ESRC

ECONOMIC & SOCIAL RESEARCH COUNCIL
1 TEMPLE AVENUE LONDON EC4Y 0BD
TELEPHONE 01-353 5252

RESEARCH PROPOSAL FORM

ESRC Ref. No.

APPLICANT(S) in alphabetical order

TITLE	INITIALS	SURNAME	DATE OF BIRTH*
DR	C. S.	FENTON	
POST			
POST			
POST			

INSTITUTION AND DEPARTMENT ADDRESS

Department of Sociology
University of Bristol

Official Telephone Number
(including STD code)

TITLE OF RESEARCH (Not more than 80 characters or spaces)

GP CONSULTATIONS, CONCEPTS OF ILLNESS:
ASIANS IN BRISTOL

AMOUNT REQUESTED

£

5. **PROPOSED START DATE***

01 04 86

6. **PROPOSED TERMINATION DATE***

31 03 87

ESTIMATED INCIDENCE OF EXPENDITURE

Indicate the total annual estimated incidence of expenditure of staff and non staff costs on pages 7 and 8. (Year 1 should be for the total cost for April-March)

Year 1	Year 2	Year 3	Year 4	Year 5	Year 6

*Please express dates numerically giving day month and year as DDMMYY

Please provide a self-contained 1000 word summary covering the principal features of the proposed research. The summary must not exceed the space allowed for on this page and page 5.

My recent two-year research (funded by the Commission for Racial Equality) on access to health services among ethnic minorities has produced clear evidence about use of services, incidence of GP visits, and the extent to which language is an obstacle in medical consultations. Over 50% of South Asian women interviewed said that language constituted a serious difficulty on their visit to the doctor and this was almost as evident among the younger as among older South Asian women. During the research I also interviewed 8 locally based GPs: it is clear that some doctors have a view of (some) South Asian patients as making inappropriate visits to their doctor and as misunderstanding the purpose of the consultation, and the nature of illness and cures. In particular two doctors spoke of ethnic minority patients as "having no concept of psychosomatic medicine" and as "expecting a pill for a pain". They recognised that non-English speaking was an obstacle but did not view this as primary i.e. they argued that even with interpreters (often family members) the cultural "gap" was not closed, the main difficulty being the differences in understandings of "psyche and soma", health and illness.

Just over 40% of South Asian patients in the study area (inner city Bristol) were registered at Health Centres (2 principal centres) at which there were no Asian language speaking practitioners and no female doctors. The rest were scattered among a dozen or so small surgery GPs, two of whom were Indian. (males). Most patients expressed a preference for a 'same language' GP and almost all women expressed a strong wish for a female doctor. The implications of this research (now drafted into a full and a summary report) will be taken up with the Regional Health Authority.

My conclusion is that these problems of health care delivery will persist for at least the next 15 to 20 years, will become more serious with the aging of the South Asian population (the number of ethnic minority elderly will double or triple by 1991 from a 1981 Census base), and that plans for interpreter services (and related schemes) will be successful only if they incorporate training for practitioners (and interpreters) and advice for patients based on highly detailed and sensitive of conceptions of health and illness among (in Bristol - and elsewhere) Urdu and Punjabi speakers.

The present research will therefore concentrate exclusively on understandings of (a) health and illness; (b) the purpose of the consultation among both patients and GPs. We will plan for the interviewing of 100 Urdu and Punjabi speaking patients at the Health Centre after a consultation with a GP. Each interview would be as long as necessary (and tolerable) - 30 to 60 minutes - to establish the primary anxieties of the patient, the language used to describe symptoms, the sense of having communicated these to the GP and achieved understanding, and the patients conception of the relationship between distress, depression, anxiety and physical illness symptoms. GPs will also be interviewed (by the Principal Investigator) to explore further the lines of questioning described above* (* their view of Asian patients).

The overriding aim of this research will be to put rigorous social science methods of inquiry and interpretation to the service of medical practice and the removal of serious obstacles to the proper access to medical care among South Asian patients, particularly women of all ages. No striking innovations in sociological theory or method are envisaged - rather the sound and professional application of established methods of interpreting "understandings" especially where these do not match as between patient and doctor. But I would certainly expect to draw important theoretical and methodological lessons. I am quite convinced that, in this little developed field (health and 'race') insufficient attention has been paid to the subjectively held cultural meanings attaching to health and illness among South Asians. Exploring these is likely to have lessons for the whole field of minority studies.

Continued.....

In the process of pursuing the research mentioned above I have established a series of vital links and 'good relations' with doctors, health authorities, community groups and others. To my knowledge there are few places in the country where this kind of opportunity exists; but the benefits of the research will be nationwide. If the committee reviewing this application would like any more attestation of willingness to cooperate etc., I will be more than ready to provide it. But, to date I can confirm that two of the GPs whom I interviewed have expressed a strong interest in this type of project; and the Regional Health Authority has continually asked to be kept abreast of my research for its forward planning purposes.

Keyword Subject Classification
for completion please refer to the Guidelines on page 2.

Insert (.) or (/)	
	H E A L T H
	C O N S U L T A T I O N
	A S I A N S

Institution Support

Indicate the direct or indirect financial support to be provided by the applicant(s) institution.

Value £

Description 40% of total cost. Rooms for research assistant, computer advice and facilities, Principal Investigator, consulting academic staff (chiefly Dr. Rohit Barot on Asian language and cultur~~who is doing related research in Bristol), University administration~~ telephones, materials.

18 Breakdown of Sections 14 – 16

Provide a breakdown and details of amount(s) requested for equipment, travel and subsistence and other costs. Justification for the request(s) must be included below or in the full research proposal if the space is insufficient.

About three quarters of non-English speakers at Charlotte Keel and Montpelier Health Centres are likely to be Punjabi speakers, many speak Punjabi and Urdu, a minority Urdu only. If a research assistant could speak Punjabi and Urdu only one Research Assistant would be necessary; otherwise two sharing the post. (I have contacted people who would be very suitable for this work). If one full-time Research Assistant, then one tape recorder and tapes would be used in the "interviewing room" at the Health Centre. If two, then two would sometimes work simultaneously. Two tape recorders and tapes capable of recording a two person conversation in a small room.

Research Assistants travel: For the first four months the Research Assistant(s) would be based at the Sociology department, and for the last four months (transcribing). Therefore the Research Assistant would have to travel daily to the Health Centre(s) for approximately four months on consulting days (6 days a week). Assuming a four mile round trip on this basis at approximately 12.50 per mile we would need approximately £150 - £200 to be sure of covering these costs.

Principal Investigator's travel would be to Health Care centres (chiefly in London) where a variety of interpreter and health advocate schemes are in operation. The P.I. would also have to consult with the Training in Health and Race Project, The Health Education Council and the CRE in London. £600 for travel Bristol - London, Leeds, Edinburgh, (related research); second class rail.

Previous applications: provide details for:–

(a) all ESRC (SSRC) awards which have terminated within the past five years.
(b) all unsuccessful applications to ESRC (SSRC) within the past five years.
(c) all ESRC (SSRC) applications/awards with which you have been associated in any way (please specify)

Reference No.	Title of Research	Other Applicants	Indicate (a) (b) (c)
	Linked student awards (1) Collaborative award scheme with M.Banton		

Commitment to Research
Each applicant should indicate below the number of hours it is proposed to devote to research if no salary is requested.

In 1985-86 the P.I. would expect to devote an average of 10-15 hours per week on this project.

Other Commitments
Each applicant should provide details of any other known or possible research commitments during the proposed period of award.

None other than normal teaching related research and writing on continuation of related CRE project.

Other organisations:

(a) Is this application currently being considered elsewhere XXXNo see below *
(b) Is this application likely to be considered elsewhere in the next six months: XXXNo see below *
(c) Has this or a similar or related application been submitted to another Research Council at any time: XXXNo

If the answer to any of the above questions is yes provide details (including the anticipated date of decision) below:–

* But I would consider sending it to the CRE

If the answer to (a) or (b) is yes the decision must be notified to ESRC as soon as available. This must be done even if ESRC makes an award.

Referees (For Personal Research Grant Scheme Only)
(Give the names of two academic referees who should be established authorities in your field of interest and who could comment upon your previous research work)

Professor Murray Stewart (SAUS) who knows of my work on Ethnic minorities and the YTS and has himself written on ethnic minorities and local authorities.

Professor M. Banton (Race Relations)

Mr. David Johnson (CRE), specialist in health and social services for the Commission having read my draft research report for the CRE.

PROPOSED RESEARCH

(a) Before completing this section, please consider carefully the guidelines to applicants on page 2. You do not have to confine yourself to the space provided here. If you do want to write more, please do so on paper the same size as this keeping within margins the same size as those on this sheet, heading each page Proposed Research (continue numbering the pages in sequence and stapling them to the back of this form).

(b) If you want the Council to consider other materials (such as working papers, off-prints, etc) you should send two copies with the research proposal form.

(c) Applicants for the Personal Research Grant Scheme and those established members of institutions who are applying for their own salary under the Research Grant Scheme are reminded of the requirement to provide an additional statement from the institution's Administrative Authorities concerning replacement arrangements and this should be appended to the research proposal.

Objectives: to discover the principal modes in which Punjabi and Urdu speakers as patients perceive illness and health and the function of the GP consultation; to relate these more broadly to general 'Asian' cultural understandings of body and soul; to reveal the degree of 'match' between these perceptions and the perceptions of General Practitioners working in Health Centres where there are substantial numbers of South Asian patients.

The field that might be described as "race and health" covers many topics including inequalities in health, in health care access, in employment in health occupations, definitions of mental illness and a small literature (in Britain) on intercultural understandings. Particularly in the BMJ articles have addressed 'race-specific' conditions such as sickle cell anaemia and thalassaemia; locally produced documents discuss obstacles to health care services among black people; and the CRE has produced a document on equal opportunity and employment in the NHS.

Few articles discuss in any depth the kind of "inter-cultural" understandings which I aim to focus on in this study. The Health Education Council pamphlet "Providing effective health care in a multiracial society" addressed the issues mainly by providing a checklist of areas of sensitivity (diets, examinations, maternity provision etc.). The literature it cites on "transcultural health care" is chiefly American. However Roger Ballard has discussed these issues in greater detail by focussing on concepts of purity and hygiene among South Asians in his "The implications of cultural diversity for medical practice: an anthropological perspective" (unpublished monograph 1983). For many Hindus and Sikhs living in Britain "the crucial organizing concept is achhut, impurity . . . not only are all dead things impure, but so too are all the waste products of natural processes". He proceeds to show how Asian concepts of purity will lead to preferences (in a medical context) which will often be misunderstood by native English nurses and doctors.

Some References

P. Townsend and N. Davidson, eds. Inequalities in Health: the Black report, 1982.

J. Mitchell and A. Wilson, Black People and the Health Service, Brent CHC, 1981.

J. Clarke, Ethnic Minority Health Staff, CRE, 1983.

J. L. Watson, ed. Between two cultures, 1977.

G. Henderson and M Primeaux, Transcultural Health Care, California, 1983.

Kings Fund Centre, Ethnic Minorities and Health Care in London, 1982.

McFayden and McVicar, eds. Obstetric problems of the Asian Community in Britain, 1981.

J. Black, Child Health in ethnic minorities, British Medical Journal, 23 Feb, 1985.

Useful journals

British Medical Journal, Lancet, Maternal and Child Health, Journal of Community Medicine, Radical Community Medicine, Journal of Epidemiology and Community Health.

...PTO

continued.....

See also,

Elders of the Ethnic Minorities Affor, Birmingham with Anil Bhalla and Ken Blakemore, Coventry Polytechnic, 1981; Malcolm Cross, Radical Community Medicine, winter 1983; Research Perspectives on Ageing; Black and Asian Old people in Britain, Jonathan Barker;Age Concern Research Unit, 1984; Mental Health among ethnic minority groups CRE bibliography 1976 and 1978; Race and Health Care in the UK, A McNaught, Polytechnic of the South Bank, 1984, Occasional Paper; Providing effective Health care in a multiracial society, Health Ed. Council 1984.

Practical applications: these are, perhaps the major rationale of the research; of paramount importance in the design of services (e.g. interpreter services, medical advice schemes) for improving delivery of health care to non-English speakers; in-service training for GPs, midwives and Health Visitors.

Permissions: Informal support is guaranteed from some of the doctors in the two main health centres (Charlotte Keel and Montpelier). I have hesitated to press this, given the uncertainty of grant award. But if ESRC must have full initial confirmation of permissions this can be provided. The Regional Health Authority knows of my work and are interested in results.

Permission of GPs will be necessary to provide a room at the Health Centre where an "interviewer" will be in attendance during consulting hours. All Punjabi/Urdu speakers will be advised (by the GP) that, if they wish/agree they may discuss their medical consultation/health anxieties/understanding with someone who shares their language, in confidence. An explanatory leaflet (in Punjabi/Urdu) will be available in the Health Centre). The system will persist until 100 interviews have been recorded (5 to 10 per week over 4 months).

Interviewer(s) will then work on transcribing and interpreting the materials; the P.I. will subsequently interview GPs to discuss their understandings of consultations with Punjabi speakers.

1st Four Months

The planning of the interview phase will take four months with the RA and PI reviewing existing materials, designing the management of the recorded interview, and conducting trial interviews; and smoothing out arrangements at Charlotte Keel and Montpelier in preparation for the interview phase.

2nd Four Months

Conducting interviews with patients. Between 5 and 10 interviews per week - for example two completed interviews in a morning consultation - would yield about 25 recorded interviews per month with a target of 100 in four months. The scheme would work in a modified way with two part-time interviewers/R.A.(s).

Final Four Months

R.A. and P.I. transcribing interviews and interpreting them. P.I. visiting GPs. Write-up of the research project would continue for at least six months after the period of grant (i.e. the period in which an RA would be employed).

Dissemination: by one day conferences organised with the Health Authorities, HEalth Education Council, GP conferences, BSA sociology of Med.; by advisory booklets for medical professionals; by articles in HMJ.

24. continued.....

Final Note:

As explained, language might require splitting the RA post. But the person engaged would have to have the following:

> Good social science training (e.g. Sociology Degree), ability to speak Punjabi/Urdu, knowledge of Sikh and Moslem cultures, and preferably, some knowledge/experience of health and social services.

Postscript

Received (March 6th, 1985) a letter from local GP - further confirming liklihood of co-operation of Health Centre GP's.

Concepts of health and illness amongst Asian women.

① Who would we talk to?
(limitation of one year.)

What age group; - decided when deciding upon this we discussed what type of data we wanted to collect. It was realised that although some work had been carried out on Asian women and the use of the Medical facilities only Caroline Currers work concentrated in detail about the women own attitudes, values and perceptions. Thus there is a lack of such data.

So we felt that it was important for this project to concentrate on a 'small' nos of women so that we could get more detailed and qualitative data.

This 'small' nos would be approx 20. women.

Then we were faced with the problem that because the numbers involved would be relatively small which women were we going to talk to?

It was suggested that it might be interesting to concentrate on middle-aged Asian women who had been in this country for a nos of years and would have been used their G.P. and had experience of visiting the hospital - especially during pregnancy + birth.

They would have a lot of 'knowledge' that they had not talked about.

This age group

a) who is available. (non-probability methods of sampling) + who introduced to.

Using 'key informants' who are interviewed intensively over an extensive period + who may supply other informants is also a well-used sampling method in Anthropological work (Tremblay, 1982 - Donovan).

Ethnographer:

Interviewer becomes an 'active listener' — building up rapport with informant.

* Must be aware at all times of the influence she is having on informant, but the method allows the validation of some stories by comparisons with others.

* Be aware of the effects of taking notes + using a recording machine in front of informants.

data then has to be organised

It is considered to essential to transcribe tapes fully - because aim of ethnography is to examine everything concerning the topic under consideration.

Data can then be organised according to the researcher's interpretation of where there are 'natural breaks', allowing the allocation of data to partic. categories (Hammersley + Atkinson 1983)

Ethnographic research is a process which does not occur, like positivistic research, in linear stages, but is shaped by the data + their setting.

The collection of data is not a distinct stage, but occurs throughout the development of theory, and is essential for the checking + validation of the theory.

Typically, the research begins with a fairly wide view of the gp or topic + then the focus is progressively narrowed as the theory develops. (Jor 1950) →

Theory + method are, ∴ integrated + a fetishism with method is avoided. (Burgess 1982)

Major criticism of ethno. concerns question of the representativeness of a small no of case studies in detail

(1 thing).

It was decicded early on that the focus of interest would be on concepts - perceptions and experiences of health.

Ethnographic and interpretive sociological work take the role of researcher as crucial.
Researcher will have prejudices + preconceptions - it is impt for these to be known to the reader thus she offers a short autobiography.

Participant observation demands (if done well) that the researcher should live with the subjects + learn as much as poss. about their live.
- In Donovans project the aim was to focus upon health + illness, and so such detail was not considered necessary. ??
— ?? - ~~settin~~ position of wo. within family, their rel'ships will all members + perceptions of role of women will influence perceptions of health + illness

① Used Semi-Structured discussion.
First meeting was aimed at allowing the informants to talk about their perception + experience of health, illness + the health services throughout their lives, beginning with their childhood + ending with the present.
The order of ques. was determined by the responses of Informants + the degree of rapport btw. the interviewer + interviewee.

② After above took place with several informants a list of points to be covered was drawn up.
These ques. were normally, but not always asked of each informant.

(B)

- Sister at C/K 13-8-87.

① She has been wking at C/K for 9yrs. Started wk as a part timer but has been wking full-time for the last 3 yrs.

② This has been since the New Scheme - with the Scanner started. Before this there had been hi % of non-attendance at BMH by ~~Bs~~ ? - as they were often frightened.

③ Now policy is to bring hospital out to the patient.

④ She took a course on how to wk the scanner.

⑤ Funding raised by various fund-raising schemes. They raised £5000 John James doubled this amount in order to buy scanner, trace machine etc. No money given from B+W.

⑥ Dr. B[redacted] started wking at C/K at this time.

⑦ She was first midwife in Bristol to do this course.
- She went on day release course for 6 weeks.
- There was particular emphasis on looking out for small babies. She feels that the system has worked well. Patients can come at any time. Says that there should be someone here at all times but there is not as they are short-staffed

⑧ She has found the link Wkers v. useful as now abt more info can be put across and also the ? can get to know the midwives better.

⑨ She feels that main problem had been of language. They had difficulty with practical things eg. how to make up bottles, or people being able to explain their pain - in many cases people

ended up not speaking although husbands did help out. There was even greater difficulty when children were used as interpreters.

Also difficulty in speaking about diet. She feels that many ♀ did not understand why putting on weight could cause problems.

Also problems when trying to explain why breast milk is best.

There were/are also cultural difficulties - with m.i.l.s saying that they never attended anti-natal clinics so why should d.i.l.s. Even with NSHs + Nurses help the. is still causing difficulties.

⑩ There has been ~~a~~ pressure to get people out into the community - as pregnancy is not an illness, but normal. - feels that midwives are caught in-between.

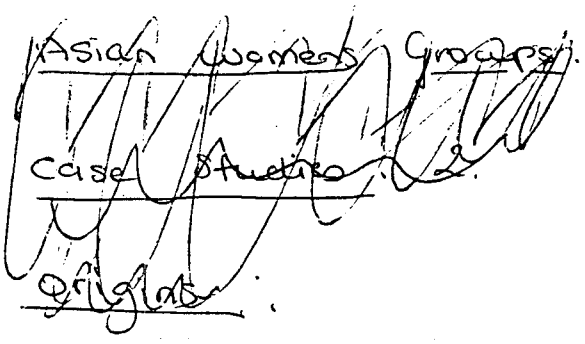
Points she would want to put over:-

① ♀ should understand the importance of coming to anti-natal clinic. There has been an improvement in this area. Keeping appointments ~~is~~ difficulty - but there has been an improvement. esp with NSHAs help.

② However timing problems as many arrive v. late. - she feels that appt. system is not wking.

③ Confidentiality much better. Many ♀ talk v. little eg if they have a blk eye they do not usually talk about what has happened.

④ She often feels that m.i.l.s think that midwives are interfering.



(5). Parent craft: As. husbands never come to classes. Husbands sometimes do not cooperate and even some of the younger ones take side with their mother.

(6) Still many cultural misunderstandings. often ♀ will not want to breast feed child for first 3 days whilst waiting for milk to clear. This is misunderstood by some to mean that they do not want to breast-feed.

(7) She feels that it is v. important to keep cultural identity - as she can see the problems this loss has caused for her people.

(8) Many people go to Dr for minor Complaints + some Drs. dish out anti-biotics too frequently.

Many Asians do not understand why they may not be paid for you.

Some think that they will solve all their problems.

Drs perpetuate this difficulty by giveing out prescriptions too easily - not all but quite a few.

Many people need to have explained to them what prescriptions are for and why etc. but most Drs. find it easier just to give them out.

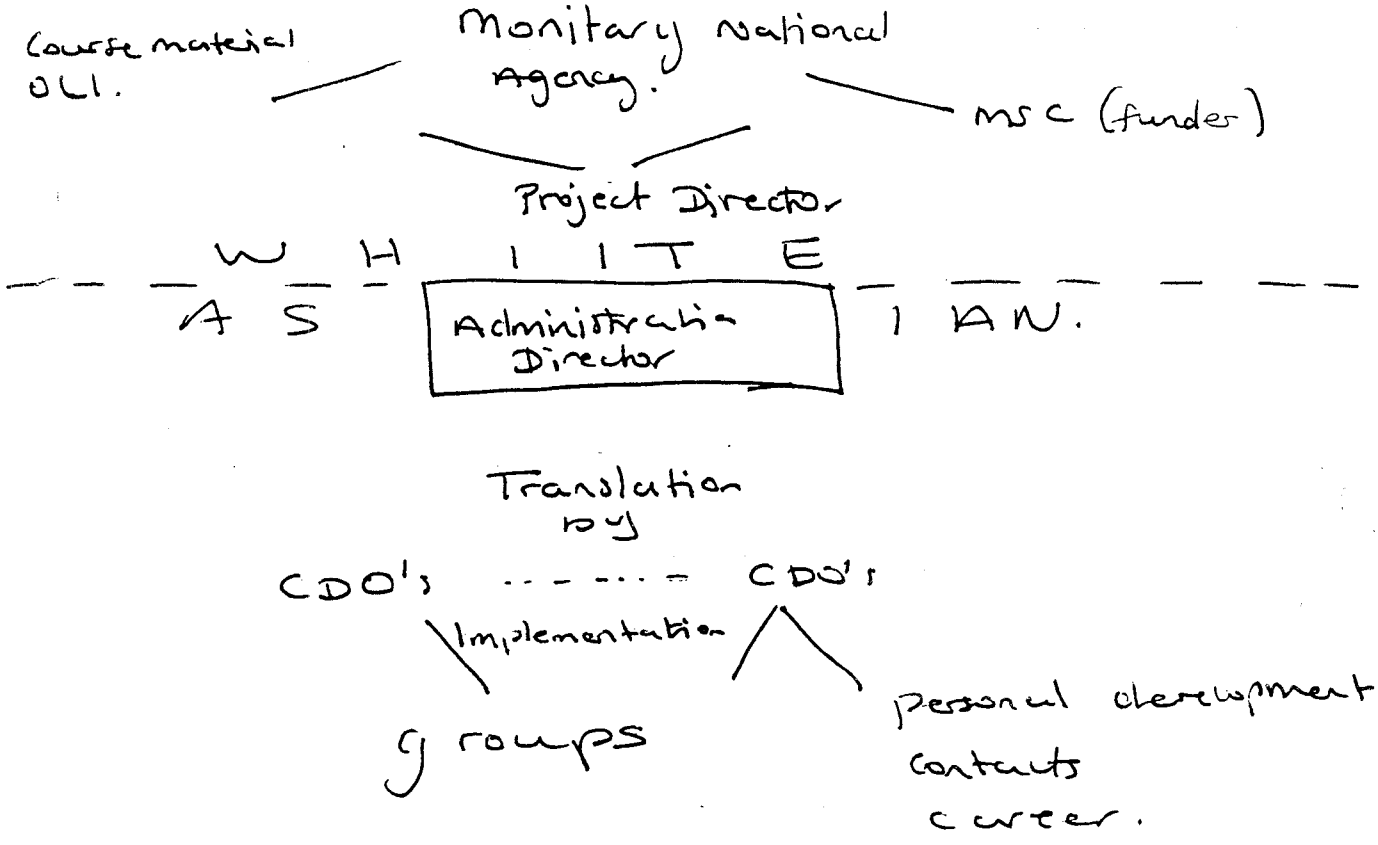
(9) I asked her why she had chosen nursing as a career. She said at the time she came there were only 3 choices - Transport, Nursing + factory ∴ this best choice of three.

(C)

Female Asian Health Centre Worker

13-8-87.

1. Difficulty of getting acceptance by other Asian wks.
   more easily accept wt person in authority. ie the white female Director.



Aim to allow Aswa to come out of the house - learn - get knowledge from CDO - Their rights - needs - requirements.

\/

context of Culture, Tradition. Religion - country - Families.

- disputes amongst women themselves - based on religious + cultural differences.

- She not sure of her role + function in the system.

- had v. little power. All decisions made from above. white - not understand the uniqueness of this situation.

- found out that training given to her is not adequate. Gets put in class with other staff who do not have to face the difficulties that she does.

- knew v. little about birth etc. when her children born. Did not talk to anyone about it. others also did not approach her had older sisters who had children but did not talk about these things with them.

- was not able to breast feed - no milk - midwife said it was because she was too intelligent - did not understand what she meant by this -

- Status - thinking of oneself as being above other - coming to terms with this - having to deal with this amongst workers.

(D)

Talk with Jenny

① She suggested that we talk to Asian women in gps and from that may be get to know the individual.
She suggested Sewing classes at Ch. H.

② She was particularly interested about issues concerning
a) Folk Medicines,
b) Racism - how these women perceived it and in what circumstances, Indeed if at all.
c) What do women want from Health Visitors etc.

③ She suggested getting in touch with OU/MSc project, Womankind and Linkworker A % Trinity Road Library, Gateen. Tel. 556202.

Meeting with Mavis and Shaheen.

① Suggested that I visited and accompanied women with the Link workers during surgery hours.

Tuesday - 1·30 to 2·30 with N.

Wednesday - 1·30 to 3·30 with Linkworker A, Baby Clinic.

Thursday - 1·30 to 3·30, N. with Anti-Natal Clinic.

Friday - 9 - 12, with N. and Anti-Natal clinic.

② S. suggested I firstly attend Link workers meeting inorder to get to know them: This is held on 26th Jan 10·00 at the Coop. Thought best if I arrive at 10·45.

③ Linkworker A is also closely involved with the Sikh Centre.

④ English classes and social Meetings are held at the Den, Halston Drive, St Pauls. — Key person here is Jamila Aftab.

⑤ Urdu Classes at taken at C.C. by a Mrs. Khan.

⑥ Sewing classes at C.C. by N. + Linkworker F

Discussion:

① Sh. emphasised that Asians feel mental symptoms physically and will thus describe them physically.

② She believed that Patients would not conceptualise what caused their health problems (phisical) and have high expectations of Doctors whom they expect to diagnose an illness and

give them something (pills, medicine, injections) to make them better.

(3) Injections in fact are highly regarded. Back home most Drs visited would give the patient an injection. This is highly regarded as doing something positive.

(4) Women rarely make a link between a stressful situation and physical pain. Or if they do they v. rarely express it as such.

The main emphasis is on keeping going, and women often say that they have little time to be ill.

(5) There is also the price involved in keeping up appearances. The concept of "kismeth" is v. strong and results in one accepting each situation as ones fate and all that can be done is to keep going + make the best of it.

Overall there is a great reluctance to talk about situations in the family as great stress is placed on not bringing shame upon them.

---

(6) Dress - perhaps more appropriate to dress in traditional style.

(7) Sh. pointed out that it would take a long time for me to get to know the women and that initially I would only get mono-syllabic answers. They would be suspicious about my motives and would want to know alot about me.

