"Do we need more geezers and fewer geeks?" Des Spence, p 510

The Commonwealth games and "Delhi belly": what India can learn from Los Angeles

PERSONAL VIEW **Karunesh Tuli**

Waiting to be seated in a restaurant in Delhi, patrons are likely to see pictures of Ganesha, Lakshmi, and Mohandas Gandhi and a plaque with the phrase "Cleanliness is next to godliness." Ganesha, the elephant headed deity, is the remover of obstacles but may owe his place in the eatery to his fondness for sweets and his great belly. Lakshmi, the goddess of wealth, sits next to the cash register. Gandhi, who perfected hunger as political protest, is the odd one in the bunch; hollow cheeked and lean framed, he was better known for his fruit and goat's milk diet than for worldly cravings. It is his experiments with sanitation, rather than his status as the "father of the nation," that justify his presence next to the sign and the gods. Oppressed by the stench at a session of the Indian Congress in Calcutta in 1901, he assigned himself the task of cleaning the latrine.

Delhi is getting ready to host the Commonwealth games in October. Joining the many concerns that attend major sports events worldwide—security issues, traffic bottlenecks, and hotel room shortages—is one that frequent visitors to the city know well: "Delhi belly" (traveller's diarrhoea). The question is not whether they'll be struck down during their visit but when.

Los Angeles has a lesson or two for the planners of the Delhi games. Twelve years ago reporters from the US broadcaster CBS carried hidden cameras into restaurant kitchens around Los Angeles county. Their report, "Behind the Kitchen Door," and subsequent broadcasts over the next few years featured cockroaches, rat droppings, "chickens sitting on the floor soaking in their own blood," and "liquid waste pouring out of the ceiling." Alarmed by the reports, the county government ramped up its response to the problem of poor food handling, shutting down a number of restaurants for violations of health codes, including, for a day, one owned by the mayor of Los Angeles, Richard Riordan. The health department, borrowing

CHRISTOPHE ARCHAMBAULT/AFP/GETTY

Delhi officials dash into localities where vendors operate, confiscate food . . . Vendors move out temporarily, returning after a few hours. This cat and mouse game does little to ensure good food hygiene

an idea first applied in the 1920s by the US Public Health Service to the sale of milk bottles, introduced the now familiar letter grades that greet customers as they enter restaurants in the county and increasingly in cities around the world.

Each Los Angeles letter grade represents intense effort by health department inspectors, who visit each restaurant at least three times a year, blessing poor performers with an additional "bonus visit." Inspections take over an hour and include rigorous examination of bathrooms, kitchens, and food storage. Restaurant owners know they cannot bribe their way out of a low grade; one owner, who has been in the business for 30 years, told me he does not offer even water to the inspectors, for they will accept nothing. Current inspections are much more thorough than the cursory checks of the pre-grade era. The result: customers can step into restaurants without worrying about food safety; and studies over the years have established improvements in restaurant hygiene and a reduction in hospitalisations related to foodborne illnesses.

Indian officials, too, are planning to issue grade cards to food vendors in the nation's capital. Their concern for the health of athletes and spectators at the Commonwealth games is welcome, but their past record doesn't inspire confidence. The Municipal Corporation of Delhi is severely understaffed. A handful of food hygiene officials struggle to cover tens of thousands of establishments. Unable to carry out systematic checks or to counsel food handlers about hygiene, they resort to raids, during which teams of officials dash into localities where vendors operate (often without a licence), confiscate food, and leave within minutes. Vendors move out temporarily, returning after a few hours. This cat and mouse game does little to ensure good food hygiene.

Indian bureaucrats are eager to improve the country's image. Glossy full-page advertisements in magazines and billboards at airports proclaim that India is "incredible." At the same time, Indians—with their rapidly growing economy, achievements in information and space technology, and a rich cultural tradition—resent comments from outsiders about the filth and disease that billboards cannot hide and spurn advice on lowly matters such as hygiene. Offended by Katherine Mayo's critique of India's health conditions in her 1927 book *Mother India*, Gandhi dismissively called it the report of a "drain inspector."

