mother, who is now 52 years old, survived almost two years in Auschwitz, where she was tortured by the Nazi SS because she was Jewish. She has written a book about her life during this time (*I am alive*, by Kitty Hart). The television crew were there to film a piece for the "Women at War" series. There was no script and we were fitted with microphones as we arrived at the camp.

The camp is just outside the town in a rather bleak area of fields and forest and remains virtually intact. Ex-Polish prisoners live there and ensure that it remains as a lasting memorial. I was amazed at the vastness and bleakness of the place. We walked through the camp, my mother explaining things to me as we went. We visited the huts where prisoners had been herded 15 to a bunk and saw the crematoria where 4 million Jews were burnt. Part of the camp was called Kanada after the country I now live in. This was where the saunas were located, where prisoners were told to have showers and saunas and in fact were gassed. Women were made to lie on the grass outside the sauna building to give the impression of a holiday camp. The area was termed Kanada as it was made out to be a place of fruitfulness and plenty—just like Canada.

In the birch forest behind the camp lie the remains of the vast pits where people were thrown and burnt alive. Today there is a swamp, but I visited one cesspit with the cameras. I dug with a stick into the water and saw ash and then pieces of bone floating in the ash.

Auschwitz was divided into Auschwitz I and II. Auschwitz I was for non-Jewish prisoners and it resembles more a prisoner-of-war camp. It is here where the famous "Arbeit mach frei" sign is. In the museum are reminders of the atrocities: mounds of suitcases with names on, mounds of children's shoes, adult shoes, shaving brushes. Auschwitz II was purely for Jews. It is a much bleaker place and was the main extermination area. We concluded our visit with formal interviews in the watchtower of the camp—the place where SS Reichsführer Himmler used to stand and observe the camp.

The theme of the filming is of a survivor from the camp relating her experiences to her son. The programme should be shown in the UK in the autumn of 1979. The purpose of the filming was, I think, best summarised by a quotation from my mother's book: "We may forgive, but we must never forget."—DAVID P HART (surgeon, Saskatchewan).

Ned Kelly laughs last

The mountains of north-eastern Victoria, rugged and inhospitable, once sheltered desperate men. At the summit of the Tolmie Ranges is Power's lookout, providing a panorama of tangled peaks and a valley far below.

Power was an example of that early Australian phenomenon—the bushranger. A fugitive from justice, he stole horses and rode to rob coaches, farms, and banks at gun point. He would then disappear into the densely timbered mountains. Being a good bushman and horseman, he knew the country well, found inaccessible hideaways, and although hunted, he survived. From his hideout, Power could survey the valley for possible pursuers. His hiding place undetected, Power bushranged for many years before he was apprehended. Further along the Tolmie road is Stringybark Creek, where another bushranger, Ned Kelly, and his gang shot three policemen searching for them on 26 October, 1878.

At the foot of the Tolmies, on High Street, Mansfield, is a monument to the mounted constables—Scanlon, Kennedy, and Lonigan. A second monument is to Dr Samuel Reynolds, an example of another early Australian phenomenon—the colonial country doctor. Born in Sussex and a graduate of the London Hospital, Reynolds migrated to Victoria, where he prospected for gold in the mountains. Not striking it rich, he returned to medicine, becoming the first doctor in the young town of Mansfield, where he practised until his death in 1901, aged 76. He became extremely proficient, influential in the Mansfield area, and known throughout Victoria. He was also brave, for the day after the murders he and a group of men rode into the mountains to retrieve the three bodies. Fortunately, Ned Kelly and his desperadoes had vanished into the rugged wilderness.

Ned Kelly was eventually captured at nearby Glenrowan and subsequently hanged. Bushranging, which had its origins in colonial rejection of oppressive authority and antipodean perpetuation of Anglo-Irish dislike and hatred, became no more in Victoria.

There are no monuments to Ned Kelly, but he has had the last laugh. He is a folk hero in Victoria, and possibly in all Australia. To be "as game as Ned Kelly" is a cachet bestowed in Australia with affection on those performing antiauthoritarian acts with élan—and not being caught. He has been romanticised by Sidney Nolan, whose Kelly series of paintings hang in Australian, British, and American galleries. Apart from the monuments in the far country, the three policemen and Dr Reynolds are virtually forgotten, while Ned Kelly, larger than life, continually reminds people in three continents of his existence.—WILLIAM C BOAKE (professor of medicine, Madison, Wisconsin).

Cresta again

I wrote last year of my riding the Cresta Run in St Moritz (15 April, p 983) and I returned again this year, chiefly to ski and see old friends. One old friend from Sheffield with a Sheffield-made toboggan kindly offered to lend it to me and, as I had ridden it before and liked it, I decided a little reluctantly to have another go and entered the seniors' race from Top.

The exact siting of the prone body upon the sliding seat of the toboggan, more correctly known as a skeleton, is vital. Steering through the many steep corners is facilitated by sliding the seat to the rear thereby enabling the grooves cut into the steel runners to bite into the ice, giving control and direction assisted by hand pressure on the front side of the toboggan.

Testing my lying position on the offered toboggan in the hut before the race a local Swiss expert observed that my "eyes should be placed behind the pillow." Puzzling out this advice I suddenly realised that the German for egg is "ei" and that "pillow" meant the seat, so I knew what he meant. Lord Brabazon used to say that the Cresta was one of the cleanest of all sports and this is true. The experts are only too ready to assist the non-experts.

Starting too cautiously and without the benefit of a practice run I was last after the first course after a very comfortable ride on my friend's toboggan. On the final course I went a little harder, took an extra few steps at the start, raked less and pushed harder, mentally thanking the Swiss expert for his good advice. After another good descent and arrival at finish, I listened anxiously for my time to be announced on the loudspeaker and heard with great pleasure that I had won the seniors' race.

An Engadine silver drinking vessel and a kiss from the secretary's wife at the presentation followed in the sunny bar of the Kulm Hotel, and I went off up to Corvatsch for off-piste skiing for the rest of a good day.—PAT O'BRIEN (general practitioner, Hartest, Suffolk).