(E)

14th Jan

04 Project - coordinator. She seemed flustered and odd.

(1) She was dissatisfied with the scheme. a) because its aims had not been clarified and had been changed over the last six months. She herself had little control the overall objectives.

In fact she seemed unsure about what direction the project was heading.

(2) She asked if we had any comments, opinions or pt.s of v. about the project. She said he would look at the leaflets (booklets) they were transcribing and make comments. He felt that they had not looked deeply enough at the cultural differences in concepts about health.

Yasha mentioned that they were going to put in pictures which depicted Asian women, but seemed unsure about what changes in the script had been made by the transcribers in order to put the message across.

The main thrust of this project seems to be to educate Asian women about aspects concerning their families + their own health.

(3) She was worried that only six months remained of the allotted time, before the 04/MSc would review their work and decide if it was worth carrying on or expanding.

She wanted to make a success of it, especially since MR. Bower had fought so hard to make it an 'Asian' only project. Yet she felt that with only six months left this might not be possible.

(4) Working in the community had led her to change in many ways. When she first came to Britain she was very shy and meek especially in relation to men. However here she was introduced to a world where social contact between men and women was more acceptable.

On one occasion she and her husband went to dinner at their white neighbours. They were made to feel welcome, however the man gave Yasha a kiss on the cheek. She was devastated, and eventually had to leave, excusing herself by saying

she did not feel well.

Even shaking hands with people especially men was something that took here a long time to get used to. However she has overcome most of her initial repugnance and has learnt to behave in a 'social' way. This means that she is capable of functioning in white society and that her inner ways are constantly changing according to need.

(5) Yet she was adamant that she did not reject her ~~asian~~ cultural backgd, infact believed that there were many important things ~~that~~ which needed to be preserved. She acknowledged ~~that~~, she believed that the self-sacrificing attitude of Asians ~~was a good thing~~. However she qualified this by saying that she would not neglect her health, as this would prevent her from carrying out the most important function in her life i.e. looking after + caring for her children.

(6) I felt that she needed to talk about her experiences, and felt able to do so with me. Perhaps I could get in touch + meet her again.

---

a) Talk to individual transcribers + find out how they go about rewriting. What changes they have had to make? What further changes they would like to make? How influenced are they by the opinions of the As. wo. they come into contact with?

b) May be able to make contacts with incl. wo. through them.

c) Impt to get to know them before I approach Gurdwaras' etc.

(F)

23rd. Jan 1987

Talk with Researcher

Getting to know the community, build up contacts in many ways. He has built up his contacts over a a number of years, usually on a one to one basis. Once people have gained confidence in him they are willing to talk to great detail about their lives.

He does not use a tape recorder, people may feel that they are giveing alot to him ie their voice. He writes notes as people are talking, usually in much detail. People sometimes will tell him to ~~wait~~ write about such + such. Really to play it by ear, as indiviuals will vary, and so your approach to them will have to change accordingly.

My experiences will be different from his because I am young and female. This is something that they will have to get used to especially since they will be interested in me + my way of life.

Main thing is to approach the situation with an open mind and take it from there. Specific problems will arise then. To be aware that there will be ups + downs during the research period - especially in situations where people are not in when they say they will be etc.

Also to keep a diary with as much detail as poss. This will be important later, ~~and~~ as it is and/in how much we tend to forget.

- write about how I overcame the peoples attitudes towards me - Indeed what they were, and if they vary.

1. Using sign lang. with Dr. C

2. How explain to wo. —
   using basic interviews — why
   — what we.

The first day that I approached the womens English Group I explained to the whole group briefly - that I was involved in a project based at the university at Thab I was interested at looking at health problems of Asian people. ~~and~~ This I told them I aimed to do by talking to women like themselves. (Prior to this I had approached Zeba who seemed to be incharge - She put the onus on me to tell the women what I was doing.).

Since this initial contact I have become more known to the group and have been to three of the womens homes inorder to have longer conversations. Thus I have become 1. well known since I have also taken on the role of a voluntary tutor as well.

I have found that the women on the whole have little understanding of what 'research' means. Each time I sit next to a woman I have to explain to her again what it is that I am doing. I try to explain it as simply as possible ie looking at Asian peoples lives mainly through talking to women. Some of them nod and smile others seem more perplexed. Usually if I try to explain things in greater detail it

about the different 'concepts' Asian people have — that is different ways of thinking about things. — I find that most women tend to shut-off + not really listen. So I try not take the cue from them if they want to listen or appear to be interested then I will talk at length otherwise I tend to let that drop and concentrate on making friends, or helping them with their work.

I have found that even in cases where I have explained adequately about my job women still do not understand it fully. The women I go

ESRC

ECONOMIC AND SOCIAL RESEARCH COUNCIL

END OF AWARD REPORT
(Edition 1 : March 1985)

Award Reference Number								
G	0	0	2	3	2	2	8	0

Award Holder(s)

Title	Initials	Surname	Date of Birth
Dr.	C.S.	FENTON	

Full Official Address and Telephone Number

University of Bristol
Department of Sociology,

Tel:

Title of Research

GP Consultations, Concepts of Illness: South Asians in Bristol

Aims and Methods of Research (restrict to this space only)

The aim was to explore subjectively held ideas and 'concepts' of health, illness, medicine and the consultation, among South Asian women in Bristol, principally Punjabi speakers with varying though often slight knowledge of English. The search for depth, sensitivity and methodology became predominant and ruled out the target of 100 interviews. 36 women were interviewed, 22 in a shorter standard interview only, but 14 of them in highly detailed repeat home-visit conversations six of which were tape recorded all in Punjabi with approximately 10 hours conversation per person. The central concern was always 'health doctors illness treatments' but the method followed entailed and demonstrated the total context of these concerns in accounts of daily life, coping, hopes, fears and critical events. Key questions about "somatisation", expectations of consultations, perceptions of "body and soul" and periods of depressive illness were illuminated by these methods.

Period of Award

1st January 1987 to
31st December 1987

Total Amount Expended

£13,390

14 Punjabi speaking women talked in great detail in repeated home visits and long conversations about their lives and their health illness, and consultation with GPs and other medical professionals. 34 (including 12 of the 14) completed a standard interview yielding data on health, attitudes to health, diet and exercise, and aspects of G.P. consultation, as well as "standard" questions on family size, date of arrival in UK and occupation. Most of the women were Moslem, a few were Sikh, and almost all come from a relatively small area either side of the Pakistan- India border in the Punjab. Stories about health and illness were fully "meshed" with stories about their daily lives, their arrival in the UK, the experiences of moving home or seeking work. Thus our reporting of "concepts of health and illness" places them in a full and detailed "context of living".

Women spoke freely about periods of "depression" and the relationship of mental stress to physical ill-health. In this connection they elaborated their understanding of the purpose of the GP consultation. This detailed qualitative approach grounded in the relationship of trust between the researcher and subjects yields information and perspectives which are extremely scarce in this field.

The often discussed notion that "ethnic minority" patients do not understand the link between "psyche" and "soma" is discredited by our data. On the contrary women speak with a high degree of sensitivity and elaboration about the relationship between spiritual and physical life. If women present 'somatic' symptoms it is not because of a failure to understand this link. It may be, however, that whilst both somatic and psychological "pains" are experienced, and the link between them understood, doctors are only expected to be able to cope with the former.

Women also spoke about their views of medicines, "drugs" and other treatments; about language and culture in the consultation; and about diet, exercise, and concepts of "hot and cold" (food and body states). This will be reported in more detail in a longer report.

We also talked to most of the GPs at Charlotte Keel Health Centre, especially those who had most Asian Patients. Other professionals were questioned including midwives, health visitors and the linkworkers.

We conclude our report (section 12 below) with a broad discussion of health, medicine, racism and social and cultural change. It is clear that experience of racial hostility (e.g. from neighbours and in the streets) has a profound effect on the health and well-being of Asian women in Britain. The effects of such experiences are particularly dramatically described in 2 of the 6 tape-recorded interviews. All tapes were in Punjabi and a crucial part of our further reporting will be the elaboration of Punjabi terms in relation to English language meanings (e.g. terms like "racism" and "depression").

This is rarely discussed in extant literature. The most important conclusions of the study are

(a) methodological - about the establishment of research relationships in this kind of setting
(b) concerning Asian women's understanding of "psychosomatic" relationships
(c) about personal experience of racial hostility and its connections with health
(d) about mental depression and
(e) the perception of GPs, the purpose of the consultation, and about medicine and food.

Modification of Methodology

The target of 100 interviews proved both unrealistic and incompatible with the aim of achieving a sympathetic understanding of patients own perceptions of health, illness and medical care. In pursuit of the major aim of the research - the exploration of lay understandings of health and medicine - we increasingly realized that this required the fostering of a relatively small number of close relationships with women in the South Asian community. The data derives from the relationships established between the Research Associate (Kanmaljit Poonia) and 36 women who agreed to talk about health and illness and their daily lives. Although the number is smaller the data is in much greater depth than may have been originally expected. This shift of strategy resulted from our concluding that this was the only way of achieving our principal objective.

Although (especially in the first three months) a good deal of our research activity was centred on Charlotte Keel Health Centre, and a number of our interviews were conducted there, we also concluded (for several compelling reasons) that the interviews were best conducted in the home. This detached the interview from an immediate consultation with the General Practitioner although this remained a central topic of the research.

1. Introduction. The aims of the research and a summary of the work carried out.

The aims of the research follow those established in the research proposal, in which I wrote:

> planning for improved health care for ethnic minorities depended on "highly detailed and sensitive understanding of conceptions of health and illness among them".
> the research therefore, aimed to concentrate on
> "understandings of health and illness, and of the purpose of the consultation"
> I argued that, in this field,
> "insufficient attention has been paid to the subjectively held cultural meanings attaching to health and illness among South Asians. Exploring these is likely to have lessons for the whole field of minority studies".

This remains a good description of the purposes of our research. The shift from a larger number of interviews, in the Health Centre, to a smaller number of interviews in people's homes, was a consequence of concluding that only by the latter method could we attain the level of detail and sensitive understanding at which we were aiming.

Summary of the work carried out

The core of the work is to be found in the prolonged "encounters" with fourteen South Asian women with whom the R.A. established friendship and trusting relationships. The amount of time spent with each woman varied but none was less than three home-visits, some many more. We estimated that there was approximately 140 hours of personal contact with these women (on a one-to-one basis mostly). Some parts of these conversations (held in Punjabi) are tape recorded; the rest are recorded in note form (in English annotated with Punjabi phrases).

12 of these same 14 women also completed a standard interview set of questions which systematically records background data, and standard questions on health and health care.

A further 22 women completed the standard interview schedule in interviews which usually took about one hour. Thus 36 women were subjects of the study altogether, 12 of whom were involved in prolonged contact with the R.A. and completed the standard interview, 22 of whom only completed the standard schedule, and 2 of whom had long conversations with us but did not complete the standard interview.

There are other sources of data which will be briefly mentioned in this short report but will form a larger part of a longer report. These include

a) observations at the Health Centre including presence at consultations
b) conversations with health visitors, midwives and other staff at the health centre
c) interviews with General Practitioners
d) meetings with members of the Inner City Health Project and
e) close contacts with the Linkworkers.

During the year we have made three presentations of the research;

1. to the M.Sc. (Race Relations) seminar series at the University of Bristol
2. to the Department of Mental Health (University of Bristol) and
3. to a day conference of the Inner City Mental Health Project at Bristol Royal Infirmary Conference Centre.

Some other brief comments

With reference to those "checklist" items which are relevant to this project:

i) There are important issues of confidentiality.
ii) The time table was adhered to but I think that one year research projects of this kind compresses the work too much and pose problems of continuity for Research Workers.
iii) The work is continuing with a new source of funding.

2. Literature

Although there is an extensive literature on doctor-patient relationships, very little of it is concerned with ethnic or 'racial' factors. The literature on Psychiatry and culture has discussed the interethnic consultation; see P. Rack, Race Culture and Mental Illness and J. Cox (ed) Transcultural Psychiatry, and the present research will comment on questions which are raised in these works.

There is a wider literature which can be grouped as "medical anthropology"; see for example, C. Helman Culture Health and Illness (1984) in which "culture" and "lay concepts of health, illness and medicine" are central concerns. Traditionally medical anthropology has concentrated on 'pre-modern' societies, although increasingly the study has included the lay concepts of modern Western urbanites. A good example is C. Helman's own (1978) ' "Feed a cold, starve a fever": folk models of infection in an English suburban community and their relation to medical treatment' in Culture Medicine and

Psychiatry, 2, 107-137.

Few studies have examined concepts of health and illness among ethnic minorities or immigrant groups settled in metropolitan societies, especially where those migrants have moved from Third World countries (e.g. India, Pakistan) and have in effect moved from village life in the Third World to urban life in, for example, Britain. (Of course by no means all Third World emigrants are "villagers".) One excellent example of such a study, based on Turkish migrants to Stockholm, is Evil Eye or Bacteria, Lisbeth Sachs, 1983, Stockholm Studies in Social Anthropology, in which Turkish women who remain strongly influenced by their Turkish-village cultural background are also engaging with 'Western medicine' in Health Centres in Stockholm. In Britain there were only two main studies which we found to correspond closely to the current research:

1. Caroline Currer's study of Pathan women in Bradford, partly published as a Chapter in Concepts of Health Illness and Disease: a comparative perspective, Caroline Currer and Margaret Stacey, (eds). Berg: Leamington Spa, 1986 and
2. Jenny Donovan's We don't buy sickness it just comes, Gower 1986, which is partly based on conversations with both Afro-Caribbean and South Asian women.

The most helpful article, relevant to our research, on mental distress among Asians in Britain, is Suman Fernando's "Depression among Ethnic Minorities" in Cox (ed).

There is a practice oriented literature typified by Health Care in Multiracial Britain, Health Education Council/National Extension College (1985), P. Mares, A. Henley, C. Baxter. RUER has published a bibliography, Race and Health, Mark R.D. Johnson, October 1983. There is also a literature on ethnicity and migrant settlement in Britain which is relevant to, though not specific to, medicine. However, Roger and Catherine Ballard have written both generally about Sikh settlement (see their article in Watson (ed) Between Two Cultures and also on health (see R. Ballard's unpublished articles). Patricia Jeffrey's Migrants and Refugees and Simon Singh "Bhatra Sikhs in Bristol", University of Bristol, Department of Sociology, B.Sc. thesis, 1977, are locally relevant studies, as is Steve Fenton's Race Health and Welfare, University of Bristol, 1985.

P. Rack, Race Culture and Mental Disorder, Tavistock: London. 1982.
Caroline Currer and Margaret Stacey, (eds), Concepts of Health, Illness and Disease. Berg: Leamington Spa. 1986.
John Cox, (ed), Transcultural Psychiatry.
Jenny Donovan, We don't buy sickness it just comes. Gower: Aldershot. 1986.
Cecil Helman, Culture, Health and Illness. Wright: Bristol. 1984.
T. Rathwell and D. Phillips, Health, Race and Ethnicity. Croom Helm. 1986.
C. Leslie, (ed) Asian Medical Systems: a Comparative Study. University of California Press. 1976.
L. Sachs, Evil Eye or Bacteria. Stockholm Studies in Social Anthropology. 1983.
S. Fenton, Race Health and Welfare. University of Bristol. 1985.
S. Fenton, Britain's Black Elderly, New Community (Spring 1988)
S. Fenton, "Racism is harmful to your health", forthcoming.

3. Setting in Bristol

There have been a number of Indian individuals and families in Bristol throughout the 20th Century and R. Barot (unpublished work) has researched some of their early life and times, including the beginnings of voluntary associations and political action oriented to India. The larger community - indeed the growth of a visible community at all - dates from the 1950s and 1969s, with males arriving before females and a typical arrival period being 1960-65 for men and the 1970s for many women. There are of course exceptions to this typical pattern.

South Asians in Bristol are from both India and Pakistan and although the Census (1981) seems to record more 'Indians' this may be affected by the date of birth preceding partition and the creation of Pakistan. (In 1981 the classification of persons by the birthplace of the Head of Household gave the following population; Indian 2,649, Bangladesh 191, Pakistan, 1,929, East Africa 624.) It is possible that those identifying as Pakistanis and as Moslems are now closer in number to those who identify as Indians (or Sikhs or the small number of Gujaratis). The Moslem groups from Bangladesh and Pakistan are more recent arrivals, have experienced more recent growth, and are more likely to live in two wards close to the city centre (Easton and Ashley). The great majority of Bristol's South Asian people are from one geographical region, the Punjab east and west of the Indian Pakistani border; to some extent and in some contexts this constitutes a common cultural focus which overrides religious or national differences. Sikh families living in Bristol may have lived their early life in villages of the Punjab which are now in Pakistan and have moved to India after partition, Moslem families making the move converse of this. The most obvious mark of this common Punjabi base is the Punjabi language spoken by most South Asians living in the inner city. This was very significant in the striking of rapport between Kam Poonia and the women who talked to her. Although there are variations in the way Punjabi is spoken (and some Pakistani women describe themselves as speaking Punjabi and Urdu) this was never a problem for the researcher.

Among the Moslem women were some of the most recently arrived; Sikh women have commonly been here longer and for this and cultural reasons may have more social contacts outside the family and a small circle of friends. The Sikh women therefore often appear "busier" (including less easy to catch for an interview), more widely socially connected, and more likely to be bilingual. However we would not be tempted into making a (Sikh/Moslem) simple distinction between more 'assimilated' Sikhs and more 'traditional' Moslems. Some Sikh families in Bristol may be very traditional in orientation; equally Moslem women are changing and coping with their lives in new ways - observable even during the 12 months of this study.

Patricia Jeffrey is a good source on Pakistani migrants to Bristol in the 1970s; the most obvious correction that we might make is that cultural changes have moved further since she wrote and the degree of encapsulation and isolation (psychological, cultural and social) which she describes would have to be modified in the 1980s. Simon Singh's thesis on Bhatra Sikhs by definition focusses on caste which was only rarely mentioned by Sikh contacts in this study, but it is clear that caste organisation remains a signal principal of social structuring of Sikh life in Bristol.

The Research Assistant, Kanmaljit Poonia, made her early contacts at the Charlotte Keel Health Centre, where there are both Sikh and Moslem 'Linkworkers' who introduced her to other women. More ready contacts were made with Moslem/Pakistani women and these leads were followed through to the

women's language class group at a local community centre. This process of making contacts is described in the next section.

4. Methods of Collecting data

The gathering of information, and establishment of contacts with people willing talk to the Researcher (K.P.), fell into three phases.

Phase 1

Familiarisation at Charlotte Keel Health Centre (January to March)

This included 3 key social processes:

a. observing the scene (and being seen in the health centre)
b. legitimation - introduction (via the linkworkers).
c. participation (in consultation as a quasi-linkworker)

Phase 2

Women talking in their homes (April to August)

Phase 1 made possible K.P.'s entree to the Women's group (at the Community Centre) and acceptance among the women as "one of us". "We-identity" between K.P. and the women was the basis of the research. From the Group K.P. made a series of individual friendships which resulted in invitations to homes. 14 women were seen on this basis (one-to-one) in repeated visits over the spring/summer.

Phase 3

Charlotte Keel Health Centre and the Sewing Class

A standard interview schedule was used to record basic background data and codable responses on health questions for the 14 (2 had to be omitted = 12). We then sought to apply the same interview schedule to other users of the Health Centre. 22 were contacted and interviewed in and/or via the Health Centre waiting room and the "Sewing Class" (which was held at the Health Centre).

We have argued that authentic views are derived from the longer encounters. This is partly confirmed by the differences between early responses (e.g. familiarization conversations in the Health Centre) and what was said in the home conversations. Full explanation of the basis of legitimation of the research with the Asian women requires much more space and detail. It is crucial to the reporting of this research, and is of much more than "narrowly methodological" interest. It included a) establishing a basis of trust and b) explaining the research to "respondents". Six of the 14 prolonged encounters were taped, the others recorded by hand written notes.

5. How women talk about health; general themes

Women talking about health, illness and medical care, and about their daily lives

a) Dimensions of their Lives: health, illness and medical care

Good health and poor health were experienced and reported within a total context of family, community, work and home-life. Periods of ill health and good health are experienced in this way and are recounted thus. In this

sense, health is not seen as a separate sphere of life nor is it conceptualized or discussed in this manner. Management of illness was, thus, fully integrated with the management of daily affairs and critical events in daily affairs were described as the "punctuating points", the start and end points of periods of illness. What we may be tempted to call "illness episodes" are simultaneously "life episodes" and this perspective informs most of what follows.

Summary of some main points

1. For almost all subjects interviewed, health and illness (their own or that of a family member) were major concerns in their lives . . . although . . .

2. A typical first response was to say that things were "alright". Later interviews frequently revealed profound anxieties and medical problems.

3. Some illnesses were recounted as being clearly related to critical life events. Some of the most often noted were: the death of a relative; arrival in England; return visits to Pakistan; coping in new circumstances in England; moving home, managing family affairs; working, inside and outside the home.

4. To the extent that people saw ill health and life circumstances as closely intertwined, the doctor's powers of intervention may be seen as limited (since the doctor may be seen as incapable of intervening in the patient's personal circumstances). Where an illness is seen as more narrowly "physical" and specific, the patients' expectations of the Practitioner may be considerable. When this is the case the patient may be disappointed by the doctors 'low key' response, disconcerted by the continuation of the medical problem and frustrated by the absence of a satisfactory or satisfying explanation of the illness and its treatment.

5. Living in England was sometimes seen, in the womens' own accounts, as related to illnesses. Certainly the women saw illness in the UK as taking different forms from those common in South Asia, or saw new and different illnesses as being more important or prevalent. Women speak of asthma and allergies in this way.

6. A general impression from the interview data is of the personal strength of many of these women as they cope with a host of demands in adapting to the circumstances of Britain. At the same time there is evidence of a considerable sense of poor health and lack of 'well being'.

A diffuse or specific sense of "being ill" seems in a number of cases to stretch over a remarkably long period of time.

The illustrative material, in the very nature of this research, is long and detailed, so only very short items can be presented in this summary report. Two cases may illustrate the "interconnectedness" of health and life courses, the "inseparability" of health ideas or descriptions from living commentaries. "Mrs. Sh." was suffering profound anxiety accompanied by physical symptoms ('my bones ache, I cannot lie down properly etc.') and this anxiety plus pain and the desperate nature of her circumstances had led her to her GP. She was having difficulty coping with her (3) young children in a high rise flat (3rd floor) from which another child had fallen. She was devastated by fear of an accident to her children. The more she stayed in (her husband was out for long hours on late evening shift work) the worse she

became. But when she went to the Park (for a walk, fresh air) with her children they suffered racial abuse (cries of Paki. etc.) forcing her back inside. Her anxiety was so deep it was physically felt. "Daily coping - housing - employment (husband's shifts) - racism - anxiety - physical pain - GP visit - pain, anxiety, 'total problem', unresolved" are all together in this situation.

Mrs. P. has worked outside the house in a Dry Cleaners ever since she came to Bristol mainly for economic reasons but also importantly because she says "She is not the sort of woman who can sit at home". For her socializing is important and the work place provides the arena for this. However she describes in detail the hard and tiring nature of such work and talks about its effects on her physical well being. She developed a skin problem but carried on working. She spoke with some pride about the fact that she continued working even though she was in physical pain. Eventually she had to stop work as her arthritis was aggravated by the long hours of standing and hardship. Thus the type of work Mrs. P. was able to get was detrimental to her health. However faced with few other alternatives she took that risk and only stopped when she was physically unable.

These two cases, to be described in fuller detail, illustrate the general point about "interconnectedness".

(b) Some more Specific Themes of the Research Data: Bristol Asian women talking about health, illness and medical care and consultation.

Where the literature suggests or implies that

(a) depression is not understood
(b) the connection between psychological states and illness symptoms (e.g. stress-induced pain) is not understood by "ethnic minority" (including Asian women) patients,

we conclude that the literature, (and maybe General Practitioners), is mistaken or misleading.

First of all, and most obviously, the women experience and describe (in Punjabi) profound sadness, a sense of immobilization, loss of sense of place, value, worth, and meaning. Some of these 'episodes' are enduring, immobilizing, accompanied by physical symptoms, sufficient to be observed by other family members as more than being sad at an understandably sad event. In other words some of the women undoubtedly described experiences and feelings with many or several of the characteristics that would be identified as "clinical depression".

In several cases antidepressant treatment was sought and prescribed. The only thing missing may appear to be either

(a) the use of the English word depression or
(b) the use of a single precise Punjabi equivalent.

(a) above has to be qualified by the fact that one or two women did know and used the English word depression. One woman who was treated for depression during an extended episode (described in considerable detail, followed by a consultation with a GP, and treatment with antidepressant tablets) did use the telling phrase

"I had the depression bemari, the bemari they call depression".

(b) above should also be qualified. No single term is used in Punjabi but several highly evocative phrases are used which describe a psychological state much more strongly than passing sadness or 'normal' unhappiness.

[(a) and (b) here require detailed description of individual cases of depression and full account of Punjabi phrases and sentences: these to be part of full report.]

In the two most clear cases of "depression" the symptoms were taken to a GP and were not presented in any disguised somatic presentation. In one case the patient was hospitalized and given "social/behavioural" advice. In the other case the substance of the depression was not addressed by the GP but the woman was prescribed antidepressants.

In all 34 standard interviews subjects were asked about "taking such problems to the GP" in a sequence of questions which first encouraged the interviewee to consider (in Punjabi terms) profound anxiety, sense of loss or isolation, and 'being overwhelmed by things'. It was in this sequence that subjects were asked "would you take such things to a GP?".

The majority said they would not - but note that this is a majority. Some said they would. Those saying they wouldn't (take such things to the GP) gave various reasons, the most common being "What could he do?". Other things mentioned included the implication that he wouldn't "understand" partly simply because of the language.

But this does not signify a non-understanding of the relationship between "psyche and soma" nor does it signify a failure to identify "depression". Partly it does indicate an understanding that doctors are concerned with soma. The fact that some, and probably most, women do see the link between psyche and soma and/or do identify a specific illness state which is primarily psychologically defined, is evidenced by the clear acknowledgement that "thinking" and circumstances which set one thinking can "make you ill". Not only is that state (of mind and body) recognized, but it may be seen to be a very important category of illness. The same phrase appeared repeatedly in the field notes translated from Punjabi into English . . . "thinking too much". In one case the possibility (of thought-illness link) is acknowledged negatively by a woman who had described a physical symptom or set of symptoms which "the doctor said was because I was thinking too much". She added that (in this instance as it were) he was wrong but not in a spirit of denying this was possible. Other similar quotes show that Asian women think of "thinking too much" as something which can make you ill.

If a psychological state accompanies a pain (or set of physical symptoms) the doctor may be approached about the pain i.e. as something which he can treat. This is different in principle from somatic presentation, although admittedly in some cases there may be a tendency to see the link (of body and mind) as causally reversed, i.e. the pain is causing the depression and so we must solve it.

The importance of the phrase "thinking too much" was often found to be expressed in connection with social isolation. You may become morbidly turned in to your own thoughts when there is nothing or no-one to occupy your mind. Thus the problem is "thinking too much" as a result of being "alone with one's thoughts". Several of the cases illustrate the point made here with detailed and evocative accounts. Particularly valuable is the evidence of the way in which the women used Punjabi and English words and phrases to describe

physical and mental conditions. This of course poses considerable problems in the definition of the boundaries of the term "depression". But it should be noted that this term is problematic in both lay and professional usage.

Discussion of 'racism' was relatively unprompted throughout the study. Personal experience and fears were described and these arose largely unprompted, and frequently, in the authentic words of the women themselves. The above case of Mrs. Sh. was the starkest and most distressing in the study and on its own describes the interrelatedness of medical and "social" problems. The crucial factor of racism (in the Park) was the key to the confinement in the high rise flat which was both a source of distress in itself [illustrating the woman in the home dwelling on thoughts of what happens when she goes out], and its results - the exacerbation of the housing problem. P.A.s, S.As and Mrs. C's stories are others which contain narrative accounts of racial hostility with descriptions of their subjective/impact - of fear, alienation, resentment and hurt. If some research and polemic (wrongly or rightly) is seen as unduly stressing racism, we could hardly omit it, since it permeates the accounts we heard.

