

book reviews

Racism in medicine: an agenda for change.

Edited by Naaz Coker. King's Fund Publishing, London. 252pp. £15.99.

The founding of the NHS in Britain in 1948 was based on socio-political forces which recognized that equity in access to prevention and treatment of ill health was the right of all its citizens. It reflected the culmination of the idealism and humanity of a people who had led and won a hard-fought global struggle against undemocratic and racist regimes. No doubt the people of Britain were also at this time coming to terms with the inevitability of the loss of their Empire. It is doubtful, however, if anyone foresaw the consequences of the gravitational pull of the NHS as a major public service employer on Britain's former colonial subjects, making it an arena where racism would become an issue. This book is a collection of papers documenting the evidence that at the close of the twentieth century the NHS was experiencing attitudes and practices stemming from racism, and offers an agenda for action to eliminate the consequential discrimination that puts immigrant citizens at a disadvantage.

Rational analysis of racism in the NHS requires evidence based on well-enunciated definitions of terms such as race, culture and ethnicity, as well as facts and figures. I found that this analysis was well presented, with use of relevant information from a wider social context. In these times, the prevalence of racist attitudes in the NHS is hardly surprising, given that a 1997 study carried out in Britain revealed that 20–26% of white people said they were prejudiced against Asian, Caribbean and Muslim ethnic minorities. Neither should it be surprising to learn of the racial discrimination and harassment felt or perceived by these NHS workers, or aspiring entrants to a medical school, given the tension in the wider community which is daily fuelled by widely-publicised events involving ethnic minorities such as inter-personal violence and pressure on social services. As an aside, it is of interest to observe that although non-white doctors suffer from under-representation at the consultant level, particularly in the most popular specialties, so do white women doctors relative to the total numbers of both in the total workforce.

The personal experiences and indignation reported by a second-generation Muslim doctor from the Indian subcontinent who has chosen to work as a general practitioner and engage in medical politics is a poignant example. However, is this experience, representative only of non-white doctors, all that different from the struggle of white people with a Jewish background, or women in medicine in our society of the previous – and some would say of the present – generation? Is racism essentially a war between the 'haves' and 'have-nots' to maintain the status quo, rather than a question of colour and cultural differences? These and many other issues are raised by the contributors to the book, who are themselves embedded in the NHS as practitioners or social researchers. The

need for a deeper understanding and ongoing attention is well argued.

Having established that racism in the NHS is principally directed against non-whites, the book examines the legal, governmental, personal and political solutions that are being applied to overcome the worst consequences of racism in the NHS. It is too early to say how successful they will be, especially for future generations of the immigrant community who wish to be integrated or assimilated into Britain, but who still feel alienated. A successful outcome overcoming racism in the microcosm of the NHS could be a paradigm for the nation as a whole.

The book is a timely source and review of information and reading, especially for policymakers in the public and private sectors and senior administrators of the NHS, as well as members of professional, regulatory, and university bodies with management roles who daily encounter people from diverse ethnic and cultural backgrounds. Rabbi Julia Neuberger's comments in the introduction to this book are worth quoting: 'It is enormously difficult to make significant changes to long-held assumptions and age-old ways of working. It takes up time that hard-pressed people working in health care can ill afford to commit. Without that time and effort, though, our health system will always be failing to meet its core values and ambitions.'

RN MAINI

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The resourceful patient.

By JA Muir Gray. eRosetta Press, Oxford. 160pp. £14.50.

According to the blurb on the back cover, 'Medicine needs revolution, not reorganisation, and the health service should revolve around the patient'. This is a handbook for (very literate) patients who want to participate fully in their own health care. The titles of the four main sections – '*The rise and fall of the Medical Empire*', '*What do doctors do all day?*', '*Skills and resources for resourceful patients*', and '*The new medical paradigm*' – give a reasonably good idea of what the book is about.

It is a hybrid book, published simultaneously on the web in hypertext (www.resourcefulpatient.org) and on paper as ordinary text. A hybrid book differs from a website in that it is designed to be printed. This will apparently 'be done on demand which does away with the need to calculate a print run or have a warehouse full of stock'. The publishers also claim that 'the text can be changed regularly twice a year without the need to pulp paper'. So far so good and I understand from my regular computer magazine that sales of e-books and visits to their websites doubled in the first half of 2002 after a very rough year in 2001.

