

Language and communication problems in an Asian community

CHARLOTTE M. WRIGHT, BM, BCH, B.MED.SCI.

House Officer, Northwick Park Hospital, Harrow

SUMMARY. A survey of general practitioners working in an area of immigrant concentration was undertaken to find out about their contacts with the Asian community. An earlier study had shown that Pakistani women mostly spoke little or no English and that they had strict ideas of modesty, which suggested problems for the health services.

Questionnaires were sent to 44 doctors and 39 (89 per cent) replied. To the question of language difficulty, 11 doctors answered that they could speak at least one Asian language, the remainder said they relied on patients' relatives to interpret. On frequency and length of consultations, more than half the doctors felt that Asians consulted more often and took up more time than English patients. Reluctance on the part of Asian women to be examined was reported by 30 doctors. However, the commonest comments volunteered by the general practitioners were not about language or modesty but about their Asian patients' tendency to complain of trivial ailments, while on the other hand they presented less often with psychosocial problems. A connection between the language barrier and apparently unnecessary complaining is postulated. It is also recommended that interpreting facilities and liaison workers should be made known to general practitioners.

Introduction

THIS study arose out of a community survey of Pakistani mothers and their children in Newcastle, which has a small yet concentrated community of Asians in the west end of the city. While their numbers are small compared with areas such as Bradford or Southall, Asians form a substantial proportion of the population in the study area, their children making up

60 per cent of pupils in one primary school. A wide range of data about home conditions and activities was gathered. Among other findings, the Pakistani women were shown to have a limited knowledge of English, few contacts outside the community, and strict ideas about modesty and propriety. This suggested that there could be problems with the health services and it was thus decided to do a survey of general practitioners in the same district about their contacts with the Asian community as a whole.

Asians have been coming into this country in substantial numbers for 25 years. They now make up 57 per cent of New Commonwealth immigrants, who represent in total 2.5 per cent of the population, though only 1.8 per cent of adults (Smith, 1976). The recent nature of the migration means that little research had been done on any but the broadest aspects of the immigrant community. Medical research has largely been restricted to studies of incidence of rickets and tropical diseases (Goel *et al.*, 1977) and of mental illness (Cochrane, 1977). The study conducted in Newcastle by Taylor (1976) concentrated on male Asian school-leavers and, while providing interesting background information, is now outdated. Saifullah Khan (1976), writing illuminatingly on the social and religious conventions governing Pakistani women in Bradford, described the practice of *purdah* adapted to this country and demonstrated the vital importance to Pakistani women of physical modesty and sex segregation.

A national survey of the immigrant population found that 43 per cent of Pakistani men and 77 per cent of women spoke little or no English and that 27 per cent of the men and more than 50 per cent of the women had had no schooling (Smith, 1976). In my earlier study (Wright, 1981), I found that 58 per cent of Pakistani women spoke little or no English, and 15 per cent of the men and 66 per cent of the women had had no schooling and were entirely illiterate. This is not surprising since illiteracy in Pakistan ranges from 58 per cent in urban areas to 79 per cent in rural areas for men and from 82 per cent to 97 per cent for women (Jeffrey, 1976).

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These figures suggest a considerable problem for the health services, taking into account the estimate that in hospital consultations a diagnosis is made from history alone in 56–82 per cent of cases (Hampton *et al.*, 1975; Sandler, 1979). Amrit Wilson (1978) has written about Asian women in Britain and provided anecdotes of their problems with health services and of the complacency of those responsible for their care. Wandsworth and East Merton Community Health Council (1978) published the results of a survey of the provisions made for immigrant patients by area health authorities across the country. This survey revealed the limited extent of these services and prompted a rash of working parties and feasibility studies. Wandsworth's own working party report (Wandsworth and East Merton Community Health Council, 1979) recommended changes, such as setting up an interpreter bureau, appointing Asian community workers and trying to ensure an even distribution of women doctors in the district.

