Ethnic Minorities, Health & Communication

A Research Review for the

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and

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by

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Executive Summary and Recommendations

This report contains a summary of the findings of over 200 'research-based' studies in health and health services delivery located within the English-language academic and practitioner-based literature relating to issues of communication between practitioners and members of minority ethnic groups or communities. It explicitly excludes all descriptive studies of particular cultures, clinical investigations of epidemiology, treatment or outcome, or other reports of health and disease in minority ethnic groups which did not consider the issue of 'communication' between patient (or community) and practitioner.

The issue of ‘Communication’ was intended to include concerns about consultation at a community level, to inform the development of planning and commissioning processes. This is clearly different from communicating at an individual level. Most research reports on Community Care and health policy issues refer to the need to access a ‘black perspective’ or take account of ethnic minority concerns. However, no research-based, or even properly evaluated local studies could be located, beyond descriptions of local initiatives seeking to address this issue. There may be good practice, but as yet it remains ‘developmental’ and cannot be considered to be ‘evidence-based’.

The structure of the report reflects the uneven spread of research. Certain issues, particularly the use of linkworkers as interpreters, 'language needs of South Asian communities', and nursing practice, seem to have been investigated more frequently than others. The discussion is organised around the three major themes identified: the needs of specific professional groups in the health service (Section 4); particular clinical issues (Section 5), and matters related to organisation and research (section 6). General conclusions are drawn, and specific recommendations put forward. The principal finding is that these issues of communication should become a fundamental part of any future planning and research, and indeed be addressed in, the training of health workers.

The majority of studies are not cited in the text, but their conclusions have been incorporated within the following list. While there remains some repetition, each recommendation has a distinct emphasis, and is supported by the evidence of a number of the studies reviewed.

Numerals in brackets after each Recommendation refer to the main sections of the text in which reference is made to the issues concerned. These are only indicative and do not mean to suggest that the recommendations are irrelevant to other health professionals or services.

RECOMMENDATIONS ARISING FROM STUDIES REVIEWED

Attention is needed to the training, supply and use of interpreters, preferably the creation of a local cadre of workers with appropriate health-related knowledge as well as linguistic skills, related to local population needs. (3.6; 3.7; 5.4; 6.3)

The training and employment of bilingual link-workers or 'health advocates' who are able to go beyond the role of 'interpreter' in transmitting information (in both directions) is very desirable. (4.3; 5.1; 5.2; 6.1)

Services, particular specialist units, should take active steps to recruit staff from minority backgrounds, and appreciate the contribution such staff can make to their overall work. (4.3; 4.6; 6.1; 6.3)

There needs to be more research into the training, communication and use of allied professions, including attention to the role of the ethnic origins of such professional workers, and their perceptions of need. (4.5; 6.1)

Untrained, 'family' and non-medical support staff should not be used to provide interpreting services. (4.3; 4.7; 5.3; 6.3)

All staff, in all sectors, require training in 'cultural sensitivity' and service delivery in an ethnically and culturally diverse society. This could include some language training to improve initial rapport-building. (1.2; 3.2; 3.8; 4.3; 4.6; 5.3; 5.7)

Communication with members of minority groups may require more personal, individual intervention, and less reliance upon indirect printed and 'mass media' methods. (3.6; 4.1; 4.4; 5.2)

There is a need for outreach and explicit recruitment to overcome barriers to service access and health promotion. (4.1; 4.2; 4.4; 5.2)

Ethnic monitoring should incorporate the recording of language and interpreter need. Present data is poor. (1.1; 1.3; 6.4)

Information content should reflect cultural sensitivity that includes awareness of diet and religion, and will then be more readily received. (4.2; 4.4)

Issues of gender in service provision may also form a barrier to effective communication: this will include attention to family roles in health information and provision of single-sex activities. (3.3; 4.1; 5.2)

When translated materials are provided, they should be bilingual: including a parallel English text - but written for and from the perspective of the minority language speaker, not translated from the English. (3.4; 3.6; 4.4; 4.5; 6.3)

Health Promotion communication should not just take account of the written content - attention should be paid to visual and oral cues (pictures, music). (4.4; 4.5; 6.3)

Health Service objectives can be achieved by facilitating the study of English, and health promotion activity incorporated into language classes. (3.6; 4.3; 4.4; 5.3)