(c.i) Medical Services

Charlotte Keel Health Centre was an important research site, especially in the first three months of the research when the Research Assistant established links with many of the professionals and staff there. There are three practices based at the Health Centre, the Asians patients are very much disproportionately registered with one of these three practices.

Early in the year we interviewed the three GPs in this practice in their surgery. The Research Assistant held a meeting with one of these three in her home. We also interviewed two GPs (one female) who constitute another practice at the Health Centre: we spoke to them in their homes. Later in the year SF re-interviewed the latter two GPs.

Practice (1) Dr.J.N. Dr.P.S. Dr.J.F.(f)

Practice (2) Dr.P.G. Dr.L.M.(f)

JN/PS/JF meeting with SF & KP (March 87)

JF meeting with KP (March 87)

PG and LM meeting with SF & KP (March 87)

PG meeting with SF (Feb 88)

LM meeting with SF (Feb 88)

We are able to draw on SF's interviews with GPs carried out for the 1983-5 research, interviews with JN, PS, PG and doctors from other surgeries/health centres, including Dr. G. and J, a two-man Asian practice with whom some of our respondents were registered. There are also field notes of meetings with linkworkers, members of ICHP and midwives.

GPs Views

Frequently in the literature (of medical sociology) doctors are portrayed as being handicapped by their adherence to what is called 'the medical model'. We cannot discuss this fully here but we can add some comments. One element

of the idea of the 'medical model' is the viewing of the body as a biological organism rather than 'the person' as a whole being. Do the GPs we met think like this? We cannot make 'final' judgement but it is clear that some of the obstacles to "treating the whole person" are not simply a result of the GP thinking narrowly about the patient in 'scientific medical' terms. The GPs may recognise the benefits of engaging 'the whole person' in the doctor/patient relationship but fail to do so for other reasons e.g. lack of time, inability to speak the patients' language, fear that a wider consultation may open up unsolvable problems, and uncertainty about how to respond if the patient did reveal a broader set of concerns with the GP. And in several senses GPs clearly do recognise the importance of non-organic factors such as housing, and family circumstances which any experienced GP knows have real effects on health.

Nor is it clear that patients want or are looking for their GP to treat them 'holistically'. Some may actually define their expectations in largely 'physical' terms and the GP recognises this. Nonetheless there appears to be a considerable gap between patients and GPs. The GPs themselves may feel that they do not know the real expectations of their patients nor have any ready way of discovering them. And they will also think of their patients as having misguided or mistaken expectations which are in principle not capable of being met. They also express concern about patient compliance (especially in regard to the taking of drug prescriptions), and about the "unnecessary visit" and "somatic presentation". But all of these fairly typical General Practitioner concerns are not necessarily seen as 'ethnic specific' - it was often stressed to us that, for example, "the anxious visit" and the repeat visit could be found in any group of patients.

Similarly the patients vary considerably in their judgements of doctors. They recognise doctor's kindness and concern but at the same time may mention the lack of adequate explanation. Asian women mention things which are 'general' among patients (e.g. the cost of prescriptions) and things which are specific - the limits of their rapport with doctors who speak only English. There is data in our study - including a whole section of the standard interview administered to 34 women - which throws a light on these questions but for which there is now insufficient space.

(c.ii) **Medicines, Prescriptions, Diet**

- drugs are seen as powerful, possibly dangerous.

- the most used Punjabi word (dhawai) best translates as "medicines", no obvious equivalent of English "drug" with its ambiguity of drug = chemotherapy and drug = drug abuse. Thus the English word drug (where used) has the connotation of dangerous drug - hence "the medicine had a drug in it".

- fears that medicines (drugs especially in tablets) may be addictive and have dangerous side effects are reported several times.

- here, as throughout, we make no necessary implication that this is "ethnic-specific". This attitude to tablets-drugs is probably common among many patients.

- medicine supplied by traditional healers, hakims seen as softer, gentler, more "natural" - like the remedies "in health food shops", better but taking longer to have these lasting effects.

- food, diet is often regarded as supremely important and expectations are sometimes derived from "hakims" who give highly specific (e.g. to a particular illness) diet advice. The absence of this in GPs advice is problematic. (cf Ballard).

- food, diet are frequently understood in relation to health in terms of culturally bound conceptions of hot and cold.

CONCLUSION

(a) Substantive

N.B. Some of the following research findings [especially (i) and (viii)] are chosen because they are contrary to accepted understandings etc. or, when explored at great length are important modification of common ideas and arguments.

(i) Asian women in Bristol spoke freely - under the appropriate circumstances - and fully about their understanding of health, illness and medicine.

(ii) There are several observable features of their view of health which are undoubtedly shared with any others (i.e. non Asians) and this would include the way in which health and illness are described. That is "health and illness stories" were told as part of "life stories" with periods of illness punctuated by life events.

(iii) There were also indications of ideas which are more "culturally specific" to Asian groups. Women spoke of food and states of the body in terms of concepts of "hot and cold" which influenced their view of health and medicine.

(vi) Women were constrained in their consultations with G.Ps, partly by absence of shared language and partly by a sense of the limits of what was appropriate to tell a doctor. Raising "non-physical" matters with a GP may be avoided on the basis of "what could he do?".

(v) "Drugs/medicines" are seen as powerful, even dangerous, as having side effects and potentially addictive.

(vi) Experiences of racial hostility were reported and described as having a profound effect on well-being.

(vii) Conversations in Punjabi (cf. with English) bring out a significantly different emphasis, some apparently "opposing" views and statements.

(viii) Asian women experience and understand "depression" even if that term is not used; more generally several women showed that they understood "depression" and what might cause it, its connection with "physical ill-health", and understood the relationship between the physical and the "psychological" - between body and soul.

(b) Theory and Method

From a theoretical point of view the highlighting of the life experiences of women, especially related to health, appears to us to diminish the salience

of polarized debates, e.g. between "class-race-structural" approaches and "ethnicity" approaches (seen as stressing "culture"). We could be said to be in a position to confirm both or produce a critique of both.

Methodologically we are staking a great deal on what we perceive to be the great gains (at least in this area of research) of close, developed relationships (with a necessarily small number of women) as the basis for the question of qualitative data on "life-health-illness-medicine". Our success or otherwise in defending this approach will be crucial.

(c) Racism, Culture and Social Change

In a short report it is impossible to engage in a debate about racism, its meaning and the analysis of it (SF has written elsewhere on this topic: see the above bibliography as well as his New Community articles and the current issue of Patterns of Prejudice).

The main contribution (very little is written on this) that we can make in a longer report will be on the perception of "racism" (or what English speakers might call racism) by Punjabi speakers who do not use the word. These are bound up with the authentic expressions of ethnic identity "our people" and of reflections on what "they" ("gori", whites), English people think of "us" ("I think they don't think well of us").

We do not devalue the political expression of concern about "racism", only point out that the Asian women to whom the researcher spoke do not a use language of "race and racism", rather they speak about their own (individual) experience with white people.

Much too could be said in a larger context about "culture" and "ethnic group culture" but here we can only make some key points very briefly. Representations of ethnic group cultures (by observers, white observers, distillations in guidance articles for medical professionals etc.) are commonly misleading and suffer from over concretising, from treating attitudes, beliefs as "fixed" or "characteristic" of of a group. This in no way corresponds to the athentic reality as we observed and heard it in the daily lives of South Asian families in Britain. [An example would be where "cultural advice" takes the form of noting that Moslems fast during Ramadan. But how different Moslem women think and act in relation to Ramadan requires much more explication.]

Our overwhelming impression is not of a fixed culture (e.g. described as a characteristic social attitude which determines this or that behaviour) but as a set of dispositions, fears, hopes and longings constantly in flux, and in response to rapidly changing circumstances. Aspects of this social change (both within ethnic minority communities and in wider society) are to be found in patterns of employment, housing and education, which were critical areas of concern among our respondents. Somewhere in this process of change the cultural definition and position of women in South Asian communities in Britain is crucial: common sociological observations on this issue are seen by us to be wrong or misleading. Related to this a similarly crucial dimension is that evoked by the term "individualism". Changes in attitudes among South Asian people we talked to, in relation to individualism are revealed in their attitudes to family life, material aspirations and in attitudes to women entering the labour force. Finally, we would say that a certain paradox developed from this study. An approach which some would describe as "cultural" and "anthropological" and (therefore) antagonistic to a politicised analysis of racism, actually ended up strengthening our view of the importance

of our awareness of racism. Left to themselves, so to speak, to describe their lives, without prompting of a specific kind, a great deal was said spontaneously which highlighted the effects of what from other vantage points would be described as racism. The people describing these things did not, for the most part, use the word racism but described their experiences fully and eloquently.

APPENDIX 1

Continued from Page 6, Number 11

Dissemination - Continued

Kam Poonia, Paper to Institute of Social Anthropology Seminar at Oxford University, 16th June 1987. "Minorities and the Health Service"

Kam Poonia, Paper to Access Course students, Soundwell College, Bristol, 10th March 1988. "Asian Women and Health"

A note on dissemination

The results of this research will be disseminated through:

- Published work
- Medical Sociology Conferences (e.g. the BSA group)
- Mixed academic and service-provider conferences, such as day conferences on aspects of service provision organised by Health Authority groups, funded projects and voluntary groups; and to respond to requests from ethnic minority organisations.

Publications

From the data collected during this year there is the foundation of a number of journal articles. In connection with previous related research, there is the potential for a book length publication.

Journals would be New Community, British Medical Journal and Sociology and more popular journals such as Health Trends, Nursing Times.

There is the basis for article length contributions on:

- somatic presentation
- depression and the recognition of psych-soma relationships
- concepts of health illness and medicine
- strategies in researching health and illness beliefs among ethnic minorities
- racism, culture and health
- the purpose of the consultation
- GPs views, patients' views, overviews.

RACE
HEALTH AND WELFARE
Afro-Caribbean and South Asian People in Central Bristol: health and social services

Based on interviews with middle-aged and elderly West Indians, South Asians, and UK-born white residents of four central wards

Dr. C. S. Fenton
Department of Sociology
University of Bristol

Researchers:
Steve Fenton, Terry Golding
Janet Hammond and Kam Rungahsawmi

Typing: Mrs. Jackie Bee

Afro-Caribbean and South Asian People in Central Bristol: health and social services

ACKNOWLEDGEMENTS

The research on which this report is based was carried out during 1983-4 and was funded by the Commission for Racial Equality and supported by the University of Bristol and its Department of Sociology.

The stimulus for investigating the issues raised here - and all manner of support and interest - has also come from the Bristol Council for Racial Equality, particularly via the continuing concern for these issues of the Senior Officer, Miss Carmen Beckford, who chairs the Health and Social Services Sub-Committee of the Council.

The views expressed in this report are not necessarily those of the CRE or of BCRE.

This present report has been produced in the Department of Sociology and I am grateful for the great help received from Mrs. Jackie Bee.

The report was entirely written by the Research Director, Dr. C.S. Fenton Lecturer in Sociology, but the term 'we' is often used to indicate the collective effort of all involved in the project. Great thanks are due to Mr. Terry Golding, Ms Janet Hammond and Ms Kam Rungahsawmi who worked as Research Associate and Assistants.

Thanks are also due to the hard-working interviewers and above all to the 250-plus people who cooperated so generously by agreeing to be interviewed.

Steve Fenton

University of Bristol, Department of Sociology

ISBN 0 86292 176 7

CONTENTS

FOREWORD

RACE, HEALTH AND WELFARE, a Report on Health and Social Services, is here presented for the first time. It is about access to and use of health and social services in the central area of Bristol, with a specific focus on black people, and particularly the middle aged and elderly among them.

It is not about all ethnic minority people in Bristol; but is almost exclusively based on interviews with Afro-Caribbean and South Asian-origin people living in four central wards.

It does not, by design, say very much about young, or younger, British born black people in Bristol; almost all our ethnic minority interviewees were born overseas and were adult and older people.

Other reports with related interests have been made, but none chose, as we did, to base their work so systematically on the experiences of residents told directly to us.

We interviewed some 50 British born whites and their interviews are referred to here primarily as a way of providing a comparative reference; 200 of 250 interviewees were of Afro-Caribbean or South Asian origin.

Reports concentrating on "disadvantage" can work as a two-edged sword. They rightly draw attention to the need for change. But they can also "confirm" an association between "racial minority" and "problems", even suggesting that minorities cause their own problems. This is wrong. People of all backgrounds and ethnic origins have problems, make problems, cope with problems and overcome problems. But some hardships, of particular kinds, affect some people more than others, and are, in considerable part, the result of unacceptable attitudes and practices.

To some people this report may appear to be too "mild" in its diagnosis of racism in Bristol. To them we say that we are in no doubt of the wide extent of racism and discrimination in Britain; anyone who denies or ignores it is ignorant of a basic fact of modern British society. But in this study we have concentrated on some highly specific questions and have tried to report what we found and heard as faithfully as humanly possible. There will be things we didn't find and didn't hear. But we hope that people are also prepared to accept that there remains enough room for negotiation, consultation and change, and a will to make it work.

Others will say "there is no problem". This is simply ignorance. In our study are reflected disadvantages and inequalities which cannot be allowed to persist in a just society. Some reflect the way in which minorities partake of inequalities suffered by many other people, some the way in which minority status is a distinct disadavantage of its own. Either way we all stand to gain both from making Britain a more just society for all its people, and a society which banishes categorically unequal treatment.

A Guide to the Way "Group Descriptive" Terms are used in this Report and by Other People.

If racist words, terms and images were less widespread than they are then we would have less need to exercise caution about the way we use language. But, tedious as it may seem to some, it is important in present-day Britain to recognise the power of images conveyed by terms, and to pay full attention to language and terminology. We must also recognise that there is no complete agreement - and probably never will be - about the appropriateness of different terms in different contexts. In this report we have tried to avoid a rigid approach but at the same time have tried to demonstrate a preference for certain terms whilst using alternatives (sometimes regularly used) sparingly. For example the term "ethnic minorities" is regularly used in Commission for Racial Equality literature, but there are arguments against its use; we have accordingly, used it, but infrequently and only in certain contexts.

Black People. It is almost certainly the case that there is more support for the use of this term - in many contexts - than for any other. We have tried to reflect this large measure of agreement (but by no means complete agreement) in our report.

Coloured People. For many years used by white English people, including government agencies in relation to so-called "coloured immigration", this is now (outside plain racist abuse terms) one of the most disliked terms, and for good reasons. All people are "coloured". And since it is so often counter-posed to 'white', black can be seen as promoting an 'equal' image which

'coloured' does not. Furthermore the term coloured is used in several parts of the world with highly specific connotations (notably in South Africa) with clear non-black implications which reflect the racist structures of the societies where it is used. It does not appear in this report except in quotations of one sort or another.

Ethnic Minority Groups. This term is fairly widely used, especially in the so-called race relations industry, and is disliked by some for that reason. It has a certain generalizing descriptive value (it could be read as being more inclusive and 'neutral' than other terms) but many would argue that the preference for"ethnic" over "racial" plays down the issue of racism in favour of a conception which appears to stress a notion of sub-cultural difference. We have used it in a few contexts where it seemed reasonable.

Immigrant. At its best this is a purely descriptive term referring to the simple fact that people move from one country and settle in another. We used it in some of the questions we asked, and as a result, the term appears where we are reporting on answers to those questions, especially in Section 3. It could be argued that it is defensible in several contexts in this study since almost all the middle aged and elderly black people to whom we spoke had been born outside the UK and they undoubtedly perceived "migration" as a central fact of their life and experience. At the same time we have not used "immigrant" in this report as a general descriptive term, and all readers should recognise that it is very frequently used in an inappropriate manner with implicit or explicit racist connotations. There are several reasons for this: a) it has often been coupled with 'coloured immigrant' (as explained above) in a way which fostered a general racist hostility to black people in Britain; b) it recalls ideas of uncertain status which seems singularly inappropriate when people have been here for many years. "Immigrants" are thought of, in key public imagery, as people who have less of a rightful claim

on resources, jobs and services. This can only be racist in its application to people who have lived and worked for many years in Britain; c) it is still very common to hear and see this term used entirely wrongly to refer to black people born in Britain; d) "immigration" policy and administration is still surrounded by racist ideas as the recent report of the Commission for Racial Equality demonstrated.

New Commonwealth. This term has appeared most commonly in official Census documents. It can, thus, apparently be used as a neutral descriptive term referring to place of birth (i.e. certain Commonwealth countries in Africa, the Indian sub-continent and the Mediterranean) of an "enumerated" person or the place of birth of the head of household in which the "enumerated" person lives. In this latter form it has been used a statistical proxy for "ethnic origin". We have used this term quite frequently in one section (the first) in particular simply because that is the chapter in which we are digesting Census figures for our own purposes. But readers should also note the serious reservations about this term and its use: a) as a proxy for "ethnic origin" it is frequently inaccurate, for example in underestimating the presence of particular groups; b) its use in government contexts is clearly a response to the defining of "coloured immigration" (the older term) as some sort of special "problem" since the countries defined as New Commonwealth roughly coincides with the "origins" of black people; c) it is counterposed to the favoured "old" Commonwealth countries which equally coincide with "white" (i.e. Australia, New Zealand and Canada) and d) it is closely linked with the definition of "patrial" in our immigration laws, the clearest expression of racism in those laws.

Terms which refer to groups within a larger grouping.

"Black people" (or the less favoured "ethnic minority groups") are overall terms and clearly have to be qualified or replaced when particular groups are being referred to in a context which requires specificity. Here one must be aware of differences in context and purpose. In some contexts full attention to "differences within" broader groupings is necessary; island or country of origin loyalties or religious differences are real and important and other peoples' sheer ignorance of them can well be insulting. In other contexts, emphasis on differences can be used as a divide and rule tactic by people who want to stress inter-group differences for purposes of opposing reform and change. For example, in our study, it was argued to me that differences among Asians prevented the provision of appropriate diets for various people who needed them. In our report we have used several terms to describe groups within the larger categories.

Afro-Caribbean. This term is used sometimes to denote black people born in the Caribbean and black people of Afro-Caribbean ancestry. Since almost all (being middle-aged and elderly) our Afro-Caribbean interviewees were actually born in the Caribbean, then in this report this term almost always means that group. Because as a term it does not have an "easy" plural form we have sometimes used the term "West Indians" interchangeably. This may not be entirely satisfactory - readers should certainly be aware that "West Indian" would be even more inappropriate for Afro-Caribbean ancestry people born in Britain. Because in a sample of 100 the number of non-Jamaican ancestry people is small, we have rarely referred to island/country origins.

South Asian/Asian. In most parts of Britain, and in many readily understood contexts "Asian" has come to mean people from the Indian sub-continent and

people from East Africa of sub-continental origin, largely because these are clearly the most numerous group of 'Asians' in Britain. But in America for example 'Asians' would conventionally mean people from the China/Japan region, and the same would be true in some parts of Britain. Asia is, of course, a huge continental region, and probably, on a world wide basis, people from the massively populous tracts of Russia (or rather the Soviet Union), China and Japan would be the most immediate connotation of 'Asian'. To make accurate distinctions (including in parts of Britain where Malaysians, Vietnamese and Chinese are numerous), other terms are regularly used. South Asian roughly corresponds with the area described as the Indian sub-continent.

In our report we have used South Asian to refer to people from India and neighbouring countries, and to people from East Africa of sub-continental origin. The confusion with the more general 'Asian' - especially given the number of Vietnamese in Bristol - is thus avoided. However it did seem tedious - once having established that this was the group to which we were referring - to keep on repeating South Asian at every juncture. So we have, as the report progresses, in several instances simply used 'Asian' taking it for granted that by then readers understand 'Asian' in our report to refer to South Asian. Readers should also recognise that there are several important country-of-origin, religious and language differences within the general category South Asian, but, again, numbers of particular groups were often too small to require reference. It does not assume particular significance in our report, but we should also note that another sub-division of 'Asian' is South East Asian which refers to the region encompassing such countries as Malaysia, Vietnam, Thailand and the Philippines.

A Final Comment on 'Ethnic Minorities Groups'.

One instance where 'black people' would seem to be an inappropriate alternative to 'ethnic minority groups' is where we might want to include white minorities such as 'Irish', a grouping which assumes importance in London and has been reflected in policies of the GLC. Groups other than Afro-Caribbean and South Asian certainly form an important part of 'multi-ethnic' or 'multi-racial' Bristol and Britain, but in our study we confined our attention exclusively to these two groups. Readers should note that the term 'New Commonwealth' (in the Census - see above) would certainly include a considerable number of white people from different regions of the world, in Bristol but more especially in some other parts of Britain.

SECTION 1

The People of Central Bristol: Birthplace and Age

The broad outlines of central Bristol demography are well-known among researchers and administrators who rely on the city-wide and small area data of the 1981 Census. We do not here add a great deal to what is known, except for our specific focus on the elderly of New Commonwealth origin.

The study focussed almost exclusively on four centre-city wards. Approximately one half of Bristol New Commonwealth and Pakistan-origin population live in the city centre wards: District, St. Pauls, Easton and Eastville under the old boundaries and Ashley, Lawrence Hill and Easton under the new. The degree to which New Commonwealth-origin residents of Bristol are concentrated in these wards has fallen since 1971, although much of the "spread" has been to contiguous wards such as Bishopston. There are only five wards where the NCWP representation is at or above the city wide proportion (4%). In the most "concentrated" ward (Ashley) just a little more than 30% of the population is of NCWP-origin. The great majority of residents in the central city area are British born whites. Equally one should look at these statistical figures the other way round, e.g. about one half of Bristol's NCWP-origin population live in wards other than those mentioned. In particular the South Asian-origin population is more spread than the Afro-Caribbean population and this is clearly true of the South Asian elderly. The Afro-Caribbean elderly are at least as concentrated in the central wards as are the general Afro-Caribbean population, though it is likely that some parts of the central area contain more elderly West Indians than others - for example parts of Montpelier contain streets where early West Indian migrants settled and still live, now being in their fifties and sixties. By contrast some elderly of South Asian origin will be living away from the city centre,

having arrived relatively recently and settled with families resident in other areas of Bristol. City-centre South Asians are more likely to be Pakistan-origin and Moslem than is true of the broader South Asian population of Bristol.

The other main change which has occurred in the socio-demographic pattern of NCWP-origin residents of Bristol is that the proportion actually born in the New Commonwealth has (understandably) fallen considerably over the last decade or so from more than two thirds to about one half and therefore (city-wide) the representation of Afro-Caribbean and Asian people in the population is about 6% in the younger age groups as against 4% overall. In past years the representation of older NCWP-origin (and almost always in fact NCWP-born) people has been very small, certainly as a proportion of the total elderly, and also as a proportion of the NCWP-origin population. Now, however, the proportion of elderly among the total NCWP-origin population is rising all the time and quite considerably. Nationally the trend is quite clear - the elderly as a proportion of all NCWP-origin population is fast approaching the pattern in the general population. The Census indicates that there are some 87,000 "elders of the ethnic minorities" in the U.K. in 1981 and another 300,000 in the 45 to pensionable age group, many of whom will enter the ranks of the elderly in the next decade. Women outnumber men in this elderly and ageing NCWP-origin population.

Already, in Avon and Bristol, this growth in the ethnic minority elderly is making itself apparent. Including Irish and 'Rest of the World' origin residents there are over 3,500 ethnic minority elderly in Avon with probably about 1,000 of them being of New Commonwealth origin (1981) some 500 or more of them living in Bristol. In the New Commonwealth rising elderly (45 to p.a.) age group there are more than 3,000 in Avon, some 2,250 of them living in Bristol. All of this represents a substantial presence of elderly people of New Commonwealth origin (and other 'minority' origins) with every indication from the numbers of people in the next oldest age group that this

presence will grow very considerably in the present decade. Projections based on several indicators suggest that by 1991 there will be about approximately 1,675 persons of NCWP-origin over the age of 60 in Bristol and about one third of them will be over 70 years old. In other words, for the first time in recent British social history, Bristol and Britain will have a very substantial Afro-Caribbean and Asian elderly population. Indeed that presence is considerable now - but in the present decade not only will it grow but also it will be a population containing a much higher proportion than at present of the older elderly people more likely to be beset with the problems of frailty and disability.

This adds a new dimension to social life, social services and health services in many ways. Above all the elderly (of Caribbean, South Aisan origin) themselves will be facing the difficulties of growing old in British society and their younger family members will be facing new difficulties and new choices. Some of these elderly will return to their country of birth (or to other countries) but many, probably most, will not, and will grow old in a country where they did not (in a considerable number of cases) expect to spend their later years. And then this socio-demographic change adds a new dimension to the work of those involved in social and health services of all kinds. If an elderly Asian woman enters a home for the elderly, what should be done if she is the first and only Asian lady in the home and does not speak English? Are patterns of health and illness likely to be different among the elderly of Caribbean and South Asian origin? With our special focus on the elderly, these are some of the questions raised by our research.

We should also note that whilst at present the South Asian and Afro-Caribbean elderly in Bristol are about equal in number, the Afro-Caribbean 'share' of the NCWP-origin elderly will grow by 1991 to outnumber the South Asian elderly because of the larger number of Afro-Caribbean people in their fifties at present and the likely slowing down of the arrival of South Asian elderly as dependants of families already here. This is important to note

because it is, for the most part, only the peculiarities of British attitudes and practices, speaking of "coloured immigrants" and, more recently, "ethnic minorities", which take all non-white UK residents together in this way. Of course many Asian and Afro-Caribbean people seek to stand together against racial prejudice and discrimination; but in important respects (say with regard to planning service provision) the inter and intra-group differences are vital.

Notwithstanding this focus on the elderly, this report embraces the needs of NCWP-origin of most ages. We knew that we could not confine our 250 interviews to the over-60s so we did ask interviewers to speak to the elderly where possible and when not, to speak to an adult member of the household. Our research is therefore not exclusively about the elderly but, as we shall see, it is "biassed" towards the older overseas-born generations of New Commonwealth-origin residents of Bristol.

SECTION 2

The People who Spoke to our Interviewers

The basis of this research report is the 253 interviews conducted in the summer and early autumn of 1983. Each interview lasted on average about one and half hours and in almost all cases interviewer and interviewee were 'matched' for language and ethnic origin. The data from these interviews has been recorded and stored on a computer (anonymously) and much can be told from the aggregate accounts of computer-based analysis. But, beyond this, I have read every interview account page-by-page and this report attempts to combine the best of analysis in an aggregated form with the richness of living accounts told by people as they responded to particular questions. Anyone reading the accounts as I have done would reach the same conclusion about these interviews. The interviewers went about their work in a very sensitive way, recorded as faithfully as possible what they had heard, and genuinely engaged the attention of the respondents; equally those interviewed gave generously of their time and spoke with great vitality about their feelings, thoughts and experiences. To read them has been exciting, stimulating, though sometimes saddening if not depressing. There is in these accounts warmth, sadness, anger, contentment and all manner of hopes, disappointments and fears. Much of what we were told can be quantified (e.g. have you visited hospital on your own account in the last twelve months?) but much cannot. But where I am suggesting things which go beyond bare figures and numbers, readers can be sure it is based on a close reading of the remarkably open responses of the interviewees.

A small number of people we interviewed were born outside the United Kingdom and were not of Afro-Caribbean or South Asian origin. But for the

purposes of this shorter report, the best way to remember our sample distribution is to say that we interviewed in the central wards 100 Afro-Caribbean, 100 South Asians and 50 whites - and this is almost exactly correct. Among Afro-Caribbean respondents there were rather more women than men, among South Asians the reverse; and almost all in these two groups were actually born in South Asia or the Caribbean. A few in both groups were in their late twenties or thirties, but most were middle aged or older adults. A third of the West Indians were over 60, only a fifth of the South Asian people were of this age. And most of the under-60 year old West Indians were over 45, whereas the under-60 year old Asians were more spread through the later thirties, and the forties and fifties. Over 40% of the whites were elderly but most of the rest were younger, the 45-60 age group being particularly low among whites of our sample - and possibly in the population of this area. All interviewees were from the four wards/plus Totterdown which were originally designated and all but 18 replacement addresses were taken from the selected enumeration districts.

