

General practice screening clinic for Bangladeshi families

ELIZABETH C LEE

SUMMARY

Aim. A screening clinic for Bangladeshi families was established in order to improve the health care provided by one general practice to its Bangladeshi patients.

Method. The clinic was run by a general practitioner, a health visitor and a Bangladeshi health worker. Patients were invited to attend household by household. The composition of each household was recorded using a genogram. Details of family illness, housing and employment were noted. A medical history was taken from each individual. Every adult was screened for diabetes and risk factors for coronary heart disease; cervical cytology was offered to women. The immunization status of all patients was recorded and adults were immunized. Children were referred to the child health clinic for immunizations. The clinic concluded with a health education session focusing on smoking, exercise and diet.

Results. Over a two year period, 58% of the Bangladeshi families registered with the practice attended the clinic, a total of 207 people. Meeting Bangladeshi patients household by household was an effective and apparently efficient way of providing basic screening and health education. It allowed the practice to learn about the structure of its Bangladeshi families, the social problems faced by their community, and the areas in which their health care could be improved.

Conclusion. This clinic provides a model which could be adapted for use with other ethnic or 'hard-to-reach' groups. It may also prove an effective way of screening all families in general practice.

Keywords: screening; health status; family health; transcultural medicine; Asians.

Introduction

BANGLADESHI people are the United Kingdom's most recent group of immigrants from the Asian subcontinent. Between 1987 and 1989, the estimated size of the Bangladeshi population in the UK was 111 000 people, which constituted 4.3% of the ethnic minority population.¹ Over one third entered the UK in the 1980s, and these were predominantly relatives and dependants of men who had come to work in the 1960s and 1970s. Most Bangladeshi people in the UK live in east London, and they are predominantly Muslims.

Although many similarities exist between the health patterns of Bangladeshi people and the indigenous British population, several important differences have been identified. In common with all people from the Indian subcontinent settled in the UK, Bangladeshi people suffer higher mortality and morbidity from coronary heart disease than the general population of England and Wales.²⁻⁴ Non-insulin dependent diabetes is three times more

common⁵ and higher mortality rates from tuberculosis, parasitic infections and nutritional diseases have also been reported.²

General practitioners know surprisingly little about the families of their own patients.⁶ In the inner city this is compounded by a high population turnover. It is further complicated in the case of the Bangladeshi community by their tendency to live in extended families, and by movement of family members between the UK and Bangladesh.

In 1988 Barton House health centre, an inner city London practice with 10 000 patients, employed a Bangladeshi health worker (a Bengali woman), as the practice had a large but ill-defined population of Bangladeshi patients. As one of several initiatives to improve the health care provided for this group, a screening clinic was established with the following aims: to define the structure of the Bangladeshi families; to screen for diabetes and risk factors for coronary heart disease; to improve the immunization and cervical cytology rates of the practice; and to provide health education. Working with families rather than individuals allowed such broad aims to be encompassed in one clinic. The clinic was classified as a special health promotion clinic and attracted payment per clinic from the family health services authority rather than per 10 patients.

Method

The clinic was run by a general practitioner, a health visitor and the Bangladeshi health worker. It was held once a week, and ran for one and a half hours (14.00 to 15.30 hours). Families were invited household by household; one household was invited each week unless fewer than four members could attend when two families were invited and given 45 minutes each. The families were identified from the age-sex register by their Bangladeshi names, invited by letter one week in advance, and telephoned on the morning of the appointment to confirm that they were coming.

On arrival the group sat in a circle, and all conversation was translated by the Bangladeshi health worker. This structure allowed the health workers and the family to look together at particular patterns of ill health or good health within the family. Everyone was encouraged to join in the discussions.

A genogram was drawn up for the household. Details of illness in the family members attending and in the parents, siblings and children of anyone present (first degree relatives) and in the aunts, uncles and cousins of anyone present (second degree relatives) were recorded together with housing and employment details for the family.

Each individual was asked about his or her past and present medical history, smoking, alcohol consumption and immunizations. Patients were asked general questions about their personal medical history and thus could control what information was revealed to the group. In order to respect confidentiality and modesty women were taken aside to ask about cervical cytology.