Staff must beware of stereotypes which suggest ethnic minorities present communication difficulties, and not rely upon stereotyped notions of culture or language ability in communicating with minority clients. (1.2; 3.2; 3.6; 4.1; 5.3; 5.4)

Any communication strategy should take account of the diversity of (and within) minorities and the fact that 'culture' is constantly changing. (3.2; 3.4; 3.7; 4.3)

The importance of physical (environmental) and economic or social deprivation should be allowed for in strategies to improve service use or lifestyle modification. (3.5; 4.3)

There is a need for the cross-cultural and bilingual validation of screening instruments (or creation of new ones). (6.5)

Health workers have communication needs too, and research should investigate their perceptions of need. (4.7)

Courses should be arranged for all health-service delivery staff (including pharmacists and other professions allied to medicine) and initial training amended to include aspects of multi-cultural working. (4.5; 4.6; 4.7)

Further research could be undertaken on non-verbal issues of communications and the process of the consultation. (4.1; 4.7; 5.4)

Impact studies are needed to test the effectiveness of interventions such as 'linkworkers', although ethical problems may arise in withholding a service which is acknowledged to be necessary. (4.4; 5.1)

There is still a need to study NON-users of services - who are naturally harder to obtain than those who are using, and therefore communicating with, services. (4.1; 4.4; 4.5; 5.3)

Despite the fact that nearly all the younger generation of minority ethnic groups are UK-born and educated, there will remain a need for language interpretation, both for elder groups and spouses or family completion migration - and possibly new groups of migrants from other sources. (3.4; 3.6)

1: Introduction

1.1 Arguments for the introduction of transcultural medicine and descriptions of 'different needs' that purport to explain ethnically distinctive patterns of health outcomes are frequently unsubstantiated by proper research evidence. As Sheldon and Parker (1991) have observed, 'poor analytical standards have typified medical research on ethnic minorities' although this is as much of a generalisation as those it criticises. Further, despite their contentions, there remains a need for research that includes 'race' and 'ethnicity' as epidemiological variables while at the same time paying attention to structural influences on health and health behaviour. The problem has often been one of the conflation of 'race' (implying genetic characteristics) and 'ethnic origin' - which should reflect cultural and personal identity, and therefore have implications for treatment. Equally, ethnicity is not a characteristic confined to 'minority groups of New Commonwealth origin' and yet research into its effects or implications almost invariably ignores the cultural, linguistic and other characteristics and needs of 'white' groups. This has led to a concentration of studies about 'communication issues' on South Asian groups, and an assumption that the critical issue is one of language, perhaps generating other stereotypes (Ahmad 1989a). Other possible explanations have been less well explored as a result.

1.2 A concentration on 'communication difficulties' may also mean that members of ethnic minorities, along with certain other social groups, are regarded and labelled as 'hard-to-reach' in terms of health promotion activity (Freimuth). Such preconceptions may lead to assumptions of powerlessness, apathy or isolation. More effective communication can be achieved by focussing on strengths of different cultures and examining the role of social structures rather than blaming individual behaviour. This requires attention to the communication needs of those delivering services. Stereotypes that patients have 'poor compliance' or are 'hard to communicate with' can hinder the attempt and be a barrier to communication (Bowler). Move from a victim-blaming or pathogenic view of minority cultures can instead lead to a more positive response and generate greater interest and co-operation amongst those hitherto regarded as 'hard-to-reach'.

1.3 Research from the North American context, both in the USA and Canada, has emphasised the importance for adequate service delivery of studying ethnicity and communication issues. This has been facilitated by a long tradition of 'race'-based data collection and a political context which ensures debate (Hahn). Gradually, competence and capacity to undertake such work in Britain is developing, along with political will or realisation of its necessity. Introducing 'ethnic monitoring' of hospital inpatient admissions should provide a further incentive or ability to develop appropriate and reputable studies.

2: Methods

2.1 As far as possible, a standardised strategy was used to search the major databases. This examined in particular all articles which contained as keywords in title or abstract mention of Communication or Communicating, Interpreters or Interpretation, or Language, and Ethnicity or any of the major Ethnic Groups. Those searched using computer-based systems included:

King's Fund share database
Leicester Medical School LPS database
Centre for Research in Ethnic Relations Resource Centre
New Community review and report collection
Health Education Authority Unicorn database
Medline; Silverplatter Sociofile; ASSIA

Non-computerised collections or reference lists and reference books including the author's own personal collection:

Ethnic Minority Health Current Awareness Bulletin (Bradford Health) (serial)
Nuffield Institute for Health Services Studies (1991)
HEA reports (sundry) and textbooks such as:
Cruickshank & Beevers; Hopkins & Bahl; McAvoy & Donaldson; Karseras & Hopkins; Karmi & McKeigue.

