Colonel Mustard in the library with an obsessional syndrome? See p 1242

Zimbabwe's health system is in a state of collapse

PERSONAL VIEW **Kate Adams**

A year is not long in the death of a nation, but I was stunned by how much Zimbabwe had changed in the past 12 months. The healthcare system is in a state of collapse. The whole country is being destroyed.

Zimbabweans stoically put up with the extreme living difficulties caused by their government's policies and its mismanagement of the economy. Since my last visit a year ago (*BMJ* 2008;336:98) 10 zeroes have been taken off the currency, inflation has reached 231 000 000%, and chronic food shortages and daily power cuts continue.

How bad do things need to get? Why don't people collectively stand up against the regime that has wrecked this beautiful and once functioning country? People are tired, hungry, scared, and oppressed. The violence perpetrated by the followers of Robert Mugabe and Zanu PF remains fresh in people's minds.

As I leave Zimbabwe, Bulawayo's health department is preparing for an expected cholera outbreak. There is cholera in Harare and other places in Zimbabwe, a sign that the public infrastructure is really breaking down.

Last week nurses and junior doctors in one of the public hospitals in Bulawayo stopped working over pay and conditions. One ward was being staffed by two student nurses who had no choice but to be there. These students are hungry. Each day they eat the same repetitive diet as their patients, sadza and cabbage, which has little nutritional value. There are reports of an outbreak of pellagra among inpatients at the psychiatric hospital. This is surely a human rights abuse. Pellagra is a vitamin B deficiency and causes a skin rash, sores, diarrhoea, and dementia. People are admitted to the adult wards with severe cases of malnutrition and pellagra. They are given plumpy nut, a rich nutritional supplement, but then discharged to the same physical environment.

Surprisingly the wards are half empty. Patients are keeping away, unable to afford the costs of transport and drugs. Those who are inpatients are very sick, most with AIDS. Urea and electrolytes can't be measured,

AP

People sitting outside a government hospital in Harare this summer, when doctors advised Zimbabweans not to get sick

the machine measuring CD4 counts has broken, and the hospital has run out of all intravenous antibiotics except gentamicin. Patients' relatives are expected to buy drugs from pharmacies in town. The drugs are costly, and the banks allow customers to withdraw only up to $Z50 000, equivalent to a single bus fare. Thousands of people queue daily for hours to retrieve this meagre sum. I meet a midwife who is heading for the bank queue after coming off night shift. She joins the queue at 8 30 am and is hoping to be finished by 4 pm, when she needs to think about returning home and preparing for work. At the end of last week the government raised the threshold that the banks can lend to $Z500 000, the cost of two loaves of bread.

Many inpatients have suspected meningitis. One young adult of unknown HIV status is fitting. It is distressing to observe, knowing that no effective drugs are available to stop the seizures. The patient's brother is told what drugs to buy. The plan is to treat for potential bacterial and fungal causes; the result of the lumbar puncture won't be known until the following week. The brother is worried where he will find the money and asks for a doctor's letter for the bank. The drugs are likely to cost in excess of $Z10m.

Another young adult with an acute psychosis is lying naked on a mattress smeared with faeces. The nurses are worried that the patient will abscond. As they can't find the keys to lock the ward they tie the patient's wrist and ankle to the legs of a hospital bed. It looks primeval. Intravenous diazepam isn't working, and the hospital has no antipsychotics. A prescription for chlorpromazine is written in the hope that the patient's relatives will have access to $Z4.6m.

The HIV clinic is running low on co-trimoxazole and an antiretroviral, and a meeting is held to discuss how to ration these drugs. Twelve thousand people have now begun antiretroviral treatment, which is a great success, but the clinics are not coping with the workload. Médecins Sans Frontières is supporting the project, but there is only so much it can do. News has just come through that because of financial irregularities the Global Fund to Fight Aids, Tuberculosis and Malaria is no longer going to donate funds for drugs to Zimbabwe—yet another blow for those on the frontline. The hospital still has no soap; some of the conditions the staff are expected to work in are becoming intolerable. One maternity unit has no gloves for the midwives to deliver babies, and a quarter of the population has HIV.

Every morning at a local doctor's house a queue forms of people seeking medical help. Last week relatives of an old woman brought her in a wheelbarrow. She is dying. There is no point going to the hospital. In any case, the relatives have no funds for transport and certainly not the costs of transporting a corpse, so they wheel her home.

Many people are now dying in Zimbabwe.

On Friday 7 November Harare's main hospital closed its doors to new admissions, unable to carry on. The state is failing in its duty of care to its citizens.

Zimbabweans I talk to have little hope for the future with a coalition government that includes Robert Mugabe. There's just too much history.

