provinces) showed that more than half the population in the region are rural dwellers. In 8 of 17 clinics which serve 500,000 of the African population, there were faulty stethoscopes, broken or inaccurate blood pressure cuffs, incorrect weighing scales, no phones or electricity, and no usable two-way radio equipment. Refrigerators for drugs worked on gas, but only when the gas was delivered. ‘Nurses hitch-hike lifts with goods delivery vans and their working hours are regulated by this.’ Supervisory clinic inspections take place 3 times a year at best. Forty mobile health clinic stations around Umtata were not functioning because the buses had broken down. Only one-half to three-quarters of the operating theatres in tertiary hospitals were functioning because of a dire shortage of nurses. At the large Cecilia Makiwane Hospital in Mdantsane, a shortage of 148 nurses permits the use of only 900 of the 1200 available beds. Similarly, in Mount Frere Hospital, in the city of East London, only 690 of the 900 beds are occupied, because of a shortfall of 150 nurses. In this ‘very unhealthy province’, unemployment stands at 48%, and more than 18% of the population are believed to be HIV positive. Only 52% of children have been immunized (nationally: 62%–64%) and the infant mortality rate is 61 per 1000 live-births (nationally: 45 per 1000).

In South Africa as a whole, the general health situation in the year 2000 is better than that described in the review published in 1995. Of course, outstanding problems still exist. According to health managers, the retention of skilled staff, doctors and nurses, is a major challenge. One-third of the hospital facilities need replacement or repair. Yet, turning to vital statistics, in the populous African city of Soweto, adjacent to Johannesburg, the infant mortality rate has fallen to a mean of 20 per 1000 live-births. The survival of the national African population has reached a mean of 63 years (equal to that of some of the poorer populations in Europe).

Sadly, in South Africa as a whole, the disastrous HIV/AIDS epidemic, despite improvements, is likely to take its toll. The infant mortality rate is expected to rise soon, and survival is likely to drop to 40–45 years. It has been predicted that half of our African children are likely to die of HIV infection, and half the adults will die from related causes—a situation which already prevails in neighbouring Botswana. It has been estimated that should all the presently affected patients at Stages 3 and 4 be treated with triple antiviral therapy, the annual expense incurred by 2010 would be three times more than the annual total South African public health care budget. As has been stressed, restraining further rise in the HIV/AIDS epidemic will greatly depend on the level of response of individuals to ‘the Government’s “ABC” strategy—to abstain, be faithful, and to use condoms’.

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ALEXANDER R. P. WALKER

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**Letter from Chennai**

THE ETERNAL DEBATE: LAKSHMI VERSUS SARASWATI

Mr Arct N. Veeraswamy, Health Minister of Tamil Nadu, laid the foundation stone for yet another medical college, the Kanyakumari Medical College, on 12 March 2001. I have often referred in these letters to (i) the disparity between the views of the Planning Commission and the Government of Tamil Nadu on the number of medical colleges we need, (ii) the fact that the government keeps building new ones when it lacks adequate staff at its existing colleges to satisfy the requirements of the Medical Council of India, and (iii) the lack of adequate finances to keep the medical college buildings in good repair. The minister said that he expected a loan of Rs 6.5 billion from the World Bank, and, as soon as the money arrived, he would improve all the *taluk* hospitals in the state. He said the health care system in Tamil Nadu is the best in India. If that is true, the plight of poor Indians dependent on government medical facilities in other states is indeed pitiable.

