

From the Editor

Ethnicity and clinical practice

They come to the clinic not only with the burden of their illness but also with the cultural fabric of their lives.¹

Our inner cities now encompass astonishing cultural diversity. More than 300 languages are spoken in the homes of London's schoolchildren. English is not the first language in one-third of London homes;² Bengali, Panjabi, Gujarati, and Hindi/Urdu are the first languages in 14% of them, and Turkish and Arabic are also high on the list. A large proportion of the patients attending some diabetic clinics are of Asian origin and, for example, 48% of those attending the Diabetic Clinic at Northwick Park Hospital are of Indian origin, representing an increase of 11% over nine years.³ The implications of multi-ethnicity in terms of healthcare delivery, at the clinical consultation, and in the process of diagnosis and treatment, are considerable, and well described in the article by Eshiett and Parry in this issue.¹

Language itself is just one of many issues, requiring much more attention than simply the presence of an interpreter. Even in our own western culture, we may 'have had the experience but missed the meaning' (TS Eliot); even in our own language, some symptoms can be difficult to express: a recent exhibition at the College described the need for 'a visual language for pain'.⁴ John Mole, in his recent article, observed that 'different cultures may use different intellectual tools to arrive at a conclusion. They can be misunderstood or misinterpreted....'⁵ Different ways of thinking can create barriers to understanding and communication. So what is needed at a consultation is an advocate who understands not only the language but also the cultural background of the patient. Such advocates are not readily available in our NHS.

Different societies have vastly different perceptions of diseases and research. It can be difficult to tackle disorders such as epilepsy if it is considered to be the consequence of a curse, or a stroke which is seen as the result of evil forces. Even within a culture, the same diseases can be seen very differently, sometimes irreconcilably so; for example, in western cultures there are divergent opinions on AIDS, chronic fatigue syndrome/myalgic encephalitis (CFS/ME) and Gulf War syndrome.⁶ In many cultures, there is no clear perception of the concept of chronic diseases leading to the need for treatment not simply to alleviate symptoms but to preserve health in the longer term. It is only recently that many African countries have started to develop programmes for the management of chronic diseases. Mental illness may present particular problems of interpretation or acceptance, and in some cultures there is no word for depression. Such differing perceptions of illness can easily lead to erroneous interpretations of patients at consultations, and may make irrelevant some of the educational programmes delivered by healthcare professionals.

Even the need for scientific research may be differently perceived: at a recent satellite workshop on 'science, religion and values' (part of a meeting of top science officials from Islamic and western countries), it was observed that despite their illustrious past in these fields, there is at present no substantial culture of science or technology in Islamic countries. An editorial in *Nature* concluded that 'the time has come to scrutinise Islam's relationship, inhibitory or otherwise, with science'.⁷

Understanding cultural differences is therefore important in clinical practice, yet many of us are unaware of these issues. A recent article in *Clinical Medicine*⁸ described the circumstances when a handshake is or is not appropriate, as well as some sensitive areas to be considered in autopsies,

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gynaecological examinations, abortion or sterilisation, or the examination of female patients. Doctors working with diabetic patients in south London would need to know that around one-third of black African or Caribbean patients use herbal medicines, that one in five of them believe blood tests to be harmful, and many use laxatives (or occasionally colonic irrigations) to improve their health.⁹

Patients' understanding at times may also be impaired: a recent study of anticoagulant therapy, including European, Indo-Asian and black African and Caribbean patients, pointed to a gap between patients' knowledge and the doctor's perception of what the patient knows. The authors of this study observed that patients' religious faith and dependence on God probably influenced both their adherence to treatment and to the understanding of the nature of their illness and medication.¹⁰

So there are still many patients of ethnic backgrounds who are apprehensive and frightened when they approach a doctor of a different background whom they may not trust. Furthermore, the doctor himself may not perceive potential difficulties in interpreting the patient's presentation. Eshiett and Parry in their article make some valuable recommendations for the way forward which need to be examined carefully and acted on in the foreseeable future. Those of us working in our major inner cities have much to consider and learn.

References

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CORRECTION

The editorial entitled 'Nuclear medicine and the physician' by Peter Ell and Henry Gray, published in the previous issue of this journal (Vol 3, No 2, 2003), had also appeared in two separate parts in *Nuclear Medicine Communications*,^{1,2} and was reproduced by permission of the editor of that journal. We apologise for omitting to state this.

References

1. Ell PJ. Strategy for the provision of positron emission tomography in the United Kingdom. *Nucl Med Commun* 2003; **24**(3):229–31.
2. Gray HW. The report Nuclear medicine and radionuclide imaging: a strategy for provision in the UK. *Nucl Med Commun* 2003;**24**(4):349–50.