

line the fact that hospitals are heterogeneous organisations with varying performances by different departments. Equally, there are real difficulties about capturing patients' experience, a dominant theme in the commission's approach. The commission has experimented with organising meetings and using patient diaries, but low response rates cast doubt on the representativeness or otherwise of the views collected. Clearly, as the commission is aware, more experiments will be needed to devise more robust methods.

But in one crucial respect the reports from the commission bring reassurance. The review teams—consisting of a doctor, a nurse, a manager, a lay person, and a clinical professional such as a therapist—examine not only the formal processes of clinical governance and audit. They also dig deeper into the organisation, interviewing front line staff to see how organisational policies work in practice. The answer is that very often they don't. Clinical audit is often fragmented, lacking an overall strategy and feedback; information systems and routine data collection are often inadequate; the system of clinical governance can fail to reach the rank and file. Similarly, the teams examine staffing levels and the delivery of services, identifying shortcomings in both (though the lack of generally accepted benchmarks for staffing levels means that the reports tend to be tentative in their conclusions on this point). Familiar problems are identified: problems in discharging patients and excessively long waits for operations for fractured neck of femur. Despite such cross cutting themes and the fact that the review teams work to a common framework, the reports vary widely. This is apparent not only in their findings—inevitably so, given the differences between

hospitals—but also in their tone and the degree in which they make their criticisms overt rather than implicit. Clearly ensuring consistency across review teams will be a further challenge for the commission as its programme gathers momentum.

Given that the commission had to invent itself from scratch, it is the progress that it has made in tackling such problems which is remarkable rather than the fact that difficulties remain. Whether or not the result will be to improve the quality of care in the NHS remains an open question: the answer will depend at least as much on what happens in the NHS generally as on the commission itself.

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Racism in medicine

The spectre must be exorcised

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Some readers' hearts and spirits will sink at this editorial, which marks the publication of a book on racism in medicine from the King's Fund, the London based health think tank.¹ In the interests of the profession, patients, society, and perhaps even the future of humanity they should, however, reflect deeply on the painful dilemmas raised by the book.

Racism is the belief that some races or ethnic groups are superior to others, which is then extended to justify actions that create inequality. Some people deny that racism is commonplace in Britain, as it probably is in every modern society. Yet in a national representative survey by the Policy Studies Institute 20-26% of the "white" participants admitted to prejudice against Asian, Caribbean, or Muslim ethnic minorities.¹ Some claim to be baffled by another plain concept, institutional racism. According to the Macpherson Report (on racism in the police), institutional racism is "The collective failure of an organisation to provide an appropriate and professional service to people because of the colour, culture or ethnic origin."¹ A simple example would be the failure of the healthcare system to make accurate diagnoses because it fails to provide the training and

facilities (interpreters) to achieve quality communication. Sceptics may still wonder why such practices are wrong. This book shows they are wrong in principle, and on pragmatic grounds.

Every member of Britain's ethnic minority populations has anecdotes of racism, sometimes minor, sometimes shocking, and I have mine. As a child, being called "darkie" or "Paki" was a daily event. When I was 17 I was offered a summer job selling door to door. When I reported for work next day the offer was abruptly withdrawn. A senior manager had overridden the manager who employed me (to the latter's embarrassment.) I have written in the *BMJ* about 20-25 applications for senior house officer posts that disappeared into a black hole. At university some friends regularly enjoyed racial banter at my expense—"You're a black bastard Raj." The house I surveyed in a middle class neighbourhood was withdrawn from sale after I put my offer in, to the embarrassment of the estate agent and expense to me. My aunt was left in diabetic coma all day in a prestigious hospital because the nurses could not communicate with her and so left her "to sleep" (a mix of negligence and institutional racism). Throughout my career I have willingly acted as an interpreter for others' Punjabi

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speaking patients because interpreting either was not available or not used. The book contains many other stories like mine. I have preferred to emphasise the thousands of positive interactions, rather than dwell on the relatively few negative ones, though these can wreck lives. I am guilty of complacency.

The world has changed. Injustice, harassment, and prejudice on the basis of colour, religion, culture, or ancestry is not tolerable to younger generations. They will welcome this book as a map to guide them in the dangerous territory they already know. For those like myself who have remained ambivalent about racism this book offers compelling reasons to change.