Most of the West Indians who talked with us in this study were Jamaica-born, though a small number came from islands such as Barbados, Trinidad, and Dominica. A high proportion of them, men and women, arrived between 1955 and 1960 and have, therefore, lived and worked in Britain (and mostly in Bristol) for twenty-five to thirty years. Some of the interviewees of South Asian origin have been here a long time, even including some who came before the war, but most came to Bristol in the 1960s and many have arrived even more recently, in the last ten or fifteen years. Given the known pattern of settlement, it is not surprising to find that women, and some of the elderly predominate among the more recent arrivals. Except for a very small number of older West Indians who have recently come to join their daughters or sons, almost all the recent arrivals are South Asian.

Pakistan-origin people are fewer than India-origin people in Bristol as a whole and Bangladeshi representation is relatively small. But in our sample - reflecting the central city sample basis[1] - Pakistan-born and India-born Moslems predominate, to the extent of about two-thirds. Most list Punjabi and Urdu as their 'home' languages, Punjabi being more commonly spoken in the household, but Urdu is favoured by some as a first language and as the language they wish to pass on to their children. Few of East African origin appeared in our sample, and most of the South Asians in our sample who were not Muslims, were Sikhs. Most of the white respondents were UK- born, indeed a majority were born in Bristol, many very close to the areas in which they had lived a great part of their lives. The non-UK born were all from Ireland, and of course the non-Bristol born included several from South Wales and London areas.

These are the people who spoke to us, for the most part so freely and openly, a tribute both to them and to our interviewers. At the end of each interview we asked people if they would like to comment on the interview itself. Not suprisingly this brought a number of wry comments - "a waste of time", "too long", "I've had these things before" - plus possibly a small majority of "no comment". More striking were the large number of people who said "I enjoyed it", "About time they asked us", "Should have done it ages ago", "Nice to know someone wants to know what we think", "Haven't had such a nice sociable afternoon for a long time" and more cautiously "all right if something comes of it", "Hope it does some good" and "let us know the results". I feel indebted to these people and the interviewers. I hope it does some good.

---

1 Sampling was based on "every seventh address" in 15 enumeration districts (in the central wards) having the highest proportion of elderly ethnic minorities (plus a sub-sample in Totterdown). The concentration on adult and elderly residents was achieved by instructions to interviewers in respect of their visit to a designated address. It is also to be regarded as a sample of central city residents, in less prosperous wards, and not representative of all areas of the city.

SECTION 3

People Speaking: A presentation of things said to us by interviewees, speaking about their expectations, their hopes and their fears

We have placed this section "People Speaking" towards the front of the report because of the importance we attach to what interviewees themselves said, as against what we, the researchers, say in our summary of answers to questions. There is great value in being able to represent summary data from a sample of people, especially with regard to questions which evoke a straightforward answer of a 'yes' or 'no' kind. For example, we are able to say what percentage of a group "live alone", or whether answers to a question differ significantly as between the younger and older members of a group in the sample. This provides us with an accurate guide to the scale of a particular difficulty (e.g. the extent of social isolation reported by a section of the sample) and a guide to the range of views found on a particular issue. But if all or most of our report follows this format, the thoughts and views of interviewees - as they expressed them - tend to recede into the background. This would misrepresent the documents (the interview records) on which this report is based by excluding a vital part of them - the longer statements in which interviews put forward their own views and described their experiences, in many cases by departing from the format of questions as designed by the researchers.

Of course, people view and treat interviews in different ways. Some people are sceptical, or tired, or busy and consequently answer questions in a routine and minimal way. Others seize the opportunity of the interview to "say what they have always wanted to say". In the present section the predominant voices are those of the interviewees and we have added little or no comment. All that the reader needs is some brief explanation of how the

assemblage of quotations was put together. We were very much influenced by the fact that, especially in the Afro-Caribbean and South Asian interviews, certain themes and messages appeared to be common to many interviews, and that these themes showed through in response to several quite different questions. The frequency of these themes surely indicates that they 'were on the minds of the interviewees' and this itself accounts for the fact that the themes appeared in response to different questions. If we summarised our data "question by question" the strength and importance of these themes would be missed.

A good example would be reporting on what people say about racism and racial discrimination. In one group of questions we asked about these things directly and many people answered not only in a formal way but also with considerable added comment. Other people say little in response to this section, but 'open up' in response to questions about "the area in which you live" or about "what you hoped for when you came to Britain". Reporting in this way also makes allowance for the fact that people see things in different ways. A significant number of people respond to a direct question about discrimination by saying that "I wouldn't like to comment on that", but we may find that the same interviewee makes highly relevant comments elsewhere in the interview. Some of our interviewees no doubt felt that we (in asking about racism) were asking about face-to-face abuse, and treated broader questions of racism quite separately. Thus one Indian man told us that he had no experience of racism - his only worry was 'being thrown out of the country'.

This section - in highlighting recurring themes of the interviews - also permits us to show readers that there <u>were</u> certain questions which were uppermost in the minds of the people to whom we spoke, and to show what these themes were. In the case of the Afro-Caribbean and South Asian interviews, two broad areas of concern became clearly evident to me as I read my way through the interview records. Among Afro-Caribbean interviewees - many of whom, as we have reported, were late middle aged and elderly - the prospect of

spending their later life in the cold climate of Britain, coupled with thoughts of their previous homes in the Caribbean, were the topics around which many of the comments of a general and revealing nature were grouped. Among South Asians, fear of attacks, insecurity of an immediate nature and in relation to tenure in Britain, and worries about the future of their children, appeared and re-appeared throughout the interviews. In concentrating on these comments we are under-representing the comments more specifically directed towards particular issues - such as the health service - but we have drawn on these comments in the relevant section and will do so again in future reports.

In the parts of the present section which now follow, "Living with racism: South Asians' experiences in Bristol" is drawn from South Asian interviews; "Settlers, soujourners and trespassers" is drawn from Afro-Caribbean interviews; and "White on Black" is drawn from interviews with whites. Two small prefacing remarks are needed: One is that all the comments quoted are from different individuals except where we state otherwise, so a large proportion of <u>all</u> interviews are represented here, excepting only those who made little or no comment on the relevant issue. The second is that, in some of the questions, we used the term 'immigrants' and in some respects this was not, in retrospect, the right term to use, especially where we were seeking to uncover attitudes and experiences with reference to 'race and racism'. It is a well-known error, of public discussion of these questions in Britain, to confuse and compound 'race' and 'immigrant'. To some degree I think we have fallen into this trap. But in two ways we may regard the terms we sometimes used as justified, or at least as not significantly distorting the responses. The first is that, with regard to the ethnic minority respondents, practically all, being older, were in fact born abroad, and viewed their experience as the experience of people who had migrated and settled in a new country (and knew that 'race' was a central dimension of 'immigration' issues in Britain). Secondly most white Bristol residents to whom we spoke readily translated a question which used a term such as

"immigrant" to include a whole range of issues associated with immigration, race and minorities. This does not altogether excuse the error of some of our questions, but it does indicate that little, if any, distortion, occurred.

Living with Racism: Asians' experiences in Bristol

When asked about race, racism and discrimination, some Asian interviewees obviously felt that it was unnecessary to go into great detail - racism was everywhere:

> "Yes (we find) racism in day-to-day life - the English treat you as inferior. There are racist attitudes in every field, especially in the media." (Man, aged 41)

This was often linked with a very common anxiety about preserving a valued way of life, threatened in this country

> "There is racism among the British - in education, job opportunities - and we worry about maintaining our culture." (Man, aged 52)

and

> "We worry about racism in Britain and about our childrens' future, job-wise, marriage, and maintaining our culture - and with the attitudes of the British generally." (Man, aged 51)

> "I worry about eviction . . . about dying in this country, and about my children not being true Muslims . . . We would like to have more respect from the second generation and also to be treated as individuals by the host country. We do not all look alike." (Man, aged 53)

As several quotes will show 'eviction', being 'thrown out' are widespread anxieties among Asian people, as in the case above. One man (aged 45) simply said he had "difficulties with immigration", others were more specific:

> I worry about being evicted from this country." (Man, aged 36)

Perhaps as telling, some only felt more secure now that they had acquired passports:

> "I used to worry about eviction, but now that I have my British passport, and so has my wife and children - I am not so worried." (Man, aged 42)

Whilst another middle aged Muslim man told us of his "immigration worries" generally, some - indeed many - had very particular worries about members of their families:

> "(Some of) my children were not allowed to stay here. These children were born here and the Home Office sent them back to Pakistan last year." (Man, aged 48)

Asians living in Totterdown seemed less anxious about their 'area' but readily spoke of problems elsewhere:

> "People living in other areas like St. Pauls and Easton face a lot of racism. We are worried about our children in these areas, and that they and women are scared to go out late evening." (Man, aged 55)

Fear about immigration and about abuse and attacks emerge clearly as recurrent concerns among the Asian residents of central Bristol and several people told us in some detail about <u>both</u>:

> "My daughter-in-law hasn't been given nationality - she has been refused. We tried for six years, now I have given up . . .
>
> "They abuse us racially - say things which hurt us - we are often called Paki. The English have a very racist attitude. My son is discriminated against in job applications." (Man, 57)
>
> "It took me six years to bring my wife. I would like to bring my mother for a permanent stay but can't due to immigration rules - she can only come as a visitor . . .
>
> "I was rebuked by a nurse in the maternity hospital for taking Asian food for my wife . . . I had a heated argument with her . . . she said I couldn't bring 'smelly food' onto the ward . . . I wanted to make a formal protest but friends persuaded me it was no use . . .
> We are very often racially abused by English people - they made threats on many occasions, swearing and so on . . . 'Pakis' is very common . . . I feel like a stranger". (Man, aged 44)

Later in the <u>same</u> interview this man told us:

> "these people treat us with so much contempt and hatred. They think we have taken away their jobs, houses - while we work day and night to earn a livelihood. The present economic climate makes worse the tension and racism. This kind of situation and racism worries me all the time . . . Yes, there are differences among Asians, and West Indians. I wish people would see how we are all victims of racism and discrimination" and he added that he had been required to show his passport to claim maternity allowance for his wife.

Immigration worries and violence appear together again - and this man added some comments about fighting back:

> "My application for British nationality has been refused . . . Our shop was broken into three times - the police came very late and the alleged culprits arrested and sent to prison but we got no compensation. And I was involved in a car accident due to drinking and driving by another man, but nothing has been done. I got no compensation and was very unhappy with the attitude of the police . . . Yes, Asians are too pacific - accept things easily - West Indians fight for their rights. There are differences . . . but we all have the same problems because of our colour." (Man, aged 54)

Still more mention their anxieties about attacks and racism:

> "This area is no good - too much trouble with the West Indians. In this area we do not get on well . . . I don't know why not." (Man, aged 31)

> "My children are unemployed because employers prefer white people . . . It is only with the skinheads that we don't get on - I got attacked by a skinhead myself." (Man, aged 50).

> "Thieves have broken in here - we would like a better area . . .
> Immigrants' wives face greater problems with racism because they are females and subjected anyway, because they are not educated, and because their costumes are different and stick out." (Man, aged 37)

Indeed profound anxieties about "our women and children" were clearly and repeatedly evident, and at least as much about violence as about cultural concerns like wanting "lady doctors for women." (Man, aged 56)

> I miss my wife and children who cannot be with me . . . We worry about attacks on our women and children . . . I had this sort of interview before in London when I asked for help to bring in my family but nobody did anything." (Man, aged 57)

and

> "Our friend's shop was broken in and the police were informed. They did not pay proper attention; instead suspected us for the break in . . .
> The most worrying thing is racial attacks on small children in school, and women. One of my relative's house was broken into by skinheads in London . . . We don't feel secure because of police apathy." (Man, aged 41)

and

> "I am very worried about my future and childrens' welfare." (Man, aged 52)

Whilst one man whom we have already quoted told us that "English doctors never try to understand our customs and habits" another told us bluntly:

> "My doctor is a racist."
> "The doctor I (sometimes) see, Dr. ....., is very rude and sometimes, even . . . I am very bad I do not go to the surgery." (Man, aged 64)

As we reach some of the female interviewees we find that though women were more vocal about such things as health services, the same anxieties about immigration 'eviction' and mere survival in a situation of a perpetual harassing insecurity came to the surface:

> "We worry about surviving in this country now that inflation is so high. . . and also about being evicted at a moments notice." (Woman, aged 46)

and just as starkly

> "I worry about the government suddenly throwing us out." (Woman, aged 48)

> "I worry about harm coming to my children here . . . and about my pension - I need help . . . Is this interview going to help me?" (Widow)

One middle aged woman was reluctant to talk about 'racism' (but did say that she had 'suffered job discrimination'. She was even more concerned about struggling to assert 'our rights':

> "Black people are braver, stronger than Asians - even the police are frightened of them . . . Asians should bond together more. Asians don't know their rights - such as about immigration - and there are not enough trained Asian social workers." (Woman, aged 46)

Yet another woman echoed the things said by men about attacks:

> "When my children come back from school, English children make trouble with them, call them 'paki' and 'blacks' - some time he comes home crying. One day my older son and his friends were playing in Victoria Park and they were abused by skinheads and then there was a fight and he came home bleeding . . .
> A friend of mind said when her daughter comes to Mosque to pray, children outside spit on her and abuse her." (Woman, aged 41)

Some comments were briefer but none the less distressing:

> "A lot of people say immigrants have problems in St. Pauls and Easton." (Woman, aged 40)

and

> "Our house needs repairs but the council don't want to know . . .
> "I have an unmarried daughter and I worry about assaults on her, I do not let her out" and this widowed woman had to 'show my passport to get my husband's pension'." (Woman, aged 54)

and

> "My husband is unemployed, depressed, violent . . . Pakistanis are less educated and subject to worse racism." (Woman, aged 47)

and, simply,

> "I want my children to join me in Britain." (Woman, aged 25)

For some the overwhelming distress was painfully evident:

> "My husband is dead . . . I am depressed . . . and very worried about DHSS . . . There is racism amongst English and West Indians . . . Solve my problem, I need too much help, I am a widow and fed up of this life. I want to know when you are going to help me." (Woman, aged 60)

Social Security and plain physical security are a constant theme:

> "We have not had DHSS for five months . . .
> Local English and black people always cause trouble. My house has been robbed and our van was stolen twice and I cannot take my children to the park because other children throw stones and say 'Paki'." (Woman, aged 54)

> "I am scared to go out at night because people like me have had broken windows and thrown stones and robbing in this area." (Woman, aged 44)

Some had little to say, and fear and insecurity almost certainly was the reason in several cases like the Muslim woman (aged 25) who told us that "she didn't want to cause any trouble"; and a Muslim man who simply spoke of "job discrimination"; and an Indian man (aged 25) who told us about having to show his passport for medical help and employment.

Perhaps some of the most indicative remarks came from a 45 year old Indian man whose whole interview record told a story of relative success in settling and finding employment. To many of the questions which had brought

forth evidence among others of great anxiety and concern this man had replied that "this is ok". But despite his steady job he told us:

> "I constantly worry about unemployment."

Apparently well settled, he told us, when questioned about racism:

> "I have no had such difficulties" but he added "I do worry about being evicted from this country at a moments notice." (Man, aged 45)

Like several others, an Indian man told us of antagonism between West Indians and Asians as well as about trouble with English people:

> "In this area we are having problems with West Indians as well as British. My home was robbed twice and one day somebody was trying to open the window and we woke up . . .
> "I enjoyed this interview with a person of my own race and language." (Man, aged 59)

and, very briefly and simply,

> "People in St. Pauls are scared." (Man, aged 51)

The apathy of the police is mentioned again:

> "Our worries are robbings, mugging, being called names. Police don't help us Indians. They help white people." (Woman from Kenya, aged 31)

and

> "Racism? . . . yes, in jobs . . . colleges . . . the police . . . This interview is a waste of time." (Woman from Kenya, aged 30)

Two more people told us about job discrimination by telling how they had to abandon their turbans, and another man told us of having to produce his passport when claiming sickness benefit. And, rather like the 'relatively secure' Indian man (above) one woman reflected the fears of others (of eviction) in discounting it:

> "I do not worry about being evicted from this country nor do I think the government will allow it." (Woman, aged 43)

An elderly Hindu woman from India agreed that there were racist attitudes among the British but told us she had "nothing to say". And a 31 year old Sikh woman just told us "I cannot bring my mother because of immigration rules".

The more we read these interviews, the more a single theme impresses itself on our minds - insecurity, uncertainty, of a material, physical and spiritual kind:

"I am depressed . . . and unemployed for 8 years. Immigrants face a lot of racism in Easton and St. Pauls." (Man, aged 57)

"Unemployed and face discrimination getting job." (Man, aged 26)

"Most immigrants probably worry about finance and deportation." (Man, aged 38)

"Ill health led to my getting the sack . . . British are racist . . . but I can't say how." (Man, aged 47)

"Good jobs are available to whites and not us." (Man, aged 47)

"I had to show my passport for benefit - and was very annoyed." (Man, aged 49)

"I couldn't get a job wearing my turban so I cut my hair." (Man, aged 39)

"Racism? well . . . you get silly remarks at work . . . The treatment we face from employers, from police, as well as in public places, is always discriminatory . . and I had to show my passport to get a job." (Man, aged 30)

"Our problem is our colour." (Man, aged 73)

"I had to show my passport for medical treatment." (Man, aged 63)

"My son suffered job discrimination because of his turban . . . we are all victims of discrimination." (Man, aged 63)

"Our house is damp, the area is not good . . . Racism? I have nothing to say." (Woman, aged 65)

"I had to show my passport for the doctors and family allowance." (Woman, aged 27)

"We worry about law and order, unemployment. I had to abandon my turban." (Man, aged 70)

"All my hopes are shattered." (Man, aged 64)

"Difficulty with immigration regulations . . . yes <u>obviously</u> we do. Racism? I don't want to say anything because I don't want to involve anyone." (Woman, aged 51)

> "After 33 years. . . this country holds no surprises for me . . . Racism? Live and let live, that is my motto, I do not like to mention anything. I worry that upheaval among blacks and whites will lead to us being ordered out of this country." (Man, aged 61)

Immigration rules, eviction, insecurity, violence, abuse, unemployment, job discrimination, being required to show passports for daily matters, police apathy, and plain worries about survival - these are the stories told by so many of the people.

"I don't suppose anything will come of it -

but its worth a try".

(A black woman commenting on our interview)

Settlers, Sojourners, Trespassers

Throughout the Old Testament, God is reminding the Israelites that they were once 'strangers' in another land so as to remind them of their own obligations to strangers in Israel.

Exodus, 22:21	Thou shalt neither vex a stranger nor oppress him: for ye were strangers in the land of Egypt.
Deuteronomy, 24:14	Thou shalt not oppress an hired servant that is poor and needy, whether he be of thy brethren or of thy strangers . . .
Leviticus, 19:33	And if a stranger sojourn with thee in your land ye shall not vex him But the stranger that dwelleth with you shall be unto you as one born among you, and thou shalt love him as thyself; for ye were strangers in the land of Egypt.
Deuteronomy, 10:19	Love ye therefore the stranger; for ye were strangers in the land of Egypt.

God is exhorting his people to treat sojourners and homeborn alike, to subject them to the same laws, the same justice, and to make judgements between brothers and between strangers according to the same just principles.

The sojourners may be in the position of hired servant; treat them well, you were hired servants in Egypt. As generations pass, you shall all be one people together.

A 67 year old woman, born in Jamaica, having lived in England since 1967, now lives alone in an Elderly Persons Home in St. Pauls. She had one child, and two grandchildren living in Bishopston. Her parents died some time ago in Jamaica. She would have liked to return and help them in their old age but she was unable, through circumstance and financial difficulty, to do so. Even if she still had an elderly parent, she could not afford to bring them to England and expect the government to look after them. We asked her if, among the difficulties she faced and knew of, were disputes and suspicions between differing groups of settlers and immigrants.

> "No . . . we may criticise each other, but we realise we are all foreigners trespassing on someone else's land."

A 64 year old woman, born in Jamaica, has lived in Britain almost 20 years. She now lives alone, her parents died in Jamaica. She has 7 children, 2 in Bristol, 2 in London, 2 in America, and 1 in Jamaica, and 14 grandchildren. Her life as an elderly person is not as she expected or hoped.

> "I didn't really expect (things to be like this) . . . being housebound and alone. The worst thing about it is my health and being housebound. The best thing would be in a position to go home to Jamaica."

Looking back on her life here

> "I felt I was never welcomed here, though I gave my services - I always felt like an outsider."

Difficulties <u>between</u> immigrant groups are <u>not</u> the problem;

> "No - the only problems stem from British attitudes."

Another woman born in Jamaica has also been here about 20 years. She lives with her husband, has 2 children in England, 1 in Jamaica, 2 grandchildren in England and 4 in Jamaica. We asked her to reflect on the life her

parents experienced in their old age, compared with what she now knows here.

> "Their life was better, they were happy. In this country we have financial worries with winter bills. In general their life was more self-sufficient. I had expected a more relaxed life after all the years of working in this country. Family things are difficult and the pension is too low to live on. My family (in the UK) is in Birmingham, my home here is damp."

Has the 'sojourner' been welcome in 'some else's land'?

> "Immigrants like myself can't ever feel completely relaxed in this country. This is not our home, I don't feel as I would back in Jamaica."

A 69 year old woman from Jamaica told us she had few family members to call upon either here or in Jamaica. But 'all her friends' are here and she is supported by contact with her 'church sisters' being a member and regular attender of the Pentecostal church. She worked for many years as a domestic in a hospital in Bristol and some years before she retired she was attacked by a patient. "I was physically abused by a patient from which I feel I indirectly suffer - I had no compensation". She suffers from cataracts and a heart complaint, the latter she feels directly or indirectly resulted from the physical attack on her, and was not diagnosed by her 'family doctor'. Her complaint went untreated until she visited a doctor privately.

Social services staff had visited her and asked if she needed help, for example with repatriation. The interviewer reports that, like other black Christians, she replies "If God will it, then it will be". The Social Services, the interviewer reports, came to regard her "as stubborn and senile".

She lives in fear. She is desperate to move and lives in constant fear of being burgled. More than once her home has been broken into, the electricity supply damaged in an attempt by a burglar to foul the alarm, and now has no heating other than a paraffin heater. The telephone across the street does not work and she has been promised (but not received) one in her

home. She fears attacks, break-ins, the cold, and has 'ladies of the night' for neighbours.

Were there difficulties between immigrant groups? No, she replied "we are all foreigners".

A man from Jamaica, aged 45, has been in Britain since 1958. He says

"I know I will go home one day, its just the money"

and

> "I pray to God I don't die in this country . . . (which) discriminates against the old. I would rather go home where the old are respected."

Differences exist between different groups of settlers and immigrants but they face white racism together.

> "All blacks are from Africa so they shouldn't see black people from other islands as different. Also Asians are different but they do face many problems blacks do. The biggest problems is blacks and Asians against white racism."

A 29 year old man from Jamaica came to Britain in 1968 and now lives alone. He believes that life in the West Indies is better.

> "The longer we remain in England the greater we lose our bearings. The racist attitude of society will never change. If you're not wanted, prepare to leave."

Many people in Bristol from the West Indies came in the nineteen fifties and sixties and are now aged fifty to sixty, facing retirement and old age in Britain. One such man came from Jamaica in 1969 and is now 53 years old. He lives alone and is not in touch with many of his relatives. His parents died in Jamaica, he has some relatives in the USA, and has five children, 2 in the UK and 3 in Jamaica. He has suffered medical problems and difficulties in his relations with his doctor. He told us of the "prejudice which social workers display towards mixed race children". He thinks of returning to Jamaica ("this place is under seige, there are no council repairs, it is being left to

rot") but worries about his "mixed race children", his illness, and the lack of support for him in Jamaica.

He gave us his thoughts on approaching old age;

> "Life will be very lonely. Especially as friends die and children grow more away from parents. The authority will treat the elderly worse than they do now. I had hoped to be able to relax. But I know friends will not be around all the time, it will be very lonely without them. Although black and white go to church together, they are worlds apart."

So for many West Indians in later life, reflecting upon their years here is reflecting upon sadness, disappointment and dashed hopes. Much of this is disappointment in their expectation of England as a Christian country and as the mother country.

> I thought this was a God-fearing country . . . I thought I could save. At the end of our working life we are thrown on the scrap heap."

One Jamaican man, aged 59, having come in 1959, went to Jamaica a few years ago and built a home for his mother. He lives alone in Bristol. His mother is happy in Jamaica.

> "My old age, if I remain in England, will be much worse than what my mother enjoys, or the white elderly in the UK . . . Black people are already lost wanderers. The young black people do not care for the elderly, there is a lot less love and care."

He told us about contact with the DHSS:

> "I have seen DHSS officers treated with disrespect by both blacks and whites - but the officers treat blacks, especially the single parent, with contempt. I heard one say 'you people have children like flies, say you have no fathers, and live off the state'."

There have perhaps, in the past, been difficulties between 'immigrant groups',

> "But now Asians and West Indians realise we all have to stick together."

A 63 year old man from Jamaica came to this country in 1960 and hopes 'to go home when I retire'. He lives with his wife, they have no children, but have relatives in Jamaica. He went back to Jamaica in 1970 but came back to Britain 'due to circumstances' which he didn't describe. Commenting on

'racism' he told us "things were better at first, are now awful, there is more antagonism between blacks and whites" (several people told us they saw things getting worse in the last few years and linked it to the recession, the 'bad times'). He knew all the difficulties about going home, especially having made one abortive attempt, but throughout the interview seemed to be telling the interviewer (and, a close reading implies, himself) that he was going home whatever the outcome:

> "My wife doesn't want to go . . . but I'm going . . . I hope I'll go home as soon as possible; I'll have my family around me. Jamaica . . . I'm going home, job or not, I'm going"

and further

> "I want to go by 1985 or I'll end up in a mental home . . . I feel that the black elderly should try to go home, you have no use as an elderly person. Home is the best place for them, people will always help."

Could we help in any way? "I only want to know if you will send me home".

Perhaps the most striking of all, he ventured to say that black peoples' experience of racism depended on whether they perceived themselves as belonging in Britain:

> "Some people don't want to go home. They make racism a problem to them, they want to be treated fairly, <u>because</u> they feel its their home - but I don't care because I know I'm going home some day."

Yes there were differences among various groups of settlers but "we all have the same problem so we should learn to live together". Like this man, another (44 year old, arrived 1960) man from Jamaica, had no anxieties about 'differences between immigrant groups':

> "No - the only problem is between whites and immigrants . . . The English are always saying go back to your own country."

A 66 year old man from Jamaica, here since 1955, answered in much the same way to the same group of questions:

> "Things were a lot better at first, but times now are very hard. Most immigrants worry about their future in this country because of the immigration laws - we are not told of our rights . . . I believe it is white racism which causes problems; I have no problems with other immigrants."

A 63 year old man from Jamaica came in 1956. He now lives alone in a nursing home having suffered partial brain damage. His wife has left, he has one child in Jamaica, and all his family contacts have been weakened. He wants to go to Jamaica and see where his parents are buried.

A 47 year old woman from Jamaica, came in 1963, lives with her husband and children and 'would like to return to Jamaica eventually':

> "Immigrants worry about their kids, might get beaten up by white mobs, picked up by the police."

Friendship offers with white neighbours had been refused: "elderly whites next door suffer illness and need help - we offered but our companionship was refused".

A Dominican man, aged 59, who came in 1956 lives with his wife and has children in Bristol, London, St. Thomas and the USA. We asked how he viewed his approaching old age: "Terrible . . . I had hoped to go back and forget about life here". And Racism? "Yes . . . and I worry about the sort of life children born here are going to have . . . and the cuts in the NHS" the last being a worry mentioned by so many of our respondents, including many who had worked in the Health Services.

