Prejudice against doctors and students from ethnic minorities

SIR,—As Dr Richard Smith states (7 February, p 328), doctors trained overseas have been disadvantaged in competing for jobs in the National Health Service. The study by Smith in 1980 proved this beyond any measure of doubt.¹ The profession's concern about the competence of many such doctors led to the recommendations of the Merrison Committee, in 1975, which required a substantial proportion of overseas doctors to take the Professional and Linguistic Assessment Board examination (PLAB), a test of professional competence at the level of senior house officer and of formal and colloquial English.

I and my colleagues undertook a career survey of overseas psychiatrists successful in the examination for membership of the Royal College of Psychiatrists.² The postal survey was funded by the Royal College of Psychiatrists (the views in the article are ours, not those of the royal college). We surveyed psychiatrists who had obtained their membership to determine whether overseas doctors fared less well than home graduates in achieving their career ambitions and tried to identify any factors that contributed to any difficulties that they encountered. Doctors who have passed the membership examination of the royal college are less likely to have been poorly trained or to be less competent and will have a fair command of English.

In January 1984 a postal questionnaire was sent to all graduates who had passed the college's examination in November 1981 or April 1982 (n=249). The questionnaire asked for a detailed curriculum vitae and information about the number of attempts at the membership examination, satisfaction regarding posts held, the number of applications made for posts, and reasons for failure in obtaining posts applied for. By the summer of 1984, 207 (83%) had returned the completed questionnaire. Of the respondents, 60% were British, 10% Irish, 17% Asian, 4% Australasian, and 7% African. Asian doctors formed the largest group of overseas graduates. A major finding of our survey was that four times as many overseas as United Kingdom graduates were still in registrar posts (27% overseas, 7% British) despite having obtained their membership examination at the same time (p<0.01). In addition, three times as many Asian as British graduates had tried to change their posts unsuccessfully. Among those successful in obtaining senior registrar jobs the posts were evenly distributed between home graduates and Asians, though there were no Asians in lecturer posts. Analysis of senior registrar posts by specialty showed further interesting findings. Twice as many British graduates were successful in obtaining posts in general psychiatry, whereas a high proportion of Asians were concentrated in mental handicap (40% Asian compared with only 3% British graduates), a difference which was highly significant (p<0.001).

Analysis of examination results confirmed a higher success rate among British and Irish graduates at the first attempt than among Asian graduates (79% v 40%). Overseas graduates were very reluctant to suggest that they had experienced racial discrimination. This reluctance may have been based on fear, as several of the respondents could not be reassured about the college sponsoring the research. A quarter of the Asian graduates who had gained membership, compared with 7% of the British graduates, two years later were still working as registrars, and many had not even been shortlisted (one overseas doctor had applied for 50 posts without being shortlisted).

Our study suggests, but does not conclusively prove, that racial discrimination may have occurred. At a practical level, to prove racial discrimination with irrefutable evidence is virtually impossible. Unless a member of an appointments committee risks complaining about a member or members who may have acted in a racially prejudiced manner in the committee's deliberations, such proof will be hard to come by. This, for obvious reasons, is something very few will venture.

Dr Smith's timely call to the profession to act is to be commended, and I hope that this advice is heeded. Non-selection of applicants from ethnic minorities on the part of some medical schools has privately been known to parents from ethnic minorities with children aspiring to study medicine. My daughter, who has now successfully applied to a medical school in London, was asked during an interview at one of the other medical schools to which she applied, "Will you be returning home after completing your training?" My baffled daughter replied that she was not necessarily seeking a career in Newcastle on completion of her training; it was only later that she realised what this was all about. As yet, she is not bitter, but, as a Geordie of Asian origin, I hope that she is never made to feel that she cannot be part of this society.

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- 1 Smith DJ. *Overseas doctors in the National Health Service*. London: Policy Studies Institute, 1980.
- 2 Bhat S, Sagovsky R, Cox JL. Career survey of overseas psychiatrists successful in the MRCPsych examination. *Bulletin of the Royal College of Psychiatrists* 1986;10:121-3.

