***A SYNOPSIS OF A* DRAFT FOR CONSULTATION**

BREAKING BARRIERS: TOWARDS CULTURALLY COMPETENT GENERAL PRACTICE.

A RESEARCH PROJECT FOR THE RCGP INNER CITY TASK FORCE

by

LYDIA YEE

FOREWORD

General practice depends for its effectiveness on an intimate interaction between doctor and patient which demands trust and empathy. Barriers of culture and language make both trust and empathy more difficult to achieve. Misunderstanding on both sides is all too easy. Doctor and patient must build a therapeutic relationship which can span the barriers. This is one of the challenges, but also one of the great rewards, of inner-city practice.

TERMINOLOGY

The term Black is used throughout this report to refer to people from racial and other minorities living in Britain who may be disadvantaged because of skin colour, race religion or cultural beliefs. Black and Minority Ethnic, Racial Minorities, Ethnic Minorities or Black and Asian are just some of the terms commonly used. The 'correct" terminology to use is a continuing subject of much controversy and debate. There is no single accepted term and there are people who do not identify themselves as Black but who share a common experience of racism as a result of skin colour, race, religion or cultural beliefs. For this reason the term Black is used as preference.

RACISM

It is recognised that we all hold beliefs that are prejudiced about people who are seen to be different because of their racial groups or skin colour. Racism, however is attributed to those who have the power to turn prejudice into acts of discrimination or unfair treatment. For instance, this may occur if GPs do not accept there are Black patients who would benefit from available interpreting services because they perceive that all patients should be able to communicate in English..

RCGP INNER CITY TASK FORCE

The Inner City Task Force was set up in 1991 with the following terms of reference:

- to identify the problems of patients and those who care for them. associated with the provision of high-quality primary care within areas of urban social deprivation

- to find and promulgate effective solutions to these problems.

- to make recommendations for future action.

Its members are college members from inner-city areas around the country and representatives from organisations with a particular interest in inner-city care, eg: General Medical Services Committee (GMSC), Association of General Practice in Urban Deprived Areas (AGUDA), Overseas Doctors' Association (ODA), the King's Fund, and National Association of Health Authorities and Trusts (NAHAT).

Its first initiative was the launch of the report of the Inner City Task Force of the Royal College of General Practitioners (Lorentzon, Jarman and Bajekal, 1994) which made recommendations for improvement in inner-city general practice. In continuing to raise the profile of issues affecting inner-city general practitioners, this Project was established in July 1995 to consider the quality of general practice consultation among Black communities.

The communities looked at were: chinese, Somali, Asian, Black Carribean. This synopsis focuses on the Asian Community.

1. INTRODUCTION

There is evidence that consultations between general practitioners and patients from Black communities are less successful. (Smaje, 1995) These patients tend to have a higher than average consultation rate, especially within the Asian population (Balarajan and Raleigh, 1995) but are perceived by their general practitioners to be consulting with trivial complaints. (Smaje, 1995) This combination tends to indicate that the patients are often frustrated in their attempts to communicate the real nature of their distress and anxiety to the doctor because, for some of the Asian groups, they also complain about the difficulties of access, language and communication. (HEA, 1994). It follows that if the quality of general practice consultations made available to patients from Black communities could be improved then access to health care services is likely to be improved and health needs more comprehensively met. (Rudat, 1994)

The research project has been established to focus on the quality of general practice consultation with different Black communities and to identify obstacles to effective communication between general practitioners and their patients. Evidence on the take-up of health services indicates that social class is a key determinant of access which means that 'the effects of class disadvantages on access to services are similar for both white and minority ethnic patients.' (Balarajan and Raleigh, 1995)

But the obstacles that set Black patients apart and differentiates their life experiences are racism and discrimination demonstrated through stereotypical views and inappropriate assumptions made about the needs of Black patients (Smaje, 1995). Naish et al (1994) in their study to investigate factors deterring Black women in East London from attending their general practitioner for cervical cytology screening suggest that language and the lack of information about the benefits of smear tests in appropriate languages were obstacles. The researchers found that once the women understood the nature of the test and its procedures, they were enthusiastic about taking up cervical screening, contrary to the general practitioners impressions that these women were not interested in preventive services.

