Ethnic Minorities and Health

M. R. D. JOHNSON, MA, PhD, *Research Fellow*

ESRC Research Unit on Ethnic Relations, University of Aston in Birmingham

There is now a substantial and growing literature on ethnic minorities in Britain, their health and their relationship with health services[1]. Indeed, publications on these topics are increasing almost as fast as bibliographers can record them, and this growing awareness of Britain's multicultural society is to be welcomed. However, it is worthwhile considering the history and impact of these publications. Despite the number and breadth of scope of articles and books, there are still significant lacunae in both knowledge and the implementation or accommodation of this knowledge in everyday practice[2]. Perhaps this is due to the apparently late start in the medical profession's awareness of Britain's changing population—and perhaps to other factors. There have been black people (that is, those of African, Asian and Afro-Caribbean origin) living in Britain for many years[3], although prior to the Second World War the majority were residents of seaport towns such as Cardiff, Liverpool and North Shields (Tyneside). This may account for one strand that can be discerned in the literature, 'Port Medicine'. By this I mean a concentration on exotic diseases, the 'sequelae of migration'[4-7] and the importation of illness. However, after 1945, and especially after 1948, migration from the 'New Commonwealth' (as it is now known) increased significantly, reaching a peak around 1962. It then declined again until we have now had a virtually static (or even negative) migration balance since 1970. Yet the first collection of papers on medical aspects of immigration does not appear until 1966[8] and contains only five medical references of earlier date (four from 1964), apart from an annual series related to venereology. Why was the medical profession so far behind the social scientists and the other caring professions, such as social workers or educators[9-12], in awaking to this new client group?

Biology and Culture

One suggestion that is met with, especially when attempting to influence the course content of trainee medical workers (nurses, doctors and others), is the notion that health is in some senses 'culture free'. While it is quite proper that we should follow the UNESCO 'declaration of experts' in rejecting the claims of 'biological race theory'[13] (those aspects of the science of eugenics which claim that a division into biological races of the family of man has genetic and other justifications), this approach also has its dangers. At one time it was acceptable to consider the human organism as operating in a constant fashion with a known response to stimuli such as disease organisms or trauma. Few physicians now hold this mechanistic view and the Alma Ata declaration of the World Health Organisation expressly includes many other aspects of a more psychological or cultural nature as having a bearing upon health. Indeed, there is a whole science of psychosomatic medicine. If we accept that illness can be interpreted in cultural terms, as the models of Balint[14], 'health belief systems' and 'the sick role' would suggest, then ethnic differences take on a significance beyond those of simple biology.

Biology, genetics and heredity do have a place in medicine for a multi-ethnic community, irrespective of 'race', which term we should reject as a physical category. The fact of physical differences, susceptibility and transmission of certain conditions, has been acknowledged in the literature, and a number of articles have appeared on sickle cell trait, thalassaemia, and other haemoglobinopathies[15,16], while other research has considered the significance of cousin marriage in certain Asian communities to the development of neural defects in their children. We might also note that, by way of compensation, multiple sclerosis is rarer in ethnic minorities[17] than in whites. However, other apparent ethnic differences such as the 'Asian low birth weight syndrome' seem to be disappearing[18] as maternal health and nutrition improve. Yet others, where incidence and prevalence rates suggested ethnic connotations of a pathogenic nature, have proved (both in physical and psychological medicine) to be illusory. In many cases these derive from uncontrolled class, or more particularly environmental, factors, such as tuberculosis[19,20] which appears to be acquired after migration. The situation of osteomalacia and 'Asian rickets' is quite possibly the same; it was called the Glasgow disease before there were Asian immigrants in Scotland to study[21]. Moreover, I am concerned that this issue alone has led to a massive campaign based on the understanding that the answer lies in health education against faulty cultural and dietetic practices[22]. More recent evidence[23] suggests that the problem may arise from what would otherwise be regarded as an extremely desirable trait, namely a high fibre diet. However, while not denying the significance of the medical condition and the spending of DHSS money on issues of concern to ethnic minorities, there is a possibility at least that the 'moral panic' behind this campaign has not helped the general situation of ethnic minorities and the way in which they are regarded by the profession. A recent and topical example of a comparable situation in