The 1982 Asian games brought colour television to India. The Commonwealth games offer corporation officials an opportunity to make a bigger contribution to the wellbeing of Delhi residents. Grade cards by themselves will not deliver food hygiene; they need to be backed by methods and human resources of the kind that have worked so well in Los Angeles.

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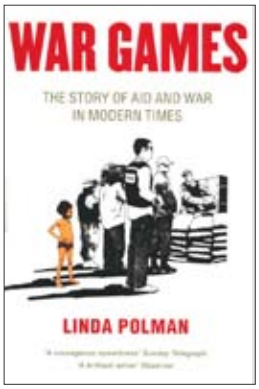
REVIEW OF THE WEEK

The danger of do-gooders

The intervention of humanitarian groups may actually exacerbate conflict, **Jonathan Kaplan** finds



War Games: The Story of Aid and War in Modern Times
Linda Polman
Viking, £12.99, pp 218
ISBN 978-0670918966
Rating: ★★★☆

The Swiss humanitarian Jean-Henri Dunant looked in despair upon the carnage of the 1859 battle of Solferino. Forty thousand French and Austrian soldiers lay dead; a similar number were left to die from their wounds. With army medical services lacking, local villagers took the casualties to stables and churches. Dunant gathered together volunteers to care for the wounded of both sides without favour, mobilising a corps of society women to give of their time and compassion. Far from a reluctance to be involved, the biggest problem Dunant had was that of "enthusiasts" turning up with inappropriate help: "most of those who brought their own goodwill to the task lacked the necessary knowledge and experience, so that their efforts were inadequate and often ineffective."

In his native country he lobbied for the creation of a donor supported, professional, international voluntary organisation that would bring medical care to all victims of war while, "by reducing the number of cripples, a saving would be effected in the expenses of a Government which has to provide pensions for disabled soldiers." Among the celebrities to whom Dunant turned for backing was Florence Nightingale, heroine of the recent war in the Crimea. To his astonishment her response was negative: voluntary medical intervention removed from governments the obligation and cost of caring for the wounded, she objected, allowing them to wage war for longer.

But in 1863 Dunant's dream was realised. The International Committee of the Red Cross was established in Geneva, on principles of neutrality: help whenever, wherever, and to whomever it was needed. In Dunant's time 90% of war casualties were soldiers, and it was for them that the Geneva Conventions were forged. As the proportion of affected civilians rose—around 50% in the second world war, at least 90% now—the conventions have changed, to extend impartial protection and humanitarian aid to non-combatants. This remains the ethical goal of all humanitarian non-governmental organisations (NGOs): to help those afflicted. But, as Linda Polman illustrates so effectively, they also need to be seen to be helping, for publicity is the key to gaining donors' attention.

When in 1994 two million Rwandan Hutus fled into the Democratic Republic of the Congo after the slaughter of around 800 000 Tutsis, the global NGO corps, who (alongside the United Nations and nearly all the world's governments) had failed to raise much outcry at mass murder, now saw their opportunity. A cholera epidemic among the refugees became "the second genocide"; and at the UN high commissioner for refugees' daily press briefings NGO spokespeople would step forward with ever bigger death estimates. "The man with the highest death toll," recorded a watchful journalist, "got on the 9 o'clock news." The refugee camps became a sea of flags, T shirts, tents, vehicles, water pumps, and latrines all decorated with the competing logos of different organisations—Médecins Sans Frontières (MSF) had theirs printed on every sticking plaster—like an "aid agency supermarket."

This public relations arena required NGOs to gloss over certain awkwardnesses: that these "victims" were the perpetrators of genocide, or its supporters; that the camps were controlled by the Hutu government in exile, which diverted aid, food, and medical care to its power base; and that the death toll arose partly from people murdered by Hutu militia for insufficient loyalty. Local nurses appointed by NGOs to run their health centres were Hutu government staff (most of Rwanda's health service had settled in the camps, from the minister of health downwards), and Western doctors performing their rounds in the tent hospitals found patients disappearing, replaced by family members of the Hutu leadership.