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Lay your money down

FROM THE FRONTLINE
Des Spence

I was born in Essex. But I have spent my life in Scotland, a place where sometimes it's not easy being English. I still have an English accent and a pathological urge to say "please" and "thank you." But this is a mere veneer, for I have gone native—my heart is tartan. I am the Hollywood stereotype, a heathen, war painted, kilted transvestite, stubbornly holding my ground no matter what, and am therefore direct and blunt. If this upsets people, so be it. So when the BMA and academics hail the benefits of the clinical elements of the quality and outcomes framework (QOF), I say I do not believe them.

In a Celtic sceptical tradition, I voted against the new contract, believing that it would jeopardise the care of patients. For long ago I lost faith in fables of medical economists' cost benefit analysis, a science so riddled with confounding falsehoods as to be little more than pagan incantations. This is now the fourth year of the contract—and four years since any doctor looked properly at the patient, obsessed instead by their computer screens and chasing the points. The government shelled out payments, making us richer, unhappier, and unpopular. And to what clinical benefit?

We have had a fanfare of studies reporting minor improvements in glycated haemoglobin, blood pressure, cholesterol—just soft surrogate markers of disease. Indeed some reports go further, suggesting a narrowing of health inequalities. But in the inner cities these are illegitimate markers of inequality; our real medical demons are the unholy trinity of alcohol, drugs, and violence, combined with the poverty of expectation. Has there been a national change in the gradient of decline in the hard end point of vascular related deaths? Have we seen a large reduction in complications of diabetes or chronic obstructive pulmonary disease? With such a highly powered public health experiment and enrolment of so many unconsenting volunteers, surely after four years we should have some hard data.

It is not just the huge financial opportunity cost, nor the well made unwell, but the wanton consumption of our medical energies that I take issue with. Our energy has been spent bean counting the measurable while dismissing the most valuable aspect of medical care, the immeasurable. Perhaps I am wrong. But I will stand my ground of absolute scepticism until some redcoat finds real evidence to run through my Jacobean heart.

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Alma-Ata no more

IN AND OUT OF HOSPITAL
James Owen Drife

Almaty, capital of Kazakhstan until 1998 and the country's largest city, is about seven hours from Heathrow: a meal, two in-flight movies, and a snack. It lies in a beautiful setting beside mountains on the country's southern border. Until 1993 it was called Alma-Ata, a Russian mistranslation meaning "father of apples."

Sitting there last week, I wondered whether the big sanatorium that housed our WHO meeting had been the scene of the Alma-Ata Declaration 30 years ago, something I remembered only vaguely but that has almost religious significance in the world of public health. A few minutes' googling disabused me.

In 1978 the first International Conference on Primary Health Care was held in a vast 3000 seat hall beside a specially built hotel. The representatives from 134 countries included Senator Edward Kennedy. The show was funded by the Soviet Union, keen to beat China onto the world stage. China stayed away.

The hotel is still there, the tallest building in Almaty. Primary care, however, has survived the fall of communism less well. Here, as in many post-Soviet countries, non-medical people use a familiar phrase when they grumble about rural health care: "You can say what you like about the communist era but …"

The Alma-Ata conference ("Health for all people of the world by the year 2000") was medicine's equivalent of the Woodstock festival, and its anniversary has inspired nostalgia among medical ex-hippies: "Yeah, man, there's been some, like, slippage. But, hey, we can still get there. Stay cool. Gather more data."

For us non-hippies it's hard to be cool. We ask ourselves why we go abroad with cash strapped organisations, offering sticking plaster to cover gaps in other people's healthcare systems. International aid budgets are laughably small, but non-governmental organisations have got used to them. You suspect that they quite enjoy being short of money. Mother Teresa and all that.

The sanatorium, formerly a health farm for the party elite, has a magnificent inner dining room. Every mealtime each table has a notice with the name of an international organisation. The tables don't talk to one another, partly because of uncertainty about which language to use and partly because that's not what aid agencies do. Cooperation would smack of big business, which demands results. International aid, although it talks big, prefers to be a cottage industry.

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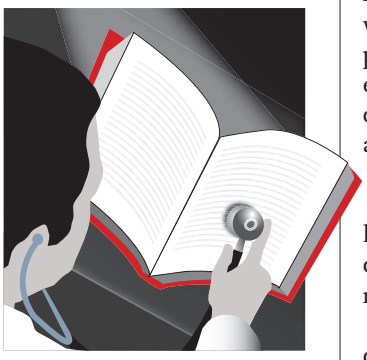
Talk of the devil

BETWEEN THE LINES
Theodore Dalrymple



Then there is diagnosis, "a physician's forecast of disease by the patient's pulse and purse." Luckily we of the NHS are uncorrupted by the purse; we diagnose instead according to the waiting list initiative and the four hour rule

For some reason that I am unable to discover, the medical profession has long attracted criticism from scribblers, litterateurs, and even bona fide authors of every stripe. The nearest I can come to an explanation of this curious fact is that most of them, the scribblers et al, were refused admission to medical school.

