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**Health Matrix: The Journal of Law-
Medicine**

Volume 4 | Issue 2

1994

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LEGAL ISSUES ARISING OUT OF MEDICAL PROVISION FOR ETHNIC GROUPS

David Pearl†

I. INTRODUCTION

THE BLACK AND ETHNIC MINORITIES¹ now account for approximately 6.2% of the population of the United Kingdom,² and it is interesting to observe that for the first time, the Chief Medical Officer has included a chapter on the “Health and Black and Ethnic Minorities” in his Annual Report for 1991.³

It is perhaps not surprising that no detailed analysis has been made hitherto of the health problems, defined in the context of Western medicine, of ethnic groups. After all, it was

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1. This article is not concerned with the difficult problem of the definition of an ethnic group. Such issues create major problems in the race relations field; for example, it has now been held by the U.K. Court of Appeal that Rastafarians do not form “a separate ethnic group for the purposes of the Race Relations Act of 1976” and therefore “a Rastafarian who was denied a job as a van driver because he wore his hair long and refused to cut it had not been the victim of racial discrimination as defined in the Act.” Paul Magrath, *Law Report: Rastafarians Not an Ethnic Group*, THE INDEPENDENT (London), Feb. 16, 1993, at 22 (reporting on *Dawkins v. Department of the Env't Sub nom Crown Suppliers PSA*, [1993] I.C.R. 517 (Eng. C.A.)). See also *Mandla (Sewa Singh) v Dowell Lee*, [1983] 2 A.C. 548 (Eng.).

2. U.K. DEP'T OF HEALTH, ON THE STATE OF THE PUBLIC HEALTH: THE ANNUAL REPORT OF THE CHIEF MEDICAL OFFICER OF THE DEPARTMENT OF HEALTH FOR THE YEAR 1992, at 139 (HMSO 1993). The proportions of the population of the U.K. by ethnic group are generally stated to be as follows: White 93.81%; Black (Caribbean/African/Other) 1.86%; Indian/Pakistani/Bangladeshi 3.05%; Chinese/Other Asian 0.70%; All Others 0.58%. *Id.* at 139, 140 tbl. 5.2. The 1991 census reveals just under 3 million people from minority ethnic groups. *Id.* at 140 tbl. 5.2.

3. U.K. DEP'T OF HEALTH, ON THE STATE OF THE PUBLIC HEALTH: THE ANNUAL REPORT OF THE CHIEF MEDICAL OFFICER OF THE DEPARTMENT OF HEALTH FOR THE YEAR 1991, at 54 ch. 3 (HMSO 1992)[hereinafter CHIEF MEDICAL OFFICER 1991].

only in 1991 that the Census of Population included a question on ethnic group of the respondents.⁴ It is hoped, perhaps a little over-optimistically, that this information will provide more accurate information about the numbers of Blacks and ethnic minorities in the U.K. Previous censuses failed to collect similar information and the question on "country of birth" in the 1971 and 1981 censuses was obviously of only limited value to demographers and policy makers.

An important consideration for policy makers in the health service is that the regional distribution of ethnic minorities should be understood. There are many reasons why particular communities have chosen to congregate in certain parts of the country.⁵ It is of interest that the Chief Medical Officer himself is aware that these "variations, together with religious and cultural differences, are taken into account when considering the health care needs of a local population."⁶

There is clear evidence of prevalence of particular diseases usually associated with diet, such as non-insulin-dependent diabetes mellitus and coronary heart disease among certain ethnic groups, including both Asians and Caribbeans. Medical literature suggests that one reason for this prevalence is that a central distribution of body fat is a characteristic particular to Asians.⁷

One must accept at the outset the resource implications for the Health Service for adopting a proactive policy in this area. In the support context, provision for translation services⁸

4. See Mark R.D. Johnson, *A Question of Ethnic Origin in the 1991 Census*, 19 NEW COMMUNITY 281-89 (1993) (discussing the background leading to the eventual acceptance of an "ethnic question" in the 1991 census).

5. See generally Verity S. Khan, *The Pakistanis: Mirpuri Villagers at Home and in Bradford*, in BETWEEN TWO CULTURES (James L. Watson ed., 1977). For example, the former mill towns of northwest England held a powerful attraction to the early settlers from the subcontinent once employed in similar activities at home. P. Werbner, *From Rags to Riches: Manchester Pakistanis in the Textile Trade*, 8 NEW COMMUNITY 84-95 (1980).

