Letter from Chennai

OUR NEW BROOM TALKS ABOUT SWEEPING
Tamil Nadu has a new medical council. For a change, we had an actively canvassed and fought election to the council, and a group of doctors who spoke much about the need to restore ethical practices in the state were elected, with Dr C. M. K. Reddy as president. The new council started with a bang, organizing a seminar on medical ethics within days of taking office. I received an invitation to attend this important meeting, scheduled for 18 October 2002, just three days before the event. It announced that there would be no less than two ministers of the Government of Tamil Nadu present, the Health Minister being the Chief Guest and the Law Minister the Special Guest, and a former Chief Justice of the Gujarat High Court would deliver the keynote address. Less than thirteen medical dignitaries would speak (3 minutes each, the invitation reassured us). Among the dignitaries I found two who I know to be running institutions that give kickbacks to people who refer patients for their services, and one connected with an unrelated donor transplant programme.

I regretted that three days did not give me enough time to get away from my prior professional commitments, and I had to miss this momentous concloure. However, I was fortunate that the meeting was covered in the city newspapers, and the News Bulletin of the PPLSS Scheme of the Indian Medical Association (IMA) Tamil Nadu. The council demanded an explanation from one doctor, who is now facing charges in the courts for running a pornographic website, and threatened to debar him from practising medicine. Apart from the fact that he does not seem keen to practise medicine anyway, I doubt whether anyone would consult him after the publicity he has received in the newspapers. I looked keenly for information on what the council planned to do about the greatest injustice being done to patients by the medical profession—the practice of seeking and accepting kickbacks for investigations. Here is what the president of the Tamil Nadu Medical Council had to say in the News Bulletin: ‘Eliminating the unethical practices by some, accepting unreasonable kickbacks from labs and scan centres…. The council is closely monitoring this issue and may be forced to step in after giving some incubation period, to initiate penal action, without regard to their seniority or professional status, at an appropriate time.’

Mr President, what is an appropriate time to stop what you yourself described as ‘this disgraceful dichotomy, which has reached unacceptable proportions’? Why do you want to incubate something which should have been eradicated years ago if your predecessors had done their duty, and that needs to be eliminated immediately to establish that you are doing yours? As Conrad put it, ‘Words, as is well known, are great foes of reality.’ The invitees were tempted with the information that high tea would be served at 5 p.m. by the kind courtesy of Comed Laboratories Ltd., Baroda. The Tamil Nadu Medical Council obviously believes it is above suspicion of any influence by the pharmaceutical industry.

Political power in Tamil Nadu alternates between the DMK and the All India Anna DMK, with everyone else an also ran. Whatever the manifesto of each party, when it comes to power it has only one item on its agenda; that is to put the leading lights of the opposite party in jail. This has been done very efficiently by our current chief minister, and was done equally well by her predecessor. We the people have to remain satisfied with the spectacle and excitement of this new game of cops and robbers. Neither party seems to remember that there is a long-suffering public which needs some service besides real-life entertainment on television. The malaise extends to the Municipal Corporation, and to the condition of our city. We, of what was then Madras, prided ourselves on the beauty of our city and the efficiency with which it provided services to its citizens. I hope you have no plans to come to Chennai, for we are going ‘high tech’. Our roads have been ripped open to lay cables for high speed internet and television communication, and then filled loosely with mud, which gets washed away in the first rain. Two-wheeler riders are especially at risk, for they can be thrown from their vehicles into the path of the city buses, which ply with reckless speed and scant regard for the comfort of their passengers or the safety of other users of the road. Crash helmets are rarely seen, and a young man on a motorcycle fell into a pothole and died of head injuries. I hope his next of kin will sue the Municipal Corporation for his murder by negligence.

The storm water drains do not drain. When it rains, they spout more water onto the already waterlogged roads. Waterborne diseases flare up and leptospirosis is rampant. Malaria is again a killer. The corporation never re-lays a road. All it does is add a thin veneer of tar on the top. Much of this washes off with the next rain, but what remains ensures that the height of the road rises. Over the years the roads have risen by a foot or more, and our gardens are therefore depressed areas. Dr Thangaraj, the Health Officer of the corporation, threatens to take action against the owner of the land on which water stagnates. And where will the hapless owner pump the water out? Not onto the road, for it entered his house from there, and will probably come back inside. Besides, Dr Thangaraj will take action if the owner does dump the water onto the road, on the grounds of health hazard again. Dr Thangaraj suggests that the owner hire a lorry and transport the water out of town.

On one or two particularly wet days in 2002, the roads were transformed into canals. Cars broke down as water entered the engines, and traffic piled up to cause enormous delays. The corporation did nothing while the heavens poured and submerged our roads and us. Now it is all over, and they have taken up desilting of the drains on a massive scale. Manholes leading to the storm water drains are open all over the city, and the unwary motorist, cyclist or pedestrian could find himself in one of them. A phenomenal amount of dirt has been dredged out of the drains, and lies on the roads, reducing the road to a narrow strip on which pedestrians must take their chances against buses and lorries. A friend with some experience of agriculture said he needed only a plough and he could grow his annual requirement of rice in the mud on the road outside his house.

