

**MIXED ETHNICITY, HEALTH AND HEALTHCARE
EXPERIENCES**

by

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A thesis submitted to
The University of Birmingham
for the degree of
DOCTOR OF PHILOSOPHY

Department of Social Policy and Social Work
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University of Birmingham
June 2001

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ABSTRACT

The ethnic composition of Britain's population continues to change. This thesis explores the health and healthcare experiences of the fastest-growing sector of our population; people of mixed ethnicity. The thesis contextualises the research with reference to 'race' and ethnicity, immigration, demography and statistics.

This research is based within a Foucauldian theoretical framework and utilises narrative data collection methods and an innovative analysis process, based on the construction of a series of metanarratives, to investigate the manner in which people of mixed ethnicity construct their identities. It also seeks to explain how their ethnicity impacts both on health status and the nature of the mixed ethnicity healthcare experience in the NHS, particularly within the doctor/patient relationship.

The findings from the research are discussed in relation to existing health policy initiatives and recommendations made for changes in the way in which the needs of people of mixed ethnicity are assessed, concluding that the present analytical categorisations are inadequate and in need of review. The research also concludes that that doctors use their powerful position to suppress the discourse of health and mixed ethnicity.

ACKNOWLEDGEMENTS

This thesis would not have been possible without the help and support of colleagues and friends too numerous to mention individually.

Particular thanks, however, are due to Dr Marian Barnes, *supervisor extraordinaire*.

Thanks as well to my partner, Ali, who encouraged me to enter academia and who has supported me financially, as well as psychologically, through the good and bad times.

Thanks also to Helen Rogers whose support and encouragement, in person and by telephone, has been invaluable.

Lastly, my thanks go to the past and present administrative and academic staff and students of the Department of Social Policy and Social Work for their support over the last three years, especially in the period after my partner's car accident.

'If I have seen further, it is by standing on the shoulders of giants.'

(Isaac Newton, 1676.)

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1. INTRODUCTION

The impetus for this research arose, as an evolutionary and developmental process, during the course of my undergraduate degree. For some time prior to this I had been aware of a growing personal interest in social justice and the needs of disadvantaged population sectors. My undergraduate degree focussed these concerns. I developed an interest in the analysis of UK health policy and the ways in which it impacts on specific groups, particularly minority ethnic populations. I became aware that a considerable amount of research had been undertaken in respect of specific minority ethnic groups, but that there was an increasing population of 'mixed ethnicity' people whose needs and experiences had not been assessed.

My initial investigations in this area suggested that there was a dearth of research into the nature of the mixed ethnicity population and, indeed, that this group of people was apparently unrecognised in any significant way. This intimated that there might be a need to develop policy initiatives to address specific health needs for this growing sector of the population.

In retrospect, it appears that my initial research hypothesis, that people of mixed ethnicity might have specific healthcare needs which if not addressed would add an additional dimension of disadvantage, was naïve. Certainly it did not take proper account of the contested and diverse nature of mixed ethnicity. Nevertheless, this project set out to assess these postulated health needs.

The early stages of the research resulted in a significant change of direction away from health *per se*, towards an assessment of healthcare experiences and the doctor/mixed ethnicity patient relationship. Inevitably, this has also resulted in the need to attempt to define the nature of mixed ethnicity in some meaningful way and to make some recommendations for future policy change.

This research is located within an interpretivist paradigm and informed by a theoretical framework centred on the theories of Michel Foucault. The qualitative data collection process in this study is based on narrative methods and the analysis is centred around an innovative notion of metanarrative analysis.

The thesis

This part of the chapter provides a guide to the contents of the thesis, which is composed of 5 Sections: 1. Introduction, 2. The Context of the Research, 3. The Research, 4. The Analysis and 5. The Conclusion. The sections are subdivided into chapters as necessary.

Section 2, the context of the research, replaces the more usual literature review with 4 chapters that contextualise this research in terms of place, history and development. In addition, these chapters provide definitions of critical concepts used throughout the thesis.

Chapter 2.1 is concerned with the history of 'race', ethnicity and racism. It discusses the conventions used in the thesis when discussing these contested concepts and provides a number of definitions. The notion of 'race' and its social, economic and political construction is discussed and the argument advanced that 'race' has no biological or 'factual' existence, rather that the purpose of its construction is to create, reinforce and reproduce the notion of 'others' and 'otherness' as a justification for treating some individuals and groups as inferiors. This chapter includes discussion of racism in Britain, noting that Government continue to use 'race' as a social division and as a statistical indicator. The second part of the chapter discusses the complex nature of ethnicity, together with the difficulty of its definition. It promotes the idea that 'race' is an exclusive and constructed term that is always imposed by an outside group with more power, than those in the so-called 'race. Ethnicity is posited as an inclusive notion that is, at least in part, voluntary, even though it is often wrongly used as a synonym for 'race'. The importance of self-defined ethnicity is also discussed.

Chapter 2.2 is about immigration to Britain and the attitudes and policy initiatives that have accompanied it. The chapter is divided into two main periods of immigration, before and after WW2. The reasons for immigration are discussed, noting that in, the main, immigration in the earlier period is as a result of religious and ethnic persecution and international trade while in the second period, the process is as a result of a need to overcome a post-war labour shortage. The chapter argues that, though there was an imperative need to increase the workforce, non-white immigrants were not welcomed by Government or population and were only accepted after attempts to employ white European workers failed. The notion that the immigrants, especially those from the Caribbean, were unskilled is dispelled and the actual processes of recruitment discussed.

A chronology of immigration events and legislation is provided, together with a discussion of the increasingly draconian controls on immigration to Britain that seem to impact disproportionately on non-white individuals. Particular attention is given to health policy responses to immigration, noting that, for the most part, they have been pathological in nature. Mention is also made of the contribution that nurses from other countries have made to the NHS, a process that continues today.

Chapter 2.3 examines the ethnic and demographic composition of Britain, largely using data from the 1991 Census of Population, but noting that the collection and analysis of this, and other ethnicity information, data is problematic. The 'ethnicity' questions from the 1991 and the forthcoming 2001 Censuses are compared, highlighting the particular difficulties for analysts trying to obtain statistics on mixed ethnicity, because of the specific process by which the data were analysed. The debate around whether it is appropriate to collect 'ethnic' statistics is discussed, noting that there are arguments both for and against this collection, based on the possible uses for the data. The composition and geographical distribution of the

population is noted, together with the causative economic, political and social factors, notably the availability of housing and employment. There is also discussion of the diversity of ethnic groups in specific locations.

Though the information available concerning the mixed ethnicity sector of the population is limited, data is presented to show that this is the fastest growing population sector in contemporary Britain. This chapter also notes that there is no clear or generally accepted definition of 'mixed ethnicity' and argues that, though it may not be of great utility for statistical analysis, self-definition is the best way to proceed.

There is a perception that the health of people from minority ethnic populations is worse than that of the dominant white population. This is debated in Chapter 2.4 with an initial discussion of the inconsistent manner in which 'ethnic' health data is collected. Particular reference is made to the disparate ways in which some ethnic groups are described, a process that makes comparison over time difficult. In a similar manner to the preceding chapter, the purpose and intent of this information gathering is discussed. Evidence pertaining to the health of minority ethnic populations, largely arising from major studies in 1994, 1997 and 1999, is presented and compared where this is possible. As a result, it is argued that, with the exception of some specific conditions, the results and indicators from the surveys provide no clear evidence that the health of minority ethnic people is worse than that of the general population. Indeed, it is argued that there are indications that the health status of minority populations is converging with that of the white population, evidenced by results from the 1999 Health Survey for England. There is discussion of the ways in which people from minority ethnic populations utilise and experience health care services. The chapter includes a discussion of other factors which influence the healthcare experience, including socio-economic issues, geographical issues and cultural difference. Particular attention is paid to

experiences of the mental health services and comparisons between the experiences and treatment of the white population and people from minority ethnic backgrounds.

Section 3 concentrates on the research project itself. It begins with Chapter 3.1 which outlines the theoretical framework, based upon the work of Michel Foucault (1926-1984). The perspective draws upon Foucault's work as a post-structuralist theoretician and concentrates on his views of power, truth and discourse. It also utilises Foucault's concept of the episteme, an unconscious code that governs individuals' ability to understand and interact with the world. The Foucauldian view of power is that it is not necessary binary or hierarchical in character, but is everywhere for everyone to use. Foucault's view on discourse is complex, but for him discourse is seen as a productive phenomenon which not only limits the nature of what can be said, but may also exclude issues from the sayable. The Foucauldian approach to truth is unusual and crucial to the data collection and analysis strategy employed in the research reported here. Foucault argues that the link between objective 'fact' and subjective 'truth' is tenuous at best, but that it is an individual's truths that are valid because they reflect that individual's experiences and understandings of the world and influence the way that people interact with others and with institutions. Foucault's theories have also influenced the research methodology and methods employed in this study. Foucault rejects, as do others, the positivist paradigm for research, preferring instead to follow an interpretationist course. This has had a particular influence on the data collection and analysis methods, which build on those of Foucault, rejecting 'fact' in favour of 'truth', but where appropriate relating truth to fact.

Chapter 3.2 outlines and discusses the research questions and their evolution. The initial hypothesis upon which this study was founded, was that people of mixed ethnicity might experience 'worse' health than the general population. A developmental process then

occurred to operationalise this question. Eventually, 4 research questions were formulated, informed by the theoretical framework and the concomitant decision to use qualitative research methods. The questions are concerned with whether people of mixed ethnicity, because of their ethnicity:

- a) have significantly poorer health status than the white population.
- b) have predominantly negative healthcare experiences.
- c) suffer from the suppression of the discourse of mixed ethnicity and health because of the exercise of power by doctors.

A last question arose from the early stages of the research and asks how people who describe themselves as being of mixed ethnicity actually describe and define that ethnicity.

Chapter 3.3 discusses the research methods employed in this study, noting that they underwent an evolutionary development process, finally resulting in the utilisation of narrative data collection. This chapter also discusses the links between the data collection methods and the theoretical perspective, concentrating on the process and application of choice at different levels. In addition, this chapter introduces the process of analysis and the manner in which the results of the pilot interviews guided the remainder of the research. In addition, this chapter discusses the researcher's experiences while conducting the narrative data collection sessions and debates the advantages and disadvantages of the methods used.

Chapter 3.4 introduces the strategy which has been used to code and analyse the data, again relating the process to the theoretical frameworks and paying particular attention to the truth versus fact dichotomy and the issues of first and second level choices. The purpose and practice of coding is described in detail.

Section 4, the analysis, is divided into 5 chapters. Chapter 4.1 provides details of the 20 narrators who contributed to this study, together with a comparison of their age, gender, ethnicity, educational achievement, employment, country of birth and present location. All names and some other minor details have been changed in order to preserve anonymity and confidentiality.

Chapter 4.2 represents the commencement of the data analysis: it is similar to the process commonly called *microanalysis*, but here best thought of as ‘micronarrative analysis’. It looks at the contents of the narratives, examines the reasons why the narrators told their stories and then groups them into a series of themes, the selection of which is supported by quotations from the narratives themselves.

Chapter 4.3 continues the analysis by moving away from micro to meta analysis. In this work, the process is that of constructing *metanarratives*, that is the production of a group narratives based on the themes identified earlier. The metanarrative can be thought of as the output of an hypothetical focus group composed of the individual narrators. Metanarratives are, necessarily, complex and result from a series of choices exercised throughout the project by both the researcher and the narrators. The production of the metanarratives not only permits a more detailed analysis of the content of the individual narratives, but also uncovers other methods of categorisation, for example manner, tone and structure. Finally, this chapter introduces the 4 metanarratives, and notes the possibility of the presence of other metanarratives within the contributing stories.

Chapter 4.4 contains the metanarratives. They are presented by discussing their content and the selection of analytical categories. The links between the content and the analytical categories are shown in diagrammatic and tabular form and, where appropriate, other variables are discussed and illustrated. Quotations from the contributing narratives are used to

provide justification for the construction of the metanarratives themselves. The individual metanarratives are presented in the subsequent chapters.

Chapter 4.4.1: The Mixed Ethnicity and Identity Story: choice and fitting-in.

Chapter 4.4.2: The Doctors' Story: health and ethnicity, power and 'professional ethnicity'.

Chapter 4.4.3: The Patients' Story I: mixed ethnicity and health status.

Chapter 4.4.4: The Patients' Story II: mixed ethnicity and healthcare experiences.

Section 4 is completed by Chapter 4.5 which comprises a summary and discussion of the section, concentrating on the context of the data collection sessions and the content of the metanarratives. Issues which did not appear in the metanarratives are discussed, as is the notion that doctors do not see themselves as patients, though this is, in reality, inescapable. Finally, the process of analysis is critically evaluated and the researcher's reflections briefly described.

Section 5 contains the conclusion. This is addressed by means of relating the research findings to the research questions and assessing the outcome in relation to current issues in health policy. Where appropriate, general recommendations are made which could be utilised to influence and formulate policy in the future. These recommendations are divided into 2 main categories:

There are further researcher reflections on and a critique of the research and analysis processes.

2. THE CONTEXT OF THE RESEARCH

2.1. Imposed 'race': voluntary ethnicity?

This chapter discusses the origins of the concept of 'race' and analyses the reasons for its creation, emergence and reproduction. 'Race' and ethnicity are compared and contrasted and I will contend that 'race' is an inadequate, inappropriate and flawed tool for social analysis which is imposed on particular population sectors for the purpose of creating a hierarchy of power and exploitation. I will also contend that ethnicity provides a more appropriate category for social analysis because it does not depend on either physical appearance or imposed definitions.

As a white British male researching in a social science environment, I have become particularly aware of my limitations in understanding the full impact of race and racism, and acknowledge that my understandings of 'race' and 'ethnicity' are, inevitably, tempered by my experience of being white. I am conscious that my analysis of 'race', ethnicity and racism cannot be value-free. As a product of the society in which I live, I inevitably carry many of the implicit value-judgements of that society. Nevertheless, I have endeavoured to understand the 'problem' of race and the struggles of those who experience racism and to give these issues the serious attention that they deserve.

Banton (1983: Ch. 1) warns of the danger of 'presentism', that is analysing historical events in terms of current concepts and norms, when discussing 'race' and ethnicity. I acknowledge this hazard, and have endeavoured to avoid it.

Conventions and definitions

The word 'race' is used within single quotes to emphasise that it is a contested term, a constructed rather than biological category. Black is used with an initial capital letter where it refers to people of Asian or African-Caribbean descent who share a common experience of racism because of their skin colour (Donovan 1984: 363). It is also used to indicate the shared experience, in a political sense, of all non-white individuals, population sectors and communities who may be visibly identified in Britain today. However, the term 'Black' is fluid and contested and must be used with caution; it may, for example, suit Sikhs from the Punjab to describe themselves as 'Black' under some circumstances or as 'Asian' or even 'Indian' under others (Smaje 1995: 26). I acknowledge that there is a risk of homogenising 'Black' and losing important geographical and cultural distinctions, though I have striven to avoid this. Quotations using these terms appear as in the original text.

'Phenotype' is defined in the Oxford English Dictionary as:

A type of organism distinguishable from others by observable features.

'Phenotypical' refers to the observable differences between organisms. The term is frequently used in debates concerning 'race' and ethnicity to distinguish so-called 'races'. In contrast, 'genotype' and 'genotypical' refer to the genetic composition of an individual organism, which can only be discovered by sophisticated scientific analysis, and does not necessarily relate to appearance.

The definitions of 'racism' used in this thesis include Bhavnani's contention that it is:

... a system of domination and subordination based on spurious biological notions that human beings can be fitted into racially distinct groups. ... both 'race' and racism come to be economic, political, ideological and social expressions. In other words, 'race' is not a social category which is empirically defined: rather, it is created, reproduced and challenged through economic, political and ideological institutions. (Bhavnani, 1997: 28.)

Henley's practical definition (1991: 2), has also been useful. It states that racism occurs when patients receive unequal treatment because of their skin colour or ethnic origin. It indicates that racism arises when individuals are in positions that give them the power to operationalise their prejudices. Other definitions have also been of use, for example:

Racism by our account constitutes a set of practices which exclude or in some way disadvantage black people. (Knowles and Mercer (1992: 115.)

... the dogma that one ethnic group is condemned by nature to congenital inferiority and another group is destined to congenital superiority ... (Benedict (1943: 97.)

What is 'race'?

Migration has always been a part of human history. It has led to meetings and interaction between people from different locations who have different cultures and beliefs. Miles (1989: 11) suggests that this led to the construction and reproduction of a set of beliefs about the 'other', partly to explain differences in appearance and partly to form the basis for interaction. These constructions of the 'other' also represent the construction of 'race'. However, this does not particularly facilitate an understanding of 'race' and Malik notes that:

One of the striking aspects of the study of race is that everyone knows what 'race' is, but no-one can quite define it. (1996: 2.)

Dominelli extends the debate, arguing that:

Relationships between black and white people have been characterised by notions of white supremacy in which white people refuse to accept the human worth of black people and structure social interaction between them accordingly. ... Black people have been portrayed as 'naturally inferior and dangerous', making **difference** – whether expressed through physical or social attributes – a basis for the justification of unequal social relations which privilege white people. (1997:2) (Original emphasis.)

The concept and representation of the 'other', and therefore of 'race', has changed and developed over time. Miles noting that the common Eurocentric definitions of the 'other', and of Western Europe as having a powerful economic, cultural and political being, began in medieval times:

The notion of Europe as an entity began to emerge only in the Eighth Century and, until at least the Twelfth Century, it was subordinate to the economic and politico-military power of the Islamic world. (1989: 13.)

In this medieval period, the 'other' in Britain was represented as phenotypically and culturally deviant from the norm and took a variety of monstrous forms often being described as the result of interbreeding with apes. 'Black' people, especially males, were portrayed as being invested with a wild and aggressive sexuality and were represented as anthropophagi, savages and barbarians. For examples of reports supporting these statements see Hakluyt (1972), though it is noteworthy that the various reports and descriptions are neither self-consistent nor stable.

In many ways, the way in which non-white people were perceived in Britain changed little for almost 500 years. The oppression continued, perhaps best characterised by the slave trade which was well-established by the late middle ages and, as early as the middle of the 15th Century, slaves from Africa were regularly transported to mainland Europe (Banton, 1967: 101). However, by 1837 there was some evidence of changing attitudes with the

establishment of the Aborigines Protection Society (Bolt, 1971:1) and the subsequent abolitionist movement. Concurrently, there is some evidence (see for example, Rex, 1970 or Bolt, 1971) that the stereotype of black males is changing so that they are represented as being of lower intelligence than white people, but without the monstrous dangers portrayed in earlier descriptions.

Darwin published *Origin of Species* in 1859 showing that all humans were of the same 'stock' or species. People from anywhere in the world can breed and produce viable, fertile offspring. This should have confirmed that 'race' does not exist in humankind and put an end to the debate, though Fyfe (1994: 73) believes that, due to pressure from the Established Church, Darwin hinted in subsequent work that human sub-species might exist.

'Scientific race'

Historians trace the concept of 'race' back to antiquity. Creationists and many Religious fundamentalists argue that humans are all descended from one individual, Adam in Jewish, Christian and some other religions. Subsequent phenotypical differences are attributed to migration, climate and environment, though it is not clear why or how rapidly these differences were supposed to manifest. Banton (1983: 38) argues that some see it as 'God's will' that people in different locations should be physically different. It is also possible to argue that, for example, Europeans, Asians and Inuit people, had separate ancestors and that Genesis is, simply, an incomplete account. Acceptance of this argument ignores an inherent difficulty; if disparate groups of humans originated in isolation, how is it that all humanity belongs to the same species?

The foundations of 'race', as we experience it today, are to be found both in the Enlightenment and in the religious revivals of the eighteenth century (Mosse 1985: 3). They

were compounded and confused by the late Victorian's acceptance of Darwin's theories of evolution and stimulated by a growing desire to explain uncertainty in scientific terms. This desire for scientific explanation was linked to a widespread perception that any phenomenon or imagined grouping should be classified and named. This process linked to, and reinforced, the concept of (white) British supremacy as a given with the connotation that this superiority was based on biological 'fact'. Smith states that it resulted in:

The erroneous belief that human races exist as distinct biological types, are identified by physical traits and reflected in cultural diversity, has a long-standing, widespread and disturbingly enduring appeal. ... Fuelled by the popularity of social Darwinism, spurious racial typologies, based on a grading of skin colour from pale to dark, soon became infused with pseudo-scientific meaning. Racial traits were linked with environmental settings, racial conflict was regarded as inherent in humanity's struggle for survival, and racial difference became linked with beliefs about the intellectual, moral and cultural superiority of white Europeans. (Smith: 1989: 2.)

There is also evidence (Tizard and Phoenix 1993: 19) that, by the late Nineteenth Century, scientific studies of 'race' entailed not only a belief that white people were superior, but that members of the Anglo-Saxon 'race' were particularly so.

The natural sciences have played an important role in the construction of 'race'. It is common for scientists to represent their investigations, discoveries and conclusions as being simple objective fact and thus value free. This is, generally, no longer considered to be the case and it is accepted that the way that science is utilised is inescapably biased by its social, economic, political and cultural context.

The so-called biological foundation of 'race' is based on the concept of categorising human beings by means of sets of phenotypes that seem to distinguish varieties of people and are passed on to subsequent generations (Sheldon 1992: 58). This concept requires the belief that

phenotypes are inevitably linked to behavioural characteristics. Rex (1983: 4) comments that this notion also requires the assumption that the characteristics of 'race' are inherited *en bloc* when formal biological proof, as well as the more common-sense skills of animal and plant breeding, indicate that this is not the case.

The majority of modern biologists and anthropologists now reject the biological definition of race. It is well-established that there is greater genetic difference within 'races' than between them (Hill 1989: 26; Weissman 1989: 102-103). The majority view is that all humans are of the same species, capable of breeding to produce fertile offspring. As such, the biological concept of 'race' is without value even though some, for example, Smith (1986), have continued to argue that it is a useful concept, though they fail to justify this claim.

'Race' as a social construct

If 'race' has no biological existence, then it is necessary to seek other reasons for its continued use as a 'common-sense' concept. Smith describes the difficulty when she says:

Races, science reliably informs us, are simply social constructions. ... such enlightenment has not dislodged the myth of race from daily life, nor has it undermined the quest for the natural origins of racial differentiation ... (1989: 2.)

She develops her argument to say that:

In the crudest sense, racial ideology may be seen as a system of beliefs which legitimises not only the identification of racial attitudes but also their alignment with dimensions of inequality. (1989: 7.)

Cohen and Bains agree and assert that:

Race is the object of racist discourse and has no meaning outside it; it is an ideological construct, not an empirical social category; as such it signifies a set of imaginary properties of inheritance which fix and legitimate real positions of social domination or subordination. (1988: 23.)

Many other researchers concur with the idea that 'race' is a social, economic, cultural and political construct (see for example: Ahmad 1992: 46; Bhavnani, 1997, Centre For Contemporary Cultural Studies 1982: 21; Fyfe 1994: 70; Miles 1989: 31 or Solomos 1993: 28).

The notion of 'race' is maintained in Western culture by the use of stereotypes which, according to Thomas are used to,

... readily classify people about whom we know very little using a descriptive, often pejorative, shorthand of personality. (1990: 374.)

Examples of stereotype might be: 'red-haired people have short tempers' or 'Black people are lazy'. Atkinson *et al* (1993: 325) contend also that stereotypes may work retroactively on memory. By this means a stereotype may extend or alter our real memories of individuals.

The media has reinforced these stereotypes with Tizard and Phoenix noting that in the nineteenth century:

'Nigger minstrel' troupes (usually white performers, painted with a garish black countenance) perpetuated the stereotype of the happy-go-lucky, lazy, singing, dancing simpleton. (1993: 19.)

Before returning to the discussion of the purpose of 'race', it is important to note that, commonly, the white people of the developed Western World do not consider that they belong to a 'racial' group. Nevertheless, 'white' is a colour and can be used in the same manner as 'black' to identify populations by reference to phenotypes (Roediger 1994: 1-17). The important difference is that 'Black' is typically used in a derogatory, negative manner; white, when used at all, generally not. These sentiments are repeated in many more recent works concerning 'race' and ethnicity; see for example Solomos and Back (1996: 22), Dyer (1988: 44-64) or Pinderhughes (1989: 91).

I contend that the purpose of the construction of 'race' is to establish an hierarchical ideology, that is a set of social, political and economic theories and practices, that allows the dominant white group in Western society to exercise hegemonic power over any subordinate group or population sector. This process has its roots in colonial expansion and Miles (1989: 27) believes that the reason that people from Africa were defined as 'other' was to place them as low as possible on the constructed and perceived hierarchy of 'race', automatically defining them as inferior and implying doubts as to their humanity. It is interesting that, since colonial times, 'Africa' has been, and continues to be, used as if it were a country rather than a continent. This can be seen as part of an homogenisation process to ensure homogenisation of the 'other'. Fyfe agrees noting that:

For wherever whites took charge of their overseas empires they raised a barrier of race to distance themselves from those beyond it and to keep them in subjection. (1994: 74.)

The influence of the media is seen again in this process, where it is used influence the manner in which individuals establish a stable sense of identity. Harris *et al* note,

... [the] Black child ... cannot avoid getting the message from television, books, and magazines that all successful, powerful, or beautiful people are white. As we become adults in a society that devalues our minority status, we continue to experience forces which tends to make us question who we are and which push us to embrace attitudes and ideas that are alien to us. (1995: 1.)

Part of the construction of 'otherness' is a process of 'racial dualism' (Robinson 1992: xii) whereby individuals are categorised either as 'Black' or as 'white', no middle ground being possible. Modood (1992: 19-21) argues that this prevents humanity's progress towards a union of equals. This process can be seen in action in the United States where large numbers of people are defined as Black even though they are phenotypically white; one black ancestor, no matter how long ago, is seen as sufficient reason for this categorisation (Sheldon 1992: 59;

Zack 1993: 3). This process of racial dualism has the astonishing effect of rendering whole populations, communities and population sectors invisible; Ahmad observing that,

... the Irish and East European minorities are classed as a 'white'; the Chinese, Arabs and other smaller minority ethnic groups are often lumped together as 'other'. 'Race' statistics, ... therefore, present only a selective and partial picture and need to be considered with care. (1992: 7.)

Racial dualism is not the only process by which discrimination and disadvantage affect entire populations. One example is that of apartheid in South Africa where 3 divisions, white, black and coloured were created. That such divisions were artificial and politically and economically motivated can be seen by the categorisation of Chinese people as 'coloured' and the Japanese people as 'white. For a full discussion see, for example, Banton (1967: Ch. 6) or Solomos and Back (1996).

Most commentators (see for example, Knowles and Mercer, 1992, Gordon, 1997 or Benedict, 1943) argue that the continued existence of both 'race', and its concomitant racism, serve the purpose of keeping others 'in their subordinate place'. Pieterse (1992: 234) suggests that one of the problems of according phenotypically different others equal status with the dominant group in society is that there is a risk that society will change, saying:

Far more menacing: they threaten to step out of the circle of otherness and to interfere with the lifelines of identity (Pieterse 1992: 234).

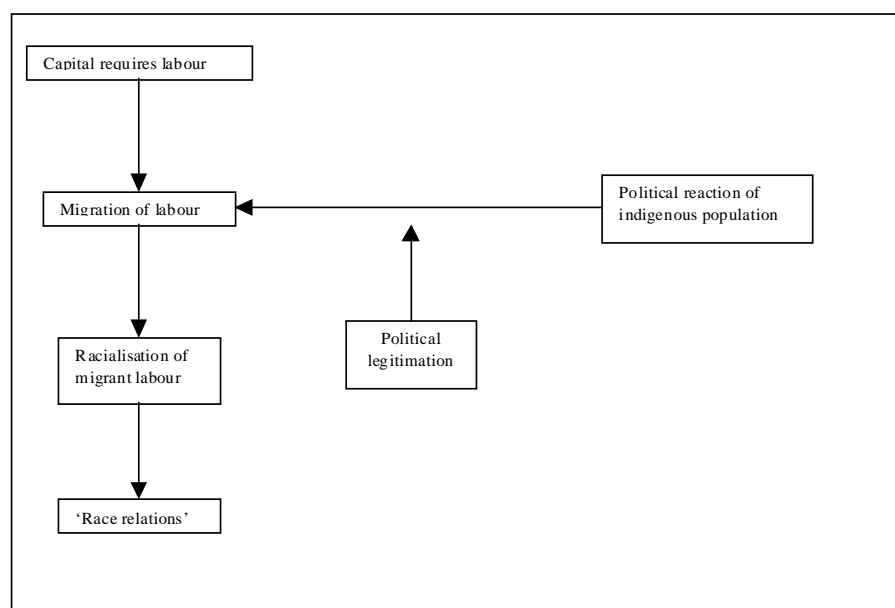
It is for this reason that Commonwealth immigration into Britain was racialised through the medium of coded language (Solomos 1992: 14) to the point that, despite the continuing high levels of post-war white immigration, popular common sense came to perceive all immigrants as Black.

‘Race’ and the state

That ‘race’ was developed to explain otherness and then to keep others in a subordinate position and to legitimate their exploitation during colonial times cannot be in doubt. For it to continue in the post-colonial epoch suggests that ‘race’ fulfils other functions. Miles contends that ‘race’, ‘... is rarely an end in itself, but a means to an end.’ (1982: 4) that has become a mask to hide economic relationships (Solomos 1993: 28-29) in which members of created subordinate ‘races’ are exploited. In this way ‘race’ can be seen as a tool of Western capitalism and, for many Marxists, another dimension of the class struggle. For others, the question of whether ‘race’ is an autonomous class relationship is still to be answered (Solomos 1993: 26-27). Solomos (1993: 241) later argues that there have been few attempts to analyse the theoretical relationship between ‘race’ and the State in Britain, though there are countless class relations analyses.

It is, nevertheless, apparent that there is a link between capitalism, the state and the construction of ‘race’. Miles (1982: 169) presents this relationship in the form of a diagram:

Fig: 2.1.1 Links Between Capital, the State and the Construction of ‘Race’.



For Miles, the most important part of this process is the political legitimization of the class position of the (Black) migrant, but subsidiary arguments suggest that migrant workers can either belong to a separate underclass because they do not share the indigenous working class experiences, or are a subdivision of the working class.

In Britain, 'race' is used by the state as a formal administrative and legislative category. Fyfe (1994: 74) argues that this makes 'race' an instrument of policy throughout all empires and that the creation of specific 'race' legislation results in a false 'authority of race' which places its existence beyond question. Miles, speaking of the Race Relations Acts and the Commission for Racial Equality says:

Government legislation takes it for granted that 'races' exist: politicians have deemed it necessary to set legal parameters for the social relations between 'races' and there now exists a special commission to encourage equality between the 'races'. (1982: 9.)

Williams (1989: xi) also distinguishes this situation and insists that the issue of 'race' has been marginalised in social policy, leading to racism in the provision of state welfare services. Dominelli agrees (1997: 29) and maintains that the British State's doctrine on 'race' and racism is contradictory. She notes that, especially under recent Conservative governments, exclusionary immigration and nationality legislation has been imposed while, at the same time, 'race' has been identified as a mechanism that can be used to divide and disadvantage. For detailed instances of the relationship between the British State and the individual, see Mama (1992: Ch. 5) or Modood (1992: *passim*).

It can be argued that the basis on which the British State understands 'race' is flawed (Anwar 1990: 607-615). The 1991 Census of Population asked a question intended to reveal the 'race'

(though 'ethnicity' is used as a synonym) of the respondent. The question in the census referred neither to ethnicity nor to 'race'. Owen noted,

... while 'white' and 'black' are pseudo-racial categories, referring to skin colour, Indian, Pakistani and Bangladeshi are legal nationalities and 'Chinese' is at one and the same time a nationality, an ethnic description and a linguistic group. (1994: 11.)

Encouragingly, there were indications soon after the 1991 Census data was made public (Owen 1996: 51-55) that the 'ethnicity question' in the 2001 Census would be more usefully phrased. This has been accomplished, though I contend that the revised question is still flawed: this is discussed in more detail in Chapter 2.3. Ahmad (1992: 44) noted that some answers to the 'ethnicity' question in the 1991 Census were based on geographical location such as Africa or the Caribbean. This usage of 'Africa' as though it were a country rather than a continent shows a poor understanding of cultural and ethnic diversity.

Sheldon and Parker conclude argument by suggesting that the use of 'race' is ubiquitous in Government agencies and commenting that,

... if public health workers continue to use the term 'race' because people act as though race exists, they are guilty of conferring analytical status on what is nothing more than an ideological construction. (1992: 105.)

Summary of 'race'

It is clear that 'race' has no biological or scientific existence and that supposed links between phenotypes and behaviour or culture are false. 'Race' is a societal construct used to create a false hierarchy of superiority/inferiority for the purpose of hiding exploitative economic relationships and maintaining the hegemonic power of the dominant group in society.

'Race' is accorded a formal, but false, existence by the state which, in Britain, holds the contradictory stance of recognising 'race' as a social division which can cause disadvantage. Chapter 2.2. contends that this process is also used to impose and support draconian British immigration and nationality legislation.

Perhaps the most important factor in the discussion of 'race' today is implicit in the foregoing arguments and descriptions. All identifications and definitions of 'race' are imposed on 'racial' groups and populations from outside those groups. They include no notion of self-definition. The individual cannot choose whether to belong to a particular 'race': society will have chosen on his or her behalf.

What is ethnicity?

The term 'ethnic' derives from the Greek *ethnikos* the adjective form of *ethnos*, meaning a nation or race. The original use of the term in English was to indicate people who were not Christian and were, therefore, regarded as heathen or pagan. Petersen (1980: 1) records that Thomas Hobbes in *The Leviathan*, advised foreign converts to Christianity to continue to obey their 'ethnic' leaders.

Some commentators suggest that 'race' has simply fallen from favour while a comparable and politically-correct term 'ethnicity' has grown in popularity. In part, this may be because, as a concept, ethnicity is difficult to define and operationalise (Ahmad 1992: 44). However, ethnicity is a highly contested term (Anthias 1998: 524) even though it is often used as a given and is not fixed (Jenkins 1997: 13). Most writers, for example Ahmad (1992: 46), Cashmore with Banton (1994: 102) or Mason (1995: 1) agree that, like 'race', ethnicity is socially constructed and is difficult to define accurately or consistently. Petersen says:

Ethnicity is a baffling reality – morally ambivalent, paradoxical in experience, elusive in concept. (1980: 29.)

While often used as an analogue for ‘race’, ethnicity does necessarily connote race, though the converse may not be true. Cohen and Bains (1988: 23) perceive a need to keep the concepts of ethnicity and ‘race’ separate while noting that they are interconnected ‘at the level of social reality’ (Cohen and Bains 1988: 27).

It is apparent that the perspective from which ethnicity is viewed is important, Miles (1982: 49) for example, comments that white British people see South Asians as ‘Indians’, but individuals from South Asia perceive a multitude of different ethnicities. Ahmad (1992: 45) agrees and argues that care must be used when researching ethnic categories so that there is no implication that ‘ethnic people’ are homogeneous.

Jenkins (1997: 13) offers a social anthropological model of ethnicity and suggests that ethnicity is principally concerned with culture and cultural differentiation and may be seen as a dialectic between similarity and difference that includes the notion of collective social identity. Culture is itself a contested term and Hartley asserts:

If you ... use the term culture as an analytical concept ... it is unlikely that you will ever be able to fix on just one definition. (1994: 68.)

Miles (1982: 47-49) also attempts to define ethnicity by reference to culture. His definition is centred on the notion that an ethnic group must have a shared culture and ancestry together with a characteristic pattern of social interaction and a desire to pursue common goals.

Richardson (1992: xii) is less clear, seeming to share a common problem of categorisation and an inability to decide whether ethnicity is a product of shared history, tradition and experience or is about nationality, place of birth and geographical location. Petersen (1980: 5-7) shows similar confusion, but also includes political location as an indicator of ethnicity. Similarly,

Husband (1996: 31) suggests that an ethnic minority may, under some circumstances, exhibit a territorial identity.

Pinderhughes (1989: 39) views ethnicity as a source of difference and believes that it embodies a combination of cultural uniqueness, socially inherited definitions of self and a sense of commonality with others. She suggests that the impact of an individual's ethnicity can be positive, negative or, indeed, ambivalent.

Sheldon (1992: 60) argues that national identity and language are important factors in ethnicity and, significantly, argues that ethnicity brings with it the concept of self-definition from within the group. Cashmore with Banton (1994: 102) agrees that language may be important and takes this discussion forward by arguing that an ethnic group is more than a mere aggregate of people or a sector of the population; rather comprising a self-conscious collection of people who are united or closely related by shared experience. Implicit in this definition is that an ethnic group feels, in some manner, marginalised from mainstream society. Crucially, Cashmore agrees with Sheldon's notion of the importance of self-definition and says:

Ethnicity, then, defines the salient feature of a group that regards itself as in some sense (usually, many senses) distinct. Once the consciousness of being part of an ethnic group is created, it takes on a self-perpetuating quality and is passed from one generation to the next. (Cashmore with Banton, 1994: 103.)

However, Cashmore retains the concept of ethnicity as culture, while noting the importance of what is termed boundary maintenance:

... they [the ethnic group] define boundaries inside which they can develop their own particular customs, beliefs and institutions – in short, their own cultures. (1994: 102.)

Miles' earlier work (1982: 47) concurs with the preceding arguments and, importantly, asserts that 'racial' boundaries are maintained from outside the group while ethnic boundaries are sustained from within. He departs from the conception of a cultural definition of ethnicity, saying:

An ethnic group is therefore to be defined not by its cultural characteristics, but by reference to the process of boundary maintenance. (1982: 47.)

Hall (1989) argues that there is no difference between culture and ethnicity and the important factor is that ethnicity defines 'belonging' rather than exclusion. It is of great interest to note that most researchers and commentators on ethnicity describe the process as creating inclusionary boundaries within which ethnic groups exist, rather than the boundaries of 'race' from which they are excluded, and Banton adds to this by declaring that:

Membership in an ethnic group is usually voluntary; membership in a racial group is not. (1983:10.)

Wallman argues that this process of boundary formation is not entirely based on cultural difference, noting that,

... two sets of people with common cultural origins placed in similar minority positions [will not] necessarily use the same elements of their traditional culture to mark themselves off from non-member 'others'. What they do use will depend on the resources they have, on what they hope to achieve ... and on the range of options available to them at the time. (1979: 5-6.)

Wallman's counter argument is that ethnicity depends on situation and implies that ethnic identity will change to suit different situations. In this fluid structure, ethnicity will be unstable and may sometimes be applied so as to exclude individuals from membership of an ethnic grouping (Anthias 1992: Ch. 2).

Though it is apparent that 'race' and 'ethnicity' are contested terms, there have been few attempts to propose alternatives, though Petersen (1980: 5-7) suggested the term 'subnation' as a possibility, composed of elements of 'race', culture, language and hereditary links. It is not apparent what, if any, advantage this would have, since Petersen himself acknowledges that the concept of subnation in no way avoids the problems inherent in other definitions.

At the present time, most observers see ethnicity as unidimensional, that is, an individual can belong to only one ethnic group (for example Tizard and Phoenix 1993: 4). There is, however, a growing interest in the concept of mixed ethnicity (for example Hall 1996: 336-344) which may be capable of utilisation in practical as well as theoretical arenas.

It is also of great interest that some (for example Hall 1989) believe that new ethnicities are being constructed all the time and, therefore, that new ethnic groups formed.

Summary of ethnicity

Ethnicity has no more physical or scientific existence than 'race'. However, it is crucially different because it is not an imposed false hierarchy of power relationships and does not depend solely on appearance or inherited characteristics. Rather it is a matter of self-definition and of the self-imposition of an inclusive boundary around an ethnic group. Its purpose is to express choice and stress 'sameness' rather than to construct 'otherness'.

MacLachan, provides a comprehensive definition of ethnicity as an inclusionary construct, saying:

The term ethnicity is often used to remove the pejorative use of 'race' and in recognition that different races may share a similar culture. Thus members of an ethnic group are seen as sharing a common origin and important aspects of their way of living. Essentially, 'ethnicity' refers to a psychological sense of belonging which will often be cemented by similar physical appearance or social similarities. The sense of belonging to a group can either stigmatise individual members or empower them through consciousness raising. Black consciousness in Britain can be seen as an attempt to empower members of a stigmatised minority group. (MacLachan, 1997: 3.)

The utility of ethnicity for social research is still to be established in detail, not least because of the difficulty of consistent definition. Ahmad (1992: 47) believes that ethnic research is useful, but that 'ethnicity' must be carefully defined with particular policy outcomes in view, but warns that:

Uncritical use of 'ethnic' data will aid racialisation and stereotyping and thus reinforce oppression of the very minorities which the data were ostensibly meant to support.

There can be little doubt that ethnicity, defined in a variety of ways, can be a useful tool for research and analysis. For example, language is relevant to the experience of NHS users, as is diet which may have ethnic relevance (Mares *et al* 1985: Ch. 8). Culture, by which many observers define ethnicity, may be relevant to users' experience too not only of the NHS but also of many other aspects of the welfare state and society in general.

'Race' versus 'ethnicity'

In summation, 'race' has an historical basis in contacts between peoples from different locations. Scientific racism was based on the creation of a false order of 'races' that placed white Europeans at the top and 'Black' people at the bottom.

'Race' has no physical, biological or 'scientific' existence. It is a social, economic and political construct based on the false assertion that phenotypical differences are inheritable *en*

bloc and can be consistently linked to behavioural difference. The purpose of the societal construction of 'race' is to create 'others' who may then be placed in subordinate positions within a hierarchy of power. This enables 'race' to hide economic differences and legitimate the exploitation of 'others'. Membership of a 'race' is involuntary and always imposed from outside the 'racial' group, creating exclusionary boundaries. It has little analytical value but persists in society, in part, because the State assumes its existence and gives it administrative and legislative reality.

Ethnicity is frequently wrongly used as a synonym for 'race'. It is a mutable, flexible and contested term which can be defined in terms of different characteristics of the people involved and can include, culture, language, religion, shared history and experience, politics and geographical location. Its context is important as is the perspective of those making the definition.

The most significant feature of ethnicity is that it is self-defined. It is then used to create and maintain an inclusionary boundary of 'sameness' rather than 'otherness'. In broad terms, membership of ethnic groups is voluntary. It can be argued that new ethnic groups, including those who would describe themselves as being of 'mixed ethnicity' are coming into existence continuously (Hall 1989).

Race has little utility as an analytical tool in social research; ethnicity does, though it is difficult to define. In terms of the persistence of 'race', it is vital to challenge the State's assumption that 'race' exists and is legitimate by encouraging the use of ethnicity as an analytical concept.

2.2. Immigration and health

History, attitudes and discrimination

The purpose of this chapter is to locate the presence of black people in England and Wales within an historical context. It will narrate the history of immigration from the Middle Ages onwards, using appropriate examples, noting that it is not restricted to non-white immigration, and offer some analysis of the reasons why this process occurred. It will examine the health policy implications of and responses to the immigration process. This chapter will also discuss 'native' responses to immigration, particularly to the immigration of non-white peoples, and argue that the United Kingdom has never welcomed black immigration. Indeed, recent surveys (Jowell *et al*, 1995: 201-209) indicate that there has been little change in attitude in recent years. Relevant economic and social factors will also be discussed.