All patients were weighed and their height measured. Measurements of blood pressure and random cholesterol level, and urinalysis were performed on adults. Where appropriate women were offered a cervical smear and tetanus, poliomyelitis and rubella immunizations were given to adults. Children's teeth were inspected for caries. Children needing immunizations were referred to the child health clinic held in the practice.

E C Lee, MRCP, general practitioner, London.
Submitted: 13 April 1993; accepted: 2 November 1993.

© *British Journal of General Practice*, 1994, 44, 268-270.

The clinic concluded with a health education session. Again this involved the whole group and focused on issues identified earlier; for example obesity was looked at as a problem for the family rather than for the individual. Smoking, exercise and diet were discussed. The results of the children's dental examinations were used to emphasize certain aspects of dietary advice.

After the clinic, details of the family structure, history and the results of investigations were entered into the patients' medical records. About a week later a summary letter, including the cholesterol results obtained from the laboratory, was sent to the family.

Patients were referred within the practice to ordinary surgeries or clinics if follow up was required, for example, to confirm hypertension. Specialist referrals were also made when indicated.

Results

Between November 1989 and November 1991, 59 households were identified of whom 34 (58%) attended the clinic including all four families who registered with the practice during this period.

The 34 families had a total of 226 members of whom 207 attended (92%) — 53 of the 59 men attended (90%), 50 of 53 women (94%) and 104 of 114 children aged 16 years or less (91%). Of the 207 family members who attended 104 (50%) were aged 16 years or less, 99 (48%) were aged 17–64 years and only four (2%) were aged 65 years or over.

The household size ranged from three to 16 members, the mean being six (mean size of an indigenous white family in the UK is 2.5 members¹). In many households married sons had brought their wives and children to live in the extended family unit.

The example of a genogram given in Figure 1 shows how the family structure was clearly defined in the clinic.

Socioeconomic status

Twenty one families were living in rented accommodation (62%) and 13 (38%) owned their own home. All but two of those living in rented accommodation were council tenants, and of the 21 families 71% complained of housing problems, primarily overcrowding and damp. Five families (15%) were currently suffering racial harassment at their home, including one owner occupier whose house had been burnt down in an arson attack.

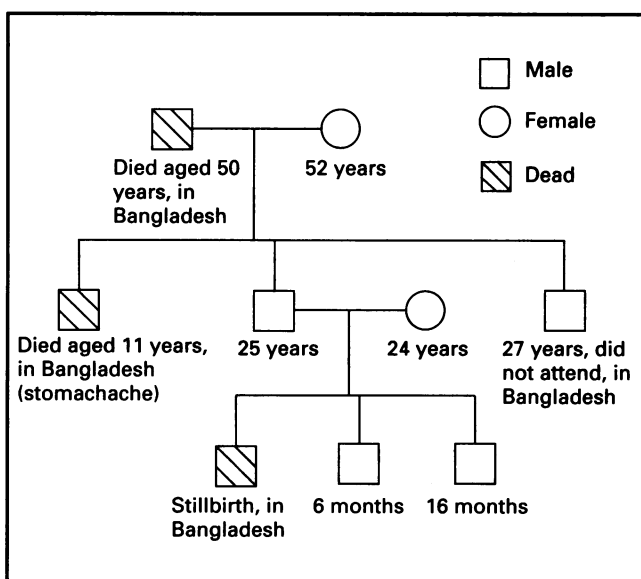


Figure 1. Example of a genogram for one household.

Of the 53 men, 27 (51%) were in employment, 21 of these working as machinists or in the restaurant trade. Younger men were less likely to be unemployed than older men. Of the 37 men under 45 years of age eight were students (school and college). Only four of the remaining 29 (14%) were not in employment compared with 11 of the 13 men aged 45–65 years (85%) — five of these 11 were on long-term sick leave or had been retired on health grounds. All three men over 65 years old were retired. Only two of the 50 women (4%) were in employment, the rest were housewives.

Coronary heart disease risk factors and diabetes

Of the 53 men, 20 smoked (38%) (all 20 smoked cigarettes but none more than 15 a day) and six were ex-smokers, four of whom had given up in the last two months. Only one of the 50 women smoked (a pipe during Ramadan).