A Dominican born woman in her early sixties lived alone, her husband having died 25 years ago. We asked about her approaching old age, what might be "best" and "worst" about it.

> "Back home I would have had more people I can talk to. After working so many years in what I consider bad conditions and paying tax and the various compulsory contributions, I had hoped to live at ease both financially and socially . . . The best thing is that Praise God, I have struggled to bring up children on my own, I am still healthy and can watch my children grow . . . The worst is that after all these years black people are still not accepted and

> we are still considered dirty. The way our pension is calculated is unfair. Pension and supplementary benefit are seen in the same light and pension is seen, rather than as an automatic entitlement, as a prop for the aged. After all, we work for that money and we deserve it . . . In the NHS, with the cuts more and more people will suffer."

Many of these people told us of feeling trapped, trapped in an unwelcoming land, feeling as strangers, trapped by circumstances, with their families divided over several countries, wanderers, people who insulate themselves against disappointment, and hostility by seeing themselves as not 'really here'. The enduring thoughts about home, for West Indians, are both real hopes, plans, projects and wishes, and fading dreams which perform a comforting function for people who feel strangers in this land. These are people who have worked, and worked hard for a long time here - but who still feel they are "trespassers on someone else's land."

"I have found myself trapped in a country which
did not like me except for my work".

A 69 year old Jamaican woman, here since 1957, now living alone.

White on Black

Some of the questions on 'personal experience of racism' were not asked of white respondents because they were not considered relevant. But we did ask white interviewees whether they believed that immigrants to Britain suffered difficulties, including having to face racist attitudes, not faced by those born in this country (suggesting 'whites' rather than British born black people). This was not a direct attempt to 'measure' the respondents own racial attitudes, although of course the answers give us some clear indications of their thoughts and feelings on this issue.

We shall see that their responses grouped into four main categories:

1. Some clear indication that the interviewee accepted that black people would be likely to have to deal with racist attitudes and discrimination.

2. Mixed views which mentioned both 'difficulties' and 'problems they cause themselves'.

3. Answers which stressed that 'they cause their own problems' or that 'they seem to do all right'.

4. Genuinely 'don't know' and plain 'no response'.

Leaving (4) aside, we shall report the substantive answers of our white respondents and we shall see that, out of just less than 50 white respondents, all first three types of answer occurred with some considerable frequency. Hostile attitudes were expressed; but so were attitudes which might be described as understanding the presence of racism and discrimination in British society.

Among the first six cases we inspected, comments were relatively few, most not answering the question of 'racism' directly; a 34 year old woman just described the area in which she lived as 'rough'; a 37 year old white woman made no hostile comments but rather saw 'immigrants' as 'having problems'; a third woman (aged 31) showed a lot of interest in our study and said 'yes' there was racism in Britain; another was herself overwhelmed by serious health problems; and a 27 year old woman answered with considerable sensitivity to questions about racism.

A 29 year old white woman said that 'they make their own difficulties' and 'there is more prejudice between immigrant groups than between them and whites' and a 28 year old woman said that 'they do all right'. But another young woman, living in the central area of Bristol, said that 'this is a good area here' with a 'mix of races'. The mistrust that exists is 'caused by ignorance'. A 73 year old resident, a woman whose parents had come from Ireland, told us "I can remember how in the 1960s there were a lot of coloured nurses in the hospital and yet they occupy the same grade posts today, with

little promotion . . . " whereas another elderly woman said "they make their own difficulties . . . and get as good if not better than us".

An 81 year old woman agreed that there was racism in Britain, whereas another elderly woman (87 years old) said that she didn't think that immigrants faced special difficulties. A 76 year old woman felt that 'they get a good deal' and 'black youngsters cause trouble' and two more older women expressed general 'anti-immigrant' sentiments. A 73 year old woman, born in Cardiff began by answering our question by saying "well yes . . . like a lot of people hate the Welsh' and went on 'there is a lot of jealousy and immigrants work harder - the British are lazy'. A 76 year old white woman simply said that 'they are blamed when things go wrong'.

An 80 year old white man, in being asked about 'immigrants' and 'racism' was typical of the 'not so sure' kind of answers: "I don't know really . . . some say one thing, some say another". But a 73 year old white man said that he did not think that racism was a big problem; "They have a better life here than the white population - they get a good deal". Two further elderly white men agreed there was racism, one saying that 'it is caused by ignorance'.

An 86 year old white man (and a Labour voter) told us:

> "I don't like them so I don't know. They have got money so why should they bother - they don't work, they don't need to worry, its their own fault about racism, (what) they deserve . . . they should go back where they belong."

And a 60 year old white man says: "a lot of it is brought on themselves". But a young (30 years old) white man agreed that immigrants face racism in Britain and adds that the difficulties within immigrant communities are 'between generations, especially in the Asian community'. Similarly a 48 year old man said: "the difficulties are mostly with the police in this area, especially for the West Indian lads . . . and discrimination over jobs". He added that, rather than disputes within immigrant communities, "their problems are probably mostly with whites".

A 30 year old man (who didn't think racism was a big problem) reserved

his comments for the Asians:

> "They don't try to mix - they try to carry on as at home and this makes it difficult for everyone".

One young woman (24) made some particularly sharp comments about 'Asians' saying that 'the English don't have a Race Relations Board to go to'. She said that Asians were given money to start businesses and our interviewer (an Asian woman on this occasion) felt obliged to deny this. 'I am not a racist' the interviewer was assured.

A 33 year old white woman said yes, immigrants do face special difficulties and singled out "language, housing, health and social service staff'.

A middle aged white man, born in St. Pauls, now living alone, showed he was tired of the question "the media should leave it alone".

And finally, two younger white men suggested that 'they all hate each other' and 'a lot of problems are of their own making'.

SECTION 4

Family Friends and Social Life

We asked a lot of questions about family circumstances partly because there are some unresolved disputes in the literature about family life among Afro-Caribbean and Asian groups and partly because, in the absence of secure knowledge, social policy in some fields tends to proceed on the basis of unproven and possibly wrong assumptions. The most prominent assumption - which we found still 'thrived' among policy makers and administrators whom we consulted during our research - is that the great strength of extended family ties among Afro-Caribbean and Asian groups obviate the need for a variety of social services. An example will make this clear; we heard of a case in which an elderly Asian man was being discharged from hospital. Part of the consideration of his case rested on assessment of social support available to him were he to leave hospital. Almost certainly the support available was overestimated because of an assumption that an elderly Asian man was bound to be surrounded by many relatives who not only cared but had the facilities and abilities to provide the necessary care. No doubt among South Asian Families in Bristol this is commonly the case - perhaps more so than among 'white' families. But in this case the assessment was wrong. Social workers and physicians cannot simply assume that the strong attachment to extended family members - and the ability to act on this sense of attachment - never fails.

If Afro-Caribbean and South Asian people suffer from this assumption, they also suffer, in some instances, from an opposite type of stereotyping - that "immigrant" ("coloured, non-white, black" etc.) families are broken, divided, weak and themselves responsible for any difficulties they face. The most important message of this research - to general readers, policymakers, and physicians - is that neither of these stereotypes is true. The people to whom we spoke, white and black - talked about their hopes and fears for their

families, their joys and disappointments. Many had invested most of their lives in their struggles for themselves and their brothers, sisters, fathers, mothers and children and grandchildren. Some, despite great difficulty, had achieved that modicum of security and family cohesion which seemed some modest but satisfying reward for years of striving. Others had experienced difficulties which had caused many of the strands of their family life to snap under the strain. Even if we were able to imagine an England, a Britain without racial prejudice, we should be careful to remember that migration across continents imposes heavy burdens, some of which are accepted and expected (as they are by all immigrants) but others of which come as rude shocks. And, for the moment, it is difficult to imagine that England.

South Asians

Perhaps the common notion of the extended family is most strongly held about South Asian people and their children. The evidence of our study suggests that extended family households are more common amongst South Asians living in central Bristol than among white and black family households in the same area of the city. Measured in terms of "household membership" about one quarter of all South Asians to whom we spoke lived in households which contained more than two generations and/or spread "horizontally" across the same generation to include brothers and sisters and their 'in-law' families. Nothing like this could be found among white or Afro-Caribbean interviewees. But, we should note, almost 60% of the South Asian interviewees lived in households conventionally described as 'nuclear families' - parents and children. This does not leave much more than a small remainder who variously lived alone, or in small groupings less than the 'conventional' nuclear or extended family. And some among this third group are people who have experienced forms of family break up commonly not believed to exist among South Asian communities. They are relatively rare, but given the strength of emphasis placed on family cohesion, and the cumulative difficulties faced by

'isolated' South Asians - especially if they speak little or no English - when such cases do occur the consequences can be severe.

But, given that most South Asians live in 'nuclear family households' there is much to be said for paying particular attention to this group in our study. Undoubtedly among a substantial minority of this 'nuclear family' group, the lack of 'extended family' in the household is compensated by the presence of extended family at least in Bristol if not in fact in streets and in neighbourhoods close by. In some cases, for example, two sons may live in Bristol, and, where the custom is for the elderly to join the households of their sons, one son will have made home for the parents, the other maintaining a smaller household and making frequent visits. Yet others live in small family situations, whilst speaking of their wish to gather people together as members of a larger family group - but are thwarted by simple material difficulties. In each of these types of cases the extended family ideal is retained in practice or retained as an unrealised aspiration - and probably as an aspiration which will remain very difficult to achieve. But an even greater number among those who could be described as living in 'nuclear family' situations are people who do not have this compensating support of extended families in Bristol or even in the United Kingdom. Some among this group are people who have made some choice in favour of a smaller 'westernised' family group; but more in number are those whose families are divided by immigration regulations, financial barriers, and by the cumulation of external circumstances which have finally rendered any hopes they had, for family unification, very unlikely of realization. These include those who told us of having 'tried for years' to get their family members (older children, parents, grandparents) 'into Britain' but now "after six years I have given up". Others have found that sequences of events beyond their control - political changes, regulation changes, expulsions - and decisions taken at different times have resulted in families being spread to distant corners of the globe - England, India, Pakistan, East Africa and Canada. Extended family cohesion, responsibilities and duties survive among Bristol's

South Asian-origin people, and the ideal survives even more strongly. But for many, perhaps a small majority, it is no longer a living daily reality. This is not to say that smaller family units among South Asian people are in any way 'unsatisfactory', nor indeed that the extended family units which have survived are necessarily free of intra-family difficulty and tension. But it is certainly not safe to assume that all or most of Bristol's South Asian people are protected from all kinds of social (and personal) need by the secure embrace of the extended family. It is probably safer to assume that this embrace is being progressively weakened and that in the process of social and family change, whilst many will adjust with great skill, others will become casualties of this change, bewildered and disappointed, and will thus face other difficulties (of home, health, security, employment) without the guaranteed support of relatives.

A particular burden of social change is borne by the women of South Asian birth or ancestry. Most will have expected to relinquish the families ties of the family into which they were <u>born</u> once they married. But, particularly for recently arrived women, this separation is not easy to bear. Separation by a few streets or a village is one thing; separation by continents quite another. Of the women in this type of circumstance, many will be unable to speak English, and may well be facing the problems of coping with pregnancy, health and social service officials, form-filling, and household management, with many of the cards stacked against them. That considerable proportion (at least one half) of both younger and older Asian women who have slight if any knowledge of the English language face some of the most intractable difficulties, as later evidence on health services will show.

<u>West Indians</u>

In discussing the family/household circumstances of the West Indians in our sample it is important to remember that over three quarters of our respondents in this group were over 45 years old. But, unlike the Asian

elderly, several of whom have arrived in the United Kingdom relatively recently to join younger kin, almost all West Indian elderly have lived and worked in Bristol for a long time - they have grown old here and passed through the various stages of family development over the years. Perhaps the notion of the extended family is not so strongly attached to the Afro-Caribbean community as to the South Asians, but nonetheless the view that all "immigrant" groups maintain strong family ties is still commonly expressed. And again there is probably some basis of truth in this notion. Traditions of family cohesion have carried over from the Caribbean; for example many older West Indians speak of the traditional regard for older members of the family and community in West Indian societies, contrasted with what is seen as the rather cold independent attitude of 'nuclear' families in the West. But whatever have been the customs, traditions and ideals of family and community in the Caribbean, few of the West Indians in our sample lived in households that could be described as containing "extended family" members.

Some of the differences between West Indian and South Asian households are a consequence of age differences and the sequence and pattern of settlement. Where elderly Asians have arrived to join younger members of the family, by that very fact they come and constitute three generation families. Given the rather later period of arrival, those South Asians who are growing old here (rather than arriving as elderly) are somewhat younger than their West Indian counterparts, and therefore some have not yet reached the point of testing out the question of whether in their later years they will be with their children and grandchildren. By contrast many West Indians growing old here have already reached that point (mostly, their own parents have died some considerable time ago, in the Caribbean) and they are finding that, in many cases - and for whatever reasons -, they are not together with their children and grandchildren. So, among elderly - or near-elderly South Asians it is common to hear them say that they hope that in their old age their children will honour their obligations to them. Some say they 'hope' . . . some say they 'expect' and some have begun to hint about their fears that their

children will have been influenced by "Western" attitudes to the family. Some older West Indians have, however, reached old age, perhaps having earlier hoped for close family ties in their later years, and found that circumstances or changing attitudes have meant that these hopes have not been realized or at least not fully realized. In addition to this - and this is something they share with South Asian people - many find that their families are divided by continents, with 'branches' of the family in different parts of England, in the Caribbean, and in Canada and the United States.

We cannot be altogether sure of the strength of the original attachment to extended family ties among people from the Caribbean, and in any event different patterns will obtain in different parts of the Caribbean and in different sectors of society. But we can be sure that most West Indians coming to this country felt, and still express, a high regard for respect for the elderly which they feel is not maintained in the United Kingdom. And we can be sure of what our own sample data tells us - remembering that the hundred Afro-Caribbean people we interviewed were predominantly older people, having arrived in the 1950s and 60s. Only two of the Afro-Caribbean people who talked to us lived in 'extended family' households, embracing more than two generations or multiple 'horizontal' connections. Close to one third (30) respondents described households which could be called conventional nuclear families - the interviewee, his or her spouse and their children. Another 20 interviewees were men or women who simply shared the household with husband or wife. Among these were couples who, probably until fairly recently, had maintained "husband, wife and children" households but whose children had now left home, many to establish family households of their own. A further 23 of the Afro-Caribbean interviewees lived alone and so these three groups (nuclear families, couples, and 'living alone') accounted for almost three quarters of our respondents. 13 of the remainder were women (and some men) who lived with their children but where the husband/father had separated, or died, or for some other reason was absent. So clearly, whatever the traditions, ideals, or past practices, the extended family household is scarcely to be found in our

sample of (predominantly) older Afro-Caribbean people. This also shows again that neither stereotype of the so-called "immigrant" family is correct: neither the strong extended family image, nor the image of widespread 'breakdown'. Wide family connections and regard for the elderly are highly valued, but these values are frequently not realized in new circumstances. And indeed family breakdowns do occur - separations, disputes and so on - but the great majority are striving to maintain family cohesion and succeeding within the limits imposed by a history of migration and sequences of choices which have often resulted in families spread over two, three or even four countries or continents.

One of the most striking aspects of this section of our inquiry was to find that one third of the elderly (60 years+) Afro-Caribbean interviewees lived alone; and another third lived with a spouse only. The further understanding of how far these smaller households can depend on family support from family members outside the household is a question which is both particular to the elderly and general as regards the whole Afro-Caribbean population. Small households may not indicate narrower ties of kinship if wider ties are strong and regular with family members in relatively close-by households. And the answer to this question, as with the South Asian group, is mixed. Some not only live in small household groups but also have few other kin on whom they can call, whilst others maintain ties with brothers, sisters, parents, grandchildren and others who are not far away. But on the whole the evidence does not suggest that our initial conclusion about the typically 'narrow' household should be greatly qualified. Particularly it is clear that the elderly West Indians living alone or only with a spouse, are frequently cut off (for a variety of reasons but especially including migration) from regular contact with members of their wider family network. For example many elderly West Indians when asked to compare their 'old age experience' with what they remember of their parents' experience, said that their own life may be materially easier (and not all were sure of this), but were likely to add that socially and psychologically their old age experience was blighted by the

absence of kin members, especially children.

In the longer report this question - to what extent smaller household family groups are supported by other family members in separate households - is discussed in more detail; here we can give some leading indications from two questions we asked of our respondents. We inquired whether the interviewees family had been able to 'keep together' and whether members of the 'wider family' lived in Bristol. A little more than a third of Afro-Caribbean and South Asian respondents judged that their families had been mostly able to keep together - compared with 56% of white respondents who said this, who may of course, have been appplying a different standard of 'family togetherness'. Rather more South Asians than the other two groups made an intermediate judgement ("some together, some apart") but 25% of South Asians, 40% of West Indians and 34% of whites described their families as mostly apart or divided (often between two or more countries). Only one third of the South Asians and as little as one fifth of West Indians reported that members of their wider family (e.g. brothers, sisters and their families) lived in Bristol. This is one part of the data which leads us to conclude that the evidence of 'small' or 'narrow' household/family groups is <u>not</u> greatly 'compensated' by the presence of kin in other households in Bristol. On the other hand the <u>value</u> placed on wider kin connections is evidenced by the large number - particularly of South Asians - who report that they maintain regular contact with members of the wider family, often by telephone, letter and infrequent vacation visits to other countries. 86% of South Asians reported such regular contact with wider kin group members, as did about 60% of Afro-Caribbean and white respondents.

We took a special look at the elderly (60+) in our sample and categorised their household situations as 'extended' (where three generations, or wider horizontal ties, were evident) 'nuclear' (parents and children) and 'relatively isolated' (interviewee and spouse, alone, etc.). By this approximation the great majority of both white and Afro Caribbean elderly could be described as 'relatively isolated' whereas about half of South Asians

would be described in this way, the other half living in extended or nuclear family groups. As these people grow older and more susceptible to infirmity and disabilities, the absence, in these cases, of full and immediate family support means that individuals will find themselves in need of services brought to the home or of care within a home.

Social contact, social isolation

The data on family situation itself tells us that a considerable proportion of South Asian and West Indian residents of central Bristol, middle aged and elderly, experience some degree of isolation, or at least are dependent on a small number of others for sustaining them in daily life. But what of social contact outside the family groups? There are a number of indications of this in our interviewes, only a 'round-up' of which can be essayed in a summary report. Undoubtedly a considerable minority - particularly of South Asians - suffer from real social isolation. Even those South Asian elderly in fairly 'united' family households may suffer isolation within the household when parents and children are away at work and at school. And to be sure those numerous younger South Asian women who do not speak English are extremely constrained in their social contacts and obliged to face the daily round with a very minimum of supportive social contact.

Our evidence also suggests that very few black residents (adult and elderly) attend or belong to community groups or associations except of a religious kind. Time and again South Asian respondents expressed their anxieties about the isolation of the older members of the South Asian communities and spoke of the need for 'somewhere they can go and meet and feel at home'. One (South Asian) GP to whom we spoke certainly regarded this as a major problem affecting both younger and older South Asian patients, particularly women, and testified that there was a clear link between this unmet need and commonly expressed depression and anxieties. Even attachment to and attendance at Gurdwaras, the Temple and Mosques (not universal,

especially among women) did not compensate for this. The strong socially supportive role of religious institutions was much more common among older West Indians than among South Asians. One cannot be sure of this, but a strong impression from our research is that the church associations of the Afro-Caribbean residents play a much stronger social role than do the Temple/Mosque associations of the South Asians.

Indeed it seems clear that the supportive role of West Indian associations, particularly the church and church based, is very strong and much welcomed - as no doubt many older West Indians know without any report telling them! People spoke warmly and openly of their 'brothers and sisters' (always referred to thus) who sustained them, visited them in sickness, and were, simply, the primary social and psychological support. Some attended church several times a week and there were several who told us about the 'lift services' - church minibuses taking them to meetings and worship. Despite this many Afro-Caribbean respondents told us that they would welcome community centre activities, secular meeting places and the like, if they felt that such a centre was at least in part organized around familiar 'Caribbean-interest' activities. Similarly many South Asians would welcome a secular centre - especially for the older people - which catered for their interests and needs.

SECTION 5

Language Use

Before turning to health and social services we present a brief summary of language use, partly because it plays such a strong part in the dealings which South Asians have with 'public' agencies. For almost all Afro-Caribbean respondents English is their first language, and although accent dialect and patois may occasionly lead to misunderstandings, English-speaking per se is not, apparently, a source of great difficulty. However a substantial minority, particularly among elderly Afro-Caribbean people, described their ability in reading English as only 'fair' and there is no doubt that this sometimes creates problems in form-filling and 'official' dealings of various kinds - for example several respondents spoke of all kinds of difficulties they had had in advancing their claims for home improvement grants.

But only one third of South Asian respondents described their 'English-speaking' ability as 'good' and less than a third described their 'English-reading' ability as good. These simple and bare figures on their own are sufficient evidence of the difficulties that many South Asian residents of central Bristol face in such things as making applications, dealing with public officials, and consulting with their doctor. But when we look at the figures 'by gender' the implications for difficulties faced are even stronger. Rather less than half of the 100 Asian interviewees were women, but only seven of them rated their English speaking ability as 'good'. And although this non-use of English is greater among older Asian women (indeed practically total in this group), it is by no means confined to older Asian women. One half of younger South Asian women described their English speaking ability as 'slight or not at all' and only a quarter described it as good. Some of the

consequences of this (e.g. for health services) will become evident in later sections.

A Note on Language and Medical Treatment

This is discussed more fully in a later section, but I would like to insert a comment about language and medical care here because it is a discrete issue standing aside from our general research data. It is clear that GPs and patients 'get by' in dealing with language by a variety of ad hoc means. There are three main methods: (apart from mere sign language, etc.)

1. having another family member in the consultation
2. drawing on a bilingual worker present in the centre (e.g. receptionist)
3. using a contact person who has no official status.

All of these are unsatisfactory. The first is unsatisfactory for obvious reasons - the strain on family members, the lack of confidentiality, the additional difficulties of making the visit (e.g. only being able to come when a child is able to accompany the patient). The second cannot be justified because of the burden it places on a person who has another job to do and the third is purely ad hoc and unreliable. All three categories involve untrained persons.

The Avon Community Interpreter Service is fully aware of these issues and has recently received some backing. If it is able to establish itself in the coming year, there will have to be considerable consultation to ensure that the service meets the most important needs. Consideration will undoubtedly be given to the question of how far the service can go beyond "mere" interpreting into the broader difficulties of enhancing understanding, counselling, and reassurance on all sides. Schemes in London have established some models for a successful service.

During the research I have also learnt - via a well-authenticated report - of instances where non-English speaking (South Asian) women are taken into a surgery together in considerable numbers, presumably as a 'method' of overcoming problems of language (by drawing on collective inter-understandings). This report comes from the London area and no evidence of this taking place in Bristol in the same form has come to our attention. But we did hear of several people being in a surgery at the same time (probably all members of the same family) and more than one of them being there for a medical reason (i.e. not just accompanying).

It seem to us that this is very far from satisfactory and illustrates what can happen when hard-pressed practitioners are required to deal in an ad hoc way with language difficulties.

SECTION 6

Health and Health Services

In this section our study concentrates upon access to health services and use of them. Are people satisfactorily registered with General Practitioners? Do they get to see them when they need them? Do they have particular worries about their health and health care? Studies of actual verifiable states of health are beyond our scope and very difficult; even more difficult are studies of the real relationship between states of health in a population and the provision of use and health services. On this highly complex issue we shall say little, and, of course, only what our research allows; on questions of attendance and service-related attitudes we have full and detailed data.

Services

Charlotte Keel and Montpelier Health Centre are the two main providers of primary health care in the central area of Bristol. About one half of the Afro-Caribbean people, and of the whites in our sample were registered at one of these two health centres; just less than half of the South Asians were registered at one of these two, principally Charlotte Keel. Small numbers (twos and threes) of the three groups were registered at other health centres (such as Eastville and Lawrence Hill), the remainder (about 40% and rather more among Asians) being registered at small independent surgeries. At these centres, as well as up to eight or so GPs per centre, there are additional services attached including social workers, health visitors and, at Charlotte Keel, a Clinical Medical Officer (the only doctor serving in these centres who is of South Asian origin - almost all are white males).

Medical professional and administrative bodies assess areas in terms of

need for General Practitioners, based on the size of patient rolls per GP in practice in that area. Judgements are then made about whether an area - at one pole - is one into which doctors might be fully encouraged to locate their work, or - at the other pole - is one which might be regarded as fully or oversubscribed with physicians. Although certainly not 'over-supplied' with GPs, this area might well be classed as intermediate, reasonably supplied and not 'open' (to new practices). But the system of classification has at least two peculiarities - perhaps flaws - which in our study case might well disguise the need for more practitioners to relieve the burdens of those working there now. One is that the GP/patient ratio includes all GPs i.e. those at small independent practices as well as at larger Health Centres. A number of small independent surgeries offer services in the area (and, we have no reason to believe offering any worse or better care than the Centres unless one considers the less immediate access to ancillary workers a detriment). And it seems certain that doctors at these surgeries have smaller per doctor patient rolls, this bringing the area average down considerably. So the Health Centres, where half or more of the area's patients attend, may be heavily burdened but this burden may be disguised in the area assessment. Secondly, a doctor/patient ratio says nothing of frequency of visit and seriousness of health care needs in an area. A thirty-year old male who has not been to his doctor for a very long time counts 'one'; so does a sixty-five-year old man or woman with a recurring health problem which requires repeated attention and care. There is every reason to believe that in the Health Centres of the central city at least, the demands are very great indeed; one Centre reported seeing about 90% of their registered patients per year. The demands presented by a high proportion of young and elderly people (not among the very highest 'by ward' for the city, but very considerable) constitute a large part of the daily work, in addition to which all known and published estimates of comparative morbidity show a higher concentration of poor health indicators in the central area by comparison with all but one or

two other wards of the city, and very strikingly different from most more prosperous zones of the city. Beyond this a concentration of hard drug abuse among young (and, often, white) people brings a heavy burden on GPs practising here - especially in the absence of government funds to provide alternative care in the face of the growing heroin abuse crisis in Britain. All taken together - with some corroboration from GPs themselves - it tells a story of extremely hard-pressed service providers. There is, in my view, a clear case for augmentation of provision, both by way of GPs and auxiliaries.

States of health

The Townsend/Simpson/Tibbs report[1] has graphically illustrated the inequality in states of health for different wards of the city and the wards in our study[2] are among that small group for which health indicators display a picture very much worse than for most other areas of the city. Higher rates of infant mortality and low birth weights were two of the problems highlighted by this study. Based on aggregate data, the Townsend/Simpson/Tibbs report is an initial attempt at an extremely difficult job of assessment, but there can be little doubt about the general thrust of its conclusions. It is more difficult to assess the link between health and health care, because so many different factors influence so many different types of ill-health (work environment, housing, poverty, diet and so on). But we must keep the results of this study in our minds in considering the findings of our own research.

---

1. Inequalities of Health in the City of Bristol. 1984. Peter Townsend, Don Simpson and Nigel Tibbs. Department of Social Administration, University of Bristol.

2. St. Pauls, Easton, Eastville and District (1981 wards).

By contrast, our study can tell us about health and services based on what was told to us by the interviewees about their health, their worries, and their attendance at health centres, hospitals and surgeries. And our 250 respondents, a systematic sample of the central area, older and, particularly, New Commonwealth-origin people, told us a great deal.

