objections are based on simple prejudice rather than anything else then I would discuss the matter further with the patient and explain that referrals are not made on the basis of the doctor's ethnic origin but on the basis of the doctor's experience, specialist training, and so on. If the patient is still unhappy then I would refuse to make the referral to their doctor of choice but would explain that (depending on my seniority) I would need to raise it with my manager/colleague. I would then raise the issue with the appropriate hospital consultant/manager and would hope that they back my decision as it is entirely inappropriate and racially discriminatory for someone to refuse an appointment with an ethnic minority doctor. There will be hospital/surgery policies about this and I would also point these out to the patient.

Of course there may be instances where a patient may have appropriate and legitimate reasons for seeking an appointment with a doctor on the basis of gender/race/religion, for example, a devout Muslim or Christian woman may feel more comfortable being examined by a female doctor. Where possible we ought to try and meet a patient's needs in such circumstances.

Finally, in the described scenario, if the patient's request for an alternative doctor is accepted, then it would leave the hospital/trust open to a race discrimination claim by the ethnic minority doctor if she/he found out.

Senior NHS human resources manager

All employers have a duty of care to protect their staff from any form of discrimination, both direct and indirect, by other staff members or, in the case of the NHS, by patients.

While we can apply disciplinary sanctions or arrange for retraining for staff, we cannot take such direct action against patients. However, that does not mean that nothing should be done. In the present scenario, the junior doctor should check that there has been no misunderstanding and that the patient is asking not to be referred to the senior doctor simply because her name makes it likely that she is of a particular ethnic origin. The junior doctor should question this, as we cannot determine an individual's ethnicity by their name alone. The fact that the senior doctor is the expert in this field should be reiterated.

If the patient is adamant that she does not wish to be seen by the senior doctor because of her ethnicity, the junior doctor should point out that the NHS does not tolerate racist attitudes and that under the circumstances it would be appropriate to refer her to another senior colleague – but only to protect the original senior doctor, not to bow to the patient's prejudices. Knowing the views of the patient, it would not be appropriate to expose the senior doctor to them. The senior colleague who then takes the referral should be told informally that the reason that she/he has been asked to see this patient is because of the patient's racist attitude and the duty of care to a colleague.

The junior doctor should also mention this episode to the family planning clinic manager, as the problem could arise again in the patient's dealings with other members of staff, including nursing and administrative colleagues.

Discussion

Whereas we should not allow our views of patients' beliefs to prejudice the treatment we provide, we cannot accept racial harassment of our colleagues. The current GMC document, *Good Medical Practice*,[1] advises doctors to respect their patients' views. The new GMC document, *Good Medical Practice: A Draft for Consultation*,[2] is out for public consultation and includes a statement that "you must not allow your views about patients' … beliefs … to adversely affect your professional relationship with them".[2] The Nursing and Midwifery Council code of professional conduct states that: "You are personally accountable for ensuring that that you promote and respect the interests and dignity of patients and clients irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture and religious or political beliefs".[3] The guidance from these two professional organisations raise questions about what constitutes a political belief and whether some beliefs should be acknowledged by professional organisations as unacceptable.

Acknowledgements

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References

1 General Medical Council (GMC). *Good Medical Practice*. London, UK: GMC, 2001. http://www.gmc-uk.org/guidance/good_medical_practice/index.asp [Accessed 25 October 2005].

2 General Medical Council (GMC). *Good Medical Practice: A Draft for Consultation*. London, UK: GMC, 2005. http:// http://www.gmc-uk.org/GMP_Consultation/documents/Good_Medical_Practice.pdf [Accessed 25 October 2005].

3 Nursing and Midwifery Council (NMC). *The NMC Code of Professional Conduct: Standards for Conduct Performance and Ethics*. London, UK: NCM, 2004. http://www.nmc-uk.org/(w5x5una2n1uyns55ciun3g55)/aDisplayDocument.aspx?DocumentID=201 [Accessed 31 October 2005].

Book Review

"Six Hundred Miseries" the Seventeenth Century Womb: Book 15 of 'The Practice of Physick' by Lazare Riviere, translated by Nicholas Culpeper. JL Burton (ed.). London, UK: RCOG Press, 2005. ISBN: 1-904752-13-6. Price: £24.95. Pages: 213 (paperback)

As soon as my review copy of this gorgeous little hardback arrived, colleagues kept picking it up, dipping into it, and asking to borrow it. [NB. This, other reviewers will agree, is a rare occurrence.]

Burton's preface, biographical notes on Riviere, and his concise and very readable introduction 'Humours and herbs in the 17th century' put the medicine of the period into context, and include some excellent reproductions of fascinatingly detailed engravings of the gruesome-looking practices of the day.

The book itself, *Of Women's Diseases, All Englished by Nicholas Culpeper, Physician and Astrologer*, consists of 24 chapters about common gynaecological conditions, some of which are easily recognisable ("Of the falling down of the womb" needs no translation, although some of the remedies seem a little extreme) and some less so ("Of mortification and blasting of the womb" refers to gangrenous conditions).

Contraception is not specifically mentioned, and Burton outlines in his introduction that it was not a preoccupation of the day. "Of barrenness" merits its own chapter, outlining the prerequisites for conception, which of course are that "the woman in her genital embracements should conveniently receive the man's sperm, she should retain it for a reasonable time, she should preserve it in her womb, she should provide fitting materials to form the embryo (blood and nutrients)" which is spot on. The description of aged virgins' genital parts and why they are unable to "easily admit a man's yard" is not for the fainthearted. The description of moist, hot and dry distempers as causes of infertility seem to describe women with various modern metabolic disorders (although "excessive carnal conjunction" is no longer considered a risk factor for infertility on its own).

There's an intriguing glossary of the herbs, animal products and minerals used by Riviere and his contemporaries, including many that will be familiar, such as Agnus Castus, sage and St John's Wort, with notes on 17th century and modern uses. Interestingly, on the same page as the ISBN number is a small print disclaimer: "The remedies … have never been tested for safety … Riviere's remedies and treatments as described in this book should not be used and are only of historical interest". Disappointing. I was desperate to use the "leaves of lettuce, willow tree, water lilies, vine tree, purslain and pennywort, flowers of violets, water-lilies and roses" bath soak for the next case of womb madness (nymphomania) I see in the gynae clinic.

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