ART

The embodiment of art

Tate Modern, Bankside, London

There were bodies everywhere at the Tate Modern on May's bank holiday weekend, not only hanging on the gallery walls but streaming through the entrance in vast numbers. The doors were closed to visitors for a while, perhaps the first time that crowd control has been needed in a public art space.

The Tate gallery's 20th century collection, housed in a disused power station on the banks of the Thames, has been divided into four broad themes—"Landscape, Still Life, History, and Nude/Action/Body." Entering the gallery through the vast and physically imposing turbine hall, our own bodies seem incredibly small. Other humans seem tiny as we rise above them on the escalators to "Nude/Action/Body" on level five, a cultural hall of mirrors reflecting how artists have looked at the human figure.

Just outside the entrance is Rodin's *The Kiss*, the art world's most famous embrace and probably one of the last great manifestations of the academic nude. Once inside, we see the body remixed and reworked by artists and shown in arresting and complementary juxtapositions. The tactile sensuality of Matisse's bronzes is beautifully matched by the inky washes of Marlene Dumas.

TATE MODERN: COLLECTION 2000

Modern bodies at the Tate: Picasso's "The Three Dancers" (1925)

Among the obvious human figures by Picasso and De Kooning, there are more oblique references to the body in the paintings of Barnett Newman. His immense flat fields of saturated colour engulf the viewer, and we are momentarily lost.

In the 1960s and '70s the body became not only the subject of art but also its medium and terrain. This period is represented by Bruce Nauman's human fountain and the relics and props used by Rebecca Horn in her performance art, exhibited as a forlorn display of objects in need of a body to bring them alive.

More recent works question our attitudes to the naked human form. How do we really look? What do we see and how can this be described? In Sam Taylor Wood's video *Brontosaurus* we see a naked man dancing, projected larger than life on to a huge wall. He is completely absorbed in dance music that we cannot hear. Instead, the gallery is filled by a classical symphony. This is a mesmerising image of a body both vulnerable and strong, and it takes ages before we notice the tiny toy brontosaurus in the video.

Bill Viola's *Nantes Triptych*, shown here as part of a temporary exhibition called "Between cinema and a hard place," is one of the most compelling works in the gallery. Two huge video screens show us real images of the beginning and the end of life. In between, a third screen shows a soft, ethereal image of a figure submerged. The figure floats, drifting in a transient passage between the two. As Hippocrates reminds us, "Art is long, but life is short."

The works at Tate Modern bear witness to our insatiable fascination with the human body, and they reflect both past and current concerns. The body has never been more important than now. We see this in art that mirrors modern science, and in artists reconsidering the body as scientists update its constitution. We are almost in possession of another kind of portrait, the genetic blueprint of humankind. We cannot escape thinking about how we look and are looked at, since the media bombard us with advice on how to sculpt and surgically alter our own bodies.

This collected representation of the body in art, and the art of the body, is a timely and intriguing reflection of shifting preoccupations and emergent visions.

Joan Beadle *senior lecturer in fine arts, Manchester Metropolitan University*

Dishing the dirt

Eat Dirt, Channel 4,
20 June at 9 pm

Eat Dirt, Channel 4's recent documentary on asthma, tackled the science behind the rise in this disease in the West. The crucial cause, it suggested, is dirt—or rather the lack of it in our daily lives.

Starting with a historical perspective, the programme linked the dramatic fall in infant mortality over the past century to a reduction in overcrowding, cleaner water, and better sewage facilities. It then showed how, more recently, the advertising industry has pressurised mothers into believing that cleanliness is next to godliness and that their children need protection from the bugs lurking everywhere. The need "to kill all known germs dead" is screamed from billboards, radios, and televisions.

Just as there has been a trend towards an environment containing fewer microbes, an opposite trend has appeared in the number of people who have asthma and juvenile onset diabetes. This rise in the incidence of asthma cannot be explained by genetics alone, since it occurred too quickly—so it must reflect environmental changes.

For a while, many scientists thought that an increase in asthma must reflect increasing exposure to pollution. But the reunification of Germany, with the realisation that the polluted East had lower levels of atopic disease than the less polluted West, soon put paid to this idea.

A new theory emerged: the "hygiene hypothesis." *Eat Dirt* charted, with amazing accuracy, the environmental studies that led to this elegant explanation. These were described with clarity by those who did the original research.

Viewers saw how living in close proximity to animals might protect humans from developing atopic diseases. Such protection, the programme suggested, might also arise from 20 people living to a house in West Africa. Antibiotic use, especially in infancy, might be associated with a higher prevalence of asthma later in life. Similar evidence showed that the hypothesis might apply to juvenile onset diabetes—the greater the number of infections, the greater the protection against developing the disease.