This Project is not intended to be judgmental: nor to lay blame for the problems of access to services on general practitioners. Rather) the Project is aimed at identifying what the barriers to effective communication might be between general practitioners and their Black patients and how to develop ways of overcoming those barriers on the basis of what has been learned from the four group discussions.

Findings from a recent postal survey of general practitioners undertaken in 1995 indicate that general practitioner respondents had received very little post-graduate training in racial or cultural issues from other agencies. Eighty two per cent of the general practitioner respondents said they had received none. Of those who reported having had training, it seemed that the most extensive training service on racial issues is post-graduate medical training (Pharoah, 1995). Ideally this training should be given earlier considering that many would-be doctors will provide services to a variety of Black communities.

2. THE BLACK POPULATION IN BRITAIN TODAY

Black people have made Britain their homes for decades. Smaje (1995) says that "the contemporary ethnic character of Britain's population was forged largely in the nineteenth and twentieth centuries; and largely as a result of British governments' own policies." He goes on to describe clearly the pattern of migration and concludes that such migration patterns have engendered the demographic structures we have in Britain today which are relevant in examining health care generally.

The point of this information is to show that the Black population is not new to Britain and all health professionals should begin to change their concept of providing care, no longer thinking in terms of a migrant population but of a section of the British population with specific needs - a principle upon which this report rests.

Table 1: Resident population by ethnic group, Britain 1991

Ethnic group	Number (thousands)	Proportion of total population (%)
White	51,87494,5	94.5
Black - Caribbean	500	0.9
Black - African	212	0.4
Black other	178	0.3
Indian	840	1.5
Pakistani	477	0.9
Bangladeshi	163	0.3
Chinese	157	0.3
Other - Asian	198	0.4
Other - non Asian	290	0.5

(Source: 1991 census local Base Statistics, OPCS crown copyright. Printed with permission)

Table 2 Proportion of people resident in Britain who were born there. by ethnic group, 1991

Ethnic Group	Proportion British Born (%)
White	95
Black - Caribbean	54
Black - African	36
Black - other	84
Indian	42
Pakistani	50
Bangladeshi	37
Chinese	28
All other	44

(Source 1991 census. Local Base Statistics, OPCS crown copyright Printed with permission.)

3. BLACK POPULATIONS AND GENERAL PRACTITIONERS; WHAT SOME OF THE RESEARCH SAYS

Much of the current literature on general practitioners and their relationship with Black patients focuses on consultation rates and use of primary health care services. Balarajan et aI.,(1989) drawing data from the General Household Survey, conclude higher rates of consultation of general practitioners among Asian and Black Caribbean people. The Health and Lifestyles Survey undertaken by the Health Education Authority indicated that average annual consultation rate per head of population is 3.6. For Black Caribbean people it is 4.2, and among Asian people it is 5.0 Within this group the Bangladeshis were found to have the highest rates at 7.9 followed by the Pakistanis at 7.1 .m

In the perception of many general practitioners, Asian patients particularly visit them for trivial conditions. Ahmad et al, (1991) suggest that Consultations with Asians tend to be less satisfying; they were thought to require longer consultations, to be less compliant and perceived to make excessive use of healthcare, including visits for trivial or minor reasons." Although they concede that the definition of a "legitimate" consultation differs between doctors and patients, no reasons are given for these high consultation rates. McCormick et al., (1990) show that the patient consultation rates for Asians and Black Caribbean people tended to be high for serious conditions. The GP Morbidity Survey reinforces this through its findings that higher consultation rates are found in Black Caribbean men and women for endocrine, nutritional and metabolic disorders, diseases of the nervous and circulatory system Black Caribbean men consult more often with mental disorders. Asian men and women tended to have higher consultation rates for endocrine, nutritional and metabolic disorders, respiratory diseases, skin diseases and diseases of the digestive and musculo skeletal systems.

