support junior medical staff in their initial management of patients with acute stroke.

As Dennis and Langhorne highlight, patients with stroke in acute facilities compete for nursing time with patients who are seen to have more urgent need. They also compete for medical, physiotherapy, and occupational therapy time. Rehabilitation of patients with stroke is time consuming and should include education and emotional and psychological support for the patients and their carers. For these reasons the use of resources by patients with acute stroke in most acute facilities is inadequate, and improvements in stroke care can realistically be achieved only by correcting deficiencies and targeting resources at the patients and their carers.

We believe that high quality care of patients with acute stroke and their carers can be achieved only by establishing acute and rehabilitation stroke units. Deficiencies in resources should be addressed to allow these units to function optimally.

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1 Dennis M, Langhorne P. So stroke units save lives: where do we go from here? *BMJ* 1994;309:1273-7. (12 November.)

Written material for non-English speaking patients

EDITOR,—We welcome D J Tuffnell and colleagues' efforts to improve communication with patients from ethnic minorities but wish to point out that there is no such language as Miripuri.[1] People from Mirpur predominantly speak Punjabi but read and write in Urdu. We agree that written information in Urdu can be helpful. Unfortunately, our experience of hospital literature in Urdu is that it is often unnecessarily difficult. Therefore it is important that if audiotapes are used the same mistakes are not repeated.

Virtually every health authority employs doctors from different ethnic backgrounds, yet these doctors are rarely involved in the preparation of strategies for communicating with patients from ethnic minorities. Communication with such patients would improve considerably if suitably qualified medical staff helped to prepare literature and audiovisual tapes.

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1 Tuffnell DJ, Nuttall K, Raistrick J, Jackson TL. Use of translated written material to communicate with non-English speaking patients. *BMJ* 1994;309:992. (15 Octpber.)

Intercultural consultations

Language is not the only barrier

EDITOR,—Jeannette Naish and colleagues challenge the commonly held belief that the factors that deter non-English speaking women from attending their general practitioner for cervical screening are the same as those that deter English speakers, according to previous studies.[1] Recruiting women through posters or invitation is likely to produce an interested group willing to share their beliefs. When the reasons for not accepting or complying with a service are being studied the beliefs of those people who do not attend are particularly valuable. Unfortunately, Naish and colleagues do not comment on whether the women who gave their views in this study had attended for smear tests.

The critical evaluation of services by users has been encouraged in Western consumer led societies. The expression of feelings (of criticism) is thought to be of value in the West. In many traditional Eastern cultures this is often considered to be "outspoken," and social deference among women is still regarded as desirable.[2,3]

When views on a valued service, such as hospital appointments or admissions, are sought, people report more decisively their dissatisfaction with practical and concrete aspects of the service, such as food, car parking facilities, and waiting times and are more equivocal about the abstract aspects of the service, such as communication and emotions.[4] Group meetings run by health workers with outside observers present are likely to reproduce this phenomenon, particularly among cultures where social deference is valued.

Naish and colleagues comment on the cultural behavioural differences between the ethnic groups but not on the effect that this may have had on their expression of views about smear tests. We cannot assume that language and the administrative system were the predominant barriers to the uptake of cervical screening by women from these ethnic minority groups, only that they were the barriers that these interested women were willing to discuss in these circumstances. Clearly these language and administrative barriers need attention, but further exploratory work with women is necessary before they can be assumed to be the limiting factors to attendance for smear tests.

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1 Naish J, Brown J, Denton B. Intercultural consultations: investigation of factors that deter non-English speaking women from attending their general practitioner for cervical screening. *BMJ* 1994;309:1126-8. (29 October.)
2 Lutz CA, Abu-Lughod L. *Language and the politics of emotion: studies in emotion and social interaction.* Cambridge: Cambridge University Press, 1990.
3 Kakar S. *Intimate relations: exploring Indian sexuality.* New Delhi: Penguin, 1989.
4 Meredith P. Patient satisfaction with communication in general surgery: problems of measurement and improvement. *Soc Sci Med* 1993;37:591-602.

Multilingual literature is useful

EDITOR,—We support the approach used by Jeannette Naish and colleagues to reach ethnic minority women and to overcome their reticence with regard to compliance in the cervical screening programme.[1] We have encountered this lack of response continuously over the past 25 years in our widespread population screening programmes, which used up to seven mobile units in the days before "age registered calls" existed.

We approached leaders of ethnic communities—who were often men—to get their agreement to speak to their womenfolk, to issue our leaflets in their language, and to introduce speakers of the language, but the authors' attempts to recruit enthusiasts in focus groups seems an excellent approach. We have successfully used similar focus groups to reach other sections of the community, such as homeless women and those in hostels and bed and breakfast accommodation, before setting up one of our mobile health screening sessions.

Our main approach has always been to produce suitably constructed and illustrated literature in a range of languages. An early version of our leaflet "Calling all Women" was translated into Urdu and Hindi in 1966 as at that time these were languages of the main immigrant groups. This leaflet has been updated over the years, and the most recent edition, produced in colour and presented in 10 languages, was launched at the House of Commons, together with our new video, "Breast Awareness is for Life," on 1 November.

As a national charity we continue to approach the local health authorities and arrange to improve their local response by use of such literature. The correct language idioms for imparting such sensitive information are essential, and much revision by experts is necessary to achieve the maximum impact and response; this is time consuming and costly.

The new edition of our leaflet "Calling all Women" is available in English, Hindi, Gujarati, Bengali, Punjabi, Urdu, Turkish, Vietnamese, Cantonese, and Somali.

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1 Naish J, Brown J, Denton B. Intercultural consultations: investigation of factors that deter non-English speaking women from attending their general practitioners for cervical screening. *BMJ* 1994;309:1126-8. (29 October.)

Prescribing exercise in general practice

EDITOR,—Exercising the body is a way to exercise the mind, it seems. Derek Browne's response[1] to our editorial[2] vindicates our argument that exercise promotion in general practice must be evaluated rigorously; we look forward to seeing the outcome in Brockenhurst. Such evaluation is essential to guide exercise promotion. Without it there is the danger of yet another runaway train steaming through primary care, using up resources that might be better spent and causing confusion en route.

Marion E T McMurdo confirms this confusion by not distinguishing between the trials on selected groups of older people, which show the importance of exercise promotion for the health of frail elderly people, and trials of prescribing or promoting exercise in the community.[3]

Felicity Green and Janet Lord regard the paucity of good scientific evidence for much medical practice as an argument against vigorous study, but we take the opposite view.[4] Randomised controlled trials of complex activities are difficult to perform but not impossible, as McMurdo and colleagues have shown.[3] The high prevalence of morbidity in older populations makes the impact of intervention easier to identify in relatively small samples, allowing one less excuse for avoiding controlled trials as a rigorous form of evaluation.

The evaluation of the scheme in Stockport deserves wide dissemination and publicity but may not offset the conclusions reached by Biddle *et al* in their recent review of exercise promotion schemes in primary health care.[5] The schemes reviewed seemed successful in that they were popular with patients, general practitioners, and leisure centres, but their effectiveness in achieving sustained increases in activity could not be measured for lack of rigorous attempts to do so. Few schemes targeted people at high risk of heart disease, and selection of participants was ad hoc. Overweight middle aged women predominated in most programmes, and the main benefits seemed to be psychosocial.