America is the association of AIDS with Haitians[24]. This is a feature not confined to physical medicine; the same effects can be found in psychiatry and its allied disciplines. A further strand in the medical literature has been a concentration on or indeed an abundance of articles about mental illness in immigrants[25]. These, while helpful to practitioners, have tended to stigmatise the whole ethnic minority community, in particular those of Afro-Caribbean origin[26]. Recent research actually suggests that some of the apparently higher rates reported confused incidence, prevalence and presentation, and that poor compliance with drug therapy led to an inflation of those figures[27].

The mention of drug therapy and compliance brings us back to the role of culture. Research on 'Asiatic Medicine'[28] draws attention to different concepts of illness and treatment and has led some physicians to believe that the use of Ayurvedic or Unani medical practitioners (Hakims and Vaids) is an important feature of Asian communities. While these concepts undoubtedly exist and colour attitudes towards health or the sick role, research in the West Midlands (supported by some on the Indian subcontinent) suggests a lesser utilisation of such practices than might be feared[29]. Similarly, other 'culturalist' concentrations on issues such as lead in *Surma* (an Asian eye cosmetic) may be diversions which detract attention from real problems—in that case away from environmental sources of lead poisoning. Nonetheless, culture is significant, and (like biology) cannot be ignored. This I take as the fifth major strand in my classification. This group, which I would term 'culturalist' writings, is, to the non-specialist reader of the medical press, the largest. In its intentions it is admirable, and perhaps its effects are equally beneficial, but that will depend upon the extent to which it reaches a wide audience and on the accuracy of its writing. There is a large body of literature that attempts to raise the level of knowledge of transcultural medicine[30] in the medical professions by describing language, religion, family patterns and health beliefs of ethnic minority groups. Some authors also advise caution in the use of 'standards' (of diet, or height/weight ratios, etc) derived from English, Anglo-American or European populations, but this is less common. More familiar are the useful training aids produced by the National Extension College, on Asian Naming Systems and Diet and Nutrition, the books by Alix Henley[31-33] and articles such as those in *Health Visitor*[34-36] which describe and try to explain the 'client' to the practitioner. Such articles tend to refer to families of Asian origin or, more rarely, to Travellers (Romanies or Gypsies). Afro-Caribbean culture has not apparently been regarded as particularly distinctive, perhaps because of a lack of apparent linguistic difference, although some sociologists have examined the 'legacy of slavery' in connection with family (marriage) patterns. There is, alas, no way of assessing how far these valuable insights are routinely transmitted to those newly qualifying, or whether the wheel is always re-invented as new practitioners encounter problems in practice. Nor are the writers themselves always entirely free from error. Few now would refer to Muslims as 'Mohammadans'[37] but not all Buddhists are Chinese[20, (p.31)] or Asians Pakistani, or indeed all minorities immigrant, just as not all Irish are building workers or all English middle class.