The European specialists were the stars of the programme. Perhaps this reflected their pre-eminence and intellect, and their role at the cutting edge of research into the role of infections in the causation of asthma and diabetes, and the use of vaccines in the treatment of multiple sclerosis and cancer.

They also had wonderful presentation skills. Either these coexist intrinsically with an interest in this particular subject, or Channel 4's researchers are particularly adept at discovering the best academics to interview. Thus a learned microbiologist, explaining how an immune system underchallenged by infection might attack pollen or house dust mites, talked of "the immune system going looking for a fight." The same academic later explained how bacteria couldn't jump from a contaminated phone handset because "bacteria don't have wings."

CHANNEL 4

A filthy kitchen looks like a health hazard, but it may protect you from atopy

We were encouraged to accept that exposure to a little dirt might be good for us. Or, in the words of the microbiologist, "If we didn't see all the good *E coli*, we would get a lot sicker when we saw the bad ones." When it comes to cleaning the house, perhaps less is more? The programme illustrated this beautifully by reconstructing a kitchen complete with filth—not a health hazard, but an opportunity to gain protection from atopy.

About halfway through, the programme began to meander, and I wondered how they would bring it to a close. We know that the optimal length of a lecture is about 20 minutes. Do programme producers know how long they can keep their viewers' attention on such difficult concepts? Stretching the data out over 60 minutes was probably a mistake.

When I have tried to explain the hygiene hypothesis to journalists, the reply has been, "So everyone should go back to having diarrhoea in infancy?" This programme did rather better in explaining the concepts to a non-medical audience. It also ended well, discussing some of the speculative work on the role of vaccinations, especially BCG and mycobacterium, in preventing asthma and other diseases. The brief asides, discussing terminal skin cancer and multiple sclerosis, were rather superficial and an unnecessary diversion.

Martyn R Partridge *consultant physician, London*

WEBSITE OF THE WEEK

Asylum seekers This week the *BMJ* considers the health of asylum seekers, which, unsurprisingly, is problematic. "There is no greater loss on earth than the loss of one's native land." So begins the site of the United Nations High Commissioner for Refugees (www.unhcr.ch/), with a quote from Euripides. Not having read Euripides in the original (though of course, there's nothing to stop me: classics.mit.edu/Browse/browse-Euripides.html) I don't know whether this was a reference to the experience of exile or displacement from agricultural land.

In Britain, the contemporary debate is dominated by the distinction between "economic migrants" and "genuine refugees." Access to the economic literature that lies behind the jargon lies at ideas.uqam.ca/ideas/data/JEL/F22.html. Few of the articles are available in full text, but just skimming the titles and abstracts is informative. Migrants invest in "language capital" and lead transnational lives.

Officials who attempt to make the distinction between migrant and refugee no doubt have a difficult task, but Britain's current policies are explained on a well designed Home Office site (www.homeoffice.gov.uk/ind/asylum/asylum_home.html), which explains Britain's current legislation, clearly designed to ensure that there are no financial incentives to being a refugee. There is a country by country guide to the 35 countries from which Britain receives most asylum applications; the explanation of the conditions that lead to refugee applications makes for harrowing reading.

The International Organisation for Migration (www.iom.int/) attempts to bridge the gap between the refugee and migrant policy: plainly the long term answers to such problems are to end the human rights abuses and wars that lead to forced migration.

Most British doctors will probably be most interested in the issue when they have patients to serve who fall into this category. The Refugee Council of England has an acceptable one page site with an address, phone number, and a little introductory information (www.gn.apc.org/brcslproject/), but if you want more than this, you'll have to write to them.

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PERSONAL VIEW

Looking after the health of refugees

Fifteen years ago I came to the United Kingdom as a political refugee from Eritrea. I remember feeling extremely vulnerable. I had lost my home, my family, my friends, my job, and my social status. I knew nothing about the healthcare or social welfare systems, and, even though I had the advantage of a good education and spoke English, it took me a long time to understand them. I received no information about the health service and was not invited to register with a general practitioner. Despite coming from an area with a high prevalence of tuberculosis I was not offered a health check on arrival.

My experience is certainly not unique. There are over 48 million refugees in the world today. The majority seek protection in neighbouring countries, largely in Africa and Asia, but an increasing number are coming to western Europe, including refugees from former eastern European countries. There are now over 300 000 refugees in the United Kingdom, and there has been an increase in the number of people applying for asylum each year—from fewer than 2000 in the mid-1980s to more than 40 000 in 1997.

