minimising contamination of therapeutic subgroups by occult de novo tumour resistance. Conversely, the therapeutic correlates now being revealed by tumour immunophenotyping suggest that customisation of adjuvant treatment regimens is now inevitable. For example, the association of abnormal c-erbB-2 and/or p53 expression with chemoresistance in vitro^{16 17} reinforces observations linking these phenotypes to the outcome of adjuvant treatments.^{18 19} Similarly, a recent report suggesting that taxanes preferentially kill p53 deficient tumour cells²⁰ provides a novel strategy for randomised studies.

Reduced local control seems an unlikely complication of pre-operative drug treatment, given the high response rates reported to date. Residual tumour masses deemed drug resistant could be excised,¹⁰ with decisions regarding radiotherapy being guided by histopathological data. Gratifyingly, patient acceptance of this approach has thus far exceeded 90%.¹² Yet although this seems a sensible way to optimise the effectiveness of adjuvant treatment, several issues need to be resolved before this second revolution of breast cancer treatment can be validated in randomised multicentre trials. Not least among these is the question: how will breast surgeons feel about withholding lumpectomy (even if only temporarily) from many of their newly diagnosed cancer patients?

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Avoiding discrimination against disabled people

A welcome new law, but problems ahead for doctors who have to decide who is disabled

See p 1352

The new Disability Discrimination Act is, according to two of its authors, Lord Henley and Mr Alistair Burt, "intended to ensure full and fair access to employment opportunities for disabled people." There is no doubt that this laudable intent will be greatly welcomed, not only by disabled people but also by all enlightened employers. The ministers went on to say that they wanted the accompanying guidance and code of practice "to help the Courts and Tribunals, employers and service providers interpret the definition." These guidance notes have since been published, and they signal a contentious time ahead for health professionals.¹

The definition of disability within the act is "a physical or mental impairment which has a substantial and long-term adverse effect on [a person's] ability to carry out normal day-to-day activities." That is a loose and broad definition that covers physical, sensory, and mental disabilities. No doubt it was intended to be broad but it will lead inevitably to a wide range of interpretation. Those most likely to be called on to define cases of disability, where it is not clearly apparent, will be medical practitioners and usually occupational physicians. In many cases, no doubt, their opinions will be challenged later by lawyers in tribunals and courts of appeal, where much of the detailed application of the act will ultimately be settled.

The guidance notes are not helpful in interpreting the definition. For example, "substantial" is described as "more than minor or trivial," and "normal day-to-day activity" as "what is normal for most people." The notes further state that "in the vast majority of cases there is unlikely to be doubt over whether or not a person has or has not a disability." That is no

doubt true for people with obvious disabilities, such as those whose mobility is only possible in a wheelchair or on crutches. But what about the person with asthma, angina, or ulcerative colitis? It will be a matter of medical opinion whether such patients, most of whom are in work, fall within the definition. If they do, occupational physicians will have a further responsibility to advise their employers of what reasonable adjustments may be needed in their workplace or working conditions to accommodate their disability and avoid discrimination against them within the act.

According to the act, a disability persists even if it has been corrected. "An impairment which is controlled or corrected (for example by medication or by the use of a prosthesis or other aid) is to be treated (a) as continuing to be an impairment and (b) as continuing to have a substantial adverse effect on a person's ability to carry out normal day to day activities, if it would have that effect, were it not controlled or corrected." Presumably, therefore, a 50 year old executive whose longstanding angina has been relieved by an angioplasty will still be regarded as disabled within the act. Suppose such an executive wishes to transfer overseas for the last years of his career, so substantially boosting his pension, but is refused on the grounds that an overseas assignment far removed from sophisticated medical care may jeopardise his health in the event of a complication of his ischaemia. Can he claim discrimination under the act?

