Patients' choice of general practitioner: influence of patients' fluency in English and the ethnicity and sex of the doctor

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SUMMARY. Asian patients' use of general practitioner services and, in particular, their interaction with doctors is not well researched. However, difficulty in communication and in the case of women, reluctance to be examined by a male doctor has been reported. This study, based on interviews with 241 Caucasian, Pakistani and Indian patients attending a general practice in Bradford, examined the relationship between choice of general practitioner and the patient's fluency in English and the general practitioner's ethnicity and sex. Both Pakistani and Indian patients, particularly women, had poor fluency in English and the use of interpreters was confined to women (11% of Pakistani women and 4% of Indian women). The linguistic and broad cultural concordance between the patient and the general practitioner was more important in the choice of doctor than the sex of the general practitioner. It was also found that while 62% of Pakistani women objected to being examined by a male doctor, this was true for only 21% of Indian women.

Introduction

THERE is little published research on Asian patients' use of primary care services and in particular doctor–patient interaction.[1,2] Asian patients' relative lack of fluency in English, heavy reliance on general practitioners who speak appropriate Asian languages and use of children and relatives as interpreters have been reported by Wright.[3] She recommended that 'interpreting facilities and liaison workers should be made known to general practitioners'. Difficulty in finding appropriately qualified interpreters has also been highlighted[4] and Richter, in an Australian study, has dismissed the use of relatives as interpreters as totally unsatisfactory.[5]

It has also been reported that Asian women are reluctant to be examined by a male doctor.[3] However, Jain and colleagues found little evidence of this in their study in Birmingham and concluded that the choice of general practitioner depended more on the proximity of the practice to the patients' home than on the doctor's sex or ethnic origin.[6]

The population of Bradford has one of the highest proportions of Asian people in the UK. It was therefore decided to examine the possible inter-relationship between ethnicity, sex and fluency in English on patients' choice of general practitioner in a Bradford health centre.

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Method

The study was carried out in an inner city health centre in Bradford over a period of three months. The health centre was selected because it is located in an area of high Asian population (Pakistani and Indian origin) and has a mix of Caucasian and Asian patients. Patients were selected randomly from those attending two general practitioners, a Caucasian woman and an Asian man (fluent in Urdu, Hindi and Punjabi as well as in English). The patients were asked to participate in the study by their doctor and after their consultation data were collected in an interview lasting about 30 minutes. Four research instruments were used — a symptoms list, a personal details questionnaire, the Nottingham health profile (results reported elsewhere[7]) and a questionnaire on doctor–patient interaction. Some of the findings from the last instrument are reported here. The interviews were conducted in English with fluent speakers of English and in Urdu, Hindi or Punjabi with the less fluent Asian patients. One of the authors (W.A.) who is a male of Asian origin and is fluent in English, Urdu, Hindi and Punjabi, conducted all the interviews.

Ethnicity and fluency and literacy in English were defined by the patient. The majority of those defined as of Pakistani and Indian origin were born in those countries — only nine Pakistani patients and four Indian patients were born in the UK. In this study the term Asian is used in a collective sense and incorporates those of Pakistani and Indian origin. Caucasian is used to describe white British patients.

The chi square test of association was used for data analysis.

Results

Patients' characteristics

A total of 245 patients aged 16 years and over agreed to participate in the study but interviews with two of the patients had to be abandoned, at the patients' request, owing to lack of time, giving a final response rate of 99%. Of the 243 patients 103 were Caucasian, 83 Pakistani and 57 Indian (Table 1). The Pakistani respondents were mainly from the Mirpur district of Azad Kashmir (northern Pakistan) and were all Muslims. The Indian respondents were more heterogeneous in terms of regional (mainly from Punjab and Gujrat) and religious background (53% Hindus, 31% Muslims and 16% Sikhs). The sex distribution within the three groups was similar (Table 1).

Table 1. Ethnic origin and sex distribution of the patients in the study.

	Number of patients		
	Men	Women	Total
Caucasian	54	49	103
Pakistani	38	45	83
Indian	29	28	57
Total	121	122	243

Fluency and literacy

The fluency and literacy in English of the Pakistani and Indian patients is shown in Table 2. Indian and Pakistani women had poorer fluency and literacy skills in English than Indian and Pakistani men. Over half the Pakistani men and about two thirds of the Pakistani and Indian women had little or no fluency or literacy in English.

Table 2. Percentage of Asian patients who speak, read or write English poorly or not at all.

	Pakistani patients		Indian patients	
	Male ($n=38$)	Female ($n=45$)	Male ($n=29$)	Female ($n=28$)
Speak poorly	58	69	34	64
Read poorly	55	69	48	68
Write poorly	58	71	45	71

n = total number of patients.

Use of interpreters

Despite their low fluency in English none of the Pakistani or Indian men and only 11% of the Pakistani women and 4% of the Indian women used an interpreter during consultations. The interpreter was always a member of the family.

Factors affecting patients' choice of doctor

Patients' fluency in English. Table 3 shows that the less fluent patients countered their linguistic disadvantage by consulting the Asian doctor who was fluent in their own language(s). Only 14% of the male patients who consulted the Caucasian doctor were poor or non-speakers of English compared with 30% of the Asian doctor's patients. Women showed an even greater contrast; over half (57%) of the Asian doctor's women patients compared with only 16% of Caucasian doctor's patients had little or no fluency in English ($P<0.001$).

Table 3. Poor or non-speakers of English (as a percentage of all patients consulting) by general practitioner attended.