6. CHIEF MEDICAL OFFICER 1991, *supra* note 3, at 56.

7. See CHIEF MEDICAL OFFICER 1991, *supra* note 3, at 65, 66 (citing P.M. McKigue et al., *Coronary Heart Disease in South Asians Overseas: A Review*, 42 J CLINICAL EPIDEMIOLOGY 597 (1989)). See also R. Balarajan, *Ethnic Differences in Mortality from Ischaemia Heart Disease and Cerebrovascular Disease in England and Wales*, 302 BRIT MED. J. 560 (1991) (illustrating that Caribbeans have a higher rate of hypertension and stroke).

8. In a different context, a Nuffield Foundation report identifies an alarming lack of properly qualified interpreters in the courts which puts non-English speakers at risk of injustice. See Scrivenor, *Lost for Words*, TIMES (London), Feb. 9, 1993.

and special dietary advice⁹ are but two examples of labor intensive activities which need to be provided by certain health authorities.

Equally important, and perhaps of major consequence for medical lawyers, are the ethical questions which emerge on a fairly frequent basis. Some of these dilemmas have been resolved, at least from the legal perspective, by a process of criminalization. For example, the Prohibition of Female Circumcision Act 1985¹⁰ provides a legal framework within which the practice of female circumcision, excision and infibulation, which is practiced in certain parts of Africa and Arab countries, has been made the subject of criminal sanction if performed in the U.K.¹¹ However, the response of individual health care workers to that practice still requires a sensitive and informed appraisal by Ethical Committees.

Thus, this article is concerned with two interconnected issues. First, the article will consider the questions relating to the provision of health services to ethnic minorities. Secondly, the article will consider ethical questions which are either peculiar to the ethnic minorities or are of frequent occurrence in that context. Overriding both questions, of course, is the important resource question.

II. THE PROVISION OF HEALTH SERVICES

The evidence supporting the statement that the ethnic minority population is not as healthy as the indigenous population is overwhelming. The Chief Medical Officer in his report for 1991 identifies that there was an excess coronary heart disease mortality in those born in the Indian subcontinent of thirty-six percent for men and forty-six percent for women aged twenty

9. CHIEF MEDICAL OFFICER 1991, *supra* note 3, at 75 (referring to the need to make dietary messages include examples from the diet of the community being addressed). See HIGHER EDUCATION AUTHORITY, ENJOY HEALTHY EATING: AN INDEPENDENT INTRODUCTION TO FOOD AND HEALTH (London 1991).

10. See generally SEBASTIAN M. POULTER, ENGLISH LAW AND ETHNIC MINORITY CUSTOMS 152, 156-60 (Desmond de Silva ed., 1986).

11. Prohibition of Female Circumcision Act 1985, ch. 38, § 1(1) (Eng.) It is "[a]n offence for any person — (a) to excise, infibulate or otherwise mutilate the whole or any part of the labia majora or labia minora or clitoris of another person; or (b) to aid, abet, counsel or procure the performance by another person of any of those acts on that other person's own body". *Id.* See generally K. Hayter, *Female Circumcision—Is there a Legal Solution?*, 1984 J. SOC. WELFARE L 323.

to twenty-nine compared with the rate for England and Wales as a whole.¹² This statistical data is based on a study of the period 1979 to 1983.¹³ There is clear evidence in the literature that those figures are predicted to rise further as a result of demographic changes.¹⁴

The Chief Medical Officer identifies high ethnic data which is no less worrying, for example rubella infections in pregnancy,¹⁵ tuberculosis¹⁶ and Hepatitis B.¹⁷ It is well known that inherited blood diseases, especially Sickle Cell disease, primarily affect the Afro-Caribbean community.¹⁸ The number of people with the Sickle Cell disorder, estimated to be about five thousand,¹⁹ hides the fact that there is a larger number with the trait. Thus, there are considerable risks in pregnancy, and screening programs have been instituted for all neonates in certain health authorities in areas with a large concentration of Afro-Caribbeans.²⁰ The Chief Medical Officer reports also on the questions relating to mental health, diabetes mellitus, cancer,²¹ osteoporosis and perinatal mortality rates.²² In all these

12. CHIEF MEDICAL OFFICER 1991, *supra* note 3, at 64.

13. Balarajan, *supra* note 7, at 562.

14. A.G. Lowy et al., *The Effects of Demographic Shift on Coronary Heart Disease Mortality in a Large Migrant Population at High Risk*, 13 J. PUB. HEALTH MED 276, 279 (1991). See also U.K. DEP'T OF HEALTH, THE HEALTH OF THE NATION: A CONSTRUCTIVE DOCUMENT FOR HEALTH IN ENGLAND 57-59 (1991).

