References

1. Galbraith NS, Barrett NJ, Sockett PN. The changing pattern of foodborne disease in England and Wales. *Public Health* 1987; **101**: 319-328.
2. Public Health Laboratory Service. Memorandum of evidence to the agriculture committee on salmonella in eggs. *PHLS Microbiology Digest* 1989; **6**: 19.
3. Corkish JD. Salmonella infections in poultry a statutory approach. *State Veterinary Journal* 1989; **43**: 188-192.
4. Skirrow MB. Campylobacter perspectives. *PHLS Microbiology Digest* 1989; **6**: 113-117.
5. Pearson AD, Colwell RR, Rollins D, *et al.* Prevention of *Campylobacter jejuni* transmission to broiler chickens by farm interventions. In: Kaijser B, Falsen E (eds). *Campylobacter IV: proceedings of the fourth international workshop on campylobacter infections.* Goteborg, Sweden: University Department of Clinical Bacteriology, 1988: 304-305.
6. Gilbert RJ, Hall SM, Taylor AG. Listeriosis update. *PHLS Microbiology Digest* 1989; **6**: 33-37.
7. Social Services Committee. *Food poisoning: listeria and listeriosis.* London: HMSO, 1989.
8. Critchley EMR, Hayes PJ, Isaacs PET. Outbreak of botulism in north-west England and Wales, June, 1989. *Lancet* 1989; **2**: 849-853.
9. MacDonald KL, Cohen ML, Blake PA. The changing epidemiology of adult botulism in the United States. *Am J Epidemiol* 1986; **124**: 794-799.
10. PHLS working party on viral gastroenteritis. Foodborne viral gastroenteritis. *PHLS Microbiological Digest* 1988; **5**: 69-75.
11. Cover TL, Aber RC. *Yersinia enterocolitica. N Engl J Med* 1989; **321**: 16-24.
12. Symonds J. Haemorrhagic colitis and *Escherichia coli* 0 157 — a pathogen unmasked. *Br Med J* 1988; **296**: 875-876.
13. Chapman PA, Wright JD, Norman P. Verotoxin producing *Escherichia coli* infection in Sheffield: cattle as a possible source. *Epidemiology Infection* 1989; **102**: 439-445.
14. Jephcott AE, Begg NT, Baker IA. Outbreak of giardiasis associated with mains water in the United Kingdom. *Lancet* 1986; **1**: 730-732.
15. Casemore DP. Epidemiological aspects of cryptosporidiosis. *Epidemiology Infection* 1990; **104**: 1-28.

Race, ethnicity and general practice

THE post-war industrial boom in the UK attracted systematic and large scale migration from the ex-colonies of the new commonwealth. Earlier migration had been largely from eastern Europe and Ireland. The context of black migration is important; the new immigrants were used to an inferior status under British rule and had a similar status when they arrived in the UK. Three decades later their relative status has changed little.[1-3]

The terms 'race' and 'ethnicity' require definition. 'Race' refers to the concept that physical, intellectual and behavioural characteristics are inherited and is based on interpretations which allow people of 'specific genetic stock' to be placed in positions of inferiority or superiority. Thus wrote the eighteenth century philosopher David Hume: 'I am apt to suspect the negroes ... to be naturally inferior to whites'.[4] Social Darwinism and the church gave these theories intellectual and moral respectability. However, sociologists have rejected the idea that human groups can be unambiguously defined in terms of their genetic make up. In sociological theory such groups are more commonly defined by reference to shared culture, such as language, customs and institutions,[5] and are referred to as 'ethnic' groups.

There is debate on the appropriate level for defining ethnicity. For example, the concept of a 'Pakistani' ethnicity[6] is apparently inconsistent with the multitude of linguistic, cultural and geographical differences between the various groups of Pakistani origin in the UK. Conversely, those originating from the West Indies and the Indian sub-continent may adopt a politically significant 'black' ethnicity, based on shared experience of racism and racial discrimination. In this context the idea of multi-level ethnic affiliation is useful, with affiliation changing according to circumstances.

In epidemiological studies 'ethnicity' has variously been based on country of birth,[7] interviewer observation,[8] name and religion,[9] or 'self-definition'.[10] Although there is no one appropriate definition of ethnic origin or a guaranteed method for gaining this information, the first two approaches are particularly fraught with problems. The history of official data on ethnic origin is stormy, with changes in philosophy and debate on the need for and use of such data.[1] One criticism is that these data have rarely been used to the benefit of ethnic minorities. The 1991 census proposes to ask an elaborate (but not uncontroversial) question on ethnic origin; significantly, it has the heading 'Racial discrimination and disadvantage'.

Race and ethnicity are important in the context of health and the use of health care. There are diseases (such as thalassaemia) which are more prevalent in some 'racial' groups than others. Concepts of health and illness, attitudes to medicine and health professionals, and the use of health services differ between cultures. In the British context, cultural differences have predominated in explanations of health inequalities between the white majority and ethnic minority groups.[11] The far greater similarities between cultures, and the importance of race and social deprivation in producing and perpetuating health inequalities have largely been ignored.[12,13]

Ethnicity and race are not simply indices of horizontal stratification but are related to socioeconomic status. There is considerable evidence of racism and, despite legislation to the contrary, racial discrimination in employment, housing, education, the judicial system and the workings of immigration policies.[1-3] Ethnic inequalities in health need to be considered against this background.

