Transcultural medicine: race, ethnicity and health

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In the 2001 UK Census, 4.6 million people classified themselves as belonging to an ethnic minority. The largest of these groups originate from India and Pakistan or are African-Caribbean. Some research has been carried out in the UK on health inequalities amongst ethnic minorities but it tends to be published in grey literature and the findings are not widely disseminated. Much innovation is project based and disappears when funding ends. The lack of coordination in NHS R&D means that there is much 're-invention of the wheel'. Hence the need to bring together those working in this area at a conference on the impact of ethnicity on healthcare in the UK.

Ethnicity and access to healthcare

Defining ethnicity is not easy. Race, birthplace, religion, language, culture and traditions all contribute to ethnicity. Many have argued that ethnicity is a non-specific 'label' which people can do without. Yet ethnicity (however defined) is an important factor influencing morbidity and mortality in many diseases. In part this is due to inequalities in access to healthcare and in part to the attitudes of individuals and of organisations to ethnicity in healthcare.

The NHS promises that: 'Services should be accessible and acceptable to all the people they serve, regardless of their ethnicity'. This includes assessing and meeting people's needs in ways that are culturally, religiously and linguistically appropriate. However, inadequate monitoring of ethnicity makes study of access to healthcare difficult. Much research is based on ethnic differences in service uptake and more needs to be done on the differences in the process of healthcare delivery. Interpretation, language and translation remain fundamental barriers to access. This is also a dynamic problem, as the language needs of an area, for example, change over time. Ethnic imbalances in access to services within the NHS, such as access to mental health support, discharge processes, pharmacy and dental services and use of women's screening services, are poorly studied.

The UK Colorectal Cancer (CRC) screening pilot was set up in 2000. It studied, amongst other things, the role of ethnicity in uptake of screening for colorectal cancer using faecal occult blood testing followed by colonoscopy where indicated. There was a significantly lower uptake for faecal occult blood testing and colonoscopy by south Asians than by non-Asians. This difference could not be explained by age, gender or deprivation index, so there is a clear need for research to examine the reasons for it.

Health of refugees and asylum seekers

Many refugees come to the UK in search of a safe haven, but this is not always what they find. Two-thirds of refugees experience anxiety or depression and 40–60% have post-traumatic stress disorder, having escaped from physical and sexual assault and torture. Paradoxically, the incidence of ill health increases in the two years after arrival in the UK. The legal and medical documentation that must be completed to prove one's refugee status may not be available in an understood language and interpreters may not be available. Refugees suffer a triple trauma paradigm. Having escaped from torture, rape and murder and facing exile and loss, they may have to

Conference programme

- **Ethnicity and access to healthcare**
  Professor Ala Szczepura, University of Warwick
- **Cardiovascular disease in ethnic minorities**
  Dr Jaspal Kooner, Ealing Hospital NHS Trust
- **Ethnicity and workforce issues**
  Mrs Naaz Coker, St George's Healthcare NHS Trust, London
- **Attitudes to healthcare of ethnic minorities – adaptive or maladaptive**
  Professor Chris Griffiths, Institute for Community Health Sciences, Queen Mary's School of Medicine and Dentistry, London
- **How we can improve the health of refugees and asylum seekers**
  Dr Peter Le Feuvre, Shepway Primary Care Trust
- **Improving mental health care in ethnic minorities**
  Dr Kwame McKenzie, Royal Free and University College Medical School, London
- **Palliative care needs of ethnic minorities**
  Dr Rashid Gatrad OBE, Walsall Manor Hospital
- **Diabetes and hypertension in the ethnic minority population – tackling the growing epidemic**
  Dr Kennedy Cruickshank, University of Manchester Medical School and Royal Infirmary
- **Prevention of kidney failure in ethnic communities**
  Dr Liz Lightstone, Imperial College London and Hammersmith Hospital

contend with the seven Ds: disempowerment, disbelief, detention, destitution, dispersal, delay and disappointment. These health issues are further compounded when doctors deny refugees access to health services. The 1989 Charges to Overseas Visitors Regulations state, 'refugees and asylum seekers are entitled to use of all of the primary and secondary services available under the NHS.' Many doctors are not aware of this. Failed asylum seekers are denied NHS care.

Attitudes to asylum seekers spill over to those who are viewed negatively as health tourists and economic migrants. A key challenge is to tackle the attitudes that individuals and institutions hold towards asylum seekers and the impact that these have on policy, practice and delivery of healthcare at different levels of the NHS.