15. In England in 1991, there were only 16 rubella infections in pregnancy, but six of these (or 37%) were in Asian women. CHIEF MEDICAL OFFICER 1991, *supra* note 3, at 66 (stating that the promotion of selective rubella immunization in the Asian community needs to be continued).

16. Here again the data is worrying. In the first six months of 1988, nearly 40% of the patients notified as having tuberculosis ("TB") were of Indian, Pakistani or Bangladeshi origin. *Id.* at 67. Even more troublesome is the observation that the decline of TB notifications from these groups is less than that recorded in the White population where the rate of infection is 25 times lower. *Id.*

17. *Id.*

18. *Id.* at 68.

19. *Id.* (citing M. Brozovic et al., *Acute Admission of Patients with Sickle Cell Disease Who Live in Britain*, 294 BRIT. MED. J. 1206 (1987); Ass'n for Consumer Research, *Sickle Cell Disease and the Non-Specialist*, 27 DRUG THERAPY BULL 9 (1989)).

20. See CHIEF MEDICAL OFFICER 1991, *supra* note 3, at 68 (reporting that the Standing Medical Advisory Committee has established a Working Party to look at the clinical management of Sickle Cell disease).

21. M.G. MARMOT ET AL., IMMIGRANT MORTALITY IN ENGLAND AND WALES 1970-78: CAUSES OF DEATH BY COUNTRY OF BIRTH 35-36, 38 (London HMSO 1984) (stating that the standardized mortality ratio is low for breast cancer and cervical cancer among persons of Indian origin, and high for cancers of the gall bladder among the Caribbean and Indian communities); R.M. Barker & M.R. Baker, *Incidence of Cancer in Bradford Asians*, 44 J. EPIDEMIOLOGY COMMUNITY HEALTH 125, 125-29 (1990).

22. CHIEF MEDICAL OFFICER 1991, *supra* note 3, at 68-71.

cases, the position is less than satisfactory, especially when it is realized that the ethnic minority population is concentrated in particular urban areas.

The U.K. government itself is concerned by these findings and is now beginning to develop health promotion strategies.²³ The Chief Medical Officer himself identifies "two major elements."²⁴ The first element is to ensure that Black and ethnic minorities "understand the health service, what it offers, and when and how they can use it."²⁵ Particular concerns appear in an article written on behalf of a Community Care project in the Central Birmingham Health Authority.²⁶ It states: "From the Asian person's perspective, services are inaccessible. We have seen that many are not told about services. The services on offer are often not appropriate and generally not geared to ethnic minority people's needs."²⁷ The second element is to ensure that all health services are appropriate to the health care needs of the local population, including the Black and ethnic minority community, and to ensure that these services are delivered in a culturally sensitive manner.²⁸ A particularly important initiative is the establishment of Services in Health and Race Exchange ("SHARE") by the King's Fund Center to serve as a resource and information center for black and ethnic minority communities and organizations working with these groups.²⁹

These statements of intent by the Chief Medical Officer, together with the type of initiative represented by SHARE, are of course all positive indicators. Another important develop-

23. Baroness Cumberlidge has been given a special responsibility for ethnic health. She is reported to have said: "We are finding that people with ethnic minority backgrounds do not get the full benefit of NHS services. We are not saying 'you have to conform.' We are saying 'please can you tell us how to help you access the services.'" Celia Hall, *NHS to Act on Unequal Service to Minorities*, THE INDEPENDENT (London), Dec. 29, 1992, at 4. A task force has been established to examine existing good practices in health care delivery to ethnic minorities and on January 6, 1993, the health minister arranged the first conference on the subject with ethnic group leaders. *Id.* See generally ACCESS TO HEALTH CARE FOR PEOPLE FROM BLACK AND ETHNIC MINORITIES 1-20 (Anthony Hopkins and Veena Bahl eds., 1993) [hereinafter ACCESS TO HEALTH CARE].