SIR,—I disagree with the statement by Drs Peter Richards and I C McManus (28 February, p 575) that a lack of community service and few interests can adequately and entirely explain the reduced likelihood of acceptance of applicants with non-European names to St Mary's Hospital Medical School, London. It should be noted that their analysis of individuals with non-European names was a retrospective one in response to my previous letter.¹

They questioned the validity of their own data, which was based on surnames, not ethnic group, and provided no information on how interviewers assessed non-academic suitability. Their previous letter also stated that it was not possible to distinguish whether the difference in non-academic suitability was because of "judgements [that] were a global response to the applicant's background, rather than to the candidate as an individual. . . . Further research is required."²

Interests have always been difficult to evaluate reliably from a University Central Council on Admissions (UCCA) application form. Contribution to the community depends very much on which community you ask about. Students from ethnic minorities preserve a sense of identity by being active members of both the community at large and their own ethnic group. Most schools, however, have little knowledge or experience of students' contributions to their own ethnic group, which is reflected on the UCCA application form.

Many of us have found that teachers advise us to state only those interests and activities that reflect integration into the community as a whole, at both the curricular and extracurricular level. Such reluctance to disclose particular aspects of cultural community service may have something to do with the finding by Drs Richards and McManus that those with fewer cultural interests (whatever that means) were far less likely to be offered admission to St Mary's.³

The fact remains that no further accurately documented and analysed information has been published about the number of ethnic minority students gaining admission. There has been a notable silence from other medical schools and London University, and UCCA has recently refused to collect admissions data relating to ethnic minority students.⁴

I find it astonishing that Drs Richards and McManus continue to suggest that the principles of natural justice should apply when so many

questions remain unanswered about the fairness of the selection process. Schools cannot simply claim equality of opportunity; they must be seen to practise it in the eyes of both the law and the community at large. The onus for this is on the schools themselves; at present, much circumstantial evidence suggests that there remains very serious cause for concern.

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- 1 Shaunak S. Admission to medical school. *Br Med J* 1984;289:1535-6.
- 2 McManus IC, Richards P. Admission to medical school. *Br Med J* 1985;290:319-20.
- 3 McManus IC, Richards P. Audit of admission to medical school. I. Acceptances and rejects. *Br Med J* 1984;289:1201-4.
- 4 Veitch A. Medical schools to face discrimination enquiry. *Guardian* 1987 Jan 30:4.

Prejudice against women doctors

SIR,—Dr Richard Smith is to be congratulated on raising the issue of racial prejudice in the medical profession and urging the collection of data on ethnic/racial origin of applicants to medical schools and doctors to NHS appointments.

There are equally cogent reasons for applying the same monitoring procedure to the gender of doctors applying for NHS appointments. The downgrading of women applicants to St George's Hospital Medical School, though less dramatic than that of non-whites, deserves more attention than the incidental mention it gets in the leading article. Now that almost half of all students admitted to medical school are women there is the complacent assumption that sex discrimination in medicine is a thing of the past. Alas, equal opportunity of entry to medicine has not automatically led to equal opportunity in career progression after qualification, as can be seen by examining DHSS data on the distribution of women in hospital medicine, community practice, and primary health care.

Despite the declared equal opportunities policy of the DHSS, our members continue to be asked discriminatory questions about their marital and reproductive intentions at job interviews. I have recently had to write on behalf of my members to two London district health authorities to point out application and appointment procedures that overtly contravene the Equal Opportunities Commission code of practice. I urge the BMA, via its local representatives and its contacts with the DHSS, to ensure that the stated equal opportunities policies of both the DHSS and the BMA are actually being implemented by selection panels at all levels within the NHS and other medical organisations.

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Early emergency care

SIR,—Drs Peter Baskett and Rodger Sleet expressed many of the arguments put forward by proponents of extended ambulance training (21 February, p 508). These are often, however, based on emotion rather than objective scientific assessment.

In designing and carrying out our study we had no preconceived ideas of the role or benefits of advanced training. To be valid the study had to be performed in an area where no extended training existed. Previous studies have failed to

assess the ability of ambulance staff to achieve successful outcomes using existing training.