2.2 Material that was merely descriptive, unsupported by research that met at least certain 'gold standard' criteria (cf Oakley et al 1995 'Sexual health education interventions for young people: a methodological review' *BMJ* 310 :158-162) or was based primarily on informal or process evaluation of special-provision projects has generally been omitted. There are already in circulation far too many descriptions of minority cultures or 'specific factors' such as those described by Qureshi. Review articles also were generally ignored except as a source of new citations, unless they appeared to incorporate some research, innovative findings, approaches or recommendations, or supplemented and updated earlier references. The majority of the material initially uncovered referred, inevitably, to USA and Canadian experience, and only those which seemed to be relevant to practice in UK, or which complemented British research, were incorporated.

2.3 It is worth noting that despite fairly high (and expected) levels of overlap between these sources, each 'pass' through a new database (or on occasions, a repeated pass through one previous searched, using slightly varied terms) produced new citations. Some researchers (e.g. Mumford, Bhopal, Ahmad) appear in multiple publications, highlighting different aspects of their research. In reporting the results of the review, only key references are identified in the text, although all the items listed have been read and their findings incorporated in the analysis and conclusions.

3: Issues

3.1 A broad understanding has been used to address the question of 'Communication'. This clearly includes all forms of health information transmission, and attempts by patients or potential users to access health services. The 'medical interview' or history-taking is part of this process, but also there are newly important processes of consultation and complaint which are taking a higher profile in health service planning. It can be seen that 'communication' is a two-way process between health service providers and planners and their clients.. This includes making demands upon the service, transmission of information about the service or about the health of the

individual, and about options in health service planning. It can be problematic from both sides, in terms of both language and content, or even the initiation of dialogue.

3.2 Barriers or problems in communication also take a number of forms. The most obvious is that of language, and this has been the issue that has predominated in research, to the extent that groups such as the African-Caribbean or Black British, for whom English is a first language, have generally been ignored or assumed to be 'problem-free'. There are a diversity of languages within the Indian sub-continent, but much research discusses 'Asians' as a single group, ignoring both linguistic and educational variety. Within language groups, or perhaps associated with them, there are also variations of culture and religion. Between major cultural groupings, there are different ways of seeing and explaining matters, and it has been suggested, of defining 'health' and 'normality'. The research evaluated in this study has found little evidence that minority ethnic groups have significantly different understandings of health and illness; most accept the 'western scientific disease-based model', but folk memories and means of expressing particular issues may draw upon older traditions. There is some truth in the assertion that 'Asian' religions have a more holistic understanding, and are at odds with the classic Cartesian distinction between 'mind' and 'body', but that debate is also a live issue within the so-called 'western' world; modern medicine increasingly recognises the role of the spiritual and the impact of mental stress on the body.

3.3 Assumption of difference may itself be a problem: in a major study of young people in west London it was noted that there were 'no significant differences between ethnic groups in their assessments of health, lifestyle and diet (or) the extent to which the groups worry about their health' (Brannen :86). Health promotion activity founded on assumptions of traditional cultural forms may be flawed: however, there were differences in behaviour and certain issues were not discussed. This could lead to a failure of the expected transmission of health information within families: 'Families and their children do not enter into communication (of) activities which may adversely affect the latter's health ... since risky behaviours are heavily sanctioned as immoral and parents do not subscribe to the model of individual autonomy' (Brannen :211). That said, adolescence is a period of non-communication in families of all ethnic backgrounds.

3.4 Language problems may also be a diminishing barrier as far as the majority, British-born minority ethnic communities are concerned. Nevertheless, they remain important, and will continue to be an issue for the elders of those groups, and for new minority groups, which may include some arising from developing European Union freedom of movement. A major concern is the lack of suitable information upon which to base planning and training. The Health Education Authority national 'Health & Lifestyle' study provides a rich source of data which should be widely used in the health services, although cautiously applied to local situations (HEA 1995).