Ambrose Bierce was not, as far as I know, a doctor manqué. He was known as Bitter Bierce because of his disillusioned attitude to human nature in most of its forms. He learnt his ironic or sarcastic style, apparently, by reading Gibbon. In 1912, at the age of 71, he went to Mexico to follow the revolution there and was never heard of again. Some say, without any evidence, that he returned to the Grand Canyon to shoot himself; others that Pancho Villa had him shot.

Bierce's most famous book, the one that is still read, is *The Devil's Dictionary*, a collection of aphorisms, many of which hit their target. For example, it defines self esteem (the lack of which on an epidemic scale is said to cause everything from crime to overeating) as "an erroneous appraisement" and patience as "a minor form of despair, disguised as a virtue."

It will perhaps come as no surprise, therefore, that when Bierce touches on medicine and doctors he does so with no very friendly feeling.

As far as I am aware he had no bad experiences with doctors, nor did he have a hated relative who was a doctor (common causes of this malady). He was cynical about doctors because he was cynical.

His definition of a medicine was perhaps not so very inaccurate for its time: "A stone flung down the Bowery to kill a dog in Broadway." I need hardly point out the difference between his days and ours, when all our prescriptions are aimed with the accuracy, and lack of collateral damage, of a cruise missile.

Then there is diagnosis, "a physician's forecast of disease by the patient's pulse and purse." Luckily we of the NHS are uncorrupted by the purse; we diagnose instead according to the waiting list initiative and the four hour rule, much more accurate signs.

A prescription in Bierce's day was "a physician's guess at what will best prolong the situation with least harm to the patient." Things are completely different now, of course; a prescription is a doctor's guess as to what will get the patient out of the room quickest with least harm to the doctor.

Some of the definitions are even more out of date. Thus the gout is "a physician's name for the rheumatism of a rich patient" and the grave a "place in which the dead are laid to await the coming of the medical student." But who would not recognise the origins of H L Mencken's wonderful aphorism that a puritan is someone who fears that someone, somewhere, is enjoying himself in Bierce's definition of pain? "An uncomfortable frame of mind that may have a physical basis in something that is being done to the body, or may be purely mental, caused by the good fortune of another."

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MEDICAL CLASSICS

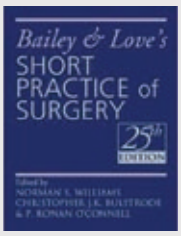
Bailey and Love's Short Practice of Surgery By Hamilton Bailey, McNeill Love, A J Harding Rains, and H David Ritchie

19th edition published 1984

I love this book. I have a big, fat clothbound 1984 edition—there have been more since, but it is mine I love. I love everything about it, from its sheer weight to its extravagance. It was at the time the single most expensive thing I had ever bought. (I didn't have a car.) I love the complete confidence it represented (it covered everything, without shame) and the beauty of studying a specialty in which a "short" practice manual had 1301 pages.

It didn't actually take me very long—I read it, cover to cover—to realise that it was old fashioned and in the main not entirely relevant to the practice of contemporary surgery (in 1985), which was in itself a useful induction to the world of journals and a salutary reminder that every book is always going to be out of date for the obsessive. But I reread it now for the language, the photos, and the snippets of salvaged joy. Where else would you find an aortic aneurysm described as a "vascular disaster," see photos of "acute cholecystitis in a professor," or have an illustrated passage on gallstones, the picture of which was captioned, "Note, however, the three pearls, usually formed of calcium carbonate in the oyster around a parasite or a grain of sand."

I learnt that a ranula was "so named because of the likeness of the swelling to the belly of a little frog";



The 25th edition was issued this year

saw a detailed sketch from the Metropolitan Museum of a Kocher's reduction of a dislocated shoulder, explaining how the method was 3000 years old; and was told that Armand Trousseau (of Trousseau's sign) "noted this sign as his own death warrant." The authors could be didactic; the same double page in my edition that illustrates "exostoses of the humerus in three sisters" has a sensible admonition: "There is a regrettable tendency to expect the student to remember the names of all the many dysplasias of bone: very little useful purpose is served by doing so," I still think that this is true.

