support my view I am concerned that the increasing numbers of prescribers will inevitably lead to more antibiotic use.

Reducing diagnostic uncertainty would be of great benefit for, as Fleming says, 'both individual patient management and for surveillance'.[13] The cost and time implications have been discussed for many years, but it remains an important potential way forward.

Finally, so much of our information on the related issues of resistance and prescribing is based on less than perfect surveillance, especially in general practice. The Royal College of General Practitioners and the Health Protection Agency undertake useful programmes but they have acknowledged limitations. A truly 'National' Health Service should be able to develop a more comprehensive policy that is robust and encompasses both hospital and primary care — but that is another can of worms.

Antimicrobial resistance has been described as a 'major threat to public health'.[14] Antimicrobials are a limited resource. Conservation is of paramount importance if we are not to allow, as Pasteur is said to have stated, that 'the microbes have the last word'.

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Safety and achieving equality amid diversity in health care

'I am becoming rather tired of endless advice as to how and why GPs should make adjustments for patients from ethnic minorities'.

So writes a GP in response to a recent special series on ethnic diversity in a well respected educational publication for family physicians. Her view typifies how equality and diversity continue to create polarised perspectives. For example, witness the rather shrill debate about interpreting services in the UK at present. Alarm at their cost to public sector has provoked a review of language services at the request of the Secretary of State for Communities no less. Our corresponding GP expresses a popular concern that 'assimilation is the most important aspect of integrating immigrants, but many patients never seem to learn English'.

Promoting safe health care requires that everyone should be able to access the care they need. Achieving equality of care amid diversity is one part of this. Many with limited English in the UK and US are among the most disempowered and disadvantaged of our patients and experience inequalities in care, mortality, and morbidity.[1,2] The case that any safe health system will always need some form of appropriate interpreting services is surely irresistible given the reality of global migration. On the other hand, there is a perfectly cogent argument for people to learn — and be supported to learn — the major language of the country in which they choose to settle and live if they are to benefit most from the systems and opportunities they encounter as citizens.

Such divergence stimulates thought and debate. It certainly makes good copy for the tabloid and general medical press.[3] However, and with the danger of casual

racism at one end of the spectrum, this polarity tends to be unhelpful. Often, solutions are not 'either or' but usually lie somewhere in between, varying according to context. As the only doctor in my practice who doesn't speak the Punjabi spoken by our local population, I rely on interpreters to practice safely. I will continue to rely on them even if my faltering attempts to offer a little intelligible Punjabi ever succeed. Many of my Pakistani patients — young and old — are trying hard, or would clearly like to learn English. Their unemployment, low paid shift work, or unpaid domestic care doesn't help matters. Neither do current cuts to heavily oversubscribed English for Speakers of Other Languages courses, or waiting up to 3 years to become eligible for free tuition. My patients' efforts to 'assimilate' put my own within their community to shame.

The aforementioned special educational series reflects a fashionable aspiration to be 'culturally competent' through knowledge of different ethnic groups in relation to health care. Our corresponding GP finds this tiresome. Again, polarity is best avoided in favour of a more balanced approach. With globalisation, it is unfeasible for health professionals to be familiar with the kaleidoscope of cultural issues that may apply in an encounter.

Defining cultural competence for clinical practice is proving rather elusive despite claims for its worth, especially in the US.[4] Similarly, research has yet to investigate routinely whether 'culturally informed' practice improves quality of care. Promising exceptions include interventions to enhance communication.[5,6] We also know interpreting services generally help, and that poor interpretation can result in adverse outcomes.[7,8] However there is little evidence to support 'cultural competence' of the special knowledge variety.

There is some reason then to have sympathy with our GP. Yet, diversity matters in clinical settings, shaping behaviours, values, beliefs, and interactions between people. Thus, it makes sense for health professionals to have some awareness of facets of culture that may be relevant to people in their local context, for example beliefs about diabetes.[9] At the same time it is folly to treat patients according to cultural assumptions and facile sets of do's and don'ts. The fundamental principle is to respond to the individual, and not their stereotype, in any clinical encounter.[10,11]

Rather than 'knowing' about cultural issues, professionals should recognise their potential importance and acknowledge that exploring them where necessary may facilitate safe and effective care for the individual. This may sharpen our focus on ascertaining an individual's particular concerns and understanding about their illness or problem — what matters most to the patient (and their family), of whatever background.

It is also worth remembering that cultural influences on health and health encounters may often be more socioeconomic or educational than, say, related to ethnicity, language, or religion. In many if not most respects, health care for many people from ethnic 'minorities' reflects the challenges for all socioeconomically disadvantaged communities.[11] High frequency of consultation, mental distress, or the recalcitrance of poor diabetes control, for example, will all be familiar in these circumstances whatever the prevailing ethnic groups.

In the UK almost 14% of the NHS comprises staff from minority ethnic communities. It is estimated these communities, which make up 9% of the general population, will provide half the growth in the UK's working population by 2010. This provides important opportunities to strengthen the diversity of the health workforce to not only reflect that of local communities, but also widen the talent in the service.

While there is no shortage within medicine from some communities, such as those from middle-class Indian backgrounds, there has been distinctly less progress across the health workforce as a whole. This means developing flexible routes into healthcare training and employment for minority communities.[11,12] Facilitating work for those often stereotyped as having cultural values precluding health careers can also be achieved.[13]

The focus of ethnicity and health research needs to shift away from the repeated definition of familiar problems, such as compromised access to care or greater disease risk. Rather, we need to use evidence we already have, and to develop further insights about the nature and effectiveness of interventions and how to implement them.[11] Here there is encouraging evidence that the knowledge and skills of diverse communities can improve quality and equality of care in tackling the health deficit that some communities face. Positive experience of community health educators and link-workers in the prevention and management of heart disease and diabetes provide good examples that might be more widely implemented.[14] Models of bilingual community advocacy in health care for disadvantaged groups also show promise, and their further definition and evaluation are much needed.

Arguably, there has never been a better and more receptive climate in which to act on inequality and diversity. Recent legislation, such as the Race Relations Amendment Act, places a statutory duty on public services to not only avoid discrimination, but also to promote equality actively. However, equality in the health workforce remains a challenge. Employment prospects and aspirations vary between and within groups, but overall staff from minority communities are disproportionately clustered in the lower career grades. A range of strategies to reduce barriers are needed, from shifts in organisational culture to use of mentors.[12]

A joint RCGP, National Clinical Assessment Service, and Department of Health workshop poses difficult questions about how best to promote equality in career progression and assessment of GPs from minority ethnic groups (RCGP/NCAS/DH, unpublished data, 2005). It highlighted how those trained overseas are more likely to be referred to the NCAS. Although the proportion of complaints to the General Medical Council (GMC) about overseas doctors is proportionate to their numbers in the medical workforce, they remain more likely to appear before GMC Fitness to Practise panels and be banned from practising than white doctors. Explanations for this remain unclear. There will

undeniably be some bad apples in any professional barrel.

The new incentivised culture of quality and performance in UK general practice offers major opportunities. With regards to safety in healthcare delivery, this should facilitate the identification of unsatisfactory practice across practitioners of all backgrounds, constructive engagement with their developmental support needs, and appropriate action to safeguard patients where necessary.

Finally, as Aneez Esmail attests in his fascinating essay in this issue,[15] celebration of what many overseas doctors have achieved in sustaining British general practice in past decades, often in challenging disadvantaged areas, is long overdue. These doctors are fast disappearing through retirement. Before it is too late, one priority could be to capture their unique experience and knowledge in ways that can inform and stimulate a new workforce still largely reluctant to replace them.

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