3.5 A number of key observations arise from the HEA study. The point is made that most minority ethnic groups regard health in a holistic fashion, and will include a greater awareness of spiritual and mental well-being in their assessments. They will also pay greater attention to such stress factors as racism, poverty and the desire for cultural maintenance, although these may be difficult to communicate to authority figures of the majority population. Poor communication with such professionals can itself lead to stress, as does being appraised according to stereotypes. All of these issues may affect communication before the question of language is met.

3.6 According to the HEA survey, six out of seven people (85%) giving their ethnic group as Indian said they spoke English, although less than half of women over 50 did so. Among 'Pakistanis', three quarters (72%) did so, but very few older women were fluent in English. For Bangladeshi communities, the proportions fell again, with less than 60% overall speaking English. These figures may be used in connection with the local Census data to provide estimates of the need for interpreters and translations, although the HEA's proportion speaking Gujerati (50% of 'Indians') is considerably higher than that normally reported and may cast some doubt on the general application of their data. Within language groups however, it is probable their findings are quite robust. It should also be noted that a third of all 'Indians' and a quarter of 'Pakistanis' in the survey reported English as their main language. Literacy in various languages and scripts was highly variable, as has been found by a number of local studies, and significant numbers were unable to read any language. There is no substitute for local knowledge and actually asking patients about language: patients may not object if given wrong language or script leaflets (Hawthorne). Equally, other studies have noted that health

professionals too often assume that Asian women do not speak or understood English. They may be able to speak a little but be shy and have a broad passive understanding (Bowler 1993: 11).

3.7 It should also be noted that certain languages have no written form or an agreed grammar: even the terminology is sometimes disputed although there is growing acceptance that Sylhetti (a non-written dialect of Bengali) and Mirpuri (Pakistani Punjabi) should be regarded as 'real' languages. The latter may be written in Urdu (Farsi) script. 'Classic' Urdu, and Punjabi in the Gurmukhi script have higher status: translation bureaux tend to use the formal languages including the very different 'Dhaka' Bengali. Migrants educated in Bangladesh may be able to read this, but few UK-educated Bengalis will do so. Given the problems of translation, and the use of 'oral' forms of language, interviews in Asian languages tended to take significantly longer than those in English.

3.8 The critical issue in communication, however, remains the knowledge and understanding (and perhaps the nature or relationship) of the partners in the exchange. American findings tend to report a need for training in trans-cultural practice, while also suggesting that 'the ideal situation is thought to occur when therapist and client share the same language and ethnicity' (Flaskerud). UK studies suggest that many Asian clients do choose an Asian GP for this reason (Johnson, Bhuhi) but that the outcome is not always satisfactory, perhaps because of diversity within the category 'Asian' (Bal, Bhopal, Madhok). The frequent recommendation of research reports (notably in therapy and community work) that there need to be more workers recruited from minority backgrounds has value, but is not a complete solution to issues of communication and service delivery in a diverse society. Professionals of minority origin deliver generic services to the white population: it should be possible for the reverse to be also true.

4: Issues for specific health professions

While the majority of concerns and recommendations arising from research into communication in the health services are relevant to all health workers, there may be some issues which are specific to particular branches. Research tends to be conducted within certain settings or key professions, and the following sections review the main groups located.

4.1 General Practice - access and use

The primary health care team remains the critical link in communication between the majority of the population and the Health Service. There is no evidence that minority groups are unaware of this although there is some data to suggest a lack of knowledge of the full range of services available. Processes of administration and questions of language also are perceived by some people in minority communities as at least potential barriers to full use.

Failure to communicate that women-only options (or female practitioners) are available can form a barrier to uptake of services such as maternity, gynaecology etc. (Baxter)

Although there are genuine difficulties of communication arising from variations in mother-tongue language, it should not be assumed either that Asian patients necessarily have a lower educational level than the white comparison population sharing the same catchment areas, or that they have greater difficulty in expressing themselves in medical terms (Rashid). It is also probable that increasingly preferred language will be English, although some regression may be expected among ageing populations, since there is at present little experience of an 'elderly' Asian population in Britain.