24. CHIEF MEDICAL OFFICER 1991, *supra* note 3, at 73-74.

25. *Id.* at 73.

26. K. Atkin et al., *Asian Elders' Knowledge and Future Use of Community Social and Health Services*, 15 NEW COMMUNITY 439 (1989).

27. *Id.* at 443.

28. CHIEF MEDICAL OFFICER 1991, *supra* note 3, at 73-74.

29. See CHIEF MEDICAL OFFICER 1991, *supra* note 3, at 74.

ment is the invitation on hospital admission forms to identify patients by ethnic group. This practice was initiated in April 1993.

However, lawyers still have reason to view with some concern aspects of the provision of health care to the ethnic communities.

The question which must be addressed is whether the wider community is ready, through its resource provision, to allocate additional provision for the health needs of the ethnic minorities in the U.K. Continuing evidence of discrimination within the Criminal Justice system has led to the enactment of Section 95 of the Criminal Justice Act 1991.³⁰ Section 95 states: "The Secretary of State shall in each year publish such information as he considers expedient for the purpose of . . . (b) facilitating the performance by such persons of their duty to avoid discriminating against any such persons on the ground of race or sex or any other improper ground."³¹

The first official report has now been published.³² A similar provision is lacking in any recent legislation on the health service. District health authorities are required under the National Health Service and Community Care Act 1990 to carry out "needs assessments" in their areas.³³ This will enable health planners to identify areas of need, but there is still no specific provision in the Act to identify the special health needs of the ethnic groups. Yet, if there is evidence that the ethnic minority population is not as healthy as the indigenous population, a strong case could be made for the enactment of a provision similar to Section 95 of the Criminal Justice Act 1991.

Is there, at the present time, a frame within which the law can provide, either on an individualized basis or as part of a wider group action, additional resources for certain sections of our community? Lawyers need to know whether there is a legal framework within which to begin to address the disturbing facts highlighted in this article. Comparisons, of course, should be made with the position in the U.S. where the argument has

30. Ch. 53 (Eng.)

31. Criminal Justice Act 1991, § 95(1).

32. KENNETH CLARKE, U.K. HOME OFFICE, RACE AND THE CRIMINAL JUSTICE SYSTEM (HMSO, 1992).

33. National Health Service and Community Care Act 1990, ch. 19 (Eng.).

been made that its health care system fails to provide for the needs of Afro-Americans.³⁴

The Chief Medical Officer identified a number of possible positive actions that should be taken to prevent discrimination in the delivery of services:

- Appropriate diet, such as Halal meat or vegetarian meals.
- Respect and facilities for religious observance and access by spiritual advisers, such as imams, pandits etc.
- Ready availability of women doctors for women patients.
- Ready availability of link workers, interpreters and advocates.
- Information in black and ethnic minority languages.
- Respect for the patient's standards of dignity and privacy, for example the provision of long nightdresses, long-sleeved clothing etc.³⁵

It might be thought that these are actions which can be initiated without any difficulty or major cost.³⁶ Of course, all initiatives have a resource implication, and Health Authorities purchasing plans reflect the priorities which are communicated to them in a number of ways, including not in the least community pressure. Sadly, there are clear indications that budgetary constraints have produced reductions in what can be perceived as "peripheral services."³⁷ Competition for resources within "types of injury," for example spinal injury as opposed to head injury, and within "types of patients," for example young patients as opposed to old patients, is almost certainly going to result in a further marginalization of ethnic minority needs. It must be observed that few Health Authorities have made much progress on developing procedures to ensure that their new contracts will improve the delivery of services to ethnic minorities.³⁸

34. See Vernella R. Randall, *Racist Health Care: Reforming an Unjust Health Care System to Meet the Needs of African-Americans*, 3 HEALTH MATRIX 127, 131-32 (1994) (arguing that health reform in America should ensure complete access and eliminate institutional racism to provide just health care for African-Americans).