All the patients included in the study were emergency cases—that is, either 999 calls or cases classed as an emergency by a general practitioner—and all had “hands on” assessment by ambulance and medical staff. To suggest that this prospectively performed study was a “table top theoretical exercise” is therefore far from the truth.

All of the patients admitted to a resuscitation area were assessed in detail, not merely the 396 who died. The patients in resuscitation areas constituted 4.6% of all the emergency cases studied in Edinburgh and 4.3% of the Glasgow cases. These figures are similar to those reported for accident and emergency departments elsewhere in Britain.

Though “abundant evidence in favour of extended ambulance skills” exists in the United States, the situation in Britain is very different. Drs Baskett and Sleet claim that “hard data” are available from centres that have had years of experience with ambulancemen trained to paramedic level. We do not know of studies of this kind that compare basic and advanced ambulance skills, and we note that Drs Baskett and Sleet do not give references for such results.

As we indicated in our paper, the benefits of advanced training will be seen mainly in patients requiring cardiopulmonary resuscitation. We do not dispute the role of early defibrillation for ventricular fibrillation, and we agree with Mr William Rutherford (28 February, p 578) that there is a strong case for concentrating resources in this area. In the absence of cardiopulmonary resuscitation by a bystander, however, the limiting factor is the time the ambulance service takes to respond. We refute the comment that “the journey times . . . leave something to be desired.” The time referred to as “journey time” in fact represents the time from the initial 999 call to arrival in hospital and not the response time of the ambulance service.

We in no way denigrated the fact that “only 54” lives might have been saved; this figure represented the maximum possible benefit, and to suggest that over 2500 lives could be saved in Britain every year is an inappropriate interpretation of our results. As the authors indicate, we took no account of the effect of extended training on morbidity. We would be delighted to hear of a scientific and reproducible assessment for morbidity in patients before they reach hospital.

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Phototherapy and dithranol treatment of psoriasis

SIR,—Dr P M Farr and coworkers (24 January, p 205) attempted to define whether ultraviolet treatment hastened the improvement in psoriasis treated by dithranol. They studied the response to three different types of apparatus: a medium pressure mercury arc lamp, an array of six 60 cm fluorescent sunlamps, and an array of six 60 cm ultraviolet fluorescent sunlamps.

I agree that both ultraviolet radiation and dithranol are effective treatments for plaque psoriasis.^{1,2} Dr Farr and colleagues’ tables II and III, however, contain clinical details that may have led to a premature conclusion about the efficacy of the different types of ultraviolet equipment studied.

Table II shows that the lesions on the non-irradiated, dithranol treated (control) arms in the patients treated with the mercury arc lamp took only 7.5 days to reach half of their initial thickness. This compared with nine days for the two other ultraviolet treatment groups.

Similarly, table III showed that the mean clearance time for the lesions on the non-irradiated arms in patients treated with the mercury arc lamp was 13.5 days, compared with 17 and 18 days, respectively, for the control arms of the patients treated with the fluorescent sun lamp and Helarium. The mean time to clearance in the irradiated arms was 13.5 days for the mercury arc lamp, 14 days for the fluorescent sunlamp tubed lamps, and 12.5 days for the Helarium lamps.

One explanation may be that the rate of clearance of psoriasis achieved with dithranol in the patients treated with the mercury arc lamp could not be improved by additional ultraviolet, whereas the psoriasis in the patients treated with the Helarium lamps and fluorescent sunlamps was clearing at a slower rate and thus the ultraviolet seemed to produce better results.

Though I accept Dr Farr and coworkers’ suggestions that improved lamps are indeed desirable for psoriasis phototherapy, I suggest that further research is needed, with randomisation of patients to the different treatment categories to permit more accurate evaluation of the potential benefits of different ultraviolet lamps.

In addition, a more suitable study would measure the effects of treatment with ultraviolet radiation and emollients alone using the different ultraviolet lamps described.¹ Dr Farr and colleagues have shown clearly the efficacy of dithranol alone in the treatment of psoriasis.

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1 Lowe NJ, Wortzman M, Breeding J, *et al*. Coal tar phototherapy for psoriasis re-evaluated: erythemogenic versus suberythemogenic ultraviolet with a tar extract in oil and crude coal tar. *J Am Acad Dermatol* 1983;8:781-9.