Because this thesis is concerned with contemporary issues, the history of immigration will be divided into two main sections; before and after WW2. These can be thought of as the 'Empire' or 'colonial' and 'post-Empire', or 'post-colonial phases'. Greatest emphasis will be placed on the second period, that of 'post-Empire' or 'New Commonwealth' immigration, commencing *circa* 1948, and the responses of the National Health Service to black immigrants from that time forward. The issues concerning 'black' immigrants will receive most prominence.

For the purposes of this chapter, 'immigration' is defined as the process of leaving a foreign country and becoming a permanent resident in Britain. The 'New Commonwealth' is intended to refer to all British and ex-British colonies whose citizens are 'black'. It is composed of all the 'Old' Commonwealth countries with the exception of New Zealand, Canada and Australia.

Immigration to Britain has taken place throughout recorded history. However, it is not the purpose of this chapter to deal with the invasions by Vikings and Normans, but to concentrate for the most part on both more recent times and the immigration of people who are visibly different from the dominant white majority.

Immigration before WW2

It is difficult to discover the numbers of non-white persons living in Britain at any specific time. White people are, effectively, subsumed into the dominant ethnic group and become 'invisible' for all normal purposes. Questions of nationality were asked in the Census of Population throughout the 19th Century, but the apparent purpose was to establish whether the respondent was Irish. Questions based on 'country of birth' were asked from 1951 onwards but do not reveal 'race' or ethnic information. In the 1991 Census respondents were asked to which ethnic group they belonged, though the possible responses to this question were limited and results may be of dubious value (see Chapter 2.3., and Anwar 1990: 607-615). There are other problems with 'ethnic' or 'race' statistics that are addressed elsewhere in this work.

In the Middle Ages, Jews emigrated, mainly from France, to Britain to escape religious persecution. Many sources (see for example: Banton 1983 or Jones 1977) suggest that these immigrants were not welcomed by the resident population, a theory confirmed by reports of attacks on Jewish communities in York, Lincoln and London in 1189 and 1190 and *Magna Carta* contains two clauses whose sole intent is to limit Jews' power. In 1290 Edward I banished all Jews from England, seizing their real estate for the Crown. (Pascoe 1968: 192). At this time Britain was becoming a great imperial power of enormous strength. Its colonies and dominions were spread across all the continents of the world, frequently described as 'the Empire on which the sun never sets'.

In the 15th Century there was an influx of Protestant refugees from France and the first black people are noted in Britain when James IV of Scotland had Africans in his court. The first five black slaves were seen in England in 1555 (Panayi 1994: 15), and the numbers of black slaves grew throughout the next three decades, but by 1590 there was increasing hostility towards them. In 1601 Elizabeth I authorised the deportation of all ‘blackamoors’ from the realm, though a small number remained in the country during the beginning of the 17th Century. In the latter half of that Century, Jews were permitted to return to England and became a considerable financial and commercial force. Throughout this period Britain continued to be a refuge for persecuted, though mostly white, minorities. For example, was a significant influx of French Huguenot (Protestant) refugees, perhaps as many as 50,000, after the revocation of the 1598 Edict of Nantes in 1685, which had given French Protestants the right to worship according to their beliefs.

From the end of the 17th Century onwards, the number of black people in Britain began to increase. Most were slaves since it had become fashionable for the rich to have black attendants. Economic factors were significant too and Walvin (1984: 34-35) for example notes the importance of the so-called ‘triangular’ trade that linked the transport of slaves from West Africa to the Caribbean and the trade in sugar from the Caribbean to England. Though not all black slaves were ‘imported’ direct to England, Fryer (1984: 19) states that many accompanied government officials and Navy and Army officers who were returning from foreign postings. Others were the personal servants to merchant sea captains. Commonly, white people tried to justify enslaving black people by emphasising their inhumanity and inferiority:

Proponents of slavery made the point that bondage was an improvement on African freedoms and that, without the restraints of slavery, Africans and their descendants could not be expected to work. (Walvin 1984: 35).

The process of slave immigration continued throughout the 18th Century and it has been suggested (see for example Panayi 1994 or Fryer 1984) that, during this time, the black population of Britain rose to between 10,000 and 15,000. At this juncture, most black people lived in London and there is some evidence of the development of a black ethnicity, at least in the sense of a shared community:

By the end of the eighteenth century a Black ethnicity had developed in London involving informal meetings in public houses. However, in the early nineteenth century, this ethnicity disappeared owing to the fact that Black people no longer moved to England in large numbers, as well as the lack of Black women, which meant that Black men married Englishwomen, whose children disappeared into white society. (Panayi, 1994: 18.)

The slave trade was abolished in Britain in 1807, though it continued until 1834 in the United States. By the beginning of the 19th Century, many black residents were sailors who had settled in Britain. There were significant black populations in London, Cardiff, Liverpool, Bristol and North and South Shields.

The 19th Century also saw the introduction of immigration control measures in England and Wales, a process that has continued to the present day, with the 1836 Registration of Aliens Act. However, immigration continued with the Irish population rising to 566,540 by 1871 (HMSO 1871) and an increasing population of Jews escaping persecution in Russia. By the beginning of the 20th Century, the Irish population was declining in numbers and Chinese immigration had commenced, though it has never been large, rising to only 156, 938 by 1991 (Government Statistical Service, 1993: 830). 1905 saw further legislation to control immigration, the Aliens Act.

When WW1 began in 1914, many men were conscripted into the Army and there was a consequent shortage of labour. New demands were made on industry and commerce for the production of munitions and the transport of men and supplies. To fulfil these needs, immigration from the colonies increased and the black population rose, most notably in Cardiff. When the war ended, unemployment increased among the black population due to a reduction in demand for munitions and transport and the return of soldiers to their former jobs. This caused a tension between black and white people culminating in a riot in Cardiff on 6 June 1919 when it was alleged that a black man made an offensive remark to a white woman. It is after this point that the stereotype of black men in Britain is modified and the black man is constructed as sexually rapacious and, perhaps more significantly, as a danger to white women, as had been the case in USA. This built upon previous images of black people as 'wild men' inevitably credited with a powerful and aggressive sexuality (White 1972: 21-22), though this image was not restricted to black men and included other outsider groups such as Jews; Pieterse says,

... the Jew was said to have an insatiable sexual appetite and large penis, the same as was said of blacks. (1992: 218.)

Because many black people were poor and unemployed, it was easy to construct them as a social problem (see for example Fryer 1984: Ch. 10), and racial discrimination, especially in employment, was rife.

WW2 onwards

Between the end of WW1 and the beginning of WW2, there was little black immigration to England. The most significant group of immigrants during this period was Jews escaping persecution in Germany, Poland and Eastern Europe. However, with the outbreak of WW2 in 1939, conscription of men into the armed services began again and, while some occupations

were 'reserved' and those involved exempted from armed service, most men between the ages of 18 and 40 were sent to fight. As in WW1, this affected the economy in two main ways. First, there was a sudden shortage of labour, both skilled and unskilled, and second, there was an increased demand for the outputs of industry. As in WW1 there was a rapid and significant increase in demand for munitions, ships and transport, but a new departure in WW2 required the production of aeroplanes and huge numbers of military vehicles. Technology had moved on too, the carrier pigeons and heliographs of WW1 being largely replaced with radio and telephone communication. These technological innovations also required more labour.

As before, the labour shortage was, in part, filled by immigration from Britain's colonies. Men came from the West Indies to work in factories, but also to serve in the armed forces. Because of the war, the proposed decennial Census of Population was not carried out in 1941 and there are, therefore, no data available as to the ethnic composition of the country's population, assuming that such a question would have been included. It is known however that hundreds of black men worked in munitions, vehicle and aircraft factories and served in the army and the RAF.

The post-WW2 labour shortage

When the war ended in 1945, the then Labour Government made unsuccessful attempts to repatriate colonial workers (Layton-Henry 1992: 242-245). In part, this was because the economy entered a period of sustained 'boom', and there was a shortage of labour in industry and elsewhere. For example, more than 3,000,000 dwellings in England had been damaged by enemy action and 450,000 destroyed or rendered unfit for habitation (Malpass and Murie 1990: 61) and an enormous, labour-intensive, rebuilding programme was underway. Wright interviewed a factory manager in the West Midlands who said:

At this time you couldn't get an armless, legless man, never mind an able-bodied one. Any worker could leave the works and get a job literally within three or four minutes simply by going to the factory next door. We tried recruiting Irish labour but this didn't come off. (1968: 42.)

To place these issues in context, the British Empire was undergoing change at the end of WW2. Colonies were becoming independent and great transformations were in progress. For example, in 1947 the India Independence Act became law, partitioning India into two Dominions, India and Pakistan. Burma left the Commonwealth after the enactment of the Burma Independence Act, and Ceylon became a self-governing dominion. The following years saw this process gain momentum. For the most part, former colonies became members of the British Commonwealth, though the membership of this organisation has not remained static with, for example, Pakistan resigning in 1972 in protest at Britain formally recognising the state of Bangladesh. It is worthy of note that, under the provisions of the British Nationality Act 1948, citizens of British colonies, and former colonies, were granted UK citizenship, together with the right to live in Britain. Over the years this right has been eroded.

New Commonwealth immigration

The severe labour shortage affected all English industry and services. It was, therefore, not unduly surprising that official sanction, and welcome, was given to the arrival of the *SS Empire Windrush* on 22 June 1948 carrying 492 immigrants from Jamaica (Fryer 1948: 3; Phillips and Phillips, 1999: Introduction). Though the arrival of these immigrant workers was officially welcomed, and recorded for cinema newsreels.

The British economy, short of labour, needed these willing hands. The door stood open. Officialdom at both government and local levels moved swiftly to make the Jamaicans feel welcome and find them accommodation and work. Jobs were found immediately for 202 skilled men; the others did not have to wait long. (Fryer 1984: 373.)

There is, however, another dimension to the story. Banton (1983: 289) suggests that this immigration was a sudden, opportunistic and unexpected development since the *SS Empire Windrush* was a troopship returning, almost empty, to England after repatriating ex-RAF servicemen to their homes in Jamaica: immigrants were not expected, having simply taken advantage of the offer of a cheap passage:

These events mark the commencement of the period of New Commonwealth immigration, the result of which has been, according to Spencer, a phenomenon in which:

In the space of less than half a century, Britain has shifted from being a virtually all white society into one in which ethnicity and race are significant social and political factors. ... [from] the first restrictive legislation on immigration in 1960s to the development of powerful ethnic communities in modern British society. (1997: Introduction.)

Spencer (1997: xiv) argues that this and the migrations that followed were not welcomed by the British Government, though they were both unwilling and unable to prevent them. This attitude is echoed by Mullard (1973: Ch. 4) who suggests that employers first tried to alleviate the labour shortage by employing white European workers and only turned their attention to the black workers of the Commonwealth when this strategy failed. Though the immigration from the Caribbean was viewed with distrust by Government and population, Mullard reports (1993: Ch. 4) that the Jamaican incomers expected to be welcomed to what they had been brought up to believe was their 'Mother Country' and were unaware of, and unprepared for, Britain's long history of hostility towards immigrants. Spencer (1997: xiv) agrees, suggesting that most immigrants had to display 'considerable initiative, self-confidence and courage' to succeed in emigrating to Britain, and then had to 'overcome the obstacles placed in their path by an unwelcoming government and society'. Banton feels that hostility was focussed on

black immigrants because they were visibly different and ‘could be seen not to belong’ he says:

Their colour was an indelible mark of their different origin and would still attract attention even if in every other respect they behaved like the native people; if they were to intermarry that same mark would be noticeable for many generations until the whole nation had become slightly coffee-coloured. For a generation that had been brought up to believe that a white skin was something to be proud of, there was no reason for people to want to change their national self-image and a good reason for them wanting to stay as they were. (1983: 298-299.)

Public attitudes notwithstanding, the immigrants from the Caribbean were welcomed by British industry and commerce. Shortages of labour meant that workers could easily leave unpleasant, badly paid or unsociable jobs with the certainty that they would have little difficulty in finding more acceptable work. The idea of introducing immigrant workers to fill these gaps was popular, though it might be argued that it helped to reproduce the contemporary culture of ‘race’ by ensuring that non-white workers could find employment only in the least desirable and most dangerous occupations.

Wright (1968: 42) and others believe that the then Government thought that it would be possible to repatriate the immigrant workers when they were no longer required. This proved not to be the case. Not only did the newly arrived workers adopt the same attitudes as the original workforce, leaving unpleasant jobs as soon as possible to seek promotion, but they also settled in England and either brought existing families to join them or entered new long-term relationships. Any thought of repatriating a member of a second generation born in Britain must be considered asinine, if not because of individual’s perception of ‘home’ then because of their nationality by place of birth.

Fryer (1984) reports that common image of the first immigrants from the Caribbean is that they were unskilled. This was not, in fact, the case. Of the 125,000 West Indian immigrants to Britain by 1958, 46% of men and 27% of women were skilled workers (Fryer 1984: 373). Employers were quick to recognise the benefits of employing migrated workers who were soon in such high demand that some companies began to recruit directly in their home countries. For example, London Transport began recruitment in Barbados in 1956 and employed nearly 4,000 Barbadians over the next 12 years (Fryer 1984: 373). The process was extended to Trinidad and Jamaica in 1965. Nor was this the only case. The British Hotels and Restaurants Association recruited skilled workers in Barbados and Spencer notes that:

For the period 1945 – 1950 official papers contain references to two officially sponsored [immigration] schemes, one for Barbadian women for domestic duties in hospitals ... (1997: 42.)

Immigration also began from the Indian sub-continent at this time, perhaps influenced by the division between India and Pakistan which had resulted in thousands of people being unemployed and homeless. Fryer suggests that immigration took place with official sanction and, for these immigrants, Britain offered,

... the prospect of a new life unthreatened by flood, famine or the miserable poverty that was their countries' chief legacy of imperial rule. (1984: 373.)

Official reactions and legislative change

The then Government's official reaction to people from the New Commonwealth was welcoming, but legislative changes have been enacted whose purpose is to limit New Commonwealth, and therefore non-white, immigration. In 1949, the report of the Royal Commission on Population, cited in Layton-Henry (1992: 242-245), argued that only immigrants of 'good stock' should be allowed entry. Though this policy could be based on

socio-economic class distinctions, it seems more likely that it should be considered racist behaviour perpetuating the artificial 'racial' divisions between ethnic groups. From 1948 to the present day, the history of immigration into Britain is one of increasing restriction and control, but also of acknowledgement of the existence of racial discrimination and attempts to prevent it. Though the term 'racism' does not usually appear in Acts of Parliament, attempts were made to introduce legislation against race discrimination as early as 1950, by means of a Private Member's Bill, though this, and a similar attempt in 1956 to outlaw race discrimination in public places, failed. However, race relations legislation was successfully enacted. It has been argued (Rose *et al* 1969:519-520) that the first, 1965, Act was seriously flawed because it related only to public places and contained inadequate powers for enforcement. The 1968 Act, however, included an important revision, section 6, which made it unlawful to incite racial hatred and also included clauses outlawing racial discrimination in employment. The more recent Act, 1976, made important progress by making it illegal to discriminate on the grounds of race either *directly* or *indirectly*, closing an significant loophole. Further legislation has resulted from the Inquiry (Cm 4262-I, 1999) which followed Stephen Lawrence being,

... unlawfully killed in a completely unprovoked racist attack by five white youths. (Cm. 4262-I: 2.5.)

Among other things, the Report of the Stephen Lawrence Inquiry created an updated definition of 'institutional racism', building on the definitions in the Scarman Report of 1981, and recognised the need to be aware of and to value cultural diversity. The provisions of the new Race Relations (Amendment) Act (2000) come into force during 2001. They amend the 1976 Act by making the Act applicable to public institutions and by creating enforceable

duties on the chief executives of those institutions. (For more information, see Commission for Racial Equality, 2000.)

While the process of enacting legislation to counter racial discrimination has progressed through recent history, a parallel process of legislating to reduce immigration has taken place. It is contended that this process has been based on the concept of reducing non-white immigration.

The first Immigration Control Act was drafted in 1954, but not presented to Parliament. The Commonwealth Immigrants Act of 1962 created a limit to immigration by requiring all potential immigrants to be in possession of an 'employment voucher' before they could be considered for immigration. This procedure allowed Government more control over immigration and was the end of large-scale immigration from the New Commonwealth. For example, in 1965, the number of employment vouchers issued annually was reduced from 10,000 to 8,500 (Layton-Henry 1992: 242). When as a result of political initiatives in Kenya and Uganda many people of Asian origin who were British passport holders were expelled, the then Government enacted legislation to restrict their immigration to Britain. The legislation took the form of a new Commonwealth Immigrants Act (1968) which specifically restricted the immigration of East African Asians. Further controls were imposed under the provisions of the Immigration Act, 1971 (which replaced the Commonwealth Immigrants Acts of 1962 and 1968).

Further, increasingly restrictive, legislation has been enacted to limit immigration to Britain, for example Nationality Act, 1971, the imposition of visa controls on visitors from India, Nigeria, Ghana, Pakistan and Bangladesh in 1986, the Immigration (Carrier's Liability) Act, 1986 and the immigration Acts of 1986 and 1988. It has been argued (see for example,

Deakin 1975, Panayi 1994 or Walvin 1984) that these immigration controls have been designed to be most effective against black immigrants.

There has been further legislation designed to cope with changing patterns of immigration and the growth in the number of asylum seekers which has been especially apparent since the dissolution of the USSR and the unrest in the Former Yugoslavia and other regions. The main purpose of the Asylum and Immigration Act (1996) and the Immigration and Asylum Act (1999) is to limit immigration by asylum seekers. It must be assumed that, because black people are visibly different, they will be disproportionately targeted by the provisions of this legislation.

Summary of immigration

To summarise, immigration has taken place to Britain since the Middle Ages and was influenced by the slave trade. For most of this period, black people were categorised as being of doubtful humanity, but at the same time of rapacious sexuality. The period of greatest immigration of non-white people has been since WW2 and has consisted of a series of migrations from different countries that was not welcomed by government, though it was unable to stop it. Migrants came from a variety of social and educational backgrounds and many were skilled. A major factor causing immigration was the labour shortage and boom economy of the post war period. There is evidence that immigrants have not always been welcomed in Britain, either by governments or the indigenous population, and have been treated, at best, as second class citizens. Indeed, the chronology of legislation suggests that whenever there are signs that there will be an increase in the number of people wanting to enter Britain, for whatever reason, then the Government response will be to enact a Law to

prevent or limit that legislation. It is apparent that it is easier to limit the immigration of those people who are visibly different from the white majority.

Health policy responses

International health controls originate from the First International Sanitary Conference in 1851. As early as 1926, a medical control policy was in operation at ports of entry to Britain. The controls were the result of a policy agreed by the International Sanitary Convention, a product of the Health Organisation of the League of Nations (Patterson 1969: 345). By 1933, Britain had 'Port Sanitary Regulations' in force which permitted authorised medical officers to exclude individuals who were suffering from cholera, smallpox, typhus, yellow fever or plague. The Instructions to Immigration Officers made under the Commonwealth Immigrants Act 1962 extended these powers to include persons suffering from mental disorder and any individual whose admission to Britain was considered undesirable on medical grounds (Cm. 2151 1962). In 1964, 68 individuals (8 from the Commonwealth) were refused entry on these grounds (Cm. 2739 1965: Sec. 28). These regulations are particularly interesting when viewed in the light of Foucault's theories, discussed elsewhere in this thesis. In *The Birth of the Clinic* (1973: 38-39 and *passim*. See also Cheek and Rudge, 1997: 707), Foucault notes that the discourse of an issue must be created before that issue can be discussed, and that this discourse will regulate the nature of the things that can be said, and the things that cannot be said. Thus to create a discourse of refusal of entry on the grounds of mental disorder creates a new restriction which had not before been available to immigration officers.

Though it is apparent that the NHS welcomed, and recruited, immigrant nurses to fill their labour shortfall, it is, perhaps, not surprising that there is little evidence of a reaction to the increased immigration of the period from 1948 to 1962. However, the Central Office of

Information (1997: Introduction) described it as, 'The most notable social change in Britain in the period after the Second World War' and Mullard records that, in the 1950s:

Speeches demanded government control of the number of blacks entering the country. Overnight, blacks were suddenly responsible for the unemployment figures, housing shortage, lack of adequate social services, schools and hospital beds. (1973: 46.)

Significantly, the process of recruiting nurses abroad is occurring again. Several NHS trusts are recruiting trained nurses from the Philippines (see for example Sandwell NHS Trust, 2001: 1). The trusts visit Manila and recruit nurses there; resonance with 1948 and the Caribbean is clear.

Health concerns at the beginning of post-WW2 immigration seem to be predicated on the assumption that immigrants, but especially black immigrants, were in some way diseased and, thus a danger to the nation. There is some evidence to support this notion, for example Spencer 1997: 93 or Rose *et al* 1969: 334, note that pulmonary tuberculosis was, relatively, widespread among people from India and Pakistan and there was a risk that it could be communicated to the British population. Rose *et al* (1969: 330) argue that this is an example of the health and welfare needs of black immigrants being constructed as social problems in a similar manner to other aspects of their lives. They say:

The extreme stereotype of the coloured immigrant, which was circulated widely, was of someone who brought disease into the country, and who, once here, created a risk of epidemics because of his(Sic) origin and living conditions. (Rose *et al*: 1969: 330)

Because of these fears, strict health checks were performed on all immigrants, though Jones (1977: Ch. 6) implies that they were much more rigorous for black people.

A more reasoned response came from the Ministry of Health in a letter dated 4 January 1965 to all GPs, in which priorities regarding immigrants were made clear (Rose *et al* 1969: 333).

The main thrust of this communication was that the most important task was to ensure that immigrants learnt to use the NHS as soon as possible:

When they settle in this country, immigrants, both aliens and Commonwealth citizens, are often very unfamiliar with our customs and, in particular, ignorant of the scope and arrangements of the National Health Services. They may at first live under very difficult conditions and some of them in their countries of origin have been particularly subject to the risk of tuberculosis.

The main problem is, therefore, to ensure that at an early date they learn how to use the Health Service and, in particular, for us to secure by voluntary action that those from countries with a high incidence of tuberculosis – particularly from Asia – have a chest X-ray as soon as possible after their arrival in the country. The proposal to secure a chest X-ray in all cases before departure from their country of origin has been very fully explored and not found to be practicable. Nor is routine X-ray of all immigrants at the port of entry a practicable procedure, though it may be possible to arrange for limited numbers to be X-rayed. (Patterson, 1969: 348.)

To help in this, immigrants were given leaflets in various languages at their port of entry to encourage them to register with a GP. To facilitate this process, the British addresses of immigrants were forwarded to local Medical Officers of Health so that they could be followed-up. This was aided by the use of a tear-off slip in Commonwealth passports. This procedure has obvious limitations, since there was limited awareness of language differences among people from large multi-cultural countries such as India. Additionally, there are issues around literacy and the alphabets which would have been used to print some languages.

Rose *et al* (1969) said of the NHS response to immigration:

Broadly, the position is that while immigrants from many Commonwealth countries contribute heavily to the staff [of hospitals] they are apparently underrepresented among patients. (Rose *et al*: 1969: 338 – 342.)

It seems that there were exceptions to this, particularly in maternity services, but this probably reflects the judgement of domiciliary midwives who were unable to correctly assess the living conditions of people from different backgrounds. This is confirmed by Fitzherbert (1967 *passim*) who found that health and social work professionals tended to assume that immigrant families were less capable than was, actually, the case. It is sad to note that there is little evidence of progress in this area. As recently as 1993, a study (Bowler, 1993: 157-78) found that midwives tend to stigmatise Asian service-users' behaviour as making an 'unnecessary fuss'. Bhopal and White, (1993: 141-145) found that health professionals' perspectives on the health care needs of Asian people are predicated on the supposedly problematic features of their cultures rather than on specific health needs.

While some health authorities provided specialist service provision for immigrant families, the rate of take-up was low (Rose *et al* 1969: 341-342), and it is suggested that this is because the NHS failed to recognise and respond to cultural difference.

In 1965, Harold Wilson's government noted that:

Immigration has not created a serious public health hazard; and such problems as have arisen in the areas where immigrants have settled have been due in the main to difficulties of adaptation to new conditions, and to disease being contracted after arrival rather than brought in. (Cm. 2739 1965: Sec. 27.)

Deakin (1970: 230) also argues that immigrants are beneficial not detrimental to society and quotes Jones who says:

The adult working population supports the old in the community. An inflow of young adult immigrants therefore --so far as current expenditure of social services is concerned -- provide a once and for all gain for thirty years in which they add to contributors but not to dependants. This more than outweighs the additional social service costs which may be incurred because of the immigrants' special health or educational requirements. (1967: 28-40.)

This can be taken as an acknowledgement that immigrant populations may have different health care needs, but that their high level of economic activity is an asset rather than a liability.

Deakin (1970: 228) also suggests that immigrants' health can differ from the resident population in two ways. Firstly, that they may have diseases that are endemic in their country of origin, and there is, as previously stated, ample evidence of this in incidence of tuberculosis. Secondly, they may be more susceptible to diseases that are endemic in Britain, for example, rubella.

There is a third difference, not noted in early works; that of diseases that are more prevalent in people of some specific ethnic origins. For example, Ahmad notes that:

While ... disease organisms such as HIV pay no attention to ethnic differences, certain biological differences do exist. (1993: 194.)

Finally, there is growing evidence of different cultural and ethnic expectations of health care (Lambert and Sevak 1996: 124 - 160) and different understandings of ill health (Kelleher and Islam 1996: 220 - 238, Davis 1992: 35 - 41).

2.3. Ethnicity and demography

This chapter discusses the ethnic characteristics of the contemporary British population, paying particular attention to ‘mixed ethnicity’ groups. It presents details of size of specific populations and discusses some of the reasons for their geographical location and dispersion, concentrating particularly on the West Midlands. This chapter also critically discusses the data sources from which the information is drawn, noting their shortcomings in group categorisation. In particular, the issue of population statistics relating to the ‘mixed ethnicity’ or ‘mixed origin’ population sector are examined and some of the problems relating thereto investigated.

Data sources and ethnic categorisations

The majority of data used and discussed in this chapter results from the 1991 Census of Population, which was the first to include a question on ethnic group. This question was presented in the manner shown below. This can be seen as an important departure from precedent as previous Censuses had sought objective information concerning the country of birth of the head of household. The 1991 question indicates a move, though flawed and incomplete, towards a subjective assessment of personal ethnicity.

Fig: 2.3.1. The Ethnicity Question in the 1991 Census

10 Country Of Birth	<p>Please tick appropriate box.</p> <p>If the 'Elsewhere' box is ticked, please write in the present name of the country in which the birthplace is now situated</p>	<p>England <input type="checkbox"/></p> <p>Scotland <input type="checkbox"/></p> <p>Wales <input type="checkbox"/></p> <p>Northern Ireland <input type="checkbox"/></p> <p>Irish Republic <input type="checkbox"/></p> <p>Elsewhere <input type="checkbox"/></p> <p>If elsewhere, please write in the present name of the country</p> <input style="width: 100%; height: 15px;" type="text"/>
11 Ethnic Group	<p>Please tick appropriate box.</p> <p>If the person is descended from more than one ethnic or racial group, please tick the group to which the person considers he/she belongs, or tick the 'Any other ethnic group' box and describe the person's ancestry in the space provided</p>	<p>White <input type="checkbox"/></p> <p>Black-Caribbean <input type="checkbox"/></p> <p>Black-African <input type="checkbox"/></p> <p>Black-Other <input type="checkbox"/></p> <p><i>please describe</i></p> <input style="width: 100%; height: 15px;" type="text"/> <p>Indian <input type="checkbox"/></p> <p>Pakistani <input type="checkbox"/></p> <p>Bangladeshi <input type="checkbox"/></p> <p>Chinese <input type="checkbox"/></p> <p>Any other ethnic group <input type="checkbox"/></p> <p><i>please describe</i></p> <input style="width: 100%; height: 15px;" type="text"/>

The next Census of Population is in 2001. A Census Test was carried out on 19 June 1997

involving almost 100,000 households in Britain. One of the results of this was that,

... no decision has yet been taken on the form of any **ethnicity question** in the 2001 Census and that the results of subsequent small-scale trials will be considered alongside the assessment of user requirements for information on ethnic groups before the final proposals are made in the White Paper to be published in the Autumn of 1998. (Office for National Statistics, 1998.) (Original emphasis.)

However, when the White paper was published in March 1999 (Cm 4253, 1999), it was reported that the 1991 ethnic group question had received widespread support in the Census Test and that the information collected had,

... enabled national and local government and health authorities to allocate resources and plan programmes taking account of the special needs of ethnic minority groups. (Cm 4253, 1999: 15.)

An ethnic group question is included in the 2001 Census, though different forms of the question will be utilised in different regions, and has been revised in order to,

... take account of 'users' requirement for additional information about people of mixed origin and sub-groups within the 'White' population, ... and to be as acceptable as possible to respondents. (Cm 4253, 1999: 15)

The ethnic group question for England and Wales is as follows:

What is your ethnic group?

◆ Choose one section form (a) to (e) then tick the appropriate box to indicate your cultural background

(a) White

- British
- Irish
- Any other White background

please write in below

.....

(b) Mixed

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed background

please write in below

.....

(c) Asian or Asian British

- Indian
- Pakistani
- Bangladeshi
- Any other Asian background

please write in below

.....

(d) Black or Black British

- Caribbean
- African
- Any other Black background

please write in below

.....

(e) Chinese or other ethnic group

- Chinese
- Any other

please write in below

.....

Source: Cm 4253 (1999), The 2001 Census of Population: 16.

The 1991 question was piloted in the 1989 Census Test (Owen, 1996: 42-45) and judged successful with 98 per cent of answers consisting of a single tick of one of the main categories. When used in the 1991 Census proper, this question yielded the following results for England and Wales:

Table: 2.3.1. Ethnic Groups in England and Wales.

Ethnic Group	Number (000s)	Population %
White	51,874	94.5
Black Caribbean	500	0.9
Black African	212	0.4
Black Other	178	0.3
Indian	840	1.5
Pakistani	477	0.9
Bangladeshi	163	0.3
Chinese	157	0.3
Other Asian	193	0.4
Other	281	0.6
Total England & Wales	54,889	100

Source: Adapted from Balarajan and Raleigh, (1995: 3) and COI (1997:8). Original data from 1991 Census.

It is interesting to note that there are differences in categories between the original question and the published results, this having been achieved by reallocating responses in the manner described below. It is also clear that there was some confusion over the categories that were chosen; some being nationalities, some political classifications, some based on skin colour and some on geographical location. It is also apparent that there was a limited understanding of the concepts of 'ethnicity' and 'race' (this issue was discussed in more detail in Chapter

2.1.). It is also interesting to note that there is a perception, expressed by the dominant white majority, that there are more Black and Asian people in Britain than is actually the case (Owen, 1994: 23).

When the 1991 Census proper was analysed, responses were reallocated according to a flowchart (OPCS, 1993) to a maximum of 35 categories and the information published as *Table A 'Ethnic Group (full and summary classifications)' in 1991 Census: Ethnic Group and Country of Birth Report* (OPCS, 1993: 830-913). These 35 groupings were then allocated to one of the 10 categories shown in table 2.3.1 above. Owen (1996: 42-43) has analysed the ethnic group (*Table A*) data and argues that while it was originally possible to identify in detail the components of the three 'Other' classifications, which are likely to contain the target population for the research reported in this thesis, this has not been done in any useful way.

However, Owen is inconsistent in his assertion that the data is capable of extensive analysis noting that,

... since OPCS has released little information about how this question [the ethnicity question in the 1991 Census] was answered, many analysts may be drawn into making sweeping assumptions about the members of this ethnic group, such as regarding them all as British-born children of Black-Caribbean people or all as people of mixed Black and White parentage. In reality, the category contains a fairly diverse range of people, and none of its components are dominant. (Owen, 1996a: 66.) (Emphasis added.)

The process of reallocation mentioned above has resulted in data loss. The diversity of the three 'other' classifications (Black-Other, Asian-Other and Other-Other) has been lost. One of the initial assumptions made in this thesis was that it might be possible to discover the size and location of the mixed ethnicity population from the Census data. However, the OPCS

processes have resulted in the homogenisation of the ‘other’ data, which probably contained details of most of the mixed-ethnicity respondents, and rendered it of little use for this study.

The racialisation of statistics

A number of commentators describe serious reservations concerning the collection of ‘racial’ or ‘ethnic’ statistics. Gordon notes that the decision to collect these data is political and it,

... should not be assumed that everyone favours the idea of racialised data collection. (1996: 33-35.)

There have often been fears that ‘racial’ and ‘ethnic’ data may be used to disadvantage the target population and it can, anyway, be argued that the collection of such data may have a negative effect on the attainment of ‘racial’ equality in Britain. Certainly, there are concerns that the collection of this sort of data is an infringement of individuals’ privacy and may pose dangers for vulnerable minority groups in a politically hostile environment. Furthermore, it can be argued that collecting ‘ethnic’ statistics may be used as a substitute for change and action and is, anyway, flawed because it is impossible to acquire information about changing diversity in this manner. Sociologist Robert Moore is reported to have said,

... given the records of governments since 1961, I would nonetheless advise the black population not to collaborate in the provision of such data. (Home Affairs Committee, 1983: 139.)

Smaje (1995: 22), too, expresses concerns about ethnic statistics, based on the arguments that official taxonomies tend to restrict choices and cause problems by concentrating on ‘race’ and thus detracting attention from racism, amalgamate conceptually different groups and, ultimately, do not provide data ‘refined enough to be useful’. There are also concerns that the ways that ethnic and ‘racial’ information may be used must, inevitably, affect the manner in which subjects respond and the nature of the data they provide.

The counter-argument, advanced by Bhrolchain is that:

Ethnicity statistics are needed to document the level of discrimination and disadvantage, to take action to combat these and to establish how far policies having this objective are succeeding. (1990: 545.)

In addition, it can be argued that the collection of this information by Government is legitimate because it is necessary to understand the composition of populations if adequate and appropriate services are to be provided. Furthermore, 'ethnic' statistics allow Government to monitor the effectiveness of legislation and policies intended to satisfy the needs of the members of minority ethnic groupings.

Mixed ethnicity

From the perspective of this research, it is regrettable that the 1991 Census question did not give respondents the opportunity to identify themselves directly as being of 'mixed ethnicity' or 'mixed origin', perhaps supplementing this categorisation with an opportunity to write in further information. This view is held also by Modood *et al* (1997: Ch. 1), who state:

A problem for all currently used methods of classifying ethnic groups ... is that they do not deal adequately with people of mixed parentage most of whom have one minority parent and one white one. (Modood *et al*, 1997: 14.)

Both the family origin question and the group membership question [in Modood *et al*'s survey] encourage respondents either to choose just one element of their heritage or to declare themselves as 'mixed', outside the main classification system. Again, it is important to identify these people directly, by asking separate questions about the family origins of both parents. A subsequent question is: with what ethnic group do people of mixed origin identify themselves most closely? **We did not ask about the origin of both parents in this survey, though we now wish we had, and recommend it for use in the next Census.** (Emphasis added.) (Modood *et al*, 1997: 15.)

As mentioned above, the question of self-categorisation of mixed ethnicity will be addressed in a somewhat more structured manner in the 2001 Census (Cm 4253: 15-16). However, it is not clear whether the data processing procedures will enable sufficient details of these categories to emerge to make analysis possible.

There are, of course, other difficulties with the categorisation of minority ethnic populations. Nanton (1992: 277) argues that most official categories are used inappropriately because they are seen as permanent and, thus, are not amenable to change over time or self-categorisation for different purposes. There is a subsidiary argument that official classifications tend to be mutually exclusive, which, coupled with the ongoing official usage of 'race' as a category and the apparent confusion between religion, ethnicity, geography and skin colour, makes the classifications of limited utility. Nanton also questions the appropriateness of the sources of ethnic categories, noting that these tended to be defined by the State until the 1970s, but that this has subsequently changed because of the growth of politically-aware minority ethnic groups. Even so, there is still a demonstrable tendency for official statistics to try to constrain people into pre-existing, inflexible categories, often using the discredited variable of 'race'. Nanton continues his argument by asking,

... if mixed groupings are likely to grow in importance should not steps be taken to develop the degree of category sophistication for this group similar to that now developed for 'Black' and 'Asian' groupings? (Nanton, 1992: 282.)

Smaje concurs regarding the problems of categorising minority ethnic groups in official statistics, noting that:

'Mixed' and 'other' ethnic categories indicate the limit of official taxonomies. The problems created by the former have been avoided in the 1991 Census question by providing no 'mixed' category, but rather two write-in categories for those who do not perceive their ethnicity to conform to any of the other seven pre-existing categories. **However, the coding frame for the census largely reallocates the write-in categories to the pre-existing ones.** Nevertheless, some 10 per cent of the non-white population is still consigned to the residual 'other' category. (Emphasis added.) (1995: 24.)

Chapter 2.1. has discussed the general nature of ethnicity and 'race', but the nature of 'mixed-ethnicity', or 'mixed-origin' is a more elusive concept. Owen's analysis of Census data (Owen, 1996: 45) suggests that the following mixed-ethnic groups exist:

Table: 2.3.2. – Mixed Ethnic Groups in Britain.

Ethnic Group	No.
Mixed Black/White	54,569
Mixed Asian/White	61,874
Other Mixed	112,061
Mixed White	3776
North African/Arab/Iranian	6,471
E.African/Indo-Caribbean	7381
Total	246,132

Source: OPCS (1993), Table A, Owen (1996: 45).

However, these data cannot be considered entirely reliable. The 1991 Census ethnicity question, in addition to the information above, produced results, after processing and reallocation, that include:

- 86, 215 ‘Other Answers’;
- 58,106 individuals in the ‘Black-Other’ category who described their ethnicity as ‘British’;
- 16,170 people in the ‘Any other ethnic group’ category describing themselves as ‘British Ethnic Minority.’

It cannot now be determined whether any of these individuals are of mixed ethnicity, only that they have not specifically chosen to identify themselves as such for the purpose of the Census.

Other analysts have reached different conclusions as to the size of the mixed-ethnicity population of Britain. Owen (1993: 18-23) estimated the population to be 309,000 or 6% of the total mixed ethnicity population in 1991, and Haskey estimates the 1996 mixed ethnicity population to be 360,500 or 7% of the total.

It is apparent that there is no 'official' definition of 'mixed ethnicity', and it may be entirely appropriate that this is the case, since current definitions of ethnicity imply high levels of self-identification and of individual decisions to associate with particular ethnic groups.

The distribution of the minority ethnic population

In the same way that there is variation in the composition of the minority ethnic population of Britain, there are similar variations in its distribution. The minority ethnic population of Britain is not evenly dispersed, but tends to be concentrated in 'more urban parts of the country' (Owen, 1994: 23), particularly in London, the West Midlands, Greater Manchester and West Yorkshire. Coleman and Salt (1996: 91) comment that minority ethnic groups tend to be more spatially concentrated than the white majority in these locations. This is not to suggest that there is a single homogeneous 'ethnic minority population. The spatial/geographical distribution of specific minority ethnic populations also varies with, for example, Africans, African-Caribbeans and Bangladeshis living mostly in Greater London. The majority of Pakistanis live in West Yorkshire and the West Midlands, while most Indians reside in Outer London with significant populations in Leicestershire and the West Midlands. Bangladeshi people are most concentrated in the West Midlands. The most spatially/geographically dispersed ethnic group are the Chinese (Parker *et al*, 1996: Ch. 1, Balarajan *et al*, 1995: 3-4). The reasons for the varied distribution of minority ethnic groups tends to be historically based around employment and housing issues, discussed below.

It is interesting to see that there is a perception, expressed by the dominant white majority, that there are more Black and Asian people in Britain than is actually the case. (Owen, 1994: 23). Amin, Gordon and Richardson (1991) carried out a 'Race Issues Opinion Survey' for the

Runnymede Trust. They found that 60% of white respondents believed that the Asian and Black population of Britain was 5,000,000 or greater. In fact, it is approximately 3,000,000.

My research concentrates on the West Midlands, particularly Birmingham and Sandwell, where non-white residents represent respectively approximately 21% and 15% of the population. Owen and Johnson (1996: 227) note that, with the exception of London, the Midlands hosts the biggest concentration of people from minority ethnic groups. The likely cause for this is that the industries of the West Midlands were in a period of sustained, post-WW2, growth which coincided with the mass migration of people from the countries of the 'old' and 'new' Commonwealth. Urban redevelopment, coupled with town planning initiatives leading to satellite housing estates, meant that inner-city areas began to lose population, but,

the extent of the decline in White residents was masked by the growth of the replacement population largely composed of migrants from the New Commonwealth and Ireland, attracted by jobs in the growing industries of the region. These migrants settled in the inner parts of the conurbation, ... which were being abandoned by the more mobile sections of the White population. (Owen and Johnson, 1996: 227.)

The trend against urbanisation continued throughout the period of maximum immigration and, as a result, people from minority ethnic populations tended to become concentrated into a few specific areas. The reasons for people remaining in inner-city areas, which, because of the decline in traditional 'metal bashing' industries, now tend to be distant from job locations, are associated with access to housing. There is evidence (see for example, Balchin, 1995: Ch. 11) that minority ethnic populations exhibit very high rates of owner-occupation. This was revealed in the 1991 Census:

Table: 2.3.3. – Household Tenure by Ethnic Group (%).

Ethnic Group	Owner-occupied	Private rented	Social rented
White	67	9	24
Indian	82	8	10
Pakistani	77	11	13
Chinese	62	21	17
Black Caribbean	48	7	45
Bangladeshi	45	12	43
Black African	28	20	52

Source: Adapted from Balchin (1995: 247; Table 11.2), Original data: 1991 Census of Population.

It is well established that there was discrimination against ethnic minority people in the letting of social housing from the late 1940s to the mid-1960s (see for example, Burney, 1967, Ward, 1992: 3-15, Skellington with Morris 1996: Ch. 7 or Smith, 1989). Local authorities often imposed a residence requirement, which was impossible for immigrants to meet. This practice meant that social housing was, effectively, unavailable for immigrants. Private rented accommodation was not only in short supply but often controlled by racist landlords, it was common for people from ethnic minorities to purchase the cheapest housing available. This is usually located in inner-city areas and is often old and of poor quality. The second Race Relations Act (1968) outlawed this indirect discrimination, but by then many people were ‘trapped’ by mortgages and, as owner-occupiers, still unable to obtain social housing. In this regard, the high levels of owner-occupation revealed should not be seen as representing wealth, as is often the case with the dominant white population, but rather as a measure of desperation.

Haskey's (1997: 28-29) analysis of the 1991 Census, affords details of the distribution of minority ethnic groups:

Table: 2.3.4. – Distribution by Region of Minority Ethnic Populations, 1991.

