gynaecological examinations, abortion or sterilisation, or the examination of female patients. Doctors working with diabetic patients in south London would need to know that around one-third of black African or Caribbean patients use herbal medicines, that one in five of them believe blood tests to be harmful, and many use laxatives (or occasionally colonic irrigations) to improve their health.[9]

Patients' understanding at times may also be impaired: a recent study of anticoagulant therapy, including European, Indo-Asian and black African and Caribbean patients, pointed to a gap between patients' knowledge and the doctor's perception of what the patient knows. The authors of this study observed that patients' religious faith and dependence on God probably influenced both their adherence to treatment and to the understanding of the nature of their illness and medication.[10]

So there are still many patients of ethnic backgrounds who are apprehensive and frightened when they approach a doctor of a different background whom they may not trust. Furthermore, the doctor himself may not perceive potential difficulties in interpreting the patient's presentation. Eshiett and Parry in their article make some valuable recommendations for the way forward which need to be examined carefully and acted on in the foreseeable future. Those of us working in our major inner cities have much to consider and learn.

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CORRECTION

The editorial entitled 'Nuclear medicine and the physician' by Peter Ell and Henry Gray, published in the previous issue of this journal (Vol 3, No 2, 2003), had also appeared in two separate parts in *Nuclear Medicine Communications*,[1,2] and was reproduced by permission of the editor of that journal. We apologise for omitting to state this.

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2. Gray HW. The report Nuclear medicine and radionuclide imaging: a strategy for provision in the UK. *Nucl Med Commun* 2003;**24(4)**:349-50.