The relationship between social status and health, as well as the provision of health care, is well documented.[14] The traditional diseases of poverty such as vitamin D deficiency and tuberculosis now have a relatively high prevalence in the socially deprived groups of Asian origin.[12,13] There is a considerable difference between infant and child health in white and black populations in the UK. Differences in the prevalence of heart disease or mental health likewise cannot be accounted for by cultural or behavioural differences; for the latter, differential diagnosis along racial lines is also an important issue.

Primary care is usually the first line of contact with the health services, and most general practitioners in large industrial towns in the UK have some patients from ethnic minorities. Sensitive care by the general practitioner and the primary care team is of paramount importance and this is aided by knowledge of the culture, religion and socioeconomic status of ethnic minority patients. However, caution is required to avoid prejudgement, prejudice or stereotyping. 'All Englishmen wear bowler hats' is an absurd stereotype; yet similar stereotypes, of Asians having

a 'low threshold for pain' or of West Indians being 'feckless parents', abound in the health service. The general practitioner must consider the patient in his or her social, psychological and environmental context; the background information must inform and not determine this process.

There are other important issues for consideration. Although patients' knowledge, culture and class can affect their susceptibility to illness, illness behaviour and pattern of service use, general practitioners and their teams must also be aware of their own attitudes and biases. The social class variation in doctor–patient communication is well recognized;[15] doctors perceive poor patients to be 'bad' patients. Racial prejudice and discrimination in the health service, acknowledged in *Action not words,*[16] are also important considerations. Although there are no published studies of racism in primary care, general practitioners generally perceive ethnic minority patients to make excessive and inappropriate use of their services[17] and to increase their workload disproportionately.[18] However, these perceptions are not always supported by objective data.[19] Doctor–patient communication is generally poor;[15] cultural and, in some cases, linguistic differences between doctor and patient can exacerbate this problem (Ahmad WIU, doctoral thesis, University of Bradford, 1989).

General practitioners have a professional responsibility to provide high quality care that is sensitive to patients' needs. For the provision or quality of care to vary according to social class, ethnic origin or linguistic expertise of the patient is unjust and a firm commitment and determination from general practitioners is required to change this. Willingness to learn about and from their patients is a prerequisite for equity and fairness in primary care. However, we agree with Pendleton and Bochner[20] that, 'convincing a doctor to change his attitude may only make his job more difficult unless he is also helped to acquire the relevant skills'. Issues of ethnicity, race and racism, and their relationship to health and health care, need to be part of the undergraduate, vocational and post-qualifying training of general practitioners. The benefits in improved doctor–patient relationship and treatment will justify the investment of time and resources in such training.

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References

1. Bhat A, Carr-Hill R, Ohri S (eds). *Britain's black population.* Aldershot: Gower, 1988.
2. Brown C. *Black and white Britain.* Aldershot: Gower, 1985.
3. Taylor MJ, Hegarty S. *The best of both worlds? A review of research into education of pupils of south Asian origin.* London: NFER-Nelson, 1985.
4. Walvin J. Black caricature: the roots of racialism. In: Husband C (ed). *Race in Britain: continuity and change.* London: Hutchinson, 1982.
5. Abercrombie N, Hill S, Turner BS. *The Penguin dictionary of sociology.* 2nd edition. London: Penguin, 1984: 90.
6. Dahya B. The nature of Pakistani ethnicity in industrial cities in Britain. In: Cohen A (ed). *Urban ethnicity.* London: Tavistock, 1974.
7. Cochrane R. Mental illness in immigrants to England and Wales: an analysis of mental hospital admissions, 1971. *Soc Psychiatry* 1977; **12:** 25-35.
8. Cox BD, Blaxter M, Buckle ALJ, *et al. The health and lifestyle survey.* London: Health Promotion Trust, 1987.
9. Donaldson LJ, Taylor JB. Patterns of Asian and non-Asian morbidity in hospitals. *Br Med J* 1983; **286:** 949-951.
10. Booth H. Identifying ethnic origin: the past, present and future of official data production. In: Bhat A, Carr-Hill R, Ohri S (eds). *Britain's black population.* Aldershot: Gower, 1988.
11. Ahmad WIU. Policies, pills and political will: a critique of policies to improve the health status of ethnic minorities. *Lancet* 1989; **1:** 148-150.
12. Donovan JL. Ethnicity and health: a research review. *Soc Sci Med* 1984; **19:** 663-670.
13. Ahmad WIU, Kernohan EEM, Baker MR. Health of British Asians: a research review. *Community Med* 1989; **11:** 49-56.
14. Townsend P, Davidson N (eds). *Inequalities in health. The Black report.* Harmondsworth: Penguin, 1982.
15. Cartwright A, O'Brien M. Social class variation in health care and the nature of general practice consultations. In: Stacey M (ed). *Sociology of the NHS. Sociological review monograph 22.* Keele: Keele University, 1976.
16. National Association of Health Authorities. *Action not words: a strategy to improve health services for black and minority ethnic groups,* Birmingham: NAHA, 1988.
17. Wright C. Language and communication problems in an Asian community. *J R Coll Gen Pract* 1983; **33:** 101-104.
18. Jarman B. Identification of underprivileged areas. *Br Med J* 1983; **286:** 1705-1709.
19. Johnson MRD, Cross M, Cardew SA. Inner-city residents, ethnic minorities and primary health care. *Postgrad Med J* 1983; **59:** 664-667.
20. Pendleton DA, Bochner S. The communication of medical information in general practice consultations as a function of patients' social class. *Soc Sci Med* 1980; **14A:** 669-673.