The use of the telephone, however, seems to be unpopular amongst Asian clients: only one study has examined this but found a strong differential in attitudes towards telephone consultation and advice: as other writers have suggested, Asian patients do seem to prefer a personal visit. This 'cultural' preference seems likely to be more robust in future than the need for interpreters but may be related to the use of 'body language' to overcome any problems in verbal communication: there may be 'a need to educate Asian patients regarding the acceptability of telephone advice' (Rashid :200).

Part of the problem of uptake of screening and other measures, related to communication, has nothing to do with 'language'. If patients do not receive information because of poor records or addressing, they will be wrongly recorded as DNA (did not attend). In one of the few studies to examine this possibility, records of the addresses of 'Asian' women were much more inaccurate than those of non-Asians: when corrected for this, uptake of cervical cytology was higher in the 'Asian' group (Bradley).

4.2 Dentistry

There has been a small but significant amount of research into communication about issues of dental health. Here too it is found that the problem is not one of negative attitudes or unhealthy lifestyles, but of a failure to communicate 'best practice' information to Asian patients, or more often, to their parents. Mothers may be deterred from attending with children by a fear of communication problems (Williams) and seek prior reassurance through established channels (eg HVs). High levels of caries and mouth disease are preventable, but advice must take account of variation within the 'South Asian' group, and the practicalities of their existence. A particular issue is that Muslims seeking *halal* foods may avoid dentally safer savouries in favour of non-meat sweet foods. Advice that is tailored to the audience achieves a good response.

4.3 Nursing care

A number of studies have examined the impact of stereo-types upon nursing care for ethnic minorities (Bowler). It is clear that their existence, and a lack of knowledge about alternative (socio-economic and environmental) factors causing adverse health and birth outcomes hinder or restrict the management of clients health (Proctor). Beliefs about pain thresholds or dependency, and lack of knowledge about personal backgrounds, can also hinder delivery of care (Cameron). There is really no shortage of material about minority groups produced for nurse education but its uptake and impact has not been studied.

It is also noted that minority communities may have poor knowledge about the role and availability of district nursing and auxiliary services (Cameron). There is however a conflict in the literature, since some who survey service providers (Hayward, Bhuhi) report their beliefs that there are low levels of

awareness amongst users, but also it is also found that many minority clients have unexpectedly good understanding of such issues as mental health symptoms and problems (Bhuhi). It is not clear if there is a low level of awareness, or a perception that services available are inappropriate and therefore ignored.

Hayward found that one in three ethnic minority mothers visited by Health Visitors in East London experienced some communication difficulty, and that these were not confined to 'Asian' (Indian subcontinent) languages - over 24 languages were identified among this group (about 3% of the workload). Trained bilingual workers are part of the answer. Language classes for women can be combined with health promotion (Leeds).

4.4 Health Promotion

This has been a priority area for communication-related research. Issues of concern have included both the content and mode of transmission of information, the availability of 'translated' materials, and their impact, and alternative means of communication. Despite the large amount of research, very much of it is repetitive in its findings, and certain key issues such as the role of the 'media' in informing minority audiences have been little examined (except perhaps in relation to HIV/AIDS).

It has been established that there is a strong demand for health-related information, and that when provided in appropriate fashion, the response (uptake of services, modified behaviour etc) is generally good. There has been a poor response to demands from the community to reflect their priorities, or to include issues such as racial inequality and stress. It may be that local providers are not fully aware of the range of materials available: this may change following the launch of the HEA directory in 1994.

Materials should be written for specific audiences in appropriate languages (not translated directly), and presented in bilingual formats. Their illustration needs to match the target group culture. Tape and video formats are advised, but may not be used in the home without further encouragement. There is a strong demand for 'tutored' viewing, and personalised presentations in community settings: the potential of language classes, religious and social centres and groups is underutilised.

Additional evidence from the Community Pharmacy study (Jesson) suggests that awareness of the leaflets available in Chemist shops and elsewhere is very low amongst ethnic minority consumers, despite the careful representation of ethnicity in most HEA leaflets. There is evidently a need to raise the visibility or awareness of such materials as well as paying attention to their content and languages. A higher profile, or personal outreach, for all health promotion activity is needed.