Class and Service Delivery

Mention of class brings to mind the 'Black Report'[38] which certainly examined class factors but, as with other reports such as the Harding Report on Primary Health Care, gave very little attention to ethnicity. Yet as Skrimshire[39] demonstrates, use of general practitioners is heavily affected by social class and any sociological author will discuss the relationship between ethnicity (or 'race') and class. Studies (such as my own[29]) which reiterate higher usage by ethnic minorities need to take this factor into account, along with income and need. When these are considered, ethnic minority patients are found to be rather more like white working class patients in their use of the NHS except in their use of emergency night calls and hospital out-patient services (lower) and child health/vaccination clinics (probably higher). What is required is more studies like those of Clarke and Clayton[40], Ronalds[41], Knox[42], or Rahman[43], which seek to examine patterns of accessibility, treatment and outcome from the clients' perspective. This approach, adopted in 1966 by Coleman for his study of Equality of Education Opportunity[44] on behalf of the US Office of Education, proved an eye-opener on the continuing existence and effects of racism (direct, indirect and 'institutional' or unintended) in American society. Community studies, or reference to non-medical sources of data to establish an understanding of the denominator in epidemiological studies, will assist us to interpret our findings in a more useful light. Equally, more attention should be paid to the use of ethnicity as a variable in everyday studies of common disease[45], whether to isolate more accurately the populations at risk[46], or to eliminate a stereotype of 'race' as a structuring factor in ill-health[47]. If this becomes normal practice, we may well return to the view stated by Dr Gans in 1966 [5 (p.88)], that '. . . most of the medical problems that face the immigrant child are problems of environmental medicine . . . Exotic disease accounts for the smallest group by far. We see, therefore, that most problems of child health among immigrants are not due to the colour of the child's skin but to the environment provided for the child by the host society'.

The solution to that, of course, lies not in ignoring the significance of ethnicity, but in realising its relationship to other social factors and working towards a wider society in which racism becomes a matter of historical interest only[48].

Conclusion

This review has concentrated upon the themes which its author has identified from the world of medical publishing. Certain issues have not been included, not because they are unimportant, but because they have seldom been seriously analysed in the mainstream of professional literature. The most significant are the issue of racism (in

practice and in society) and the role of 'overseas' or ethnic minority medical staff. Indeed, these two may be linked in some respects, but there seems little recognition of their significance for the health care of British ethnic minorities. This theme may be the next in a process which began with 'Port Medicine', a concentration on the exotic and imported conditions, and went on to 'Eugenic Medicine'. Having examined genetic transmission and variable susceptibility to disease, certain conditions became almost 'fashionable medicine' (or what certain sociologists term 'moral panics') with all the benefits and hazards associated with fashion. Alongside this developed a stream of writings on mental illness, drawing its conclusions in line with the prevailing ideological consensus. 'Cultural Medicine', borrowing from the psychiatric model, presented separatist views of exotic behaviour or pluralist explanations to assist in the understanding of 'difference'. The balance has now swung back to service provision, but with a greater emphasis on understanding the effects of differential provision and need. It is to be hoped that this trend towards increased sensitivity, consciousness of ethnicity as a significant factor or variable, and consideration of its effects in common disease (and treatment) will continue, as we develop our awareness that we live in a multi-ethnic community that will continue to enrich our lives and enlarge our medical understanding.