The HEA Health and Lifestyles Survey (1994) suggested that patients from Black communities are more likely to attend open surgeries where there are no appointment systems, because they prefer it. Badger et al. (1982) in their study of Asian patients suggest this has the possible disadvantage of

reducing opportunities for health promotion and decreasing the amount of follow-up consultations. Black patients' waiting times is also longer than the UK average as indicated by the HEA Health and Lifestyles Survey: Average wait for UK population is 18 minutes, for Black Caribbeans it is 27 minutes and for Indian people it is 30 minutes In part this can be explained by the use of open surgery by members of Black communities and as would be expected, they are dissatisfied with the long waiting times. This is also borne out in the discussions we had with the tour groups interviewed While open surgeries are considered preferable by Black patients, little data is available about whether they are informed of the benefits of appointment systems.

Language difficulties can hinder the delivery of effective primary health care. Yet the proportion of patients whose first language is not English and who make use of formal interpreters is small. Informal interpreters are often the only option available to patients and they are often friends or close family members, including children. Research (MORI, 1994) shows that most people who use informal interpreters report difficulties such as inhibition in discussing personal issues and problems with accuracy of interpretation.

4. OUTLINE OF THE PROJECT

4.1 THE THEORY

At the heart of this Project is the desire to hear directly from members of different communities about their experiences of consultations with their general practitioners in order that suggestions can be made for future improvements. Far from being a paper exercise. this Project is intended, through the Royal College of General Practitioners, to make recommendations to bodies responsible for training general practitioners with a view to improving future curricula, to health authorities as purchasers of health care services, to medical schools as educators of future doctors and to the Department of Health with its lead on policy development.

4.2 THE MODEL

The core of the Project model focused on the meeting with the four community groups and discussions about their experiences of GP consultations.

Local facilitators were identified in each of the four areas to organise and run the group discussions. They contacted men and women from their communities from all age groups ranging from teenagers to older people in their eighties. The selection criteria for facilitators included, among other things, experience of community work and having a network of community members to contact for the meeting. The facilitators were also responsible for facilitating the discussion and for providing a report afterwards

4.3 THE INVOLVEMENT OF GENERAL PRACTITIONERS THROUGHOUT

A key principle of the Project has been to include general practitioners in all the group discussions. The general practitioners were under strict instructions to resist defending their positions in the face of criticism but were instead present to hear firsthand from community members about their experiences of consultations with their doctors. The general practitioners would also be able to endorse the report's recommendations to colleagues and to aid its implementation through the Royal College of General Practitioners.

5.3 THE ASIAN COMMUNITY

There were about twenty participants and as with the other groups, more women than men attended the meeting. They ranged between the 30 to 65+ age group. The main languages spoken were Gujarati, Punjabi, Urdu and Hindi

5.3.1 COMMUNICATION DIFFICULTIES

Issues of language are usually understood to affect only people who did not speak English fluently. With the Asian group interviewed, there were few language barriers and less need for interpreters because they were mostly registered with Asian general practitioners, most of whom had multi-lingual staff.

The group reported that language barriers can be created by the use of medical "jargon" or other unfamiliar terms. Some people complained that their general practitioner would not explain the medical terms used satisfactorily which left them unclear about their health condition.

Although language is a part of effective communication, this is not complete without considering other aspects of communication such as listening skills, use of body language and general attitude. Many participants did complain about their general practitioners' unhelpful attitude which deterred them from visiting the doctor. One woman said her doctor reprimanded her for using the emergency out-of-hours service because it would cost the NHS too much money. Another was told not to be too knowledgeable about her heart condition because she wasn't a doctor. Patients reported being frightened of being struck off the general practitioners' lists and were therefore reluctant to complain. In some cases, participants had family pressure to stay with the family doctor which made it difficult to complain.

Several older participants complained that younger Asian doctors preferred to communicated in English, not accounting for the fact that perhaps younger Asian doctors brought up and medically educated in Britain may not be as fluent with their mother tongue as they would like to be.

By contrast, there were also participants who were very pleased with their doctors' attitude.

5.3.2 EXPERIENCE OF GENERAL PRACTICE CONSULTATIONS

Many of the women participants preferred to have women general practitioners but recognised a shortage of them in the area. Although some practices only had male doctors, participants felt they were compensated by having female nurses with whom they could more freely discuss intimate health details.