How is an employer to know which of his or her employees are disabled? The code of practice states that "an employer is not under an obligation to make an adjustment if he does not

know, and could not reasonably be expected to know, that a person has a disability which is likely to place the person at a substantial disadvantage. An employer must therefore do all he could reasonably be expected to do to find out whether this is the case." Employers therefore have an obligation to determine which of their current or potential employees are disabled if they wish to avoid inadvertent discrimination within the act. Current employees must be asked directly whether they consider that they have a disability, and potential employees must be asked the same question in the normal recruitment process. The respondents will then fall into one of three categories: those who are clearly disabled within the act; those who have a disability, but it is not clear whether the disability comes within the act; and those in whom the disability is disputed by one side or the other.

People falling into the second and third categories will again need to be medically reviewed, and discrimination against the disabled must be guarded against during recruitment. It would be discriminatory, for example, to medically examine those people who claimed to be disabled but not those who did not. If a medical examination or a medical review is a part of the recruitment process then it must be applied to all the candidates, or at least all the short listed candidates, and not only those who seem to have disabilities or other medical problems.

Although the act will give redress to disabled people who believe that they have suffered discrimination, it will not give them a preferential right to employment. Employers will continue to have an obligation to ensure that employees are physically and mentally capable of performing the jobs for which they have been selected and without risk to their own health and safety or the safety of others.²

While the act also gives disabled people new rights in getting goods and services and buying or renting land or property, it is in the area of employment that doctors, particularly occupational physicians, will be most involved. Their expertise must ensure that many of the act's ambiguities and uncertainties are resolved with fairness to both disabled people and employers. It will require the wisdom of Solomon.

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Age, ethnicity, and mental illness: a triple whammy

We need validated assessment instruments for specific communities

A major public health issue for the next century is the increase in the number of elderly people from ethnic minority groups. The large numbers in the 40-64 year old cohort will soon be in the over 65 group, which is traditionally associated with particular health, social, and economic needs.¹⁻³ Attention has tended to be focused on the physical health of these groups,⁴ and this, together with the traditional stigma of mental illness, has led to relative neglect of the mental health of older people from ethnic minorities.

Up to 15% of elderly people are known to suffer from depressive symptoms, of whom one third have an illness requiring treatment, often associated with physical illness.⁵ Prevalence rates for dementia range from 1.1-2.2% in those aged 65-69 to 31.6-36.0% in those aged 95-99.⁶ The equivalent figures can only be estimated in ethnic minority groups, especially since they are underrepresented in their use of secondary services such as psychiatric outpatient clinics. This may be due to a low prevalence of illness, lack of presentation, lack of detection, lack of referral, or any combination of these.

Elderly people from ethnic minority backgrounds are heterogeneous communities.⁷ The assumptions held by society about community strength, extended families, and informal support may be both false and racist.⁸ "Double jeopardy" has been used to describe the double challenge of racism and agism faced by people from minority backgrounds,⁹ and socioeconomic deprivation has been added to form "triple jeopardy."¹⁰

Existing instruments for screening for depression and dementia were developed for use in the indigenous white population. Western ideas of distress and symptoms are not necessarily true for other ethnic groups, and it is difficult to translate emotions into English even if language skills are honed or an interpreter is present. For example, symptoms described as "pressure in the head" could mean stress or high blood pressure; "aching all over" could be a rheumatological symptom or may convey distress. Research has shown that the

results of formal screening tests are less valid for people of different cultural backgrounds, lower literacy, and educational attainment.^{11 12}

The NHS research and development programme has funded a project based in general practice to validate screening tests for depression and dementia in elderly subjects from ethnic minorities, assess their acceptability and reliability, and document service uptake and user expectations. The project aims to provide reliable and valid instruments that could be used in the community and provide data for use in epidemiological studies. The study will use community focus groups to help modify present screening tests, creating culturally relevant and acceptable instruments. A formal translation process will ensure that translated material is sensitive and accurate.^{13 14} This information will allow us to provide services that are appropriate to actual rather than perceived need.

Without valid instruments we cannot perform the necessary assessments in ethnic minority communities, and without such assessments the size of the problem will remain hidden. The result will be crisis management, which is both unsatisfactory and inexcusable. The individual elements of the triple jeopardy can be tackled in isolation—but the real challenge is to unravel the complex interaction of the three elements.

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