system systematically threaten effective and quick passage of ambulances despite attempts to regulate them. Communication between the Palestinian Red Crescent and the Israeli Defence Force, and agreements between them have more often failed than worked.

A special chapter is dedicated to the threats and violence by non-state actors, from generalised violence against civilians (Liberia) to the difficulties faced by the International Committee of the Red Cross/Crescent (ICRC) in its attempt to create safe havens of healthcare in coordination with the Taliban in Afghanistan, and healthcare in a "caliphate" (Iraq and Syria). Describing how difficult upholding international humanitarian law can be, the book quotes a 2007 al-Qaeda propaganda video that said that "the amount of respect we hold for your international law is even less than you show for our defined Islamic Shariah" and cited "international infidel law" (p 254).

While concluding his book, Rubenstein calls for more and coordinated health activism. He rejects a cynical acceptance of the seemingly "new normal" with its lack of respect for international standards. He highlights signs of hope, such as political mobilisation against arms sales in many countries including in producer countries such as the UK and USA, and the response of Israel, during the second Intifada, to "pressure from monitoring and human rights groups, the media, and its own military officers to enable safe medical evacuation" (p 303).

He calls for more effective and coordinated mobilisation of health activism, domestically as well as globally. Recalling violence against Turkish and Syrian doctors as examples, he reminds the reader that solidarity at a national and international level can work and contribute to wider initiatives to end such violence.

The book does not contain Indian cases of violence against healthcare workers and facilities, but the reader in India will not find it difficult to identify parallels.

Perilous Medicine is a guiding and foundational book that should appear on the obligatory reading list for students and scholars working on conflict and peace studies, human rights, international humanitarian law, but also those in law school and medical or nursing school. The book provides a solid ground and source of information for human rights advocates and NGOs, and challenges governments and international organisations to adhere to standards and policies to protect healthcare from the violence of war. In addition, the book also reaches out to the general (lay) public, and should be read by journalists and media editors.

BOOK REVIEW

Self portrait of a rural surgeon

VIJAYAPRASAD GOPICHANDRAN

Kavery Nambisan, *A Luxury Called Health: A Doctor's Journey through the Art, the Science, and the Trickery of Medicine.* New Delhi: Speaking Tiger Books, 2021, Rs 599. ISBN: 978-93-5447-069-1.

As an afterword, Dr Kavery Nambisan refers to her book as a "self-portrait". It is when I reached this part of the book, that all the events, incidents, anecdotes, and stories fell into place and made sense. I had the urge to re-read the book from the start. In fact, the second reading was far more rewarding than the first. I could understand the reason why Dr Nambisan had organised her material the way she had, and marvelled at the brilliance of the sometimes jerky narrative. But I must first describe what I felt during my initial reading.

The book's back cover blurb and comments by other writers, a politician, and a healthcare activist, gave me the impression that it focused on the status of healthcare in India, had narratives of patient stories and a history of the evolution of the health system and practice in India. Dr Nambisan is well known as a fiction writer and her command of the language in depicting the characters and their relationships in her novels is unparalleled. I was curious to read this work of non-fiction, which I believed would take me through a doctor's journey through "the art, the science and trickery of medicine" as indicated in the tagline. From the prologue to Chapter 11, there were small glimpses of the health system in India, and a little sprinkling of patient narratives. It had a strongly autobiographical tone and described the early life, education, and career of Dr

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Nambisan in detail. The narration was dragging, and I did not understand how all this qualified as a description of the state of medical practice in India. However, even these sections did have flashes of brilliance. In the chapter *"Safaai Karmachari"*, Dr Nambisan describes an interaction with her mentor, Professor Sells, following a dramatic job interview. Dr Sells asks her why she is so withdrawn at work and advises her to question, argue, disagree and confer. He says, "…aim to be a surgeon if that's what you want. Or you will end up a shrinking violet all your life" (p 75). This description brings out a rather emotional mentor-mentee moment and such moments usually transform the lives of eager students.

When I reached Chapter 12 "Why not Bihar?" I suddenly sat upright, and the book became more gripping. The story of Dr Nambisan's work in the hinterlands of Bihar and Uttar Pradesh brought out the realities of rural healthcare delivery. In those chapters, I could feel her aching back, the burning heat, parched throat and sleep-deprived burning eyes through hours of relentless service to the poor and vulnerable patients in those regions. Suddenly my respect for this brave, uncompromising, quality-conscious rural surgeon soared as I raced eagerly through the pages. Dr Nambisan injects a subtle humour into her narration of the difficulties she faced in the Ramakrishna Mission hospital in Vrindaban, especially the gender stereotyping; but the actual experience must have been very painful. The way she stood up to the negligence, apathy, poor quality of care and incompetence, acting always as a patients' advocate and hence earning the wrath of her patriarchal bosses in the department of surgery, further increased my respect for what she has achieved in rural surgery.

And then, bang in the middle of the book, on page 150 is its very best chapter. I am not sure if it was placed there strategically or coincidentally. Either way, it is a stroke of brilliance. The chapter titled "The Rural Hospital" is a beautiful description of a typical rural health facility. For someone, who wants to set up a rural hospital, it is a blueprint that has emerged out of grassroots experience and wisdom. I have been associated with a rural health centre for more than 10 years now, and I found the description perfect and learned so much I can implement in my own work.

