the urban melting pot

London GP **Paul Dakin** examines the challenges and opportunities in cross-cultural healthcare

The elderly lady in the clinic spoke no English. As a medical student entrusted with describing her symptoms, I was delighted she had brought her granddaughter. 'Don't worry' the teenager said proudly, 'I've come to translate'. I relaxed, confident in the promise of success. 'Where is the pain?' I began. The young lady turned to her grandmother. She bellowed loudly in a Cockney accent 'Gran - where is your pain?' I'm not sure who was more confused - the old lady or me!

Over recent years, we have seen people come from all over the world and settle in Britain's cities. There are an estimated three million people from ethnic minority background in the UK. In inner London, there is an even larger concentration, representing 26% of the population. To the Christian health worker, this represents a great challenge but also a tremendous privilege.

From the covenant with Abraham onwards, God gave his people a mandate to bless the nations of the world[1]. This may mean travelling to different parts of the globe. Increasingly we have found that the world has come to us. We have a specific call to cross cultures with the gospel[2], whether with compassionate action or opportune word.

We are privileged in being able to be the good news to representatives from so many people groups. But this is not always straightforward. 'People from the remotest parts of the earth have come to the greater cities of the West, where we are able to reach out much more easily with much less cost. There is however, the added complication of cultural mix and sometimes cultural clashes as people of many cultures are folded into urban life together.'[3]

Challenges

Communication is one common source of frustration. Of course, the majority of people from minority ethnic groups have no language difficulty. Those who represent the first generation, or recent arrivals to the country, may experience problems. Many of us have faced the awkward situation of trying to conduct a consultation without an adequate interpreter, or have been embarrassed by having to use a younger member of the family.

But communication is more than the use of language. We may find a mismatch of expectations based on different understandings of our professional role. Requests may appear to be inappropriate from our perspective, or we may feel ill prepared for them. A lot of energy may be spent in resolving problems with housing, schooling, and employment. Instead of a consultation with one individual, other members of the family may want to be seen at the same time.

We may have little experience in identifying what is acceptable within a particular group, reading the appropriate 'cues' from the symptoms and descriptions offered, and having a knowledge of the family and cultural dynamics. 'A multicultural approach in medicine helps in the identification, quantification and management of the problems of multi-ethnic patients, especially the elderly and women who are most likely to adhere to their own culture.'[4]

Our own cultural background and our extensive familiarity with the NHS may cause us to forget that these are not shared by everybody. If we are not disciplined in our thinking, there may be a temptation to label all consultations with representatives of the same group as frustrating and even 'heartsink'. If we aim for a high standard of care, some people will need a greater than average length and frequency of consultations, multiple referrals, and increased frequency of prescriptions.

'Heath authorities should seek to provide a service clearly entitled to these communities, whether they are proportionately few, such as the Chinese population, or where almost half the population is of ethnic origin, ie in areas such as Newham and Brent.'[5] We know that the greatest prescription we have is that of 'ourselves'. To offer dignity to people who have not always received such treatment in their country of origin, or even here, is a precious resource. This involves time, a listening ear, and sometimes flexibility.

We must remember that there is a biblical bias towards the 'alien' - the foreigner, the stranger, the refugee. Within the law and practice of Israel, there was provision and protection. 'When an alien lives with you in your land, do not ill treat him. The alien living with you must be treated as one of your native born. Love him as yourself for you were aliens in Egypt.'[6]

A Question of Status

Refugees and asylum seekers are among those who most need this special provision. There are three main categories assigned to asylum applicants:

Refugee status:
- full political asylum is granted
- right given to stay indefinitely in UK on a 'resident permit'
- has the right to travel outside the UK
- may apply to be joined by spouse and children

Exceptional leave to remain:
- granted leave to stay 1 year
- may be renewed
- 'the applicant does not qualify for refugee status but . . we do not think it right to enforce departure from the UK' (Home Office)

Refusal:
- refused right to stay and will be deported subject to appeal

All asylum seekers and their families have the right to be registered with an NHS doctor. There is no obligation on GPs to check the immigration status of people joining their lists. Asylum seekers are exempt from charges and entitled to free prescriptions, irrespective of whether or not they receive income support.[7]

There are 363,000 refugees and asylum seekers in Britain. 85% are in London. In Haringey, a north London borough, 9% of the total population and 25% of the ethnic minority population fall into this category. Although representing origins in 33 countries, the largest groups come from areas which are either well represented in the local population eg Turkey or are active trouble spots eg Somalia, Democratic Republic of Congo (previously Zaire), Ethiopia, Sri Lanka.

The majority of asylum seekers are aged under 40. Most are healthy on arrival. Many are separated from their families. Two fifths live in temporary accommodation, and only 7% are in permanent employment. Over 50% admit to being tortured[8]. The consequent need for emotional and social support is immense. Health professionals and local churches have an important role to play, especially since so many are fearful of active involvement within their own communities for fear of harassment by security or party officials.

Opportunities

We are told there are around 12,000 unreached people groups in the world. That is, groups for whom the gospel has not been communicated in an accessible form because of language or cultural barriers[9]. Some of these are represented within our major cities.

We have the opportunity of extending to them our expertise alongside our Christian compassion. We must not abuse our professional setting in order to proselytise. But there are occasions when questions will be asked about our motivation and underlying beliefs. There may even be those who invite a deeper discussion and welcome prayer. The involvement of local churches, advice centres, support groups, and other caring agencies may also prompt opportunities to share the gospel.

'There are many races, religions, customs and cultures. This diversity does not necessarily imply that one is right and another wrong, but it does constitute a major challenge to the people of God, a challenge to relate adequately to the intricate system of beliefs, cultures and values in our world, in order to communicate intelligently the gospel to each person without compromising the heart and essence of its message.'[10]

In other words, in order to cross cultural barriers, we can dress the unchanging gospel in someone else's clothes. Health workers in our cities have a role to play in this process, without compromising their integrity or professionalism. We can identify and research particular groups, so that our provision is more appropriate. We can pray for our patients before or after they come into the consultation. We can reject the last traces of misunderstanding, frustration and prejudice. We can be available, be open, and allow God to serve through us.[11]

We can look forward to the day when there will be 'a great multitude that no-one could count, from every nation, tribe, people and language, standing before the throne and in front of the Lamb'[12].

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References

1. Genesis 12:1-3
2. Matthew 28:19-20
3. James S. Acts 13 Cross-cultural training manual.
4. Qureshi B. Transcultural medicine. Kluwer Academic Publications, Lancaster. 1989
5. Balarajan R and Raleigh V S. The ethnic population of England and Wales; the 1991 census. *Health Trends* Vol. 24 No. 4. 1992
6. Leviticus 19:33-34
7. LMC Guidance to GPs on homeless people, refugees and asylum seekers. 1997
8. Refugees and asylum seekers in Haringey. Haringey Council. 1997
9. Montgomery J. Dawn 2000: 7 million churches to go. William Carey Library. 1959
10. Mohabir P. Worlds within reach. Hodder and Stoughton, London. 1992
11. Dakin P. Crossing Cultures. Nelson Word/Pioneer. 1994
12. Revelation 7:9