Certainly there is greater scepticism, and the priests are not so trusted. Yet one might argue that this is no different from liberal approaches to religious faith: testing assertions, accepting variant authorship and interpretation of holy writ, and understanding that those apparently eternal truths have to be set in their context. And the liberal faith has prevailed. Public devotion to the concept of a tax funded, universal NHS has actually increased since the early 1980s, as concern about its wellbeing has grown.[2] Even Margaret Thatcher dared not privatise the NHS, merely introducing attenuated market forces into the service.

But the NHS of the future will have to adjust to a new relationship with society. Creature beloved of the faithful it may be, but the liberal and intellectual among the faithful will be impatient with being asked to believe three impossible things before breakfast. The ideal will remain strong, but the practice of the priests has to measure up. To receive public trust they must show that they give good value for our votes and money. The quality of care provided must fit those concepts of compassion and fairness written into the original holy writ of 1948. Priests who misbehave must be disciplined. Individual temples that are unwelcoming must be reformed. New ways of praying—at easy access, walk-in services that complement the continuing relationship with a priest—must be welcomed. The belief is in universal availability. No one wants to wait two weeks to pray.

The challenge for the NHS is to continue to meet the expectations of a service that is felt to embody what is good about our society, with a moral purpose. But support is not unconditional, and if the NHS cannot show that it is still good for our health, public faith, and political support, will be eroded. As in modern Britain, the faith may appear in new ways—from the evangelical (NHS Direct) to the fundamentalist (integrated care, holistic approaches, and complementary medicine), and the orthodox must take note.

A recent study from America showed that people who go to church regularly live longer than those who do not.[3] Faith remains a key to good health. That faith does not have to be in religion. It can be in a family, a community, and public services. But well founded faith in the NHS is a vital component of its role in making society feel better about itself and helping individuals to feel secure that they will be looked after at times of need. So recognising the NHS as a creature of faith, an institution in which people have faith, is essential if it is to recognise itself as the product of a value base. And that value base in turn requires it to be more coherent about what it is, who it is for, and how its priests and priestesses will be good to its congregants. Then no prophet will need to come along and condemn them for failing to do what is right. To paraphrase the prophet Micah: "For what does the Lord require of you, but you deal fairly, love compassion, and walk truthfully in the path of ethical practice."

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1 Klein R. The goals of health policy: church or garage? In: King's Fund. *Health care UK 1992/3*. London: King's Fund, 1993.
2 Mulligan J. Attitudes towards the NHS and its alternatives. In: King's Fund. *Health care UK 1997/8*. London: King's Fund, 1998.
3 BBC News Online. Church going improves life expectancy. 1999; 23 July.

Medicine and the marginalised

They deserve the best, not the poorest, care

> And though I have the gift of prophecy, and understand all mysteries, and all knowledge; and though I have all faith, so that I could remove mountains, and have not charity, I am nothing.
>
> *Corinthians* 13:1

Who, Christian or not, could disagree? The idea of paying special attention to "the poor and mean and lowly" is a central part of the Christmas story and of most religions. It is a belief that underpins medicine. Yet it is a belief that is constantly forgotten. Medicine usually fails marginalised people.

It is more than a quarter of a century since Julian Tudor Hart's famous paper on "the inverse care law"—that those who need medical care the most are the least likely to get it.[1] The law is seen in its most extreme form on a global scale: the highest rates of sickness and premature death are in the developing world, whereas medical care is concentrated in the developed world. Evidence continues to accumulate that the law applies everywhere, and things are probably getting worse not better.[2]

Jonathan Mann, the Harvard professor who was killed in 1998 in the Swiss Air crash, introduced a new way of thinking about these issues by combining thoughts on public health and human rights.[3] He would illustrate his thinking by arguing that when HIV is introduced into a society it will eventually be concentrated among those whose human rights are most neglected. It is found in the babies of women too poor to have their HIV infection diagnosed or treated, prostitutes whose clients refuse to wear condoms, and addicted prisoners who are denied access to clean needles and pure drugs.

One group whose human rights are regularly compromised are people with learning difficulties.[4] Doctors in most specialties will encounter these patients, not least because they have higher rates of many conditions, including epilepsy, dementia, hepatitis, peptic ulcer, and dysphagia. The number of people with learning disabilities is increasing as their life expectancy improves, and most now live in the community. Yet we have growing evidence that they are receiving poorer treatment than the general population. Reports in the *BMJ* this year have shown how rates of cervical screening among women with learning disabilities are scandalously low.[4,5] Research among this community is sparse, but the suspicion is that studies of other treatments and preventive

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interventions might find the same. A Dutch teenage psychiatric patient with learning difficulties was kept in restraints for five weeks because suitable care could not be arranged, igniting a much needed debate on services for those with learning difficulties.[6] Some of the failures may result from lack of training among doctors in managing patients with learning disabilities, but there may also be discrimination.