I do not mean to go into that argument again. The minister casually slipped in what I thought was his most significant statement. He said that in a government order dated 9 March 2001, the government had permitted non-clinical doctors to do private practice. I understand that under the British Raj all doctors in the department in which they worked, by the time I entered the service, only those holding clinical posts were so privileged. All those in non-clinical teaching departments, and those in administrative posts, were denied the right, and were given a non-
practicing allowance, the amount of which was laughable, and in no way compensated for what they could earn in practice. As a result, fewer and fewer doctors opted for non-clinical services. Only a minority of the physiologists, pathologists or pharmacologists were driven by a burning desire to do research. Some had failed postgraduate examinations in clinical subjects and wanted to remain in the city till they passed at a subsequent attempt, some wished to stay in the city for domestic reasons, and some wanted to keep their evenings free for their family. Anyone who wanted to make a career in the medical profession took to clinical disciplines, whose adherents were permitted to practise. The service of Saraswathi (Goddess of Learning) was admirable in theory, but the medical profession had shifted its allegiance to Lakshmi (Goddess of Wealth). The government specified that it should be a consultation practice but, since the term was never defined, it allowed the doctors to do anything they wished, including performing surgery, conducting deliveries and administering injections. The government demanded that no doctor in service should own a nursing home or a dispensary; consequently, many spouses became owners of such medical business establishments.

The full-time system was devised to satisfy the educational ideal that a teacher’s salary should be large enough to relieve him of any reason to supplement it by seeing private patients. The teacher’s ability and time should be placed entirely at the service of his students and of the patients entrusted to his care as a teacher and investigator. What is the appropriate level of remuneration for a full-time non-practicing doctor? The security of the full-time system, the facility provided to lead an academic life and do research, and the prestige traditionally associated with teaching are clear compensations for the fact that, all over the world, full-time salaries are substantially lower than what a leader of the profession could make in practice. However, the difference should not be so vast that the world and the teacher himself feel that he is a fool to continue in academia.

Salaries in Tamil Nadu were always meagre. However, since the service rules permitted practice, and since the rules could be bent enough to allow the government doctor to do almost anything in private, many doctors enter the Tamil Nadu Medical Service because it provides them the best of both worlds—the prestige of teaching and the ability to influence young minds on the one hand, and the wealth of practice on the other. Since this did not apply to non-clinical doctors their numbers dwindled and it became necessary for the government to accept non-medical scientists as teachers of the basic medical disciplines. But for some years the vagaries of government service have kept them away too and there are now few takers for these posts. Allowing, say, the Professor of Anatomy the right to practice should balance the scales to some extent.

Is it a bad thing to allow these teachers to spend their evenings in private clinics? Those who think so will point to the fact that they should spend those evenings learning more about their field of work, or perhaps in the laboratory advancing the frontiers of medical knowledge. On the other hand, having been forced, when I was a student of pharmacology, to study a host of medicines which had not been used for some decades (kurchi alkaloids, pelletierine tannate, and the like), I feel the Professor of Pharmacology who actually uses the drugs he teaches about will be better qualified to convey the right information to his students. William Osler was appointed pathologist to the Montreal General Hospital in 1876, and physician to that hospital in 1878. At McGill, he taught physiology, pathology and medicine. There is still a tradition in some foreign universities for teachers to simultaneously hold posts in clinical and basic sciences. Tamil Nadu may not climb to the pinnacle of scientific excellence as a result of this decision, but at least there are likely to be teachers to take classes for aspiring medical students.

NOT A DROP TO DRINK

Chennai faces a dry summer. The north-east monsoon was a miserable failure and contributed barely a week’s supply of the city’s needs. The population of the city grows and grows, but we remain dependent on the same lakes which have supplied us for all of the last century. On 15 February 2001, we were reassured by the Managing Director of Metrowater that the combined storage of the city’s reservoirs was 1379 million cubic feet (mcf). Since our requirement was 47 mcf per week, it seemed that we had enough to last us till the next monsoon in July. But even if we do not drink more water in summer or bathe more often, does not more water evaporate from the surface of the lakes? The only addition to the water supply of the city has been the much touted Krishna water scheme, thanks to the largesse of our northern neighbours in Andhra Pradesh. Will this last through the summer?