Region / Metropolitan County, (MC)	Black-Caribbean	Black-African	Black-Other	Indian	Pakistani	Bangladeshi	Chinese	Other-Asian	Other-Other	All ethnic minority groups	White	All ethnic groups
South East	66.3	83.5	56.6	52.9	29.9	63.6	53.3	72.4	57.9	56.2	29.9	31.4
Greater London	58.2	77.1	45.2	41.3	18.4	52.7	36.1	57.1	41.7	44.6	10.3	12.2
East Anglia	1.0	1.1	4.0	0.8	1.2	1.0	2.4	1.9	2.6	1.4	3.8	.3.7
South West	2.5	1.3	3.7	1.3	0.8	1.4	4.3	2.3	4.3	2.1	8.8	8.4
West Midlands	15.6	2.5	1.5	18.9	20.7	11.9	6.1	5.8	8.4	14.1	9.1	9.4
West Midlands (MC)	14.4	1.9	8.8	16.8	18.5	11.1	3.9	4.5	6.5	12.4	4.2	4.6
East Midlands	4.9	1.6	6.0	11.8	3.7	2.6	4.8	3.7	4.9	6.2	7.3	7.2
Yorks & Humberside	4.3	2.3	5.7	4.8	19.9	5.1	5.2	3.7	6.2	7.1	8.9	8.8
South Yorkshire	1.2	0.6	1.4	0.4	2.8	0.7	1.4	0.7	1.6	1.2	2.4	2.3
West Yorkshire	3.0	1.2	3.7	4.1	16.9	3.7	2.5	2.3	3.6	5.4	3.6	3.7
North West	4.3	4.4	9.0	6.6	16.2	9.1	11.1	4.5	8.2	8.1	11.6	11.4
Greater Manchester	3.4	2.5	5.2	3.5	10.4	7.0	5.3	2.5	4.4	4.9	4.5	4.6
Merseyside	0.4	1.4	2.4	0.3	0.2	0.4	3.6	0.6	1.9	0.9	2.7	2.6
North	0.2	0.7	1.1	0.9	2.0	2.2	3.2	1.6	1.8	1.3	5.8	5.5
Tyne & Wear	0.1	0.4	0.5	0.5	0.8	1.7	1.8	0.8	0.9	0.7	2.1	2.0
Wales	0.7	1.3	1.9	0.8	1.2	2.3	3.1	1.9	2.6	1.4	5.4	5.2
Scotland	0.2	1.3	1.5	1.2	4.4	0.7	6.7	2.3	3.0	2.1	9.5	9.1
Great Britain	100	100	100	100	100	100	100	100	100	100	100	100

Source: Haskey (1997: 28: Table 8A).

Haskey also produces these statistics to show the proportion of the population that comes from minority ethnic groups:

Table: 2.3.5. – Minority Ethnic Populations as a Percentage of the Total Population, by Region, 1991 (Significant Concentrations.)

Region / Metropolitan County, MC	Black-Caribbean	Black-African	Black-Other	Indian	Pakistani	Bangladeshi	Chinese	Other-Asian	Other-Other	All ethnic minorities
South East	1.9	1.0	0.6	2.6	0.8	0.6	0.5	0.8	1.0	9.9
Greater London	4.4	2.4	1.2	5.2	1.3	1.3	0.8	1.7	1.8	20.2
West Midlands	1.5	0.1	0.4	3.1	1.9	0.4	0.2	0.2	0.5	8.2
West Midlands MC	2.8	0.2	0.6	5.5	3.5	0.7	0.2	0.3	0.7	14.6
East Midlands	0.6	0.1	0.3	2.5	0.4	0.1	0.2	0.2	0.4	4.8
Yorks & Humberside	0.4	0.1	0.2	0.8	2.0	0.2	0.2	0.2	0.4	4.4
West Yorkshire	0.7	0.1	0.3	1.7	4.0	0.3	0.2	0.2	0.5	8.2
North West	0.3	0.1	0.3	0.9	1.2	0.2	0.3	0.1	0.4	3.9
Greater Manchester	0.7	0.2	0.4	1.2	2.0	0.5	0.3	0.2	0.5	5.9
Great Britain	0.9	0.4	0.3	1.5	0.9	0.3	0.3	0.4	0.5	0.5

Source: Adapted from Haskey, 1997: 28: Table 8b

Other statistics are available, for example it is possible to look at the proportions of people in Health Authority catchment areas. The most recent statistics for the areas covered by this research are:

Table: 2.3.6. – Minority Ethnic Population as a Percentage of Total Population (Health Areas).

LOCATION/HEALTH AUTHORITY	% OF RESIDENTS IN ETHNIC GROUPS OTHER THAN WHITE
England and Wales	5.92
West Midlands Regional Office Area	8.24
Birmingham Health Authority	21.36
Sandwell Health Authority	14.69

Source: Office for National Statistics (1997: 24).

Another measure, used by Owen (1994: 25) and Balarajan *et al* (1995: 5), is to use a ‘diversity’ scale to record ethnic variety in terms of the proportion of minority ethnic groups in a given area. This work indicated that the most diverse districts in Britain were:

Table: 2.3.7. – Ethnic Diversity in Districts, 1991.

DISTRICT	% of Ethnic Minority Groups
Brent	44.8
Newham	42.3
Tower Hamlets	35.6
Hackney	33.6
Ealing	32.3
Lambeth	30.3
Haringey	29.0
Leicester	28.5
Slough	27.7
Harrow	26.2
Waltham Forest	25.6
Southwark	24.4
Hounslow	24.4
Lewisham	22.0
Birmingham	21.5
Westminster	21.4
Redbridge	21.4
Wandsworth	20.0
Luton	19.8
Islington	18.9

Source: Owen (1994: 25), Balarajan *et al* (1995: 5), original data from 1991 Census.

The information above shows that there are multiple difficulties in attempting to obtain statistical data about minority ethnic and mixed ethnicity populations. Different categorisations are often used by different researchers, making comparison difficult. Little information has been collected about people who do not fit, or do not choose to accept, the definitions of ethnicity that are suggested by researchers.

Even when the opportunity is given for a respondent to 'write-in' their own self-definition of ethnicity, there are problems, for example in the case of the 1991 Census of Population where analysts recategorised 'other' ethnicity information resulting in the loss of potentially valuable analytic categories. To some extent, such actions are understandable. The effect of 'write-in' ethnicity fields on questionnaires may result in unmanageably diverse results. However, whilst recategorisation may be defensible in terms of assessing the need for specific services for example, it still results in the loss of detail and the involuntary categorisation and homogenisation of minority ethnic groups.

The mixed ethnicity population

For the purpose of this research, individuals of mixed-ethnicity are seen as the product of a union between parents of different ethnicities or who are themselves of mixed ethnicity.

Berrington states that:

One result of inter-ethnic unions is a population of mixed ethnicity. ...
Over three-quarters of the mixed population are UK-born and over half
are under the age of 15. (1994: 517.)

Modood *et al* (1997: 29) cite Hall (1996) and Alibhai-Brown and Montague (1992) and assert that so-called 'mixed' marriages have often been viewed as contentious by the dominant white population, saying:

Mixed marriages have often been a contentious issue. A common form of racism is for the dominant (white) group to object to 'miscegenation' if their daughters and sons marry the oppressed (non-white) minority. In contrast, the objections have sometimes been raised from the minorities' point of view if marrying white people is seen as a betrayal of the community identity.

They refer to Berrington (1996: Section 7.1) who notes that mixed ethnic marriages form only about 1% of partnerships in the total population. Much of Berrington's work uses 'ethnic' to mean 'non-white', even though there is a growing recognition that 'white' can, and should, be seen as an ethnic grouping (see for example, Mason, 1995: 17). Berrington declares that:

Indeed, the number of inter-ethnic unions is clearly an indicator of the extent of integration and mixing between ethnic groups. (1996: 178.)

However, her reasoning for this assertion is not explicit and contains many stereotypical images, for example suggesting that marriage patterns between ethnic groups in the UK are different from some assumed norm because they differ from those,

... of the original population from which ethnic minority individuals in Britain come. (Berrington, 1996: 178.)

This argument ignores the fact that many ethnic minority individuals in Britain may be three generations removed from immigration; some more.

Nevertheless, Berrington's analysis of Census information, though the sample sizes are very small, gives access to useful data on inter-ethnic unions, noting that:

Over the last decade a consistent picture has emerged whereby ethnic minority men are more likely than ethnic minority women to be married to a White partner and for inter-ethnic unions to be most common among those of mixed and Afro-Caribbean ancestry, and least common among those of South Asian origin. (Berrington, 1996: 198.)

Berrington reports that inter-ethnic unions are most common among black men and among people who categorised themselves as 'Black-Other', 'Black-British' or 'Black/White mixed' (Berrington, 1996: 199-200). Couples aged between 16 and 34 years are more likely to be in

mixed ethnicity relationships than people in older age groups. This information is tabulated below.

Table: 2.3.8 – Inter-Ethnic Unions. All Married and Cohabiting Men and Women, Resident Population, Great Britain, 1991.

Ethnic group of male partner	Ethnic group of female partner										
	White	Black-Caribbean	Black-African	Black-Other	Indian	Pakistani	Bangladeshi	Chinese	Other-Asian	Other	Total
White	126,150	102	41	63	71	10	0	79	148	139	126,803
Black-Caribbean	225	559	8	10	4	2	0	2	3	12	865
Black-African	48	16	208	4	2	1	0	0	0	2	281
Black-Other	76	3	2	62	1	0	0	0	2	1	147
Indian	135	2	4	1	1,762	18	0	5	4	5	1,935
Pakistani	42	0	0	1	6	775	0	0	4	3	831
Bangladeshi	7	0	2	0	4	1	217	0	0	2	233
Chinese	34	0	0	0	2	0	0	234	0	0	270
Other-Asian	55	4	1	1	4	4	1	2	296	6	374
Other	218	2	1	2	7	4	0	2	5	191	432
Total	126,989	728	267	144	1,863	815	218	324	462	361	132,171

Source: Berrington (1996: 199, Table 7.9)

The usual statistical problems apply when attempting to obtain more up-to-date data. The Census collects information on marital status and the relationships between adults living at the same address, but ethnicity information is not recorded when marriages are registered, so no continuous statistics are available. Some information is collected by the Labour Force Survey,

but this represents a ‘snapshot’ of the situation at a particular moment in time rather than continuous data.

Berrington reports that:

Unsurprisingly, levels of inter-ethnic unions are particularly high among the mixed ethnicity populations who are classified either as Black-Other (if they reported themselves as Black-British or Black, Black/White mixed) or Other (if they reported themselves to be of mixed Asian-White descent). Over half of men and women classified as Black-Other are reported to be living with a white partner. (Berrington, 1996: 199)

It is not clear, however, why this data is perceived as ‘unsurprising’.

However, marriage and cohabitation are not the only measures of ‘mixed ethnicity’. Modood *et al* (1997: 16) asked respondents if they had family origins among a list of minority ethnic groupings. The results were as follows:

Table: 2.3.9. – Perception of Ethnic Group Membership. (Column %)

Family origins	White British/Irish	Black Caribbean	Indian Caribbean	Indian	Pakistani	Bangladeshi	Chinese	Other	Mixed
Group Membership									
White	100	1	1	1	1	2	1	55	13
Black Caribbean	-	81	69	*	-	-	-	-	14
Black African	-	1	*	-	-	-	-	11	1
Black British	-	13	7	*	-	-	-	-	15
Black Other	-	1	-	-	-	-	-	-	2
Indian	-	-	8	97	1	*	-	2	4
Pakistani	-	-	-	*	98	2	-	-	*
Bangladeshi	-	-	-	*	*	95	-	-	*
Chinese	-	-	-	-	-	-	98	*	2
British Asian	-	-	*	1	1	1	-	-	5
Mixed	-	2	15	1	-	-	1	7	40
Other	*	*	-	*	*		*	25	4
Total	7110	2058	74	4521	3665	1939	427	80	488

* = less than 1%.

Source: Based on Modood *et al* (1997: 15: Table 1.1)

This suggests that the definition of 'mixed ethnicity' or 'mixed origin' is not well developed, though this seems to be a move towards choice and self-definition.

Summary

There are many problems associated with the collection, analysis and use of ethnic and 'racial' statistics. These include problems of officially constructed, but limiting, taxonomies and the reallocation of Census 'write-in' categories to pre-defined groupings resulting in the loss of data concerning 'mixed ethnicity'. The data is then further compromised by different analysts utilising different categories and groupings. It is also probable that concerns that the data may be used to disadvantage minority ethnic groups affects the subjects' responses and, thus, the nature and quality of the data obtained.

It is apparent from analysis of the manner in which ethnic statistics are collected, that 'official' statistics utilise, at best, a residual definition of 'mixed ethnicity' or 'mixed origin' and that there is confusion as to what constitutes a minority ethnic group, let alone the concept of 'mixed ethnicity'.

It is evident that my research needs to accept individual's definitions of 'mixed ethnicity', but also that it may be useful to have some sort of a standardised definition, if this is possible. This could be along the lines of a person who has one parent who self-defines, perhaps, as 'Black' and one parent from the White majority. However, such definitions soon become extremely complex and carry the risk, mentioned above, of losing information on difference and diversity. They should, therefore, be no more than guidelines as it is crucial that individuals should define their own ethnicity.

It is important to remember that all population statistics do not concern just impersonal data, but represent human beings. Though the indications are that the absolute number of people of 'mixed ethnicity' is relatively low, this does not mean that they are statistically, or socially, insignificant. There is evidence, that people of mixed ethnicity in Britain are part of the fastest growing population sector (See for Example, Berrington, 1996: 204, Lloyd, 2001: 1-3, Runnymede Trust, 2001: 1 or Black Britain, 2001). At the moment, this increasing population sector shares the same spatial characteristics as its 'parent' minority ethnic populations. It is not yet clear whether this will remain the case. Nevertheless, the mixed ethnicity population will become more numerically significant in the relatively near future, and will be worthy of study so that its needs can be assessed and addressed. The research described in this thesis is a preliminary stage in the process.

Though this analysis has produced interesting data regarding the ethnic demography of Britain, it is conceivable that statistics, as described in this chapter, are not the best means of investigating the target population and that qualitative methods will serve better.

2.4. Ethnicity and health

This chapter explores the relationship between ethnicity and health by examining the incidence of ill health among different minority populations and looking at the incidence and prevalence of specific illnesses. It commences with a discussion of the collection of ethnic health data, before looking at data concerning specific morbidity.

Unusually for this thesis, this chapter relies largely on the secondary analysis of quantitative ‘ethnic health’ data. Whilst this is seen as important contextual information, it is important to note that ‘mixed ethnicity’ does not appear as an ethnic categorisation for this information, since no such data has been collected. There is some qualitative data about the subjective experiences of healthcare for people from minority ethnic populations which is discussed below.

The collection of ethnic health data

At the present time, the collection of data on ethnic group and health is inconsistent. Though there was an ‘ethnic group’ question in the 1991 Census, the subsequent consolidation of the data has led to questionable results. The report of the Independent Inquiry into Inequalities in Health (Acheson, 1998: Section 10) notes that only ‘country of birth’ is recorded on death certificates and this means that ‘ethnic’ mortality data from official sources is restricted to migrants. Indeed, the nature of this data recording means that it can be used only as a general guide, since there need be no link between ethnic group and country of birth. Additionally, although the NHS Contract Minimum Data Set (CMDS) requires health care providers to collect ethnicity information in respect of day and in-patients, there is no such requirement in the primary care sector (Bahl, 1998: 10). CMDS collection is further complicated because of the manner in which the data is categorised, leading to the conflation of ethnic categories.

These difficulties become more apparent when investigated in depth. Ahmad (1992) for example, argues that the current methods of recording ethnic data serve to render whole communities invisible, saying,

... the Irish and East European minorities are classed as 'white'; the Chinese, Arabs and other smaller minority ethnic groups are often lumped together as 'other'. 'Race' statistics, ... present only a selective and partial picture and need to be considered with care. (1992: 7.)

The reasons for collecting 'ethnic' health information need to be carefully scrutinised. There have often been fears (mentioned above, see Chapter 2.3.) that 'racial' and 'ethnic' data may be used to disadvantage the target population and some argue that the collection of such data may have a negative effect on the attainment of 'racial' equality in Britain. Moore argued that it was not necessarily in the interests of black people to help Government with the collection of this data (Home Affairs Committee, 1983: 139.).

This position is supported by others, for example, Ahmad says,

... since World War 2 there has been an increase in Britain in the collection of statistics which are categorised along the lines of 'race' or ethnicity. This has not been a neutral exercise in pursuit of knowledge that has evolved hand in hand with concerns about the 'race problem'. These statistics become part of the 'numbers game' used to justify racist immigration laws and help fuel anti-black feeling in Britain. The process of racialisation of statistics reflected and reinforced racist state policies. (1992: 41.)

Unless there is clear evidence that ethnic statistics are to be used in a positive way to improve the health status of black and minority ethnic communities, concerns for the ways that ethnic and 'racial' information may be used must, inevitably, affect the manner in which subjects respond and the nature of the data they provide.

Rawaf and Bahl (1998) believe that this evidence exists and feel that its collection is vital, stating that opportunities exist for the improvement of the health of minority ethnic groups but that the collection of 'ethnic' statistics is a vital component of the process because,

...without a proper and comprehensive health (and social) needs assessment, these areas of potential and needed improvements cannot be identified, prioritised and acted upon properly. (1998: xi.)

Rawaf and Bahl (1998: 24-24) extend this argument and produces a list of reasons why he believes that ethnic health statistics must be used to underpin an assessment of ethnic health need:

- To improve service planning (commissioning) and resource allocation;
- To identify health matters where further improvements might be made;
- To identify the most effective intervention(s) for a condition;
- To achieve social change through social marketing (for successful marketing people are grouped according to the similarity of their needs);
- To monitor changes in relation to factors that influence and determine health;
- To justify funding;
- To generate information for advocacy;
- To respond to central directives;
- To justify decisions already made;
- To advance research and development;
- To confirm or enhance information;
- To display technical competence;
- To form part of service evaluation.

This perspective is shared by others, for example Bhrolchain who says:

Ethnicity statistics are needed to document the level of discrimination and disadvantage, to take action to combat these and to establish how far policies having this objective are succeeding. (1990: 545.)

The contrary view that ethnic statistics cannot, in themselves, improve the disadvantaged position of minority ethnic groups because they are utilised out of context and because successive governments have not committed themselves to the elimination of racism and ethnic disadvantage is argued by Booth, saying:

The lack of political will on the part of the government has long been accepted as the framework ... within which [ethnic] data are produced. The real need is thus not for better definitive data, but for a new framework of political will aimed at reducing and eradicating racial disadvantage and discrimination. It is only within this context that appropriate data can be instrumental in reaching that aim. (1988: 263.)

This standpoint too is shared by other researchers, for example Smaje (1995: Ch. 1) argues that ethnic health statistics are counterproductive and potentially dangerous because, among other reasons, they are inflexible and serve to mask racism.

The arguments against collecting 'ethnic statistics' can be summarised as follows:

- There is a perception that 'ethnic' data may be used to disadvantage vulnerable groups in a (potentially) hostile political environment. There is anecdotal evidence that the National Front supported the introduction of an 'ethnicity' question in the 1981 Census of Population.
- The collection of 'ethnic' data may be used as a substitute for taking action.
- The collection of this type of data intrudes on the right for people to treat others as they wish.

- The concepts of ‘ethnicity’, ‘diversity’ and ‘difference’ are too complex to be captured usefully in this way.

The arguments in favour of the collection of these statistics can, likewise, be summarised:

- If ethnically sensitive health services are to be provided, then it is essential for the Government to be aware of the size and needs of specific minority populations, and to know where and how they live their lives.
- The collection of ‘ethnic’ data aids Government in assessing and monitoring the effectiveness of policies and service provision designed to meet the needs of minority ethnic groups.
- It assists the process of social reform by emphasising discrimination and disadvantage.

The general health of minority ethnic populations

There seems to be a general perception in health literature that black and minority ethnic populations in Britain suffer from poorer health than does the dominant white population.

This is assessed and discussed below.

There are a number of diseases, notably, haemoglobinopathies, which are, largely, restricted to black and minority ethnic populations. These will be discussed later. This section will, initially, concentrate on the incidence of diseases which affect the entire population.

There have been 3 major surveys of the health of Britain’s minority ethnic populations. The first conducted by Rudat (1994), the second by Nazroo (1997) and the last by Erens *et al* (2001).

Rudat's (1994) survey was concerned with the health and lifestyles of England's black population. His main findings are shown below:

Table: 2.4.1. Incidence of Specific Health problems (% of Population)

	African-Caribbean	Indian	Pakistani	Bangladeshi	UK Population
Back pain	25	20	24	20	29
Breathing difficulties	11	9	12	11	10
Severe arthritis	8	8	9	13	10
Depression, anxiety	7	8	9	5	14
High Blood Pressure	12	8	8	9	14
Stomach problems	5	6	9	14	No data
Diabetes	5	6	5	8	2
Heart Disease	2	3	4	6	3
Stroke	2	1	>0.5	1	>0.5
Sexually Transmitted Disease	1	1	0	0	>0.5
Anorexia nervosa	0	1	>0.5	>0.5	1

Source: Adapted from Table 23; P. 46, Rudat K (1994), *Health and Lifestyles: Black and Minority Ethnic Groups in England*, London, Health Education Authority.

Rudat (1994: 47) also examined the prevalence of illness or disability that limited the ability to work or to carry out normal household tasks. The following incidence was found:

Table: 2.4.2. Incidence of Limiting Disability or Illness (% of population)

	African-Caribbean	Indian	Pakistani	Bangladeshi	UK Population
Women	16	18	19	24	16
Men	17	16	22	26	14
All	17	17	21	25	15

Source: Adapted from Table 24; P. 47, Rudat K (1994), *Health and Lifestyles: Black and Minority Ethnic Groups in England*, London, Health Education Authority.

Nazroo (1997) conducted a national survey of minority ethnic health. The ethnic groupings used in this survey differ from those employed by Rudat, but the results are similar:

Table: 2.4.3. Long-Standing Limiting Illness Rates (% of population)

	All ethnic minorities	Caribbean	All South Asians	Indian	African Asian	Pakistani	Bangladeshi	Chinese	White
Men	11	12	12	11	10	14	14	6	15
Women	12	16	11	12	9	10	9	6	16
Total	12	14	11	12	9	12	12	6	16

Source: Adapted from: Nazroo, James, Y (1997), *The Health of Britain's Ethnic Minorities: Findings from a national survey*, London, Policy Studies Institute. (The Fourth National Survey of Ethnic Minorities). Table 2.3: 14

Erens *et al* (2001) has produced the most recent statistics in this regard:

Table: 2.4.4. Prevalence of Limiting Longstanding Illness (% of population)

	African Caribbean	Indian	Pakistani	Bangladeshi	Chinese	Irish	General Population
Men	24	21	22	30	14	29	25
Women	27	25	23	22	12	27	26
Total	25.5	23	22.5	26	13	28	25.5

Source: Adapted from Erens *et al* (2001: Section 2.2.1.)

These ethnic categorisations are, again, different making comparison difficult, and the results of the surveys differ significantly in sample size and magnitude. Nevertheless, the results are clear. The surveys indicate that the health of adults in minority ethnic populations, assessed by limiting illness or disability, whilst generally worse than the general population have improved, at least in relative terms. Bangladeshi men still report the highest rates of long-standing limiting illness, though the ratio has reduced from 1.86 in Rudat's (1994) survey to 1.20 in that of Erens *et al* (2001).

Nazroo found similar results for the other conditions investigated by Rudat's survey:

Table: 2.4.5. Prevalence of Hypertension (High Blood Pressure) (%)

	All ethnic minorities	Caribbean	All South Asians	Indian	African Asian	Pakistani	Bangladeshi	Chinese	White
Men	10	15	9	10	11	6	10	4	15
Women	12	23	8	6	5	12	11	5	17
Total	11	19	8	8	8	9	11	4	16

Source: Adapted from: Nazroo, James, Y (1997), *The Health of Britain's Ethnic Minorities: Findings from a national survey*, London, Policy Studies Institute. (The Fourth National Survey of Ethnic Minorities). Table 2.9: 25.

Table: 2.4.6. Prevalence of Heart Disease (% of population)

	All ethnic minorities	Caribbean	All South Asians	Indian	African Asian	Pakistani	Bangladeshi	Chinese	White
Men	4.7	4.3	5.0	4.8	3.1	6.0	7.6	4.1	8.0
Women	3.3	4.3	2.9	2.7	2.2	3.8	3.7	1.7	6.2
Total	4.0	4.3	4.0	3.7	2.7	4.9	5.8	2.8	7.0

Source: Adapted from: Nazroo, James, Y (1997), *The Health of Britain's Ethnic Minorities: Findings from a national survey*, London, Policy Studies Institute. (The Fourth National Survey of Ethnic Minorities). Table 2.7: 23.

Table: 2.4.7. Prevalence of Diabetes (% of population)

	All ethnic minorities	Caribbean	All South Asians	Indian	African Asian	Pakistani	Bangladeshi	Chinese	White
Total	5.6	5.9	5.9	5.5	4.0	7.6	7.4	2.2	2.2

Source: Adapted from: Nazroo, James, Y (1997), *The Health of Britain's Ethnic Minorities: Findings from a national survey*, London, Policy Studies Institute. (The Fourth National Survey of Ethnic Minorities). Table 2.11: 26.

Erens *et al* (2001: Section 3) take a slightly different approach to these issues. They identify a series of risk factors associated with cardiovascular disease (CVD) and then establish their

prevalence in minority ethnic populations. These factors are: angina, heart attack, stroke, heart murmur, irregular heart rhythm, ‘other heart trouble’, high blood pressure and diabetes.

Table: 2.4.8. Prevalence of CVD Risk Factors (% of population)

		African Caribbean	Indian	Pakistani	Bangladeshi	Chinese	Irish	General Population
Angina	Men	1.9	5.4	2.9	3.9	1.8	4.8	5.3
	Women	2.2	1.7	1.5	1.3	0.4	2.9	3.9
Heart Attack	Men	0.6	2.8	2.7	3.2	1.2	3.7	4.2
	Women	0.6	0.2	1.0	0.1	-	1.6	1.8
Heart Murmur	Men	2.1	1.5	0.6	0.3	1.2	3.1	3.0
	Women	2.4	1.6	1.4	0.7	1.9	3.1	3.3
Abnormal Heart Rhythm	Men	2.3	2.8	1.9	1.3	1.0	4.7	5.0
	Women	3.1	2.2	1.8	1.4	1.5	4.9	4.8
‘Other’ Heart Trouble	Men	0.8	1.6	0.1	1.8	0.7	2.3	1.6
	Women	0.6	0.6	1.0	1.0	0.8	2.1	1.4
Stroke	Men	3.2	2.5	0.7	1.2	0.7	2.0	2.3
	Women	0.8	0.7	0.6	0.4	0.2	2.0	2.1
Diabetes	Men	7.8	7.7	8.7	10.6	4.2	4.2	3.3
	Women	7.9	4.7	5.3	5.9	2.6	2.4	2.5

Source: Adapted from Erens *et al* (2001: Table 3.1.)

The ethnic classifications utilised differ from Nazroo’s, but comparison is still possible.

Table: 2.4.9. Incidence of High Blood Pressure(% of population)

	African Caribbean	Indian	Pakistani	Bangladeshi	Chinese	Irish	General Population
Men	41.9	35.7	25.5	23.6	27.9	40.6	40.8
Women	28.8	23.6	16.1	12.3	22.5	27.6	32.9

Source: Adapted from Erens *et al* (2001: Section 7.4.)

Table: 2.4.10. Prevalence of Diabetes (% of population)

	African Caribbean	Indian	Pakistani	Bangladeshi	Chinese	Irish	General Population
Men	7.8	7.7	8.7	10.6	4.2	4.2	3.3
Women	7.9	4.7	5.3	5.9	2.6	2.4	2.5

Source: Adapted from Erens *et al* (2001: Section 3.3.3.)

Diabetes, in particular, has high particularly high prevalence rates in minority ethnic populations. In addition to its contribution to CVD it has major affects on individuals' lifestyles and it the most common cause of blindness in adults in Britain. In addition, diabetes often leads to peripheral circulatory disorders which frequently results in the need to amputate feet and lower limbs.

In addition to the results above, there have been a number of studies specifically of this condition. Though they suffer from the usual problems of ethnic categorisation, they are still useful indicators; the results are shown below:

Fig: 2.4.1. Surveys of the Incidence of Diabetes Mellitus

Study	Location	Age range	Ethnic Group	Males Prevalence (%)	Females Prevalence (%)
McKeigue <i>et al</i> (1991)	W London	40-64	European	4.8	2.3
			South Asian	19.6	16.1
			African-Caribbean	14.6	
McKeigue <i>et al</i> (1988)	E. London	35-64	Bangladeshi	22	23.0
			Non-Asian	10	4.0
Simmons <i>et al</i> (1989)	Coventry	20-79	White	2.8	4.3
			Asian	11.2	

Nazroo's survey also asked respondents to assess their own health, with the results shown below:

Table: 2.4.11. Respondents' Self-Assessment of General Health (column %)

	All ethnic minorities	Caribbean	All South Asians	Indian	African Asian	Pakistani	Bangladeshi	Chinese	White
Men with fair/poor health	29	33	29	26	26	34	35	20	26
Women with fair/poor health	35	39	33	32	27	38	41	28	32
Totals									
Excellent/good	68	64	69	71	74	64	62	76	71
Fair	20	24	19	17	18	22	21	16	19
Poor/very poor	12	12	12	12	8	14	17	9	10

Source: Adapted from: Nazroo, James, Y (1997), *The Health of Britain's Ethnic Minorities: Findings from a national survey*, London, Policy Studies Institute. (The Fourth National Survey of Ethnic Minorities). Table 2.2: 18.

The results of the respondents self-assessment of their general health indicate that about a third of all people from minority ethnic groups feel that their health is fair or poor, with the highest rates among Caribbeans, Pakistanis and Bangladeshis. In comparison, more than a quarter of white people reported the same. Chinese people have the lowest self-assessment of poor or fair health.

Nazroo argues that the results for all the health indicators, particularly those for general health shown above, demonstrate that there is 'a great burden of ill health among Britain's ethnic minorities' (Nazroo, 1997: 21). However, some indicators show that minority ethnic health is, in some circumstances, better than that of the general population. It is important to note, however, that the results for the different indicators are not uniform across the different minority ethnic groupings. In general, the worst health, assessed by those reporting that they

had fair or poor health, long-standing or limiting illnesses, is most pronounced among people from the Caribbean, Pakistani and Bangladeshi ethnic groups. Indians and African-Asians report lower rates, and the Chinese the lowest rates of all.

Rates of ill-health also differ by gender and, for the most part, women report worse health than men in all minority ethnic groups. Overall, Nazroo argues that the evidence,

... suggests that Pakistanis and Bangladeshis had the worst health among the ethnic minority groups, followed by Caribbeans, then Indians and African Asians, and the Chinese group had the best health. (1997: 21)

Table: 2.4.12. Self-Assessed General Health Status (population %)

Self-assessed General Health Status		African Caribbean	Indian	Pakistani	Bangladeshi	Chinese	Irish	General Population
		Good/Very Good	Men	69	72	72	55	76
	Women	64	64	65	64	72	76	75
Bad/Very Bad	Men	8	9	11	18	5	7	6
	Women	10	12	12	11	4	6	7

Source: Adapted from Erens *et al* (2001: Table 2.11.)

This more recent data confirms Nazroo's findings with only minor modifications. In the Health Survey for England 1999 (Erens *et al*, 2001: Table 2.11) the difference in reported self-assessed bad health between women and men is not as marked as in Nazroo's work. It is less apparent that women from minority ethnic populations report worse health than men, particularly in the case of Bangladeshi people. Though the health differences continue to be mediated by gender divisions, the findings of this report argue that Bangladeshi people experience the worst health, followed by Pakistanis, Indians and African-Caribbeans. The

only group to report less self-assessed bad or very bad health than the white population are Chinese people.

The mental health of minority ethnic populations

There are specific mental health issues for people from minority ethnic populations. Fernando (1991: 33) gives an history of mental health stereotypes noting that they are based on the mental inferiority of the 'other' and that they have been used as a justification for disadvantaging non-white people and even as a rationalisation for slavery.

Though they express concern about the accuracy of the figures, Barnes, Bowl and Fisher (1990:165-168), note that the average rate at which individuals were referred to psychiatric health services varies from 116.7 per 100,000 for the whole population to 204 per 100,000 for African-Caribbeans. They also observe that people of African-Caribbean origin are more likely to enter the mental health system by referral from the courts or the police than any other group. Barnes, Bowl and Fisher suggest that these high rates of referral do not necessarily reflect a higher incidence of psychiatric illness among the minority ethnic population. They feel that this phenomenon can be explained, in part at least, by the current theoretical and practical framework for psychiatry which is based on a Western European model. This view is supported by their citation Littlewood and Lipsedge (1982) who remark:

One cannot understand mental illness in ethnic minorities by looking only at the patients. (Littlewood and Lipsedge 1982: 35)

With regard to compulsory detention after referral, African-Caribbeans are detained more frequently than white or Asian people, and when referred under the emergency section of the Mental Health Act 1983, 80% of African-Caribbean people were detained compared with 59% of white and Asian people (Barnes, Bowl and Fisher, 1990: 169).

Fernando (1991: Ch 3) discusses some problems with psychiatric diagnosis that may lead to the overrepresentation of minority ethnic populations within the mental health system. In particular, there is a difficulty concerning the theoretical and cultural basis for diagnosis. People with different cultural backgrounds may not fit the Western psychiatric model and result in misdiagnosis because,

... the thinking in Western psychiatry is at variance with that in other cultures across the world. (Fernando, 1991: 73.)

For Fernando (1991: 106, 1995: Ch. 1) it is entirely inappropriate that paradigms of mental health for people of minority ethnic origin should be established from a framework based entirely on Western beliefs and culture. Such a process can only result in continued misdiagnoses because:

Concepts of mental health developed in one culture may be very different from those in another. ... questions of race and culture must be confronted ... and 'health' must be seen in the context of culture. ... deviations from 'health' must be evaluated by procedures that incorporate culture and race, and not in a manner that excludes culture from 'illness' and denies or ignores the effects of racism ... (Fernando, 1991: 196.)

Balarajan and Raleigh (1995) also note that some minority ethnic populations appear to have higher rates of diagnosed mental illness. They report that:

African-Caribbeans in Britain have higher admission rates to psychiatric hospitals and are diagnosed as schizophrenic 3-6 times more often than the white population. The incidence of schizophrenia in British Caribbeans is also much higher than the incidence reported for Jamaica. Rates of Schizophrenia in second generation British-born black people are reported to be even higher than the rates in first generation African-Caribbeans. Black people are over-represented among patients compulsorily detained under the Mental Health Act, and in police admissions to psychiatric hospitals. It is also known that they receive different and stronger forms of treatment, and differences in clinical management can only be partially explained by differences in diagnosis. (Balarajan and Raleigh, 1995: 29)

King *et al*, conducted a survey of 93 subjects in London and found that:

Raised incidences of schizophrenia were not specific to African-Caribbeans, which suggests that the current focus on schizophrenia in this population is misleading. Members of all ethnic minority groups were more likely to develop a psychosis, but not necessarily schizophrenia. **The personal and social pressures of belonging to any ethnic minority group in Britain are important determinants in the excess of psychotic disorders found.** (*Added emphasis.*) (1994: 1115-1119.)

Indeed, Nazroo's (1997: 46) findings suggest that the general psycho-social health of minority ethnic populations is slightly better than the majority because people from ethnic minorities are slightly less likely to suffer from things like tiredness, lack of energy and sleep problems.

Smaje (1995: 64-68) supports these findings too. He notes that admission rates to mental hospitals are higher among all ethnic minorities than the white population and that admissions for schizophrenia are very high for male African-Caribbeans, more than 4 times the rate for white males in England. He suggests that there are indications (see for example, McGovern and Cope, 1987) that rates are even higher among *British born people of Caribbean origin*.

However, Smaje (1995: 65) argues that the high rate of admissions is, at least in part, an artefact because Caribbean patients are:

Less likely to have been in prior contact with a GP and more likely to have been referred by the police or detained by them in a 'place of safety' under the 1983 Mental Health Act.

Up to three times more likely to be admitted or detained compulsorily under the 1983 Mental Health Act.

More likely to be diagnosed as violent and to be detained in locked wards, secure units and special hospitals.

More likely to receive more 'physical' treatments – such as major tranquillisers and electro-convulsive therapy in cases where it does not appear to be indicated – at a more intensive level and without earlier recourse to less radical therapy.

More likely to be seen by junior staff.

Smaje continues his argument by suggesting that this is part of the racist process of creating a 'Schizophrenia epidemic' among African-Caribbeans that actually reflects the racism and ethnocentric nature of psychiatry in Britain. His argument is centred on three main issues:

Psychiatrists are racist or prone to invoking racist stereotypes which inform their diagnoses.

Ethnic or cultural differences in the presentation of disease are such that psychiatrists mistake minor symptoms or delusions for schizophrenia.

Psychiatry is an instrument of social control, which identifies people from minority ethnic groups with 'madness' and, in association with other instruments such as the systems of education and criminal justice, conspires to marginalise and pathologise them.

Part of the process described by Smaje is based on historical negative stereotypes of black people. Browne (1995: 67-68) argues that black people are,

... portrayed as having some increased propensity to dangerousness and risk. (Browne, 1995: 67.)

Furthermore, there is a perception that young black males require higher levels of supervision and restraint than other non-black individuals (Browne, 1995: 67). With regret, Fernando

(1995: 212-213) concludes that the prospect for changing these stereotypes and the actions based upon them is not promising.

Barnes and Bowl (2001) confirm Smaje's report that, for African-Caribbeans, the mental health experience is different in both quality and quantity. They say,

... you are more likely to receive hospital treatment, to be diagnosed as having a psychotic illness and to be subject to compulsory detention; less likely to receive psychotherapy; and likely to be given higher levels of medication. (Barnes and Bowl, 2001: 80.)

Barnes and Bowl continue (2001: 82-93) to note that black people have higher rates of admission to psychiatric hospitals and that the rate of compulsory admission is much higher than that for the majority white population. Barnes and Bowl discuss the possibility that the black population in Britain suffers higher levels of stress than the dominant white population and note that there are minority ethnic groups that suffer from socio-economic deprivation which must add to this stress. In particular though, they say:

Our own view is that the greater incidence of stress, associated with poor social and environmental conditions and racism, should not be ignored, particularly not its role in the experiences of particular individuals when they seek explanation of and help with mental distress. (Barnes and Bowl, 2001: 84.)

Erens *et al* (2001) do not specifically report on the mental health of adults, but assess the psychological health of children using a 'Strengths and Difficulties Questionnaire' (SDQ) (Erens *et al*, 2001: Section 13.3.2.), designed for children between the ages of 4 and 15. The details of the SDQ and its scoring procedures are described in detail by Goodman (1997: 581-586). Essentially, the higher the score, the worse the respondent's mental health. The findings suggest that Indian and Irish girls and Pakistani boys and girls were likely to have higher scores than the general population. The other differences are not considered to be significant.

Table: 2.4.13. SDQ Scores

	African Caribbean	Indian	Pakistani	Bangladeshi	Chinese	Irish	General Population
Boys	14	15	22	13	11	8	12
Girls	12	16	17	12	8	14	8
Total	13	15.5	18.5	12.5	9.5	11	10

Source: Adapted from Erens *et al* (2001: Section 13.3.2.)

Haemoglobinopathies – sickle cell disease and thalassaemia

Haemoglobinopathies are a group of blood disorders that are hereditary. They vary in impact and severity, but can be extremely painful and, potentially, lead to very serious complications, discussed below. Until recently, these conditions were thought to be specific to black people, but this is now known not to be the case (see, for example, Anionwu, 1993, Balarajan and Raleigh, 1995 or Anionwu, 1996). In general, only people of ‘pure’ northern European origin (if such a thing exists) are not at risk of these diseases, though the likelihood varies among different ethnic groups. The Sickle Cell and Thalassaemia traits are recessive genes. Carriers of these genes do not necessarily suffer from the disease and only if both parents are carriers will the disease be inherited by the child; the risk being twenty-five percent (Balarajan and Raleigh, 1995: 53).

The frequency of the occurrence of these traits is shown in the following tables:

Table: 2.4.14. Incidence of Haemoglobinopathies

Sickle Cell disease

Ethnic Group	Frequency
African-Caribbean	1 in 10
West African	1 in 4
Punjabi Sikh	1 in 100

Thalassaemia

Ethnic Group	Frequency
Chinese	1 in 15
Cypriot	1 in 7
Asian	1 in 10
African-Caribbean	1 in 50
White British	1 in 1,000

Source: Adapted from Anionwu (1992: 78, Table 5.1)

Haemoglobinopathies are diseases which affect the production or composition of haemoglobin, the chemical which carries oxygen in the human bloodstream. Whilst Smaje argues that these diseases,

... are of relatively minor importance in terms of their contribution to the overall burden of ill health among ethnic minority populations ... (1995: 128.)

they have potential consequences that can be life threatening including damage to the bone structure, damage to the eyes, increased risk of stroke and infection and a reduction in life expectancy. However, the most common symptom of these disorders is a series of painful crises which have a detrimental effect on quality of life. Brozovic *et al* (1989: 103-113) suggest that the disorder manifests in Britain in a different manner to the places of origin, the incidence of painful crises being more frequent, accounting, in some areas, for up to forty

percent of haematology hospital admissions. Interestingly, *The Health Survey for England 1999 – The Health of Minority Ethnic Groups* makes no mention of haemoglobinopathies.

Use of health services by minority ethnic populations

The results of Erens *et al* (2001) survey suggest that people from all minority ethnic populations except Chinese men and women and Irish men are more likely than the general population to have visited their family doctor within the last 2 weeks. However, the data does not make clear the purpose of the consultation. Indeed, the higher attendances by women could be due entirely to their role as family carers; that is, the visits could be with or on behalf of children. There are multiple other possibilities too, for example women may attend for contraception or perhaps some reason as prosaic as obtaining a doctor’s signature on a passport application. Only Bangladeshi men take more prescription medicines than the general population, though, with the exception of Chinese men and women and Pakistani men, the differences are not large. In terms of outpatient attendances at hospitals, Chinese men and women and Pakistani and Bangladeshi women show significantly lower rates of attendance than all other groups. The information on GP consultations and use of prescription drugs is shown in more detail in the tables below.

Table: 2.4.15: Use of GPs – Contact in Past 14 Days (%)

	African Caribbean	Indian	Pakistani	Bangladeshi	Chinese	Irish	General Population
Men	16	17	15	22	8	10	12
Women	21	22	24	21	16	20	18
Total	19	19.5	19.5	21.5	12	15	15

Source: Adapted from Erens *et al* (2001: Table 11.1).

Table: 2.4.16. People Not Using Prescription Medicines(%)

	African Caribbean	Indian	Pakistani	Bangladeshi	Chinese	Irish	General Population
Men	62	65	72	55	77	63	61
Women	58	61	63	58	71	53	51
Total	60	63	67.5	56.5	74	58	56

Source: Adapted from Erens *et al* (2001: Table 11.13).

The data from Erens *et al* (2001) has been used to illustrate the utilisation of primary healthcare by minority ethnic groups because it is the most recent. There have been other studies though the findings have been similar. However, sometimes other variables have been considered. Rudat (1994: 61) for example assessed factors including the possibility that surgery hours were inconvenient, that the surgery was too far away, that it was difficult for patients to park, that the surgery was located in a high crime area, that there was poor disabled access to the building or that the patient had difficulty in walking. It is interesting to note that, with the exception of the variable 'difficult for patients to park', members of minority ethnic populations had worse scores than the UK population as a whole. The most likely explanation for this phenomenon is that, rather than it being easier for non-white people to park, in fact their levels of car ownership is lower than the rest of the population. This suggests that Rudat's research uncovered health issues for people from minority ethnic populations that are associated with poverty.