2 Lowe NJ, Ashton RE, Koudsi H, Verschoore M, Schaeffer H. Anthralin for psoriasis: short contact anthralin therapy compared with topical steroid and conventional anthralin. *J Am Acad Dermatol* 1984;10:69-72.

AIDS counselling and informed consent

SIR,—Dr Alan B Shrank (14 February, p 445) objects to counselling patients before he requests a test for antibodies to the acquired immune deficiency syndrome (AIDS) and does not see this as part of good history taking. If he had seriously been considering a diagnosis of AIDS surely he should be thankful that the pathologist may have protected him, and perhaps his employing authority, from the consequences of taking the specimen without fully informed consent. If the patient had subsequently been found to be positive for the human immunodeficiency virus (HIV) and his wife seropositive and pregnant after the honeymoon would Dr Shrank have been judged negligent in having failed to advise against pregnancy until after the serological results for the husband were known, especially as pregnancy may precipitate clinical AIDS in the female carrier of the virus as well as probably infecting the fetus?

Unlike Dr Shrank I have coped with a clinically well bisexual patient who, unfortunately, when tested elsewhere was found to be positive for antibodies to HIV but had no knowledge that the test was being performed until he was presented with the result. Fortunately, this patient did not commit suicide, unlike some HIV positive

patients, and he remained clinically well and had not infected his wife or child. This episode has reinforced my conviction that counselling before as well as after the test is in the patient’s interests, and only very exceptionally can it legitimately be omitted. The council of the BMA endorses this view,¹ as does the Department of Health and Social Security, whose representative has added (in a personal communication) an important note: “Although it may have been common practice in the past to test patients for all sorts of diseases without specific consent, the advent of AIDS is causing the profession to question the wisdom (and legality) of such practices.”

May we also set aside the spurious argument that compares patients positive for antibodies to HIV to patients with cancer because AIDS is, like some forms of cancer, invariably fatal; how often are patients with cancer put at risk of losing their homes and jobs as a result of innuendo? Fortunately, some doctors acknowledge that they have sexual “hang ups” that preclude them from discussing frankly and with confidence and sympathetic understanding sexual questions with the patient that need cause neither embarrassment nor offence to either party. Hopefully, more doctors will follow their peers and attend training in AIDS counselling; they will then be in a better position to help their patients.

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1 BMA. *Third statement on AIDS*. London: BMA. 1987.

Tennis elbow: conservative, surgical, and manipulative treatment

SIR,—There is a very simple cure for many patients with tennis elbow, which is little known and which is only briefly hinted at by Mr Thomas G Wadsworth (7 March, p 621).

Some years ago, when I played a great deal of tennis, I developed the typical lateral elbow in my right arm. This steadily worsened and was relieved for a day or two only after cortisone injections by an orthopaedic colleague. Rest gave no more than temporary relief, and I began to think that I should stop playing tennis. I mentioned this intention when operating at a cottage hospital one day. A general practitioner in the theatre, Dr M R Sheridan, bluntly responded: “Rubbish! Go to Briggs’s in Wood Green high street and get yourself a racquet with a bigger handle.” I took the doctor’s advice and went to Briggs’s shop as soon as I finished operating and bought a new racquet with a handle 3.75 cm larger in circumference than my existing one.

A day or two later I played three sets of tennis with Dr Sheridan. On taking my first service, I said: “I shall never be able to serve with this large handle.” My medical advisor retorted: “Shut up! You’ll be alright by the end of the first set.” He was absolutely right. Within half an hour I had adjusted my grip and never had any recurrence of trouble in the next 30 years. Lateral elbow pain is also often caused by gripping too small handles on shears and other garden tools. This can be prevented by building up the handles to the requisite thickness, and I have helped many sufferers to cure themselves in this way.

The mechanism of relief is simply explained if the position of the wrist when the hand is gripping objects of different thicknesses is studied. The smaller the circumference of the object held, the less the degree of dorsiflexion of the wrist. As progressively thicker objects are held dorsiflexion increases, reducing the tension on the forearm extensor muscle origins. It seems that with a