4.5 Professions Allied to Medicine

It is important to remember that a significant amount of medical care is delivered by 'allied professions', notably pharmacists, opticians and physiotherapists, who may be consulted without recourse to the conventional medical establishment. There is an absolute gap in the research related to this element of service delivery, despite the fact that communication with such professions is equally important. The concomitant of this is that there is very little information about the issue of impairment or disability in minority communities. One pilot study of deafness in minority communities suggests an added dimension of exclusion which should be further explored (Sharma), and a start has been made on examining issues of speech therapy (Mumby, Bellman). Some literature, mostly American, was located relating to 'transcultural occupational therapy' but very little published research-based work exists on British ethnic minorities and therapists or opticians.

The only medical-related professional service for which research based evidence on communication issues exists is that of Pharmacy. Even here the evidence is slight, and the authors 'would not claim this study to be definitive' (Jesson et al 1994). However, certain themes are re-iterated by their study and other valuable insights made.

As with other research, a significant proportion of Asian respondents could not read English: of these, over half were illiterate in any language. As expected, significant numbers used pharmacists where staff were of the same ethnic origin, but even so, less than one in four of those for whom English was not their first language were given a verbal translation of prescription instructions. It should not be assumed that young Asian staff will be fluent in Asian languages: it was also the case that only four informants felt they had not been understood by the pharmacist. All were UK-born and under 44 (:115).

Considerable problems were found in understanding the instructions on medicines, reported by 16% of all ethnic minority consumers, and a research experiment in the study confirmed the need to pay closer attention to this element of communication (:106-7). The use of pictograms or non-written means of briefing is recommended.

4.6 Staffing and Training Issues

There has been recent recognition that there may be issues of communication within medical training. So far, work has focussed on problems of, or discrimination against, trainees of Asian origin (Dillner, Wakeford). Research evidence suggests that UK-born and UK-trained Asian doctors perform as well in written and oral examinations as 'native' whites. Nevertheless, there remains some suggestion that trainees from minority origins perform differently in examinations, and this requires additional study.

A further question has also been raised, but not yet researched, as to the effects (or numbers) of minority patients acting as 'cases' in clinical examinations. This may raise the issue of the training of medical students more generally for practice in a multi-racial society, and their communication skill needs. This has yet to be researched beyond examining the provision of information, in studies that require updating (Rylance 1987) although it is clear that health professionals do feel a need for better training, and themselves experience communication difficulties (Higham 1988).

4.7 Communication needs of health workers

Nursing staff report a variety of problems in practising in ethnically diverse neighbourhoods, including a lack of awareness of knowledge about cultural differences as much as language (Higham). Without this background information their ability to develop a therapeutic relationship is hindered and they also suffer from stress (Murphy).

Communication problems are not limited to work with Asian patients, and African-Caribbean clients may be described as having speech impairments. Equally, language barriers may lead to under-diagnosis of communication impairments. Non-verbal gestures, and nuances, are also significant (Cameron). The use of 'language switching' as a means to maintain rapport

with a patient and hence improve care has been observed in a bilingual setting - Welsh and English. Nurses who made an effort to learn some conversational phrases found 'patients were particularly appreciative' (Roberts 1994).

5: Issues associated with specific 'Clinical' areas

In addition to the research which is 'profession' based, other work has been conducted around particular 'disease' groups. In practice, these can be seen largely to relate to diabetes and mental health. There is clearly scope to develop work on service delivery and intervention in relation to other key health issues.

5.1 Outcomes

Despite the repeated recommendation of, and occasional implementation of projects providing, 'linkworkers' (Bahl 1988) or health advocates, there have been few properly controlled impact studies, although it is true that there may be ethical problems in setting up appropriate 'control groups'. However, despite lack of clear attribution to improved communication, there is some evidence (Mason, Parsons) of improved clinical outcomes associated with such interventions. Generally here and in relation to health promotion, the conclusion of Dorn and Murji in relation to drug abuse prevention holds true: 'The literature on outcomes of community prevention with specific community groups is insufficiently developed to allow ... empirically-based conclusions'.

5.2 Diabetes

A major area of service provision that is relatively well researched concerns Diabetes care in the community. As with dentistry and other issues, it is re-iterated that 'lack of knowledge is not due to indifference' (Wilson). Equally, communication difficulties lead to poor self-management. Communication must take account of literacy as well as languages spoken, and also of household roles: in some cultures men might not cook, and women may not shop (Hawthorne). Communal kitchens in temples and other community

social venues are neglected sites of communication and eating. Linkworkers and personal visits are shown to demonstrate good returns (Wilson). Training of diabetic clients may require education in the use of meters and recording. Outreach and development of community-based self-help groups produces measurable clinical effects (Simmonds).