Attitudes to chronic disease

Videotaped consultations in primary care revealed differences that depended on ethnicity and shared language. For example, a white patient with asthma was more likely to set the tone of a consultation, making it easier for the doctor to explore the patient's explanatory model and attitude to self-management. By contrast, with a Bangladeshi patient the doctor was more likely to set the tone of the consultation, leading to a lack of congruence of explanatory models between the patient and doctor and thus a less satisfactory outcome.

Relatively little is known about the impact of ethnicity on attitudes to self-management of chronic disease. An innovative randomised study on Bangladeshis in east London trained lay people to deliver a chronic disease self-management programme in a culturally sensitive way. The outcome was greater confidence in self-managing chronic disease, although patient attendance was poor. Patients who completed the study reported increased confidence and self-management skills. Their attitudes to health tended to be positive; for example, they viewed illness as a test which resulted in a good outcome. Amongst those who withdrew from the study, more negatives attitudes were found; for example, illness was seen as their punishment or Allah's will, making any intervention futile. Thus within one ethnic group, different individuals expressed very different attitudes.

Improving healthcare

Several schemes have examined methods of increasing ethnic minority access to healthcare.

In a study aiming to raise awareness of kidney disease amongst ethnic minorities, the screening programme revealed previously undiagnosed type 2 diabetes mellitus, and hypertension and microalbuminuria in more than 30% of known diabetics. Despite similar degrees of renal impairment, Asian participants had a lower calculated creatinine clearance than whites or blacks, indicating a requirement to validate these calculations for Asians.

Mortality from coronary heart disease is 1.4 times higher in Indians in the UK than in Whites. The west London Coronary Risk Prevention Programme invited Indian Asians to attend their GP surgery for a standardised work-up for known cardiovascular risk factors. A team of 58 general practitioners, hospital staff and 12 coronary risk assessment nurses delivered the screening programme. Seventy per cent of those invited attended and half of these patients had identifiable coronary disease risk factors.

The rate of psychosis among African-Caribbeans in the UK is two to six times higher than in Whites. In the absence of a biological cause, social factors are the most likely cause. However, African-Caribbeans with a psychosis were more likely to be coerced into treatment, more likely to receive psychotropic medication and less likely to receive psychotherapy or culturally based rehabilitation. In addition, they were more likely to fall into the criminal justice system. The Antenna Outreach Primary Preventive Service in Tottenham, London, for 16- to 25-year-old black youths, was a community-based project run by local lay individuals after specific training. Part funded by the NHS, the project worked with schools, and other organisations, creating networks to aid early referral and to provide mentors, support at critical times and advocates for those in need. Outcomes of the project were excellent, with 50% of the participants in work or education and six attending university. This highlighted the effectiveness of embedding services in a community, and consulting and engaging that community.

Healthcare staff

The NHS has employed individuals from ethnic minorities for many decades. Urban areas such as London and Birmingham rely on health professionals from overseas to meet their staffing needs. Yet in today's NHS, ethnic diversity is presented as a challenge or even a problem to be studied during staff training 'away' days. Staff are taught about Asians, Black-Caribbeans and Africans, as groups of people, in the belief that the 'characteristics' of these groups (whatever they are) readily apply to individuals. This is nonsense; for example, an Asian may originate from India, Pakistan, Bangladesh or China and have different cultural practices depending on their particular origin. They may be the first or second generation born here and have differing requirements from the healthcare system. Ethnicity is not a problem in itself, but it is made into one when people from ethnic minorities are denied access to resources and treated differently to other individuals.

Under the Race Relations Amendment Act 2000,

> *NHS agencies have a statutory duty to have due regard to the need to eliminate unlawful discrimination and make explicit consideration of the implications for racial equality of every action and policy.*

In a survey of racial harassment within the NHS in 2001, of the 494 staff interviewed 58% had either experienced or witnessed racial harassment, and 46% had experienced racial harassment within the last 12 months. Doctors from ethnic minorities experience discrimination, lack of support and bullying as they progress through their careers. Racism and racial harassment reflect systematic failures of NHS and medical leadership. Efforts must be made at the political, professional and

managerial level to rid the NHS of these practices, as they demoralise and betray part of its workforce.

Conclusion

This conference considered many areas in relation to ethnicity and health. Much research has been carried out at local level, but this is often not disseminated in peer-reviewed literature and does not become part of everyday practice. More research is required into the causes of health inequalities affecting members of the ethnic community. The evidence upon which policies and clinical practices are based is inadequate, thus hindering replication of successful schemes in other parts of the NHS. The Centre for Evidence in Ethnicity, Health and Diversity at the University of Warwick and De Montfort University and the London Health Observatory will in future gather together health and ethnicity research. The Royal College of Physicians can also play a role by serving as a forum for sharing research and knowledge in this area.

In the pursuit of the 'health of our nation', the health of ethnic minorities must also be addressed.