The 2001 invasion of Afghanistan placed humanitarian intervention under new ethical pressures. "NGOs are such a force multiplier for us," announced the US secretary of state, Colin Powell, "such an important part of our combat team." And by May 2003 some of the NGOs flooding into Baghdad in the wake of the US invasion of Iraq were requesting permission from the occupying coalition provisional authority to bear arms in furtherance of their aid missions. The harm suffered to the principle of humanitarian neutrality became explicit when the Baghdad headquarters of first the International Red Cross and then the UN were demolished by bombs. Western aid groups withdrew their expatriate staff from Iraq.

The scenario wished for by Henri Dunant and warned of by Florence Nightingale has come to pass. The global army of humanitarian volunteer groups, all vying for publicity, prominence, and funding, is growing exponentially: a web search for NGOs working in Darfur generates some 300 000 referrals. The aid that NGOs distribute can allow armed groups to wage war for longer, not just by feeding combatants but in providing money and resources to sustain the conflicts. Funds are embezzled by officials and warlords, militias demand dollars to guard clinics and aid distribution points, a tax may be extracted for the "use" of children for vaccination and injured people for rehabilitation.

Yet the lure of doing good remains. "The humane desire to lighten a little the torments of all these poor wretches . . . creates a kind of energy which gives one a positive craving to relieve as many as one can," observed Dunant. And a UK medical school is offering the country's first intercalated BSc degree in disaster medicine, to begin in September. It should be hoped that the syllabus will include such insightful texts as Polman's *War Games*.

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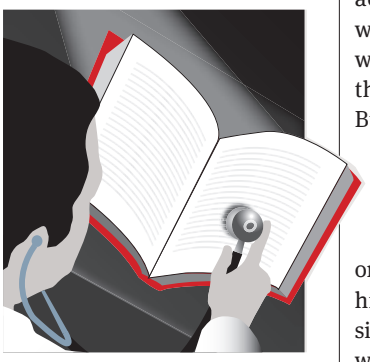
The global army of humanitarian volunteer groups, all vying for publicity, prominence, and funding, is growing exponentially: a web search for NGOs working in Darfur generates some 300 000 referrals

A question of euthanasia

BETWEEN THE LINES
Theodore Dalrymple



There surely cannot be many plays in which a 13 year old is portrayed trying to strangle her severely disabled brother

Richard Hughes (1900-76) is now mainly remembered for his novel *A High Wind in Jamaica*, published in 1929, and for having been the friend of Dylan Thomas. Kingsley Amis and Philip Larkin made slighting reference to him in their correspondence, but that is no evidence of any bad qualities on his part.

Initially, however, Hughes wanted to be a dramatist, and it was as such that he first came to prominence. George Bernard Shaw called Hughes's first work, *The Sisters' Tragedy*, which he wrote aged 22 in 1922, the finest one act play ever written. It was produced at the Royal Court Theatre. Hughes went on two years later to write the first play in the world specifically for radio, called *Danger*.

The Sisters' Tragedy deals with the question of euthanasia. (Young men write surprisingly often about death, perhaps because it is for them of purely abstract interest and of no application to themselves.) Two sisters, Philippa, aged 28, and Charlotte, 19, devote themselves to looking after Owen, their 24 year old brother, who has a form of subacute sclerosing panencephalitis after measles, leaving him deaf, mute, and blind. Charlotte is engaged to marry but does not want to leave Philippa to look after Owen on her own.

There is a younger sister, too, called Lowrie, who is 13. She is at the stage of questioning everything, and the play begins after a pet rabbit has been savaged by the family cat and left alive but seriously injured and in terrible pain. Charlotte kills the rabbit; and of course Lowrie starts to ask questions as to whether it is sometimes right to kill. She is told that it is.

Lowrie draws the rather obvious but not quite accurate analogy between the rabbit and her brother. There is, for example, no evidence that Owen is actually suffering, whereas the rabbit was screaming after the cat attacked it. But Lowrie decides that it would be better for all concerned if Owen were dead: not only better for Owen himself but for her sister Charlotte, who would then be free to marry her fiancé.

