existing impairment, who had a 65% risk of new damage.⁹

Paramedical workers in leprosy programmes have acquired considerable skills in palpating nerves for tenderness, testing muscle function in hands and feet, and assessing sensory loss with monofilaments every month. Dermatologists should do this routinely too. The nylon Semmes-Weinstein monofilaments for detecting sensory loss were developed for use in leprosy programmes and have recently been taken up by diabetes programmes. Patients presenting with new muscle weakness or sensory loss should be treated with a course of prednisolone, starting at 30–40 mg daily.¹⁰ Preventing new nerve damage remains a challenge, as illustrated by the double blind randomised controlled trial reported in this issue of the *BMJ*¹¹ (p 1459). New multibacillary patients were randomised to receive either 20 mg of prednisolone or placebo for the first four months of treatment. Whilst new nerve damage was reduced during steroid treatment, when steroids were stopped there was an increase in nerve damage. This suggests that the biological mechanism of nerve damage is a powerful long lasting immunological event. This trial's results do not support the routine use of prophylactic steroids in all multibacillary leprosy patients. Type 1 (reversal) reactions affecting skin and nerve should be treated with a four to six month course of steroids. Type 2 (erythema nodosum leprosum) reactions affect about 20% of patients with lepromatous leprosy. These episodes can be treated with a short course of steroids. In severe and repeated episodes thalidomide is more effective than steroids, but it must be used with great care, especially in premenopausal women.¹²

For many patients leprosy is a devastating diagnosis, and they need reassurance that they will be non-infectious within 72 hours of starting treatment, cannot pass on the infection by touch, and will not necessarily develop deformities.

The contribution that dermatologists make to the treatment of leprosy is increasing. The integration of

leprosy into mainstream services offers opportunities for developing improved links with dermatologists. Leprosy programmes could become more effective by involving dermatologists in training for neurological assessment, providing monofilaments, physiotherapy, and footwear for patients with established nerve damage.

Diana N J Lockwood *consultant leprologist*

Hospital for Tropical Diseases, London WC1E 6AU
(diana.lockwood@lshtm.ac.uk)

Bhushan Kumar *professor of dermatology*

Department of Dermatology, Venereology and Leprology,
Postgraduate Institute of Medical Education and Research,
Chandigarh, India
(kumarbhushan@hotmail.com)

Competing interests: DNJL was a paid adviser to Pharmion during their application to the European Medicines Agency to have thalidomide licensed for use in the treatment of erythema nodosum leprosum.

- 1 World Health Organization. *Chemotherapy of leprosy for control programmes*. Geneva: WHO, 1982. (Technical Report Series, 675.)
- 2 World Health Organization. *Report on third meeting of the WHO technical advisory group on elimination of leprosy*. Geneva: WHO, 2002. WHO/CDS/CPE/CEE/2002.29
- 3 WHO Expert Committee on leprosy. *Seventh report*. Geneva, World Health Organization, 1998. (Technical Report Series, 874.)
- 4 Lockwood DN. Leprosy. *Clin Evid* 2002;8:709–20.
- 5 Girdhar BK, Girdhar A, Kumar A. Relapses in multibacillary leprosy patients: effect of length of therapy. *Lepr Rev* 2000;71:144–15.
- 6 Ji B. Does there exist a subgroup of MB patients at greater risk of relapse after MDT? *Lepr Rev* 2001;72:3–7.
- 7 Lockwood DN. Rifampicin, ofloxacin and minocycline (ROM) for single lesions in leprosy. What is the evidence? *Lepr Rev* 1997;6:299–300.
- 8 Villahermosa L, Fajardo T, Abalos R, Cellona R, Balagon M, dela Cruz E, et al. Parallel assessment of 24 monthly doses of rifampicin, ofloxacin and minocycline (ROM) versus 2 year WHO multidrug therapy (MDT) in multibacillary leprosy. *Am J Trop Med Hyg* (in press).
- 9 Croft RP, Nicholls PG, Steyerberg EW, Richardus JH, Withington SG, Smith WC. A clinical prediction rule for nerve function impairment in leprosy patients—revisited after 5 years of follow-up. *Lepr Rev* 2003;74:35–41.
- 10 Britton WJ. The management of leprosy reversal reactions. *Lepr Rev* 1998;69:225–34.
- 11 Smith WCS, Anderson AM, Withington SG, van Brakel WH, Croft RP, Nicholls PG, et al. Steroid prophylaxis for prevention of nerve function impairment in leprosy: randomised placebo controlled trial (TRIPOD 1). *BMJ* 2004;328:1459–62.
- 12 Lockwood DN, Bryceon ADB. The return of thalidomide: new uses and renewed concerns—a reply. *Lepr Rev* 2003;74:290–3.