Smaje's (1995: CH 5, 6) agrees in general terms with both Rudat (1994) and Erens *et al* (2001), finding similar levels of GP consultation.

Table: 2.4.17. Hospital Outpatient Attendances(%)

	African Caribbean	Indian	Pakistani	Bangladeshi	Chinese	Irish	General Population
Men	33	30	27	28	20	34	33
Women	33	27	21	24	19	32	31
Total	33	28.5	24	26	18.5	33	32

Source: Adapted from Erens *et al* (2001: Table 11.9).

Subjective healthcare experiences.

It is clear that people from different ethnic groups sometimes have subjectively different health care experiences. Though the vast majority of people from minority ethnic groups are registered with a GP (Rudat, 1994: 54-60), and therefore receive what Smaje (1995: 103) calls ‘adequate levels of care’, there are a number of other issues that should be considered, some of which are discussed below.

For some people from minority ethnic populations, access to healthcare is, effectively, limited by language (see for example Mares, Henley and Baxter, 1985: Ch. 5 or Matthews, 2001: 173-174). Individuals whose first language is not English may, therefore find the healthcare experience threatening and difficult to access. Mares, Henley and Baxter (1985: 31, 56-76) discuss the issues of language as a barrier to health care and offer a number of possible solutions designed to render the experience more positive. Ahmad (1992: 330-341) for example found that South Asians, particularly Pakistanis, in Leicester experienced considerable problems with English which affected their utilisation and experiences of healthcare. It is important to realise that, according to the Commission for Racial Equality

(1978) there will be a sizeable non-English speaking population in Britain well into the 21st Century, mostly composed of older people.

There are cultural issues which affect the quality of the individual's healthcare experience. These may, for example, include issues of cultural 'modesty' for Muslim women who may be unwilling to consult a male GP (Rashid and Jagger, 1992: 197-201) and, similarly, Ahmad, Kernohan and Baker (1989: 153-155) note that 62% of the Pakistani women interviewed in their Bradford study objected to examination by a male GP, though circumstances forced them to accept it.

It is possible that individual's health care experiences are affected by racism in service delivery. Norman (1985: 66-68), for example, feels that there is an issue around the idea that some minority groups, especially Asians, find hospitals and health centres frightening. Smaje (1995: 110) sees three types of racism in service delivery by the NHS. These are direct racism, indirect or institutional racism and ethnocentrism when inappropriate assumptions are made on the basis of the majority regarding the needs of people from minority ethnic groups . However, Smaje indicates that it is almost unnecessary to identify the different types because the result, disempowerment of the service user, is the same whatever the cause. Other writers have commented on racism in the NHS, an example of earlier work being Torkington's *Racial Politics of Health* (1983). Torkington (1991, Ch. 1) argues that racism is ubiquitous in all British institutions and feels that, although racism is finally on the NHS policy agenda, little has really been achieved and,

... at worst the attempts are dangerous because they give the impression that the institution is 'doing something' and therefore that it is unreasonable to label it racist. (Torkington, 1991: 26)

Torkington (1991: 27) repeats Rooney's (1987) argument that the concept of real change with regard to racial issues is a threatening challenge for institutions that will often be resisted. She agrees with Rooney that racist ideology within the NHS is still powerful and is based,

... within a power structure which has historically discriminated against the most powerless members of society. (Torkington, 1991: 27 - 28)

Other cultural issues are important too. People of different ethnicities may not describe their symptoms in ways which are familiar to GPs. Mares, Henley and Baxter (1985: Ch. 5) indicate that there can also be major differences in expectations and culture between the service user and the health professional, in particular that perceptions of illness and the descriptions usually given of them tend to be culture-specific, for example an Asian woman suffering from osteomalacia might describe the symptoms as 'aching bones', but it is unlikely that this would result in correct diagnosis. Lambert and Sevak (1996) note that not only are descriptions of symptoms dissimilar for people from some minority ethnic groups, but so are expectations of health and illness. This is echoed in a number of moving first person accounts, see for example Kelleher and Hillier (1996) or Wilson (1994).

Overall, the health care experience for people from minority ethnic populations is mediated by a number of factors, such as racism, language barriers and cultural perception, that do not impact on the white general population to any marked degree. It seems probable that these multiple additional factors, which Norman (1985) calls 'triple jeopardy', result in the minority ethnic population's health experience being less satisfactory than that of the white population.

Summary and the future

Collection of ethnic health data is inconsistent, with 'country of birth' used as a flawed shorthand for 'ethnic group'. Birth and death Certificates do not collect useful information on

ethnicity, and the results of the 1991 Census must be used with care because of the consolidation procedures employed by the Office of Population Censuses and Surveys (OPCS, 1993: Table A). Views on the usefulness, and purpose, of the collection of ethnic health statistics are divided, and there is some evidence that members of minority ethnic groups believe that such information will be used against them. There is clear evidence (for example, Acheson, 1998: Sect. 10, Bahl, 1998: 10, Smaje, 1995, Ch. 1) that 'official' statistics are limited both in scope and accuracy.

The assertion is made that the health of the adult members of minority ethnic populations is, generally, worse than that of the general population (see for example Rudat, 1994, Nazroo, 1997 or Erens *et al*, 2001). However, the evidence is, in part, ambiguous. For many indicators, the health of people from minority ethnic populations is as good or better than the general population. There is a problem that the studies of health and 'ethnicity' do not necessarily make a clear link between the variables. Thus it is known that, for example, that African-Caribbean men are more than twice as likely to suffer from diabetes as the general population. However, it is not clear that the prevalence of this condition is caused by ethnicity or 'race'. Some research, for example Rudat (1994) and Norman (1985) attempt to link socio-economic factors, but others do not. Erens *et al* (2001: Ch. 9) notes that there are differences in eating habits and nutrition, but attributes these entirely to cultural influences, when another explanation might involve a comparison of the amount of money that different individuals or groups are able to spend on food. This thesis acknowledges the importance of socio-economic issues in health, but detailed research into those issues would be beyond the scope of this research.

In general, the prevalence of longstanding illness is higher in Pakistani, Bangladeshi and Irish men and among South Asian and African-Caribbean women, than the general population and lower for Chinese men and women. Chinese women and men are less likely to report acute illness than any other part of the population. All minority ethnic groups, except Chinese, are more likely to assess their own health as bad or very bad than the general population.

Pakistani, Chinese and Bangladeshi men have significantly lower blood pressure than men in general. This is also true of Bangladeshi and Chinese women, but Pakistani women exhibit the opposite. However, when adjusted for age, there are no important differences between minority ethnic populations and the general population, except that Indian men have higher blood pressure.

African-Caribbeans and South Asians consult their GP more frequently (between 1.46 and 2.64 times as often) than the general population. Chinese men and Bangladeshi women exhibit the lowest rates of mental stress. The use of prescription medicines, is particularly low (ratio 0.51) for Chinese men and high for men from South Asia (1.26 – 2.04).

This has been used as a justification for the collection of ethnic health data by employing the hypothesis that there are links between ethnicity, migration and health. This is commonly linked to racist assumptions of the inferiority of health and health care in the other countries. However, if these assumptions were correct, then it would be reasonable to assume that variations in health between ethnic groups would approach the norm for the whole population in a comparatively short time and only any differences attributable to ethnicity would remain. That there are differences in the incidence and prevalence of some specific conditions has been shown in the preceding section. Nazroo (1997: 62) cites Gordon's (1982: 973-984) research and asserts that,

...we would expect variations in health to diminish as new generations are born in Britain. In fact, there is some evidence from the USA to suggest that within one or two generations the health of ethnic minority populations becomes similar to that of others in the country to which they migrated (Gordon 1982:973-984), supporting the possibility that ethnic variations in health are a consequence of differences in environmental risk in different countries of birth.

However, there is now evidence (Erens *et al*, 2001: Section 13) that, with the exception of these specific conditions, this change is occurring. These changes are becoming measurable in young people from minority ethnic populations. For example, the percentage of boys in the general population reporting limiting long standing illness is 11%. The incidence for boys from all minority ethnic groups is lower, ranging from 6% for Irish to 10% for Indian and Pakistani. The incidence for girls from minority ethnic groups is similar.

Table: 2.4.18. - Prevalence of Limiting Longstanding Illness.

	African-Caribbean	Indian	Pakistani	Bangladeshi	Chinese	Irish	General Population
Longstanding Illness – Boys (%)	9	10	10	7	8	6	11
Longstanding Illness – Girls (%)	9	6	7	7	4	9	9

Source: Adapted from Erens *et al* (2001: table 13.2.)

When children from minority ethnic populations assess their own health, they indicate that they experience similar health to the general population, though a slightly higher percentage of children from Pakistani, Bangladeshi and Irish populations suggest that they experience more bad or very bad health than the population as a whole.

Table: 2.4.19. - Self-Assessed General Health.

	African-Caribbean	Indian	Pakistani	Bangladeshi	Chinese	Irish	General Population
Good/Very Good Health – Boys (%)	88	89	87	84	91	94	91
Bad/Very Bad Health – Boys (%)	1	1	2	2	2	0	1
Good/Very Good Health – Girls (%)	90	87	92	89	91	91	92
Bad/Very Bad Health – Girls (%)	1	1	2	2	0	2	1

Source: Adapted from Erens *et al* (2001: table 13.4.)

If this trend continues, it seems likely that the health of adults from minority ethnic populations will approach the norm for the general population. This is not to say that specific conditions to which some genetic groups are prone will vanish, indeed, it is possible that they may spread through out the whole population. This has already been noted with sickle cell disease. Remaining inequalities in health may prove to be caused by deprivation and social exclusion rather than any other reason.

Nevertheless, some diseases continue to show high prevalence rates among black and minority ethnic populations. These include diabetes and the haemoglobinopathies. Black people are over-represented among admissions to psychiatric hospitals and anecdotal information suggests that some groups, particularly African-Caribbeans, are more likely to suffer from schizophrenia. However, research indicates that this is not the case and that the over-representation is the result of complex reasons (see for example, Fernando, 1991, 1995, Bowl and Barnes, 1990 or Barnes and Bowl, 2001) that include racist health practices.

In terms of subjective healthcare experiences, there can be little doubt that, for reasons discussed in detail above but centred around racism and cultural difference, people from

minority ethnic groups have a more negative experience than members of the dominant white population.

3. THE RESEARCH

3.1. Theoretical perspective: the power of discourse: the discourse of power

The theoretical perspective taken by the researcher has a significant impact on both the conduct of the research and the analysis of the findings, being particularly important in the understanding of the ways in which individuals perceive both their health status and their experiences of the health care process. This research relies upon a perspective of power and discourse, based on the works of Michel Foucault, described below. The utilisation of this perspective in no way devalues the use of different frameworks by others. However, it has guided this research in specific ways which are discussed below and in Chapters 3.3. and 3.4.

Access to services and the way in which service providers treat individuals and groups is influenced by power. Power is a complex process and relationship, which different theorists see in different ways. In the same manner, discourse is much more than a simple verbal interchange between two individuals. For the purpose of this study, however, it seems appropriate to use a perspective that is about power and the way in which people are either included or excluded from participating in discourse. The purpose of this chapter is to discuss some different theoretical perspectives on discourse and power and to explain the choice of a Foucauldian framework for this thesis.

What is discourse?

Discourse is a controversial and contested term, capable of many different definitions, interpretations and usages. Probably its most basic and most common use is in linguistics when it refers to a speech unit larger than a sentence. For example, many commentators see literature as discourse. Similarly, a conversation between two or more people can also be seen as a discourse. While this research sees the individual narratives as discourses in their own

right, the term is used, by groups ranging from social scientists to the media in a much broader sense than this, and has developed into something both more vague and more wide-ranging. According to Mills, it has,

... become common currency in a variety of disciplines: critical theory, sociology, linguistics, philosophy, social psychology and many other fields, so much so that it is frequently left undefined, as if its usage were simply common knowledge. (Mills, 1997: 1.)

Though different theorists perceive discourse in dissimilar ways, for the purpose of this study, it is primarily the social positioning of discourse which is of importance. Discourse is, inevitably, social in nature and may take different forms in different social settings. For example, Macdonnell says,

... dialogue is the primary condition of discourse [and] discourses differ with the kinds of institutions and social practices in which they take shape and with the positions of those who speak and those whom they address. (Macdonnell, 1986: 1.)

In this research, dialogue means something greater than face-to-face- conversation and includes the use of documents and other media as carriers of discourse.

Disparate individuals and groups see discourse in different ways. Some perceive it as the transmission of ideas, others as a means for the reproduction of theories, paradigms and norms or as abstract arguments. However, it is important to understand that it is the concepts and language of discourse which give expression to the different meanings assigned to them and which depend, among other things, on the position and power of the people or groups which use them (Pêcheux, 1982: 111) and who relate them to ideological positions. In this particular project, there is the possibility of a further dimension of difference, ethnicity, which affects the meanings and understandings of discourse (see for example, Bremer *et al*, 1996, especially chapters 2 and 3). Pêcheux was particularly interested in natural sciences and

historical materialism (Macdonnell (1986: 56), but his work makes a significant contribution to the social science understanding and analysis of discourse with his assertion that it is impossible for any discourse, even supposedly 'neutral' scientific discourse, to be value free even though they are commonly presented in this manner. Others agree, for example Althusser (1976: 116-120), who states that discourses inevitably incorporate value systems arising both from their producers and their economic, social and political context.

Discourse and 'truth'

Many branches of science, whether physical or social, commonly suggest that their theories, and therefore their discourses, are 'true', that is that they are in concurrence with reality.

Macdonnell (1986: Ch. 4) and others (for example, Hindess and Hirst, 1977: 10) reject this empiricist position and suggest that discourse can only be composed of ideas. Whilst it has value, this position is impossible to support since, while 'truth' may be a matter of interpretation (see for example Megill, 1985: 223.), the existence of some material objects is not a matter of dispute, though different meanings can be attributed to them. This is, of course, a somewhat simplified view of a complex argument. Hirst and Hindess themselves developed it further, though limiting the definition of discourse to 'speaking and writing' and insisting that the paramount feature of discourse was the order of concepts it contained (Hindess and Hirst, 1977: 7, 73). This is a very narrow view of discourse, that is of little use in analysing research narratives.

Discourse versus ideology

In this research, the concept of ideology extends to include more than the notion of a set of ideas and beliefs. It incorporates the view, stemming from Marxist literature (See for example Abercrombie *et al* (1994: 207-208) that such ideologies necessarily contain a realist false

consciousness and that this makes them unsuitable for the analysis of narrative data, though some theorists (for example, Mills, 1997, Hall, 1982) argue that social research and analysis must be based on either ideology or discourse and that the two are incompatible. It is apparent that drawing on discourse is the currently preferred route, though it is likely that this is a result of analysts wishing not to appear overtly political, even though discourse, as discussed above, inescapably implies specific value systems that are inevitably political in nature.

Ideology is irrevocably linked to the crude Marxist model of analysis where the institutions of society and power are seen as simplistic, binary and negative. Discourse appears to lack the clear political linkages of ideology and, therefore, offers a different way of thinking about and analysing power structures. However, it is evident that the development of discourse theory owes much to the Marxist notion of ideology. (For a full discussion of this issue, see Mills, 1997: Ch. 2). When considering ideology and 'truth', (see for example, Althusser, 1984), ideological theorists frequently take the position that their analysis is 'scientific' and not affected by the real conditions of existence; it is outside them. This perspective is of little use since it is well established that no socially constructed system of analysis can be value-free.

Foucauldian 'truth' and discourse

Foucault can be seen as a postmodern, post-structuralist theoretician. This project draws upon his discussions of power and discourse and relies on understanding Foucault,

... in terms of his post-structuralist opposition to the humanist concepts of subjectivity and truth ... (Bevir, 1999: 346).

Foucault rejects the notion that 'history', 'truth' and 'fact' are objective and unchanging and, thus, along with many others, discards the positivist paradigm,

including the concepts of behaviourism, empiricism and naturalism (Hughes and Sharrock, 1997: Ch.2), first described by Auguste Comté (Seale, 1998:105), and later developed by

Durkheim (1970). This paradigm maintains that there exists a single social reality or truth consisting only of things that are available to the senses of the individual and capable of only a single objective interpretation. Though it has guided social science research for many decades, and continues to exert a powerful influence over quantitative research, it is rejected for this project because it lacks flexibility and is capable of perceiving only two dimensions of social phenomenon, 'true' and 'false'.

Foucault's philosophy overcomes this dichotomy by introducing a diverse approach that encourages flexibility and a perception of the social world as multiple while rejecting a single fixed world-view. For example, it can be demonstrated as a 'matter of fact' whether it rained in a particular location at a specific date and time; however, whether the event will figure in a narrative will depend on many factors such as the importance of rain to the events in an individual's life and the significance of the rain to the story that is being told, as well as that person's opportunity to experience the event. The inclusion of the 'fact' of rainfall in a story will, therefore, be a matter of choice.

Foucault perceives truth as multi-faceted and but loosely related to objective fact (see for example Kendall and Wickham, 1999: Part I or Prior, 1997: 63-79) noting that the phenomenon he describes as the 'gaze' (Foucault, 1973: 39), which can be interpreted as the analytical process, exercises control over 'truth' rather than being subject to or dedicated to it.¹ Indeed, Foucault's belief that fact is only a tool to prevent further

¹ This concept of the 'gaze' is a useful example of the difficulty in understanding terms created in other cultures. Foucault's actual French phrase, translated as the 'gaze' is *le regard*; the meaning of this term is seen by the French as much broader than simply *looking*; it implies both norms and social controls, but does not easily cross a language barrier, much less the barrier to understanding that exists between different cultures.

discursive development, in the belief that fact will stifle interpretation, is of paramount importance (Megill, 1985: 223) and links the theoretical framework to the actuality of discourse suppression. Additionally, Foucault rejects the need to produce grand theory, instead suggesting that there are an infinite number of ways in which events can develop and that the promotion of grand theory prevents this development.

Foucault, particularly in his earlier work, held that there was a mechanism or system of codes which govern the manner in which individuals understand the world, and therefore the manner in which they act in the world. He called these codes epistemes and argued that an episteme,

... delimits the totality of experience in a field of knowledge, defines the mode of being of the objects that appear in that field, provides man's everyday perception with theoretical powers, and defines the conditions in which he can sustain a discourse about things that is recognised to be true. (Foucault, 1970: xxii.)

Foucault's epistemes are part of the development of his notion of discourse (see below). Bevir (1999), suggests that they are an important component of the discursive process, arguing that they are taken for granted and never questioned and noting that:

Far from the epistemes that govern our thinking being the reflection of a natural order or a product of rational deliberation, they themselves construct both the world we study and the concept of rationality that we adopt. The way we perceive the world and the way we classify things depend on the codes that govern our thinking. (Bevir, 1999: 346.)

Epistemes set and fix the rules by which a concept is understood at the specific time that the episteme or analysis code is created. Foucault and others contend that, because epistemes fix meaning at a specific point, they cannot develop incrementally but must change by means of a discontinuity (for a full discussion of the concept of discontinuity see Appadurai (1996)).

Thus, an episteme, once created, will be incapable of change, though a new episteme may

come into play which appears little different, it is not likely, however, that the original episteme will vanish.

The nature of narrative data collection is parallel to this process, though operating on a much shorter time scale, so that, if a narrator is interrupted, the original story will end and a new one begin.

Foucault's notion of discourse is radically different from others. It is, for example, entirely different from the simple use of language for communication, though this is a component. It differs too from descriptive literary discourse and even the questioning scientific discourse: Cheek and Rudge (1997) define it concisely stating,

... discourse is a certain way of thinking and talking that, whilst it allows for some possibilities precludes others. (Cheek and Rudge, 1997: 707.)

Henriques *et al* (1984) suggest that Foucauldian discourse obeys a series of rules. In particular, they argue that discourse is controlled and methodical and that the rules that control discourse encompass more than one specific discourse. Many features are thus regulated, such as the way in which discourses may or may not combine or articulate and the manner in which differences are established between disparate typologies of discourse, for example the difference between the discourse of physical science and that of art. Most importantly, these are the rules of,

... production of the possible statements...[that] ... delimit the sayable.
... Every discourse is part of a discursive complex; it is locked in an intricate web of practices, bearing in mind that every practice is by definition both discursive and material. (Henriques *et al*, 1984: 105-6.)

So, for Foucault, the process of discourse, though not limited to the verbal process but including the notion of other intellectual or physical capacities, is,

... whatever constrains – but also enables – writing, speaking and thinking. (McHoul and Grace, 1993: 31.)

Foucauldian discourse is more than just a textual or linguistic process; it is a practice that, according to Horrocks and Jevtic (1997: 87) consists of three components; firstly, the social and cultural areas in which discourse appears, for example, the family or the workplace; secondly, people and/or institutions which have authority and knowledge, for example doctors and the discourse of medicine, and lastly, a system by which different types of the same phenomenon, for example health care experiences, can be compared. An example from this research could consist of an NHS Trust workplace as the social/cultural area from which the discourse derives, the process of being an NHS patient in contact with doctors as the people/institution dimension, and daily life, as narrated to the researcher, as the system of comparing similar experiences. Significantly, Foucault is not concerned with ‘truth’ as empirical fact; of more concern are the social, political and historical circumstances in which statements become perceived as true or false.

Foucault sees discourse as productive, in the same way that he perceives power as productive (see below), that is as,

... practices that systematically form the objects of which they speak.
(Foucault, 1973:49.)

Furthermore, Foucault asserts that power does not simply produce the objects or discourses, but that these produced objects gain authority and legitimacy from the exercise of power (Daudi: 1986: 258). In addition, Foucault’s discourse cannot stand alone; it is an integral component of the society, and therefore the power relationships that both produce discourse and are produced by it. Foucauldian discourse can, therefore, never be considered value-free. Mills (1997: 16-17) develops this saying that discourse, as a structure can be distinguished

because it will contain a systematic structure involving behaviour, concepts, ideas and manners of thinking in particular settings. It is reasonable to assert, therefore, that there is an array of discourses around ethnicity, health and ethnicity and health in the same manner that there is a set of discourses around, for example, feminism. See for example, Seidman (1998: Ch. 7.)

Importantly, Foucault (1981: 52-53) views discourses as means of struggle as well as a system of controls (see below). That is, discourse is much more than simply a description of struggle, it is or it produces, the struggle itself,

... as history constantly teaches us, discourse is not simply that which translates struggles or systems of domination, but is the thing for which and by which there is struggle. (Foucault, 1981: 52-53.)

Not all analysts agree with this interpretation. Freundlieb and others, for example, state that Foucault has failed to provide sufficient room for the effects of human agency and argue that,

[his] ... work on discourse analysis is neither lucid nor uncontroversial. (1994: 153.)

Power

Initially this project's analysis was based on the use of a conflict perspective, because of the theoretical background of the notion of 'race', that is that it is a socially constructed hierarchy of power which places 'white' at the top (the most powerful) and 'black' at the bottom (the least powerful). Other gradations of colour (skin colour) are allocated descending locations between the top and bottom positions. This hierarchy is always externally imposed by the powerful on the least powerful. It is about the creation of people who look different as 'other', or often as monstrous others, and is used to justify their exploitation (See Chapter 2.1).

However, there are anomalies in that people who do not belong to designated groups (however they are designated at any particular time, for example by skin colour, national origin, language usage or religion) may find themselves outside the structure and considered to be of less worth than the lowest member of the established hierarchy. There are particular issues for people of mixed ethnicity. As discussed in Section 3.3, there is no coherent 'mixed ethnicity population'. Therefore, there has been very little opportunity for this diverse group to develop a collective identity and use this to obtain recognition and power in the way that has happened for other factions in the past. Examples include workers' rights movements, Feminism and Gay, Lesbian and Bisexuals. For a more detailed account, see Seidman (1998: Ch. 7).

Power can be perceived in many ways, some of which are discussed below.

Power, like discourse or ethnicity is a contested term. There are many definitions, ranging from simple to highly complex. Hobbes (1968: 150) argues that it is nothing more than a collection of attributes, possessions and abilities used to further human purposes. Hindess (1996: Ch. 1) asserts that there are two basic concepts; the first is power,

... as a simple quantitative phenomenon ... nothing more than a kind of generalised capacity to act. (Hindess, 1996: 1.)

Hindess' second definition embodies the first, but includes the right to act in addition to the simple ability. Other theorists create different categories, Lukes for example (1974) has three dimensional views of power. The one-dimensional form, equivalent to Hindess' capacity to act, is concerned with making decisions,

... a focus on *behaviour* in the making of *decisions* on *issues* over which there is an observable *conflict* of (subjective) *interests*, seen as express policy preferences ... (Lukes, 1974: 15.)

Lukes' second dimension of power, which like the single dimension equates with the pluralist notion that power can only be identified where there is identifiable conflict, makes a qualified critique on the behavioural base of the one-dimensional view and develops this to include both decision-making and non-decision making. Conflict in this view departs from the pluralist idea and can be overt or covert. The third dimension further develops the critique of the behavioural focus and the decision making process is now concerned with control over political agenda which may, or may not, be through a decision making process. Conflict, in this perspective may be covert, overt or latent and interests may be subjective or real. Lukes' second and third dimensions of power can be seen as developments of the capacity to act and the distinctions made by Lukes which separate non-decision making from the decision not to act are useful and can be seen in a similar manner to Foucault's discursive structures because they control the sayable. However, while Lukes' two and three dimensional views of power are useful and flexible analytical tools, they assume that power is hierarchical, that is that there are powerful people and institutions at the top of a hierarchy that descends through less powerful people and institutions until they reach the powerless. There are other views of power which are relevant, especially elite theory (see for example, Mosca (1939) or Pareto (1963)) and Foucault's perspective (see below).

Clearly, power has a role in the suppression of discourse, because power is required in order to impose the structure. This asymmetric, class-based power was the basis for sophisticated Marxist theories. Marx himself said:

The ideas of the ruling class are in every epoch the ruling ideas, i.e. the class which is the ruling material force of society is at the same time its ruling intellectual force. The class which has the means of material production at its disposal, has control at the same time over the means of mental production, so that thereby, generally speaking, the ideas of those who lack the means of mental production are subject to it. The ruling ideas are nothing more than the ideal expression of the dominant material relationships, the dominant material relationships grasped as ideas; hence of the relationships which make the one class the ruling one, therefore, the ideas of its dominance. The individuals composing the ruling class possess, among other things, consciousness, and therefore think. (Marx, 1970: 64)

This is, essentially, the form identified in later Elitist theory by Mosca, who describes the ubiquitous formation of the two classes necessary for this structure, saying:

In all societies ... two classes of people appear – a class that rules and a class that is ruled. The first class, always the less numerous, performs all political functions, monopolises power and enjoys the advantages that power brings, whereas the second, the more numerous class, is directed and controlled by the first. (Mosca, 1939: 50)

Mosca's conclusion that a classless society was an impossibility was developed by Roberto Michels who studied socialist political parties in Europe (Michels, 1959). He reached the conclusion that the elitist nature of society had a parallel in large organisations and that even groups who were ostensibly democratic are, inevitably, controlled by a small, powerful minority. This led to the formulation of Michel's *Iron Law of Oligarchy* (Ball and Dagger, 1991: 182) which states that power, either in society or in large organisations, cannot be shared equally. Rather it is the nature of societies and organisations that real power is concentrated in an elite. Michels concludes that,

... elites rule the world; they always have, and they always will. (Ball and Dagger, 1991: 182.)

The overarching conclusion reached by elite theorists, that the equal sharing of power amongst all members of a group, and by inference this includes sharing power with both

service users and providers, is impossible and that all organisations and societies will be controlled by a powerful minority, is important. It can be argued that it is this process which both controls the hierarchical position of individuals and groups in the social construction of 'race' and influences their access to services. That doctors are members of a powerful professional elite is clear (See for example, van Dijk, 1998)). It may be that it is the exercise of this elitist power which leads to the suppression of discourse concerning health and ethnicity. As a means of explaining how some individuals and groups experience differential access to services and are treated differently by medical professions, this is an attractive theory. However, it is not the only theory which is of use.

The manner in which Foucault represents power is central to this study. Foucault does not see power necessarily as the binary asymmetric relationship of, for example, Marxists. Instead, power is perceived as a free-standing productive force (Foucault, 1977: 27) that exists throughout society and may or may not attach to institutions and individuals, depending on circumstance. Foucault said:

Power is everywhere; not because it embraces anything but because it comes from everywhere ... Power comes from below; that is there is no binary and all-encompassing opposition between ruler and ruled at the root of power relations, and serving as a general matrix – no such duality extending from the top down and reacting on more and more limited groups to the very depths of the social body. One must suppose rather that the manifold relations of force that take shape and come into play in the machinery of production, in families, limited groups and institutions, are the basis for wide-ranging effects of cleavage that run through the social body as a whole. (Foucault 1977: 93-94.)

Foucault is often misrepresented as believing that power and knowledge are interchangeable (see for example, Nola, 1988: 109); however, this is not the case (Kritzman, 1988: 43).

Foucault, however, said that his target had not been to analyse power as a phenomenon, but to emphasise power only as one of the ways in which humans are created as subjects, that is as

self-aware individuals (Foucault, 1982: 208). Critically, Frow develops Foucault's concept of power and connects it to discourse, saying:

If power is no longer thought simply as a negative and repressive force but as the condition of all speech, and if power is conceived as polar rather than monolithic, as an asymmetrical dispersion, then all utterances will be potentially splintered, formally open to contradictory uses. (Frow, 1985: 206.)

This statement can be seen to agree with Foucault's argument that power is not binary in nature but is rather diffused throughout social relations and that it permits as well as restricts all behaviours. Foucault said:

We must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact, power produces; it produces reality; it produces domains of objects and rituals of truth. (Foucault, 1977: 194.)

Though it is acknowledged that Foucault's concept of power is based on the Marxist conflict between Capitalists and Workers, he has, crucially, developed and extended the binary concept of power to include a new 'mechanism' of power' (McHoul and Grace 1993: 62).

However, he feels that power is consolidated in society: In *Power/Knowledge* Foucault says:

This new mechanism of power is more dependent on bodies and what they do than on the earth and its products. It is a mechanism of power that permits time and labour, rather than wealth and commodities, to be extracted from bodies. It is a type of power which is constantly exercised by means of surveillance rather than in a discontinuous manner by means of a system of levies or obligations distributed over time. It presupposes a tightly knit grid of coercions rather than the physical existence of a sovereign. It is ultimately dependent upon the principle, which introduces a genuinely new economy of power, that one must be able simultaneously both to increase the subjected forces and to improve the force and efficacy of that which subjects them. (1980: 104.)

This focus on the body, the individual as the seat of power is fundamental to the way in which this project utilises Foucault's interpretation of power to investigate and analyse the use of

medical power as a force, and as a set of relations of force (McHoul and Grace: 1993: 40) exercised by individuals and institutions, to suppress discourse around issues of ethnicity and health.

Foucault's notion is that power appears everywhere in society and is available to everyone (Hindess, 1996: 100). He suggests, too, that it has an aggregating effect resulting in what Bevir (1999) calls a regime of power. He states that, in Foucauldian theory:

Power exists throughout society, appearing in innumerable micro-situations dealing with an array of issues, where the cumulative effect of these micro-situations is a given regime of power. (Bevir 1999:349.)

This process suggests the creation of a set of controls which exercise positive or negative power over discourse. The controls are external to the discourse and can, for example, define a discourse as sane or insane, true or false and intelligible or unintelligible. Thus, the creation of external controls may render some discourses, for example the mixed ethnicity/health discourse, unacceptable and, therefore, inaccessible. Indeed, Foucault refers to these controls as '... systems of exclusion' (Foucault, 1981: 52-55) and developed the idea to include the process of discursive objection (Foucault, 1981: 57-59, 61-64) and controls over, not only the nature of discourse, but of those who are permitted to contribute to it (Daudi, 1986: 261).

For the purposes of this project, power can be seen to be productive in three ways:

Firstly, Concept Power – the idea that produced the research into the discourse of health and mixed ethnicity related to medical power and the suppression of discourse.

Secondly, Researcher/Narrator Power – intended to be a process of facilitation to aid the production of narrative and the creating of new truths.

However, there is evidence in the data that, in some circumstances, the researcher and narrator may be thought (by the narrator) to be in an asymmetric power relationship with the narrator,

with the researcher sited in the position of greatest power. For example, some narrators apparently seek the approval or validation of the researcher to their stated position or interpretation of events. If other data collection processes had been utilised, such as an unstructured interview methodology, there might be concern that the participants in the research had given responses calculated to obtain the researcher's approval. Since the narrative procedure followed in this project does not include interviewer responses, this potential pitfall has been avoided. Nevertheless, there is a covert opportunity for the researcher to exercise power over the narrator. This is in connection with the choices that the narrator makes when analysing the collected data. This is discussed in greater detail in Chapters 3.3. and 3.4.

Thirdly, Narrator Power – the opportunity for the narrator to unlock stories and tell them for, potentially, a variety of ends, for example to disclose information about 'good' or 'bad' contacts with doctors and the NHS.

Summary of the theoretical perspective

Power is a contested term. It may be simply a collection of attributes used to further individuals' aims, the ability or capacity to act. It can be binary or elite power, the means by which some groups or individuals dominate other individuals or groups and the manner in which they attain their objectives in the face of resistance and opposition. Power can also be thought of as a free-standing productive force that is ubiquitous and available for everyone's use.

Discourse is a contested term. It can mean something as simple as the word structures of a dialogue or something as complex as the production of a means of struggle or a set of internal and external controls to produce and limit the sayable. In the context of this research, it is

concerned with understanding, specifically between people of different cultures and ethnicities, but also between powerful professionals and their clients. It is also about the production of narrative and struggle and about the process of seeking and producing explanation and legitimation of narrators' voices, stories and perspectives. In this regard, the relationship between 'truth' and 'fact', that is, the *what* of stories is of less significance than the *how*, the process of story generation.

This research acknowledges the difficulty of understanding or translation of language, which in itself may be sufficient to question if it is ever possible to share understanding between different cultures whether these are based on linguistic, professional or ethnic divisions. In part, this may be because concepts are understood in such radically different ways that there is, effectively, no common ground. For a fuller discussion of these issues, see Robinson, (1998).

3.2. The research questions

This research project, as described earlier, is concerned with the health status and health experiences of people of mixed ethnicity.

The research questions, in the same way as the research methods, have undergone a process of evolution to reach their present state. The basic underlying supposition was that there was a specific mixed ethnic population in England that might experience 'worse' health than the general population. This led to subsidiary hypotheses which have developed into 3 main questions and one, 4th, supplementary question which arose during the preliminary stages of the research.

This is a qualitative research project (see Chapter 3.3.) informed by a theoretical framework based on the works of Foucault (see Chapter 3.1.). It follows that little analytical value is placed on the collection of objective 'truth' or 'facts', though objective data is sometimes referred to in order to establish whether narrators' perceptions concur or conflict with them. This is particularly noticeable when comparing the metanarratives of Chapter 4 with the statistical data of Chapter 2.4. The overall purpose of the research is to discover, discuss and explain the perceptions, feelings and beliefs of narrators concerning their health status and healthcare experiences. Because of this subjective qualitative approach, some of the concepts in the research questions have been defined in specific ways, as discussed below.

The Research Questions

- 1. Do people of mixed ethnicity, because of their ethnicity, have significantly poorer health status than the white majority population?**
- 2. Do people of mixed ethnicity, because of their ethnicity, have predominantly negative healthcare experiences?**

- 3. Do people of mixed ethnicity, because of their ethnicity, suffer from the suppression of the discourse of mixed ethnicity and health because of the exercise of medical power by doctors?**
- 4. How do people who define themselves as being of mixed ethnicity describe and define their ethnicity and identity?**

In question 1, the term ‘significantly poorer health’ has been approached in 2 distinct ways. First, the context (Chapter 2.4.) reports quantitative data from a series of surveys concerning the health of people from minority ethnic populations, because there is no specific data for people of mixed ethnicity. Much of this data is in terms of events, but in part, it records such subjective classifications as ‘self-assessed general health status (see Table: 2.4.12.). This contextual information is used to assert that there are differences in the health of the white population and that of people from minority ethnic groups, but that these differences are centred on either specific conditions/illnesses or relate to socio-economic status. Second, the self-perceived health status of the narrators who contributed to this research is described and analysed by means of metanarrative (see Chapter 4.4.3.).

Question 2 does not attempt to define ‘predominantly negative healthcare experiences’, but relies on the descriptions given by narrators as they relate either their own or their children’s experiences of consulting family doctors (see Chapter 4.4.4.). The analysis of this question also uses data provided by family doctors and predicated on the concepts of doctors’, or medical, power (see Chapter 4.4.2.). This question acknowledges that the doctor/healthcare professional/patient interface is contested and its boundaries may not be stable, since everyone will at some time be a health care service user. Crucially, the evidence gathered to answer this question depends on narrators discussing and illustrating their healthcare experiences in relation to their self-defined ethnicity. This evidence is then selected, by

different actors, in the narrative collection process and the subsequent analysis (see Chapters 4.3. and 4.4.), to illuminate these experiences.

Question 3 uses my term ‘suppression of discourse’ in 2 discrete ways. First, it implies that ‘discourse’, defined as the dialogue between doctor and patient (see for example Macdonnell, 1986: 1) is controlled by the doctor as the most powerful participant. By implication, doctors may use this process to decline engagement with particular issues, the health implications of mixed ethnicity for example, for a multiplicity of reasons. Second, this question utilises ‘discourse’ defined in a manner informed by Foucault’s theories (see Chapter 3.1.) as a productive process that not only permits, but limits the range of that which can be said. Thus, if a doctor suppresses the discourse of health and mixed ethnicity, the action is greater than a simple refusal to engage, resulting in an inability to discuss or interact with the issue, since for all practical purposes it does not exist.

Question 4 arose from the pilot stages of this project. It had been assumed, perhaps naively, that there was an existing generally accepted definition of ‘mixed ethnicity’ and that some statistical data would be available for analysis, because it was known that an ‘ethnic group’ question had been included in the 1991 Census of Population. Whilst this Census question may be considered flawed (see Chapter 2.3.), for the first time, it gave the opportunity for individuals to define their own ethnicity.

At an early stage in this project, it was clear that there were difficulties of definition and it became apparent that a number of issues needed consideration. First, the data from the 1991 Census of Population was processed by the Office of Population Censuses and Surveys (OPCS, 1993: 830-913) utilising a procedure that resulted in the characteristics of people who may have defined their ethnicity as ‘mixed’ being, effectively, lost or at least subsumed within the characteristics ‘Black’ and ‘White’. Second, the pilot interviews yielded multiple

definitions of 'mixed ethnicity' and it seemed probable that the manner in which individuals self-define their ethnicity and identity were crucial to their healthcare experiences. Last, the pilot interviews and discussions indicated that, no matter how individuals define themselves, others will make definitions of them based on varied criteria. It was felt that these 'outside' definitions might have an impact on the healthcare experience.

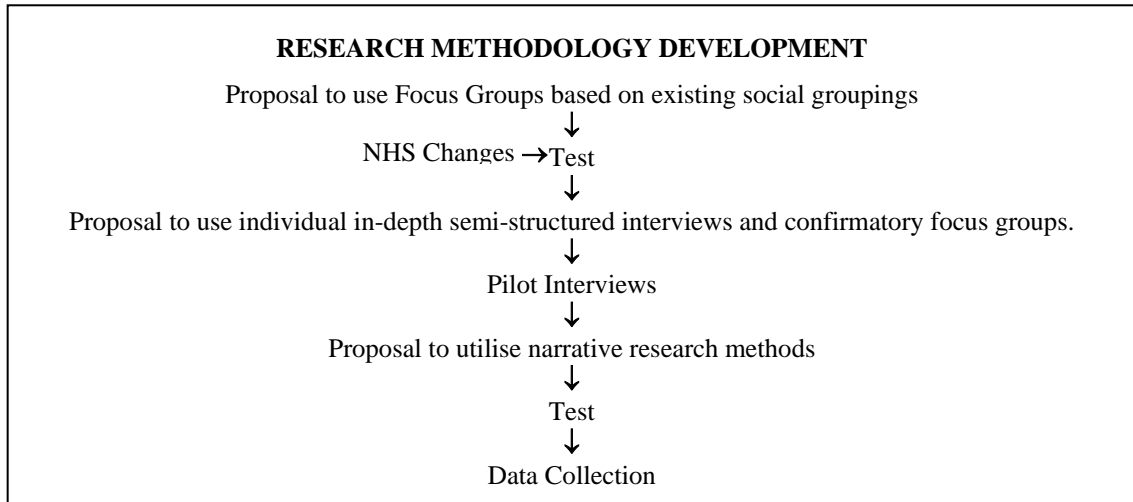
The methods by which data was collected to seek answers to these questions is discussed in Chapter 3.3.

3.3. Methods: choice and process

This Chapter is about the processes used to gather and analyse data for this research project. Because of the nature of the final collection process, a separate chapter discusses the practical methodology and analysis. The chapter briefly considers the need for a methodology before discussing the choices that were made, together with the reasons for those choices, and the practical procedures, setbacks and successes that were involved. Firstly, the chapter outlines the originally proposed methodology, with a discussion of the reasons why it was changed. Secondly, the chapter goes on to describe the pilot interview phase of the research, together with the findings from this part of the research. Finally, the chapter describes the need for a further change of methodology, culminating in the use of narrative research, and discusses this in detail.

The methods used in this project went through a sequential process of modification and development before the selection of the final method. This process was more than a simple choice of a research paradigm and methodology and, in part, results from the nature and location of the people who compose the target population. Nor should this process be regarded just as 'trial-and-error'. Rather it represents attempts to utilise theoretically sound methodologies which are adapted to particular circumstances. This developmental progression is an integral part of the research process and has valuable implications for other researchers who may venture into this territory. In this project, the following developmental process occurred:

Fig: 3.3.1 - The Development of the Research Method.



The selection of the research method is predicated on the nature of the information required. For research that requires statistically reliable data about large populations, survey or other quantitative methods will be appropriate. If, however, the research concerns the experiences, feelings, attitudes and beliefs of a small number of individuals, qualitative methods will be more useful. The actual methodology selected will depend on the nature both of the type of research and the information that will be collected. Miles and Huberman (1984: 42) suggest that exploratory research topics require less structured methodologies.

The original methodology

This project was designed around the concept of qualitative research since it is intended to discover attitudes, opinions, beliefs, feelings and experiences of a small population sector, a process which requires data richness and depth; additionally, published data from the Census shows that this is a small population.

The intention of this research project, as discussed earlier, was initially to construct a database of adults, in Birmingham and Sandwell, who were prepared to describe their ethnicity as 'mixed', utilising snowball sampling methods in the absence of any existing sampling frame

(Arber, 1993: 73-74). The next stage was to conduct a series of ‘one-off’ focus groups, selected as far as possible from existing groupings, such as community centre users, parent/teacher associations or lunch clubs. The purpose of this proposal was to discover mixed-ethnicity users’ experiences of health care, their perceptions of health care needs and demands and their perceptions of the NHS response to these. The final stage of the research proposed to utilise in-depth semi-structured interviews with selected health commissioners in an endeavour to discover the issues that professional health commissioners believe important in the area of mixed ethnicity and to seek their perceptions of the commissioning process. In particular, the intent was to establish the extent to which commissioners effectively assess the health care needs of their populations, the manner in which ‘need’ and ‘appropriate health service provision’ are defined and assessed and the extent to which appropriate health care provision is available so as to provide a responsive and ethnically sensitive service. This designed-in distinction between ‘health care professionals’ and ‘service users’ was so that it might be possible to compare the differences in perceived health care need between the groups.

