reviews

BOOKS • CD ROMS • WEBSITES • MEDIA • PERSONAL VIEWS • SOUNDINGS • MINERVA

Inequalities in Health: The Evidence

Eds David Gordon, Mary Shaw, Daniel Dorling, George Davey Smith

Policy Press, £18.99, pp 272
ISBN 1 86134 174 1

The Widening Gap: Health Inequalities and Policy in Britain

Mary Shaw, Daniel Dorling, David Gordon, George Davey Smith

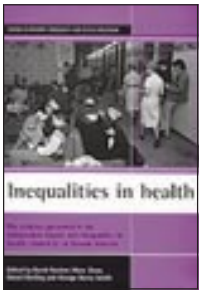
Policy Press, £16.99, pp 294
ISBN 1 86134 142 3

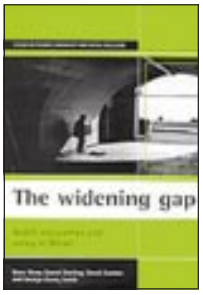
Rating: ★★, ★★★

Inequalities in Health is a useful collection of state of the art papers, written by British experts for the Independent Inquiry into Inequalities in Health. The inquiry, commissioned by the newly elected Labour government in 1997 and chaired by Sir Donald Acheson, reviewed the evidence on inequalities in health in England in order to identify areas for policy development likely to reduce these inequalities. In 1998 it published its report with only a summary of the evidence, and now we have the complete evidence in our hands. There are 19 reports, on topics ranging from children to ethnic minorities, from housing to nutrition, and from mental to oral health.

It is clear that this inquiry has done more than any previous commission, both in Britain and elsewhere, to base its recommendations on scientific evidence. In comparison with its immediate predecessor in Britain—the 1995 King's Fund report *Tackling Inequalities in Health*—not only has the scope of the inquiry widened but the evidence on mechanisms underlying inequalities in health has become much more detailed.

And yet the evidence base for policy making is still very unsatisfactory. Those who would like to see some proof of effectiveness before large scale measures are taken will be disappointed. Most of the reports argue, on the basis of results from observational research, that a particular factor or mechanism contributes to the inequalities in health; they then develop some policy options that are likely to change the exposure to the factor or mechanism. That's fine because it suggests that the policy will reduce inequalities in health, but it is not enough because it does not tell us what the real quantitative impact of that policy will be. That can be determined only on the basis of an intervention study—not necessarily a randomised controlled trial but, say, a quasi-experimental study showing that a particular measure reduces inequalities in health or simply improves the health of disadvantaged groups.





Such evidence, however, is typically not available. Fortunately, the independent inquiry did not fall into the trap of policy nihilism and distilled 39 recommendations for policy development from the evidence.

It has since been criticised for its long "shopping list" of recommendations without any clear priorities, but the fundamental reason is that we do not know what really works and what does not. In so far as the recommendations are followed by the British government, one would hope that all measures are accompanied by thorough evaluation studies, so that future inquiries, both in Britain and elsewhere, have more evidence to build on.

The Widening Gap

The Widening Gap, although written by the editors of the previous book, is completely different in character. It is based on an original variation of the geographical approach to inequalities in health. It presents health inequalities by contrasting the parliamentary constituencies having the worst health with those having the best health. The "worst health" million—the million inhabitants of Britain having the highest premature mortality—live in 15 constituencies in Glasgow, northern England, and the centre of London, which are characterised by high levels of poverty and other indicators of socioeconomic disadvantage. The "best health" million live in 13 prosperous constituencies located mainly in southern England. An appendix gives detailed data for all constituencies, including the names of current members of parliament in an apparent attempt to raise feelings of responsibility among politicians.

The book also reviews the explanations of inequalities in health and describes the widening of the health gap in recent decades, again using the geographical approach. The most interesting chapter for me, however, was the final one, which reviews the recent policy debate in Britain. It is highly critical of both the independent inquiry and the current Labour government.