5.3 Psychiatry and Psychology

In the absence of clear physical signs, and given that 'normal behaviour' and expression of mental states are very likely to be culturally determined, the issue of 'communication' is of particular significance to practitioners in the field of mental health. There is an extensive research-literature on the development of 'standardised measures' (qv) to tackle such issues. Other literature assumes communication and measures relative levels of recorded pathology, or debates causality and cultural influences on mental health. The assertion that help-seeking behaviour is stigmatised, and that this forms a barrier to service use amongst South Asian groups, is not proven. Staff need greater awareness of cultural difference while being alert to dangers of accepting stereotypes.

An alternative perspective notes that the issue of language can go both ways, and a concentration on 'first generation' migrant problems may conceal the issue (with Chinese clients) that 'for these young people where assimilation (sic) may be regarded as desirable, a language problem could induce frustration and ... possibly lower self-esteem' (Furnham :112).

5.4 The Consultation

Other than studies of nursing, there are few research-based investigations of the processes or outcomes of the clinical consultation. A study relevant to this issue and a common stereotype, did establish that (for reasons apparently related to their childhood), African-Caribbean subjects were significantly less likely to express pain. Although Asians undergoing ear-piercing reported more pain than whites ('Anglo-Saxon'), this difference was not significant (Thomas 1991). American research suggests that staff may evaluate patients' pain differently, according to ethnic origin of the client (Calvillo).

Other relevant studies, mostly regarding 'somatisation' of symptoms, have tended to be reported in the context of the development of psychiatric screening instruments. Their conclusion is not that Asian patients have difficulty in expressing themselves, but that they tend to use somatic metaphors which are poorly understood. Use of interpreters can lead to loss of up to 50% of information as well as hindering rapport. This requires the use of skilled (and properly trained) bilingual staff. Practitioners must ask simple questions and be aware of the clients's background and possible cultural reticence either in replying or expressing uncertainty.

6: Organisational and Research-related Issues

A third category of studies relates to some organisational aspects of the health service, and the conduct of research itself. While interwoven with previous concerns, these require separate attention, and may have greater relevance to a different readership.

6.1 Public Health Medicine & Contracting

In general, there is little research into the issue of consulting with the community, or the impact of the new contracting procedures which should be based upon popular input to priority setting. It can be demonstrated that there are few representatives from minority backgrounds on relevant boards (Jewson 1993). A new trend is the use of research into community expectations as a means of overcoming that lack of input, and the apparent failure of complaints systems to provide feedback from minority groups (Imtiaz). As there is great variation in the local composition of minority populations it is necessary to undertake local studies to establish the 'local base' (eg. Shah & Piracha) which will combine both demographic and needs-based information. Other techniques of consultation and communication for this purpose have been advised but not evaluated in a research-based fashion. It has been established that bilingual workers with adequate health service knowledge can conduct discussion groups in community settings which lead to satisfactory levels of response and effective community consultation.

6.2 Complaints

The absence of complaints from minority patients does not indicate an absence of distress: when directly enquired of, higher levels of dissatisfaction are expressed, and it may be the absence of appropriate information about, or mechanisms for, complaining that prevent Authorities and Trusts from obtaining the necessary feedback from clients (Madhok, Imtiaz).

6.3 Using and Leaving Hospitals

A major issue (Rawlins, Coventry, Madhok) would appear to be the provision of information for patients entering or being discharged from hospital. It is generally reported that levels of communication are poor and services rely upon patients own 'interpreters'. Few Asian patients seem to receive written information. A lack of comparative studies makes it hard to assess the relative strength of this issue but there is enough evidence to back up key recommendations regarding the provision of hospital interpreters, language-competent or ethnically matched workers, translation of leaflets and the provision of such information in alternative media (such as cassette or video). It is also possible that recruitment of more workers from minority backgrounds would improve communications with (or awareness of) community-based groups which would facilitate 'care in the community'.

A number of papers report concerns over information about 'coming into hospital', but few have researched it. In general, there are few places where such information has been made available in 'Asian' languages, and even fewer patients report seeing or receiving it (Madhok). Consequently, other services (such as specific dietary provision) are poorly understood or used, and dissatisfaction felt.