35. CHIEF MEDICAL OFFICER 1991, *supra* note 3, at 73 tbl. 3.7.

36. See Jay Ogden, *Seasoned Workers*, SOCIAL WORK TODAY, Feb. 20, 1992, at 18 (describing the provision of halal food and other special food to the ethnic elderly in Birmingham); G. KARMI, LONDON: NORTH WEST & NORTH EAST THAMES REGIONAL HEALTH AUTHORITY, THE ETHNIC HEALTH FACTFILE (1992).

37. In 1992, the Government gave only £500,000 towards help in this area. ACCESS TO HEALTH CARE, *supra* note 23, at 7.

38. For a detailed and informed discussion, see Mark R.D. Johnson, *Chartering for Black Citizens' Rights*, 18 NEW COMMUNITY 316, 317 (1992). However, notwithstanding a

One can predict a future case where a Health Authority fails to provide Halal meat, for example, and an action is brought to court by an aggrieved individual or individuals to force the particular Health Authority to make such provision. One must assume that such an action is likely to be faced with the immediate difficulty that a court would consider such issues as being unsusceptible to legal control, bearing as they do on resource allocation.

Similar issues were raised in *R. v. Secretary of State for Social Services, ex parte Hincks*,³⁹ *R. v. Central Birmingham Health Authority, ex parte Walker*⁴⁰ and *R. v. Central Birmingham Health Authority, ex parte Collier*.⁴¹ In all three cases, the courts declined to intervene. As Sir John Donaldson MR said in *Central Birmingham Health Authority, ex parte Walker*:

This court could only intervene where it was satisfied that there was a prima facie case, not only of failing to allocate resources in the way in which others would think that resources should be allocated, but of a failure to allocate resources to an extent which was *Wednesbury* unreasonable, . . . , or, in simpler words, which involves a breach of a public law duty⁴² Even then, of course, the court has to exercise a judicial discretion. It has to take account of all the

generally negative report, Johnson does state that some action is now being taken in some authorities to examine what the specific service delivery needs of minorities might be and "to write those rights and legitimate expectations into the contracts." *Id.* Johnson cites as an example the "King's Fund project to promote ethnic sensitivity in contracting with Coventry H[ealth] A[uthority]." *Id.*

39. [1980] 1 B.L.M.R. 93 (Eng. C.A.), available in LEXIS, Enggen library, Cases file (involving orthopaedic patients at a hospital in Birmingham who had waited for treatment for periods longer than was medically advisable). See also IAN KENNEDY & ANDREW GRUBB *MEDICAL LAW* 387-89, 423-26 (1994).

40. 1987 3 B.L.M.R. 32 (Eng. C.A. Nov. 25, 1987), available in LEXIS, Enggen library, Cases file (where health authority lacked sufficient resources to carry out an operation on a "hole in the heart" baby). See also Craig Seton, *Heart Baby's Surgery Success*, *TIMES* (London), Nov. 26, 1987 at 1, 44.

41. (Eng. C.A. Jan. 6, 1988) (LEXIS, Enggen library, Cases file) (concerning a "hole in the heart" baby). See also KENNEDY & GRUBB, *supra* note 39, at 428-29 (discussing the case).

42. See *Associated Provincial Picture Houses, Ltd. v. Wednesbury Corp.*, [1947] 2 All E.R. 680 (Eng. K.B.) (holding that under a review of reasonableness a court is only entitled to investigate the actions of local executive authorities "with a view to seeing whether it has taken into account or controversy, . . . has neglected to take into account matters which ought to be taken into account").

circumstances of a particular case with which it is concerned.⁴³

A private negligence action is also almost certainly bound to fail on similar public policy considerations. In *Knight v. Home Office*,⁴⁴ Mr. Justice Pill said, "In making the decision as to the standard [of care] to be demanded the court must, however, bear in mind as one factor that the resources available for the public service are limited and that the allocation of resources is a matter for Parliament."⁴⁵

However, it is at least arguable that both a public law action directed against a Health Authority and a private negligence claim could succeed in certain situations. The germ for a legal assault in this area is obtained from a fascinating case, *R. v. Ethical Committee of St. Mary's Hospital Ex Parte H*.⁴⁶ This case concerned a very different factual situation from the one under discussion. A decision by the ethical advisory committee of the hospital to support the doctors' refusal to provide *in-vitro* fertilization ("IVF") treatment was unsuccessfully challenged on judicial review.⁴⁷ The plaintiff had been rejected by the local Social Services Department as a prospective adopter and as a foster mother because she had previous criminal convictions for prostitution.⁴⁸ The judge found that the grounds considered by the ethical committee for regarding her to be unsuitable were reasonable.⁴⁹ However, in the course of the judgment, the judge did say that if the IVF treatment had been refused for a wholly irrational reason, for example if the couple were Black or Jewish, then such a refusal should have been struck down by a review court as unlawful.⁵⁰ Thus, the refusal of treatment on non-medical grounds is clearly review-

43. *Central Birmingham Health Authority, ex parte Walker*, at *2.