Difficulties with the original methodology

Whilst no obvious difficulties have arisen as a result of the researcher’s gender and ethnicity, in practice, it was impossible to locate the target population sector, that is those people who are willing to identify themselves as being of mixed ethnicity. In addition, the ongoing changes in the structure of the NHS, particularly in the way in which this has impacted on Health Authorities, presented problems (see Fig: .3.1. above). It became apparent (see Chapter 2.3) that the ‘mixed ethnicity’ population sector is ill-defined in official records. Attempts to identify this sector by means of Local Authority documents, for example Community Profiles, proved fruitless as Local Authorities employ the faulty categories used in the published data

from the Census of Population. It is also became clear that, if the research project was limited to the originally proposed geographical areas, then it would prove impossible to locate enough subjects. Because of this, and the small apparent size of the target population sector, the scope of the research has been widened and is no longer limited to selected wards in central Birmingham and Sandwell, though these areas continue to be the primary geographical focus.

Not only was it difficult to locate members of the target population sector, but the postulated existing social groupings, which were to provide a source of focus group members, do not exist. There is no accessible population of mixed ethnicity people; rather there are individuals who do not comprise coherent groupings. Under these circumstances, the methodology was changed. The redesigned methodology proposed to utilise semi-structured interviews with individuals still selected by means of snowball sampling, initial contacts being developed by various strategies. This new methodology would overcome the problems associated with the absence of suitable existing social groupings and the small size of the target population.

There are, of course, important ethical issues concerning confidentiality and the preservation of anonymity. All interviewees knew that the interviews were to be anonymous, but in some cases, this is insufficient; there is, for example, only one Cultural Competence Co-ordinator in Sandwell NHS Trust. These issues have been discussed individually with the interview subjects separately consenting to the way in which they will be described in this thesis.

A number of different strategies were employed in order to contact members of the target population sector. In particular, a preliminary telephone survey attempted to identify those individuals within Health Authorities with responsibilities for commissioning health care for people from minority ethnic groups and people of mixed ethnicity. The results suggest that this is a contested area in health commissioning. No Health Authority has a department or

individual responsible for commissioning for people of mixed ethnicity, though there was no reason to expect this. Some responses to the follow-up question, 'Can you tell me who is responsible for commissioning health care for people from minority ethnic populations in your area?' produced comments such as:

We don't know (East Norfolk Health Authority, Rotherham Health Authority, Manchester Health Authority, South Staffordshire Health Authority).

Don't know, really (Salford and Trafford Health Authority).

Try Public Health (South Essex Health Authority).

But we don't do that (County Durham Health Authority).

We don't have any ethnic people (Northumberland Health Authority).

There's no ethnic people here (South and West Devon Health Authority).

It's not separate (Barnsley Health Authority).

Of the one hundred and five Health Authorities surveyed, only sixteen (15.2%) said that they had specific people or departments who were concerned with the health of minority ethnic populations. None had provision for people of mixed ethnicity. Thirty Health Authorities (28.6%) were unable to identify a contact person or department. While this survey was only indicative, these results are symptomatic of the low profile of, and low priority given to, the health of and health care provision for people from minority ethnic populations.

Originally, the plan was to approach the contacts discovered by the telephone survey as subjects for interview. In practice, the substantial changes within Health Authorities occasioned by the introduction of Primary Care Groups (PCGs) (Cm. 3807, 1997: Ch. 5) has resulted in significant reorganisations. Sandwell, for example, is now divided into three PCGs, there is now no individual with responsibility for commissioning for minority ethnic

populations and the Health Authority, in common with many others, no longer employs those staff members who had this responsibility. Because of these changes, the original methodology required revision.

The pilot interviews

The next stage was to pilot a set of semi-structured interviews to assess whether this was an appropriate method to use in this research and, between October 1998 and February 1999, six pilot interviews were completed, the tape-recordings transcribed and basic analysis completed. All interview subjects have been female, though it was not clear at this stage whether this was chance, self-selection or the result of some other process.

Details of the Pilot interview subjects are shown in the table below.

Table: 3.3.1. – Pilot Interview Subject Details.

Ethnicity	Health Care Professional?	Age
Mixed	No	32
Mixed	No	33
Mixed	No	24
Mixed Pakistani	No	31
White	No	34
Black British	Yes	43
Jamaican	Yes	35

Pilot interview analysis procedures

The data analysis for this research has been partially undertaken using Scientific Software's 'ATLASi' (Version 4.2: Build 58) qualitative data analysis programme. The detail of this software is described elsewhere.

The pilot interviews were initially analysed using a combination of enumerative, investigative and iterative/narrative modes (Grbich, 1999: 222-223, Punch, 1998: 222, Bouma and Atkinson, 1995, Ch. 10), with the intention that the output be used to guide the next stages of the research. Enumerative methods, in this instance, centre on a simple content analysis of the transcribed interviews seeking instances of recurrence of issues. In part, this has been accomplished by using ATLAS.ti's 'wordcrunch' facility. This is a part of the programme that is used to identify the frequency with which words are used and to sort them, if required, into ascending or descending order. The software permits the user to exclude a chosen list of words. This facility is employed so that pronouns, prepositions and conjunctions are not included (for example, and, but, this) since they result in large usage statistics which, in this instance, are without value. This is also the commencement of a thematic analysis. The investigative mode seeks to understand events which may lie behind the superficial content of the interview so that, for example, the impact of power relationships may be understood in a particular setting. The iterative/narrative mode is that in which the researcher collects data from field interviews then reflects upon the data and notes any themes that emerge (May, 1998, Ch. 10). It is important during this procedure to ensure that the data remains in context and is not fragmented and decontextualised by the process of analysis (Punch, 1998: 222). The iterative mode is, essentially, indistinguishable from the coding/analysis stage utilised in the development of grounded theory (Strauss and Corbin, 1998: 55-101).

If the analysis is to be valid and reliable, and the results credible to other researchers, it is vital that the methodology is systematic and comprehensive so that all subjects are included and analysed using the same procedures. At the same time, the analysis procedure is dynamic; that is, it can develop over time while retaining the ability to permit easy retrieval of data. The stages of data analysis are as follows:

- **Immersion.**
The process by which the analyst becomes familiar with the collected data.
- **Coding/indexing.**
The process of identifying specific data as interesting and marking them so that they can easily be found for further analysis.
- **Thematic summary and Analysis/interpretation.**
The grouping of data around emerging issues in order to identify typologies and concepts and grouping data around themes for result presentation.

Analysis of the pilot interviews

A number of words had a high incidence in the pilot interviews, defined as occurring in context more than 10 times during the course of the interview. There were:

Black(s), Community, Culture, Different, Doctor(s), Ethnic(ity),
Groups, Health, Identity, Mental, Mixed, Problem, Race, Racism,
School, White(s).

In this early stage of the research, the significance given to these words is debatable.

However, they are useful, not only as a means to establish the content of the interviews, but also in terms of setting the initial parameters for the thematic summary.

An initial set of codes was developed based upon the theoretical framework and the growing understanding of the interview content. These codes are simple words and phrases used to identify the occurrence of events or concepts within the interview transcriptions. Initially, seventeen codes were created as follows:

'Race': Exclamation: Access: Coping strategy: Discourse suppression:
Discrimination: Ethnicity: Health: Identity: Ignorance: Inappropriate
description?: Medical power: Mixed: Politics: Position:
Prejudice/Stereotyping: Racism?: Stress

It is unlikely that these codes would have been definitive, even if the methodology had not developed further; they were designed to be modified and codes added, deleted or modified as required. The analysis software permits the analyst to create various different links between codes and to use these links to view the data in different ways. At this stage in the analysis, temporary links were created between 'identity' and 'position' and between 'medical power' and 'discourse suppression'. In addition to codes, the transcribed text can be annotated with memos which can be used to capture concepts generated by the data or simply to make notes relevant to that section of the text. Codes, memos and their associated quotations are retrieved and manipulated by the various search routines built into the software. ATLAS.ti can be used to display the occurrence of codes within interviews, which helps to understand both the content and the structure of the interviews.

Findings from the pilot interviews

The Pilot interviews identified a number of common themes. These are discussed in greater detail below and include:

- The concept of mixed ethnicity
- Identity and mixed ethnicity
- Health and mixed ethnicity
- Medical power and discourse suppression.

The concept of mixed ethnicity

This study made the initial assumption that there was an accepted definition of mixed ethnicity. This is incorrect. It is now apparent that individuals choose to define their ethnicity in extremely personal ways that may be predicated on disparate issues, such as individual

experiences of racism, a desire to 'belong' to a specific group, the belief that there is no choice in ethnic group membership and many other factors including skin colour and perceived heritage. However, it is apparent that 'mixed ethnicity' is both a social construct and a contested term for which there is no universal or agreed definition. It is worthy of note that there is common ground within the definitions in that the definers sometimes use similar criteria to arrive at different definitions. A common example of this is skin colour. (See Chapter 2.1.)

Identity and mixed ethnicity

An issue common to four of the six pilot interviews was 'identity', which is also discussed in the section on health and mixed ethnicity. This was described and referred to in different ways, but centres around the potential for an 'identity crisis' among people of mixed ethnicity. It was expressed as a 'problem' because people of mixed ethnicity may feel that they do not fit into either the Black or White worlds and may have to make difficult or complex choices. Some subjects saw this ability to make such choices as a positive opportunity; others felt oppressed by it. One subject described it as an opportunity to celebrate black heritage. Other subjects expressed opposing views. It is interesting to note that several subjects referred to this ability to choose as 'taking sides'. This suggests that, for these interview subjects, any ethnic difference between Black and White may be perceived in terms of a confrontation. One subject said:

People just have to take sides ... they have to choose.

Not all the pilot subjects agreed. Some argued that there is a purposive division between groups and that it is inappropriate to make such choices.

Health and mixed ethnicity

All the interviewees were aware that the research concerns the concepts of the impact of mixed ethnicity on health and that the original hypothesis suggests the existence of a linkage between the two. Three interviewees stated that they thought that ethnicity had no impact on their health. The remaining three subjects argued that their personal experiences support the existence of such an association. For example, one person discussed the notion of obesity in South Asian Women living in England together with the notion that 'thin equals poor' in the Pakistani culture. There was also a connotation, in this instance, that obesity was deliberately achieved because to appear wealthy, or at least not-poor, increased marriage opportunities. Obesity is a major contributory factor in coronary heart disease and stroke (Department of Health, 1993: 20), and a causative factor in other illnesses, and this may, therefore, be an issue with regard to people from specific cultural backgrounds.

Two other subjects identified specific health issues around mixed ethnicity and health that they thought important. These concerns were, largely, around the fact that people of mixed ethnicity, although appearing White, may be subject to specific diseases that are almost unknown in the White population. Particular anxieties were expressed about haemoglobinopathies such as Sickle Cell Disease or Thalassaemia, though there was also concern about Tuberculosis. Additionally, psychological health was discussed and linked to the concept of identity, one interviewee suggesting that a clear sense of identity was vital to the promotion of good psychological health and that identity crises could lead to a risk of self-harm and mental illness. One subject identified skin care and hair care as important health concerns for Black people of African or African-Caribbean origin. Several interviewees commented that it was difficult to get information relating to health and ethnicity and felt that most General Practitioners, no matter what their ethnicity, were ill-informed in this area. One

interviewee, when discussing her son's health, said that she thought that his negative reaction to doctors was a major difficulty.

Medical power and discourse suppression

All of the interviewees mentioned difficulties in their relationships with their family doctors. These centred on the concept of doctors' power and the medicalisation of life (see for example, Illich, 1990 Ch. 2 or Gabe, Kelleher and Williams, 1994) and the loss of control experienced by some people when consulting their family doctor.

For some interviewees, the most important issues were about family doctors not spending enough time with the patient, not being thorough enough and treating patients as though they are ignorant of their, or their children's, health. One interviewee gave the example of her GP refusing to discuss treatment regimes in detail and not permitting her, as the patient, to articulate health needs. One subject said,

They really just don't want to know ...

Another interview subject complained that doctors abused their power, sometimes dealing with people in an off-hand manner that, effectively, excludes them from treatment. It was clear that these interviewees thought that the treatment they receive from their family doctor was mediated by their ethnicity, though there are some indications that they believe that this might not be the case. The notion that they were not allowed to take responsibility for their own health was repeated, one interviewee saying that, if she was not assertive, then the doctor would ignore what she said and would simply hand over a prescription.

One interviewee, the white mother of a mixed ethnicity child, described how she perceived a high level of discrimination from her doctor and suggested that this was experienced by the parents of mixed ethnicity children when consulting their own doctor's 2 subjects, one of them

a health care professional, reported that she felt that doctors treated the mothers of mixed ethnicity children especially badly.

Some interviewees expressed concerns that family doctors often appear to be driven by negative stereotypes in connection with mixed ethnicity. One subject gave an account of a White woman being sent for an AIDS test simply because she was married to a black Nigerian.

The issue of medical power and discourse suppression was inferred from the content of the interview transcriptions and a post-interview discussion with one subject, who said,

I think my ethnicity matters, why won't he listen?

The topic of discourse suppression was an unexpected finding from the interview pilots. The interviewees were passionate about these issues and this resulted in the research concentrating on this area.

Racism

All the interviewees reported experiences of racism and discrimination. In addition, two also thought that they suffered negative discrimination because of their gender. These experiences ranged from racist treatment during childhood in France to perceived racism from GPs and racism in employment in the NHS.

The way forward

The main themes to emerge from the pilot interviews were issues concerning identity and mixed ethnicity, health and mixed ethnicity, racism and the influence of medical power in the suppression of discourse around health needs. Whilst the central issues for the research have

become fixed at this stage, they are not necessarily rigid. That is, there is scope for topics and issues to change in appropriate circumstances.

The series of pilot interviews showed the need for a further developmental change in the methodology, since the proposal to utilise semi-structured interviews relies to too great an extent on the pre-definition of the issues and topics by the researcher. It was apparent, for example, that the postulated assumption of a widely accepted or agreed definition of mixed ethnicity is incorrect and the hypothesised link between mixed ethnicity and health is doubtful. The pilot interviews contain personal definitions of individual ethnicity which, whilst they have common themes, do not lead to an overarching classification. Furthermore, the medium of the interview may be too rigid, and potentially too threatening to a marginalised group, to permit the development of themes and issues that are of importance to the subject group, rather than to the researcher. For example, the issue of GPs suppressing discourse would not have arisen had a post-interview discussion not taken place between the researcher and an interview subject. This change to a more reflexive data collection method is seen to be in keeping with an exploratory research project and it is believed that such a process will enable subjects to exercise some direction over the research and, thus, to gain partial ownership of it.

In terms of the computer data analysis, even from this small number of interviews, there are indications that some of the analysis codes may be superfluous, poorly defined and erroneous. Certainly, upon reviewing the nature of the existing codes, there were difficulties of definition, for example, discrimination is, at best, a contested term. If it is to be used, it will require a more rigorous definition. The coding process was been developmental and on-going in this pilot phase and continued through the main data collection and analysis phases.

The choice of narrative

The findings of the pilot interviews indicated a need for a more general exploration of the issues around mixed ethnicity and health than had been initially thought. As a result, the focus of the research was directed away from an attempt to define issues and the 'facts' of an individual's health experience towards an exploration of how the experiences had been interpreted by the people involved.

Because Foucault's work stresses the centrality of both the subject and the researcher to the research, as well as the productive nature of discourse and the multiple nature of truth (see for example Kendall and Wickham, 1999: Part I or Prior, 1997: 63-79 in addition to Chapter 3.1.), a strategy of narrative research was chosen. This is particularly appropriate because narrative research, in common with some other methods, rejects the positivist paradigm (see for example Lieblich *et al*, 1998: 1) and moves towards a more interpretational model of enquiry (Sandelowski, 1991: 161-166), seen to be of particular use in an exploratory setting.

The nature of narrative research

Narrative research is complex and wide-ranging, but can be broadly defined as a qualitative research method based on the analysis of socially constructed stories which, significantly, are based on choice and interpretation (Stillar, 1998: 15) and rests on Foucault's position that,

... there are no facts, only interpretations. (Megill, 1985: 223.)

Narrative research is concerned with the story, the portrayal of a series of events in some sort of sequential order, as the object of the research. It is not a psychoanalytical approach, but is interested both in the details of the events and the interpretations placed on those events by the narrators. It aims, in part,

... to see how respondents in interviews impose order on the flow of experience to make sense of events and actions in their lives. The methodological approach examines the informant's story and analyzes how it is put together, the linguistic and cultural resources it draws on, and how it persuades a listener of authenticity. (Riessman, 1993: 2.)

Some theorists argue that the telling of stories has further purposes; Abma, for example, feels that narratives are also used to try to persuade the listener towards a particular position. She says:

People give meaning to chaotic experiences and try to persuade others of their perspectives by telling stories. (Abma, 1998: 821)

This position is supported by Gee's assertion (1985: 11) that:

One of the primary ways – **perhaps the primary way** – human beings make sense of their experience is by casting it in narrative form ... (original emphasis).

The narrative then is the depiction of a sequence of past events as they appear in present time to the narrator, after they have been processed, analysed and constructed into stories. Among other things, they may be justifications for or rationalisations of past behaviour, or explanations or understandings of events constructed for different reasons and purposes.

The narrative method exhibits a number of positive attributes, both for the researcher and for the subject. From the subject's perspective, there is the opportunity to 'tell their story', perhaps for the first time, to a willing and interested listener and, sometimes, to 'set off on their own paths for their own purposes' (Riessman, 1993: 18) or to raise pity or concern (Gergen, 1994: 206-207.) Additionally, telling the story allows the subject the opportunity to exercise a series of choices and to make definitions, both of themselves and of the events that they are describing, and to feel that they are involved in and therefore 'own' part of the research. This is evidenced by the nature of some of the narrative disclosures, for example the common experience of racism, which are often presented in a manner which suggests that if

the narrator shares this information, it will be used for the common good. For the researcher, the advantages include the nature of narrative which is innately cross-disciplinary (Riessman, 1993: 1) permitting simultaneous access to multiple situations. For example, it was common for individual subjects in this project to discuss racism in a variety of different social and professional settings. Thus, the initial attempt to assign individuals to the binary categories of 'health professional' or 'health service user', immediately, became contested. Additionally, the process tends to generate very rich and deep data and its inherent reflexivity enables the researcher to locate himself or herself as part of the process of data origination (Mason, 1996: 108). Narrative research appears to be of particular value in exploratory work for a number of reasons, particularly that not only does it not require any prior knowledge of subjects or issues, as would be required for the production of a schedule for structured or semi-structured interviews, but that it rejects such a need. Some more practical considerations are discussed below.

Shortcomings of the method for the subject appear, at first sight, to be confined to the practical issues of willingness to participate and the availability of time to do so. However, other factors should be considered. When relating their story, subjects are, often to a significant degree, 'exposing' themselves to the researcher. This exposure may be perceived by the subject, and the researcher, in a variety of ways. These range from a perception of feelings of embarrassment to, perhaps the disclosure of some criminal or violent act which they committed or to which they were subject. For example, one narrator gave a harrowing account of her personal experience of racism as an NHS employee, describing her feelings, emotions and actions in detail. Another subject gave an account of the use of illegal drugs. Such exposure may make the subject feel vulnerable to the researcher. Unsurprisingly, there are ethical issues arising from this which are discussed below. In addition, there may be some

disquiet on the part of the narrator who feels that her or his story is being 'taken' by the researcher and is no longer their sole property. It is not clear whether this is perceived negatively or positively by the subject. Discussion with colleagues suggests that the experience of narration can, under some circumstances, be cathartic (Atkinson *et al*, 1993: 443, Zimbardo, 1988: 469), but this suggestion must be viewed with caution, especially since, in this instance, the researcher has no formal psychological training and the process of narrative research in this study has no psychotherapeutic intent.

From the researchers' perspective, and operating on the assumption that access, informed consent and active participation have been successfully negotiated, disadvantages are focused around the difficulty of analysing the narrative, ethical issues and the potential effects of the experience on themselves. For example, one narrator disclosed a history of physical and emotional abuse which she believes was caused by a conflict between her ethnic background and that of her then partner. This disclosure led to moral and ethical dilemmas, for the researcher, as to how to deal with this information in the context of the research as well as in the process of narrative generation.

Narratives are, inevitably, social constructs. Bruner (1981: 11-13) suggests that the process of narrative is, like Foucault's notion of discourse, productive. That is, it invents a world and, perhaps, represents a continuing process of interpretation and reinterpretation. Riessman agrees, stressing that narratives are not natural phenomena in the positivist manner that 'natural science' was once seen as being capable of only one reading, and saying that,

'... interpretation is inevitable because narratives are representations'
(1993: 2).

Further analytical difficulties arise when attempts are made to relate narrative to truth, especially within a Foucauldian theoretical framework (see Chapter 3.1.). Thus, 'truth', in the

context of this narrative research, is not an unchangeable, empirical whole because such a thing does not exist; thus all narrative is interpreted and depends on active choices made by the reader, the writer and other interpreters. In addition, early analysis of the data obtained in this study suggests that narrators reflect on the story at the time they are telling it and make revisions and modifications in the process. It is also felt that some subjects may be seeking the researcher's approval for, or validation of, their past actions. Since narrative separates subjective 'truth' from objective 'fact', it becomes problematical to use the criteria frequently utilised to assess the worth of research, for example, validity, reliability and generalisability, commonly used in quantitative studies (Koch and Harrington 1998: 882-290). Koch (1998: 1183) argues that it is better to rely on the concepts of credibility and dependability. These criteria rely on the transparency of the research design and the self-consistency of the stories in relation to the theoretical perspective's concept of 'truth'. In part, at least, this is necessary because stories are unique social constructs that are impervious to the application of the criteria more commonly associated with quantitative research.

Practical considerations

Researching sensitive issues, such as ethnicity, is often problematic and the gender and ethnicity of the researcher must be considered in relation to the detail of the narrative 'truth' imparted. There is a potential for a narrative to be related differently to different audiences and to be interpreted and received differently. I am conscious that, as a white British male, I am a member of the dominant group in our society (Miller, 1976: 6-8), and bear its implicit values which, inevitably, must influence my interpretation of data. There are additional implications when researching issues with and about people of different ethnicity. However, this is an integral and positive component of this research project's Foucauldian theoretical

framework which emphasises the pivotal position of the researcher as a receiver and interpreter of narratives.

It is interesting that most research reports, and indeed methodology texts, fail to include a discussion of the settings for data collection, even though this may often be a significant factor since there can be little doubt that a person's physical and psychological comfort affect the process of narrative production. Some practical factors are set out below.

As far as possible in this project, meetings have taken place on the narrator's 'home ground' in that the subject has been encouraged to choose the location. This procedure has the particular advantage that the narrator can choose a locale in which they feel safe and, in consequence, feel more at ease and thus more willing to participate in the narrative process. As a practical consideration, with the intent to enhance the subject's feeling of security, the narrators were sent some basic information and contact details at an early stage so that they were able to evaluate and/or verify the identity and legitimacy of the researcher though, in practice, none have done so in any formal sense. Where space permitted, chairs were arranged so that the subject and the researcher were placed in as close proximity as seemed appropriate while endeavouring to avoid any possibility of the appearance of a confrontation. Subjects were always asked to give their permission for the research to be recorded on audiotape and an unobtrusive microphone was used; confidentiality and anonymity were assured. Subjects were invariably advised that the tape-recorder would be switched off at their request and shown how to do this themselves, if they wished. This happened in two sessions, when subjects wished to impart information that they may have felt to be either extremely personal or potentially incriminating.

Research is frequently seen as a one-way process in which information is elicited from the subject and flows to the researcher. In the practice of narrative research, this does not seem to be the case (See for example Oakley, 1981: 30-31), and, in any event, narrative research is not like an interview which is intended to be a,

... conversation between interviewer and respondent with the purpose of eliciting certain information from the respondent (Moser and Kalton, 1971: 271)

The narrative data collection session has no process of question and answer, though some focus is achieved by means of the initial contact and supporting letter and a preliminary discussion of the purpose of the research. Subjects are encouraged to feel safe and comfortable and to talk about whatever they feel is appropriate. With only one exception in twenty-one sessions, subjects have appeared to relax and gain confidence as the process proceeds, and have been willing to share their stories at length and in detail.

Narrative sessions are always allowed to self-terminate. That is, they reach natural endpoints, either for example when the narrator has reached present time in their story, or are terminated at the narrator's wish, something that has occurred on only a few occasions during this study, always because the narrator has other time commitments. A suggestion from research colleagues that the sessions will stop 'because people run out of story to tell', seems not to be the case.

Any face-to-face qualitative data collection requires the development of a relationship between the researcher and the subject. This may range from simple social politeness to something deeper. Clearly, if the subject is to be comfortable, then there is a requirement for friendliness, but not over effusiveness. In narrative research, the relationship must be formed quickly and at the start of the data collection process, since, unlike the process of interview,

there is no continual prompting or questioning. Nor is it normal practice, during narrative collection sessions, for the researcher to make non-lexical signs and sounds since this may affect the production of the narrative.

The process of collecting narrative data, in common with unstructured and semi-structured interviews, seems often to include the subject's perception of the researcher as an 'expert'. It is unexceptional for the researcher's opinion to be sought on issues contained in the narrative, either as part of the subject's process of validation and legitimation of past actions or simply to gain a third-party's advice on future actions. In this project for example, one individual sought the researcher's approval for a course of action in which they had challenged a perceived racist situation in the provision of healthcare and another sought advice on the legitimacy of her foreign marriage under English law. It is difficult, or impossible, not to be affected by these requests but it is vital that no action is taken during the data collection, since this would halt the narrative flow, and no opinion expressed before or afterwards which would suggest that the researcher subscribes to any particular perspective. Discussions of specific issues sometimes take place after the narrative is completed, but these are not recorded and do not form part of the research. It is clear that there are significant dangers in stating opinions when issues are only partially known to the researcher, and it is acknowledged that the researcher has no 'right' or duty to interfere in the subject's life.

There is, however, an additional dimension to the perception of the researcher as an 'expert'. This might, perhaps, be best described as an ethical dilemma centred on the question which might be phrased, 'what am I, the researcher, to do with this information that is the admission or disclosure of some criminal or violent act?' This situation has occurred on a number of occasions in this study, one where a narrator disclosed a history of being subject to physical

and emotional abuse from her partner, and another when a narrator discussed the detailed use of illegal drugs. In both instances, a solution was discovered, with support from colleagues, which did not breach anonymity or confidentiality. However, the importance of setting-up a support network for the researcher in anticipation of this sort of event cannot be overstressed.

The last dimension to be considered is that of the researcher reflecting on the process and content of the research. In this study, this is accomplished by means of a research diary or journal where the researcher's thoughts and feelings about specific events, and the research process as a whole, are recorded. This is seen as a valuable addition to the research methodology (see for example Mason, 1996: 165 or Edwards and Talbot, 1999, 67-69).

Analytical experiences

As mentioned earlier, the ATLAS.ti computer package was used to aid analysis. This type of software is, perhaps, best viewed as an immensely sophisticated tool to arrange and code data that also enables the user to search and sort data and to ask complicated questions. It has a number of advantages which include its non-hierarchical nature, its ability to construct graphical networks and its advanced query tool. It must be emphasised that, notwithstanding its high level of refinement, this software does not replace the intellectual effort required to achieve a meaningful analysis. Additionally, systems for arranging and retrieving data are not value-free and therefore should be utilised with care. Mason notes that:

Cataloguing and indexing systems are not analytically neutral. In other words, in choosing or devising a particular system, you are at the very least making certain assumptions about the kinds of phenomena and units you are cataloguing and the kinds you are not (and indeed what count as data and what do not)... In fact, you are likely to be making a whole series of further assumptions too, the consequence of which will be to open up some analytical possibilities, and to close off others. (1996: 108.)

The analysis of narrative data is intrinsically complicated for the researcher (Mishler, 1984: 67), by the issues of choice and selection, which are almost infinite. Choices are made by all the contributors to the narrative and to the analysis; the storyteller exercises choice when the story is told by making a series of interpretative decisions which affect the narratives relationship to actual happenings. Riessman argues, however, that:

The historical truth of an individual's account is not the primary issue. Narrativization assumes points of view. Facts are products of an interpretative process. (1993: 64.)

Because of the complexity of both narrative data and the analysis process, some argue (see for example Stillar, 1998: 15-18) that the content is always a matter of selection and, because of this, that the analysis is always subjective and interpretational (Riessman, 1993: 17-18). This fits well with the use of a Foucauldian theoretical framework.

Advantages and disadvantages of narrative

Narrative inquiry, when undertaken by skilled researchers, is an extremely effective way of obtaining data. In some circumstances, as has already proved to be the case in this research project, subjects may be willing to tell stories containing highly personal and intimate details which they would not discuss if other methods were used (see for example Langellier and Sullivan, 1998: 77-78). Narrative gives the opportunity to access data which may be unavailable elsewhere; personal experiences and interpretation of such events are rarely documented and may be difficult to access by other qualitative methods (see for example Lieblich, Tuval-Mashiach and Zilber, 1998: Ch. 1). It can enable access to areas previously only investigated by quantitative means and add depth and richness to the data. In this study, subjects have felt able to discuss, among other issues, their experiences of racism, negative experiences with family doctors, issues around their personal identity crises and choices and

to make extremely detailed reports of events in their lives which, potentially, would leave themselves or others open to prosecution. It seems unlikely that interviews would have obtained data of this quality.

Skills required of the researcher include the ability to become and remain unobtrusive and to resist the impulse to interrupt the narrative flow by asking questions at inappropriate moments. To do so may result in the storyteller 'losing their thread' and, in effect, beginning a new narrative rather than continuing along their previous course. In this particular, narrative research differs markedly from such strategies as interviewing where it is common for the discourse to be composed of a question – response loop. This means that it can be difficult when undertaking narrative research to ascertain whether or not terminology and understanding are shared between subject and researcher (see for example Borland 1991: 63-77). The normal 'checking-back' techniques of the unstructured/semi-structured interview are inappropriate because they may damage or halt the flow of the narrative, as discussed above. To stop the production of a particular narrative may mean that a specific story will never be told. This is seen as a critical distinction between unstructured interviews and narrative research.

In this research project, it was thought that the notion of 'mixed ethnicity' had been adequately defined in the research question, though part of the purpose of the research was to develop a fuller understanding of this concept. The pilot interviews however indicated that this was not the case and that the researcher's definition of 'mixed ethnicity' was not shared by any of the subjects; some, for example, wanted to talk about 'race', others about culture, skin colour, language or place of birth. Still others had rejected the concept of 'mixed ethnicity' and made distinct and deliberate choices about membership of specific ethnic

groupings. It is now acknowledged that the concept of 'mixed ethnicity' is disputed and developing and the preliminary analysis has raised the question of whether the notion of mixed ethnicity is useful, or should it be discarded or replaced with a new concept, such as that of 'new ethnicity'? It is important to note that it is the research methodology itself that has highlighted the importance of the contested definition of mixed ethnicity.

It is, obviously, more difficult to complete analysis of narratives where concepts are not shared, though it might be argued that concepts are never, in reality, shared. However, there is an acceptance that individual self-definition, even when this results in a plurality of meanings, is both appropriate and useful, demonstrating the diversity of the issues under investigation.

A further issue, discussed above, concerns whether or not the subject has been 'truthful' in their account. Early analysis of some narratives suggests that they are not entirely self-consistent, a common measure of factual accuracy; one subject in particular told a series of stories which were mutually inconsistent and that contained factual errors. The concept of 'truth', as it is used in this analysis, is only tangentially related to the ideas of factual accuracy. The important issue may not be the 'truth' of the stories, but may be centred on the question of why the subject chose to tell them in this way.

Reflections on the narrative method

This section is concerned with findings about the use of this specific methodology, rather than the content of the narratives, which is discussed later. A number of issues arise, which are considered in order.

Narrative size

The literature (for example Lieblich *et al*, 1998: Ch. 1), and experience within this study, suggest that narratives can have a wide range, a term which is intended to encompass length, but also to include a notion of breadth, in terms of the richness and variety of data obtained. This has proved to be the case in this study, with some sessions lasting in excess of two hours. Resulting practical difficulties are that the narrative is long and the transcription extremely time consuming. The problems of choice in analysis increase almost exponentially with the length of the narrative. There is, of course, an attendant potential advantage; the wider the range of the narrative, the more information likely to be imparted.

Irrelevant content

Some of the narratives generated for this study initially appeared to possess only limited relevance to the research topic, despite subjects being aware of the issues under investigation. In the case of this exploratory research, this is seen as a positive feature because it has uncovered issues which had not been considered when the original research questions were framed.

Unexpected findings

Some narratives present unexpected information. Again, this is seen to be a positive feature in the same way as the notion of irrelevant content. In this research, the pilot data collection sessions produced unexpected findings around the concept of medical power and the suppression of discourse, which guided the later stages of inquiry.

The process of analysis

The analysis of the narratives, discussed in more detail below, is like that of the pilot interviews, a combination of enumerative, investigative and iterative/narrative modes. It is

inappropriate to assume that a story is simply linear and mono-dimensional and the analyst should attempt the most comprehensive analysis possible (Rose and Webb, 1998: 559). There is, therefore, a need for the analysis to be systematic and comprehensive so that all subjects are included and analysed using the same procedures in order to ensure that the results are accessible to other researchers. At the same time, the analysis procedure remains dynamic, so that it can develop over time while retaining the ability to permit easy retrieval of data.

The initial stages of analysis, as previously described, are: immersion, coding and indexing and thematic summary. In the case of immersion, as the data is transcribed and assimilated, it becomes increasingly familiar. However, it is difficult, even with a small number of transcribed narratives, to retain anything other than basic concepts. Because of this, the transcriptions were entered into ATLAS_ti as 'primary documents' and analysed in the simplest way by the calculation of word frequencies. This information was then summarised and used to indicate themes emerging from the data. Subsequent, more detailed, study leads to greater immersion and familiarity with content, aiding deeper analysis.

The computer-aided coding/indexing in this study was undertaken within a structure called an hermeneutic unit, that is, a data structure that allows all the documents relating to one project to be treated as a single entity. The software allows the user to code relevant data, crucially without changing the original document. The coded document can be viewed on screen or printed. ATLAS_ti is seen as a significant improvement on older software, such as QSR Nud*ist or Ethnograph, because it allows documents to remain external to the analysis, does not restrict the size of quotations and allows the creation of non-hierarchical networks to aid analysis. A justification of the data coding strategy is discussed below.

The thematic summary has identified a number of potentially important issues including the contested definition of mixed ethnicity, identity and mixed ethnicity, mixed ethnicity and health, medical power and discourse suppression and racism. Clearly, there are issues concerning the selection of specific words as potentially meaningful and a need for the analyst to make choices. To a large extent, these choices are predicated on the theoretical framework which suggests that medical power is responsible for the suppression of discourse in the articulation of health care needs. The subsequent stages of analysis are more complex and time consuming. Specific data are extracted from the transcripts and linked into a series of networks which are used to illuminate, explain and evaluate the issues within the theoretical framework.

Issues arising

This project demonstrates that narrative is a useful and flexible tool for exploratory research, particularly when the issues under investigation are sensitive. However, the already convoluted process of analysis is further complicated by the ubiquitous issue of choice and the acknowledged nature of narrative as a social construct. For some, there are further complications and concerns around the issue of 'truth', but for this research, Foucault's notion of the absence of fact or the multiple nature of truth is adopted and it is seen as more important to try to assess why people tell their stories and truths in different or dissimilar ways.

It is, perhaps, more interesting to reflect on the way in which the decision to use narrative research affected not only the manner in which the project was conducted, but also the nature of the issues to be researched. In this instance, this guiding effect has been particularly useful in steering the exploration and definition of the issues under investigation.

It would not be correct to assert that narrative is a simple method of research or that it is suitable for all qualitative studies. However, in respect of this research, it is felt that narrative has been a useful and helpful choice of methodology that has illuminated difficult issues and guided the nature of the later phases of enquiry.

3.4. The coding and analysis strategy

This chapter sets out the analysis strategy for the research project. It examines the nature of the analysis methodology in relation to the collected data and associates this with the selected Foucauldian theoretical framework, noting the similarities and differences between epistemes and analysis codes. The section then examines the purpose of coding, the requirements of a coding stratagem and some practical considerations thereof. In this regard, it is particularly important to be aware that analysis is not a discrete process, rather it is something that takes place throughout the project. Coffey and Atkinson (1996: 10-11) say that,

... [analysis] is a pervasive activity throughout the life of the research project. Analysis is not simply one of the later stages of research, to be followed by an equally separate phase of 'writing up the results'.

Analysis is necessary in order to understand what has been said, to relate it to context and theoretical perspectives and to establish whether this process provides a robust and rigorous answer to the research questions.

Analysis method

The analysis method involves 4 phases, which have been briefly referred to above:

Immersion: A two-stage process whereby the data is reviewed by means of macro/microanalysis. In the first stage, the data are transcribed and then examined as a whole and summarised, seeking recurring or common themes; this procedure is, in part, undertaken by means of ATLAS.ti software. In the second stage, the data are examined line-by-line seeking detailed support for the themes identified in stage one. Short summaries of each story are then prepared to provide an accessible reminder of content. These processes enable the analyst to get a 'feel' for the data, leading to an understanding of the issues that are important to the narrators.

Coding: The process by which specific data are identified as significant or ‘interesting’ and then marked so that they can be located for further analysis. For a more complete discussion of the coding procedure, see below.

Thematic summary: The grouping of data and their codes into themes or ‘families’ as they emerge from the coding process.

Analysis: A process by which the data are described, interpreted and explained.

The nature of the data collection

The results of narrative data collection differ markedly from the product of other qualitative data collection methodologies such as structured interviews. Narratives (stories) have a number of characteristics which impact on both the nature of the collected data and the design of the analysis process. In particular, the following points are significant:

Story size: If all the collected data is to be available for analysis, narrations must be transcribed verbatim. In this project, the data collection has resulted in the gathering of more than 80,000 words of narrative transcript. Individual stories have ranged from just over 1,000 to more than 10,000 words in length.

Tangential content and unexpected findings: Though the production and recording of narrative can be seen as an interaction between the narrator and the observer, this is not entirely the case. The researcher provides a stimulus for the start of the story by focussing the narrator on the topic under investigation, in this case the notions of health and mixed ethnicity. The researcher does this in two stages, the first by formal letter when the narrator is invited to participate and the second verbally at the beginning of the data recording session. However, once the narration commences, the narrator rather than the researcher is in control

of the narrative production and any input, especially verbal input, may provide a significant distraction and, thus, terminate the present story and initiate a new one.

There is always the possibility that a narrative, though supposedly focussed on the research topic, will deviate markedly from the main issues under investigation. This is not necessarily a negative experience: this process has illuminated issues which had not been considered when the research was planned, in part because early narratives in this project repeatedly produced unexpected themes which have influenced subsequent inquiries and analysis. In particular, the pilot interviews suggested that narrators were more interested in the power relationship of the doctor/mixed-ethnicity patient interaction than in any direct physical relationship between mixed ethnicity and health.

Social Construction and the ‘Truth versus Fact’ dichotomy: It is acknowledged that narratives are social constructions rather than the simple reporting of ‘facts’. They are, however, subjectively truthful. The multiple nature of ‘truth’ is discussed in the chapter on the theoretical perspective.

The issue of choice: The production of narrative is the result of the narrator exercising a series of choices (first level choices) and interpretations. Narrators produce their truth by making a series of choices which can be influenced by many factors, for example whether the narrator trusts the researcher and believes that the promised anonymity really exists. The narrator may decide to make definitions to serve their own ends and/or to promote their own agenda, for example, one individual chose to narrate a history of the parent support group which they co-ordinated, possibly in the belief that the researcher would be willing to participate. Another subject disclosed a very personal history of physical and psychological abuse. It may also be that narrators select particular events on which to base their stories in

the belief that they may be interesting to the researcher or provide an opportunity for the narrator to 'make a point' concerning how she or he feels they have been treated. This behaviour is discussed in the next chapter.

Inevitably, the choices exercised impinge on the relationship between the narrative and actual happenings. In addition, the analyst will then exercise similar choices (second level choices) in selecting data for analysis; these subsequent selections having similar impact to the first level choices exercised by the narrator. For the purposes of this research, objective fact is not important; individual perceptions and recollections are perceived as being of greater significance.

The purpose of coding

The coding of research data consists of two main forms; one used for quantitative data and the other for qualitative. In quantitative analysis, coding is a purely mechanistic and entirely static process (see for example, Moser and Kalton, 1971: Ch. 16) whereby verbal or numeric answers are reduced to simple codes so that responses can be measured in the form of 'how many?'. .

Coding in qualitative analysis is more complex and performs a different role. Strauss and Corbyn properly regard coding as a dynamic, rather than a static, process and suggest that, reduced to basics, it is intended to be:

The analytic process through which concepts are identified and their properties and dimensions are discovered in the data. (Strauss and Corbyn, 1998: 101.)

Qualitative coding fulfils a number of functions. These include:

- Discovering and identifying themes, patterns, and categories in the data. Marking apparent connections and relationships between events and/or concepts and theories.
- Describing and quantifying events. Noting the scope and intensity of events.
- Building an understanding of phenomena.
- Marking connections between events, concepts and theories.
- Making comparisons and contrasts.
- Building a 'logical chain of evidence' (Denzin and Lincoln, 1998: 187).
- Developing themes or 'families' of codes to enable analysis from different perspectives.
- Coding acts so as to freeze particular events/issues/stories/etc., at the time they are coded.

Some commentators, notably Glaser and Strauss (1967) and Strauss and Corbin (1998) maintain that theory can emerge from the process of coding. However, it is not clear that this is the case. In fact, if coding is taking place within a theoretical framework, as it must, whether the framework is explicitly acknowledged, implied or unacknowledged, then this premise is flawed. Glaser himself (1992) bitterly refuted Strauss's use of the process, though maintaining that it was a useful and practical research tool. This research project supports this countervailing view and maintains that theory must underpin the research from the beginning if the end result is to be self-consistent. Indeed, it is contended that theory is always present in research and analysis, even if it is not acknowledged. These concepts link closely to Foucauldian ideas of discourse both as a productive and as a restrictive notion.

The coding strategy

The primary requirement of a coding strategy is that it is systematic and theoretically based. If bias is to be avoided, all data must be selected and treated, as far as is possible, in an identical manner. Choices exercised by the analyst must be recorded, justified and repeatable so that all data are identified and selected by the application of the same criteria.

Burns suggests that the process consists of:

1. Develop a list of coding categories.
2. Code.
3. Collect data for each code & analyse. (Burns, 2000: 435)

Burns uses 'collect' not in the sense of gathering new data to fit the codes, but rather the extraction of data from that already collected. The coding strategy utilised for this project is based on Burns' process but includes some of the practical procedures, rather than the theoretical intent, of Glaser and Strauss (1967), and is, in part, the result of the structure of the computer software being used to aid analysis, ATLAS.ti.