Of the 103 adults, nine were found to be hypertensive (9%) (blood pressure greater than 160/95 mmHg on three consecutive occasions), and four of these were new diagnoses. Five adults had a random cholesterol level of greater than 6.5 mmol l⁻¹ (this was already known for three of these patients), and all five had other major risk factors for coronary heart disease.

Of 43 men over the age of 20 years, seven had non-insulin dependent diabetes (16%); one of these cases was diagnosed in the clinic. Of 41 women over the age of 20 years, only one had non-insulin dependent diabetes (2%) and this had been diagnosed previously. A further four people had glycosuria but went on to have normal glucose tolerance tests. Of the 34 families screened 13 had a positive family history of diabetes in first or second degree relatives (38%).

Cervical cytology and immunization

Prior to the clinics 19 of the 50 women had attended for a cervical smear. During the clinic, 14 smears were taken and 13 women were identified who did not need one (three had had hysterectomies and 10 were never sexually active). The uptake rate was thus improved from 38% (19/50) to 89% (33/37). Only one woman had ever had an abnormal smear. This was an inflammatory smear which returned to normal within six months.

Of the 104 children, 86 were fully immunized (83%), and 11 were partially immunized (11%). Seven children who had emigrated to the UK within the last two years needed to have all their immunizations. All 18 children needing further immunizations were referred to the child health clinic but only three attended.

Of the 103 adults 43 were up to date with their tetanus and poliomyelitis immunizations and 45 were immunized during the clinic (the remaining 15 declined immunization during the clinic). One adult was given a rubella immunization.

Other findings

Several patients who had been lost to follow up were identified at the clinics, for example a woman with severe learning difficulties and behavioural disturbance was being cared for by her family with no medical or social support. She now attends a day unit several days a week.

One family was referred for family therapy at the Queen Elizabeth Hospital for Children, London. The mother was known by the practice to be depressed, but when the whole family was seen together it was realized that two of her children were also depressed and suffering from peptic ulcer disease. The clinic thus produced a clearer picture of the family pathology.

It was found that three families had had children who had died and three had had stillbirths. All of these deaths, except one stillbirth, had occurred in Bangladesh and had not been known about by the practice. Many of those in the 30–59 years age group had suffered losses in their own childhood, for example mothers dying in childbirth or of infectious disease.

None of the families reported drinking alcohol and there was no evidence of any alcohol related morbidity.

Discussion

The Bangladeshi family screening clinic was innovative in screening families household by household. This allowed their health needs to be considered as individuals, as families and as an ethnic group. It also appeared to be an efficient use of time and resources.

Of the 59 households invited 58% attended the clinic. It is known that up to one third of non-respondents to questionnaires have moved from the address noted in their general practice records or the family health services authority register.^{5,7} Barton House health centre had a patient turnover of 40% in 1988 and it is presumed that the non-attenders had moved, although no attempt was made to verify this.

The structure of the community, as well as that of individual families was clarified for the practice. Half of the population who attended the clinics were aged 16 years or less and only 2% were aged 65 years or over. The practice can anticipate an increase in maternity, work and child health as these children reach adulthood. The working patterns of the community were similar to those reported for Bangladeshi communities in the labour force survey.¹ There are high rates of unemployment and long-term sickness, particularly in men aged 45–65 years. Most of the working men were machinists or in the restaurant trade—physically demanding and poorly paid work. Dissatisfaction with rented accommodation is prevalent among many council tenants in Hackney (personal observation) and the Bangladeshi people attending the clinic were no exception. Because of their large families, overcrowding is a particular problem. Five of the 34 families were suffering from racial harassment. This puts an immense strain on the community, and health professionals must know about it and offer any support they can.

The Bangladeshi families studied had high rates of childhood mortality and stillbirth. Once the practice knows about this, it is in a much better position to understand the community's anxiety about childhood fever, or to treat maternal depression.