The concepts of race and ethnicity are complex, but understanding them is essential.² Simply put, race is the group you belong to as a result of a mix of physical features, ancestry, and geographical origins, as identified by others or, increasingly, by self. The concept is broadening to include social and political heritage, making its usage similar to ethnicity. Modern genetics undermined the biological concept of race, and Nazi racism discredited eugenics. Races are based on a few physical features (such as colour and facial shape) of small direct importance to health. Ethnicity is the group you belong to as a result of a mix of cultural factors that include language, diet, religion, ancestry, and race, collectively of great importance to health. Race and ethnicity are usually used as synonyms. Race and ethnicity clearly serve important functions, including the development of identity, belonging, and social relations.

One conundrum is that a denial of difference is no solution, mainly because the current norms are based historically on the needs of the "white" population. The resulting ethnocentric (eurocentric) approach can be tackled only after an analysis based on examination of differences. Such an analysis requires data by racial or ethnic group (for ethnic monitoring), which requires a classification, which in turn requires acknowledging the concepts of race and ethnicity—which perpetuates their use to accentuate differences and provides the potential for abuse.

Humans have a compelling interest in differences—usually at the expense of acknowledging similarities. Disraeli, then British Prime Minister, said to the House of Commons in 1849 "Race implies difference, difference implies superiority, and superiority leads to predominance." Focusing on problems more common in minority groups portrays the minorities as weaker. When research implies genetic factors as the cause of racial differences in health, racial minorities may be perceived as biologically weak. In these circumstances biology and medicine become the servants of racism. Science helped justify slavery, social inequality, eugenics, and immigration control.² Medicine has played its part, the most notorious modern example being the syphilis study in black subjects in Tuskegee, Alabama.³ Racism causes death in epidemic proportions, as in Nazi Germany, Bosnia, Serbia, and Rwanda. Like a deep seated sepsis, at best racism causes chronic malaise and at the worst death.

Racism can be compounded by other forms of discrimination, for example, on the basis of sex or disability. Antiracism activity sits squarely in the wider arena of the struggle against oppression.

Equity is the core ethical principle underpinning discussions of ethnicity and health care. An equitable

service would meet equal needs equally, but this requires a diversity in the organisation of services, to ensure uniformity in access, use, and quality at the point of delivery. While the NHS is not yet versatile and flexible enough to provide an equitable service, it is trying to change. For example, two studies in Teeside showed surprisingly high levels of satisfaction with specific NHS services in the predominantly Pakistani South Asian community there.⁴ The challenges identified by the studies were well within the scope of the service. Improvement in services for ethnic minority groups will almost certainly benefit the whole population, for many issues are common to all—for example, the desire for carers of the same sex. Meeting the healthcare needs of ethnic minority groups needs to be seen as a key responsibility of the service, not a chore or a problem of ethnic minorities.

Stark inequalities in the health and health care of minority groups exist, but documenting inequalities may have little impact on reducing them. Racism is the most disturbing of the potential explanations for such inequalities. I have argued that actions to reverse inequalities, including tackling racism, should not be delayed by the necessary but difficult and lengthy quest for research evidence.⁵ *Racism in Medicine* has confirmed my view.

The book provides ample evidence that racism in medicine matters, with studies showing discrimination against medical students from ethnic minorities, overseas doctors, and British trained doctors with foreign sounding names and harassment of ethnic minority health professionals by managers and patients. This book's essential message is that reliable testimony and qualitative and quantitative research confirm racism in medicine, and that it must stop. Fair and open practices are needed for selecting people for study, employment, assessment, discipline, service on decision making bodies, career progression, and rewards. Talent and ability have no racial, ethnic, or cultural exclusivity.

To extirpate racism in medicine needs more than legislation; it needs winning over the hearts and minds, and particularly the consciences, of both the rank and file and leaders of the profession. The ample guidance from the profession and the departments of health, ably summarised in the book, can now be combined with the powers of the Race Relations Amendment Act 2000 and human rights legislation to promote change. The noble profession of medicine should seek to be in the vanguard of the historical and global struggle against racism.

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