The initial selection of themes

The process of coding results from stage one of the analysis method (discussed above), immersion. The word-counting facilities of the software are utilised to list frequently used words, which are grouped into issue areas that form the basis of the coding list. The list is divided into two categories (see Appendix 2), which may be described as event codes and concept/theory codes. Event codes can be seen as subjective/descriptive and are internal (describing) controls. Concept/theory codes are seen as external (defining) controls. Internal controls are those which the narrator imposes to produce the story; thus, they may assert that specific events are examples of racist behaviour. External controls are imposed by the researcher. They could, for example, define a specific example of behaviour, seen by the

narrator as discrimination, as racist. They attempt to create theoretical linkages and explanations from narrators' descriptions.

In order to perform the word frequency count, it was necessary to prepare a composite document containing all the transcripts from the narrations which was then subject to ATLA's 'wordcrunch' set to produce results in a table of declining frequency of word use. However, this is not simply a mechanistic process; the researcher has to make a series of decisions as to what should be included and why. This process is, inevitably, one of evaluation and interpretation in which second level choices will be exercised and the meaning of individual words assessed.

- The number of different words used by narrators exceeds 5,000, and many of these words are utilised once only. In order that the task could be accomplished within a reasonable time, the following selection criteria were used:
- Conjunctions, pronouns, prepositions and some adjectives relating to dimension (for example, very, really, etc.), are ignored.
- Personal proper nouns are ignored.
- Words used less than 8 times are ignored, though this is an arbitrary pragmatic decision, unless they are variants of or synonyms for words which would otherwise be included. Different and plural forms of the same noun and associated adjective are consolidated (for example, 'America', 'American' and 'Americans' are rendered as 'American' and 'doctor', 'consultant', 'GP' and 'surgeon' are rendered as 'doctor', unless there is some compelling reason why this should not be so, as for example in the case of 'black' and 'blacks'). This process is not applied to similar verb/noun forms (for example, 'abuse' and 'abused' are rendered separately). Again, this is confirmation that the process of theme selection involves cerebral as well as mechanistic processes.
- From the remainder, words were grouped on the basis of the themes of the research.

It is not intended that the thematic classifications should be exclusive; in fact, the opposite is the case. It is acknowledged that words may fit into multiple thematic categories.

The results of the initial selection process

The initial process of word counting, consolidation and thematic grouping resulted in three categories; ethnicity and identity, health and health care, and power relations, categories that are very similar to those defined in the pilot interviews. These categories reflected the issues perceived during the collection of the data, a confirmation of their appropriateness. These categories were selected because they appear to have the potential to provide substantive answers to the research questions.

These three groupings informed the initial selection of analysis codes, though the codes were not exclusive to categories. The codes are designed to perform two functions.

1. To mark the data to show occurrences of internal (describing) controls.
2. To question the data with regard to the instances of external (defining) controls

The practical coding process

All of the stories have been transcribed verbatim and the word-processed files allocated 'primary document' references in the ATLAS.ti qualitative analysis program. The data has been coded for analysis using the codes referred to above.

Analysis

The actual process of analysis takes place throughout the research project rather than as a separate, freestanding phase of the undertaking (see, for example, Coffey and Atkinson, 1996:

10-11 or Mason, 1996: Ch. 7). It consists of a number of different approaches and techniques including:

- Describing and comparing narrators' experiences.
- Interpreting the data so as to trace the development of the phenomena of discourse suppression.
- Explaining how the phenomena operate in society in relation to the chosen theoretical framework.

Coding and the theoretical perspective

For a full discussion of the theoretical perspective, see Chapter 4.1. Foucault perceives truth as multi-faceted and but loosely related to objective fact (see for example Kendall and Wickham, 1999: Part I or Prior, 1997: 63-79) noting that the phenomenon he describes as the 'gaze' (Foucault, 1973: 39), which can be interpreted as the analytical process, rather than being subject to or dedicated to truth actually seeks to exercise control over it.

Foucault, in his earlier work, describes a mechanism or system of codes which define the way in which individuals understand their world, and therefore the manner in which they act. He referred to these codes as *epistemes*, which he said placed limits on the content of individuals' world-views and control the production of discourse and the concept of truth. These epistemes have a significant parallel in the process of analytical coding because they are part of the development of discourse (see below). Bevir (1999), suggests that they are important, noting that:

... they themselves construct both the world we study and the concept of rationality that we adopt. The way we perceive the world and the way we classify things depend on the codes that govern our thinking. (Bevir, 1999: 346.)

A shared role of epistemes and analysis codes is to set and fix the rules by which a concept is understood at the specific time that the episteme or analysis code is created. Because of this

snapshot effect, analysis codes and epistemes do not develop incrementally but must change by means of a discontinuity (for a full discussion of the concept of discontinuity see Appadurai (1996).

There are, however, differences between epistemes and analysis codes. The most significant is that the process of analysis coding, as far as possible, must be entirely conscious and continually challenged: analysis codes are not inherently legitimate and this should never be assumed. Foucauldian epistemes are taken for granted and never questioned (Bevir 1999: 346). However, codes may be as inflexible as epistemes because they impose a specific interpretation on events and represent the second level choices made by the researcher.

This section has described and explained the dynamic analysis methodology for this project, noting that analysis must necessarily take place at all stages and refuting the idea that it is a discrete process that can stand alone. The nature of narrative data has been discussed, observing that the unusual configuration of this research data has a unique structure that impinges on the analysis. It is contended that the nature of the data and the collection methodology influences the method of analysis and requires it to be extraordinarily flexible; it is for this reason that the theoretical framework for the analysis is based upon the interpretivist, postmodern, post-structuralist theories of Foucault, paying particular attention to the perceived difference between subjective truth and objective fact and noting the parallels and differences between epistemes and analysis codes.

The need for coding data has been examined and the requirements of a repeatable and replicable systematic coding strategy set out, emphasising that the criteria normally applied to quantitative research are inappropriate for a qualitative project. The results of this preliminary

process are discussed and tabulated where appropriate so as to clarify and justify the selection criteria used and highlighting the need to treat all data in an exactly similar manner.

4. THE ANALYSIS

4.1. The narrators

In order to preserve anonymity and confidentiality, all names and some minor details have been changed.

- Aminah** Is 46. She is a mixed ethnicity female from Sandwell. She is a registered nurse, has a masters degree and is employed full-time by the NHS, in a non-clinical post. Her country of origin is Jamaica.
- Andrea** Is a 40-year-old white female from Sandwell. She has a research degree and professional qualifications and is a full-time GP. Her country of birth is England.
- Anna** Is 46 years old, female and of mixed ethnicity. She comes from Sandwell. She has a nursing qualification and is employed full-time by the NHS in a non-clinical capacity. Her country of birth is Jamaica.
- Claire** Is female, 19 years old and of mixed ethnicity. She is a full-time undergraduate student and was born in England.
- Eve** Is a 22-year-old mixed ethnicity female from Birmingham. She is educated to Masters level and is a student. She was born in Canada.
- George** is a 51-year-old white male from Sandwell. He has an undergraduate degree and professional qualifications. He is a full-time GP and was born in England.

- Heather** Is a black, 29-year-old female from Sandwell. She has an undergraduate degree and a professional qualification and is employed full-time in a clinical capacity by the NHS. She has a mixed ethnicity child, and was born in England.
- Jane** Is a white, 35-year-old female from Oxford. She has an undergraduate degree and is employed part-time. Her country of birth is the United Kingdom. She has a mixed ethnicity son.
- Janet** Is a 22-year-old mixed ethnicity female from South Birmingham. She has no educational qualifications and is unemployed. Her country of birth is the United Kingdom.
- Jason** Is a 38-year-old mixed ethnicity male from Wolverhampton. He has a professional qualification and a full-time job. He was born in UK and has mixed ethnicity children.
- Jayita** Is a 29-year-old female from North Birmingham who identifies her ethnicity as 'mixed'. She has a Masters degree and is employed full time. She was born in Pakistan.
- Kamal** is 47 years old, male and of mixed ethnicity form South Birmingham. He has a research degree and professional qualifications. He is a full-time GP and was born in Pakistan.
- Lynne** Is a mixed ethnicity female, aged 33, from Wolverhampton. She has no educational qualifications and is employed full-time. She was born in England.

- Manjit** Is a 31-year-old mixed ethnicity male from the Midlands. He has an undergraduate degree and a nursing qualification and is employed in that capacity by the NHS on a full-time basis. He comes from England and has a mixed ethnicity child.
- Martha** Is a 45-year-old mixed ethnicity female from West Birmingham. She has a professional qualification and is employed by the NHS in a full-time clinical job.
- Mary** Is white, female and 26 years old. She comes from Sandwell and has a Masters degree and a professional qualification and is employed in a clinical position in the NHS. She was born in Ireland and has a mixed ethnicity child.
- Renuka** Is aged 44, female and defines her ethnicity as 'mixed'. She has no educational qualifications, but is employed full-time. She was born in Pakistan.
- Sarah** Is 33 years old, white and female. She has a Masters degree and a professional qualification and is employed full-time by the NHS in a clinical post. She was born in UK and has a mixed ethnicity child.
- Shishir** Is 31, male and of mixed ethnicity. He comes from Birmingham and has an undergraduate degree and professional qualifications. He is a full-time GP and was born in the UK.

Stephanie

Is a 31-year-old white female from Sandwell. She has an undergraduate degree and is employed full time in the NHS in a clinical post. She is in a mixed ethnic relationship and has children. She originates in Scotland.

Table: 4.1.1. – Subject Details

No.	NAME	GENDER	AGE	ETHNIC CODE	COUNTRY OF BIRTH	EDUCATION	JOB TYPE	LOCATION
1	Janet	F	22	M	UK	NQ	U	S. Birmingham
2	Eve	F	22	M	Canada	M	S	Birmingham
3	Jayita	F	29	M	Pakistan	M	F	N. Birmingham
4	Janet	F	35	W	UK	D	P	Oxford
5	Aminah	F	46	M	Jamaica	M	F	Sandwell
6	Anna	F	36	M	Jamaica	D	F	Sandwell
7	Renuka	F	44	M	Pakistan	NQ	F	West Bromwich
8	Stephanie	F	31	W	UK	D/P	F	Sandwell
9	Heather	F	29	B	UK	D/P	F	Sandwell
10	Mary	F	26	W	UK	M/P	F	Sandwell
11	Lynne	F	33	M	UK	NQ	F	Wolverhampton
12	Manjit	M	31	M	UK	D/P	F	Midlands
13	Sarah	F	33	W	UK	M/P	F	Midlands
14	Martha	F	45	M	Malaya	P	F	W. Birmingham
15	Jason	M	38	M	UK	P	F	Wolverhampton
16	Shishir	M	31	M	UK	D/P	F	Birmingham
17	Andrea	F	40	W	UK	R	P	Sandwell
18	George	M	51	W	UK	D/P	F	Sandwell
19	Kamal	M	47	M	Pakistan	R	F	S. Birmingham
20	Claire	F	19	M	UK	D	S	C. Birmingham

Ethnicity Codes

B = black

W = white

M = mixed

Job Codes

U = none

F = full time

P = part time

S = Student

Education Codes

NQ = no qualifications

D = degree

M = masters degree

R = MD/PhD

P = professional qualification

Data Summary

Males = 5

Females = 15

Mean age = 34.4

Age range = 32

Ethnic M = 13

Ethnic W = 6

Ethnic B = 1

4.2. Classifying the stories: reasons and themes

People have many reasons for telling their stories. This chapter looks at those stories by classifying them according to the reasons why people tell them and the themes that emerge. The reasons and themes are chosen (second level choices) by the researcher/analyst and it is inevitable that these choices are subjective, though informed by the theoretical framework. That the choices are subjective is not a negative feature of the analysis since it is faithful to the Foucauldian perception of multiple truth and interpretation. At the same time, this process of choice confirms that a binary power structure is in operation. That is, at this point in the analysis process, the narrators no longer have control of their stories; they can no longer exercise their (first level) choices, nor are they able to withdraw their stories from the research process. Though this chapter fragments the stories themselves, by emphasising specific content, the process of narrative research within a Foucauldian theoretical framework ensures that, not only is the integrity of the story maintained, but there is no sense of judging or assessing the 'facts' of the narration since, as discussed earlier, the relationship between 'truth' and 'fact' is of little relevance. The wholeness of the stories is emphasised by this process of analytical fragmentation, since it is fundamental to the understanding of characteristics, content and context which will indicate the presence or absence of similar discursive formations. This is an important phase in the construction of the metanarrative analysis in the subsequent chapter.

Reasons

Narratives can be classified according to the reasons why they are told or the intent of the telling. Assessment of these reasons is a second level choice made by the researcher/analyst but, in this instance, has been checked-back with 3 of the narrators, selected on an

opportunistic basis, by means of brief telephone conversations. Narratives do not necessarily fall solely into one of the types listed below; it is common for narratives to combine reasons either concurrently or consecutively. The stories from this research fall into the following classifications.

Why do I want to tell my story? because...

... you asked me to.

It was apparent from the responses to the requests for research subjects that people complied for a number of reasons. These seemed to include the desire to please the researcher or out of respect for the previous 'layer' of the snowball sample, that is, the person who had introduced the individual to the research. These sorts of reason are common in many forms of social and commercial research and it is not unusual for 'market researchers' to achieve high levels of compliance without the need for a direct incentive. However, this research project indicates that there is at least one other important factor, that of being invited to tell a story. Comment on this phenomenon was frequent and one narrator said:

I've never had anybody like you to listen to me before; it's interesting to have a captive audience! (Manjit: 47.)

Clearly, narrators welcome the opportunity to tell their stories to an attentive audience and, to some extent at least, this explains why people were willing to participate in this research.

... no-one else has listened to me/This is the only chance I've had.

Many people never have an opportunity to tell their stories. This may be for myriad reasons; individuals lead busy lives and may not have time to tell stories or there may be no audience to listen. Some people record their lives in diaries and journals, but this is a different process, uses other skills and has a different feel to the dynamic process of narration. It may be that

some are discouraged from narration because they feel that their audience may be critical or judgemental or, simply, that the audience may disagree or challenge factual evidence. Other issues may be present too, for example, a narrator may feel that the disclosure of personal history may render them vulnerable or even, conceivably, liable to prosecution. However, the narrative data collection process empowers the narrator and encourages them to tell their story in a safe environment, free from challenge or judgement.

... I want people to understand/I want to justify what I did/ I want the world to know what has happened to me and this may be the only chance I get.

This reason follows-on from the first. Several narrators took the opportunity to tell stories of very personal experiences and the actions that they had taken. For example, several narrators disclosed illegal behaviour (cannabis use, shoplifting, abusive behaviour). It is unlikely that they would be willing to disclose these behaviours in a setting where they did not feel safe. Individuals may feel safe to make such disclosure in other confidential interview settings, but it is one of narrative research's strengths that they can choose to do so, without the choice arising from prompting questions, as is the case in many other qualitative research methods.

... I want to defend or seek approval of or support for what I did/ I want your sympathy or pity/I want to persuade you to accept my perspective.

This reason follows from the second and is closely linked to it. Because narrative data collection sessions do not permit the 'checking-back' processes common in other qualitative research methods, the researcher can never be certain that the received meaning, that is, the researcher's perception, is the same as the narrators. Nevertheless, narrators seek approval or support for their actions in their narrations. For example, one narrator talked at length about his personal use of cannabis and how this process led to his becoming both an 'expert' cannabis user and a 'teacher' to the next generation of mixed-ethnicity cannabis users. His

explanation and justification of this behaviour was that it is a parallel process to the introduction of alcohol use to white youths. He said:

... it's [cannabis] being sourced in a social way. Do you understand what I mean? What I mean is, think back to how did you get introduced to booze? ... what usually happens is that your peers informally educate you in how to drink. There would have been somebody there to drag you home. In the same way, that's how cannabis is taught [to mixed ethnicity people]. (Jason: 274.)

Other narrators spoke about how they had reacted to racist behaviour, either towards themselves or towards their children. This classification implies a more proactive narration, containing more questions and statements of position than are found in the simpler narratives.

... I have a particular point to make, and this is my chance.

This is a less common occurrence and, in this project, has been mainly concerned with narrators wanting to speak about their concepts of mixed ethnicity. For example, one person who exhibited a particular interest in the economic position of people of mixed ethnicity, said:

... what people are missing is that, there is, actually, a class structure developing in the black and the mixed race community. I think that mixed people should try to fit into the black groups, that's where they belong and that's really important if we're to have our own power and finance structures. (Jason: 188.)

Other narrators spoke, in detail, of the need for people of mixed ethnicity to make choices and the strategies that could assist them.

... I want to work through what has happened in my life so that I understand.

Some narrators appear to want to discuss particular events in their lives for their own purposes, not for the intention of getting support, help or even understanding from the researcher. Rather this process seems to be about rendering their own experiences understandable. Several narrators told stories about specific events that had been important in

constructing their world-views. It seems likely that, with one exception, the stories are unrehearsed and form part of the narrators' process of understanding.

Several narrators told how they had come to understand their identity as people of mixed ethnicity. One narrator related how she had managed to come to terms with being 'gay and mixed-race', others spoke of difficult periods in their recent histories. There is evidence in the narrative transcripts that narrators are 'working through' this process as part of the development of the story and as part of their own process of understanding. This can be inferred from pauses, location of the story in place and time by reference to outside events, alteration of detail, self-questioning and self-checking being undertaken by the narrators during the narration. For example, one story included a section where the narrator used the story to make sense of her personal history. She said:

... because one of us had to convert to the other religion, to get married because the Sikhs wouldn't accept me because I was a Muslim. The Muslims wouldn't accept my husband because he was a Sikh, so what he did was, well, he said to me would I convert my religion to Sikhism, and I said no, I have always been a good Muslim and I've been brought up religiously. Because he was born in this country, my husband, err, he didn't know much about his own his own people so he suggested that he should convert to becoming a Muslim. So, he converted himself to a Muslim and then we got married, through the Muslim law. The funny thing was I didn't even get married the English way as well, you with me? It's very, very complicated. Unfortunately, my husband passed away last year, umm, well, we gave him a burial and everything, because he was a Muslim. (Renuka: 34-47.)

... I think you [the researcher] are an expert and I want your help/I want to please you.

It was a common experience during the narrative sessions for the narrators to seek the researcher's help or advice. One narrator wanted to know if her child should accept an opportunity to be an advertising model, another sought assistance because her Muslim marriage was not recognised by English law. She said:

... according to them, I'm just a common-law wife, for the 20 years I was married to him. So I didn't get no widow's pension, no nothing. (Renuka: 50.)

The narrator then asked what I, the researcher, thought she should do about the situation.

Other narrators said:

... it's only because ... you showed me respect and who you are that I talk about being mixed. Normally I'd put 'Black African'. (Janet: 79-80.)

Some narrators apparently wanted to please the researcher. One stated:

Well, it's because I am conscious that this is a research interview and I wanted to use language that you would find appropriate. (Heather: 16.)

... I [the narrator] am an expert; you should listen to me.

Advice and instruction is a frequent component in the narratives. The comments range widely,

but some examples are given below:

I wouldn't recommend anybody to do it [marry into a different ethnic group]. And I would say, if you do do it, speak to somebody that's done it before, because when the crunch comes, like it came when my daughter was born, they can't help but fall right back into the way that they've been brought up and trained. (Mary: 193.)

I set up the group [a mixed ethnicity support organisation] I suppose about five years ago, six years ago, because at the time I was, sort of, felt quite isolated myself, I seemed to be the only one who was actually celebrating my son's black heritage. (Jane: 13.)

Another narrator explained that she had written a manual for practitioners working with black children of mixed parentage and recommended that it should be purchased as a resource for this research.

Themes

Four major themes have emerged from the research. These are:

- Mixed ethnicity.
- Mixed ethnicity and identity.
(Sub theme) Being told you could be white
- Mixed ethnicity and health.
- Medical power and discourse suppression.
(Sub theme) The collection of 'ethnic' statistics
(Sub theme) Racism/racist behaviour
(Sub theme) Policy & experiences.

These themes are complex and contested and arise in the narratives from different people for different reasons. They are discussed below and illustrated with extracts from the narratives.

Mixed ethnicity

That all definitions are social constructs is no longer a matter for debate; the definition of 'mixed ethnicity' is no exception. The content of the narratives shows that the concept of mixed ethnicity is complex and contested, and suggests that there is no definition which would be acceptable to all. This is further complicated because although the membership of ethnic groups is, in part at least, a matter of individual choice, those choices are 'invisible' and will not be seen by hypothetical outside observers. This results in the observer making his or her own judgement of an individual's ethnicity, frequently based on skin colour. For example, narrators said:

People are funny, you know. When we were on holiday ... we met up with this guy on timeshare, and he said to me, gosh! How long have you been here? And I said 4 days and he said Wow! Where did you get that tan? ... I didn't know if he was being, you know, thick or what. (Lynne: 37.)

I mean, maybe I'm jealous because people don't try to get me to join black organisations. (Claire: 407.)

... people they look at this (displays hand) and they see it's black – they're not going to see mixed – they see black. ... so that's the part I stand behind, is black. (Janet: 47-48.)

... I've been Greek, I've been Italian, I've been, like, Israeli, I've been everything! I mean this is coming from people who actually are those ethnic groups, as well. So I know that people don't look at me and see me like that. And even when they know that I am half-Asian, they don't seem to quite take it in the same way as they would if I looked it. (Claire: 226.)

Mixed ethnicity? Is that like mixed-race? What we used to call half-caste? (Jason: 154.)

In school I would be attacked, physically and verbally by men because I would refuse to speak Arabic. I couldn't speak it. Then I would be attacked by the white groups because I was black. (Eve: 106.)

I think people are comfortable, you know, with well I think he looks Asian so we'll tick him as Asian, so they may well look at my son and say, well you know, he looks a bit light for Asian, but you know, he's got to be Asian hasn't he, you know, he's got to be Asian, so they'll tick that or maybe they'll think he's just been on holiday, you know, because he speaks perfectly good English we'll stick him in the white box. (Sarah: 418.)

The individual definitions of mixed ethnicity made in the narratives are based on a number of different criteria. These include:

- Links to appearance and perceptions, usually based on skin colour, but including other issues, such as accent. These definitions are made by people of mixed ethnicity and other observers.

And people say to me you know, my friend came to see you, but she wasn't sure it was you. And I say, how did you describe me and they say the brown one or the dark one. I am the dark one. (Martha: 226-227.)

... they were absolutely amazed to hear my response, because my voice did not sound like a Pakistani. (Martha: 80-81.)

- Definitions are made by people of mixed ethnicity based on links to parents, ancestry, family names, family structures, inherited characteristics, maternal identity and multiple cultures.

So I feel I'm really a mixture of different cultures. (Eve: 64.)

I am a woman of many nations. (Martha: 7.)

I think having parents who have such different backgrounds has given me an insight into different sorts of cultures. (Claire: 19-20.)

- Links to feelings and beliefs, for example that mixed ethnicity is a burden or a blessing, about adopting a country, fitting-in, being accepted or feeling like a guest or of feeling that 'there's no-one like me'. These definitions are usually made by people of mixed ethnicity.

I would describe my ethnicity as a collection of values, both cultural and religious; national as in my place of origin, OK, because although I am an Afro-Caribbean? According to one set of parameters, am I really an Afro-Caribbean? I could ask so many different questions. I've heard someone class myself as Afro-Caribbean, the reason being there are some extremists, I don't want to label them, that are reading the Weekly Gleaner, the letters page, where I've got nationalists, they say that we are Africans, not Jamaicans. (Anna: 323-331.)

- There is evidence, too, that individuals see mixed ethnicity in ways that, because of distance and ignorance, are indistinguishable by others. Narrators said:

... my mother comes from Antigua and my dad comes from St Kitts - that doesn't sound very different when you're here, but it's a big difference when you're in the West Indies. (Heather: 19-22.)

... my husband is from St Kitts and I'm from Jamaica. And to be quite honest with you he might as well be from, you know, Timbuktu in Africa. They're completely different cultures. (Aminah: 293-296.)

- Decisions made by others can be important, for example: racist behaviour, assumptions about individual's behaviour based on negative stereotypes or assumptions based on family names, one narrator said,

I've noticed that if I go up and give my name, people are expecting a name that does not sound like [mine]. And then I have to spell [my name] to them. Yes. It's very common, they look at me and they don't expect a name like [mine]. (Martha: 83-85.)

Obviously, they just make a judgement on how somebody looks when they walk through the door. What they'll be expecting when I change my name to [a 'typical' Sikh name], I don't know! (Sarah: 263-264.)

Others may also label mixed ethnic people, for example, narrators report:

They've called my son a half-breed, you know? They say he's got an Asian father but his mother's white. (Manjit: 300-302.)

It's like what I was saying earlier about what you call half-castes. It just doesn't matter to me. Because it's not, it's not the label it's the meaning behind the label. (Jason: 153-156.)

Nor is this phenomenon confined to white people as the labellers:

I'm a problem because the whites call me black and the blacks say we don't know which side you're on, so what do you know about it? And then you find that the child will take sides and they'll go where they are accepted. (Anna: 857-860.)

Official labels are made for many reasons and are ubiquitous. They are often problematic for people of mixed ethnicity who feel that they do not fit comfortably in a category such as 'Black British', for example:

I still find it hard when I have to describe myself for official forms or whatever, I choose the 'other' because that's the only description that suits me. But if there's an opportunity to write in a description, I cannot. I really cannot do that. ... because there isn't a box for me, there isn't one that's Anglo-Burmese/Indian-Armenian. Of course, there should be! (Martha: 18-24.)

I can tick the box 'Asian', but when it comes to religion, I mean, I could tick 'Sikh' but then they'd decide that he was some turban-wearing person with a long beard! So, I refused to tick any of those boxes for them. But I do think it's going to be interesting to see what group my child fits into. (Sarah: 39-44.)

People just like to put you in boxes. I mean, filling out my maternity form, you know, they wanted to know about ... what I was and what my religion was, then what [my partner] was. And I said, I haven't the faintest idea. (Sarah: 35-39.)

... the boxes you have to complete sometimes ... either they'll say, like, mixed race or they'll say 'other' and then they usually have a space, so I'll go for 'other' and then I'll just write in the space. (Claire: 72-79.)

[I] tick the Indian box because the question I ask myself is what are these people wanting from me? ... I tick the Indian box, because ... you're limited in choices: English White, Irish White, European White, but never English/Asian. I know there were more choices than that in the Census, but they still didn't give me a real opportunity to say what I wanted to. Anyway, I don't want to be called 'black other', I'm an individual. (Manjit: 230-238.)

But I don't think it's too important what we call people that come from different cultures or races or whatever. I mean, there's so few times it's actually going to matter really. But I suppose that some official somewhere will have pigeon-holed [my son] in any case, maybe there won't be a box for him to tick on forms, I don't know, and I'm not sure I care. Maybe he can be called 'White Asian'? I wouldn't have a problem with that... (Sarah: 356-366.)

Mixed ethnicity and identity

All the narratives included content on the topic of identity and mixed ethnicity, though some stories were much more detailed than others. More than half the narrators spoke of their own struggle to decide their ethnic identity and many discussed the issues and choices that were facing mixed ethnicity people in general and their children in particular. It was clear that most

narrators saw these choices as confrontational, that is that there was a need for individuals to 'choose sides' and that, even though such choices were possible, they might be limited by outside factors and influences. These are the 'invisible choices' mentioned above. It is apparent that there are nearly as many definitions of 'mixed ethnic identity' as there are people making choices. When talking about identity and mixed ethnicity, narrators said:

When I think about [mixed] ethnicity, to me, I think of people who are non-white, that's the immediate association I have with that word.
(Martha: 26-28.)

... for the first fifteen, ten or fifteen years of my life I didn't really identify myself really as black and this is because of the strength and the talents of my mum and her family. (Jason: 16.19.)

But people of mixed race have got to make a really specific decision ... Some mixed people choose to be white, but you have to ask why?
(Anna: 515-517.)

... when I was young, black girls used to call me mixed race and the white girls used to call me black. So I didn't know what I was. (Janet: 71-73.)

I didn't understand where I fitted in the world and, I suppose, I had to make some choices ... (Kamal: 66-67.)

I was aware right from day one that if I didn't actively seek out every kind of way of giving him the message that he should be proud of his black heritage, then he was going to get a message from the majority of people around him that, actually, they'd prefer it if he was to pretend he was white. (Jane: 104-109.)

I exercise choice sometimes, I make a choice to be British, because I've been so Anglicised. I've had plenty of time to feel I'm British ... but I never feel quite as though this is home. ... [but] I just don't feel I belong; it's a terrible feeling of rootlessness. (Martha: 212-220.)

It's like he decided to have different ethnicity at different times for different reasons and he knew that white people wouldn't be able to tell the difference. (Anna: 828-831.)

But I don't think of Fiji as home the way I've heard some Jamaican's talking – I was born in England and, even though I'm half-and-half, I'm a product of the English culture. (Claire: 154-158.)

People who look, you know, like us, dark-skinned we'll be in with the black people, right? I mean, no disrespect, no white people are going to turn round and say 'that person's white'. Because, you know, your skin colour doesn't show that, so they'll stick there. But still, we'll be special because there's no place for us. (Janet: 127-132.)

... mixed-race or mixed-ethnicity people, I think they're best described as spaghetti junction and for the sake of an easier life for them to live, they're going to have to take sides. (Anna: 926-929.)

I don't know about every mixed-race person ... but they have to go through it, they go through this identity thing because they've got 2 sides, one side saying well you're white the next side saying you're black, you know? (Janet: 57-62.)

I talked to a black girl recently, she said she was English. I asked her where she was born and she said England. I asked her where her parents were born and she said Jamaica. When I asked her why she hadn't said she was Jamaican, she couldn't see why she would want to. But I said that she got some of her culture, her ethnicity, from Jamaica. (Anna: 734-740.)

My family background's really strange and [my children] don't, like, see my mother and I just say to them that my dad's black and my mum's white. (Janet: 111-116.)

You can't be in the middle ... there's no way. Personally I think you can't be in the middle ... you can be there or there, know what I mean? (Janet: 125-127.)

I think that mixed people should try to fit into the black groups, that's where they belong and that's really important if we're to have our own power and finance structures. (Jason: 322-323.)

Being told you could be white

This section represents a sub-theme of identity and mixed ethnicity. Many of the narrators describe times when they have been told that they could 'pass as white'. These suggestions arise from the dominant white population's belief that to be white is everyone's ambition and desire to be white because of the unspoken assumption that this is the best thing to be. An assumption confirmed by Vidal for example, who quotes the president of McDonald's in Japan who said:

If we eat McDonald's hamburgers and potatoes for 1,000 years we will become taller, our skin will become white and our hair blonde. (Vidal 1996: 12)

This desire to assimilate 'others' is common in history (see Chapter 2.1), and is predicated on the notion of the dominant white ideal. Though some mixed ethnicity people showed an awareness that they could choose to change their identity for their own purposes, one narrator noting that he could choose to be Indian, South Asian, Punjabi, a Sikh or British as the mood took him. Others implied that these choices were offered, even sometimes imposed, when they said:

...she's mixed ethnicity ... she's the woman that was told to change her surname and she could pass for English, white English ... (Jane: 279-281.)

... everyone else seemed to want me to pretend he was white. (Jane: 17-18.)

Something you always find, particularly with light-skinned children like my daughter, people say to her, you could be white ... (Lynne: 448-451.)

Sometimes it's quite difficult to be sort of half-and-half; people sometimes say, well, you could pass as white and that offends me a bit, actually, yeah. It makes life difficult in some ways because people can say stuff that's quite racist, because they don't realise where you come from ... it's a bit irritating, because why should I want to reject my background and my family and, I suppose, part of my culture too? (Claire: 356-371.)

I mean [my partner] is alright because he looks so westernised, he doesn't particularly look Arab, he look slightly foreign, but not a great deal ... (Stephanie: 256-258.)

However, the physical ability to 'pass as white' is superficial and simplistic. The connotation is that the person of mixed ethnicity should 'choose to be white', presumably on the basis that white is best or, at least, is dominant and thus attracts benefits withheld from others.

Chapter 2.1 has discussed issues of choice and imposition of racial and ethnic groupings. The capacity to choose one's ethnicity is mediated by a number of factors for example skin colour and the perceptions of others. A Black individual may choose to be a member of a White ethnic grouping or vice-versa, but other issues intervene. Prime amongst these is the perception of others. No matter the choices made by an individual, others will have immediate perceptions of them, often based on stereotypes (see for example, Donald and Rattansi, 1992: 24 – 29), which may reimpose a position within a racialised grouping and thus the individual's choice may be negated, initially at least, before any contact made is between actors. If this is the case, then the individual's capacity to choose his or her ethnicity may have an impact only where there is an opportunity for direct communication.

Mixed ethnicity and health

There are multiple dimension to the theme of mixed ethnicity and health. Of these, 2 will be considered: the possible link between mixed ethnicity and health status and the possible link between mixed ethnicity and health care experiences. These issues are discussed in greater detail in Chapter 4.4.

There are links between ethnicity and health status. These are discussed in detail in Chapter 2.4. However, while there are clear 'ethnic' links to specific conditions, there are no indications that membership of any minority ethnic grouping, including being a person of mixed ethnicity, has a demonstrable link to either good or bad health. The bulk of evidence points to poor health being a result of social and economic deprivation. This may be direct, for example in terms of poor diet or inferior living conditions, or indirect, for example immigrants from developing countries may have resided in areas where no health service was accessible. There is another dimension of health, sometimes referred to as the lay model,

which considers whether or not the individual feels and believes that they experience good or bad health. These beliefs and feelings are closely linked to individual experiences of NHS contacts. There is an extensive literature on these issues; see for example Wilson, 1994, Jones, 1994 or Wilkinson, 1996, all of which describe individual's healthcare experiences.

In the following part of the chapter, narrator's comments have been divided into two sections. The first is composed of comments made by service users and the second of comments made by doctors and other health professionals. The comments indicate that, for the most part, people do not feel that their health is determined by their ethnicity. However, it is interesting to note that the comments tend to suggest that people are not satisfied with their doctors' knowledge of health and ethnicity and that, in turn, doctors agree that, for the most part, it is not an area in which they take great interest. This concept is explored further in the section on medical power and discourse suppression.

Though the narrators are notionally divided into service users and health professionals, this categorisation is necessarily fluid and potentially inconsistent since, inevitably, all health professionals are health service users. In some instances, therefore, narrators will appear in both groups based on my assessment of where they should be located at any particular point in the narrative. For example Manjit, a nurse, appears in the service user category and Anna, a non-clinical NHS employee, appears in the health professionals group. In general, all of the people in the 'health professionals' group are clinicians; individuals who are employed by the NHS in non-clinical capacities are included in the group only where their contribution is seen to originate from the professional rather than the personal part of their life. It is possible, at times, to report the comments of GPs as a separate group, even though they can be service users. Where appropriate, this is done.

[Service users]

I don't think being a Pakistani has any effect on my health, not at all. Not a thing. (Renuka: 110-111.)

I think overall what he [her mixed ethnicity son] suffers from most is actually doctors. (Jane: 194-196.)

Well, I'm not sure that people of mixed ethnicity ... have special health needs. (Manjit: 7-9.)

But the issues about his health will be down to his family and his doctor. I think it would be much easier for someone of lighter skin. (Sarah: 379-381.)

Of course, doctors don't know anything about mixed ethnicity and health ... most doctors wouldn't even see it as an issue. (Sarah: 6-7.)

Going back to health and ethnicity, doctors are so ignorant! I mean, you know, most GPs have no idea about, say, thalassaemia – even when they've heard of it, they don't know anything about its incidence. They say things like, your background must include the possibility ... but no, not that I'm aware of, because we don't come from that region, that place where thalassaemia is likely. But some doctors are switched into this, so I'm always asked, you know, is this an issue? But really, all they're doing is showing their ignorance! (Manjit: 374-385.)

I learnt about sickle cell off my friend, not from the GP – I mean I never had anything off him, no. Not from the midwife or nothing. (Lynne: 73-75.)

[GPs and other Health Professionals]

I think one of the big areas is mental health. Mental well-being, rather. (Aminah: 305-306.)

I mean, know that some racial groups have a higher predisposition towards some medical conditions than others, but that's all very well documented these days, I'm more interested in making sure that people that come to see me are treated for the illnesses that they come here with. (Andrea: 20-21.)

I know there's a health gap that affects ethnic people ... (Heather: 155.)

Health needs, that is the medical side, its about diseases or disorders that are prevalent – I don't agree with the word 'prevalent' – but let's just say that they're [people of mixed ethnicity] more susceptible to. (Anna: 23-25.)

One of the things I've learned through working as a doctor here is that people's race matters. (George: 68-70.)

Many of the GP's comments reflect a particular perspective, that health and ethnicity is only a problem of communication and understanding, but that the onus should be on the service users to develop the ability to communicate with doctors, rather than doctors with patients:

Let me start off by telling you the problem I find most difficult with ethnic people. They really don't know how to tell me about their symptoms, they seem to think that I should be able to tell them! They come in here and they want to tell me about their lives, and what I want to know is what their health problem is, their medical problem, so that I know how to treat them and sometimes, it's really difficult. (Andrea: 6-14.)

I do see quite a lot of the practice's Muslim women patients ... that's because Muslim women will only go to female family doctors, their religion won't allow them to be touched by men who are not their husbands, but mostly they just suffer from the same conditions that all women have, either they have problems because they've got children or they have problems because they haven't got children. I mean, there's no racial link with that is there? (Andrea: 87-91.)

When I was a medical school, the issue of race never came up in our training at all. Or, I suppose that might have been one of the lectures I skipped. But I don't think it's an issue. (Andrea: 106-109.)

I've had to learn a lot about health and race since I came here, it wasn't such an issue where I was before and certainly, it hardly got mentioned in my training. (George: 37-41.)

The practice, well, we've got 6 partners, we're all English except Doctor [name deleted], he's from Hong Kong, well, his family were from Hong Kong, I think he was born here. I've never talked to him about the issues around race, but perhaps we should look into that a bit further and see if it's a value added service we could provide ... (Andrea: 116-121.)

I don't think we do a particularly good job of looking after ethnic minorities. I think they do have different health needs in, perhaps, the way that, umm, they manifest themselves and the way that their ... the words that we use don't necessarily mean the same things to them. (Sarah: 78-81.)

It's interesting that some African-Caribbeans believe that an English diet is the cause of diabetes and if they go home to Jamaica, then they'll get better – of course, that won't happen. Some Asian peoples believe that diabetes is like a virus and it'll go away – particularly if you eat the right food. And they also do feel that if they do go back to India, their diabetes will go away. (Stephanie: 126-130.)

These health professional attitudes sometimes extend to stereotypical descriptions of how some minority ethnic group's behaviours and backgrounds:

I was thinking of diabetes really, though that's one of the other things I was going to say, that people's culture can affect their response to illness. I have a number of African-Caribbeans, mostly men, who have diabetes. Mostly it's very mild, but it's a condition that tends to worsen as people get older, but if I was talking to you and you had diabetes, I would be pretty confident that, if I gave you a regime to follow and told you to stick to a particular diet, then that's what you'd do. These men from the Caribbean, they just ignore me. So, all that happens is that their diabetes gets worse more quickly and they usually become insulin dependant in a relatively short time. Then they don't manage their insulin effectively and they'll be in and out of hospital for the rest of their lives. Now I'm sure, in my own mind, that this is because of their culture. They really don't seem to believe that diabetes won't get better on its own. They think it'll just go away, like flu and, of course, that isn't what happens. (George: 82-98.)

I think there are links between race and mixed-race and disease too. I mean, people that came from India often didn't have enough vitamins, so they've got rickets and so on. ... things like sickle cell anaemia affects the Afro-Caribbean community, umm, it's to do with their haemoglobin and their red cells, but I understand that it causes tremendous amounts of pain, it's supposed to be terribly painful. (Martha: 45-54.)

Medical power and discourse suppression

This research is largely about medical power and the use of that power to suppress discourse, in particular the discourse of health and mixed ethnicity. The term 'discourse suppression' is used here to describe the beliefs and perceptions of mixed ethnicity respondents that they have not been allowed to discuss issues of ethnicity which they believe impact on their health.

The term is used also as a reminder that Foucault's perception of discourse is that it both permits and limits what may be said about any issue or topic.

Possible causes and explanations for this suppression, and the implications for existing and future policy initiatives, are discussed later. This section is concerned with the initial comments made by narrators suggesting that the phenomena exists and is reproduced. Similarly to the other sections, service users' comments are given first followed, in this instance, by GP's comments. However, it is worthy of note that everyone in this country is a service-user of the NHS, so this binary distinction is, at best, fuzzy. Nevertheless, it serves to illustrate significant differences in the way that individual narrators perceive both themselves and their assessment of their position in the binary power relationship of doctor and patient.

[Service users.]

There's nothing in the health centre about race and mixed race children either ... it's just like they've closed the door on it – it's a problem they don't want to talk about. (Lynne: 364-368.)

I think it's very difficult for the patient to challenge the GP, I mean they've come there for help and that's what they want and they're worried that, if they argue or make demands, then the GP will not give them the right service. (Sarah: 265-270.)

I think mine just try to fob me off. They're just in a rush to do it and they want to see the next patient ... (Janet: 143-144.)

I think it's a very true reflection of what the NHS and doctors in particular are like. If you piss-off your GP, then your GP's not going to play ball with you ... (Sarah: 181-183.)

But I don't think my GPs know, or care, about ethnicity ... it's almost as if they'd rather not talk about it, certainly, when I tried to talk about the ethnicity of my son and whether there were any things I needed to know about, they didn't want me to ... or maybe, they just felt that they hadn't got time. (Sarah: 153-157.)

It seems to me that GPs don't know – and don't want to know – about any link between ethnicity and health. Maybe tried to talk about the ethnicity they believe that it'll just go away as the races mix? (Heather: 117-119.)

Of course, GPs have a licence for power, but they use that power to make life easier for themselves ... it's much easier to diagnose a patient without actually letting them speak, that only complicates the issue with the patient's feelings and knowledge. Much better to keep them quiet and not let them talk about their problem. (Heather: 120-121.)

... and another thing that one of the white mothers raised at the time was the fact that she's married to a Nigerian, she has one son already and she was pregnant with their second child and the doctor that she saw when she was first pregnant was suggesting that she ought to have an AIDS test. And, you know, that was also really despicable but, you know, there is a sort of whole assumptions that because she was married to a Nigerian. Jane: 71-76.)

I don't think doctors put enough emphasis on people's culture and ethnicity when they're seeing them. I mean, people might describe illnesses, or symptoms I guess, differently depending on what they're used to. I know my Nana describes his arthritis as being gampy, but I don't think an English doctor would understand that. Maybe he'd ask Nana to explain, but maybe he wouldn't either. (Claire: 313-322.)

When I tried to raise it with one of the GPs, he was one of the white ones, he told me, basically, not to be silly that race and where you come from hasn't got anything to do with your health. (Sarah: 149-152.)

One time when [my daughter] was really little, she had these pains in her wrist and elbow and, even though my husband hasn't got sickle cell, I was, sort of worried, you know? I suppose I just wanted the GP to tell me it was OK, really, you know, but instead he was looking for injuries and he just wouldn't listen to what I was scared about. (Lynne: 352-360.)

My doctor is white English he doesn't care. (Janet: 147.)

I don't think it's that GPs ignore the idea of ethnicity with patients, it's just that they can't communicate with them ... (Renuka: 251-252.)

I find, generally speaking that the medical profession tend to have very strong views that are rooted in, sort of traditional British colonialism. (Aminah: 382-384.)