The prejudices of good people

Leadership is needed to combat continued institutional racism

If it is only bad people who are prejudiced, that would not have such a strong effect. Most people would not wish to imitate them—and so, such prejudices would not have much effect—except in exceptional times. It is the prejudices of good people that are so dangerous.

Vikram Seth. *A suitable boy*. London: Phoenix, 1993.

In October 1998 a young black man, David “Rocky” Bennett, died while under the care of the NHS at a psychiatric secure unit in Norwich. An inquiry team led by a retired high court judge, John Blofeld, found that Mr Bennett, who had schizophrenia, was killed by being held face down on the floor for 28 minutes by at least four mental health nurses. He had been restrained with unacceptable force after he punched a nurse, believing that he was being racially victimised. Apart from investigating the circumstances of Mr

Bennett's death, the inquiry team looked more broadly at the way in which black and ethnic minority communities are treated by the mental health services of the NHS. Blofeld concluded that people from black and ethnic minority communities are not getting the service they are entitled to. He described the institutional racism that was responsible for this as a “disgrace” and a “festering abscess which is at present a blot upon the good name of the NHS.”¹

The term “institutional racism” was defined in 1999 by another retired high court judge, William Macpherson, in the Stephen Lawrence inquiry. This was set up to investigate the failure of a police investigation into the murder of a young black man. Macpherson described it as “the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, and ethnic origin.”²

BMJ 2004;328:1448–9

Examples of how institutional racism may operate in the NHS

- A consultant from an ethnic minority is suspended because of concerns about her clinical performance. Her operative complication rate for certain specialised procedures is considered high. In the external assessment of her work no comparisons are made with her white colleagues. That other more senior white consultants had more serious operative complications becomes apparent at the employment tribunal. Nothing was done by members of the senior management team in the hospital to deal with these concerns even though they were aware of them. That action is taken to protect patients in the case of the ethnic minority consultant is correct, but the process was discriminatory because white consultants were not treated in the same way.
- A consultant is denied discretionary points because the committee maintains that he did not show an above average contribution to his work. A white consultant was given discretionary points simply because he said that he was working hard. The committee did not independently assess and record its own assessment by reference to criteria and guidelines. Decisions were made in group discussions, by reference to general reputation rather than any objective criteria. No records were kept for any of the deliberations.
- Assumptions are made about the external qualifications of some doctors who have qualified overseas. Their training is considered inferior even though they have completed the relevant postgraduate qualifications in this country. No attempt is made to assess their experience and clinical ability by reference to work in this country. They are denied further training opportunities and end up in staff grade positions or as locums. They never obtain the experience required to become consultants.
- Complaints made to the General Medical Council have more chance of being investigated if they are made by hospital trusts or primary care trusts. These organisations are more likely to investigate complaints about doctors who trained overseas or come from ethnic minority backgrounds, possibly because they make assumptions about their training, experience, and competence. The same level of investigation is less often applied to complaints raised against white doctors because of perceptions about their reputation. Because fewer complaints about white doctors originate from trusts, they are less likely to be investigated when complaints are made to the GMC.

Most people wrongly believe that this means that everybody in an institution is in some way overtly or unconsciously a racist. However, the most important point about understanding what institutional racism means in an organisation such as the NHS is how processes, structures, and values operate to disadvantage black and ethnic minority patients and staff. It is unwitting prejudice, ignorance, and thoughtlessness that lead to institutional racism.