In common with most western European countries and the United States, the United Kingdom requires asylum seekers to demonstrate that they have been personally targeted for persecution in order to quality for refugee status. This strict interpretation of the 1951 United Nations convention on the status of refugees is reflected in a high refusal rate. In 1997, 76% of applications were rejected.

Refugees face health problems similar to those of other deprived and ethnic minority communities, as well as specific health problems from the physical and mental after effects of displacement and social isolation, war, and sometimes torture, and communicable diseases, of which tuberculosis is the most important. The growing scale of the problem has prompted the European Commission to look at refugees' health needs, and its report will be released in the autumn.

It is estimated that 85% of refugees in the United Kingdom live in London, but local services are often poorly equipped to meet their health needs. From the moment they apply for asylum, refugees are eligible for health care under the NHS. However, poor knowledge of the system and language barriers limit their access to services. Interpreters are often unavailable, and even when they are present it can be impossible for refugees to explain complex health and social problems during a brief consultation.

More than half of the cases of tuberculosis in London occur in people born outside the United Kingdom, but the current screening system reaches only a small minority of new entrants. About a half of asylum seekers declare themselves on entry and are given a medical examination and a chest *x* ray examination. Only a quarter of these are notified to the consultant in communicable disease control in the health authority of intended residence, and only a small fraction are followed up to rule out tuberculosis.

Not only is this process flawed, it is also stigmatising. It has more to do with protecting the indigenous population from an infectious hazard than promoting the health of new arrivals. What is needed is a better way of identifying them and a more comprehensive health assessment that includes an introduction to health services and an explanation of their rights and responsibilities.

> Eighty five per cent of refugees in the United Kingdom live in London

Although the arrangements in London are far from ideal, the city does have the advantage of a long history of settlement by new immigrants. Health and social care providers have made efforts to develop services to meet the health needs of refugees, and there is a network of informal support among the diverse cultures in the city. The 1999 Asylum and Immigration Bill, which is going through parliament at present, proposes to disperse refugees to other parts of Britain and to substitute income and housing benefits for vouchers and support in kind.

Although income and housing are priorities for refugees, a sense of community is also important. There is a risk that they will choose to return to London even at the expense of living outside the official welfare support system, which would compound the effects of deprivation and leave health and social services to deal with the resulting poverty, unemployment, overcrowding, and homelessness.

Refugees' health is discussed in a report from the Health of Londoners Project which was published earlier this year. This makes recommendations about facilitating registration with primary care, strengthening translation and advocacy services, and improving initial health assessments.

As long as there are conflicts in the world and as long as the divide between the rich and poor countries exists, people will continue to flee persecution and poverty. I hope that we are able to treat them with care and dignity.

Yohannes Fassil *community health development manager, Kensington, Chelsea and Westminster Health Authority*

SOUNDINGS

Student feedback

The medics' revue is a tradition that does not stand still. Compared with our own efforts as students, today's shows have more sophisticated backing tracks, more gender equality, and much more bumping and grinding (all of it from the male members of the cast). The comparison is memory based, however, not evidence based. Ours was a pre-video generation—something that causes me mingled regret and relief.

Today's performers seem so confident, with their synchronised dance routines involving all four limbs and their benign responses to heckling colleagues. The targets hardly change but the satire can still be original. This year an offstage voice announced a preclinical lecture: a Chinese student stood gravely at a lectern and spoke in fluent Cantonese, with the occasional insertion of "immunology … T cell … cytokine…"

As a senior member of staff you enjoy the obvious jokes, like the dean's face on the sun rising above the Meditubbies, but you sense that others are passing you by. Young teachers whom you regard as rather trendy are lampooned because their clothes are out of fashion. You smile uneasily.

But it goes deeper than dress sense. The students are cool. The Ali G lookalike appeared last year but not this year. The humour is post-ironic and post-stereotyping: "Aren't you from Ethiopia?" "No, I'm from Sri Lanka. It's just that I've shaved my head." What on earth must these knowing undergraduates think of our clumsy attempts to teach them correct attitudes?

For the staff, the revue provides better feedback than a sackful of questionnaires. This comes less from the scripts than from audience reaction, as some remarks are greeted with a roar of the laughter of recognition. It tells you a lot about other people's teaching styles, though the most spectacular response is when female students name a would-be Don Juan.

An annual jab of disrespect should be compulsory for everyone, particularly those of us whom overconfidence could otherwise lead into danger. The BMA would benefit—but who would put on the show?

I left happy, and not just because I had been sung about by a bowtie-bedecked chorus. There is something life affirming about people putting heart and soul into doing a thing well. And about a virtuoso trumpeter. As Ali G might say, it gives you hope for da future and dat's good, man, innit?

James Owen Drife *professor of obstetrics and gynaecology, Leeds*