Method

In the earlier study, the 39 mothers interviewed were identified by sampling Pakistani children from primary schools in the main area of immigrant concentration—the west end of the city. All the nine schools in the area were approached and asked what proportion of their pupils were Pakistani. In the centre of the chosen area the schools had between 25 and 40 per cent Pakistani children, while of the four schools on the edge two had less than 2 per cent and two had none at all. It was thus possible to define a distinct study area—an oval—one-and-a-half miles long by one mile wide. Because it was likely that some families might go to doctors outside their immediate neighbourhood, for the survey of general practitioners the area was extended southwards and westwards to make it two-and-a-half miles by one-and-a-quarter miles. All the general practices within this area were approached; there were no practices to the north and east for several miles.

A questionnaire and an explanatory letter were sent to all the general practitioners. A research group working within the area took on the administration of the survey, and their secretary phoned reminders where appropriate. The questionnaire had 15 questions, of which nine were structured and six open-ended. The doctors were asked whether they spoke Urdu, Punjabi, Hindi or Bengali, well, slightly or not at all, and what help, if any, they had in the event of language difficulties; what was their estimate of the proportion of Asians on their list, within the ranges of less than 5 per cent, 5–10 per cent, 10–25 per cent, 50 per cent or more; which national group did they think predominated. They were questioned on the rate and length of consultations with Asian patients compared with non-Asians; whether they encountered reluctance on the part of Asian women to be examined; whether there was a woman doctor in the practice and if not, how they coped in cases of extreme modesty. The doctors were also asked whether they felt that Asians presented more often or less often than other patients with specific complaints, and whether they had any general comments to make about their work with Asians.

Results

Forty-four general practitioners were approached and five declined to participate, giving a response rate of 89

per cent. Only four doctors had more than 5 per cent but all had some Asian patients. Of the national groups, Pakistanis predominated, along with a fair proportion of Indians, a few Bangladeshis and a handful of Vietnamese.

Eleven of the general practitioners (28 per cent) spoke at least one of the languages specified in the questionnaire, but only three spoke Punjabi—the mother tongue of all the Pakistanis and most of the Indians. (However, most Indians and Pakistanis understand at least some Urdu and Hindi: Urdu is the national language of Pakistan and Hindi that of India and although written in different scripts, these languages have a common origin and are similar; Punjabi is closely related to both the other languages.)

Five doctors spoke one or more of the languages well, and this number included the three doctors who spoke Punjabi; six doctors spoke either Urdu or Hindi only slightly. Four doctors were also fluent in Bengali, the language of the Bangladeshis. Using the general practitioners' own estimates of the proportion of Asian patients on their lists, it was possible to calculate that about one half of the Asian population were attending a doctor who spoke an Asian language.

Four doctors had more than 5 per cent Asian patients on their list. Two of these doctors, with 5–10 per cent and 25–50 per cent Asian patients respectively, were of Asian origin themselves and spoke Punjabi fluently as well as Urdu and Hindi. One woman doctor, who had 10–25 per cent Asians on her list, was of English origin but had learnt some Hindi in order to communicate better with her Asian patients. The fourth doctor, with 5–10 per cent Asian patients, spoke no Asian languages. It was estimated that these four doctors, whose surgeries were all in the centre of the study area, saw, between them, nearly one half of the Asian population in the area.

No specific assessment was possible of the extent to which general practitioners saw the language barrier as a problem, and only five doctors commented specifically on language. None of the practices had access to any interpreting facilities; 29 doctors (74 per cent) depended on patients' relatives.

In reply to the questions about rate and length of consultations, 20 general practitioners (51 per cent) estimated that Asian patients consulted more often and 25 general practitioners (64 per cent) felt that consultations with Asian patients took longer than those with non-Asians. None felt that the Asians consulted less often or took up less time (see Table).

In answering the open-ended questions, 10 doctors said spontaneously that their Asian patients consulted more often for trivial complaints and a further four doctors felt they attended more often for minor gastrointestinal and urinary tract infections. Seven doctors thought their Asian patients were more demanding. Three doctors did feel that Asian patients were also more grateful.

| Questions about Asians' consultations | More (number of responses) | Same | Less | No response |
|-------------------------------------------------------------------------------------------------|-------------------------------|------|------|----------------|
| Do you find that your Asian patients consult more, less or as often as non-Asian patients? | 20 | 18 | 0 | 1 |
| Do consultations with Asian patients take more, less or same length of time as with non-Asians? | 25 | 13 | 0 | 1 |

Five of the general practitioners were women but only one of them spoke an Asian language. Seventeen doctors had no woman doctor in their own practice to whom they could refer patients. Problems with Asian women patients were said to arise 'often' by six doctors and 'sometimes' by 24. These problems mainly concerned physical examinations, particularly vaginal examination. Eight doctors said they had never had these problems; two of the eight were women and only one an Asian himself. In practices with no woman doctor to refer the more modest women to, referral to hospital or the presence of a chaperone were sometimes required in order to complete an examination.