References

1. Johnson, M. R. D. (1983) *Race and Health, A Select Bibliography.* Aston University, Birmingham: RUER.
2. Rathwell, T. (1984) *Social Science and Medicine,* **19,** 123.
3. Fryer, P. (1984) *Staying Power—Black People in Britain since 1504.* London: Pluto Press.
4. Schwarz, K. (1966) in *Immigration: Medical and Social Aspects,* pp.27-37. (ed G. E. W. Wolstenholme and M. O'Connor.) London: Ciba Foundation and J. and A. Churchill.
5. Springett, V. H. *et al.* (1958) *British Journal of Preventive Medicine,* **12,** 135.
6. James, M. J. (1976) *Practitioner,* **217,** 246.
7. Bell, D. R. (1978) *Prescribers Journal,* **18,** 100.
8. Wolstenholme, G. E. W. and O'Connor, M. (eds) (1966) *Immigration: medical and social aspects,* London: Ciba Foundation and J. and A. Churchill.
9. Banton, M. (1959) *White and coloured: the behaviour of British people toward immigrants.* London: Cape.
10. Triseliotis, J. (1963) *Case Conference,* **9,** 7.
11. Kent, B. (1965) *Social Work,* **22,** 4.
12. Cohen, J. C. (1968) *Race as a factor in social work practice.* London: National Association of Social Workers.
13. UNESCO (1983) *Racism, science and pseudo science.* Paris: UNESCO.
14. Balint, M. (1957) *The doctor, his patient and the illness.* London: Pitman Medical.
15. Evans, D. I. and Blair, V. M. (1976) *Archives of Disease in Childhood,* **51,** 127.
16. Griffiths, K. D., Raine, D. N. and Mann, J. R. (1982) *British Medical Journal,* **284,** 933.
17. Craelius, W. (1978) *Journal of Epidemiology and Community Health,* **32,** 155.
18. Clarkson, M. G. *et al.*(1982) *Archives of Disease in Childhood,* **57,** 867.
19. Khogali, M. (1979) *Journal of Epidemiology and Community Health,* **33,** 134.
20. Innes, J. (1981) *Postgraduate Medical Journal,* **57,** 779.
21. Goel, K. M. *et al.* (1981) *Lancet,* **2,** 405.
22. DHSS (1983) *Stop Rickets Campaign.* Save the Children Fund for DHSS Asian Working Group.
23. Heath, D. A. (1983) *Postgraduate Medical Journal,* **59,** 649.
24. Smith, H. M. (1984) *Medical News,* **16,** 14.
25. Rack, P. H. (1982) *Race, culture and mental disorder.* London: Tavistock.
26. Littlewood, R. and Lipsedge M. (1982) *Aliens and Alienists.* Harmondsworth: Penguin.
27. Burke, A. W. (ed) (1983) Transcultural Psychiatry/Racism and Mental Illness. (Special edn). *International Journal of Social Psychiatry,* **30,** 58.
28. Aslam, M. and Healy, M. (1983) *Update,* **27,** 1043.
29. Johnson, M., Cross, M. and Cardew, S. A. (1983) *Postgraduate Medical Journal,* **59,** 41.
30. Oureshi, B. (1983) *Pulse,* October 29, November 5, November 12.
31. Henley, A. (1982) *Caring for Muslims and their families.* London: DHSS/Kings Fund/NEC.
32. Henley, A. (1983) *Caring for Sikhs and their families.* London: DHSS/Kings Fund/NEC.
33. Henley A. (1984) *Caring for Hindus and their families.* London: DHSS/Kings Fund/NEC.
34. Lam, E. (1980) *Health Visitor,* **53,** 254.
35. Pearson, R. (1982) *Health Visitor,* **55,** 426, 477, 533.
36. Schofield, J. (1981) *Health Visitor,* **54,** 138, 183, 248.
37. Dodge, J. S. (1969) *The Fieldworker in Immigrant Health,* p.69. London: Staples Press.
38. DHSS (1980) *Inequalities in Health.* Report of a DHSS Research Working Group. (Since republished by Penguin 1982.) (Townsend, P. and Davidson, N.)
39. Skrimshire, A. (1978) *Area disadvantage, social class and the health service.* Social Evaluation Unit, Oxford University.
40. Clarke, M. and Clayton, D. G. (1983) *British Medical Journal,* **286,** 621.
41. Ronalds, C. *et al.* (1977) *Journal of the Royal College of General Practitioners,* **27,** 281.
42. Knox, P. (1978) *Environment and Planning A,* **10,** 415.
43. Rahman, S. W. (1982) *Update,* **24,** 617.
44. Coleman, J. S. (1966) *Equality of Education Opportunity.* Washington: US Office of Education.
45. Morrison Smith, J. *et al.* (1971) *Clinical Allergy,* **1,** 57.
46. Morrison Smith, J. and Cooper, S. M. (1981) *Postgraduate Medical Journal,* **57,** 774.
47. Brennan, M. and Stoten, B. (1976) *New Society,* 681.
48. Cooper, R. (1983) *Radical Community Medicine,* **16,** 5.