Garbage piles up on our roads and pavements, stinking to high heavens. We see giant rats and their larger cousins, bandicoots, rummaging through the rubbish. My objections are not just on aesthetic grounds. I am reminded that the outbreak of plague in Surat some years ago was blamed on the insanitary conditions that prevailed in that city. Chennai is ripe for an epidemic now.

Our roads would make a roller coaster feel smooth. We have no water in our taps and a surplus under our feet. Foul smells assail us all round. We have piles of garbage and rodents galore, uncertain electric supply and telephones that pack up at the first
Letter from Croatia

WOUNDS CAUSED BY LOW-VELOCITY HAND GRENADE SPHERES

Several recent reports deal with wounds caused by modern high-velocity bullets.\(^1\)\(^-\)\(^5\) However, few reports analyse the potential of close-range shotgun discharges in causing wounds.\(^6\)\(^-\)\(^11\) Shotgun shells have a pellet load similar to that of the assault M75 hand grenade (ex-Yugoslav Federal Army Arms Factory ‘S. Rodic’ Bugojno, Bosnia and Herzegovina), which contains approximately 4000 spheres, 3 mm in diameter in a plastic shell. These shells are dangerous at point-blank range because of the small kinetic energy loss.

During the 1991–92 war, Osijek University Hospital functioned as a war hospital for the north-eastern region of Croatia.\(^12\) During the 18 months (May 1991–November 1992), 4545 injured were managed at the Department of Surgery, Osijek University Hospital.\(^13\)\(^-\)\(^16\) Among them, 25 sustained injuries by M75 assault hand grenade. We studied the hospital records of these patients (3 women and 22 men) who had a mean age of 24 years and were followed up for 3–5 months after injury. Six patients were civilians and 19 were army personnel. The mean transportation time from the site of injury to the hospital was 50 minutes. X-ray exploration was done in all patients.

Patients underwent either a limited or a formal surgical procedure. Limited surgical procedure included limited excision, wound irrigation and antiseptic coverage, systemic antibiotics and observation. Formal surgical procedure meant general anaesthesia, wound excision, exploration of the projectile path and, if necessary, opening of the body cavities (laparotomy). No attempt was made to remove pellets that were not conveniently found during wound treatment.

The mean hospital stay was 13 days for those 13 patients who were admitted to the hospital. The remaining 12 were discharged after the surgical procedure.

Four patients had a single injury and 21 had multiple injuries. Injuries of the lower extremity occurred in 14 patients and of the upper extremity in 13 patients. There were 2 traumatic amputations, both of which required surgical re-amputation. Ten patients had head injuries, and 10 had thorax injuries. There were 7 patients with abdominal wall injuries.

Six patients had penetrating injuries (body cavity penetration, explosive bone fractures, opened joints, vascular injuries), which occurred in association with head injury (3/10 patients) thoracic injury (1/10), abdominal wall injuries (2/7), and 4 of 27 patients with injured limbs had injuries of the deeper structures (2 ampu-
...tations, 2 bone injuries, 1 radial artery lesion). There were 2 brain injuries, 1 eye injury, 2 lung injuries, 1 liver, 1 spleen, 1 stomach, 1 colon and 1 diaphragm injury.

Five patients underwent a formal surgical procedure (2 re-amputations, 2 thoracic drainages, 1 diagnostic abdominal lavage, 1 abdominal exploration with suturing of the stomach and colon and splenectomy, and 1 eye operation), and the remaining 20 underwent a limited surgical procedure. Antibiotics such as penicillin, aminoglycoside and metronidazole were administered in 20 patients.

One patient was evacuated early and was lost to follow up; the remaining 24 (96%) had no postoperative complications.

Wide surgical debridement, routine antimicrobial prophylaxis and delayed closure are the principles for managing severely contaminated wounds in wartime. Since pellets leave the plastic bombshell unclustered and spread quickly, they behave as isolated, small, low-velocity missiles with small wounding potential. Even when penetrating deep into the body, they cause minimal disruption and no temporary cavitation while releasing most of the energy to the surface even at point-blank range.

Our experience indicates that the majority of low-velocity wounds by a hand grenade may be safely treated in a limited manner. It appears that penetrating injuries caused by the M75 hand grenade demand a careful, conservative surgical attitude.

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Letter from Glasgow

TACKLING SUBSTANCE MISUSE AMONG YOUNG PEOPLE: EXPERIENCES OF A MULTI-ETHNIC SOCIETY

Hello, or as they say in Scotland hawzitgaun? which translates to ‘How is it going?’ – an old, affectionate greeting exchanged between acquaintances here. It has been some time since my last ‘Letter from Glasgow’—over two years, in fact—and much has happened. Suffice to say that since my last letter, I have changed jobs, but I am still in Glasgow. However, during this time I have also been fortunate enough to have been awarded a Winston Churchill Travelling Fellowship and I will share with you some of my experiences of the Fellowship.