As with the other groups, participants in this group wanted to be examined by their general practitioners. The consultation did not feel complete otherwise. The perception that doctors only wrote prescriptions was repeated. "Some doctors are writing out your prescription as you are talking without even examining you. " It is clear the quality of general practice consultation is affected by this perception. Thorough examinations are highly valued. In many cases, it is appropriate for general practitioners to write out prescriptions for patients - perhaps this should be a supplementary part of the consultation rather than the focus of it. Reluctance to do home visits and delays in referrals were mentioned as problems too.

Understandably, where language was less of a problem, patients were able to be more critical and there seemed to be many more complaints about the organisation of the practice and the attitudes of the staff.

5.3.3 THE RECEPTIONIST SERVICE

It was inevitable that in discussing the quality of general practice consultation, commenting about services from other members of the practice team would also arise. The attitude of receptionists was referred to on several occasions. Several people reported receiving a hostile reception that was unwelcoming and discourteous. Participants complained of having to wait longer than usual to see the doctor. ‘If the doctor is late that's alright. If patients are late, they are told to come back another day. This is very embarrassing when receptionists tell you off in front of other waiting patients."

As gatekeepers to general practitioners, training for receptionists is vital because they affect how patients feel about visits to the doctor.

5.3.4 PRACTICAL SUGGESTIONS

The following are suggestions for change as suggested by the Asian group.

- Training doctors in communication skills will enable them to empathise with their patients.

- Identifying the problems faced by receptionists in order to improve support for them. Training is also essential

- Inner-city practices tend to have larger list sizes when the population's needs are greater and there are more single-handed general practitioners. This implies general practitioners being over committed with too many patients and not enough time to offer individual consultations. One participant said his doctor saw 28 patients in two hours and that the time available was too short. Reviewing the list size of inner-city general practitioners could be one way of ensuring longer consultations.

- Open surgery offers easier access to the doctor without the restriction of appointment times. However, this has its disadvantages too which should also be pointed out to patients.

- Being rushed during the consultation makes patients feel uncomfortable. General practitioners are expected to offer more time to patients and to examine them before being sent away.

- Information telling patients of the service they can expect to receive during the consultation should be clearly displayed. Patients must be enabled to understand clearly whether they are being treated within the NHS or as private patients.

- Information about the complaints process should be produced in the appropriate community languages.

5.5 GENERAL SUMMARY

The overwhelming impression was that Black patients want the same things as all patients

- to be taken seriously

-to be valued to be given time

-to be listened to and to be heard to be appropriately touched

The wish to be touched and properly examined was a recurrent theme and perhaps this basic human need assumes greater importance in an environment which is perceived as hostile.

A word about examinations

There was much dialogue in the discussion groups in relation to being examined by general practitioners. In contrast to simply being given prescriptions - which many patients complained was their usual experience - participants said they wanted to be examined by their doctors. It was this examination that made the consultation feel "thorough" to the patients. The participants would have wanted the relevant health checks (blood pressure checks, urine tests, blood sample tests, and so on), but realised this may be time consuming and not always necessary. People did however express a need for non-verbal reassurance by their doctors that they were "okay' physically. This reassurance might, for example, be given by a touch on the arm. This appropriate physical contact is all the more important when expression in words is limited because of language barriers.

"By expression in words the communication between doctor and patient becomes explicit. Only if the doctor can find words which the patient recognises as describing his or her own experience. can the patient be certain that he or she has been understood. " (Heath, 1995)

6.1 THE RECOMMENDATIONS

In the light of the findings**,** the Project recommends the following measures if the quality of general practice consultations is to be improved for Black patients. The recommendations are grouped according to the audience whom they are targeted towards and suggestions are made on whether they should be undertaken in the short or medium term. (ST and MT)

1. ROYAL COLLEGE of GENERAL PRACTITIONERS (RCGP)

1. Greater emphasis on general practitioners appropriately touching patients during the consultation. This recurring theme across the groups is worth listening to because tactile communication is just as important as verbal communication in order to reassure patients, and, perhaps in some cases, will go a long way towards aiding recovery. General practitioners need to accept that ensuring patient satisfaction during the consultation can be time-consuming and seemingly inconvenient, but results in a better relationship between the patient and them. Appropriate touch can make up for deficiencies in verbal assurance impeded by language difference. (ST)