There surely cannot be many plays in which a 13 year old is portrayed trying to strangle her severely disabled brother. Despite Lowrie's opinion that Owen would be better off dead, he fights back and makes it clear that he does not want to be strangled. Incapable of speech, though, he makes only what the family calls "Owen's noise."

Lowrie does not take the hint, however, but rather concludes that her method of euthanasia was a foolish one. She tries another method, this time successfully: she sends the blind Owen out for a walk, straight into the pond—which rather implausibly seems to abut immediately on to the French windows—knowing that he will drown in it, as he does.

Owen's death does not have the liberating effect on family life that Lowrie hoped for. After she has confessed that she virtually killed Owen, Charlotte's fiancé decides that he does not want to marry into a murderous family; instead he threatens to go to the police. As for Lowrie, she begins to hallucinate Owen, in a psychotic attempt to restore the status quo ante.

The play, incidentally, was written 11 years before J R Dawson proposed measles virus as the cause of subacute sclerosing panencephalitis.

Theodore Dalrymple is a writer and retired doctor

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MEDICAL CLASSICS

Zalma By Thomas Mullett Ellis

First published 1895

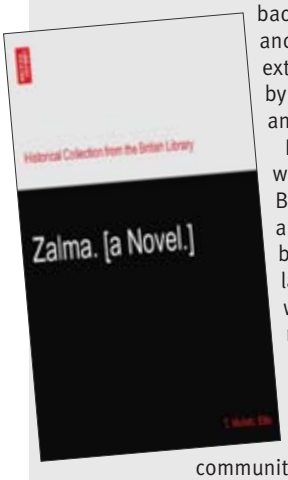
The use of biological agents in warfare and terrorism is often regarded as an idea that emerged in the 20th century. The anthrax mail attacks of September 2001, directed towards two Democratic senators and several news media offices in the United States, are well remembered by many.

Others may recall the British experimentation with anthrax spores on Gruinard Island, off the west coast of Scotland, in 1942. Few, however, will be acquainted with the 1895 novel in which Thomas Mullett Ellis wrote what is one of the first accounts of the use of anthrax as a weapon.

In this tale Zalma, the beautiful, intellectual, and seductive daughter of an anarchist count, was rejected by her husband to be, the Duke of Umbria, and fled to England in great distress. There she married a young Englishman, using her charm and cunning to put in motion what the *Glasgow Herald* of 12 December 1895 described as a "magnificently murderous project."

Zalma planned—in her resentment and hatred towards humankind—to destroy all of humanity by sending tubs of anthrax germs to various international centres and by releasing the organisms from strategically placed balloons.

As *The Standard* noted in its somewhat scathing review (15 February 1896), the novel was also scattered with "excited Anti-vivisectionist females . . . [and] scenes of horror in the dissecting-room of a savant," all of which served as background to Zalma's "diabolical and quite impossible scheme for the extermination of the human race by the sudden dissemination of anthrax microbes."



In that same year H G Wells wrote his short story "The Stolen Bacillus"—relating another anarchist's attempt to steal cholera bacilli from a bacteriological laboratory and poison the London water supply—and thus *Zalma* received significant contemporary attention.

The book was reviewed in several newspapers, and the medical and scientific community also provided comment on the content of Ellis's novel through the columns of the *BMJ* (1897;1(1896):1101). The *BMJ* considered that the book presented a "bald misrepresentation of biological objects and methods," and yet it was sufficiently popular that a special, gilt edged edition was published in 1897.

On 1 December 1895, the year after *Zalma*'s initial publication, the *Glasgow Herald* reported that a gentleman had appeared in New York who held "Zalma's tenets, though he has adopted slightly different methods of promoting them." He had apparently taken to leaving phials of disease causing agents in street cars, which he "thoughtfully label[led] 'diphtheria,' 'cholera,' 'pneumonia' . . . in order that each victim may choose his own disease."

We should recognise, therefore, that "Zalma's followers" came into being in the century when the microbial cause of anthrax and many other diseases had first been recognised.