Using genograms to record each family's composition allowed often large and complicated households to be quickly documented. As well as recording those present, the genogram drew attention to absent members. In a community that is divided between two continents, and which has high mortality rates,³ this is especially valuable. However, storing this information in an accessible form has proved difficult. As the practice uses neither family folders nor family records cards, relevant details from each genogram were summarized in each patient's medical notes.

Working with a whole family allowed particular disease patterns to be identified and risk factors to be highlighted. For example, in one family it was determined that the father and three brothers of the head of the household had died of heart attacks. The discussion with this family focused on the implications of smoking and obesity, and all adult family members were screened for hypertension, hyperlipidaemia and diabetes.

Being together as a family encouraged a relaxed atmosphere and lively discussions. Sharing information between family members as well as with health workers was an important aspect of the clinic. Younger adults and children were generally well informed about health issues, particularly the risks associated with smoking.

Hypertension and hyperlipidaemia are no commoner in Bangladeshi people than in the general population.⁵ In future, all adult clinic attenders will have their blood pressure recorded, but only patients with other major coronary heart disease risk factors will have their cholesterol level measured.

Only 38% of the men smoked, none more than 15 cigarettes a day. Eight per cent of the men had given up smoking in the last two months. In their study of Bangladeshi people in the east end of London, McKeigue and colleagues found that nearly all Bangladeshi men smoked.⁵ Patients attending the screening clinic may have underestimated their smoking because they were talking to their own general practitioner whom they knew disapproved. However, the families present did not dissent and so this may be a real lower rate of smoking. None of the Bangladeshi women smoked cigarettes.

One new case of diabetes was diagnosed. The overall rate of diabetes among adults over 20 years of age was 10%. It was interesting to note how familiar the families were with diabetes, as 38% had a positive family history in first or second degree relatives.

Cervical cytology rates were markedly improved, partly by performing smears in the clinic, but also by identifying women who did not need one. It is culturally unacceptable for unmarried Bangladeshi women to be sexually active, and so, with only occasional exceptions, it is unnecessary to screen single women.

The clinic failed to improve the childhood immunization rates appreciably. The discussions revealed how confused families were about what immunizations their children had had in Bangladesh. It is clear that children who are over the age of five years when emigrating are at risk of remaining unimmunized. Few children in need of immunization returned to the child health clinic, possibly because parents felt that immunizations would have been given in the family screening clinic if they were important. It is now planned to immunize children in the screening clinic.

All the staff involved enjoyed running the clinic and it was clearly appreciated by the Bangladeshi community — some families contacted the practice to make an appointment having heard about the clinic from other families. This innovative approach to addressing the health care of Bangladeshi patients is a model that could be adapted for other ethnic or 'hard-to-reach' groups. It may also be a useful way of gathering information and making a basic assessment of any family in general practice.

References

- Office of Population Censuses and Surveys, General Register Office for Scotland and Department of Economic Development in Northern Ireland on behalf of Department of Employment and European Community. *Labour force survey*. London: HMSO, 1989.
- Pedoe HT, Clayton D, Morris JN, *et al*. Coronary heart disease in east London. *Lancet* 1975; **2**: 757-761.
- Balerjan R, Bulusu L, Adelstein AM, Shukla V. Patterns of mortality among migrants to England and Wales from the Indian subcontinent. *BMJ* 1984; **289**: 1185-1187.
- Marmot MG, Adelstein AM, Bulusu L. Lessons from the study of immigrant mortality. *Lancet* 1984; **1**: 1455-1457.
- McKeigue PM, Marmot MG, Court YDS, *et al*. Diabetes, hyperinsulinaemia, and coronary risk factors in Bangladeshis in east London. *Br Heart J* 1988; **60**: 390-396.
- Tomson P. The family history and the family doctor [editorial]. *Br J Gen Pract* 1991; **41**: 45-47.
- Bowling A, Jacobson B. Screening, the inadequacy of population registers [editorial]. *BMJ* 1989; **298**: 545-546.

Acknowledgements

Thanks to Ms Liz Weber and Ms Shalina Choudhury who ran the clinic with me, and to Dr J Fuller and Dr M Whitfield for their comments on the text.

Address for correspondence

Dr E C Lee, Gaywood House Surgery, North Street, Bedminster, Bristol BS3 3AZ.