Health among our interviewees

The most indicative question probing for the interviewees self-assessment of health was "Do you have any medical condition which requires regular visits to a GP or Hospital?" One half of the Afro-Caribbean respondents said 'yes' compared with about one third of white and South Asian people. This high incidence (for all groups) of regular health problems is undoubtedly partly explained by the higher age profile of our specific sample of the adult and older population and the fact that the Afro-Caribbean group in our sample was a proportionally 'older' group clearly accounts for some of the difference between them and the other two groups. When we look at the elderly only, the numbers become rather small for secure analysis but the data does suggest that health problems requiring regular GP or hospital visits are more common in the 60+ age group of West Indians than the other two groups. Indeed two thirds of the 60+ year old West Indians reported a health cause for regular medical visits, as against a half in the other groups. One half of the approaching elderly West Indians (45-59 years old) - a large part of this total group - reported 'ill health requiring regular visits' as against just more than a quarter of the approaching elderly South Asians (the whites in this "approaching elderly" age group - as mentioned above - were too small in number for discrete analysis). If we were to compare these assessments of ill health with general (by age group) figures for frequency of visit to the GP (as an index of poor health) we would conclude that there is a higher

incidence of ill-health in our sample groups than in the general population.

People describe their medical conditions with varying degrees of precision (about one third offered no comment beyond mentioning a recurring problem) although many, of course, provide a very clear picture of their health or ill-health. Medical practitioners - particularly those working in the city centre - will know just how to read this section of the report, that is with due caution but also with due interest in what this kind of report can indicate. They will also be able to compare what we say with the accumulated experience of their professional practice.

Afro-Caribbean

Heart and related diseases receive most frequent mention in this group but this was closely followed by rheumatic/arthritic types of complaint. Diabetes was mentioned several times, as were 'chest' and 'back' complaints. Particularly noticeable (though not the most frequent) was the mention of eye problems, corroborating the Birmingham study[1] which reported a higher rate of eye problems in Afro-Caribbean groups than others. Mention of high blood pressure (hypertension) was also common (this can be seen when we looked at answers to questions about other members of the family and their health worries - for example older Afro-Caribbean women mentioning the blood pressure problem of their husbands). Comments from doctors in our study area, and pieces of evidence from other reports suggest that all doctors need to be alerted to the possibility of a higher incidence of high blood pressure among middle aged and elderly West Indians. With all due caution - given the proper boundaries of professional expertise - it is worth noting that diabetes and eye problems are both mentioned and that there is a known connection between the two. This may be particularly worthy of mention because of the

1. Elders of the Minority Ethnic Groups. 1981. Anil Bhalla and Ken Blakemore. Birmingham: AFFOR.

(estimated) high numbers of undisclosed diabetics in the population for whom earlier detection and control would be very beneficial, including in the prevention of later eye difficulties.

South Asians

The South Asian respondents were, on the whole rather younger than the Afro-Caribbean respondents, only 18 being over 60 compared with 33 among the Afro-Caribbean group, and most of the rest more evenly scattered through the 30s, 40s and 50s. This alone would greatly account for the fact that one third of South Asians (compared with half West Indians) reported a continuing medical matter which required regular medical visits. Five of these were younger women attending in connection with pregnancy care. The only categories of complaint which got several mentions among South Asians were heart disease, diabetes and chest complaints. The category of chest complaints certainly requires additional discussion because of the difficult question of the degree of severity of this type of illness - from the 'minor' chesty cough to the serious chest infection or disability. But our data cannot allow us to be sure about this question because it would have been impossible to secure the kind of detail necessary to a judgement - and wrong to try. But we can be fairly sure that many GPs - in facing patients of all backgrounds - are understandably anxious to point out that medicine has little to offer to deal with the "common cold"; and equally patients are anxious about recurring chest complaints which, especially for persons unaccustomed to the Bristol climate, may be experienced as severe and worrying. I am quite convinced that there is a 'gap' here - in understanding - which needs to be closed. We also asked GPs whether they had any reason to believe that diseases of the elderly were occurring at an earlier age among Afro-Caribbean and Asian patients - partly because one other study had suggested that this was the case - and the response was mixed. One GP told us that he had no evidence to support this,

another suspected it to be the case and described one or two instances in his recent experience where heart disease had developed in young South Asian males.

Whites

The small number of white interviewees in the age band 45-60 makes comparison difficult in medical questions. They resembled the Afro-Caribbean group in that over 40% were over 60 years old, but were similar to the South Asians in that most of the rest were in their thirties and forties. About one third of all white interviewees reported some recurring medical problem and the only complaint which received several mentions was the rheumatic/arthritic category. But although age differences go some way to explaining the higher rate of reported medical problems among West Indians, it is also the case that 60% of Afro-Caribbean elderly spoke of a continuing problem compared with half of the white and Asian elderly.

USE OF SERVICES

Registration

There have, in other areas of the United Kingdom, been some indications of low registrations in inner city areas, with GP services characterised by the single (elderly) male GP lock-up surgery, subject to a variety of difficulties (e.g. vandalism). In these areas, often with a highly fluid population (i.e. high 'in' and 'out' mobility), persons with complaints may tend to present at out-patient clinics and casualty centres. This does not seem to be characteristic of Bristol's central city areas. The wards in our sample are not especially characterised by high mobility (other wards of the city, e.g. Redland, have higher rates) although our study will disguise this to some extent by its concentration on the older, more residentially stable,

population. Although one GP mentioned his worries about security for his practice's small surgery premises, and there are a number of small surgery-based practices in the area, the kinds of problems experienced in other parts of the country, do not appear, or at least not to the same degree, in central Bristol.

Indeed, almost all our interviewees reported that they were registered with a practice, with 40% to a half of all groups being with GPs in the Health Centres. Other 'fringe-of-the-area' Health Centres and the smaller surgeries, account for the remainder, and, in fact, a small number of 'independent' GPs account for almost all the non-Health Centre registrations. About 75% of all interviewees volunteered the name of their GP(s) and it is clear that patients are rather unevenly distributed through the available GPs by ethnic groups. That is, there is a tendency to concentrations of registrations, with (e.g.) GP 'A' occurring frequently among West Indians and GP 'B' frequently among South Asians. GPs in the area were aware of this. We asked about any inclinations to change registration, and for the most part patients did not appear to be anxious to change, nor did many report having changed for reasons of dissatisfaction. However, there were a number of mentions of 'rows' which had led to changes, and various dissatisfactions were expressed in other ways which we shall discuss. Most notably, among Afro-Caribbean people, there were a considerable number who told us of seeking second opinions in a private consultation - with some indication that this was a consequence of failure to 'get what they were looking for' from their regular GP. In some cases (of this type) the dissatisfaction with the GP (in a specific episode) was clear, as was the sense that a private consultation had 'got to the bottom of it' (although one person did mention getting a private opinion and "it was the same"!). But on the whole people were simply expressing the view (this is almost exclusive to West Indians) that 'you get what you pay for' and 'when you are paying, people have to pay attention' and, more sympathetically, that their difficulty with their regular GP was a function of the pressure of the

GP's practice. So, that substantial minority of Afro-Caribbean people who told us about seeking a second, private, opinion, were, in effect, telling us about "buying the professional's time" - and most felt it had been worth it. GPs appear to be aware of this, and one told us of his dislike of this practice and his own unwillingness to be consulted on this basis. Most white and Asians viewed the seeking of private medical care as, simply, "beyond their means".

GP Visits

Visits to the GP are one indication of people's need for medical attention, and an indirect indication of states of health. However the seriousness of the reason for the visit varies greatly, as does the inclination of people to go, some attending and some staying away unnecessarily or ill-advisedly. In that sense, GP visit rates are an imperfect indication of health needs, but an indication nevertheless. I know of nothing - prejudice aside - to suggest that the inclination to visit the doctor (i.e. especially "unnecessarily") varies systematically from one group to another and the arguments about class differences in visit rates have been inconclusive. Lower social classes certainly do make more frequent GP visits, but the known poor health profile (i.e. class inequality in health) clearly accounts for much of this difference. It is also probable that more educated and self-confident patients have greater success in manoeuvring their way toward care beyond primary (GP) services.

Available studies previous to ours typically asked about visits in the last fortnight or month; those concentrating on 'ethnic minorities' had asked about the last month, and so did we. This makes comparison difficult with the fortnightly (Social Trends) data but rough approximation from fortnightly to monthly data certainly suggests that the Afro-Caribbean and Asian respondents in our study attend surgery or Health Centres to see their GP more frequently

than (age and class-) comparable groups in the population. The direct comparison with the Birmingham elders study suggests that our study is corroborating and confirming a pattern of rather higher visit rates among South Asians and Afro-Caribbean people in Britain, remembering that the respondents in the Birmingham study were exclusively over 60 years old, whereas our interviewees were predominantly older, especially the Afro-Caribbean group.

	Afro-Caribbean	Asian	Whites	
Seen GP within last month	68%	70%	57%	Birmingham elderly
	57%	47%	40%	Bristol sample

The higher percentage of Afro-Caribbean people in our study who reported a GP visit in the last month is certainly influenced by the larger percentage of that group in the older age groups; Afro-Caribbean visit percentages in the oldest group are only slightly higher than those for the oldest Asians (although both are notably higher than for the oldest white group). The 'age effect' on the Afro-Caribbean 'rate' comes primarily from the next oldest age group (45-59) in which Afro-Caribbean people reporting visits are a much higher per cent than that of South Asians in the same age band. Although the Afro-Caribbean people within this band are older than the Asians in the same band, this probably does indicate a rather high prevalence of reasons for visits in this approaching elderly West Indian population.

The same order of difference between our sample groups appeared when we looked at percentages who had visited their GP within the last twelve months. 75% of Afro-Caribbean respondents had done so, as had 70% of South Asian respondents, and 60% of white respondents. In sum, then, the frequency of visit data indicates that, in the main, there is no simple problem of access[1] to the GP. Taken with other evidence, they do appear to indicate a rather higher rate of visit among Afro-Caribbean and Asian patients than among

---

1. That is, no indication, in this sample, of lower than expected rate of visit. But access is sometimes used to mean more than 'simply' getting to the care centre, to include getting satisfactory care as well.

whites, and probably that this is evidence of a poorer health profile. Some indication of this is that, of those West Indians who had visited their GP in the last month, two thirds had also spoken of a continuing health problem which required regular medical visits. The high percentage of 'approaching elderly' West Indians who had made a recent visit suggests that health difficulties may be appearing rather more than the average in this under-60 age band.

Hospital Visits

The fact that the majority of people in all groups (75% Afro-Caribbean, 70% South Asian and 60% whites) had visited their GP in the last twelve months meant that we could inspect the figures for comparisons between age bands. But the numbers making hospital visits (on their own account) in the last twelve months are much smaller, making analysis more difficult and conclusions about age differences unsafe. We can, however, make some tentative points about hospital visits which should be read with appropriate caution.

There are two main points to be made: 1. our sample data about ethnic group differences in hospital visits do not replicate the pattern found in regard to GP visits i.e. rather more visiting by Afro-Caribbean and South Asian groups. And, 2. this may be taken as corroborating what other researchers have argued, that is that the relationship between ethnic origin and visits at the level of primary services (rather higher ethnic minority use, rather lower white use) may be reversed in the case of services beyond the primary level. A researcher in Birmingham has written that "white respondents improved their apparent low use of GPs by going directly to hospital outpatient and 'emergency' clinics".

Our sample data show that, whilst rather higher percentages of Afro-Caribbean and Asian interviewees had visited GPs recently, somewhat higher percentages of whites had visited hospital in the last month and in the last year. (Hospital visits in the last month: whites 20%, ethnic minorities 15%;

and similar small differences in 'the last year' - over 60 of all 250 interviewees had made a visit to hospital in the last twelve months). This cannot be taken as conclusive evidence that, allowing for age and illness, whites are making more use of services beyond primary care. But all our data point in the same direction as previous studies, and it is - on the face of it - surprising that the pattern observed in relation to primary care does not 'carry over' to hospital-based care, especially considering the high proportion of elderly and approaching elderly among Afro-Caribbean interviewees, and considering the numbers among them reporting recurrent health difficulties.

Further studies will have to examine highly specific elements of medical services beyond the GP consultation (hospital care, out-patients clinics) and will need to explore the way in which people typically get to use these services. In the meantime I believe we must give serious consideration to the strong possibility raised by our and other studies - that while Afro-Caribbean and Asian people appear, for the most part, to be readily getting to primary care, they are less readily finding access to services beyond primary care. Apart from the findings of other researchers, and the suggestive pattern in our own "visit" data, there are indications tending to support this view in our research.

One GP, for example, told us that some South Asian patients, having been directed to a hospital-based clinic, did not make the advised visit for a number of reasons. They may not fully understand the reasons for further exploration of a particular condition, especially if the condition ceased to be acute before the planned visit. But also they may be very apprehensive about making the trip to a large impersonal health institution at some distance from their home 'across town' to a part of Bristol unfamiliar to them. Socio-economic inequalities certainly have an effect on people's ability to get around (car ownership, access to a lift, expensive public transport) and these inequalities affect peoples' use of services where such

travel is involved. In addition to the travel difficulties there may be considerable social and psychological barriers to making full use of hospitals and clinics. Many people - especially South Asians with English language difficulties - are more likely to be anxious about negotiating telephone calls, and dealing with receptionists in the hospital situation. Language is, of course, a formidable difficulty in the GP/Health Centre visit and consultation but in the local health centre this is probably alleviated by a degree of familiarity (for both receptionist and patient, or doctor and patient). After the first visit or so, receptionist and doctor will recognise the patient and trace the name and record, even if there is some difficulty. Someone may be 'around' as an ad hoc interpreter, and if the patient has to bring, for example, a child to help with English it is not so far to go to a Health Centre or surgery which is 'just around the corner'. For all the difficulties of Health Centres, this reasonable familiarity makes coping that much easier; but this is almost certainly absent in many remote hospitals and clinics.

Furthermore, the 'reasonable familiarity' is greater for the staff too - in the two main central city Health Centres, Afro-Caribbean and Asian patients will be turning up pretty regularly and may constitute a third or half of the patients seen by receptionist and doctor in a particular morning. In the hospital or clinic, the South Asian woman who arrives for a consultation - and speaks little or no English - may be the only such person seen that morning, that week, or even longer.

The systematic evidence about access in the above sense (negotiating the journey, the receptionist, the appointment) in our study refers to primary care, but interviewees were often ready to give us specific accounts of difficulties in access to hospital care. Health centres and local GPs, and their reception and auxiliary staff are "not perfect" but they have worked out ways of coping (e.g. with differences in attitudes or custom and language) as have their patients. My strong impression is that this has not occurred in

hospitals and that whatever difficulties are faced in patient/GP relations (and reception) are faced much more acutely in the hospital situation. One interviewee told us that his poor relationship with his GP resulted from his GP being a racist - simple as that. But the qualitative evidence of our study (the stories told to us in the interviews, the reported events and conversations) indicates that the tough problems of 'race relations' (including direct and indirect racial hostility) are more prevalent and more worrying in relation to care beyond the primary level than in the GP/Health Centre consultation. One of the most distressing accounts given to us in the interviews was told by a younger South Asian man who had visited his wife when she had been in hospital. She could not eat the food which was provided and eventually her husband had brought some 'home-food' with him on a visit. A ward nurse, on seeing this, had immediately ordered him to "get that smelly stuff off my ward". The man was naturally very upset but was dissuaded from making a formal complaint by friends who told him it was more trouble than it was worth.

Finally, there are a couple of further indications about non-primary care in our interview materials. Interviewees were asked whether they had found any difficulty in 'being referred to a consultant' and whether they 'had a special medical problem for which they would like better treatment and hadn't been able to get it'. 16 people answered yes to the first question - but 10 of these were South Asians. And 33 answered yes to the second question - and 20 were West Indians. All this suggests that two areas give cause of concern - the process whereby people make the transition from GP to hospital/ clinic care, and the experiences of Afro-Caribbean and perhaps especially South Asian people once they get to clinics and hospitals.

Contacting the GP, getting along with staff, securing some satisfaction from the consultation

Our discussion so far has been almost exclusively concerned with "access" measured by frequency of visit - or percentage of groups making recent visits to hospitals or GPs. Of course in discussing possible reasons for differences we have made reference to such factors as travel and familiarity. In relation to the GP/Health Centre visit we have systematic data about "access" in two further senses, one the simple (or not so simple!) business of making contact and 'getting there', the other some assessment of gaining satisfaction from the visit. Our data show that, while 'reasonable familarity' probably does make primary care less problematic than hospital visits etc., there are

1. real problems of health care access in the sense of 'making contact' and 'gaining satisfaction' and
2. that these problems are especially acute, indeed alarmingly so, among South Asians, even more especially among South Asian women.

Before discussing these topics in detail, three things ought to be made clear. First of all the 'percentage' data reported, unless otherwise indicated, are percentages of all interviewees regardless of their good or poor health. So for example, the X% reporting 'no difficulty' in 'getting the treatment you want' will include those with no health problem. Secondly, the language difficulty pervades all aspects of the South Asian picture - it is a problem of 'contact' (being understood on the telephone) and of 'gaining satisfaction' (being understood in the consultation). Afro-Caribbean respondents have similar difficulties to white respondents ('getting the doctor to explain to us') and some specific complaints ('they treat us like second class citizens'); but overall the percentages of whites and Afro-Caribbean respondents reporting problems in contact and gaining satisfaction are roughly similar while the South Asian group is distinct from both in showing much higher percentages with 'contact' and 'understanding'

types of difficulties. Thirdly, readers should be careful to note that whilst difficulties of all kinds are reported, many interviewees speak very warmly about their doctor or about the NHS ("if they would only stop the cuts") or both.

Contact

We asked the question about 'getting in touch with your GP' in such a way that most understood it to indicate making appointments and calling reception and the like, although some, understandably, told us about such difficulties as actually getting to the doctors. 65 of all interviewees (250) told us of the difficulties getting in touch with their GPs and we should immediately note that 43 of these were South Asians for whom language was the primary difficulty. The 20-plus whites and West Indians who mentioned difficulties all spoke of having no car or no telephone as the primary obstacle, whereas about three-quarters of the South Asians reported difficulties 'getting in touch' were in fact referring to problems of understanding and being understood in the 'approach' to medical services. Thus approximately two-fifths of all South Asians interviewed told us of (contact problems and inspection shows that more than half the female South Asians told us this). We find this to be a disturbing indication from our data, that is that so many, especially South Asians, are experiencing difficulties in the very fundamental matter of getting in touch with health services.

Gaining satisfaction

We cannot claim to pronounce on satisfaction in health care in any final sense because peoples' expectations differ and people would disagree on the definition of the satisfactory consultation. But our data do provide a relatively clear picture of the kind of difficulties patients have, some of them to a disturbing degree.

We can begin with a general question by which we asked interviewees whether "language was a difficulty in consulting doctors or hospitals". No whites or West Indians said that this was a problem but over two-fifths of South Asians said that it was for them - and again this was true for more than half of the females. Although elderly female South Asians were more likely to report this difficulty, the (language) problem was by no means confined to the elderly and although these are very generally-expressed difficulties (in contacting and dealing with the GP) their very scale is enough to suggest that this problem ought to be highlighted and that steps need to be taken to overcome it - because it indicates real obstacles in the very fundamentals of securing health care. Some of those who reported no such difficulty did not do so because they 'overcame' it by taking others with them to the consultation. Although some patients and GPs appear to regard this as a tolerably satisfactory ad hoc solution, it cannot really be regarded as such since the 'third person' presence is just as likely to interfere with consultation, especially if it is a child or even a husband. Equally the drawing on some bilingual person who happens to 'be around' cannot be regarded as satisfactory either because being called upon interferes with the normal duties of such a person, or because they are not trained interviewers or counsellors.

Most of the other "difficulties" which we explored showed the same pattern, with South Asians more likely to report 'yes' and women among them much more likely to have difficulties than the men. Thus 15% of all South Asians spoke of difficulties 'getting along with staff' but a quarter of South Asian women did so. 20 of all interviewees spoke of difficulties following the doctors instructions, but 15 of these were South Asians; 28 spoke of difficulties 'getting the GP to explain' and 17 of these were South Asians. Language clearly underpins these difficulties to a considerable degree but to speak of them as 'language problems' is probably to underestimate them, since they will frequently by compounded by cultural misunderstandings. We did not

ask our interviewees about their culturally grounded assumptions about health and illness or about the proper relationship between patients and doctor, but our question about preferences for a GP 'of the same ethnic group' gives some indication. 10 West Indians and 7 whites said they preferred (or would prefer) a GP of 'same ethnic origin' but over a third (and for women two fifths) of South Asian interviewees expressed this preference.

The results were even more striking when we asked about preference for a doctor of 'the same gender'. Most white and Afro-Caribbean males were 'indifferent' about the gender of their GP and a minority of both whites and black women expressed a preference for a woman doctor. And indeed nearly forty per cent of South Asian males expressed a preference for a male doctor. But the most striking answers of all show that two-thirds of the South Asian female respondents would prefer a female doctor, all the more striking when we consider that evidence suggests that few, if any, will actually have a female doctor. The interview answers show that this preference is strongly felt among all South Asians - a great number of the men expressing no preference 'for themselves' spontaneously added that they were very concerned to have female doctors available for the 'women folk'. The preference for a female doctor is at least as strong among younger South Asian women as it is among older South Asian women, and this is no doubt influenced by the likelihood of gynaecological consultations among women of child bearing age. The anxieties about this sensitivity to the gender of the doctor have been expressed several times in research of this kind. We are fairly sure that it is largely an unmet need in inner city Bristol because of the virtual absence of female practitioners in the area. Very few of the relevant (city centre) practices contain female doctors, and they are often part-time or trainees; none of the health centre doctors or surgery based doctors mentioned by our interviewees were women.

In access to health services (defined as 'getting in touch' etc.) the most outstanding problems are faced by South Asian patients, particularly women, because of language and understanding barriers. In access to services defined as gaining satisfaction the language barriers facing South Asian women are also severe, as we have seen. But this should not lead us to imply that this group alone faces difficulties, or that language is the only difficulty. We have already seen that Afro-Caribbean respondents were particularly likely to seek a second (private) opinion, and this appeared to be an expression of dissatisfaction with the 'ordinary consultation' and a feeling that one had to buy the attention of the practioner. Comments about wanting more personal attention from the doctor were fairly common in all groups, especially white and Afro-Caribbean, and a quarter of South Asian patients spoke of their wish for more 'sensitivity to Asian patients, and the need for more Asian speakers'. Several comments reflected the reactions of patients to brusque and busy doctors in practices where per patient time was under severe pressure from the waiting room ('I wish they would examine you first and write the prescription second instead of the other way round'). These kind of sentiments are found in all three groups. It is, however, crucially important to remember that the Afro-Caribbean and Asian people experiencing some 'impersonal treatment' in the health service, are also people who have had a multitude of reasons to conclude that there is systematic hostility to their presence, as black people, in Britain. (We will discuss people's direct experience of racism in a later report.) Now we may point out that, in general our respondents did not single out the health services as an area in which they had experienced racial hostility (jobs, immigration and other 'areas' loomed too large for this to be the case, plus, of course, fairly common appreciation of the health service), but neither was the health service excluded. At the very least we have to be aware that interpersonal difficulties (e.g. between doctor and patient, receptionist and patient) can have an 'added edge' for those who have experienced hostility in several other

areas of public and social life. It is also clear that black users of health care services can and do face the kind of hostility, abruptions, and impatience which they experience in other spheres.

In discussing access problems in the sense of 'gaining satisfaction' (as opposed to in the sense of 'getting in touch') the main point to make is that, whilst some South Asians make general criticisms which they share with other groups (e.g. of waiting lists), the tendency is for South Asians to specify the same kinds of cultural and linguistic problems in reference to both senses of access. We saw that language was important as an obstacle in 'getting in touch' and in understanding in the consultation situation. Asked to comment more generally on the health services, South Asians tended to mention group-specific problems such as the 'need for Asian midwives', 'more Asian speakers in the service' and the need for greater cultural sensitivity in pregnancy and relations with health visitors. By contrast, white and Afro-Caribbean interviewees shared many common concerns (fears about the cuts, impersonal treatment) which were not "race-specific". At the same time some Afro-Caribbean patients mentioned some group specific matters.

Perhaps two things were the most noticeable in the latter category:

1. a general sense that black people were treated as second-class citizens (several people used this phrase), including in medical situations;

2. specific complaints that receptionists patronized black people, or that doctors somehow patronized patients in 'jokey' relationships. One patient for example, went into considerable (and quite sensitive and thoughtful) detail about this, explaining that her doctor was kindly and pleasant - she had a good relationship in this sense. But she also felt that a certain joking approach had the effect of treating her like a child, and obviating serious discussion. As a result, she said, 'I try not to go unless I have to'.

Other comments (and, sometimes, detailed stories of incidents and case histories) were often general rather than group or 'race' specific, deriving from a history of unsatisfactory dealings with the health services. So, for example, several Afro-Caribbean (and South Asian) interviewees worried about 'expensive prescriptions', and several Afro-Caribbean (and white) interviewees

spoke of the need for 'more personal interest from the Doctor'. Other things receiving mention were the 'need for more medical research' (less spent on bombs!), 'more doctors available, especially at weekends' and (very commonly among both black and white interviewees) 'reduce the waiting lists and stop the cuts'. It need hardly be said that many people are genuinely worried about the deterioration of the service, and, of course, many West Indian women are also speaking of visible signs of 'cuts' which they see in their working lives as well as in the role of patient.

Some Doctor's Views

We spoke at length to five Health Centre doctors, one Health Centre Clinical Officer (child development) and one (South Asian) 'small-surgery' GP. Since the findings of this research will eventually be translated into proposals and suggestions which we hope will be of help to all concerned (doctors, auxiliaries, patients) we will soon speak to more of the locally based GPs but this had to be postponed because of the urgency of getting out this summary report. For the moment it ought to be noted that (axiomatically) I spoke to the doctors more ready to meet researchers and this probably selected out doctors with a 'community' view of their work.

I ought also to point out that doctors were not readily inclined to speak of, say, typical characteristics of Afro-Caribbean or Asian as opposed to white patients. It was the researcher (me) who was asking the questions! So, although, in their efforts to help me, they offered some characterisations of a general kind, it would not be at all fair to represent their views as typifying an ethnic group in one way or another. Almost all added this caution to their comments, and the reader should have the same caution if I appear to construe their remarks in this way. This is the other side of the coin to the caution that among all the complaints and frustrations of patients are many expressions of appreciation of the health services, and, in some

cases, of particular doctors with whom patients have had long and satisfactory relationships.

One of the most notable aspects of my conversations at Montpelier was the clear way in which doctors thought about their difficulties as the difficulties of an inner city practice - rather than as difficulties primarily identified as 'race relevant'. This is undoubtedly, with some exceptions, the case. A high proportion of registered patients are seen in a year and the practices are very busy. The incidence of alcohol and hard drug abuse (neither identified as 'ethnic minority' problems) impose severe burdens on medical practice including disputes and even violence in the reception area or surgery room. Black patients may be involved in arguments at reception 'but by the time we hear about it, it has blown over'. In such disputes the doctors agreed that patients probably would hold that they had been victims of racial prejudice. There seemed to be a tendency for doctors to conclude that difficulties of this kind were more likely to occur with younger black patients, alongside a view that older West Indians were "excellent patients" - friendly, forthright and conscious of their rights. Difficulties of a different kind - associated with language and cultural sensitivity - were linked to South Asian patients, few in number at Montpelier, much more numerous at Charlotte Keel. Indeed the severe language difficulties of Montpelier were in connection with the recently arrived Vietnamese immigrants/ refugees and no real solution to this problem had been found. At the time of writing the claim for additional funding (over £100,000 to cope with special needs in the area) had been met first with a grant of £39,000 over two years and, later, an augmentation up to £100,000. Discussion - and some dispute over the use of this additional funding continued. One of our important conclusions is that, if black people are not <u>per se</u> at the centre of many of the difficulties experienced in an inner city practice, they <u>are</u> numerous in their use of health services which <u>are</u> disproportionately burdened with these

difficulties. This must itself, in some measure, influence the quality of service received - from doctors and staff under considerable pressure.