The text is cut up into small chunks because, 'Jakob Nielsen, one of our gurus, has found that people don't mind clicking but they

hate scrolling'. In practice this leads to a staccato style and makes it read like an exam notes book. Clicking on an underlined word (here italicised) in the online version leads to a web page. Thus, one discovers that Jakob Nielsen is 'the web usability czar' and the page to which one is directed includes a photo of him which can be downloaded. Clicking on Paul Starr's *The social transformation of American medicine* leads to the Amazon site where 'our price is £17.50' but 'we are unable to offer this title'. Clicking on *Emma* leads to Amazon again but clicking on the author leads to the Jane Austen information page. Clicking on *David Halberstam* leads to a site operated by a firm called Royce Carlton who can organise that he (among others including Kay Redfield Jamieson, Oliver Sacks, Susan Sontag, Terry Waite and Jonathan Miller) come and give a talk to your organisation. Some of the links are simply distracting. To explain the attraction of complementary medicine, Muir Gray suggests that patients in some orthodox hospitals feel 'just like a

number in a huge machine as awesome and impersonal as the *Metropolis* of Fritz Lang'. It is not clear to me why the resourceful patient should wish to know about a classical German film maker. I often find excessive referencing in medical history articles irritating, but these web links are references gone completely mad! It was a surprise to find that St Peter was not underlined in the following sentence: 'The doctor is expected to act like St Peter, holding the keys to illness, to unlock the door through which many wish to pass.' Perhaps he doesn't have a website?

The resourceful patient would find quite a lot to interest and educate him in this book if he could avoid being distracted by the web links. However, he would probably be equally well informed by reading a broadsheet newspaper every day and watching a few episodes of the American television drama *ER* (which is quoted twice with a web link).

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letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by e-mail to: Clinicalmedicine@rcplondon.ac.uk.

The use of oxygen in acute exacerbations of chronic obstructive pulmonary disease: a prospective audit of pre-hospital and hospital emergency management

Editor – The paper by Denniston *et al* (*Clin Med* September/October 2002, pp 449–51) strengthens previous evidence that patients with AECOPD are frequently given uncontrolled oxygen therapy which may cause respiratory acidosis. A majority of their patients (and ambulance crews) did not identify COPD as the cause of the patient's breathlessness and BTS Guide-

lines were not followed when COPD was correctly identified.

Because of similar problems in the North West Region, a North West Oxygen Group was formed to produce regional guidelines for emergency oxygen use in AECOPD and other causes of sudden breathlessness. The North West Oxygen Guidelines were agreed by the Regional Societies of Respiratory Physicians, Emergency Physicians and ICU specialists and published in the *Emergency Medicine Journal*.¹ These Guidelines are based on a review of the literature concerning the relative dangers of hypoxia and hypercarbia.² The guidelines aim at a target oxygen saturation of 90–92% for COPD patients treated in ambulances and on arrival in emergency departments prior to the availability of blood gas results. This will prevent most cases of hyperoxia and acidosis. One further issue is that patients with AECOPD are usually given oxygen-driven nebulised treatment in ambulances. The empty nebuliser chamber (with high flow oxygen-mask) is often left in place for long periods of time and may contribute to hyperoxia and acidosis. We have suggested that nebulised treatment should be limited to six minutes in these circumstances.

Like Denniston and colleagues, we are piloting a COPD alert card for patients with previous episodes of respiratory acidosis for whom a lower target oxygen

saturation may be appropriate. These Guidelines have been approved by the Clinical Effectiveness Committee of the British Association of Accident and Emergency Medicine.

I can supply coloured flow-charts summarising the North West Guidelines together with a copy of the COPD Alert Card to any readers of the journal who wish to send me an e-mail at the following address: ronan.o'driscoll@srht.nhs.uk

References

- 1 Murphy R, Mackway-Jones K, Sammy I, Driscoll P *et al*. Emergency oxygen therapy for the breathless patient. Guidelines prepared by North West Oxygen Group. *Emerg Med J* 2001;**18**: 421–3.
- 2 Murphy R, Driscoll P, O'Driscoll R. Emergency oxygen therapy for the COPD patient. *Emerg Med J* 2001;**18**: 333–9.

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Editor – We agree with Denniston *et al* (*Clin Med* September/October 2002, pp 449–51) that the use of uncontrolled oxygen therapy in patients with acute exacerbations of chronic obstructive pulmonary disease (AECOPD) is common. The authors indicate that they are investigating the use of a COPD card to be held by the patient. We gave a wallet-sized