The inquiry is criticised for its lack of prioritisation—"the fundamental role of poverty and income differentials was lost in a sea of (albeit worthy) recommendations ranging from traffic curbing to the fluoridation of the water supply." The government is criticised for not keeping the promises the Labour party made while it was still in opposition—"New Labour believes that taking money from the rich and/or middle classes is political suicide"—and for its half-hearted response to the independent inquiry.

Although I disagree with the authors' conviction that poverty is the main factor in explaining inequalities in health, their analysis of the potential impact of current government policies on inequalities in health is enlightening. My impression is that the British government is now doing more than any other European government to reduce inequalities in health, but the authors are probably right in saying that still more needs to be done in order to have a real impact. This is a challenge and a lesson for all who are working to reduce inequalities in health.

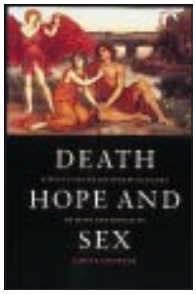
J P Mackenbach *professor, Department of Public Health, Erasmus University, Rotterdam, Netherlands*

Reviews are rated on a 4 star scale (4=excellent)

The BMJ Bookshop will endeavour to obtain any books reviewed here. To order contact the BMJ Bookshop, BMA House, Tavistock Square, London WC1H 9JR.
Tel: 020 7383 6244, Fax: 020 7383 6455
email: orders@bmjbookshop.com
Online: bmjbookshop.com
(Prices and availability subject to change by publishers.)

Death, Hope and Sex

James S Chisholm



Cambridge University Press, £17.95, pp 310
ISBN 0 521 59708 0

Rating: ★★

There have been many attempts to use evolutionary theory to justify controversial moral or social positions. In the 19th century the British social philosopher Herbert Spencer proposed a social Darwinism that would marry evolutionary ideas and Protestant ethics. In the 1970s, the discipline of sociobiology gained popular appeal for its synthesis of the natural and social sciences. And in Sweden's recent policies of eugenic sterilisation the state itself was attempting an enforced "survival of the fittest."

James Chisholm wants to save evolutionary theory from accusations of misuse and abuse. We have nothing to fear from it, he argues, for it offers a humane explanation for our behaviour and a potential route to a world of greater health, freedom, and justice. To support his radical claims, he takes the reader through a stepwise series of theoretical ideas, building layer on layer to create a new species of medicine called "evolutionary public health." Will this species survive? It is too early to say, but the beast is certainly an interesting one.

While the racy title and erotic cover art might suggest a light read, nothing could be further from the truth. Chisholm almost bludgeons the reader with the weight of his academia. The language is burdened by jargon, and there are few breaks in the text-rich pages.

He starts with a rejection of postmodernism, arguing that "all forms of life have knowledge" that cannot be socially constructed. Our minds, repositories of this knowledge, have evolved to represent the risks in our environment so that we can determine the best strategy for reproductive success. Slaves to our selfish genes, all of us must frantically ensure that we leave offspring behind. But how do we know which is the optimal strategy? Chisholm's elegant theory is that children gauge what kind of future lies ahead from their early emotional attachment experiences. Their emotions will guide them to the most valuable reproductive strategy. "As eyes sense light and ears sense sound," he says, "emotions sense value."

The best strategy is one that makes the best use of available resources. When parents have few emotional and material resources to invest, their children can "sense" that their future is a risky one. And here lies his evolutionary explanation of unhealthy behaviour. If we face a risky future, our best reproductive strategy is to have unprotected sex at a young age with multiple partners. Men in a high risk situation will fight off other male competitors with violent acts. These "syndromes" of behaviour are ultimately damaging.

Chisholm fortunately steers clear of reactionary cant. Rather than demonising single mothers for failing to invest in their children, he uses his theory to suggest an "evolutionary medicine." We have a duty to address inequalities across socioeconomic groups, he argues, because these cause children to adopt unhealthy reproductive strategies. We should instead adopt social arrangements that equalise children's capability to choose and attain valuable and healthy futures. In his stirring conclusion, he writes: "The capability to achieve a good human life includes the freedom to do so."