2. There is a widely held view that general practitioners write prescriptions as a cure for all health problems without undertaking examinations. General practitioners inevitably have to write some prescriptions for patients but the complaint is this is all they do. Where doctors were praised, they were found to be good listeners, solely interested in their patients' welfare. Prescription writing should form a part of the consultation and not the focus of it. (ST)

3. Training courses should include such topics as listening skills and non-verbal communication in relation to Black communities. It should also raise awareness about the different Black

communities and their culture. Most patients present themselves to general practitioners during periods of ill health when morale will already be low. Sympathy and empathy are essential to proper communication. (ST)

4. Where patient simulation is used in assessment, it is important to include a Black perspective to the course structure. (ST)

5. Acceptance of the principle that all general practitioners and their practice colleagues need to undergo training on racism awareness which includes among other things, the status of refugees in this country and how to treat Black patients in a culturally sensitive way. The development of a strategy for implementing this principle within a specific period. The need for racism awareness training applies also to general practitioners in training. (ST)

6. Training for general practitioners on the nature, purpose and correct ~c ~f advocacy and interpreting services for patients The message should be widely spread that using family members as advocates and interpreters is not good practice. There will be occasions when family members will inevitably be used as advocates and interpreters. The requirement that general practitioners ensure they secure the patient's informed consent to using a family member as interpreter before proceeding with the consultation. Family members should also be asked if they agree to undertake the interpreting. (ST)

7. The idea of open surgery without the rigidity of appointment times is attractive to many patients. As well as having recourse to open surgery, practices should also consider publicising, in a variety of languages, the merits of appointment systems for patients especially in terms of follow up consultations and undertaking effective health promotion. (ST)

8. As part of their education, general practitioners in training should have contact with community organisations to experience at firsthand the life experiences of Black patients. If the experience of general practitioners on the steering group is anything to go by, VTS groups could benefit from the opportunity to meet with focus groups from local Black communities. (MT)

9. Prominently displaying in the surgery what services NHS patients can expect to be charged for such as travel vaccinations, signing passport applications or completing insurance forms. (MT)

10. Quality Indicators have been produced by the NHS Ethnic Health Unit for general practitioners and other members of the primary health care team to improve health service support for Black patients.

General practitioners and their teams may want to take the opportunity of working through the indicators (MT)

II. HEALTH AUTHORITIES

11. Health authorities and general practitioners should ensure appropriate training for receptionists. Their gate-keeping role can be used to the advantage and not as is currently perceived, the disadvantage of patients. (ST)

12. The targeting of information about general practice services at local Black populations in order to clarify expectations patients have of their general practitioners. Health Rights, a London-wide voluntary organisation, has produced a series of leaflets and cassette tapes in various community languages entitled, Getting to Know Your GP"
(ST)

13. High-quality information for newly arrived refugees and other people coming to live in Britain about the structure and use of the NHS. (ST)

14. General practitioners should also have access to a pool of interpreters during out-of-hours calls. (MT)

15. Producing a local register of general practitioners who treat non-NHS patients and are therefore entitled to charge a fee for the consultation and any subsequent treatment**.** (MT)

16. Many general practitioners are opting for GP commissioning as a means of influencing planning and provision of services. Health authorities are charged with allocating resources to general practice commissioning groups. Health authorities should ensure that any local resource allocation policy adequately takes account of inner-city deprivation factors. (ST)

17. Health authorities to offer training for primary health care teams on collecting ethnic monitoring data. Done effectively, the information can be used to improve standards of patient care and ensure equity of access to services. (MT)

III. HEALTH AUTHORITIES AND THE RCGP

18. Emphasis on the need for general practitioners, health authorities and Trusts to employ more staff from Black communities to reflect the make-up of their local population. General practitioners are only part of the primary health care team. Patients are also seen by other members of the practice team and communication barriers should be minimised wherever possible. Schemes to encourage this already exist in places such as East London. (Atrij et al. 1996) (MT)

19. Better publicity through community organisations, appropriate language leaflets and audio/visual material about the complaints procedure. The findings indicated a low level of complaints made compared to the high level of dissatisfaction with general practice services. Black

patients should be informed of support during the complaints process and given assurance that they will not be "struck off' the register for doing so. (ST)

20. Better liaison between health authorities, general practitioners and local community organisations would encourage better flow of information generally. (ST)

21. The strategy of attracting and retaining general practitioners is of current national concern, especially in inner-city areas Health authorities' liaison with local Medical Practice Committees (MPCs) to set priorities for recruitment and retention is key. (MT)

22. Involve inner-city general practitioners in developing the curriculum for GP registrars.

3. Responses from Asian participants.

i) Total number of completed questionnaires. 28

ii) Languages spoken.