When I worked as a surgeon during a rather savage war (in a developing country, a long time ago) I read it again and again. It wasn't as practical as the invaluable volumes I and II of *Primary Surgery* (edited by Maurice King), but it was sometimes psychologically life saving. Quite apart from the bullet and explosive wounds, non-traumatic pathology in a war gets worse, not better; people present later and thinner, everything is worse. The book's calm tones, and the sensational pictures, made me remember that it all had happened before, and in the olden days this was what you did. For me at that time it was, unexpectedly, just what it said on the cover: a short practice manual. And I still think that the book's rationale for amputation is the best ever: the limb should be "dead, deadly, or a dead loss." It's a wonderful book.

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REVIEW OF THE WEEK

"You are bipolar, and I claim my £5"

One of the first things trainee psychiatrists learn is that you cannot make a diagnosis just by observing behaviour. **Gwen Adshead** takes the BBC to task for attempting such diagnoses on camera

Horizon: How Mad are You?
BBC 2, 11 and 18 November at 9 pm
www.bbc.co.uk/programmes/b00fm5ql
Rating: ★☆☆☆

In a country house in England 10 citizens came for five days to live together and engage in a series of tasks. All their activities were videotaped, and three mental health professionals (psychiatrist, nurse, psychologist) were set the task of observing them closely over the whole period. The professionals' aim was to work out which people had a past diagnosis of one of five common mental disorders: social anxiety, bipolar disorder, depression, obsessive compulsive disorder, or an eating disorder. The overall aim of the programme makers was to show how easy or difficult it was to identify mentally ill people just by looking at behaviour—to examine (as a portentous voice stated, over shots of Hever Castle), the "thin line between normality and mental illness."

The end credits said that the Royal College of Psychiatrists had assisted the programme makers, and I guess that they could hardly refuse. All the participants in the programme (both the group members and the experts) said that they wanted to emphasise how little psychiatric diagnostic labels tell you about a person and how external behaviour is not a good way to assess mental states. I suspect it was hoped that the programme might undermine the stigma of mental illness, that it would show that even if you have a mental illness you can still have a healthy functioning lifestyle (if taking part in reality television is marker of health). I think there was also a message that if mental health professionals can get it wrong (and they did, fairly comprehensively), then no one should be too quick to determine another person as mentally ill.

It seems mean to carp at what was essentially a jolly British game: a cross between pin the diagnostic tail on the donkey, detection of the diagnosis-in-disguise ("You are bipolar, and I claim my £5"), and psychiatric Cluedo ("Colonel Mustard in the library with an obsessional symptom"). It seemed to be a successful game: at the end there appeared to be genuine pleasure and interest within the group, as those who had endured mental ill health in the past shared their enjoyment that no signs of disorder were obvious. One or two people were wrongly identified as having had a mental disorder in the past, but they did not seem too concerned. The experts acknowledged the complexity and limitations of the task and were kindly and careful in their approach.

I don't think this kind of game would have been played with cancer patients. I thought there was a subtle message that mental illness is different from physical illness: that it does mark you for life

But I was uneasy watching the programme, and I remained uneasy afterwards. One of the first things that trainee psychiatrists learn is that you can't (and indeed must not) make a diagnosis just by observing behaviour. Diagnosis in psychiatry is like diagnosis in any other branch of medicine, a complex mix of art and science, and you can spend a professional lifetime getting good at it. The professional skill is to get beyond the superficial to the person underneath; as a patient said to me recently, "Your job is to show what makes me human."

So why make a programme suggesting that making diagnoses in this way may be possible? What if the experts had identified everyone correctly? (I identified four of the five former patients but made completely the wrong diagnoses.) Would that have given some credence to the idea that you can detect mental illness just by looking? History and personal narratives of experience are essential parts of diagnosis. Isn't there something ethically dubious about trying to carry out a major medical procedure in a negligent way on camera?

This last question made me wonder about perpetuation of stigma. I don't think this kind of game would have been played with cancer patients. I thought there was a subtle message that mental illness is different from physical illness: that it does mark you for life, and that it was a happy accident of the game that not all the patients were "found out." Such a programme doesn't help the current emphasis in mental health services on recovery: that you can be a former psychiatric patient just as you can be a former oncology service user or former orthopaedic patient.

I also thought this programme an example of the British mistrust of the whole enterprise of taking the mind seriously and of the persistent, subtle denigration of mental health professionalism. And yet the mind is what makes us who we are, what gives us our identity and makes life meaningful. I think the BBC could do better by the 25% of licence fee payers who have either recovered from mental illness or are living with mental distress and who need others to understand and support them.

All the participants said that they wanted to emphasise how little diagnostic labels tell you about a person

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See also Review, *BMJ* 2008:337;a2641