44. [1990] 3 All E.R. 237 (Eng. Q.B.).

45. *Id.* at 243. *But cf.* Law Reform (Personal Injuries) Act 1948, 11 & 12 Geo. 6, ch. 41, § 2(4) (Eng.) ("In an action for damages for personal injuries (including any such action arising out of a contract), there shall be disregarded, in determining the reasonableness of any expenses, the possibility of avoiding those expenses or part of them by taking advantage of facilities available under the National Health Service Act, 1946, or the National Health Service (Scotland) Act, 1947, or of any corresponding facilities in Northern Ireland.").

46. [1988] 1 Fam. L.R. 512 (Eng. Q.B.), available in LEXIS, Enggen Library, Cases file.

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id.*

able by a court. As one commentator has said in connection with this case, "A patient denied renal dialysis or surgery because the consultant in charge refused to treat divorced people or Labor Party members might well have a remedy."⁵¹

This hypothetical illustration enables us to construct the parameters of a legal framework which in effect provides the Health Authority with broad discretion in the medical field. This enables it to take into account resource implications which are unchallengeable in a court, but which refuse to allow wholly irrational decisions.

The difficulty of such a model, of course, is simply that it leaves too much to chance. Discrimination is often not openly acknowledged. When it is, it can be dealt with by current legislation. More difficult to deal with is the attempt to tackle the different health needs of the ethnic minorities.⁵² In this context, the law operates perhaps only at the margins.

III. ETHNIC MINORITIES AND ETHICS OF MEDICINE

The following advertisement appeared in the *Law Society Gazette* for January 27th, 1993:

TRANSCULTURAL MEDICINE
Medical Practitioner specializing in Transcultural Medicine (dealing with patients from different cultural, religious, and ethnic background) available to assist in relevant cases.

A number of issues are raised when considering this and similar advertisements appearing elsewhere. First and foremost, it is necessary to consider exactly what is meant by "transcultural medicine." Presumably, the writer of the advertisement is offering to provide alternatives to Western medicine, perhaps the "traditional" medicines such as Ayurvedic or Chinese, or at

51. MARGARET BRAZIER, *MEDICINE, PATIENTS AND THE LAW* 23 (1992).

52. See Kamila Hawthorne, *Asian Diabetics Attending a British Hospital Clinic: A Pilot Study to Evaluate Their Care*, 40 *BRIT. J. GEN. PRAC.* 243 (1990). In addition, it is also important to identify some disturbing evidence of discrimination within the health service with respect to the recruitment and employment of health personnel. See *CRE INVESTIGATION INTO THE REORGANIZATION AND REGRADING OF NURSING* (1992).

least offering information to respondents on where such alternative medicines can be obtained. Does the phrase suggest, for example, that certain medical-cosmetics such as "surma"⁵³ will be available by the process of a single telephone call?

The Chief Medical Officer in his Report for 1991 identifies the necessity for health professionals to be aware that some Black and other ethnic minority patients will be using "alternative medicines" as well as, or as a substitute for those prescribed.⁵⁴

Practitioners of alternative methods of treatment are not registered under or regulated by the Medical Act 1983⁵⁵ and alternative medicines are not registered under the Medicines Act 1968.⁵⁶ Thus, a practitioner of alternative medicines cannot call himself a medical doctor, and anyone who "wilfully⁵⁷ or falsely pretends to be or takes or uses"⁵⁸ that name is committing a criminal offense under Section 49(1) of the Medical Act 1983. However, the existence of alternative medicine provides a hidden dimension to the provision of health care in the U.K. for members of the ethnic minority groups, and it is as well that this dimension is understood. At the present time, this provision is unregulated and not susceptible to any control by the professional bodies or any other institutional framework. There is certainly a case for suggestion that such practitioners should be controlled by some regulatory provision. Notwithstanding a certain level of apprehension, it is thought that the understanding of the alternative methods of treatment will have a more positive effect on the health of the ethnic minorities than any insensitive attempt to undermine the efficacy of