6.4 Research

It should be recognised that research is itself a major tool of communication, as well as requiring communication to gather information. Many of the issues here are not unique, but the findings are all taken from research in health service settings.

There is for those attempting a scientific approach to sampling a major problem in identifying and approaching respondents. 'Name recognition' is extensively used to locate 'Asian' respondents but contains certain biases, including the omission of significant minority groups, and those who have 'anglicised' their names.

Telephone and postal surveys have a very poor response. Personal visits, if necessary to the home, and using wherever possible 'matched' interviewers (certainly by gender, and preferably by origin as well as language competence) are recommended.

Surveys should be designed to offer some benefit to the community: they should work through community-based groups and avoid communicating an impression of 'white norms'. While it is very important that all studies should pay attention to issues of race, ethnicity and language, studies focussing upon minority community issues which pathologise minority cultures or ignore legitimate differences, receive poor responses. They should be designed in consultation with communities and around their own perceptions of need. This will include attention to concerns about poverty and racial exclusion.

The HEA 'Health & Lifestyle' study contains an extensive discussion of translation and interviewing issues. Survey design requires attention to issues of Gender and Age. There tends to be a poor response to self completion questionnaires by 'Asian' respondents.

Ethnographic, group interview and tape-recorded studies, as well as qualitative analysis, are all seen as having great value, and are sometimes more acceptable. The 'Coventry' model of working through English language and similar community-education groups seems to be gaining acceptance as a means of approaching community groups for information (Richardson) but still needs personal visits.

There is a common observation that retrospective studies of ethnic health were seriously hampered by poor recording or other data problems: some may arise from failure to acknowledge ethnic difference, and certainly few records report language use: there appears to be a continuing reluctance to record information which may reveal differences.

From 1st April 1995 the collection of 'ethnic monitoring' data for all admitted patients will provide a new source of data which should be comparable with the 'baseline' data of the 1991 Census. Maximum use should be made of this source of information, particularly when associated with information on language and religion, to overcome the deficiencies of earlier research using inconsistent categories and unconnected to clinical data on outcome.

6.5 Standardised methods and measures

A key issue in clinical practice is the development of robust and simple measures for assessment. The widely used General Health Questionnaire has been validated for Chinese users (Chan) and the Nottingham Health Profile is believed to be robust for Asian groups (Ahmad et al 1989b). Tests for children's development are not culture free, but they have not been evaluated. Research in Britain has, in general, concentrated upon identifying the degree to which standardised mental health instruments (GHQ, Langner-22) are not suited for use in a multi-ethnic society because of cultural interpretations of their questions (Currer). Recently some studies have developed instruments such as the Bradford Somatic Inventory and Hospital Anxiety & Depression Scale (Mumford) to prevent the under-registration of psychological distress through the over-literal translation of somatic metaphor.

Urdu is 'a rich and expressive language for communicating emotional states', but 'the reporting of symptoms of any type is not culture free' (Mumford 1992 :204). Bal (1986) also reported poor recognition of psychiatric disorders among Asian patients by GPs, including Asian GPs - but does not state whether there was a shared language. It is however clear that there need to be similar projects in other languages, and indeed in other fields. American research is presently exploring the use of 'culturally specific tools to assess attitudes and beliefs related to cancer and its treatment to facilitate appropriate and satisfactory interventions' in oncology (Nielsen 1992). Similar attempts have been made to validate the GHQ-28 on Japanese, Turkish and 'European' populations (Iwata & Saito) and it is clearly necessary to produce such independent measures for minority populations found in the UK.

7: Conclusion

There are undoubtedly communication issues which are particular to minority ethnic groups. In acknowledging this, it must not be forgotten that they also share the experience of the majority population in respect of the receipt of misinformation, barriers arising from fear, gender, poverty or other economic and social factors, and exposure to the 'popular media'.

Research into 'communication' and health service use by the 'majority' should examine the degree to which these impact upon minority groups, using appropriate and sensitive ethnic group questions and (if necessary) boosted samples to ensure adequate data for analysis.

Communication problems have been demonstrated, and recommendations made to overcome those identified. They have not necessarily been shown to be a major cause of ill-health, but are associated with inequalities of uptake and esteem. It is clear that attention needs to be paid to the communication skills and techniques of service providers: the demand for information and a willingness to take account of it is evident on the part of the potential consumers.

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