Patients who are poor speakers of English	General practitioner attended	
	Male Asian	Female Caucasian
Male	30 ($n=89$)	14 ($n=21$)
Female	57 ($n=74$)	16*** ($n=43$)

***$P<0.001$, after Yates correction and based on chi square tests on 2 × 2 tables. n = total number of patients consulting general practitioner. Data on the doctor was not recorded for 16 consultations.

Ethnicity and sex of general practitioner. The influence of the general practitioner's linguistic and cultural attributes on patients' choice of general practitioner is also apparent (Table 4). More than two thirds of the Caucasian doctor's male patients were Caucasian and although the Asian doctor had a fairly even spread of male patients from the three ethnic groups, overall nearly two thirds of his patients were of Pakistani or Indian origin ($P<0.05$). The pattern was even stronger in female patients; while over two thirds of the Caucasian doctor's female patients were themselves Caucasian, 80% of the Asian doctor's patients were Pakistani or Indian ($P<0.001$).

Table 5 shows the percentages of patients who said they would object to being examined by a doctor of the opposite sex. The importance of linguistic concordance between doctor and patient is illustrated further; although 62% of Pakistani women had said they objected to being examined by a male doctor a majority had consulted the male Asian doctor who was fluent in appropriate Asian languages (Table 4). Table 5 also shows that while a higher proportion of Pakistani women (62%) than men (32%) objected to being examined by a doctor of the opposite sex the reverse was true for Caucasian and Indian patients. Of all the groups, Pakistani women had the highest (62%) and Indian women the lowest proportion (21%) of objectors.

Table 4. Percentage of patients choosing doctor by ethnic origin of patient.

Patient's sex and ethnic origin	General practitioner attended	
	Male Asian	Female Caucasian
Male	($n=89$)	($n=21$)
Caucasian	38	68
Pakistani	33	22
Indian	29	10
	$P<0.05$	
Female	($n=74$)	($n=43$)
Caucasian	20	70
Pakistani	45	28
Indian	35	2
	$P<0.001$	

n = total number of patients consulting general practitioner. Data on the doctor was not recorded for 16 consultations.

Table 5. Percentage of patients who said they would object to being examined by a doctor of the opposite sex by ethnic origin.

Patient's ethnic origin	Patient's sex	
	Male	Female
Caucasian	40	23***
Pakistani	32	62**
Indian	33	21

***$P<0.001$, **$P<0.01$ after Yates correction and based on chi square tests on 2 × 2 tables.

Discussion

The results of this study confirm that patients of Asian origin, particularly women, have poor fluency in English.[8] This is consistent with the findings of other studies.[3,7] The poorer fluency of Pakistani and Indian women than men is also consistent with their having received less formal education than men (Ahmad WIU, unpublished data). Lack of fluency in English has implications for doctor–patient communication, the active management of illness as well as prevention.

The infrequent use of interpreters can be explained by the less fluent patients attending the Asian doctor. Consistent with other research, interpreters were patients' own children or relatives.[3] The use of untrained interpreters has been criticized as unsatisfactory,[5] but the use of children as interpreters is doubly worrying — both the parent and the child may be embarrassed by the problem and the information that the doctor or patient receives may thus be censored. There may also be problems in understanding medical or anatomical terminology.

The Asian patients countered their linguistic disadvantage by consulting the Asian doctor. The linguistic and cultural concordance between the patient and doctor was more important in the patients' choice of general practitioner than the doctor's sex. This was particularly true in the case of Pakistani and Indian

women and this contradicts Wright's findings.[3] It is also surprising as 62% of Pakistani women said that they would object to being examined by a male doctor, yet the majority of them had consulted the male Asian doctor. There may be several explanations for this apparent contradiction. First, it may be that most of the women who consulted the male doctor did not expect to be examined. Jefferys and Sachs[9] reported that the proportion of patients expecting an examination ranged from 37% to 56% (in five general practices) in their 1972 study and 22% to 57% in their 1975 study (six practices). Secondly, the embarrassment caused by examination by the male Asian doctor may be more than offset by the potential benefit from improved doctor–patient communication. Thirdly, the patients' reported objection to examination by a male doctor may refer to complaints of a more intimate nature. Finally, if consultation with the female doctor requires the use of an interpreter, this may negate some or all of the perceived benefit from being examined by a female doctor. No data was available on the nature of the consultations and these findings, therefore, need to be interpreted with care.

The differences in the attitudes of Pakistani and Indian women to being examined by a male doctor are noteworthy, and emphasize the heterogeneity of these groups. Pakistani women expressed most reluctance to being examined by a doctor of the opposite sex and Indian women the least. It is interesting that greater proportions of both Caucasian and Indian men than women expressed reluctance to being examined by doctors of the opposite sex.

It is probable that some women are tolerating unacceptable consultations because of the linguistic need to consult an Asian doctor. There is also evidence from health visitors and health liaison workers working in Bradford that a considerable minority of Asian, particularly Muslim, women are not consulting their general practitioner for gynaecological conditions and are therefore going without proper medical care (K. Lumb, personal communication). There is a need for research to quantify this issue in the community.

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Acknowledgements

Our thanks to the general practitioners (Drs M. Singh, V. Wilson, C. Orgles and F. Hingston), the staff and the patients at Kensington health centre, Bradford, for their help, to Dr Kathy Lumb for comments and to the Yorkshire regional and Bradford district health authorities for financial support.

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