... when you're pregnant, you know, if the midwife or health visitor knows you're not with the father of the child and, you know, the father's black, then actually the way they treat you is like a third or fourth class citizen, really. (Jane: 229-233.)

Asian people who come to hospital and because they can't speak English and can't communicate, they are just pushed onto one side. (Renuka: 123-125.)

Of course, we seem to be taught by all our experiences that doctors are all-powerful and I think they are sort-of taught the same things too and that we should respect them and believe everything they say. Even though, it's obvious that GPs can't know everything or even very much in detail about some things. (Sarah: 275-280.)

There are a number of indications, too, that some people resist the discourse suppressing power of doctors:

I [tell him that I] don't come to see you that very often, so when I do come and see you, I need you to listen to me. He just sits there. And I tell him. And that's the time when he tells me to go to hospital then. I have to tell him I'm not leaving until you know the pain I'm in. (Janet: 173-178.)

GPs statements appear to attempt to justify this position.

I really don't have time to talk about it with my patients and, obviously, they don't think it's an issue either or they'd tell me about it wouldn't they? Or, I suppose, they would move to another practice if they thought my partners and I were not addressing issues that they think are important. (Andrea: 109-114.)

I don't see the point, I really don't think it's good use of my time to talk about what a patient's ethnicity is, especially if I don't think it's relevant to why they have come to consult me. I am a very busy family doctor and my job is to get patients well again, it's just of no interest to me. (Kamal: 175-179.)

But really, I don't let the idea of race get in the way of my diagnosis ... I'll look at what is wrong with a person and I'll prescribe the right treatment to make that person well again. Patients don't come to me to tell me about their ethnicity, I'm sure that they don't think that it's an issue at all, why should the colour of a patient's skin affect his health? It's not something that I would take into account when I am making a diagnosis, no, not at all. (Kamal: 93-99.)

My patient's don't come to see me to discuss their racial background, they come because they're ill. It's hard enough being a doctor without being asked to waste your time. If a patient wanted to talk about their race I would tell them that it has nothing to do with their health so they should not take up my time with it. I suppose, that if they persisted, I might suggest that they have a psychiatric assessment.... (Kamal: 179-186.)

A GPs working life is complicated enough already without having to worry if you're treating people appropriately because of their ethnicity. (Andrea: 85-87.)

The foregoing statements are particularly interesting, because, upon analysis, they suggest that doctors may suspect the presence of a problem. For example Andrea's 'they don't think it's an issue either or they'd tell me about it wouldn't they?', acknowledges the possibility of a difficulty, while denying any opportunity to discuss it.

Other statements made by service users and health professionals have been grouped into related segments below, since they suggest a number of other areas of importance to the analysis.

The collection of 'ethnic' statistics

The collection of ethnic statistics was referred to in the context Chapters 2.1., 2.2., 2.3., and 2.4. These contextual discussions challenged the need to collect ethnic statistics and discussed the problems of the racialisation of statistics. Narrators have provided additional evidence that they are aware of some of the issues involved in the collection of this information and illustrate the belief that such data collection is of little use.

I don't know even why we collect ethnic statistics in the NHS. But I suppose people of different races do get different diseases, that's true, yeah. (Renuka: 161-163.)

I think that it's right to collect ethnicity data though, especially thinking of the NHS, though I suppose it depends what you're going to do with the information and it depends what you actually mean by it, because, you know, it's the same you know as I said earlier, you know, if you went to the tick-box of Sikh, that automatically brings up all these ideas about what somebody's like. I mean, tick the Church of England box but what that means to me is totally different to someone, who, you know, is a churchgoer all the time. (Sarah: 368-376.)

I wouldn't have thought that the NHS does a great deal with it at all, I mean, we don't collect, we're supposed to but we don't ... it's a load of rubbish because the vast majority of people I know feel uncomfortable asking people, so they make the assumptions for them and we don't ask them in [one of the professions allied to medicine] but nursing staff, particularly people I've talked to, don't like to ask people, so basically they make it up and tick whatever box they like. (Sarah: 388-395.)

One narrator used the non-collection of ethnic statistics by her service to say:

I don't believe that we should have special services for different populations, I think that all medical services should be mainline, they should be for everyone. Otherwise, it can reinforce the isolation of different communities and, of course, it's much easier to cut funding if it's a discrete service, especially one for minorities who might not access it very well anyway... (Heather: 106-112.)

Racism/racist behaviour

There is no longer any doubt that Britain is a racist society and that this racism is both personal and institutional. MacPherson's report (CM 4262: Ch 6) on the murder of Stephen Lawrence makes two useful definitions that, along with the definitions referred to in Chapter 2.1., have guided the research:

"Racism" in general terms consists of conduct or words or practices which advantage or disadvantage people because of their colour, culture or ethnic origin. In its more subtle form it is as damaging as in its overt form. (CM 4262: Section 6.4.)

"Institutional Racism" consists of the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantage minority ethnic people. (CM 4262: Section 6.34.)

Almost all the narrators told their experiences of racist behaviour either as people of mixed ethnicity or as the parents of mixed ethnicity children. Some medical professionals' stories include discussions of behaviours that seem to be racist. Again, the comments from service users and GPs are shown separately. They said:

[Service users]

Well, I'm treated worse. They [doctors] basically have a negative attitude about white women who have black children anyway, don't they? (Jane: 227-229.)

I was always seen as different ... (Anna: 116-117.)

... they [the narrator's family] was having things pushed through the door saying, oh you know, your daughter's a nigger-lover and letting her people down and one thing and the other. (Lynne: 212-215.)

[My father] believes that doctors and health professionals know everything so he won't question the treatment he's given and he won't complain and he won't ask questions. He won't ask for an explanation of the way that he's being treated – he's a recipient not a participant, he's just passive and he lets doctors do whatever they want to him because they know best. (Heather: 69-75.)

... if they want to come and live in this country, this is the hospital, this is the system we have, well they should just come to it. Or you could say, well, they have the right to live the life that they live and we should go out to them, because you know you get loads of people complain terribly about you know about how we bend over backwards for immigrants. (Sarah: 431-437.)

... my doctor treats me as if I was white. (Renuka: 258-259.)

[GPs]

I don't think that ethnicity is important with people of mixed-race, especially if they're half-white. Most of the mixed-race patients I treat, I just treat them as if they're white and I don't let ethnicity come into it. (Andrea: 16-19.)

I have no idea how many mixed-race people there might be in the area, and frankly, I'm not that interested. I've told you already that I try to treat everybody as if they're white – I really think that that's good enough. To be frank, I feel that it's a bit more than good enough. (Andrea: 81-85.)

Healthcare experiences

This part of the chapter illustrates narrators experiences of healthcare, grouped under a series of headings chosen to illustrate that the perceptions of the patients are quite different to those of the doctors. Patients chose, for the most part, to discuss negative health experiences. Only a few of these themes are described here, but they are used to guide later analysis.

Doctors' attitudes

... I think that it's out of order for a doctor not to understand that there are specific problems for some racial groups. But doctors do like to think that they know everything they need to, and that me, the patient, knows nothing. (Jason: 312-314.)

Doctor's perceived misunderstandings of cultural/ethnic issues

... some of my partners feel that it's [the provision of chaperones for women from some minority ethnic groups] a terrible waste of money and won't provide the service if they are not specifically asked. (George: 110-119.)

... the people that you can't find any, you know, physical reason for this pain syndrome that they have and I wonder whether it is the way that they express themselves for other reasons; mental health reasons or whatever, you know, or just because they come from different cultures. (Sarah: 108-113.)

Patients' perceptions and experiences of 'off-hand'/racist treatment.

I just need them to explain more to me. Explain what's wrong with my child, you know? I need to know, I need more explanation. Even about myself, I need better explanation. (Janet: 221-223.)

I think mine [her doctors] just try to fob me off. They're just in a rush to do it and they want to see the next patient, so ... (Janet: 143-144.)

I take my kids, but he's not really checking them properly – and he just gives you things and says 'take this and give it to your child', and he's not checking, not checking them properly. (Janet: 166-169.)

When [my partner] and I went to see our doctor when [she] was pregnant, he wanted me to be tested for TB and AIDS – I mean, you know, that's really offensive! I might have understood if he'd wanted to test for sickle cell, but he didn't know anything about that. (Manjit: 335-339.)

But even though my ethnicity doesn't seem to make any personal difference to my health or the way I'm treated by doctors, it does for some other people that I know ... a friend of mine has got very bad arthritis, she went to the doctor about it and, apart from telling her to get cod liver oil, he didn't really do a hell of a lot. (Claire: 251-272.)

... the doctor was really saying to me don't be stupid. (Jane: 43-44.)

I think sometimes they treat me badly because of the person I am. So I don't go to the doctors that much, even if I've got a cold I stay at home. (Janet: 159-161.)

Health professionals suggested reasons for poor treatment?

... there's a problem that many West Indians see medical treatment as charity and, they don't want that because it's white charity. (Heather: 147-149.)

GPs need to be more ethnically mixed so that they can understand the populations they work with and the whole primary care thing needs to be inclusive – also needs ethnic minority people in the middle grades in the NHS, they're there in the low grades and the high grades, but neither of those are the ones who decide what the service is really going to provide. We need some black policy makers too, there really aren't any black planners or commissioners. (Heather: 135-141.)

These themes and contexts are pursued in and inform the analysis phase of the research.

4.3. Metanarrative analysis

The purpose of the metanarrative analysis is to seek evidence to support the hypothesis that people of mixed ethnicity, *because of their ethnicity*:

- Have significantly poorer health status than the white majority of the population.
- Have predominantly negative healthcare experiences.
- Suffer from the suppression of the discourse of mixed ethnicity and health because of the exercise of medical power by doctors.

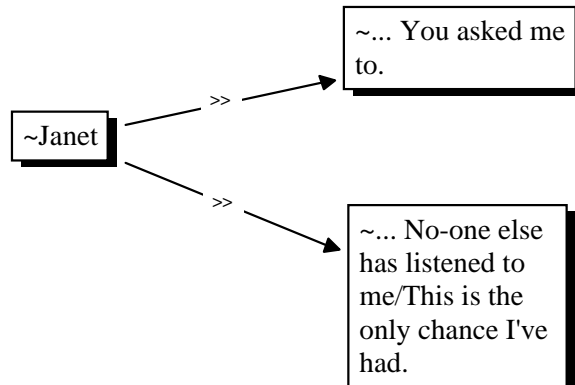
An additional element is to examine how people of mixed ethnicity describe their identities and their ethnicity.

The analysis of narratives by means of their intent and content (see previous section) does not give a full picture of their complexity and tends to fragment the stories so that they are not seen as wholes. However, it is still valuable to be able to see not only the links between stories and the means of their classification, but also the complexity of these links and the ways in which they vary between narrators. The multifaceted nature of these links reflects the complexity of the narrative and provides information on a number of associated factors, for example, awareness and knowledge of minority ethnic group health issues and experiences. An additional dimension of analysis is then to be able to compare different stories in terms of both their complexity and their links to different classifying criteria. These analyses, through the connection with the Foucauldian theoretical perspective, will be used to inform discussions on existing healthcare practices and the effects of discourse suppression and to make suggestions for future policy changes.

The simple classification of stories by intent/reason for telling described above is useful to understand the issues that are important to the narrators, but does not clearly show the similarities and differences between stories. These similarities and differences may arise for many disparate reasons, some of which are discussed below. The classification analysis process has been developed in order to show linkages between the stories, their content, the reasons why they are told and the manner, tone and structure with which they are told. Links are defined when various issues are prominent in the narratives. Thus the part of a story dealing with the way in which the narrator sees their ethnicity as a component of their identity would be one link. Similarly, the part of a story that tells of the way that a narrator has chosen a way of fitting into society would be another. The types of links are explored more fully below. It is difficult to imagine these linkages, or to describe them verbally, so visual network diagrams have been created and are shown and described below. Each of these classifications will be illustrated in turn.

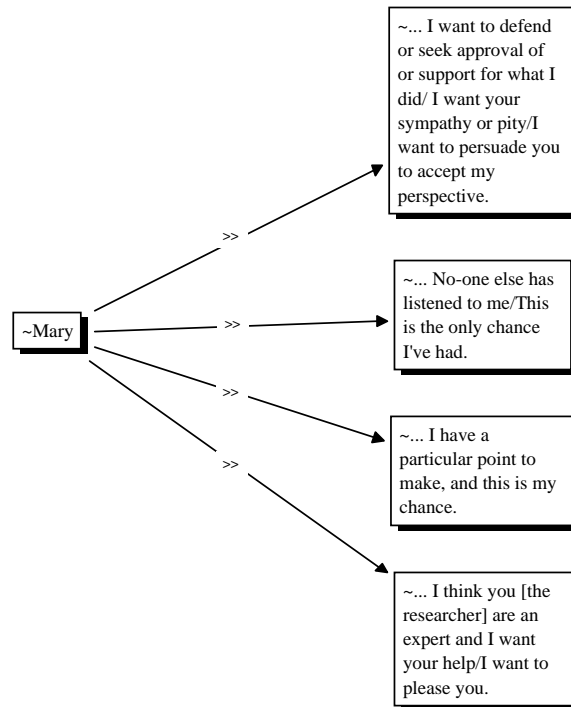
The production of these network diagrams is part of the analysis. The initial diagrams for each topic are often complex, difficult to understand and far from user-friendly. However, they represent an essential step in the reasoning process and, where, necessary, have been either simplified or presented in different formats throughout this chapter.

Fig: 4.3.2. - Story Classified by Intent – Janet.



The classification of some of the stories is more complex:

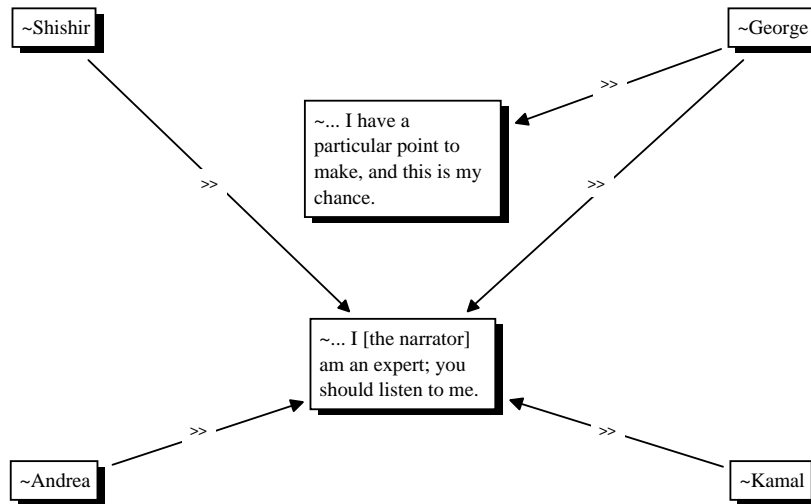
Fig: 4.3.3. - Story Classified by Intent - Mary



The advantage of this process is that the stories are not deconstructed, but remain entire and undivided, though the constituent components are available for identification and analysis.

In addition, the stories can easily be grouped by known variables so that links for narrators, for example, from the same professions can be seen. This is illustrated by:

Fig: 4.3.4. - Stories Classified by Professional Group – GPs.



Manner, tone and structure

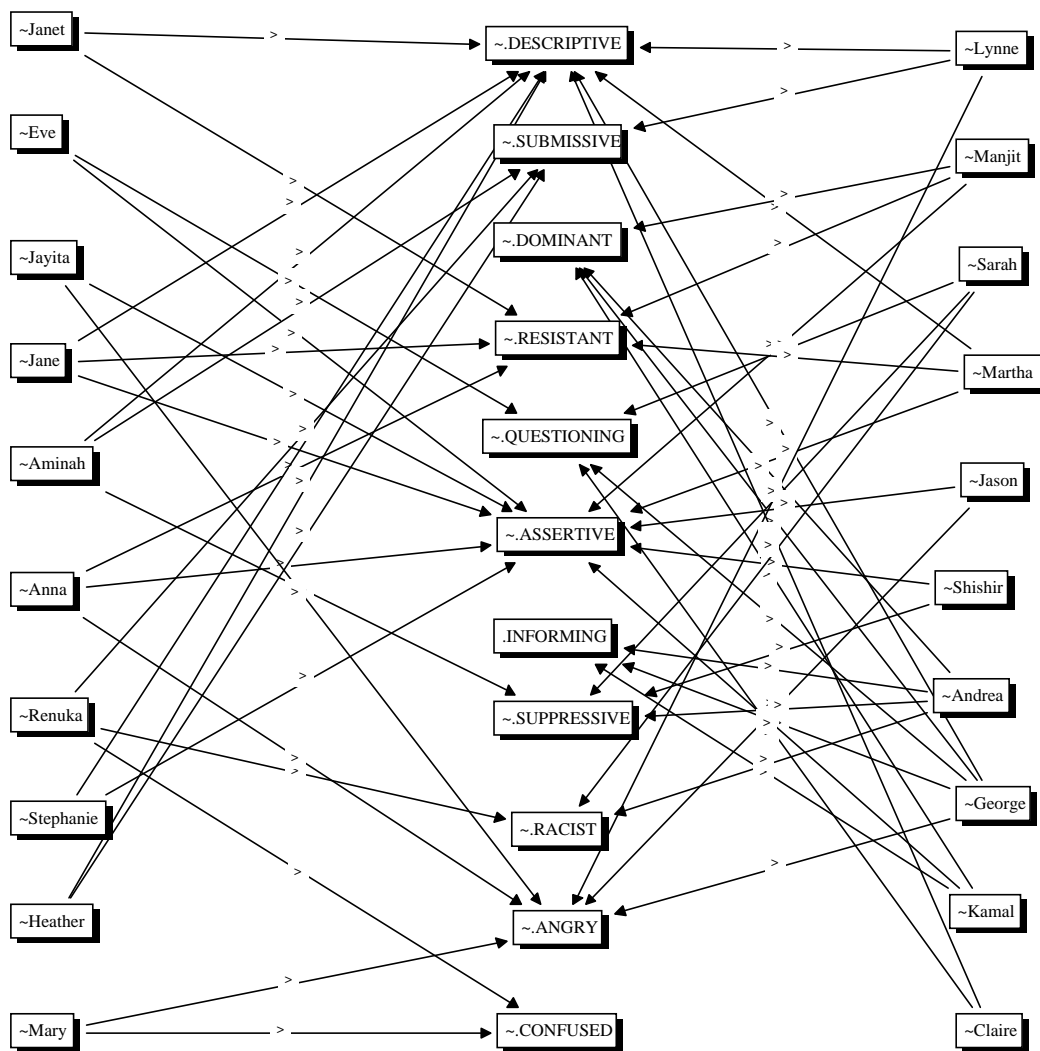
In the same manner as intent, the narratives have been categorised by manner, tone and structure. That is, the manner and tone in which the stories were told, as perceived by the researcher, has been allocated to one of several categories. In the main, these categories are self-explanatory and connect closely with the intent categories. However, the emphasis is not on the purpose of the story telling, but rather on the manner in which the story is told. It is readily acknowledged that this is a subjective categorisation. The categories may require some explanation.

Resistant. This category is intended to record a discursive structure that might be labelled ‘anti-racist’ or ‘anti-discriminatory’ in intent.

Racist. Denotes the use of verbal structures which are perceived as either consciously or unconsciously racist.

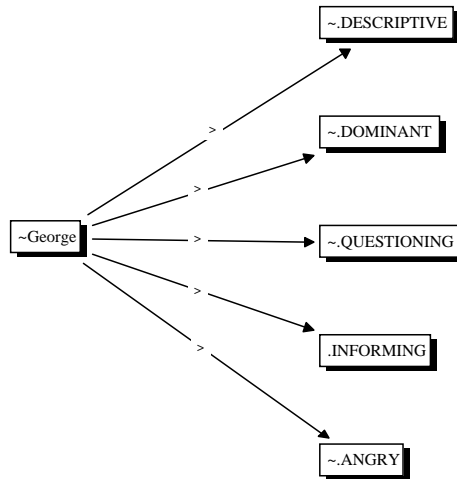
Confused. This category was included when it appeared that some narrators were either telling stories that seem irrelevant to the research project or were telling stories that display high levels of internal inconsistency. To some extent, this category may be seen as judgmental, though this is not the intent. Rather its purpose is to record the perceptions and impressions of the researcher.

Fig: 4.3.5. - Stories Classified by Manner, Tone and Structure.



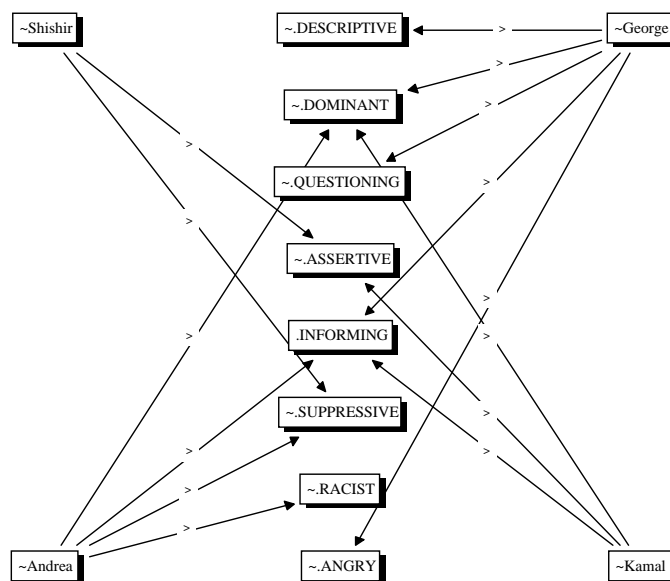
As with intent/reason for telling the story, the entire network is complex and confusing. When simplified, by focussing either on the stories or on the manner, tone and structure categories, the networks become easier to understand and to use, for example:

Fig: 4.3.6. - Story Classified by Manner, Tone and Structure - George



Again, the analysis looks at groups of narrators/stories as well as individuals, in an effort to establish commonalities as well as differences, for example:

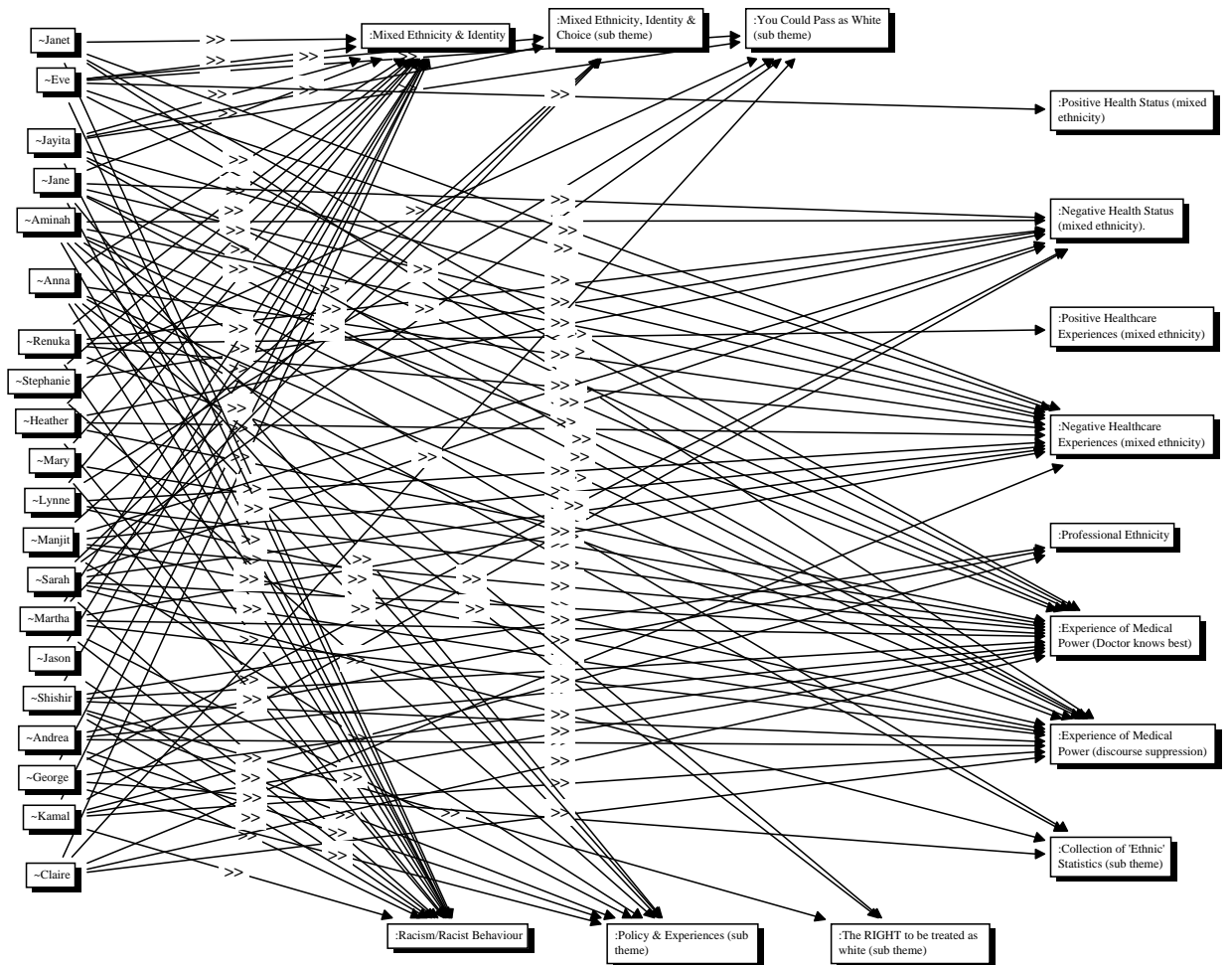
Fig: 4.3.7. - Manner, Tone and Structure – GPs.



Theme and content

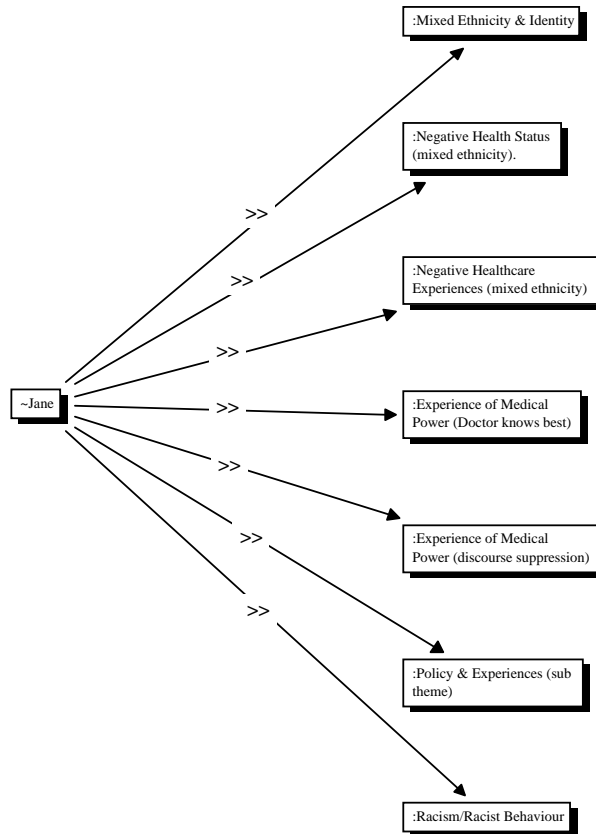
A network of the themes and content of the narratives has been created in the same manner as those for intent/reason and manner, tone and structure. The holistic network, in this instance, is so complex that it had to be constructed with a different layout in order that the links could be seen at all. It is unlikely that, in this form, it aids analysis, other than by again demonstrating the complex links present in this analysis; see below.

Fig: 4.3.8. - Stories Classified by Theme and Content.



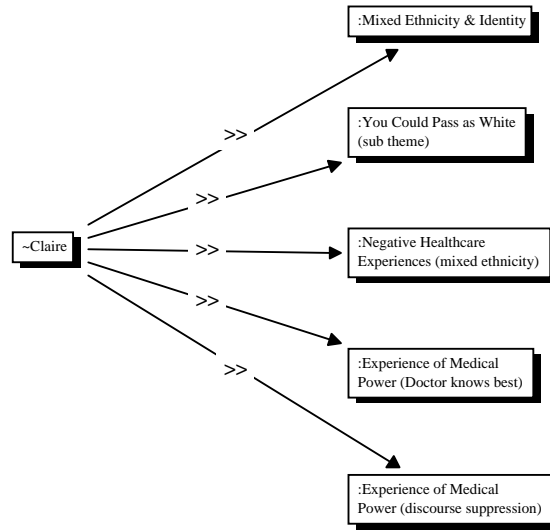
However, as with the two previous examples, when the networks are simplified by reducing the number of categories in view, it becomes a useful tool, without harming the ‘wholeness’ of the individual story.

Fig: 4.3.9. - Story Classified by Theme and Content - Jane



As before, some narratives are less complex.

Fig: 4.3.10. - Story Classified by Theme and Content – Claire.



Examining the way in which each story connects with the categorising variables is not the only way in which to examine the relationships between intent, manner, tone and structure and content. It is equally useful to invert the process so that, for example, the differently identified intent classifications can be seen in relation to the number of stories so categorised, though some are more complex than others. For example:

Fig: 4.3.11. - The Links Between Stories and the Category *I think you [the researcher] are an expert and I want your help/I want to please you.*

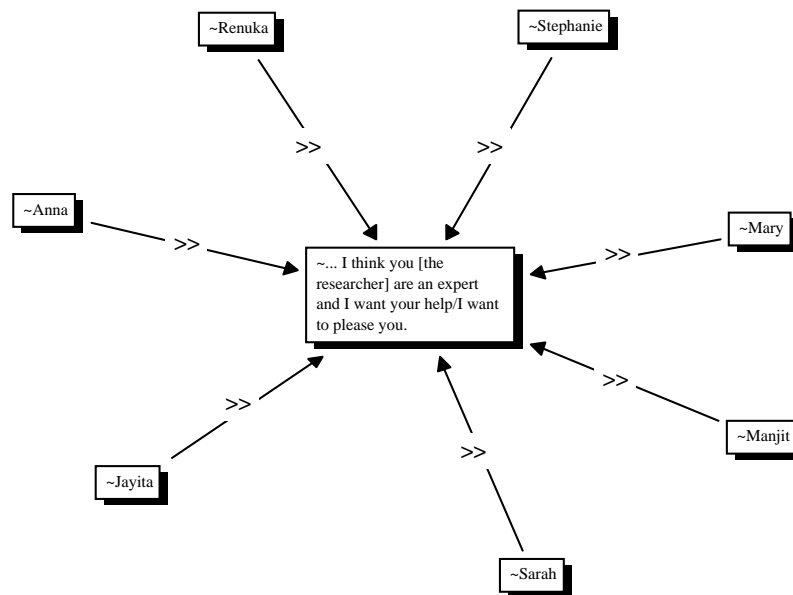
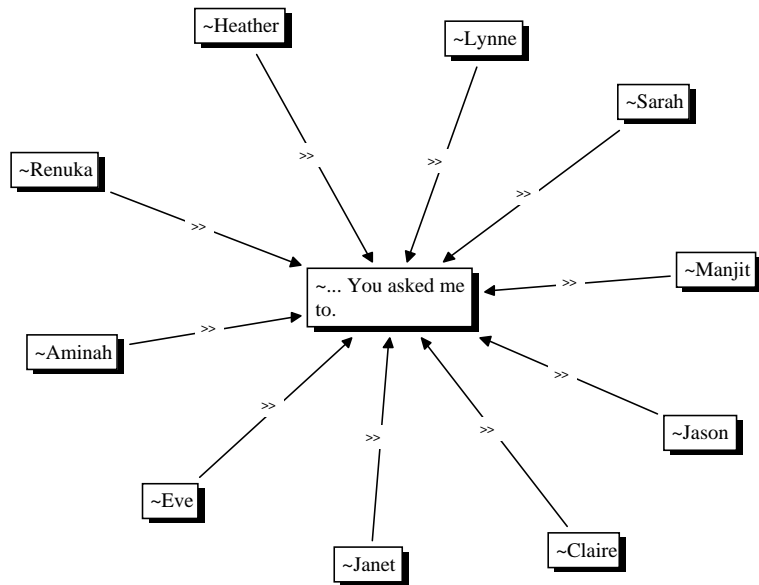
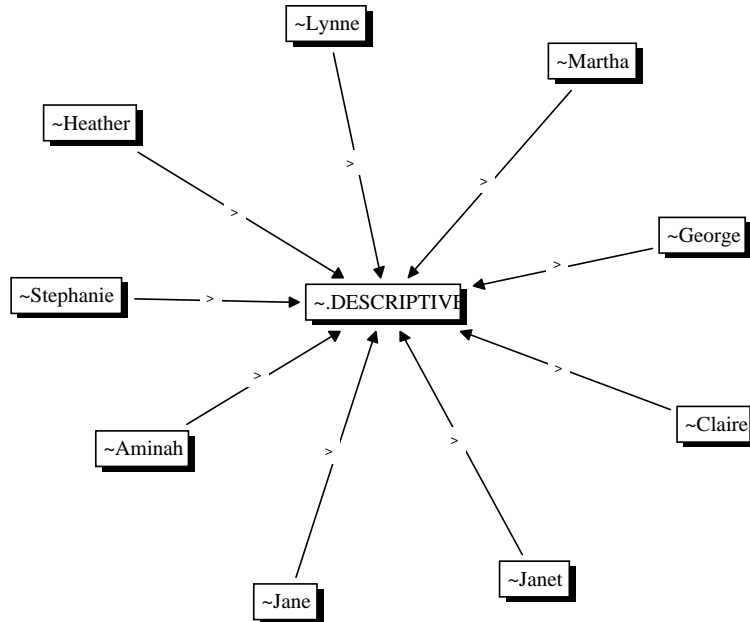


Fig: 4.3.12. - The Links Between Stories and the Category *You asked me to.*



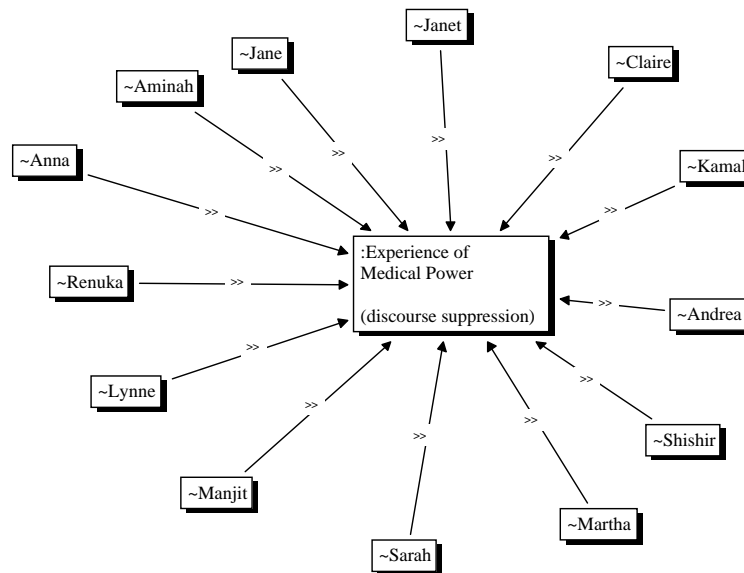
This process has been repeated for the Manner, tone and structures.

Fig: 4.3.13. - The Links Between Stories and the Manner, Tone and Structure *Descriptive.*



The process has, finally, been used to see the relationship between multiple stories and individual theme/content categories.

Fig: 4.3.14. - The Links Between Stories and the Theme/Content Category *Experience of Medical Power: Discourse Suppression*.



Metanarrative analysis

This final process has indicated that the stories can also be examined from a different perspective, that of grouped narratives, referred to here as metanarrative. It is possible to construct a number of composite narratives from the individual stories, guided by the analysis above. This procedure maintains the integrity of the individual narratives, but allows a more sophisticated analysis of narrative groups or metanarratives. It is a more complex process than simply categorising stories in terms of their themes, content or origin. Rather it is a cerebral process of combining stories that speak of similar matters in similar ways. It is, again, acknowledged that the issues of choice are important and that the choices made in grouping the stories into metanarratives are those of the researcher, guided by the research and the theoretical framework.

The quotations selected for use in this section can usefully be thought of as the sort of statements that might be made by participants in a focus group using the title of each metanarrative as the subject of discussion. Though the quotations are, necessarily, fragments of individual narratives, they combine holistically as an analytical tool. As with all the analytical work in this research project, choices and selections have had to be made. This has been done as systematically as possible within the theoretical framework.

The stories that make up metanarratives are not specific to any single metanarrative. Stories cross the boundaries between metanarratives for many reasons, but one example is that of ‘The Doctors’ Story’ and ‘The Medical Power, Ignorance and Discourse Suppression Story’. There are many crossing points between these two metanarratives since, whilst some participants in this research are GPs by training and professional practice, all participants are consumers of healthcare. Thus it is sometimes difficult to distinguish between a GP as a *doctor* and a GP as a *service-user*. This difficulty affects the metanarrative composition and means that, for example, health professionals may be included in metanarratives which, at first sight, appear to be mutually exclusive. Foucauldian theory argues that the epistemes that govern these two behaviour pattern will be different, but this does not necessarily mean that they will be mutually exclusive. However, it may not be possible for an individual’s behaviour to be governed by two epistemes at the same time (see Theoretical Perspective, Ch. 4.1., with reference to discontinuities). It is not always possible to discern the position from which an individual tells their story, but where this can be differentiated, appropriate comment is made.

There is an additional component of the metanarrative which will be common to all and which is more difficult to assess, that of the feelings of the narrators. This element has been

examined by looking at the links between the individual stories and the **manner, tone and structures** (see Fig: 4.3.15). All the individual stories have multiple links to the different **manner, tone and structures**. The links are shown in the matrix below, a more user-friendly format than diagram presented as Fig: 4.3.5., Stories classified by Manner, tone and structure so that it is relatively simple to see the dominant manner, tone and structure for each component of the metanarrative, though the scope of this research is insufficient to permit a thorough investigation of this aspect. A black cell in the matrix indicates the presence of the specific manner, tone and structure variable. Though this process does not explain an individual's feelings at the time the story was told, it is felt that it is the best available indicator.

Fig: 4.3.15. - Narrative Links to Manner, Tone and Structure.

STORY	DESCRIPTIVE	SUBMISSIVE	DOMINANT	RESISTANT	QUESTIONING	ASSERTIVE	INFORMING	SUPPRESSIVE	RACIST	ANGRY	CONFUSED	DOMINANT MANNER, TONE AND STRUCTURE
1												Descriptive/Resistant
2												Questioning/Assertive
3												Assertive/Angry
4												Descriptive/Resistant
5												Descriptive/Submissive/Suppressive
6												Resistant/Assertive/Angry
7												Submissive/Racist/Confused
8												Descriptive/Assertive
9												Descriptive/Submissive
10												Angry/Confused
11												Descriptive/Submissive/Angry
12												Dominant/Resistant/Assertive
13												Questioning/Suppressive/Racist
14												Descriptive/Resistant/Assertive
15												Questioning/Angry
16												Assertive/Suppressive
17												Dominant/Informing/Suppressive/Racist
18												Descriptive/Dominant/Questioning/Assertive/Informing/Angry
19												Dominant/Assertive/Informing
20												Descriptive/Questioning
Links	9	4	4	5	3	11	3	4	3	6	2	

This matrix indicates that, overall, two categories are most prominent, ‘Descriptive’ and ‘Assertive’. It might be expected that many stories would be predominantly descriptive, since a story must contain contextual material if it is to be in any way relevant to the present.

However, the predominance of the ‘assertive’ variable suggests that many narrators use their stories for more than mere description. This matrix is used in the analysis below, though not in the ‘mixed ethnicity and identity story’, simply because most of the narratives are included and an attempt to evaluate by manner, tone and structure only causes confusion.

Metanarratives can be constructed only when the analyst has an intimate knowledge of the data; something that can only be gained by the processes discussed elsewhere, but particularly including the need for immersion in the data. (See Chapter 3.4).

The Metanarratives considered here are:

- **The Mixed Ethnicity and Identity Story: choice and fitting-in.**
- **The Doctors’ Story: Health and ethnicity, power and ‘professional ethnicity’**
- **The Patients’ Story I: Mixed Ethnicity and Health Status.**
- **The Patients’ Story II: Mixed ethnicity and healthcare experiences.**

There is at least one further metanarrative which, though important is not considered in depth:

- **The Mixed Ethnicity Body.**

There are multiple references to the concept of the ‘mixed ethnicity body’ in the stories.

These notions are often around skin colour, and others perceptions of ethnicity because of skin colour, but other characteristics are mentioned, notably hair and hair care:

I said she's like my friend, mixed – it was the hair. (Anna: 529-530.)

I have to say that the issues are hair care [and] skin care (Anna: 849 – 850.)

They've all got the curly hair which is associated with being Arab (Stephanie: 91-92.)

My nephew, he's mixed race and he's got very, very, very light skin (Lynne: 468-469.)

it would be much easier for someone of lighter skin (p 15: 379-380.)

I didn't know where I fitted in to the world, because, as you can see, my skin is dark (Kamal: 57-59.)

And people say to me you know, my friend came to see you, but she wasn't sure it was you. And I say, how did you describe me and they say the brown one or the dark one. I am the dark one. (Martha: 224-227.)

There are hints in the narratives, often concerned with issues of skin colour and care and hair type and care which suggest that some people of mixed ethnicity see their bodies as, in part, defining their identity. Analysis of this metanarrative has not been attempted because, first, there is not enough data in the narratives and, second, because such an analysis would take the research, initially at least, in a more biological and physical direction, which is not its main purpose.

The metanarratives are created through an analytical reasoning process, based on the linkages between categories and stories. Though each creation follows the same process, it is, of course, different in detail and content. The initial phase is to create a network which includes the required categories, stories and linkages. This stage provides a visual indication of the complexity of the issue being investigated. The second stage is to tabulate the data from the network so that the complexity and nature of the links can be better assessed.

4.4. The metanarratives

The purpose of the metanarrative is discussed in Chapter 4.3.

All of the metanarratives will be dealt with in a similar manner. They commence with a discussion of the content, the linkages chosen to analyse the content and details of stories which have not been included. The linkages between the analytical categories and the various individual narratives are then presented in diagrammatic and tabular form, together with an analysis of the complexity of the links. The contributions made to the metanarrative by the individual stories is then discussed and illustrated. Finally, a metanarrative is presented.

4.4.1. The mixed ethnicity and identity story: choice and fitting-in.

Though this thesis deals with the issue of identity for people of mixed ethnicity, it attempts this in a social rather than a psychological manner. It records and discusses the ways in which individuals define their identity in a social sense, choice and the choices made by others.

Previous chapters have discussed the possibility that people may choose to define or redefine their ethnicity in different circumstances. It is acknowledged that the narrative data collection sessions were such a circumstance when individuals may have chosen to redefine their identity on the basis that they were aware that they were participating in legitimate academic research concerned with mixed ethnicity and health. There is evidence from the narratives that some individuals defined themselves as ‘people of mixed ethnicity’ when they would usually self define as ‘Black’. For example, one person said:

it’s only because you showed me respect that I said ‘mixed’ – normally I’d put ‘Black African’. (Janet: 79-83.)

The analysis categories selected for the construction of this metanarrative are, ‘Mixed Ethnicity, Identity and Choice’, ‘Mixed Ethnicity and Identity’ and ‘You could pass as white’. They have been chosen because they encapsulate the central issues, and include one of the

frequently referred to choices for many people who self-define their ethnicity as ‘mixed’, the suggestion by others that ‘you could pass as white’.