The Winston Churchill Travelling Fellowship enabled me to visit Canada for two months to study how they tackle the problem of substance misuse among young people in a multi-ethnic society and how we can apply their experiences in Scotland. It also provided me with a chance to learn more generally about health and healthcare organization in Canada, and a chance to reflect on how we can do things better in Scotland.

Canada’s overall health profile is very good. For example, life expectancy for women is 81.4 years and for men 75.8 years. Expenditure on healthcare in 1999 was 9.3% of the Gross Domestic Product (GDP) compared to around 6% for Scotland. Canada’s healthcare system is publicly financed but privately delivered. The provinces have the prime responsibility for healthcare (apart from some key exceptions such as aboriginal people). There is no national healthcare system but 10 provincial and 3 territorial health insurance plans.

Interestingly, as per the 1996 Census, 44% of the Canadian population reported at least one ethnic origin other than British, French or Canadian. Among the 15 largest ethnic groups are Canadians of German, Italian, aboriginal, Chinese (900 000), South Asian (750 000), Filipino (250 000), Jamaican (200 000) and Latin American (200 000) descent. Over 11% of the population regard themselves as one of the visible minority groups, which the Canadian Government defines as persons, other than aboriginal peoples, who are ‘non-Caucasian in race or non-white in colour’.4
Further, there are three constitutionally recognized groups of aboriginal people: Indians (roughly 800,000); Inuit (40,000); and Metis (mixed Indian and white heritage 200,000). The three groups have distinctive heritages, cultures, languages and religious beliefs. They collectively form about 3.5% of the population. The Indian and Inuit populations in particular have much poorer health than Canadians, and have a higher prevalence of alcohol, drug and solvent misuse problems. In addition to this, they may also have a higher prevalence of mental and/or physical health problems, and emotional and sexual abuse problems.\(^5\)

Although the licensing laws and regulations for alcohol sales and consumption are different from those of Scotland with wide variations between provinces in Canada, the striking impression about alcohol use in Canada is the similarity to Scotland. Alcohol is ubiquitous and accepted in society with its attendant problems such as alcohol misuse, drinking and driving, binge drinking and youth experimentation with alcohol.\(^6,7\) For most Canadian and Scottish adults, drinking alcohol is the norm. But drinking in excess causes problems of road traffic accident (RTA) injuries and deaths and also, indirectly, problems of poor role models for young people.\(^3\) Nevertheless, there is some evidence that in Scotland young people start to drink earlier and may have different patterns of drinking. In 1998, among 15-year-olds, 92% in Canada had tried alcohol (Scotland, 98%), 34% (Scotland, 44%) of boys and 22% (Scotland, 45%) of girls drank at least once a week.\(^9\)

The drug strategies of Canada and Scotland are similar and both countries espouse a broad-based approach to tackling drug problems.\(^10,11\) Cannabis appears to have become part of the youth culture in Canada as well as among some groups in Scotland. The use of drugs such as heroin and cocaine vary among young Canadians and both have serious short- and long term health and non-health problems for young people who use them. In both Canada and Scotland, the use of illegal drugs appears to be higher than figures for European countries.

With this diversity of population, the impact of alcohol and drugs in Canada is different for the various ethnic minority groups. For example, it is only now that strategies, with the support of federal and provincial governments and aboriginal communities, are beginning to provide effective de-addiction services within the context of wider socioeconomic change.\(^12\) A number of key issues have been identified for aboriginal and visible minority groups and these include:

- The deep-rooted problem of racism against both aboriginal and visible ethnic minorities;
- The issue of whether to develop specialized services for specific groups versus the need for all mainstream substance misuse services to deal with all their clients;
- The dearth of research and lack of consistent and comprehensive information on substance misuse in ethnic minorities;
- The need to integrate traditional aboriginal approaches and best practices in conventional substance misuse treatment and develop a holistic approach;
- Incorporating both traditional healing practices and providing access to a full range of treatment programmes and approaches, including harm reduction;
- Involving aboriginal people directly in planning, developing and delivering treatment programmes and services;
- Addressing the needs of young aboriginals on reserves and in cities, where homelessness compounds the problems;
- Alcohol misuse in Toronto and Vancouver among young Punjabis;
- Heroin use among Chinese youth;
- Khat misuse (a plant chewed for its amphetamine-like effect) in young Somalis; and
- Crack cocaine use among young African-Caribbeans.

In Canada, a start has been made to develop effective services to tackle substance misuse among youth belonging to ethnic minorities within a wider context of public health strategies and socioeconomic development. There is an aboriginal proverb in Canada, ‘It takes a whole community to raise a child.’ In a nutshell, that sums up what we have to do in Scotland to tackle alcohol and drug problems—use a broad, community development approach, bring together different agencies involved in substance misuse to provide effective services, and deal with the underlying reasons for substance misuse among young people belonging to ethnic minorities such as poverty, lack of education and training opportunities, unemployment and racism.

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