This is a weighty read, and the pay off doesn't quite match the effort involved. I was left with many unanswered questions. Why do we need to invoke evolution in attempting to create justice? What about the social construction of inequality? If the goal of life is reproductive success, where does that leave childless couples? Later this year, two evolutionary biologists will publish a book claiming that rape confers an evolutionary advantage on the perpetrator. Chisholm has a long way to go to reassure us that evolutionary explanations are more humane than social ones.

Gavin Yamey *BMJ*

A book that changed me

Why I am not a Christian

Bertrand Russell

Routledge, £9.99, pp 208
ISBN 0 415 07918 7

In 1969, at the age of 17, and after eight schooners of lager and a night of murderous vomiting to celebrate my final matriculation exam, I left my home in rural New South Wales and moved to a university hall of residence in the parental Gomorrah of Sydney. In the room opposite me was an earnest man from Hong Kong, 10 years my senior, who late at night would tap on my door to invite me to play chess and drink jasmine tea. He was studying for a PhD on the mathematical philosopher Gottfried Leibnitz, and his room was full of books with titles that both frightened and excited me at the prospect of all I would need to know now that, overnight, I was no longer a child. On the first night I entered his room the title of one burnt into my brain—Bertrand Russell's *Why I am not a Christian.*

Such profanity promised to fit well with other unwritten books that swirled in my callow head: *Why I No Longer Live with My Parents; Things To Do with Naked Girls; Mind Altering Drugs for Beginners.* I asked if I could read it, and I recall switching off my light at 3 30 am, drunk with excitement at the eloquent defilement that I'd just consumed. Not since I'd wolfed down *Lady Chatterley's Lover* in an afternoon at the age of 13—after being handed it by a conspiratorial librarian with pearls and hair in a bun—had I had such joy from a book.

I'd been brought up in the high Anglican church, and God had been a problem for me ever since I, at about age 10, had asked my parents, "If God made the world, who made God?"—something that Russell now informed me was the naïf's way of phrasing the argument from first cause. The imperious canon from our cathedral was invited home for afternoon tea to plug the dyke of the boy's worrying scepticism: staring at me with that look, he said there was simply no need to keep on asking the question—it all just started with God. "Sure … right," I thought. Church for me had been the pageantry, the lusty singing on cold Sunday mornings, the scented mothers fussing with scones and jam after the service, but especially the chance to pash choirgirls after practice on Thursday nights. I'd had little truck with the theology, and the stuff about heaven seemed patent anthropocentric wish fulfilment, clasped to the bosoms of the mostly aged parishioners who seemed determined to believe in it all.

The shackles of the afterworld fell off that night, and in rode the exhilarating awareness that my gut level scepticism in fact had whole tribes of authors to support it. Russell's book was soon followed by Joachim Kahl's *The Misery of Christianity: Or a Plea for a Humanity Without God.* This catalogued the horrors wrought in the name of religion, while championing the values that many religions wanted to claim as their own. Jean Paul Sartre's essay *Existentialism and Humanism* consolidated the rift while securing the importance of taking responsibility for your beliefs and values. It also gave me a French philosophical badge that I wore as an undergraduate, along with my pretentious Gitanes cigarettes and taste in excruciating films by Bresson, Renoir, Resnais, and Truffaut.

Russell's book, and much of what I learnt about his life, embodied two of the most important things in my later life—passion for justice and intellectual scepticism. It'll be in my own 17 year old's Christmas stocking this year.

Simon Chapman *associate professor, Department of Public Health and Community Medicine, University of Sydney, Australia*

PERSONAL VIEW

Stronger campaign needed to end female genital mutilation

Female genital mutilation is considered to be the most dangerous ritual custom still practised. It is performed in 26 countries, and more than 100 million women have been mutilated, with two million girls subjected to the ordeal each year. The procedure is carried out in Western countries among immigrants from African countries, and it is estimated that the number of girls at risk or who have already been mutilated is 168 000 in the United States, 42 000 in France, and 10 000 in Britain.

We interviewed 14 African women who had undergone the procedure and were living in France. They were all members of African cultural associations unrelated to the campaign to abolish female genital mutilation. Thirteen had undergone clitoridectomy and one had been infibulated. Ten were Muslims and four were Christians. Only one woman favoured the practice, although her 2 year old daughter had not yet been mutilated. Two were uncertain, although one out of their four daughters had had the procedure performed on them. Religion and social pressure were the arguments justifying mutilation.