53. "Surma" is "a fine powder which looks rather like mascara, but instead of being applied to the outside of the eyelids it is painted on to the conjunctival surfaces of the eye. From there it is washed by tears from the eyes, swallowed through the back of the throat and hence absorbed into the blood. Asian parents appear to be applying it . . . to the children's eyes not only for cosmetic purposes but also to relieve eye-strain and soreness, as well as to ward off evil spirits. . . . [S]urma. . . often contains lead sulphide. . . [and] [n]umerous children are being admitted to hospitals every year suffering from lead poisoning as a result of using [surma]". POULTER, *supra* note 10, at 287-88.

54. See, e.g., David & Leslie, *Eastern Treatment and Eastern Health*, 6 J. COMMUNITY NURSING 16 (1979).

55. Ch. 54 (Eng.).

56. Ch. 67 (Eng.).

57. *Wilson v. Inyang*, [1951] 2 K.B. 799, 804 (Eng.) (holding that an African did not willfully use the title because he honestly held the belief that he could call himself "Naturopath Physician, N.D., M.R.D.P.>").

58. Medical Act 1983, § 49(1).

such alternatives. At one level, of course, there is here an important principle of the freedom for individuals to attempt alternative cures, if they so wish, to those available in Western medicine.

It is obviously true that some "traditional" remedies may be injurious to health, including as mentioned earlier the toxicity of "surma."⁵⁹ For example, it has been argued that the paramount concern is the health of society as a whole and therefore the State is under a duty "to intervene in the public interest."⁶⁰

In this context there is a particular problem surrounding the use of certain drugs such as cannabis which are illegal at the present time. Such use is often portrayed as ethnic-based, in particular, among West Indian Rastafarians who use it for religious and medicinal reasons.⁶¹ Cannabis is a controlled drug whose use was criminalized under the provisions of the Misuse of Drugs Act 1971.⁶²

Attention must be directed also to so-called "cannabis psychosis." Black support groups say that labelling certain mental disorders as being brought about by "cannabis psychosis" is an easy option for diagnostic difficulties in relation to the mental health problems of Black patients. Thus, the argument goes, psychiatrists in particular look no further than cannabis smoking as a cause for mental disturbance among young Black Rastafarians.⁶³ From the legal perspective, there is necessarily an identification with psychiatrists who follow this approach. Yet, such simplistic and all-embracing attitudes may well hide other explanations which still require research and analysis. It is too easy to erect a concept of a "cannabis psychosis" for an illness

59. See *supra* note 53; Ali, Smales & M. Aslam, *Surma and Lead Poisoning*, 2 BRIT. MED. J. 915 (1978); M. Aslam, S.S. Davis & M.A. Healy, *Heavy Metals in Some Asian Medicines and Cosmetics*, 93 PUB HEALTH (London) 274 (1979).

60. POULTER, *supra* note 10, at 287.

61. Some doctors, such as Joycelyn Elders the Surgeon General of the U.S., have gone on record as saying that they will back the medical use of cannabis, especially in relieving pain in relation to patients with cancer, AIDS and Multiple Sclerosis. See, e.g., *Health: Cannabis: Why Doctors Want It to be Legal*, THE INDEPENDENT (London), Feb. 23, 1993, at 14.

62. Ch. 38 (Eng.).

63. See Chris Ranger, *Race, Culture and the 'Cannabis Psychosis': The Role of Social Factors in the Construction of a Disease Category*, 15 NEW COMMUNITY 357, 360 (1989).

which is not easily understood. There is almost certainly a danger to stereotype illness on the basis of race in this context.