Lack of evidence is not what prevents us from understanding if the problems exist. Research has shown that ethnic minority doctors, who form nearly one third of the workforce of the NHS, are disadvantaged when they apply to medical schools or for hospital jobs at both junior and senior levels, and are more likely to be suspended if concerns are raised about their performance.³⁻⁵ They are more likely to be disciplined by the General Medical Council.⁶ Ethnic minority staff in the NHS are paid less and disadvantaged in the allocation of discretionary payments.⁷⁻⁸ They are more likely to face bullying and harassment from both patients and staff, and they are overwhelmingly over-represented in the more junior ranks of staff in the NHS.⁹⁻¹⁰ The Bennett inquiry listed the evidence, which showed that Africans and Afro-Caribbeans were over-represented in the mental health services, received a more coercive spectrum of care, were more likely to be regarded as dangerous, and were more likely to be overmedicated.

Therefore, the real question is not if the problem exists but why it continues to exist. A lack of training or inquiries is not the reason why the problem continues. The police, for example, held over 130 000 days of antiracism training over a four year period, but that did not prevent racist misconduct.¹¹ For the medical profession the problem is one of recognition that, just because individuals are not racist, this does not mean that institutional racism cannot exist. I have rarely met doctors who are obviously bigoted, but I have met many who deny the problem of racism but act in ways that result in certain groups of people being disadvantaged. What people think is not what matters—what they do is what matters, and in that respect the medical profession in the United Kingdom has a long way to go.

So what should be done? Leadership is critical, and the reality is that not a single leader of the medical profession has taken on the task of lancing this festering abscess. Every head of a medicopolitical organisation, every president of a royal college, and every dean of a medical school must look at his or her area of responsibility and ask themselves if ethnic minority staff and patients are receiving the service they are entitled to. Why are ethnic minority doctors over-represented in lower grades in the profession? Why are more complaints made against ethnic minority doctors, and why are there more suspensions? Are admission policies operating equally? Are our present curriculums teaching all students about cultural sensitivity and awareness? With virtually no ethnic minorities in these influential positions, and with only 1% of trusts' chief executives from black and ethnic minorities, the challenges are huge. Exhortations and good intentions abound but action is virtually non-existent.

Aneez Esmail *vice-president*

Medical Practitioners Union, MSF Centre, London SE1 3UD
(aneez.esmail@man.ac.uk)

Competing interests: AE is a member of the Medical Practitioners Union, which campaigns against discrimination in the medical profession. He acts as an expert witness in employment tribunals for doctors alleging discrimination against employers.

- 1 Norfolk, Suffolk and Cambridgeshire Strategic Health Authority. *Independent inquiry into the death of David Bennett*. February 2004. <http://image.guardian.co.uk/sys-files/Society/documents/2004/02/12/Bennett.pdf> (accessed 5 Mar 2004).
- 2 Macpherson W. *The Stephen Lawrence inquiry*. London: Stationery Office, 1999. (Cm 4262-1.) www.archive.official-documents.co.uk/document/cm42/4262/4262.htm (accessed 5 Mar 2004).
- 3 Esmail A, Everington S. Racial discrimination against doctors from ethnic minorities. *BMJ* 1993;306:691-2.
- 4 McManus IC. Factors affecting likelihood of applicants being offered a place in medical schools in the United Kingdom in 1996 and 1997: retrospective study [with commentaries by Esmail and Demetriou]. *BMJ* 1998;317:1111-7.
- 5 Commission for Racial Equality. *Appointing NHS consultants and senior registrars: report of a formal investigation*. London: CRE, 1996.
- 6 Esmail A. Complaints may reflect racism. *BMJ* 1994;308:1373-4.
- 7 Royal College of Nursing. *Stepping stones. Results from the RCN membership survey 2003*. London: RCN, 2004.
- 8 Esmail A, Abel P, Everington S. Discrimination in the discretionary points award scheme: comparison of white with non-white consultants and men with women. *BMJ* 2003;326:687-8.
- 9 Department of Health. *Tackling racial harassment in the NHS: evaluating black and minority ethnic staff's attitudes and experiences. A report for the Department of Health by Lemos and Crane*. London: DoH, 2000.
- 10 Department of Health. *Medical workforce statistics*. www.publications.doh.gov.uk/STATS/mdworkforce_may03_tab6.xls (accessed 5 Mar 2004).
- 11 Carvel J. We need to identify what people are doing wrong. *Guardian* 2003 February 13. <http://society.guardian.co.uk/mentalhealth/story/0,8150,1147206,00.html> (accessed 5 Mar 2004).