Most doctors also encounter addicted patients, but many general practitioners are unwilling to accept on to their lists people addicted to illegal drugs.[7] These patients are likely to create many more difficulties than the average patient, but they also have many more medical problems. If a separate system of care has to be created for them it seems highly likely that it will fall to lower standards than the general system. This is exactly the point made 20 years ago by the Royal College of Psychiatrists in arguing against a separate prison medical service.[8] At long last that advice is being heeded by the authorities in England,[9] but for years prisoners, particularly the large proportion with mental health problems, have suffered from poor health care. Indeed, many prisoners end up in prison primarily because of the failure of mental health services. And when prisoners are referred to the hospital service they may find themselves shackled to the bed, even in some cases while giving birth.[10]

There are other marginalised groups who have high rates of health problems and poor services. These include homeless people, refugees, and travellers.[2] With all marginalised groups the poorer standard of care seems to stem from a combination of ignorance, fear, and prejudice plus a feeling that they should adapt to the services rather than the other way around. These same factors also seem to be at work in the case of very large groups—particularly elderly and mentally ill people—who are not marginal in numbers but who are marginalised in the services they receive. The "debate of the age" has focused attention on medicine's failures with elderly people,[11] while many psychiatric hospitals run at over 100% capacity, and carers of the mentally ill struggle with wholly inadequate support.

Much attention is now being paid to Britain's poor results in patients with cancer and heart disease, the major killers. Politicians are feeling the heat over the poor performance, and the Secretary of State for Health is planning to make them priorities, sidelining the usual political concern with waiting lists. The problem in a severely constrained health service is that services to marginalised groups may become still worse. The current fashion for politics by focus group means that the problems of the majority, "comfortable Britain," are given priority because the focus groups include few if any people from marginalised groups. The main interest that the majority have in marginalised people is keeping them out of their back yards.

So how to respond? Thankfully some people, often inspired by religious faith, are willing to devote themselves to caring for marginalised people. There are others, perhaps marginal themselves in some way, who cannot find places in the more popular parts of medicine and who drift reluctantly into the care of marginalised groups. Unfortunately those who care for marginalised groups themselves become marginalised.

Improving care for marginalised groups will thus need much more than exhortation from the pulpit or a journal—because most people are unwilling to take on the extra difficulties of caring for these people when, far from bringing professional or monetary reward, it brings the reverse. Real change requires—as always—professional and political leadership, unceasing commitment from the top, a clear vision of what is needed, resources, and a strategic approach. Medicine may somehow need to rediscover its religious underpinning while operating in an increasingly secular world. Otherwise, it's hard to see that anything will be different in 10 years time.

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1 Hart JT. The inverse care law. *Lancet* 1971;i:405-12.
2 Webb E. Children and the inverse care law. *BMJ* 1998;316:1588-91.
3 Mann J. Health and human rights. *BMJ* 1996;312:924-5.
4 Aspray TJ, Francis RM, Tyrer SP, Quilliam SJ. Patients with learning disability in the community. *BMJ* 1999;318:476-7.
5 Hall P, Ward E, Djuretic T, Laing-Morton T, Guy M, Gill M, et al. Cervical screening for women with learning disability. *BMJ* 1999;318:536-7.
6 Sheldon T. Dutch crisis in care of learning difficulties. *BMJ* 1999;318:78.
7 Keen J. Managing drug misuse in general practice. *BMJ* 1999;318:1503-4.
8 The college's evidence to the prison services inquiry. *Bull R Coll Psychiatry* 1979;May:81-4.
9 Joint Prison Service and National Health Service Executive Working Group. *The future organisation of prison health care.* London: Department of Health, 1999.
10 Dillner L. Shackling prisoners in hospital. *BMJ* 1996;312:200.
11 Tonks A. Medicine must change to serve an ageing society. *BMJ* 1999;319:1450-1.

Absinthe: what's your poison?

Though absinthe is intriguing, it is alcohol in general we should worry about

Absinthe, the emerald green liqueur associated with excess, is back in business. Having been banned in many countries in the early 20th century, its newly fashionable image, combined with global purchasing opportunities through the internet, has brought its revival. Since 1998 several varieties of absinthe have again been available in Britain—from bars, stores, and mail order. But is absinthe a special problem or simply part of a general concern about excessive alcohol consumption?

Originally formulated in Switzerland, absinthe became most popular in 19th century France. Between 1875 and 1913 French consumption of the liquor increased 15-fold.[1] It became an icon of "la vie de bohème," and in fin-de-siècle Paris l'heure verte (the green [cocktail] hour) was a daily event. Although never as popular in Britain, the fashion of mixed drinks with a "spot" or "kick" of absinthe was reported in London as late as 1930.[2]

Many creative artists had their lives touched by absinthe (Toulouse-Lautrec, Oscar Wilde, Picasso).[3] The illness of Vincent van Gogh was certainly exacerbated by excessive drinking of absinthe,[4] and one of his six major crises was precipitated by drinking.[3] Van

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