Gujurati	Punjabi	English	Hindi	Bengali
12	8	11	1	7

Urdu	Sylheti
7	2

iii) Sex:

Male	Female
12	16

iv) Age range (yrs)

10-20	20-30	30-40	40-50	50-60	60-70	75+
6	4	5	7	3	2	1

v) Is your GP male or female?

Male	Female	Both available in practice
24	2	2

vi) How long have you been seeing your GP?

less than 1 year	1-5 years	more than 5 years	don't know
5		5	180

vii) How often do you see your GP?

once a month	more than 10 times a year	5-6 times a year
11	8	6

once a year	cannot remember	never
2	0	0

viii) Would you prefer to see a male or female GP?

Male	Female	No Preferences
8	11	8

ix) Do you have to make an appointment to see your doctor?

Yes	No
18	10

x) How are you treated by your doctor?

Good	Fair	Bad	Don't Know
11	7	10	0

xi) Is your doctor from the same community as yourself?

Yes	No
14	14

xii) Would you prefer to see a doctor from the same community?

Yes	No	No Preference
10	1	14

xiii) Have you ever been dissatisfied with your doctor?

yes	No
13	14

xiv) Did you do anything about it?

Yes	No
6	7

REFERENCES

1. Ahmad W I U et al. (1991). General practitioners' perception of Asian and non-Asian patients. Family Practice, 8: 52-6.

2. Ahmad, W et al. (1991). Patients' choice of general practitioners: importance of patients, doctors, sex and ethnicity. British Journal of General Practice, 41: 330-331.

3. Ahmad, W I U (ed) (1993). 'Race' and health in contemporary Britain. Open university Press.

4. Atri, J et al. (1996). Fairshares in Healthcare. British Medical Journal, 312: 614-17.

5. Badger, F; Arkin, K and Griffiths, R. (1982). 'why don't general practitioners refer their

16. Lorentzon, M, Jarman, B and Bajekal, M. (1994). Report of the Inner City Task Force of the Royal College of General Practitioners. Occasional Paper 66. London, Royal College of General Practitioners.

17. Naish, J, Brown, J and Denton, B. (1994). Intercultural consultations: investigation of factors that deter non-English speaking women from attending their general practitioners for vervical screening. British Medical Journal. 309: 1126-8.

18. Pharoah, C. (1995). Primary health care for elderly people from black and minority ethnic communities. Studies in Ageing: Age Concern Institute of Gerontology and King's College London. London, HMSO.

19. Rudat, K. (1994). Health and Lifestyles: Black and minority ethnic groups in England . London, Health Education Authority.

20. Sharda, A. and Yee, L. (1995). Primary Health Care Quality Indicators: Improving health services for black and minority ethnic populations. NHS Ethnic Health Unit. Department of Health.

21. Slingsby, C. (1992). How do I boost clinic uptake? Medeconomics, 48-53.

22. Smaje, C. (1995). Health, race and ethnicity: Making sense of the evidence. London, King's Fund Institute.

23. Spence, J. (1960). The purpose and practice of general medicine. Oxford University Press.

24. Taylor, David. (1991). Developing primary care: Opportunities for the 1990s. Research Report 10. London, King's fund Institute and The Nuffield Provincial Hospitals Trust.

25. Tomlinson, Sir Bernard. (1992). Report of the inquiry into London's health service, medical education and research: presented to the Secretaries of State for Health and Education. London, HMSO.

26. Wakeford, R et al. (1992). Does the MRCGP examination discriminate against Asian doctors? British Medical Journal, 305: 92-4.

27. Health Rights (1995). You and your doctor: a guide to help you get the best from family doctor services. Audio cassettes, London.