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The memory class

FROM THE FRONTLINE
Des Spence

Sunday night, and the exams were still two weeks away. It was *Songs of Praise* on the television or a Dickens period drama in 50 nail grating episodes. Bored, we played cards. We had no money; playing for matchsticks being pointless, the only option was playing for forfeits. So pouring cooking oil, salt, and curry powder into our five chipped mugs we salivated and sweated in fear of failure. We, the academic elite, all had great minds of memory; indeed one of my flatmates could visualise any word and read it backwards in his head. But he wasn't any good at cards. I heard him retching in the toilet throughout the night.

The regurgitation of knowledge is the key to power. Knowledge is the stock and trade of the professional classes. We might not be able to peel a potato, but we can remember facts, and we sell them for a high premium. Even now during selection for medical school we still choose the academic "brightest" with a minimum three As at A level. Today's profession may look more diverse, but in many ways it is unchanged—we are all memory machines. But testing memory through examination is deeply confounded by education, home life, opportunity, and class. It is little wonder then that the profession has remained stubbornly middle class, because we are selecting our own, with the exam system geared in our favour.

Today there seems little need to have an encyclopaedic memory, however, because an 8 year old with a smart phone can access millenniums of medical knowledge in an instant. Knowledge is losing its premium. And pure academic ability is often a proxy for the concrete, inflexible thinker, a dangerous characteristic in a rapidly changing world. And as in all disciplines medicine needs attributes other than total recall, such as problem solving, integrity, caring, kindness, coping, and, above all, creativity. Some universities are tackling such concerns by using the UK Clinical Aptitude Test, which seeks to test for aptitude rather than knowledge. The reality, however, is that this is becoming yet another exam for the already advantaged to be tutored.

Surely it is important and desirable that the profession be diverse and representative. But the lowest social class remains hugely under-represented and we, the memory class, hugely over-represented. Do we need to rethink our biased obsession with factual ability? Do we need more geezers and fewer geeks? In defence of traditional exams, however, they are at least a measure of hard work, a medical fundamental. There is no perfect medical selection process, and it seems that change is forever unlikely. Perhaps we should try something different—a game of cards with forfeits might be the answer.

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Why many patients shouldn't be in hospital

STARTING OUT
Kinesh Patel

Rules are drummed into us from the earliest moments we are taught clinical inpatient medicine. We must see patients daily. We must check the observations chart. We must document findings in the notes. All these seem pretty sensible.

Paradoxically it is completely acceptable for inpatients not to see a doctor at weekends. And woe betide any patients in hospital when Christmas or Easter extends the weekend to four days, unless of course the team has decided in advance that the patient is unwell. Is this negligent? Surely patients who are deemed ill enough to need acute hospital care shouldn't go for 72 hours without seeing a doctor?

People who are ill enough to need care in hospital should be seen daily. But the reality is that many patients in hospital do not need to be there at all. The irony is that people in hospital for reasons to do with social care, such as waiting for a place in a care home or even waiting for their house to be cleaned, become medically unwell by virtue of being there, which in turn means they cannot leave.

There is an inexorable pressure to reduce the time that people spend in hospital. Entire departments are judged on how effective they are at discharging patients—and how often they come back. But for a third of the week nothing happens.

What keeps people in hospital for weeks is rarely medical and more often social. We have become adept at managing patients outside hospital—a prime example is intravenous antibiotic treatment at home—as long as they don't have social care needs. But this is at the price of neglecting our long stayers.

"They're still waiting for their social package," chirps the house officer. Usually that leads to a friendly wave from the end of the bed, and the ward round moves on to the next patient. Some doctors intermittently try to stamp their feet in protest but soon give up when they realise their impotence when dealing with social services.

Commands such as "Start them on intravenous antibiotics" are usually followed swiftly and without question. Orders along the lines of "Get this patient to a nursing home" tend to be ignored, because they are outside our sphere of influence.

Perhaps what is needed is to remove the NHS's responsibility for looking after people without acute medical problems, but this would reveal the huge hidden demand for social care in the community, a demand that may be impossible to meet.

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