When nearing the end of my first reading of the book, I was still unsure what the book was all about. Was it a collection of patient narratives, a peek into the rural health system in India, or a description of the practice of medicine in the country? None of these categories seemed to fit. Though all these elements were present, I felt it was an autobiography which described the experiences of a rural surgeon. It was only the Afterword which confirmed that the author intended the book as a self-portrait. In my second reading, I could appreciate the leisurely building up of the background of the early life, schooling, and foreign education of the young doctor. She sketches beautifully the rather routine, middle-class, protected life of a young girl, and the sudden exposure to the traumatic reality of healthcare in remote rural India. She then contrasts that to the corporate life that follows, concluding with a general practice in Kodagu. Traveling through these phases of her life with her gives the reader the context which moulded this strong willed, uncompromising surgeon who continues to serve the poor and vulnerable.

There were some glaring errors, and I hope these are corrected in future editions. In the chapter titled "Go West", ECFMG is expanded wrongly. The actual expansion is Educational Commission for Foreign Medical Graduates. On Page 174, antibiotic resistance is defined as "overuse of antibiotics leading to the body becoming resistant to the drug if it is used for future illness". In fact, antimicrobial resistance is when the micro-organism becomes resistant to the drug so that it escapes from being killed by the drug. It is not a change in the body of the patient, but a change in the micro-organism.

I also found myself disagreeing with Dr Nambisan in a few places. In the chapter, "The Four Prongs of Illness", she describes genetic factors, stress, nutrition, and environment as the four major determinants of illness and, as an afterthought, includes lack of physical activity as a determinant. This is a very minimalistic view of health and illness. We know very well that disease causation is very complex and several social determinants like gender, caste, class, education, neighbourhood, social networks, social capital, behaviours, cultural and political context can influence health and illness. In the chapter on Covid-19, Dr Nambisan endorses the use of ivermectin, doxycycline, budesonide inhaler, bromhexine, fluvoxamine, famotidine, and antihistamines. While she mentions the irrational use of antivirals and how it led to more harm than good, it is not clear why she endorses some of these therapies with poor or weak evidence. She suggests in this chapter that ivermectin is a low cost and safe drug which has been in use for a long time in India, and it must be used to prevent and treat Covid-19. She questions the World Health Organization's repeated dismissal of the efficacy of ivermectin, but does not provide any evidence to support her belief in its effectiveness. She makes a fleeting mention of such cheap and effective drugs having been shown to be effective in large randomised controlled trials. The systematic review and meta-analysis of 15 randomised controlled trials by Bryant et al, showed evidence that ivermectin is protective [1]. However, this systematic review is flawed, as the studies that were included were highly heterogeneous. When heterogeneous studies are combined, the effect sizes of a few large studies will skew the overall findings [2]. A subsequent well-conducted Cochrane systematic review concluded that it was uncertain whether ivermectin reduces mortality or improves the clinical outcomes [3]. Dr Nambisan also mentions that we are "drumming up the frenzy for vaccine" as the preventive strategy. This statement seems to imply that the efforts to increase Covid-19 vaccine coverage are unnecessary and wasteful. In the current context of vaccine hesitancy and

inequitable access to vaccines in India, such statements are not very helpful.

Overall, I feel that Dr Kavery Nambisan's book is an interesting read and has several brilliant sections. I wish that it had been described, right at the start, as the self-portrait that it is, and not as a peek into medical practice and the health system in India.

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BOOK REVIEW

Racialising diabetes

COLLEEN FULLER

Arleen Marcia Tuchman. *Diabetes — A History of Race & Disease.* Yale University Press, 2022, 288 pages, $32.50 (Hardcover) ISBN 9780300228991

During the Covid-19 pandemic, debates have emerged about whether, and if so why, people of colour are more susceptible to the virus. In Canada, for example, racialised and indigenous populations have a significantly higher risk of severe Covid-19 infection and mortality [1]. This has prompted several studies to determine whether this is due to socioeconomic factors or if the genetic makeup of racialised groups places them at greater risk. As David Naylor, co-chair of Canada's Immunity Task Force, puts it, what proportion of the higher Covid rates in Toronto's black communities was linked to socioeconomic conditions — "and how much could be genetic?" [2]. This is the question that Arleen Tuchman seeks to address in this brilliant and thoughtful book. She exposes the "fraught relationship" (p xvii) between race and the wide health disparities between people from different racial, ethnic and class backgrounds, and provides a close look at the economic, social, cultural and political context which shapes how we understand diabetes and those who have the disease.

Tuchman begins by asking how experts have typically explained the higher rates of diabetes among Indigenous, Black and Hispanic Americans as compared to Whites. She finds that "among the many risk factors, which include age, gender, and economic status, none has figured as prominently in explanations of observed health disparities as race" (p xvii). That focus has diverted efforts and resources away from eliminating health inequities rooted in class differences and racism, while supporting a powerful narrative that those who have diabetes are themselves to blame.

The first four chapters of the book explore how the characterisation of diabetes — including what it is, who it affects, and how it progresses — has been influenced by class and racial bias from the late 19th century to the mid-1980s. Tuchman begins her story in 1870, when diabetes emerged in the European literature as a "Jewish malady", an assertion that travelled comfortably across the Atlantic to the United States. By the turn of the century, the idea gained traction in parallel with the increase in immigration to the US from around the world and rising xenophobia and anti-Semitism. There were those who argued that increased migration of Jews, especially from Eastern Europe, would increase the overall incidence of diabetes — a premise that helped fuel support for curtailing immigration. But if diabetes rates were, in fact, higher among Jews than non-Jews — an assertion that rested on rather patchy evidence — very few looked for explanations beyond a highly biased stereotype of Jews as a biologically distinct "race", subject to extreme anxiety.

Assumptions about race were shifting opportunistically during this period, but the aetiology of diabetes itself was a work in progress and the stereotype of anxious Jews fit nicely with the prevailing theory that diabetes was a disease of the nervous system. Throughout the book, Tuchman explores this interplay between racial and class bias, on the

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