Among the 11 women who opposed the procedure, eight of their 11 daughters had already had it, but they bitterly regretted the fact.

Mutilation is illegal in Europe and the United States, and for this reason international medical authorities have rejected the idea of doctors performing the procedure to prevent physical complications. Some immigrants send their daughters to Africa for holidays, where the mutilation is carried out. Education about the dangers of the practice has increased in Africa, but it is insufficient.

We believe that only by changing the social and political position of the women at risk will they become aware of their sexual oppression, so the education programme needs to be more targeted and ambitious. Although the Koran does not prescribe female genital mutilation it is almost exclusively practised in countries with a high Muslim population. It does not exist in Islamic countries, such as Saudi Arabia and Iran. The procedure would decline if it was condemned by religious authorities and the media.

Social pressure is another obstacle. Mothers consider the procedure to be a criterion for marriage, so any education campaign must also be addressed to men who must be persuaded not to require their future wives to have had the procedure. Some people have proposed an alternative ritual, and in Kenya girls have been sent away for a week in isolation and taught anatomy and physiology, with the idea of developing self esteem. But is this really necessary? It would be better to prohibit the procedure without substituting anything else.

The women we interviewed considered their daughters' mutilation and their sons' circumcision to be similar. Male circumcision is also a form of genital mutilation since it involves removing a healthy part of an organ. How can we convince mothers that they should not mutilate their daughters while they could continue to have their sons circumcised? The dilemma is that male circumcision is widely spread, has a religious significance, has a low morbidity in developed countries, and is practised even in countries where female genital mutilation is unknown. Because of the fear of compromising the eradication of female genital mutilation, male circumcision is tolerated as doing less harm.

JEAN-MARC BOUJU/AP PHOTO

A 6 year old Somali girl has her legs tied together after her mutilation and eats only sticky rice to prevent her from urinating

If you would like to submit a personal view please send no more than 850 words to the Editor, BMJ, BMA House, Tavistock Square, London WC1H 9JR or email **editor@bmj.com**

Pascal Abboud and **Christian Quereux**, *obstetricians and gynaecologists, University Hospital of Reims, France,* **Georgette Mansour**, *obstetrician and gynaecologist, Hospital of Soissons, France,* **Fadila Allag** and **Michele Zanardi**, *midwives, University Hospital of Reims, France*

SOUNDINGS

The new kids

They came last Monday, just as the ones before them did—anxious, eager for all the knowledge we can give them in the four weeks they will spend with us. Are we ready for the challenge?

The sixth year students have a schedule for passing through the wards here at the hospital: 12 groups of about 15 students, distributed throughout the year, after which they are supposed to be ready for their final tests and they can rightly be called doctors (in training, but undeniably doctors).

And now we have the third group of the year with us, rubbing elbows with us on the morning rounds, eating in the cafeteria, discussing patients' conditions in the corridors, wanting badly to impress us, earn our respect, and prove themselves as equals in the appalling task of taking care of other people's lives. I must say that some of them have a real calling to become true doctors, to such an extent that it's not uncommon to hear complimentary remarks made about them—not, of course, in front of them.

But the reverse is also true. We are the object of their scrutiny, measured and weighed, and then we are either absolved or condemned according to very specific standards: knowledge ("Yes, Dr X knows a lot, but did you listen to Dr Y during last night's round? Brilliant"); bedside manners ("I thought that she was about to eat alive that patient who refused her medicine"); and sympathy ("We love Dr Z, she's such fun and so gentle.") Sometimes when I walk along the ward I think that I can see the judges on both sides, eyeing the adversary and passing their final judgments.

Even if I have less contact with the students than my colleagues—other than responding to a request for a psychiatric evaluation on the ward—I make the most of the opportunities and try to learn from them. What do they need from me and my friends? What do they expect to achieve in the medical profession? If I were one of them—as I was 12 years ago—would I enjoy this phase of my education?

And, 12 years from now, will they care to remember us?

Ricardo S Silva *psychiatrist, São Paulo, Brazil*