Other practices have been criminalized. For instance, attention already has been given to outlawing the practice of female circumcision through the Prohibition of Female Circumcision Act 1985. Not all commentators welcome such interventions. For example, one writer in an article published in 1984 prior to the legislation prohibiting female circumcision, but during a period of intense media coverage of this issue, identified the dilemma when he wrote:

Purely elective cosmetic surgery is an obvious case where the right of the individual to consent to treatment is not seriously questioned. Breast reduction, for example, is an unnecessary and mutilating operation involving considerable pain and scarring for the patient. If justification for its performance were called for, medical evidence of anxiety and depression brought on by the woman's dissatisfaction with her body would undoubtedly be sufficient to outweigh the injury inherent in the treatment. . . . Precisely the same justification would be pleaded in support of the legality of female circumcision and should, by analogy, in the absence of further justification for its prohibition, be sufficient. In both cases the women's perception of themselves reflects the demands of the social group to which they belong. This justification is the greater in the case of female circumcision where its necessity extends beyond mere aesthetic appeal, being crucial to the women's status with the group.⁶⁴

One may seriously challenge the analogy with breast reduction or enhancement. Such cosmetic surgery is usually a matter of free choice, whereas female circumcision is imposed on young girls by their elders. However, there is some strength in what the writer implied in the above comment for one should not underestimate societal pressures on some women to conform to stereotypes. One must consider what lies ahead for the girls who are not circumcised in accordance with their community practices.

The writer's argument could, of course, also be used to justify other "marginal" activities such as the acceptance of

64. Hayter, *supra* note 11, at 325.

“gender selection,”⁶⁵ yet here again the perceived advantage of such a procedure in certain sections of the community might be tested against the ethical values to be adopted by society as a whole in this controversial area.

Another topical illustration of the same dilemma, but going beyond simple questions relating to ethnic groups so as to include religious minorities, is the issue of autonomy in medical decision-making. This problem is most acute in relation to attempts to provide blood transfusions for Jehovah’s Witnesses or “Born Again” Christians and their children, some of whom are followers of the Fundamentalist approach to the sanctity of blood.⁶⁶ There have been a number of recent instances where members of the Jehovah’s Witnesses have bled to death after hemorrhaging during a routine operation in a situation where the doctor is aware of the patient’s view on blood transfusions because the patient’s religious beliefs prevented the patient from having transfusions.⁶⁷

Thus, the question of diverse medical practices raise ethical questions regarding self-determination and autonomy together with critical questions of resources.⁶⁸

III. CONCLUSIONS

We return to the dominant question identified in this article, namely that of resources. The current ideology in the U.K. places on budget holders the primary responsibility to ensure that resources are used in accordance with the priorities laid down by the budget holder in question. This is as true of health

65. A private member’s bill outlawing such activities was defeated in the House of Commons, Feb. 23, 1993. Children (Prohibition of Sex Selection) Bill 1993, Hansard, 219 H.C. Official Report col. 769-772.

66. See *Re T*, [1992] 4 All E.R. 649 (Eng. C.A.) (holding that T did not give consent due to her medical condition and that her mother had undue influence in T’s decision to refuse a blood transfusion); *Re S*, [1992] 4 All E.R. 671, 672 (Eng. Fam.) (declaring “that a Caesarian section and any necessary consequential treatment which the hospital and its staff proposed to perform on the patient was in the vital interests of the patient and her unborn child and could be lawfully performed despite the patient’s refusal to give her consent”). See generally Andrew Grubb, *Treatment Decisions: Keeping It in the Family*, in CHOICES AND DECISIONS IN HEALTH CARE 37 (Andrew Grubb ed., 1993).

67. See, e.g., *Woman Dies*, THE INDEPENDENT (London), Feb. 5, 1993, at 2 (reporting that a Jehovah’s Witness died because she refused to have a blood transfusion after suffering a hemorrhage during a routine operation).

68. Another example, in relation to blood substitutes there is no doubt that the alternatives, which are available, are likely to be substantially more expensive than blood or blood products themselves.

providers as much as it is of education providers or any other provider of services. This Thatcherite ideology inevitably makes minority groups and interests more vulnerable than they would be if services were based solely on needs. Inevitably ethnic groups' needs are marginalized within such an environment; however, it is to the law that such groups turn in the extreme situations. Judicial review procedures require refinement to enable class actions to be more readily available; *locus standi* rules need to be reappraised, and strategies similar to Section 95 of the Criminal Justice Act 1991 need to be introduced into the health area. The law must learn to be more proactive, since at the present time there has been little legal activity in this arena. The message is simple: there is plenty for law and lawyers to do.