Despite the assurance provided by Metrowater, we, the people, are not so confident. I used to get water for three hours every night. I now receive that supply once in three days. We have a thriving industry in water supply by lorries. Many operators draw water from wells in villages around the city, transport it in lorries and sell it to the citizens of Chennai. There are problems. The lorry drivers are paid on the basis of the number of trips they make each day and, consequently, they are the most feared users of the roads. Speed limits are not for them. Water is heavy, and the laws of physics make a heavily laden lorry driven at a high speed a fearsome object, impossible to halt within short distances, and these lorries are involved in more accidents than any other type of vehicle. Perhaps a greater danger is that the water they draw is that which the villagers use for agriculture; as a result, their livelihood is threatened. Since we are on the sea coast, there is the constant fear that salt water may find its way into the water table, and irreparable damage may be done. District authorities have deployed police constables to guard the rural wells and levy a penalty for every offence, but it is apparent from the movement of water lorries in the city that this does not seem to be working. Every official has his price, and with a lorry load of water selling for Rs 750 or thereabouts, and, driving fast enough, the possibility of eight round trips in a day, this is hardly a deterrent.

The Managing Director of Metrowater, Mr C. P. Singh, is in the news every day. However, apart from asking us to abjure extravagance in the use of water, he offers little hope of concrete steps to improve the position. One of the things he wanted us to do was to harvest rain water to replenish the water table. His appeal pricked my conscience. I have complained about Metrowater for years but done nothing to help the water supply myself. Here was an opportunity. Metrowater announced that it has a web site which gives a list of approved contractors to implement rain water harvesting and has even published a chart of approved rates. I found both at www.chennaimetrowater.com. There were 36 approved contractors, the tariff did not seem too heavy and I called up the one nearest my house. He fixed an appointment, but did not turn up. I called him again and fixed another appointment and again he did not come. So I moved to another, and another. I have had six worthies make appointments twice each and fail to keep them. I hope I will have something installed before the next monsoon. Perhaps the publication of the tariff was a mistake. If the
Substance Use Disorder: A Manual for Physicians. Rajat Ray (ed). Drug Dependence Treatment Centre and Department of Psychiatry, All India Institute of Medical Sciences, New Delhi, 2000. 198 pp, Rs 125.

In the context of increasing drug and alcohol abuse in India, this manual is timely and relevant. The contributors to this book belong to different medical schools in India, and the editor has wide experience with a specialized programme on the treatment of drug dependence in Delhi. The book is targeted at 'General duty medical officers', presumably from the government service in India. Yet the style of presentation of this book is more appropriate as a 'Resource material for trainers' rather than a quick reference for the general duty doctor. The chapters even give suggestions for the formats of slides and an overhead projector, which are useful for those teaching the subject.

There are 16 chapters in this book; a fair attempt at covering the subject comprehensively. However, this attempt has made many chapters over-inclusive and less reader-friendly, while others retain a crisp presentation of relevant material. The production quality is poor, and the smudged letters, poor quality of paper and desk editing, could have been avoided to make it more presentable and marketable at the quoted price. In spite of all its shortcomings, the book would be useful for those teaching this subject as well as general duty doctors, because much of the information relevant to India presented in the book is not easily accessible.

Many chapters in this book are specific to India, and reflect the views of government programmes, but do not necessarily relate the different practices in the country, especially in areas which have a strong presence of non-governmental organizations and traditional practitioners. This bias has influenced chapters such as 'National programme', 'Community-based treatment', and so on. However, the information in these chapters is also not easily accessible from other published documents and is thus valuable for policy-makers. The chapter on 'National laws to control drug abuse' is useful for physicians, policy-makers, and all others involved in the intervention for substance users, because they are seldom found in an easily understandable format in any of the available documents. The chapters on 'Epidemiology of drug abuse' and 'Aetiology of addictive behaviour' could have been shorter and restricted to the most useful information relevant to the general duty doctor. The general duty doctor involved in acute institutional care will pay little attention to these chapters as well as those on 'Monitoring trends of drug abuse' and 'Prevention of drug abuse', which are predominantly theoretical.

Several chapters dealing with the principles of and issues...