Five doctors said spontaneously that they felt Asians consulted less often for psychosocial problems or were generally more reticent. Two doctors felt that Asians were more likely to present with masked depression.

Discussion

The tantalizing aspect of these results is that they allow no direct estimate of the extent to which general practitioners see language as a problem when dealing with Asian patients, although the evidence of the Asians' poor knowledge of English and the lack of interpreting facilities in the practices suggests a problem of some magnitude. The use of relatives as interpreters, who themselves may have only limited English and will tend to give a bias to the interview, is unsatisfactory. A study of an interpreter service in Australia (Richter *et al.*, 1979) dismissed relatives as of little use; and Cox (1977), writing on psychiatric care, pointed out the inadequacies of untrained interpreters.

However, the commonest comments made spontaneously by the general practitioners were not about language but about their Asian patients' tendency to complain about trivial matters (described by one doctor as the 'foreign ambience syndrome'). Setting this with the statement from one general practitioner that trivial complaining ceased to be a problem once she had learned Hindi, it would seem that language and trivial complaining are intimately linked. One can postulate

that what the general practitioners perceive as trivial complaints are in fact ailments that the language barrier prevents from being explained adequately by the patient and thus from being diagnosed and managed appropriately by the doctor. Patients who attend frequently for trivial ailments are often thought to be manifesting some underlying need or problem that remains unexpressed. Certainly this would accord well with the suggestion that Asians were less likely to consult for psychosocial problems, and also with the observations of Hussain and Gomersall (1978) that depressed Asian immigrants show a strong tendency to present with physical symptoms. In my earlier study (Wright, 1981) the women who scored poorly in a screening test for mental illness nevertheless professed themselves to be happy and contented.

It is disquieting that the general practitioners apparently view the trivial complaining as simply a nuisance and may not delve any deeper for reasons or take any steps to improve communication. At a seminar to discuss the results of the project, most of the doctors present were previously unaware of the fact that there are two Asian liaison health visitors in the study area. Nor were they aware of the possibility of the local Community Relations Council providing voluntary interpreters.

Another factor to be considered is that many of the Asians have come from areas with little access to Western-style medicine. The gap is filled by a wide assortment of indigenous practitioners working within their own system of medicine, in many ways very different from that practised in the West (Marniot, 1955; Neumann *et al.*, 1971). It seems likely that Asian immigrants will find many aspects of British medicine puzzling and unsatisfactory by their standards of 'normal' care. This might well result in apparently trivial and inappropriate complaining.

The other major problem uncovered was that of female modesty. The previous study had demonstrated that 76 per cent of the women felt it was essential to veil their heads when out-of-doors and at all times they were dressed from head to wrist to ankle in loose, unrevealing garments. It is not surprising that the general practitioners had difficulty when examining Asian women, although the fact that only six doctors said it was a frequent problem raises the question as to whether most of the women are overcoming their modesty, or whether they are not being examined or are submitting to examination under duress. It is possible that some women are being referred to hospital unnecessarily.

The overwhelming impression from the result is of general practitioners puzzled by the influx of Asians to their practices, aware of considerable problems of management and yet unable or unwilling to make appropriate adjustments. It seems that each doctor sees his Asian families as his private problem and does not look for, or expect, aid from elsewhere. This is likely to lead to frustration for the doctor and inadequate or inappropriate

ate care for his Asian patients. Considerable initiatives are necessary from health authorities, not only to provide liaison health visitors and interpreters, but also to make doctors aware of these services.

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Dr C. M. Wright, 93 Uxbridge Road, Rickmansworth, Hertfordshire.

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