Some 'race-specific' comments (with caution!) were offered by doctors. There was, for example, some hint in our materials of what has been more than a hint elsewhere - that both older and (perhaps especially) younger ethnic minority cases of mental stress or mental illness present particular - and new - difficulties for doctor and patient. There are certain reasons to suppose that minority groups (along with other groups in the population) may be particularly subjected to stress of all kinds, sometimes resulting in difficulties of mental health and stability. The consultation/treatment problem lies in the fact that establishing rapport with patients of different backgrounds - where the difficulty is emotional and mental in character - can present new problems with which practitioners are ill equipped to deal. One GP certainly volunteered the suggestion that this may result in inaccurate diagnosis of breakdown in ethnic minority patients. We cannot - and should not, since this was a topic largely unexplored in our research - say much more than this, except, in a report of this summary kind, to draw attention to this very important question and suggest the urgency with which it need to be addressed.

GPs at Montpelier were also aware of the question of diet, especially in relation to Rastafarian families where some cases of rickets had been identified. This has been investigated (and reported in the medical journals) by a Montpelier doctor, and at Montpelier the feeling is that appropriate measures were taken in a sensitive way. Some material on diet (especially in relation to South Asians) have been circulated among GPs. With regard to what could be regarded as a more clearly 'group-specific' illness - sickle-cell disease - I can only report that GPs at Montpelier and elsewhere were obviously aware of the disease and its specific implications (i.e. its nature and its predominance, statistically, among peoples of certain zones of the world) but did not appear to attach the sense of urgency to the question that one might have expected. Since doing the research the Sickle-Cell Society -

OSCAR - has taken part in a public meeting at St. Werburgh's and the issue has been raised in Bristol for the first time publicly. Again there is a great deal to be said here but it is a topic which requires specific and focussed treatment - we would certainly advocate the opening up of this issue for serious discussion among GPs and others. For the moment patients should be reassured that patients about to have operations and receive anaesthetic are screened for sickle-cell disease if they belong to 'at risk' groups. Furthermore the doctors in the central city to whom we spoke appeared alert to the need for performing checks whenever (especially young) patients presented with indicative symptoms. One doctor however certainly seemed to share my personal view - that more ought to be done than is being done, although just what are the most important steps to take is both difficult to determine and controversial.

Body and Soul

The definition of what is a treatable, and primarily "physical" illness is almost certainly one of the stickiest problems for both GP and patient and for the relationship between them. On the one hand doctors are increasingly aware of the psychological basis of some somatic complaints (or complaints expressed as 'somatic') and some doctors then redefine some of their work as counselling work rather than 'pill-prescribing'. This fits in with patients who express the wish to be understood as people not just as patients with physical symptoms. On the other hand this disposition may lead patients to the view that doctors are taking their physical symptoms less than seriously. And then the feeling on the part of patients that they are anxious to have some tangible indication of a 'cure' being initiated, is experienced by the doctors as 'patients demanding a pill for a pain' or being 'pill-bottle oriented'. Each of these misunderstandings (and including the obvious

contradictions) are circulating in the perception of doctors by patients and of patients by doctors. One element in this "circulation of perceptions" is the view, tentatively expressed by some doctors, that some West Indian patients (and at Charlotte Keel, South Asians) may be particularly anxious to see the tangible cure for the ill, and, in addition, unlikely, unable or unwilling to give expression to health complaints in anything other than physical terms. Again one must caution that doctors were not seeing the purely 'somatic' definition of illness as characteristic of all South Asians or West Indians, or as exclusive to them. Indeed one GP argued that many patients, white and black, had difficulty giving expression to non-physical aspects of ill-health.

Not surprisingly this is especially a problem at Charlotte Keel among South Asian patients (with UK born white male doctors) when language further intervenes in the expression of anxieties and non-physical symptoms or bases of ill-health. For some patients of South Asian origin, it is, in one doctor's view 'all soma and no psyche'. At the same time doctors with no ability to speak e.g. Punjabi, are aware that their capacity to open up non-physical health related issues is extremely limited. The fact that a South Asian doctor told us that medical consultations with South Asian patients sometimes developed into emotional and psychological catharses suggests that South Asians are not, in the right circumstances, averse to exploring the links between the distress felt in physical forms, and the anxieties of everyday life. Furthermore when language is not shared, language and cultural differences are not only tending, in some cases, to prevent the counselling approach from even developing - not to mention 'working' - they are also constituting an obstacle to the more routine exploration of a plain physical complaint.

Although doctors were - rightly - unwilling to generalise about ethnic categories of patients (insisting that their answers to my questions should read 'some Asian patients . . . etc') I nonetheless gained the impression from

my conversations with them that there was a possibility that, in some dealings with Afro-Caribbean and particularly South Asian patients, doctors might be inclined to include, say, 'Asian patients' in a loose mental classification of those patients who were likely to misunderstand the consultation process and its purpose. This possibility may be inferred from doctors speaking of (some) ethnic minority patients not understanding that the common cold was untreatable, not having any appreciation of psychosomatic aspects of illness, and being unable or unwilling to give an account of their 'illness' beyond description of painful bodily symptoms. If this were at all disproportionately the case, it would account for the feeling of some black patients that their ill health complaint was not being taken sufficiently seriously. The irony is that, while the 'common cold' symptoms of these patients may be quite sharply experienced, the alternative reassurance which may come from a broader counselling approach is not readily available because of the 'cultural gap' between doctor and patient. Doctors sometimes expressed considerable frustration that their messages about the proper basis of the consultation were not getting home. The implication is that they saw some Afro-Caribbean and South Asian patients as continuing to make inappropriate demands on the service.

I must stress that this problem (of a kind of a non-meeting of minds in the medical consultation) is far broader than any specific question of 'ethnic minority' patients. I would suggest however that there are elements in the situation (particularly the language/cultural understandings) which make us anxious that a mismatch of expectations, and certainly a failure of reassuring counselling, is occurring with disproportionate frequency in consultations between white male GPs and, particularly, female South Asian patients. To say any more about the consultation, and the possible consequences of misunderstandings, requires us to speculate beyond the bounds of the evidence of our study, but such speculation may be valuable since so little is written on this issue, and some of the questions are being raised openly for the first

time. This being the case, practitioners may benefit from a discussion of possibilities not directly indicated by measurable research findings, but nonetheless supported by reasonable inference from what information is available.

Let us say then that a 35 year old woman, born in Pakistan, and recently arrived (say in 1978) in the United Kingdom and Bristol, visits her GP because of severe discomfort in her throat and chest as a consequence of a viral infection which had lingered over some considerable time. She is anxious because of the same kind of illness has recurred each winter that she has been in Britain, and indeed, has seemed scarcely to 'clear up'. The family are poor, any income beyond state benefits (claiming of which is experienced as a fearsome trial, not least because of inability to speak and read English) is unreliable and meagre, and the home in which the family lives is too small for their needs, damp, and in a poor state of repair. The woman is also worried about one of her children who has similar repeated infections and a chesty cough; she has to keep him off school, and when he does go she is worried about the stories he brings home of his being called names and bullied on the way home. She and her husband though legally settled in the United Kingdom, hear of frequent instances of Asian families - or members of them - in great difficulties over immigration regulations, and have a diffuse but constant and real fear that their right to remain is under threat. She describes her symptoms as best she can by a mixture of sign language and occasional English words - she has had no guidance on how to describe health symptoms to an English GP and is far from sure just what he expects. Her older daughter has sometimes accompanied her on such visits to 'official places' but is at the moment unwell and being looked after by her grandmother who lives with her brother-in-law some distance from her own home.

None of this 'story' is taken from an actual case but every single bit of it could be substantiated as 'likely' on the basis of evidence which we have.

The GP welcomes the patient, having noted that she has visited several

times over the last few years, especially during her pregnancies when she appeared anxious and apprehensive but in the end had uncomplicated satisfactory births. She has also visited before, showing considerable anxiety about her own health and that of her children, but previous experience has suggested that she had no serious underlying health pathology. The present visit appears to have been promoted by the severe discomfort of what is, in all likelihood, a 'common cold' infection. But before proceeding to give the same advice that he gives to all patients anxious about coughs and virus infections, he reassures himself, as best he can in the time available and within the constraints of communication, that there is nothing serious which he ought to pursue further. He then begins to explain to the woman that her illness is not serious, is 'nothing to worry about', and that medicine has nothing to offer beyond advising rest and 'taking care', to the sufferer from the common cold. He is disconcerted by his inability to make this clear, and fully aware that there are anxieties in the patient's mind which no doubt affect her general sense of healthy well being. But is he also aware that he has consistently found it extremely difficult - or impossible - to reach into these anxieties. He sees the patient out sensing that his efforts at reassurance will not have succeeded but at a loss as to what more he can do. He calls in another, older, South Asian female patient, and begins the process again.

The patient leaves feeling quite uncertain as to whether she has succeeded in communicating to her doctor all the health worries she brought with her. The doctor was kindly but seemed to be saying that there was nothing wrong, nothing to worry about, but did not set in motion any course of action which promised to make her better. There still seemed to be plenty to worry about. She wondered about asking her husband to get in touch with a distant friend of the family who was a nurse in a Bristol hospital and might be able to talk to her and reassure her. In the weeks which follow the consultation she manages her difficult home circumstances as best she can but

often feels anxious and, when alone, quite depressed and tired. Her son has been off school again and she can't be sure how unwell he is and how much he is simply afraid of going to school. As the weather gets worse and the house colder, she stays in even more than usual and finds herself listless and depressed (even if she wouldn't use such a word, either in English or Punjabi, to describe how she felt). The discomfort of chest and throat has receded a bit but then returned and she has become increasingly unconvinced that 'there is nothing to worry about'. Some two months later her son is again unwell so both she and her son decided to visit the health centre again, together.

If such a construction of events is at least tolerably close to reality, it would go a long way towards explaining some commonly observed phenomena:

> the GPs feeling that some patients do not understand the common cold;
>
> that, try as they will, educating the patient out of the 'pill for a pain' expectation does not succeed;
>
> that some South Asian patients make frequently visits concerned over things about which he can do little;
>
> the patient's feeling that the doctor has not understood her complaint or has not taken it seriously;
>
> that she remains far from reassured and
>
> that she visits the GP again within a relatively short space of time.

The doctors to whom we spoke were trying very hard to avoid stereotyping patients along 'ethnic' lines. They know very well, for example, that their patients are divided into 'regulars', 'infrequents' and 'stayers away' but that these categories do not follow precise ethnic lines. If we accept that something like the above 'sketch' process commonly takes place and allow the possibility that some doctors make some 'probability guess' that links 'inappropriate visit' with ethnic background (i.e. the doctor raises the threshold where he becomes anxious about the chance of a 'real' pathology) then we might have a partial explanation of how, in such cases, some serious health difficulties could remain undiagnosed, undisclosed, and only uncovered

at a seriously late stage in consultations.

It is futile to recommend measures which might improve these types of situations unless we recognize that one severe constraint is a factor largely beyond doctor's or patient's control - the amount of time which a GP can spend with each patient. If the GP is as sure as humanly possible that he is not 'missing' any serious pathology, he is probably telling himself that 'undue time' with this patient is at the expense of the time he can spend with a patient whom he knows to have serious health difficulties. Patients often sense this and repeatedly apologise to the doctor 'for bothering him' for 'taking up your time'. How do you practice holistic medicine in four and a half minutes? This leads me to suggest that the best solution might be to provide a more enriched service of health counselling which in the case of South Asian patients would have to be sensitive to all the issues of family, religious, and linguistic differences. Health visitors do some of this work, although their efforts have of necessity to be concentrated on certain categories of patient - the elderly and, especially the young mother and child. It is worth noting that, in our study, health visitors not only received an overwhelming majority of 'yes, satisfied' formal responses to our question, but also received an impressive number of spontaneous warm tributes faithfully recorded by the interviewers. This was true in all groups whom we interviewed.

There are of course things which can be done in working with General Practitioners and their staff themselves. Although one told me that a seminar on "ethnic minorities and medical practice" might be seen by busy GPs as 'another meeting', I also have reason to believe that some GPs would welcome an opportunity to raise the whole range of issues to which this report points.

SECTION 7

Social Services and the Afro-Caribbean and South Asian Elderly

Readers will recall that our sample, whilst including many interviewees below the age of sixty, was 'tilted' towards the adult and elderly residents of central Bristol, in order to make possible a special focus on issues relevant to older residents. Whilst, in our health data, this became a sub-topic of the general topic of access to health care, in social services the focus was almost exclusively on the elderly. This was partly because the diversity of social services is so great - we focussed on those which particularly affect the older citizens. It also means that the most relevant responses were from the 33 Afro-Caribbean respondents, 18 Asians, and 22 whites who were actually over 60. Nonetheless there was a considerable amount of relevant comment from all respondents (for example from younger South Asians expressing their concern for older people) and especially from the approaching elderly group whom we asked how they viewed the prospect of old age for themselves. This group was particularly large (44) among the Afro-Caribbean interviewees.

The focus then, within the social services, was on services likely to be used by the elderly, and these included:

1. Home helps and meals services,
2. Day centres
3. Accommodation, especially Elderly Persons Homes and Sheltered Accommodation.

Two particular questions were in our minds at the outset of the study:

A. How severe are the problems of isolation and dislocation among the elderly of the ethnic minorities? Or, conversely, what should be made of the assumption, sometimes made by 'providers', that the strength of extended family support among ethnic minorities obviates the need for social services?

B. Where need is demonstrated, what kind of provision is most needed or desired? In particular, what are the attitudes of South Asian Afro-Caribbean origin people towards forms of "special provision", such as homes for particular groups in the population?

Answers to the first question require a brief reiteration of earlier discussion of family structures among our Afro-Caribbean and Asian respondents. We should recall, for example, that about 35% of both groups reported that their family "had been able to keep together for the most part"; 13% of South Asians and 32% of Afro-Caribbean interviewees spoke of their family as "mostly separated", and 10% of each group told us that their families were divided between the "UK and abroad". Older Asians were less likely (than younger Asians) to report divided families (because of the pattern of immigration as discussed) but older Afro-Caribbean interviewees were more likely (than younger black respondents) to report divided families, over 40% of them telling us that their family was mostly separated. When we asked "is your wider family here in Bristol?", 32% of Asians said yes, and only 20% of Afro-Caribbean respondents said yes.

Finally, we should recall two other things: Firstly, that one third of the Afro-Caribbean elderly reported living alone and that a further third lived with their spouse only. We discussed this along with evidence of any compensating presence of family members in other households (but 'in reach, and in contact') and concluded that although some older Afro-Caribbean people could expect support from nearby kin, more were likely to be isolated or relatively isolated from other members of their families, from whom they may once have looked for support in their later years. Secondly, although very few of our elderly South Asian respondents were living alone, there was evidence that some were relatively isolated, and even more evidence of considerable anxiety about the social position of the Asian elderly (in terms of satisfying and comforting social contact) even though most were reunited with their sons and daughters. Approaching-elderly South Asians (growing old

in this country) quite commonly expressed anxieties about the degree of support they might expect in their later years. In general we argued that our evidence disconfirmed both extreme stereotypes - of the secure embrace of the extended family guaranteeing the support of Afro-Caribbean and Asian elderly, OR of widespread breakdown of family structures. We can probably expect that, no more and no less than native born elderly, older people of New Commonwealth origins will find themselves in need of social support beyond the family, especially as an increasing number among them reach into their "seventies" and above when frailty and infirmity become more common.

Knowledge of and use of services

Knowledge of 'elderly-relevant' services was high among West Indians, particularly among the elderly themselves, but was appreciably lower among South Asians. Use of these services is low in both groups, although West Indians make some use of home-help services, and a number are beginning to take up places in Elderly Persons Homes. Sheltered accommodation was the least well-known of all types of provision. Attitudes expressed towards these services fell into certain broad categories, the most common being that people very much hoped to avoid dependence upon them, seeing them as a last resort especially in the case of 'living in a home', a perspective shared by many white respondents. Asian interviewees were particularly likely to mention their expectations of support from their children and families, variously expressed as a hope, or as a hope that may not be met. West Indians were more pessimistic in this regard, reflecting the fact that more of them had actually reached or almost reached old age, and could perhaps see that they might come to depend on support from outside the family. West Indians were also likely to mention the possibility of a return to the Caribbean - seen as something that they would expect to remove the possibility of ever having to finish their days in a home in the UK - but this too was variously expressed as an

intention, a hope, or indeed as a fading hope. When it is a fading hope it may have a particularly significant psychological function. The dream of the return alleviates the sharpness of the anxieties about a dismal old age in Britain; but it may also get in the way of firm planning (to the extent that this is possible at all) for the contingencies of old age.

For Afro-Caribbean interviewees (showing "all" first, and "the elderly" in brackets) 82% (91%) had heard of Day Centres, 79% (91%) had heard of home-helps, 81% (94%) had heard of Elderly Persons Homes, and 63% (66%) had heard of sheltered accommodation, the last being the only provision of which any substantial number had no knowledge. For the Asians the same figures were Day Centres 68% (72%), home-helps 63% (67%), meals service 58% (67%), Elderly Person Homes 58% (72%) and sheltered accommodation 55% (67%). Services are better known among the elderly to whom they may be relevant in both groups but overall the Asians were less likely to recognise the services we mentioned. Among South Asian elderly there were scarcely any who reported using these services, though 2 mentioned their home-helps, and one reported attending a Day Centre. However a quarter of the elderly (N = 33) West Indians reported having a home-help, and smaller numbers mentioned using Day Centres and the meals services; 4 were resident in Elderly Persons Homes.

Would you use these services if they were, in some way, differently organized?

Answers to this question (asked about each service) are particularly hard to judge because of the possibility that some might answer 'Well, yes, I might' without ever having given the question a great deal of thought prior to the interview, and this would be the case among those who most firmly believed that it 'would never come to that'. In assessing likely demand we have to allow for this possibility, but we also have to accept that some people may find themselves in a need which they had not - (or do not now) - anticipated. With these cautions we can report that a considerable number of both Afro-

Caribbean and South Asian (elderly) told us that they could see themselves using some of these services if they met certain needs and 'tastes', and these answers were particularly persuasive if interviewees went on to speak of the kind of modified provisions they might hope for.

Day Centres

14 of the 33 elderly West Indians to whom we spoke said that they would take advantage of Day Centres if 'they were differently organised' and more than half of them mentioned the sort of things they would look for. Some mentioned quite practical things - 'if they were nearer home', 'if we knew more about them' - but rather more mentioned their wish for Centres with compatible activities 'if there were West Indian activities' and 'if they were more culturally suited'.

Only 5 of the 18 elderly Asians said they might use Day Centres, giving much the same kind of view of what would prove attractive.

Meals Service

Nine of the 33 elderly West Indians expressed interest in the meals service, as did 10 of the 44 'next elderly' and almost all of these spoke of hoping for 'better, more compatible food'. Among South Asians (with vegetarian or Halal meat or other diets) there were few who looked for the provision of meals from a service outside the family home, but nonetheless three of the most elderly (of 18) and 14 of the next elderly (of 42) told us that they might use such a service if it included food compatible with traditional tastes.

Homes for the Elderly

West Indians. Four of our elderly Afro-Caribbean interviewees were

residents of EPHs - and each one expressed in various ways, their dissatisfactions with life in 'a home'. It should be noted that our four interviewees are among what is still only a small total of all West Indians in EPHs in Bristol - and perhaps no more than a dozen. But, given the general distaste (in all groups) for 'ending up in a home', the number of older West Indians who replied that they might use such homes 'if it became necessary' and if the home met their needs was quite striking. Sixteen of the 45+ year old black respondents (N = 77) [ten of the 60+ age group (N = 33) and 6 of the 45-59 age group (N = 44)] spoke about what they would hope for if they came to depend on living in an EPH. All spoke of things which might make them feel 'more at home' and of wanting to see the homes function 'more flexibly'. Those who had experience of Elderly Persons Homes also spoke of the lack of privacy and a kind of routine impersonality. (We comment below on interviewees view of 'racial integration' in homes.)

South Asians. By way of contrast, scarcely any of the South Asian interviewees looked to EPHs as a solution to problems of accommodation which, no doubt, seemed more remote to them. Evidence from other areas of the country suggests that - however reluctantly - the need for residential care will be felt among Asians too. When we visited Handsworth the staff of the Asian Resource Centre supplied us with information which showed that there was an increasing demand for residential places among older Asian people, although not necessarily in an EPH. A considerable number of South Asian elderly people had been found accommodation in sheltered accommodation units, and many others were on a waiting list. We have already suggested - on the basis of the evidence of our own study - that we should not always assume that the extended family arrangements will preclude the need for accommodation. As the need becomes more pressing, some of the disinclination to look to this kind of provision is gradually overcome. We can expect this to

happen in Bristol - gradually a growing number of cases will arise where the need for placing an elderly South Asian person in a home will be felt. And gradually the presumption against using such provision will weaken. It is then - over the next few years - that the response will have to be flexible and imaginative, because the language, religion and diet "tastes" of residents will constitute issues of provision which have not been faced before.

Returning, in summary, to the Afro-Caribbean older people, it is evident that, by comparison with South Asians, they are much 'further along the road' in both experience and attitudes. In experience of old age and approaching old age, many more of them have had cause to consider what might await them. In attitudes, Afro-Caribbean elderly people in Britain and Bristol have moved from simple distaste for a remote possibility (needing accommodation and possibly care, other than in their own home) to active consideration of real alternatives.

Home-helps, reliance on help from others

We have already seen that a number of Afro-Caribbean interviewees had experience of the home aid service. And over one third (13 of 33) of the elderly (60+ years old) in this group could see themselves coming to need this service. This is not surprising considering the number of older West Indians who were living alone, or just with their spouse. Only just over a half of this elderly group had a telephone, and five of the fifteen who did not have a telephone, also did not have ready access to one. About one in four of this elderly group (8 of 33 elderly West Indians) reported that they were anxious about how they would cope in an emergency, such as having a fall at home. Although South Asian elderly respondents did not expect to look to the home help service in managing their homes (only one lived alone), there was considerable anxiety about being able to cope in the home, in particular in

relation to fears about 'security' i.e. fears about all sorts of dangers such as intruders, burglaries, and attacks. And again several South Asian elderly people had no telephone and, in some cases, no access to one, and were worried about coping with domestic emergencies.

Attitudes of ethnic minority (elderly) to "integrated" and "separate" home provision

In other parts of the UK, and both in relation to EPHs and to sheltered accommodation for the elderly, the question of 'ethnic origin' has been given considerable attention. It is a complex issue, partly because there are many different kinds of need and provision - public sector, voluntary sector/ housing associations, larger and smaller residential homes providing for people needing care and attention, and sheltered accommodation units providing for a maximum of independence. Very closely related are all the issues surrounding 'care in the community', and the use of (and "emptying of") hospital beds in the care of the elderly, including the mentally and physically infirm. No single piece of research, no single report can hope to cope with all these variables, but, in the longer run, all these issues need to be taken together. It is also complex because there is no single 'perfect answer' since the dimensions of management in each of these 'sectors' are so different, and because it is not simply a matter of integrated or separate provision.

In public (EPH) provision (and to some extent in other sectors) there has been a very strong presumption in favour of taking people into residential homes on a 'traditional' basis of need, irrespective of ethnic origin. Indeed one could go further than this. The very suggestion that 'ethnic background' could or should be a factor in any way influencing allocation of places in homes/flats, is one that raises hackles, being seen as a signal assault on all just principles of provision. The very first requirement is for managers,

providers, and policy makers to think their way past this initial response and recognise that no-one is asking for special treatment in the sense of a favouritism which breaches the principles of just allocation on the basis of need.

The real question is whether, when undoubted need does arise, what consideration should be given to ethnic background as a factor involved in the very business of meeting needs and providing homes with a tolerable measure of internal compatibility and harmony. The strongest argument in favour of 'taking people as they come' is the dominant norm of racial integration, expressed not only by 'providers' but also by many of the older Afro-Caribbean elderly themselves. It is somehow seen as a sad day if we admit defeat by making separate provision on the basis of race or skin colour. Afro-Caribbean elderly people also mention the unhappy reactions which such provision might provoke, sensing that 'white' British people would look on it with disfavour. They also fear that separate provision (for say, West Indian elderly) would be inferior provision, leading to ghettoes of black elderly mirroring the structured disadvantage of black people in other spheres. All these reservations are reflected in people's responses to suggestions of 'separate provision' - along with the more diffuse but strongly expressed notions about 'favouritism' which, we have argued, are fundamentally irrelevant.

The contrary arguments should not really be seen as arguments in favour of "separate provision" since the actual provision responses are likely to be much more flexible than an exclusively 'racial basis' of allocation - a notion which distracts attention from the mature consideration of policy. The following arguments should be seen as ones which may be adduced in favour of some sort of attention to ethnic background in managing entry to EPHs and units of sheltered accommodation for the elderly.

1. Where Afro-Caribbean or South Asian elderly enter - in ones and twos, inevitably, in the first instance - homes which are almost all white-anglo in their membership, these members of minorities are frequently very much estranged, partly on account of hostility from fellow residents or staff.

2. Many Asian and Afro-Caribbean elderly, whilst in no way thinking in terms of racial separation, would deeply appreciate being surrounded by people with whom they felt at home with whom they could speak easily and share sentiments and memories.

3. It may be that we ought to balance the ideal of racial integration against the liking of the elderly, of all groups, for the familiar and the compatible, and, perhaps, their higher resistance to accepting new patterns. There are certainly precedents in the voluntary sector for a 'similarity of background' basis of residential homes, e.g. home for the Methodists, or for particular nationality groups based on mutual funds.

4. Where special provision includes meeting dietary and religious needs, these can more readily be achieved where there is some measure of 'congregation' of groups.

There are, then, arguments on both sides, as our respondents readily recognised. The real argument, we have suggested, is whether some special provision be made, and if it is, how and with what assurance that it will meet real needs and be of good quality.

In the interviews (re: "Special Provision") we asked over 200 South Asian and Afro-Caribbean people the following question:

> 'In some places in Britain, elderly persons homes have been provided with a particular group in mind (say for 'the elderly Bengalis'). What is your view of this for any group, including your own?'

Answers were open ended but categorised as

- Yes, a good idea
- Not a good thing, people should mix
- Not for me, but all right for those who want it

and these three categories covered most responses although a few said things which we made special note of, such as 'against all homes' or 'that would be like a ghetto'.

Afro-Caribbean (N = 98) responses on "special provisions"

Yes	No	good for some	against all homes	like a ghetto	NR
27	47	14	2	2	6

The largest single group is clearly those who were broadly 'against the idea' and many of these added some comment like 'people should mix', an indication

of the strength of the norm of integration. Other forms of opposition were based on thoughts about the reaction and divisions which might be provoked or on the quality of the provision itself. On the other hand a quarter of the interviewees gave broad approval to the notion, and others were open to the idea for 'those who want it', making about 40% who are not in principle opposed. The patterns of response among the 60+ age group was similar to that for the whole group, although a slightly lower proportion expressed outright opposition.

From our conversations - with groups and individuals during the research, this is probably an accurate assessment of the state of opinion among Afro-Caribbean people in general and the elderly in particular. It certainly shows that there is real resistance to the idea of separate provision, especially when what is envisaged is seen as contrary to the norm of integration. But some cautions need to be added. Firstly, the group endorsing some form of separate/special provision is no small minority which can be disregarded. Secondly, in areas of the country where numbers (of black elderly) are larger and real exploration of alternatives has gone further, 'opinion' seems to move towards some form of special provision - for example, in parts of London, such as Haringey where we met and chatted to Afro-Caribbean elderly Association members. Thirdly, few elderly black people are in homes, but as their numbers increase, hearsay of unhappy experiences may rise and have an effect on expectations. Fourthly, some of the opposition, to 'special/separate' provision was more based on a fear of the 'ghetto effect' than on dislike of the idea in principle. We cannot and should not disregard the views of roughly half West Indians who do not endorse such special provision - many of whom expressed a real commitment to goals of integration; but we should also note the support for some form of 'special response' in provision, and recognise that this 'opinion group' may grow.

Among South Asian interviewees opinion is much less divided and the number against special provision (7) is so small that we need not report in

table-form. 76 of the Asian interviewees said that they thought that this type of special provision was a good thing, with no significant differences between age groups. 15 of the 18 oldest respondents replied in favour, as did 28 of the 41 next oldest, of whom a further 6 simply expressed a view against all homes. The other small but significant fact to report is that three interviewees made mention of special provision "especially for Asian women". In addition the idea of providing additional/special diet foods at homes, or centres where the elders of the ethnic minorities might meet, was given overwhelming approval by both Afro-Caribbean (74%) and Asian (80%) respondents.

Who Should Provide? The state, the voluntary sector, self-reliance and self-help.

We put to our interviewees the idea that groups sometimes organized themselves, in various ways, to provide facilities - such as homes, meeting place centres - and that this might be seen as a kind of alternative to reliance on public provision. We asked for their view of this, through a question which may be taken as predisposing them to regard "self-help" of this sort as a "good thing". It should be recognised - it certainly was recognised by our interviewees - that this does not uncover a single-dimension opinion - e.g. for or against state provision, but allows for a variety of opinions, including such as "the state should fund services - such as elderly persons homes - but allow local groups to participate fully in their management and planning". Our interviewees clearly understood what 'we were driving at' and their variety of responses reflected this.

	Self-help a good idea	State and self-help	State should provide	other	NR	Total
Afro-Caribbean	32	21	22	5	15	98
South Asian	34	11	37	10	11	103

About one third of both groups expressed support for voluntary self-help projects as a mode of provision of service. There is no specific suggestion (in the interview reports) that those endorsing this view were actively opposed to state provision, though undoubtedly some, among both Asians and West Indians do express the view (at various points in the interview) that ethnic minorities must 'look out for themselves', sometimes in recognition that they do not expect, or have come not to expect help from others. On the other hand, over forty per cent of both groups indicate support for an expectation of state provision or a combination of state assistance and self-help. Indeed the phasing of a question tending to invite support for self-help and the open ended responses could be taken to attach more significance to the response 'the state should provide'. It is true that many expressed a kind of gratitude for various forms of public provision - particularly the National Health Service - which they know compares favourably with services in their country of origin. But respondents were also aware that they had worked a long time in this country, paid their taxes and contributed to national insurance - and thus felt that they had made the contribution necessary to merit public support, for example in times of ill-health or in old age. This view may be taken as tempering any enthusiasm for self-help projects as a way of providing services. At the same time many to whom we spoke - especially among West Indians - said, in various ways, that self-reliance was a kind of optimum (if you could achieve it) because then the uncertainties of reliance on public provision were removed.

SECTION 8

Race and Social Policy in Bristol and Avon

In the last few years some of the most hopeful signs of progress - in countering racism, in pursuing policies of equal opportunity in employment and promotion and allocations, and in awareness of special needs of ethnic minority groups - have come via the work of local authorities. Section 71 of the 1976 Race Relations Act stipulates that the requirement not to discriminate

> "applies to acts done by local authorities in the same way as it applies to acts done by private persons. In addition it imposes a duty on all local authorities to make appropriate arrangements with a view to securing that their various functions are carried out with due regard to the need
>
> (a) to elimimate unlawful discrimination; and
> (b) to promote equality of opportunity and good relations between persons of different racial groups."

Local authorities have therefore been asked to examine:

(a) their own role as an employer

(b) their role as a provider of services (social services, housing, education, youth and community service)

(c) their role in meeting new or additional demands and needs, often via Section 11 of the Local Government Act or Urban Aid.

In conducting this research we interviewed a number of officers of departments of the local authorities (as well as health officials) and will report on this fully in the future. Here we can briefly state some main outlines of the situation in Bristol and Avon, and follow this with some comments on improvements which are needed, with special reference to the issues raised in this report.

Most observers would agree that local Authorities in particular parts of

the country (for example, Bradford, and some of the London Boroughs and the GLC) have led the way in attempting to meet both the spirit and letter of the law as outlined above. This is not to say that these policies have been acknowledged as unqualified successes - rather that there have been clear signs of political will to make innovations in the field of equal opportunity and service provision with special attention to ethnic minority groups. Sometimes these 'leads' reflect the strong presence of Afro-Caribbean and Asian groups in the authority area, though this alone is not a sufficient condition for a policy commitment. Those places which have taken new steps appear to have benefitted from a combination of coordinated pressure groups, favourable local political configurations, and responsive programme directors in the authorities. It is also clear that nothing is achieved without hard work and willingness to face conflict and concerted opposition. Within the Afro- Caribbean, Asian and other minority groups themselves there is no necessary agreement on priorities and strategies, and there is no special reason to assume that there should be. Arguments and disagreement develop and have to be thrashed out. Equally white groups in the population respond in different ways, from the supportive, the indifferent and the outright opposed to policies or programmes which are sometimes seen as favouring a particular group. The point is that some authorities have gone a considerable way down these roads - they have passed the stage where the very principles of equal opportunity and special needs are discussed and have agreed 'umbrella' policy commitments. They have passed the stage of appointing officers in various departments with special responsibilities for the implementation of these polices in specific fields. They have reached the stage where programmes of action, innovation, consultation, review, monitoring have been in position for some time and are thus in a position to evaluate progress.

My view of Bristol and Avon, is basically, that, as authorities, they are some way further back down these roads than other authorities. But this need be no obstacle to future progress if emerging commitments can be translated

into effective action, especially since these authorities stand to learn from the successes and mistakes of others. Locally it is only in the last two or three years that questions of equal opportunity and special needs have moved up the agenda to gain visible and active consideration. In many of the city and county departments which provides services, it is in the last few years - even the last few months - that serious consideration of 'racial equality' has been promoted for the first time. Understandably much of the early discussion centres on general principles - since permanent officers of service departments are sometimes being asked to question ideas which they have consciously or 'unconsciously' followed for many years. The transition now has to be made to consideration of the details of implementation and priorities. In other words, if (for example in social services) we begin by asking "can or should services be changed to meet the needs of particular clienteles" we move to asking "granted that new needs exist which current services do not meet, how can we change our services in such a way as to ensure that we are not excluding some groups from the full benefits of our activities?".

In considering the relationship of our research and the issues it raises, to the development of 'race-related' policies in Avon and Bristol we must begin by recognizing both that certain policy initiatives - and appointments - have been made, and that some channels exist for consultation. It is beyond our scope to comment fully on these here. But we may note that the Education department has adopted a policy statement on 'racial equality', Avon has agreed on equal opportunities statement and begun to pursue implementation by the appointment of new officers or the provision of instruction and new procedures for existing officers and departments, that the Housing department of the City has begun to monitor housing applications (for ethnic background) and that the Social Services department has an Ethnic Minorities specialist

post and is planning a senior coordinating appointment in this field[1]. The training division of Social Services has taken a particular interest in race issues and a conference on the subject was recently held in Bristol, with the cooperation of the Bristol Council for Racial Equality. During our research we also made inquiries with relevant related bodies - such as the University and Polytechnic Social Work departments, and with the Housing Associations. These will be reported on separately.

In all these sectors and organizational 'avenues' whereby new programmes can be developed - with activities and serious consideration of equal opportunity and 'racial equality' policies - our judgement is broadly the same. That is, with varying levels of awareness and commitment, these issues have reached the agendas of relevant groups, but only a few small steps have been taken. It is not only that not enough has been done, but also that in many areas not enough is known about what can be done and not enough set in motion to provide the occasion for evaluating current practice. The next few years will tell whether Avon and Bristol can respond to new needs and meet responsibilities to black people in ways that have undoubtedly been neglected to the present. This is particularly urgent for a group on which we have focussed in this study - those black elderly who are reaching their "sixties and "seventies" in the present decade. We shall now make some comments on possible policies and programmes, especially as involving local authorities, but also as involving the delivery of health care.

Putting the issues on the agenda: recommendations

We must consider both <u>how</u> to raise these issues effectively, i.e. in such a way that tangible results may be seen, and <u>which</u> issues to raise, what

1. At the time of writing, proposed committee structures (e.g. for consultation on "equal opportunity") remain very much in dispute.

recommendations to make, i.e. decide our priorities. Obviously researchers are only one among many groups of people with views as to what should be done - our primary task is to uncover the issues. On the other hand we cannot ask a lot of questions and simply walk away. The people whom we interviewed told us many things which they would like to see done and several made it clear that 'action was the only justification for research'. At the very least our report should speak for the people who have given so generously of their time.

Strategies. Many of the issues which we raised fall within the ambit of the country and city authorities, and minority groups and residents of the central city area will seek to influence local politicians to represent them effectively. When items reach the agenda of committees, sub-committees and working groups, it is essential that representatives of all relevant groups are well-briefed after a maximum of consultation so that proposals can be brought forward with a high degree of conviction.

The best known committee in this area is the Tripartite committee which brings together representatives of the councils and the Bristol Council for Racial Equality. This committee does not appear to have been an effective vehicle for forwarding health and social service matters. There are many people who would like to see this committee reviewed and revised. If this is done it is essential that a special place be created for the consideration of issues related to the social services. The committee has often met as a large group probably reflecting an anxiety to see many issues raised and a wide spectrum of people represented. The time has come for smaller groups to be convened which can concentrate on single issues and carry them through to their conclusion. This also entails having firm procedures whereby agreed recommendations of the Tripartite Committee can go forward to City and Council committees with the full weight of the Tripartite Committee (or alternative structure) backing. If these were regularly and clearly done, then over a period of one or two years participants would be able to see whether

Tripartite Committee recommendations were having a telling effect - as against descending into a mere forum for airing views.

We recommend that the Tripartite Committee (or its successor) constitute a sub-committee or working group exclusively concerned with "Social Service" items and that this working group should, on a regular basis, bring forward fully-supported proposals, for the approval of the full committee, these proposals, on gaining the assent of the full committee, to go forward as specific recommendations to the appropriate committee of the City or County.

The Bristol Council for Racial Equality has an active interest in all affairs affecting racial and ethnic minorities and has been closely involved in this research (funded by the Commission in London). Not all people regard the BCRE, its council members, executive committee or officers as the best or 'approved' means of advancing specific interests and it can certainly not be regarded as the only avenue for this. But the Council has the benefit of a certain public recognition and the ability to negotiate (if not always to secure) representation on public policy committees. It also contains within its membership representatives of most private and public bodies and individuals in Bristol and its general council meetings can act as a very effective arena in which to hear views, raise issues and reach some preliminary consensus on priorities. None of this can be done without conflict, discord and disagreement, some of which are so deep and frustrating as to lead groups and individuals to 'abandon' their links with the council. However justified this has been in the past, our view is that the BCRE has, now, the opportunity of being more effective than for many years past. Members, supporters and potential supporters need to accept that there are bound to be divisions and differences over strategies and priorities, but at the same time be willing to pitch in and argue their case in an atmosphere of mutual respect. There is no reason why all the groups represented in the council should automatically agree on all or even most things; but there is a common enemy in the racist attitudes and practices which continue to affect us

all, and it is common for opponents of particular plans to seize upon the slightest indication of discord among and within minority groups.

The Health and Social Services sub-committee of BCRE is the most important body for raising issues relevant to this report. Over the last few years it has discussed most of these issues and gained some expertise in several areas. In the reseachers' view two things need to be done to expedite the work of this sub-committee. One, there should be a further sub-division of 'Health' and 'Social Service' matters, and two, there should be some recognition that the time has probably come for a shift away from broad discussion of issues to the drafting of highly specific proposals in limited areas.

We recommend that BCRE give full consideration to the creation of two sub-committees, one for health matters and one for social service matters. (This is particularly important because the channels of further discussion are so different, i.e. the health authorities as against the local authorities). And we commend that both these sub-committees draw up agendas of itemised priorities for action.

Of course, precisely what the Council does is entirely a matter for its members and officers; we can only recommend or suggest. And general readers should be aware that there are substantial constraints on what a local Council (for Racial Equality) can do; legal, administrative and financial constraints, nowhere more evident than in the undue pressures bearing upon the full-time officers.

Beyond the political/policy making level of the Authorities, the consultative/lobbying role of BCRE, there are the activities of voluntary groups, urban aid funded projects and local community pressure groups. In our view these have shown encouraging signs of growth in recent months and years. The Easton, St. Pauls and St. Werburghs special health group has been very active in raising issues at a local level and in making sure that it expresses the views and interests of local residents. The Bristol Resource Centre does

a great deal to help individuals and groups, especially where the need is for advice, know-how and information. The representative associations are well-established, although their role in making and advancing concerted representations on specific issues is limited by their resources and the constraints on the time of their officers. In the health field in particular there will be a need for new departures, because of the need to consult with the various health authorities. The community health councils have been helpful in individual cases, but it seems certain that new channels of representation will have to be created in order to advance 'minority' issues in medical policy making and administration.

SECTION 9

Items for Consideration: Recommendations

Benefits Advice

Studies in other parts of the country suggest that those most in need of benefits, of various kinds, are the people least able to negotiate their way towards receiving them. This was most amply demonstrated to us in our visit to Handsworth where the Asian Resource Centre was virtually overwhelmed with calls for assistance from (particularly) elderly South Asian residents who had not known how to take advantage of social services as administered from 'conventional' centres. There are difficulties of language, a lack of sympathy or understanding, and expertise on the 'official' side; and clients may suffer from not knowing of benefits, being afraid of the consequence of pursuing them, and from difficulties with forms and applications. The areas of difficulty mentioned frequently in our study were:

a) the need for help in obtaining home improvement grants

b) for help over pensions and supplementary benefit

c) for help in claiming sickness and invalidity benefit and

d) for advice in dealing with immigration regulations.

Our experience of Handsworth, and other centres, has convinced us that black people will not gain the benefit they need and deserve from these sources unless a central advice and aid centre is created which is designed to achieve maximum sensitivity to the anxieties of Afro-Caribbean, Asian and other ethnic groups. We recommend that this be pursued as a policy objective.

Siting of district social service offices

The Avonvale Road siting of the main local social service offices is a factor in the poor access of black people to services. We recommend that serious consideration be given to creating a sub-centre office sited closer to the heart of the central city area.

Day Centres

The evidence of acute loneliness and distress among elderly Asians and some elderly West Indians is overwhelming and will grow as a problem in the next few years. Although small numbers of these people attend existing Day Centres and Community Centres, we do not have evidence that present provision is filling the need for meeting places, locally and conveniently sited, with an atmosphere of sensitivity to a potentially growing 'minority group' clientele. We recommend that efforts be made to provide such a centre or centres either by a new provision or adaptation of existing provision.

An Asian Women's Centre

The difficulties faced by (especially) non-English speaking South Asian women are so diverse that as well as giving attention to their needs in particular areas (e.g. at the Health Centres) serious consideration should be given to the provision of an 'omnibus' advice/aid/community meeting centre oriented specifically to the interests of Asian women of all ages. We recommend that initiatives to this end be given the fullest support.

Accommodation

An increasing number of elderly Afro-Caribbean and Asian residents of

Central Bristol are likely to find that they need some form of support by way of accommodation. For those less constrained by ill-health or frailty, the 'supported independence' of sheltered accommodation is undoubtedly the best form of provision. In other parts of the UK steps towards this kind of provision, with due sensitivity to special needs, have been taken. In particular we recommend that entry into existing units of sheltered accommodation be fully explained and 'opened' to ethnic minority groups, with procedures established to overcome the difficulties which can arise when a person enters a unit singly as the first and only Afro-Caribbean or Asian person in that accommodation. We also recommend that voluntary groups, in cooperation with existing housing associations, or by the formation of new associations, find ways to develop new or refurbished accommodation designed with the needs of Afro-Caribbean and/or Asian elderly in mind.

We also recommend that the social services department review its procedures for admission and care, in the light of an expected increase in the need for residential care among elderly Afro-Caribbean and Asian people. The social service department and the home officers in charge are not unaware of this question. The department has organized in-service training course for EPH staff at which the care of 'minority' elderly has been discussed. And officers in charge of homes replied promptly and fully to enquiries carried out during this study (see future reports). But consultation must continue because the soci-cultural and care issues related to the black elderly merit a good deal of focussed attention, especially considering that few if any Afro-Caribbean and Asian elderly have expected to spend their later life in a home and that, for staff, the questions of care which arise are new and complex.

In connection with public, housing associations, and private sector provision of all types of accommodation for the elderly we strongly recommend the establishment of consultation between management groups and representatives of minority associations/BCRE/pressure groups. Some such contacts have taken place on an ad hoc basis, but on nothing like the scale to

give us confidence that in Bristol and Avon we will cope adequately and sensitively to the needs of the next few years. It should be noted that the regional office of the Federation of Housing Associations is situated in St. Pauls and their director has shown willingness to be consulted on what housing associations can do in providing for minority group elderly, especially since precedents from other parts of Britain (such as Leicester) are increasingly available.

Finally, particular attention needs to be given to the policies of the City Housing Department and Avon County Council. The County in particular has stated and restated its wish to pursue policies of maintaining elderly in their own homes whereever this is possible. No doubt this is a policy with much to recommend it, especially if sufficient funds are provided to support people in their present homes, i.e. care brought to the home. But one special point should be noted. Many black elderly people live in areas of the city - especially close to the M32 motorway and underpass - which are specially difficult for the elderly to negotiate. Elderly people are extremely apprehensive about 'getting about' when this involves the likes of the underpass, difficult journeys, and difficulties of access to shops and services. These difficulties are always compounded when friend/neighbour/ family support is wanting. Maintaining the elderly in their own homes is a particularly unsuitable 'policy' in such cases yet at the same time public sector alternative provision in the central area is limited.

Health Services

Afro-Caribbean and Asian people in general are on the whole, judging by the evidence of our study, registered with GPs in surgeries or Health Centres and visiting their doctors when the need arises. The visit pattern *per se* does not indicate any restriction of access to primary care. The fact that Afro-Caribbean and Asian people report slightly higher visit rates than whites

is almost certainly largely accounted for by rather poorer health profiles in these groups. The doctors with whom we spoke showed some considerable awareness of the issues we raised. There is however certainly scope for increased attention to a number of problematic areas of medical care and practice, and among some doctors at least a willingness to take up questions of care in greater detail is evident.

Our study did produce evidence of problems and difficulties which are a cause for concern, and in three areas in particular:

1. Achieving a satisfactory consultation especially with South Asian patients where language is a obstacle or barrier;
2. Meeting the needs of South Asian women; and
3. Achieving satisfactory access and communication in relation to hospital treatment (as against primary care)

Language and communication in the consultation

It is clear that there is a non-meeting of minds over the purpose and function of the consultation, the definition of illness and the communication of all kinds of worries and anxieties in the relation between Asian patients and (typically) white male doctors. Some of these things - in particular questions of attitudes to medicine and definitions of illness and distress - are so complex that no single recommendation could be expected to cover them. For patients there is a clear need for augmentation of advice services so that patients could be given the opportunity to raise issues about medical care, the use of drugs, and ways in which access to care beyond primary care can be managed. Doctors can sometimes deal briefly with such issues in a consultation but I see no prospect for this being a main or sufficient vehicle for giving general advice, about access to and use of services, to patients. The obvious conclusion is that there is a need for either the creation of new paramedical posts (of medical counsellors) or the expansion and extension of the functions of existing support staff such as health visitors.

It was very noticeable that many Afro-Caribbean, and particularly, Asian patients expressed considerable approval of and gratitude for the help they had received from health visitors; but it is probably also the case that this mostly functions in relation to young mothers and their children. We would recommend that serious attention be given to the extension of medical support services of a medical counsellor/health visitor nature so that medical service advice could be given, and in a manner which would secure the confidence of black patients, especially those who do not speak English. It would have to be understood that such counsellors would not replace the medical consultation; it (counselling) would have to be done by people with a sound grasp of elementary medical knowledge allied to skills in counselling. If a team of such advisers were available at Health Centres, in the medium to longer term the efficiency of the consultation itself would be immensely improved.

As regard the question of provision of an interpreter service per se the situation remains fluid and we (the researchers) hear of new developments at the Health Centres. We can certainly say that during the period of research, the provision for overcoming the barriers of language between patients and doctor were quite inadequate. The situation in this respect in the central city health centres needs to be held under constant review and provision needs to be made for not only instituting an interpreter service with secure funding and good training of personnel, but also monitoring of the service's efficiency and success, especially with a view to its extension into other areas of care and service,

All of our remarks above about language, the consultation and South Asian patients apply a fortiori to South Asian women and attention to detail (i.e. differing language needs and different religious sensibility) must include acute sensitivity to the particular and sometimes severe difficulties of Asian women in relation to health care and a satisfactory consultation. But, beyond this, medical planners and administrators must be sharply conscious - or must become conscious - of the depth of feeling in relation to female patients

(especially Asian women) and the preference for female practitioners. We recommend that the health authorities immediately place on their planning agenda a priority of increasing the number of female practitioners available to patients.

Although our evidence on hospital care is less complete - than what was related to us about primary care - we did conclude that difficulties of access, communication and the understanding of causes of conflict and resentment were more serious in the case of care beyond the primary level. Hospital personnel from receptionists to consultant are less frequently seeing Afro-Caribbean and Asian patients (as a proportion of all the patients they see) compared with health centres in the central city, and it seems certain that friction is more likely and more serious. This results in more dramatic cases of distress and dissatisfaction among black patients and probably also some disinclination to take full advantage of services outside the local primary care centres. The only initial step that can be taken is a programme of training and retraining geared to ensure that hospital personnel are more aware than they are at present of the needs and sensibilities of Afro-Caribbean and Asian patients - and indeed of the relatives of these patients who visit them during hospital stays. We recommend that such programmes of training be instituted at least to the level of day conferences and seminars for administrative and medical staff whose work brings them into closest contact with Afro-Caribbean and Asian patients. The provision of adequate and suitable food within the hospital services is a clear example of a reform which need not be costly or difficult but which would make a very considerble difference to the experience of black patients needing any protracted stay in hospital. Similarly awareness training for reception staff (for example in comprehension of Asian names) would, if successful, make a very great difference to the sense of well being and welcome experienced by, particularly, Asian visitors to hospitals.

We would also like to see arrangements made for day conferences and

seminars in which locally-based medical staff, particularly doctors themselves, could focus attention on the range of issues raised by this report. Our section on health drew attention to the possibility that older West Indians may suffer rather more than the average for the age group from poor health and there are some indications of which complaints are most frequently reported. Most physicians are aware of, for example, the possibility of a higher incidence of hypertension among middle aged and older West Indians. But a great deal could be gained from focussing attention on the best contemporary knowledge about ethnic minorities and incidence of illnesses. And although awareness of the nature and incidence of sickle cell anaemia is well established in the medical profession, there is disagreement about which, if any, monitoring procedures are advisable. The Organization for Sickle Cell Anaemia Research recently held a public meeting in Bristol and it was clear that this constitutes an issue of very considerable concern for black residents of Bristol.

Such one day conferences would also need to address the question of consultation styles. It would be extremely useful if practitioners with regular contact with Afro-Caribbean and Asian patients were to participate in discussion of conceptions of illness, reliance on drug prescriptions, and related topics. It would be all the more useful if black representatives could, at the same time, speak to practitioners about typical anxieties and concerns of black patients. There is a need, too, for a raising of the issue of the elderly, and the elderly suffering from mental illness, and of "ethnicity" and mental illness in general. Cultural differences make for superadded difficulties in the diagnosis and management of mental illness and there is a growing literature on how these problems are being manifested in multi-racial Britain. Many practitioners would welcome guidance on many of the issues we have raised in this section and we strongly recommend the organization of (as a minimum) a day conference for medical practioners and other relevant staff at which "race and health" would be the object of

instruction, enquiry and discussion. This would be a very minimum response to the new needs and demands faced by health service workers, demands which will increase as the black elderly population increases in the coming years. We would be pleased if this report provided the stimulus to such a conference - and, we would hope, further action - and we would be willing to help organize such a conference and seek funding for it.

Final Summary

Our report provides systematic evidence, for the first time in Bristol of the growth of a black elderly population with new needs which are not currently met, or adequately met, in the present range of public services. Some of these needs are only just beginning to emerge, others are already acutely felt. In either case, those involved in the planning and provision of services need to know, and will want to know, how best they can respond. This indicates the need for the widest possible circulation of this report, but more importantly, for its being placed on the agenda of a whole range of planning and consultative bodies. Particularly acute are the questions of accommodation for the aging Afro-Caribbean and Asian population, where domestic support cannot be guaranteed and where family cohesion has been weakened; the wider question of social isolation among elderly Afro-Caribbean and, particularly South Asian people and the anxieties to which this gives rise; the question of multiple difficulties of Asian women, particularly as shown in this report in respect of language and medical consultations; the response of hospital and other 'beyond-primary care' institutions to ethnic minority patients and visitors, and the need for additional advice services in relation to both health and welfare centres.

Just as our summary report does not cover everything which our research investigated - or not always in full detail - so our recommendations cannot be expected to cover all the felt-needs of minority groups. There will be groups

and individuals with views and priorities which are not mentioned here and which may conflict with view were have expressed. So we must stress again that we are a research group whose basic brief was to examine broad areas of concern about services and minority groups. This is especially important in a city with a relatively small black population where systematic and focussed attention of many of these issues has been slow to develop. But we have also stressed that mere numbers cannot be allowed to dictate our conclusions. We are raising the question of the responsibilities we all owe to each other as fellow citizens.

Some Relevant Publications

Health Education Council/National Extension College for Training in Health and Race, Providing Effective Health Care in a Multiracial Society. 1984

Peter Townsend and Nick Davidson (eds), Inequalities in Health: The Black Report. Penguin, 1982.

Peter Townsend, et.al. Inequalities in Health in the City of Bristol: a preliminary review of statistical evidence. University of Bristol, Department of Social Administration and Avon Planning Department, 1984.

Kings Fund Centre, Ethnic Minorities and Health Care in London. London, 1982.

J. Mitchell & A. Wilson, Black People and the Health Service. Brent CHC, 1981.

P. Torkington, The Racial Politics of Health - a Liverpool Profile. Sociology Department, Liverpool University, 1983.

John Clarke, Ethnic Minority Hospital Staff. CREW, 1983.

Allan McNaught, Race and Health Care in the United Kingdom. Polytechnic of the South Bank, Occasional Papers, 1984.

Radical Community Medicine. Special Issue "Race and Health", No. 16, Winter 1983-4. Several articles including Malcolm Cross, et.al., "Race and Primary Health Care in the West Midlands".

Research summaries and bibliography, Mental Health among Minority Ethnic Groups. CRE, 1976 and 1978.

AFFOR (Birmingham), Elders of the Minority Ethnic Groups. All Faiths for One Race, Birmingham, 1981.

Jonathan Barker, Research Perspectives on Ageing, Black and Asian Old People in Britain. Age Concern, 1984.

Both CRE (Commission for Racial Equality) and BASW (British Association of Social Workers) have produced a number of guides and surveys related to social work in a multi-racial society including:

A Guide to Services for the Ethnic Elderly. CRE, 1981.

Social Work Training in a Multi-Racial Society. CRE, 1976.

Social Work in Multi-Cultural Britain. BASW, 1982

Multi-Racial Britain: The Social Services Response. CRE, 1978, 1980.

Medical Publications

Dunnigan, et.al., "Policy for Prevention of Asian Rickets in Glasgow", BMJ, 282, 357, 360, 1981.

H. G. Langford, "Is Blood Pressure Different in Black People?", Postgraduate Medical Journal, 57, 745, 1981.

McFayden & McVicar (eds), Obstetric Problems of the Asian Community in Britain. Royal College of Obs. and Gyh., 1982.

M. J. Robinson, et.al., "Ethnic Differences in Perinatal Mortality - a Challenge". Journal of Epidemiology and Community Health, 36: 22-26, 1982.

John Black, "Child Health in Ethnic Minorities; the difficulties of living in Britain". BMJ, 290: 615ff, Feb. 1985.

M. W. Arthurton, "Some Medical Problems of Asian Immigrant Children". Maternal and Child Health. 2: 316-321, 1977.

Joan Henthorn, et.al. "Screening cord Blood for Sickle Haemoglobinopathies in Brent". BMJ, 289: 479-480. 25 August 1984.