The notion of ‘mixed ethnicity and identity’ occurs in almost all the narratives (16 out of 20) and is central to this research. The category ‘mixed ethnicity, identity and choice’ arises from two sources; firstly, there is the issue of choice of ethnic group membership (see Chapter 2.1.); secondly, this issue of choice and the difficulties in making it, is discussed, in some detail, in a quarter of the narratives, with narrators saying:

... if you're from a mixed background, then you're fortunate because you've got more choices than most people. (Manjit: 317-319.)

I exercise choice sometimes, I make a choice to be British. (Martha: 212.)

Imagine what it's like if you're mixed and you don't know which side of the fence to choose. (Anna: 947-948.)

Finally, the category ‘You could choose to be white’ is included. It fits well with the two preceding categories, though this suggestion seems to be especially problematic for a number of reasons. The person making the suggestion is always (in this research) white. There is an implication that the person of mixed ethnicity ‘should’ make the decision to be white, partly because their lives will be easier, but more importantly for the reason that it reinforces the position that ‘white is best’. Narrators said:

... sometimes, in very stressful situations I've ... I've been told before I could pass for white. I might choose that then, but in normal circumstances, no. (Jayita: 26-28.)

Some mixed people choose to be white, but you have to ask why... . (Anna: 516-517.)

Perhaps they want to choose to be white because they've had so much racism happen to them, through their schooling and everything (Lynne: 457 – 460.)

The initial network and analytical table are shown below.

Fig: 4.4.1.1. - Network of Linkages: The Mixed Ethnicity Story: Choice and Fitting-in.

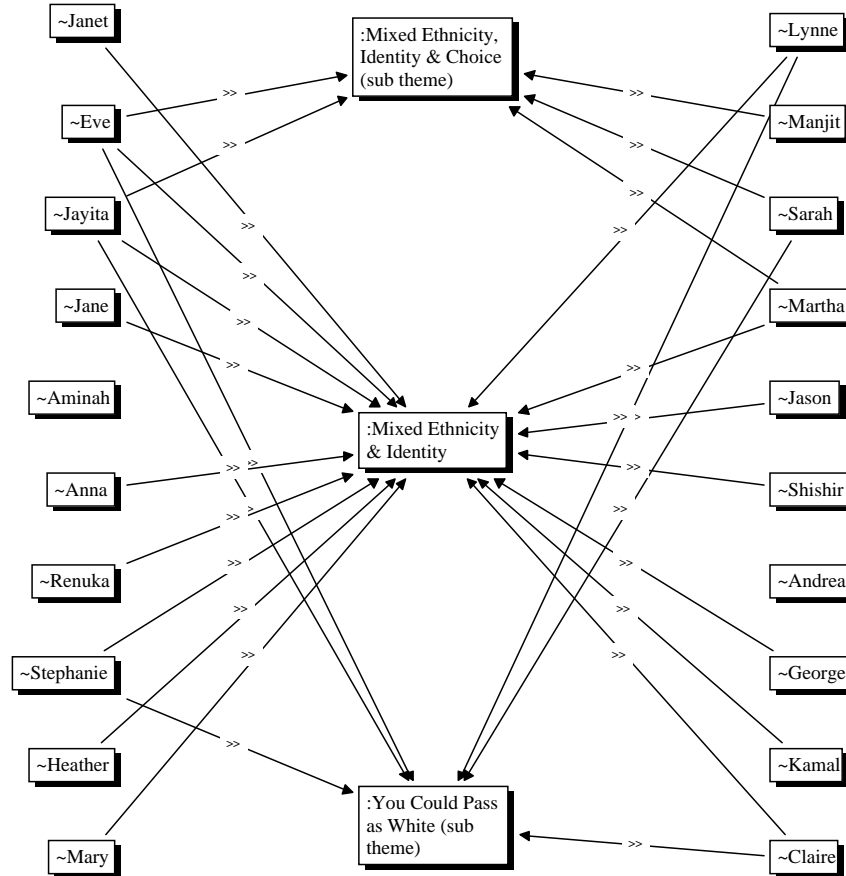


Table: 4.4.1.1. - Table of Linkages: The Mixed Ethnicity Story: Choice and Fitting-in.

Link Type	No. of Stories	Identification
No Links	2	05, 17.
1 link to <i>Mixed Ethnicity & Identity</i> .	10	01,04, 06, 07, 09, 10, 15, 16, 18, 19.
1 Link to <i>Mixed Ethnicity, Identity & Choice</i> .	1	12.
2 Links to <i>Mixed Ethnicity and Identity + You could pass as white</i> .	3	08, 11, 20.
2 Links to <i>Mixed Ethnicity & Identity + Mixed Ethnicity, Identity & Choice</i> .	1	14.
2 Links to <i>Mixed Ethnicity, Identity & Choice + You could pass as white</i> .	1	13.
3 Links to <i>Mixed Ethnicity& Identity + You could pass as white + Mixed Ethnicity, Identity & Choice</i> .	2	02, 03.

The preliminary network diagram indicates that this metanarrative is especially inclusive, with almost all the stories from this research participating. This initial part of the analysis also indicated that this metanarrative is not especially complex, in terms of the number of links between each story and the analysis categories. Of the 18 stories involved 11 had only one link: 10 had a single link to ‘Mixed Ethnicity and Identity’ and 1 had a single link to ‘Mixed Ethnicity, Identity and Choice’. 5 stories had 2 links: 3 were linked to ‘Mixed Ethnicity and Identity + You could pass as white’, 1 to Mixed Ethnicity & Identity + Mixed Ethnicity, Identity & Choice and 1 to Mixed Ethnicity, Identity & Choice + You could pass as white. Only 2 stories had 3 links; in both instances these were to Mixed Ethnicity& Identity + You could pass as white + Mixed Ethnicity, Identity & Choice.

Story 17 and story 5 had no links and were, therefore, excluded from this metanarrative for the reasons discussed below. Story 17 was narrated by a white, female GP, Andrea. The synopsis, manner, tone and structure and content of this particular narrative suggests that it is not surprising that the narrator does not participate in this specific discourse:

Fig: 4.4.1.2. - Story Classified by Manner, Tone and Structure – Andrea.

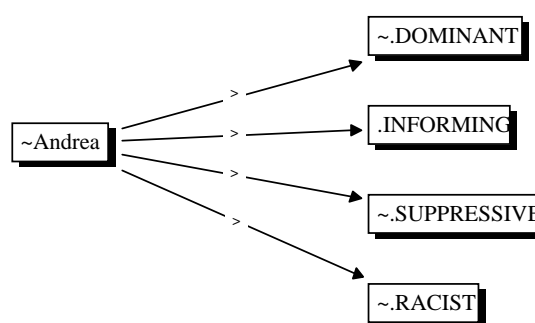
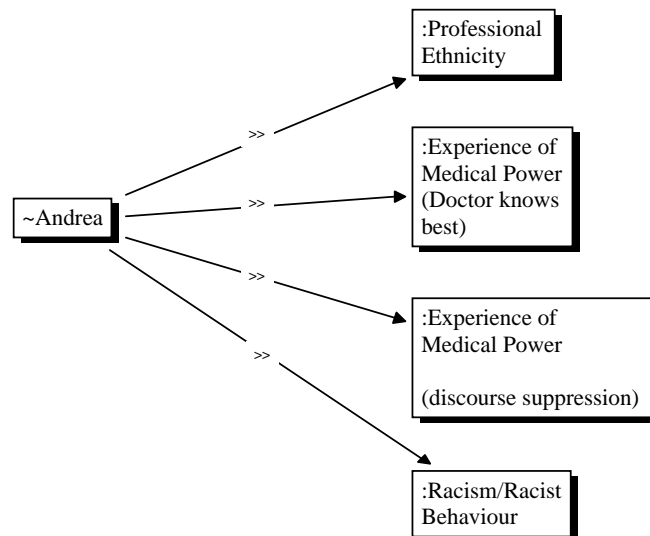


Fig: 4.4.1.3. - Story Classified by Content – Andrea.



The story itself was focussed on the ‘problems’ that she, as a white GP, experienced with ‘ethnic people’, her assertion that ethnicity was unimportant in her professional life and her stated view that it was appropriate to treat everyone ‘as if they were white’ suggesting that she had failed to engage with the notion of ethnicity as an important factor, preferring to subsume the concept of mixed ethnicity within the dominant white ethnicity:

I don't think that ethnicity is important with people of mixed-race, especially if they're half-white. Most of the mixed-race patients I treat, I just treat them as if they're white and I don't let ethnicity come into it. Why should I? (Andrea: 16-19.)

Furthermore, this narrator problematises anything that she perceived as ‘ethnic’, saying,

... I would describe myself as British, but you can see that I'm white, so it's not a problem for me. (Andrea: 26-27.)

She also demonstrated a lack of knowledge and understanding of minority ethnic health issues and believes that,

...they're probably healthier anyway because of things like hybrid vigour. (P17: 45-46.)

For these reasons, Andrea’s story has not been included in this metanarrative, though some quotations are employed to illustrate specific points, since while the narrator does not participate in the metanarrative, some of her statements serve to elucidate various points within it.

The non-inclusion of Aminah’s story was surprising because this narrator comes from a self-defined mixed ethnicity background. However, although she spoke at length about ethnic health issues, she addressed identity only in vague and impersonal terms, concentrating on ‘race’ and ‘racism’ as identifiers. Because of this lack of engagement, the story is not included in the metanarrative.

Fig: 4.4.1.4. - Story Classified by Manner, Tone and Structure – Aminah.

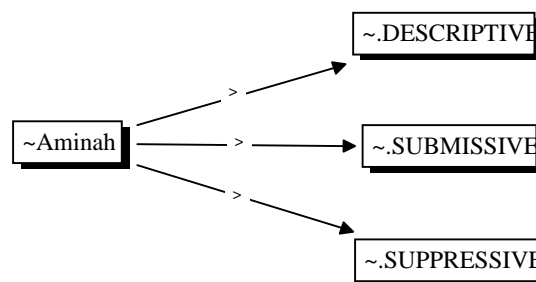
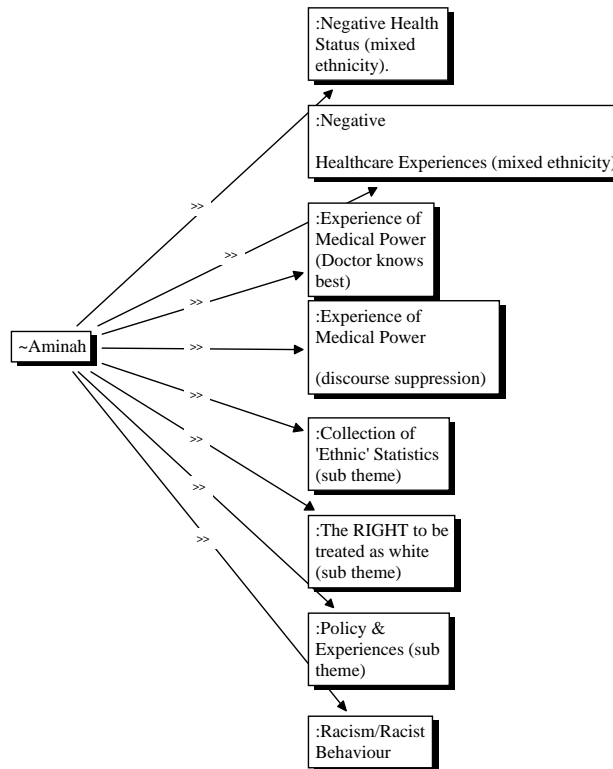


Fig: 4.4.1.5 - Story Classified by Content – Aminah.



Both Andrea’s and Aminah’s stories dealt with mixed ethnicity and identity in a way that was perceived to be external to the individual. It was not that they necessarily said that ethnicity and mixed ethnicity were not important, simply that they implied that they were not important in their own lives or in the way that they treated others.

The narratives yielded 27 different definitions of ethnicity and 59 different definitions of mixed ethnicity, suggesting that, on average, each narrator made about 4 different definitions of these concepts in their narratives. (See Appendix 3 for details.)

How the narratives begin

When people start to talk about how they fit into the society where they live, their initial comments are often about describing and defining their perception of themselves, their identity and ethnicity. For example, narrators in this research said:

I’ve always been black, I’m used to it. (Anna: 110.)

I call myself Pakistani; but my father's African ... if I have to choose, I call myself Black. I'm really comfortable with that. (Jayita: 22-27.)

You can't be in the middle ... there's no way - personally I think you can't be in the middle ... you can be there (gestures) or there, know what I mean? (Janet: 125-127.)

Sometimes it's quite difficult to be sort of half-and-half; people sometime say, well, you could pass as white and that offends me a bit, actually, yeah. It makes life difficult in some ways because people can say stuff that's quite racist, because they don't realise where you come from, which is quite comical in sometimes, because you can then pull 'em up on it <LAUGHS> I mean, actually, yeah it's a bit irritating, because why should I want to reject my background and my family and, I suppose, part of my culture too? (Claire: 356-371.)

Some talk about how they describe their own ethnicity, or that of their children, though these comments link strongly to the knowledge that decisions made by others are important (see below):

I think at the end of the day the children themselves are going to be the ones that come up with terms that they want. They must define it themselves. (Jane: 91-93.)

... there's lots of half-caste children around now. (Heather: 101-102.)

Some people will say half-caste, half-breed, mixed-race, dual-heritage, multi-heritage ... (Jason: 113-114.)

The metanarrative now progresses from simple descriptions of where narrators see themselves in the world to explanations of the choices that they make, or feel able to make, that results in both their perceived 'place' in the world and the means by which they achieve this position.

These are 'internal' descriptions, that is, they are how the narrators see themselves, rather than their perception of how they are seen by others. Typical observations are:

... people of mixed race have got to make a really specific decision – you [the researcher] didn't have to. Some mixed people choose to be white, but you have to ask why. (Anna: 515-517.)

The same narrator, speaking about a friend, said:

It's like he decided to have different ethnicity at different times for different reasons and he knew that white people wouldn't be able to tell the difference. (Anna: 828-831.)

Other comments include:

... they have to go through it – they go through this identity thing because they've got 2 sides, one side saying well you're white the next side saying you're black, you know? In addition, it's where you find that central thing, where you find your resting-place. (Janet: 57-62.)

Imagine what it's like if you're mixed and you don't know which side of the fence to choose. (Anna: 945-948.)

I didn't understand where I fitted in the world and, I suppose, I had to make some choices. (Kamal: 65-67.)

... mixed-race or mixed-ethnicity people, I think they're best described as spaghetti junction and for the sake of an easier life for them to live, they're going to have to take sides. They do take sides and there are consequences for the sides they take and the sides they reject. (Anna: 926-930.)

I really can't say what I am, because, I mean, I respect the both sides--- I change who I am according to my mood and what I'm doing. Sometimes I'm Pakistani, sometimes I'm black. If I have to tick a box on a form, I try not to. It shouldn't matter what people think (Renuka: 157-161.)

But I think everybody who's living outside their native culture goes through an, a sort of, identity crisis in their teenage years. I suppose, you know, that if you're from a mixed background, then you're fortunate because you've got more choices than most people. (Manjit: 315-319.)

It is interesting to note that one narrator, a doctor, who under some circumstances, such as when describing himself historically, said that she was of 'mixed race' noted that the decision on where to fit-in was, for him, external but not imposed in the way that some others are. He said:

... in a way, where I fit was decided for me when I went to medical school - I mean, my father was a respected doctor in Pakistan, and he was a GP over here and it was always understood that I'd be a doctor too. And because there's doctors from many races in England, as soon as I qualified, I felt that it wasn't, you know, a problem, where I fitted any more. I was a doctor and I knew I'd always have the respect of my patients. (Kamal: 67-74.)

All narrators do not agree, in fact, their definitions vary widely. Some cannot understand why others make some choices. One said:

I talked to a black girl recently, she said she was English. I asked her where she was born and she said England. I asked her where her parents were born and she said Jamaica. When I asked her why she hadn't said she was Jamaican, she couldn't see why she would want to. She had never been to Jamaica. But I said that she got some of her culture, her ethnicity, from Jamaica. (Anna: 734-740.)

Another, in describing a friend, said:

... he didn't want anything to do with his culture, only the food. I would say he likes the food, but the rest of it, he probably doesn't want to be associated with. (Stephanie: 94-97.)

The narrators recognise that the choices that they make are personal or, at least, not negotiated with others. That is, even though they have expressed a choice, other people will see them, and thus make choices about them, independently. They said:

People who look, you know, like us, dark-skinned we'll be in with the black people, right? I mean, no disrespect, no white people are going to turn round and say 'that person's white'. Because, you know, your skin colour doesn't show that, so they'll stick there. But still, we'll be special because there's no place for us. (Janet: 127-132.)

I've been called Nigger and sometimes it matters and sometimes it don't - it depends on so many things. (Jason: 156-157.)

... my one sister ... sees herself as black and she could actually move to Jamaica and live in Jamaica and fit in and be accepted. I couldn't. (Jason: 130-134.)

Another described early experiences, saying:

I had lots of problems as an adolescent in France. Because my skin is dark, I was taken to be a North African. I was treated as a North African. (Eve: 94-96.)

When narrators talk about how and where they, or their children, 'fit' into contemporary British society, they say:

... people look at your kids and at you and, sort of, wonder 'where do these kids fit'? (Janet: 104-105.)

You always find, as well, with mixed race, specially like with mixed race, they either go one way or the other. Either they've got all white friends or they've got all black friends. (Lynne: 234-238.)

This last statement is supported by others and includes a suggestion that the choice will depend on where an individual person feels accepted:

But people of mixed race have to make decisions about their identity when they're teenagers. I think that this is why sometimes they grow towards, like, more friends from more black people than they do with white because, they'm torn, you know? (Lynne: 274-280.)

They say, 'I'm a problem because the whites call me black and the blacks say we don't know which side you're on, so what do you know about it?'. And then you find that the child will take sides and they'll go where they are accepted. (Anna: 857-861.)

Other people define their notions of 'fitting-in' and the ways that they link this concept to the idea of 'mixed ethnicity and identity' in disparate ways, some of which are proscriptive. For example:

I think that mixed people should try to fit into the black groups, that's where they belong and that's really important if we're to have our own power and finance structures. (Jason: 322-324.)

However, another consideration appears at this point in the discussion; and is concerned with the knowledge that, no matter what choice about ethnicity, or membership of any particular ethnic grouping, is exercised by an individual these choices may not be known to any other person. Thus there is a likelihood that others' perceptions of an individual's ethnicity and their 'place' in the world will be different.

If they're looking at nationality, then our children, born in this country, won't be classed as Jamaicans by the Jamaican Government, and if they're here they won't be classed as English by this Government. So what are they? (Anna: 494-498.)

That a person is able make a choice about her or his identity is a vital constituent of freedom, but that this choice may be partially invalidated by the uninformed choices of others is crucial. This dichotomy is complex, but is reinforced because there is an unspoken assumption by the dominant population that it is, in some way, better to be white:

I do wonder whether people have a tougher time because they're mixed ethnicity, I do wonder about that. I think to myself, 'light skinned'. If he was lighter skinned, he may have an advantage. (Manjit: 284-288.)

Indeed, the position that 'white is best' must be considered racist, not least in the way that some medical professionals use it to problematise the presentation of people of other ethnicities. One GP, having already noted that she was white 'so it's not a problem', said:

They really don't know how to tell me about their symptoms, they seem to think that I should be able to tell them! (Andrea: 7-9)

This assumption is frequently targeted, by white people, at people who have defined their ethnicity as 'mixed', often in the form of 'you could pass as white. Why don't you?'. This assumption was mentioned frequently in the narratives and was a constituent link of 6 narratives in this metanarrative:

... sometimes, ... I've been told before I could pass for white. (Jayita: 26-27.)

I seemed to be the only one who was actually celebrating my son's black heritage and everyone else seemed to want me to pretend he was white. (Jane: 15-18.)

I was aware right from day one that if I didn't actively seek out every kind of way of giving him the message that he should be proud of his black heritage, then he was going to get a message from the majority of people around him that, actually, they'd prefer it if he was to pretend he was white. (Jane: 104-109.)

Something you always find, particularly with light-skinned children like my daughter, people say to her, you could be white. (Lynne: 448-451.)

This dominant perception that to be white is, in some indefinable way to be better is frequently challenged, often by the parents of mixed ethnicity children: one remarked:

I've had to take a bit more control in terms of the other [child] because it would be easy for [him] to just slip into, slip away into white culture, just become another white man. (Jason: 386-389.)

... people of mixed race have got to make a really specific decision – you didn't have to. Some mixed people choose to be white, but you have to ask why. (Anna: 515-517.)

These statements strongly support the argument that the dominant white population still attempts to perpetuate the notion of 'race' as an hierarchical social construct designed to reproduce and sustain white power, especially as 'white' is rarely perceived as an ethnic grouping (see Chapter 2.1.). It further argues that, in the case of people of mixed ethnicity, it endeavours to do this by assimilating and subsuming their ethnicity and identity into the white majority by offering limited choices that are predicated on the assumption that 'white' is, in some intangible, almost subliminal way, better than 'black' or 'mixed ethnicity'. The messages are not always obvious, and do not argue that 'black or mixed ethnicity is bad' nor that 'black or mixed ethnicity is good', simply that 'white is good'.

The absence of a 'black or mixed ethnicity is bad' and the presence of a 'white is good' description links to Foucault's epistemes and theories of discourse. This argument can be considered epistemistic because it fulfils Foucault's definition by being a underlying and unconscious rule that controls both the behaviour of individuals and their view of the world and tends to provide 'theoretical powers' (Foucault, 1970: XXII.) to legitimate the dominant group's position. It fits Foucauldian discursive structures because the nature of discourse is to both permit discussion of some issues, in this instance that 'white is good', while restricting the discussion of others, in this instance the discourses 'black or mixed ethnicity is good' or that 'black or mixed ethnicity is bad' are rendered illegitimate and, therefore, cannot be discussed. Thus it provides a control over the manner in which people use the discourse of mixed ethnicity and, to some degree, accounts for the common perception of the narrators that

they are offered restricted choices of where they 'should' fit into British society. (See Cheek and Rudge, 1997 and Foucault, 1970: XXII.)

The metanarrative

The metanarrative 'The Mixed Ethnicity and Identity Story: choice and fitting-in' can be constructed from the 18 contributing stories and can be regarded as a relatively simple story, at least in terms of the linkages that it forms to the analytical concepts. It is composed of four main phases, though these are not entirely discrete and there are many overlaps. The metanarrative constructs this story as a linear, logical developmental process. In the contributing narratives, this was not necessarily the case.

This synopsis attempts to let an hypothetical narrator summarise the metanarrative with words of the story shown in the boxes below.

PHASE I – DEFINITIONS AND DESCRIPTIONS

This is the person I am. I am this person through many factors such as where I was born, where my parents were born, where I live, my religion, how I see the world, the colour of my skin, how I perceive my cultural heritage, how I perceive my nationality, where I feel my home is; what I call myself.

I am a complex person. I do not always fit into the categories that people expect and my behaviour may not be what they expect. That is my decision.

In some ways I'm fortunate; I have two cultures and two histories to draw on.

PHASE II – CHOICES, FITTING-IN AND ACCEPTANCE

I made choices about the person that I am. I did this for a number of reasons that include:

I felt I had to fit in.

Not knowing where you fit into the world can be painful; I had to take sides: I couldn't 'sit on the fence'.

I had to choose whether I was white or black, or something else.

It was my way of dealing with my identity.

Sometimes I can choose to be a different person.

I wonder where my children will fit into the world: will their lives be easier if their skin is light?

PHASE III – CHOICES MADE BY OTHER PEOPLE OF MIXED ETHNICITY

I can't always understand why some mixed ethnicity people make the choices that they do.

I can't understand why someone would want to be cut off from half their heritage.

PHASE IV – CHOICES MADE BY OTHERS

I realise that I can choose to be who I want, but other people's choices of who I am may be different.

Other people's choices can make my life difficult.

People see the colour of my skin and, have particular expectations of who I am and how I will behave.

What people call me can be hurtful.

When I fill in forms, there isn't a box for me to tick.

PHASE V – FREEDOM TO CHOOSE, BUT WHITE IS BEST

Sometimes people tell me that I could 'pass for white'.

I get the impression that people would prefer me to be white: that would make their lives easier because they would know how to treat me.

People assume that I would like to be white, because my life would be easier. Mostly, I don't feel like that.

4.4.2. The doctors’ story: health and ethnicity, power and ‘professional ethnicity’

This metanarrative has much clearer boundaries and is much shorter than the first. In part, this is because its construction is limited to the inputs made by the four doctors who participated in the research. Each of these participants was a family doctor, currently in practice. The construction of this metanarrative relies on contributions from the doctors’ narratives where they treat themselves as doctors rather than occasions when they may see themselves as patients or service users.

In addition to being more clearly delineated, the metanarrative is narrower in scope and there is also a more marked consensus of opinion, and more agreement as to the dominant manner, tone and structure of the narratives, as shown in the table below.

Fig: 4.4.2.1. - Manner, Tone and Structure: The Doctor’s Story: Ethnicity, Power and ‘Professional Ethnicity’.

STORY	DESCRIPTIVE	SUBMISSIVE	DOMINANT	RESISTANT	QUESTIONING	ASSERTIVE	INFORMING	SUPPRESSIVE	RACIST	ANGRY	CONFUSED	DOMINANT MANNER, TONE AND STRUCTURE
16												Assertive/Suppressive
17												Dominant/Informing/Suppressive/Racist
18												Descriptive/Dominant/Questioning/Assertive/Informing/Angry
19												Dominant/Assertive/Informing
Links	1	0	3	0	0	3	3	2	1	1	0	

This initial analysis suggests that the doctors’ story is predominantly dominant, assertive and informing, though there are significant sub-texts comprising suppressive and racist components.

The categories that have been selected for the production of this metanarrative are, ‘Negative Health Status (mixed ethnicity)’, ‘Professional Ethnicity’, Experience of Medical Power (Doctor knows best’, ‘Experience of Medical Power (discourse suppression)’ and

‘Racism/Racist Behaviour’. This metanarrative relies more on interpolation than its predecessor. This is because it is rare for narrators, who know that their words are being recorded, to make overtly racist statements. However, the manner in which people speak and, in particular, the ways in which they refer to members of minority ethnic groups is indicative of their stance in this regard. In some instances, quotations from narratives which do not comprise this metanarrative are included as examples or illustrations. These quotations are included because, though the narrators do not participate personally or directly in the metanarrative, their comments illuminate the issues from outside.

The notion of ‘Negative Health Status (mixed ethnicity)’ occurs in half of the doctors’ narratives. This category refers to doctors’ expressed opinions that people from minority ethnic groups, and therefore people of mixed ethnicity by implication, suffer from particular health needs because of their ethnicity. For doctors, these concerns are mostly about haemoglobinopathies and diabetes mellitus, both of which are more prevalent in minority ethnic populations. There are suggestions that some doctors believe that this means that the diseases will become prevalent in mixed ethnicity populations too. Others disagree.

I have read some reports of sickle cell disease transferring to the white population through marriage between races, but I haven't seen any cases like that. (Andrea: 77-79.)

There are some obvious health implications, I mean we know that people from the Caribbean and some parts of Africa, are likely to carry the genetic marker for sickle cell disease and it's been obvious for a while now that, if the people from different races have offspring, then those genetic markers are going to be dispersed into populations where they were unknown previously. (George: 70-76.)

People from Pakistan and India and Bangladesh, they're the people that need medical help much more than anyone else in UK, much more than white people do. (Kamal: 22-25.)

The concept of ‘professional identity’ is contested even within this thesis. However, it is not meant to be simply an analogue for ‘professional identity’; something more is intended. That professionals in general, and doctors in particular, have a clearly defined and powerful professional identity is well-documented (for example: Foucault, 1973, Green and Thorogood, 1998 or van Dijk, 1998). My term ‘professional ethnicity’ is used here to imply that there is an additional dimension to the concept of professional identity. This ancillary feature is concerned with the perceived manner in which GPs treat their own ethnicity, apparently subsuming it within their professional identity and becoming ‘a doctor’ rather than, for example, ‘a Pakistani doctor’. It is contended that this subsumation has a negative impact on doctors’ treatment of people from minority ethnic groups.

‘Professional ethnicity’ is apparent in three of the stories. Of the small number of doctors who participated in this research, three quarters implied by tone, structure and manner that ethnicity was something that was about other people. It is difficult to find absolute evidence for this, but it can be illustrated by comments from doctors that suggest that ethnicity is not worthy of discussion in medical treatment, or by statements about individual doctor’s identity. This demonstrates the point made earlier, that the metanarratives are not self-contained, but have concepts and statements that can cross between them. In particular, the concept of identity and fitting-in is repeated here, albeit with a different emphasis.

I don't think mixed race is much of a problem here, well, not in medical terms anyway ... (Andrea: 43-45.)

It is not apparent from context, however, whether the ‘here’ in this quotation refers to geographical location in which Andrea works or to the notion that ‘here’ might represent the issues of identity and fitting-in.

... in a way, where I fit was decided for me when I went to medical school ... because there's doctors from many races in England, as soon as I qualified, I felt that it wasn't, you know, a problem, where I fitted any more. (Kamal: 67-73.)

'Experience of Medical Power (both doctor knows best and discourse suppression)' occurs in all of the stories. There is a continual implication that medical knowledge should not be challenged, even though it seems obvious that a GP cannot know everything. This is apparent to patients too. One said that it was clear that all our experience leads us to believe that doctors know everything, even though it is obvious that this cannot be the case (Sarah: 275-280.)

Finally, 'Racism/Racist Behaviour' again occurs in three out of four narratives. This category is dependent entirely on the researcher's perceptions of statements that seem to offer negative comment on others' ethnicity. It is difficult to evaluate these statements, so the quotations from the transcripts are kept in context so that it can be seen that their meaning has not been misinterpreted.

For example, Eve, speaking about the attitudes of native Americans said,

...and the people ... the more they're given, the more they take... (Eve: 55-56.)

Lynne describes the response of a white driver when she was parking her car with her black partner and mixed ethnicity child,

... he shouted, typical of your bloody sort ... (Lynne: 296-297.)

Similarly, Kamal described his African-Caribbean patients as 'stupid'.

Fig: 4.4.2.2. - Network of Linkages: The Doctors' Story: Ethnicity, Power and 'Professional Ethnicity'.

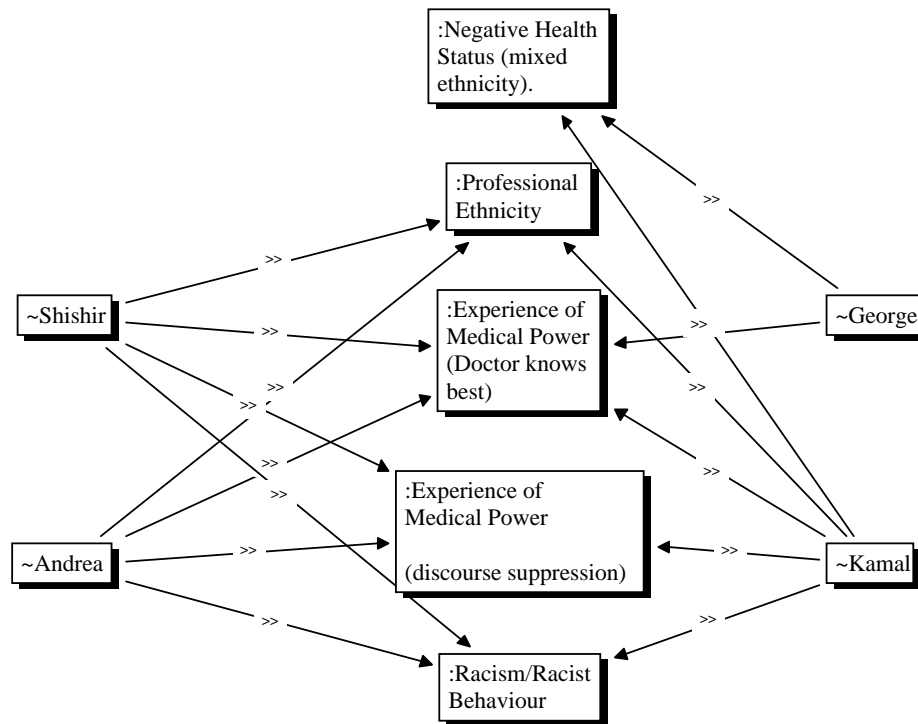


Table: 4.4.2.1. - Linkages: The Doctors' Story: Ethnicity, Power and 'Professional Ethnicity'.

Link Type	No. of Stories
2 links to <i>Negative Health Status (mixed ethnicity) + Experience of Medical Power (Doctor knows best).</i>	1
4 links to <i>Professional Ethnicity + Experience of Medical Power (Doctor knows best) + Experience of Medical Power (discourse suppression) + Racism/Racist Behaviour.</i>	2
5 links to <i>Negative Health Status (mixed ethnicity) + Professional Ethnicity + Experience of Medical Power (Doctor knows best) + Experience of Medical Power (discourse suppression) + Racism/Racist Behaviour.</i>	1

The preliminary network diagram and subsequent table indicate that this is a multifaceted metanarrative. There are a total of 15 linkages to 5 analytical categories, suggesting that the individual component stories are complex. In the first metanarrative, 'The Mixed Ethnicity

Story: Choice and Fitting-in', the majority of the narratives had only 1 link to a category and only 2 stories had 3 links. In contradistinction, in this metanarrative all the stories' links are multiple, ranging in number from 2 to 5.

How the narratives begin

Doctors chose to start their narratives in different ways. They said:

Let me start by telling you the problem I find most difficult with ethnic people... (Andrea: 6-7.)

Let me start by telling you a little about the area I work in and the people who live here. (George: 6-7.)

OK, I'll start by telling you about myself. (Kamal: 7.)

I see myself as a doctor first, a man second and an Indian last. (Shishir: 6-8.)

This represents an interesting variety of viewpoints with 2 narrators speaking of themselves and their identity, 1 talking about the demography of the area in which he works and the other problematising 'ethnic' people. To some extent, these themes are apparent throughout the stories, showing the different ways in which doctors see the people who are their patients and the world in which they live and work.

The trend is then for doctors to talk about the health of mixed ethnic people in two distinct ways. The first is to discuss the specific links between ethnicity and health and the second is to discuss what the doctors present as the ways in which people of different ethnicities react to illness and the healthcare experience.

When talking about health and ethnicity, doctors said:

I do see people with some of the haemoglobinopathies, I don't have anyone on my list who's got thalassaemia major or anything like that. (Andrea: 75-77.)

Mixed race people are tough. My feeling is that I see fewer mixed race people than any other group. (Shishir: 14-16.)

On the whole, they don't seem any different to any of the other children I treat. They have the same childhood illnesses and accidents, though it does seem to me that they don't have such a high incidence of asthma (George: 30-34.)

The perceived implication from the stories about health and ethnicity was that, for most doctors, it is not an issue with which they should be concerned. Though they all exhibit knowledge that members of some minority ethnic groups are more prone to some specific conditions than members of the white majority, it does not seem to be identified as an important issue. It was apparent that some narrators had particularly stereotypical, or at best outdated, views on such conditions as sickle cell disease, one saying,

... of course, you can only get sickle cell if you're from the West Indies ... (Shishir: 180-182.)

The doctors then went on to give accounts of the ways in which they perceived that their mixed ethnicity and minority ethnic group patients interact with doctors and react to the healthcare experience:

... if you're ill, you need to be able to follow your doctor's orders so you will get well again. I mean, really, that's all they have to do, I tell them what to do and if they do it, they'll recover and if they don't they'll die. I tell them this, I say, you must do what I tell you, I am a doctor and I know what is best for you, you must do as I say. The Pakistani people they will do this and the English people will too, but the West Indians, they're lazy and they don't listen and then they don't recover. I think the mixed race people are a bit like that too, because a lot of them are well educated, they get sent to the better schools, you know, they think they know what's good for them, they think they know better than I do, and I am the doctor, you know? (Kamal: 140-152.)

They really don't know how to tell me about their symptoms, they seem to think that I should be able to tell them! They come in here and they want to tell me about their lives, and what I want to know is what their health problem is, their medical problem (Andrea: 7-11.)

I have a number of mixed-race patients, mostly men, who have diabetes. ... if I was talking to you and you had diabetes, I would be pretty confident that, if I gave you a regime to follow and told you to stick to a particular diet, then that's what you'd do. These men, they just ignore me. ... I'm sure, in my own mind, that this is because of their culture. ... They think it'll just go away, like flu and, of course, that isn't what happens.(George: 84-98.)

The foregoing suggests that the doctors that contributed to this research have a specific viewpoint that their minority ethnic and mixed ethnicity patients, because of their ethnicity, are both uninformed about their health and incapable of following 'doctor's orders'. It was especially noticeable that one narrator initially problematised her non-white patients and then complained that they did not use terms which she understood when seeking her professional advice. This suggests that some family doctors are either ignorant or uncaring of differing cultural or ethnic needs and perceptions, an issue that is prominent in the third metanarrative.

Doctors also gave the impression that their time was not only valuable, but short; not to be squandered on what they perceived to be unimportant issues. This fits with the analysis category of 'Experience of Medical Power (discourse suppression). For example:

Anyway, I've said a lot to you [the researcher] and all you've done is listen. Now, I'm busy and I shall have to get on, is there anything more I can tell you, please ask? (Kamal: 130-132.)

This comments are particularly interesting. It suggests that this narrator thought that his time was so valuable that I should not be 'wasted' participating in research. This may have been an attempt by the narrator to terminate the session; probably a patient would have left at this point. However, because of the nature of the narrative data collection process (see Chapter

3.3.) it is inappropriate for the researcher to respond to this sort of statement. In the event, Kamal continued to talk for a further 20 minutes without further stimulus.

I'm really too busy to worry about the ethnicity of my patients, I've got better things to do with my time. (Shishir: 201-202.)

I don't see the point, I really don't think it's good use of my time to talk about what a patient's ethnicity is, especially if I don't think it's relevant to why they have come to consult me. It's hard enough being a doctor without being asked to waste your time. (Kamal: 175-182.)

There are clear indications in the narratives, both the doctors' and others', that doctors are perceived as powerful. Though this research has not investigated the basis of this power, it seems to arise from a mixture of respect for the individual's intelligence and also for the medical profession as a whole. Statements from service users along the lines of 'doctor knows best' are frequent, and they are made by doctors as well as by other service users. For example:

I say, you must do what I tell you, I am a doctor and I know what is best for you, you must do as I say. (Kamal: 144-146.)

There are all the nutritional issues for people of different races too, and they don't know what is good for them. (Heather: 158-159.)

... we seem to be taught by all our experiences that doctors are all-powerful and I think they are sort-of taught the same things too and that we should respect them and believe everything they say. (Sarah: 275-278.)

But doctors do like to think that they know everything they need to, and that me, the patient, knows nothing. (Jason: 312-314.)

The quotations above all contain language that can be considered to be evidence of racist attitudes and behaviours. It seems that some doctors believe that it is acceptable to treat people from minority ethnic populations in the same manner as the white majority. For example, one GP said:

The race of most of my patients here is that they are from Pakistan or India. I tend to check all those patients for TB ... because there's a high incidence of TB in India and these people are always going back to visit their families. (Andrea: 27-32.)

This particular narrator seems to be basing her definition of 'race' on skin colour because she says elsewhere:

I don't ask somebody what their ethnicity is when they come for a consultation. I mean, I can see if they're black or white. (Andrea: 67-68.)

This approach, while seeming to be giving special care to patients of different ethnicities is, in fact, discriminating against them since she provides no evidence that she subjects white travellers or immigrants to similar diagnostic procedures.

Other narrators made implicit or explicit racist statements:

... quite a lot of my patients have diabetes, most of them, I suppose, are black men, but they're stupid, you know? (Kamal: 136-138.)

So, I just don't think we have a problem with race here, especially not with the mixed-race people you seem to think are interesting. As I've said, if you just treat everybody the same, treat them as if they're white, how can there be a problem? I never hear about one anyway. (Andrea: 136-140.)

There is evidence too that doctors do not always allow any consideration of the relevance of ethnicity to health and appear to be unwilling to discuss it. This is examined in more detail in the next metanarrative, 'The Patients' Story: Mixed ethnicity and healthcare experiences.', but it is important here too. For example, one narrator said:

A GP's working life is complicated enough already without having to worry if you're treating people appropriately because of their ethnicity. (Andrea: 85-87.)

This statement of position was echoed by other contributors.

This type of racist/suppressive position is part of other metanarratives too. It suggests strongly that doctors know that they are in a position of binary power with regard to their patients. It argues that doctors use this power to place themselves outside the usual ethnic groupings and to adopt a sort of 'professional ethnicity'. Whether this is done consciously is not clear, though it seems to represent an epistemistic position in that it is a stance that is rarely challenged and controls the relationship between the concepts of 'doctor' and 'patient' and, crucially, the nature of the healthcare experience. Inevitably, the application of doctors' power will influence the dynamic of how patients represent themselves to their doctors.

The metanarrative

During the production of this metanarrative, it became clear that, rather unsurprisingly, it links strongly to the next 2; 'The Patient's Story I: mixed ethnicity and health status' and 'The Patients' Story II: Mixed ethnicity and healthcare experiences.' In particular, though there is evidence of discourse suppression in the Doctors' Story, it is in the Patients' Story that this is described and explained in detail. Though the two metanarratives are constructed from different sources and from dissimilar perspectives, it is difficult to separate them.

The Doctors' Story has four main phases that, as before, tend to overlap. It differs from the first metanarrative because Phase IV, concerned with racism and discourse suppression is implicit, rather than overt. As before, the hypothetical words of the metanarrative are shown in the boxes below.

PHASE I – DESCRIPTIONS AND DEFINITIONS

I am a doctor first and a human being second.

I am individual, like every doctor and see the world through my perspective.

I know that I am intelligent and that I have the respect of patients in my community.

I think that my professional ethnicity is part of my identity and I see myself as a doctor first and as a member of an ethnic group second.

PHASE II – DOCTORS ARE POWERFUL AND THEIR TIME IS VALUABLE

Because I am a doctor, I expect people to understand that I know how they should be treated if they are ill.

They should follow my instructions because I know best: I expect them to do this.

My time is precious and I don't want to waste it. Because of this, I do not have time to be concerned with things that are not central to my diagnosis and treatment. Don't waste my time.

Generally, I do not think that ethnicity has an important impact on health.

PHASE III – HEALTH STATUS AND PATIENTS’ HEALTHCARE EXPERIENCES

I know about the conditions that are more prevalent in people from some foreign countries. The conditions that I always mention are sickle cell disease, thalassaemia and diabetes mellitus.

Apart from the more prevalent conditions, I think that the health of patients from minority ethnic groups and, particularly, people of mixed ethnicity is much the same, or better, than the white patients I treat.

I think people of mixed ethnicity are less likely to follow my instructions: to some extent, I think this is because they don’t understand illness in the way that white people do.

PHASE IV – RACISM AND SUPPRESSION OF DISCOURSE

I can tell my patient's ethnicity by looking at them.

I find that people from minority ethnic groups cannot always describe their symptoms in ways that are useful to me.

I try to treat my patients as though they were white: I believe that this is the best thing I can do.

Even so, I treat patients from non-white groups differently from white patients. I believe that I do this for their own good.

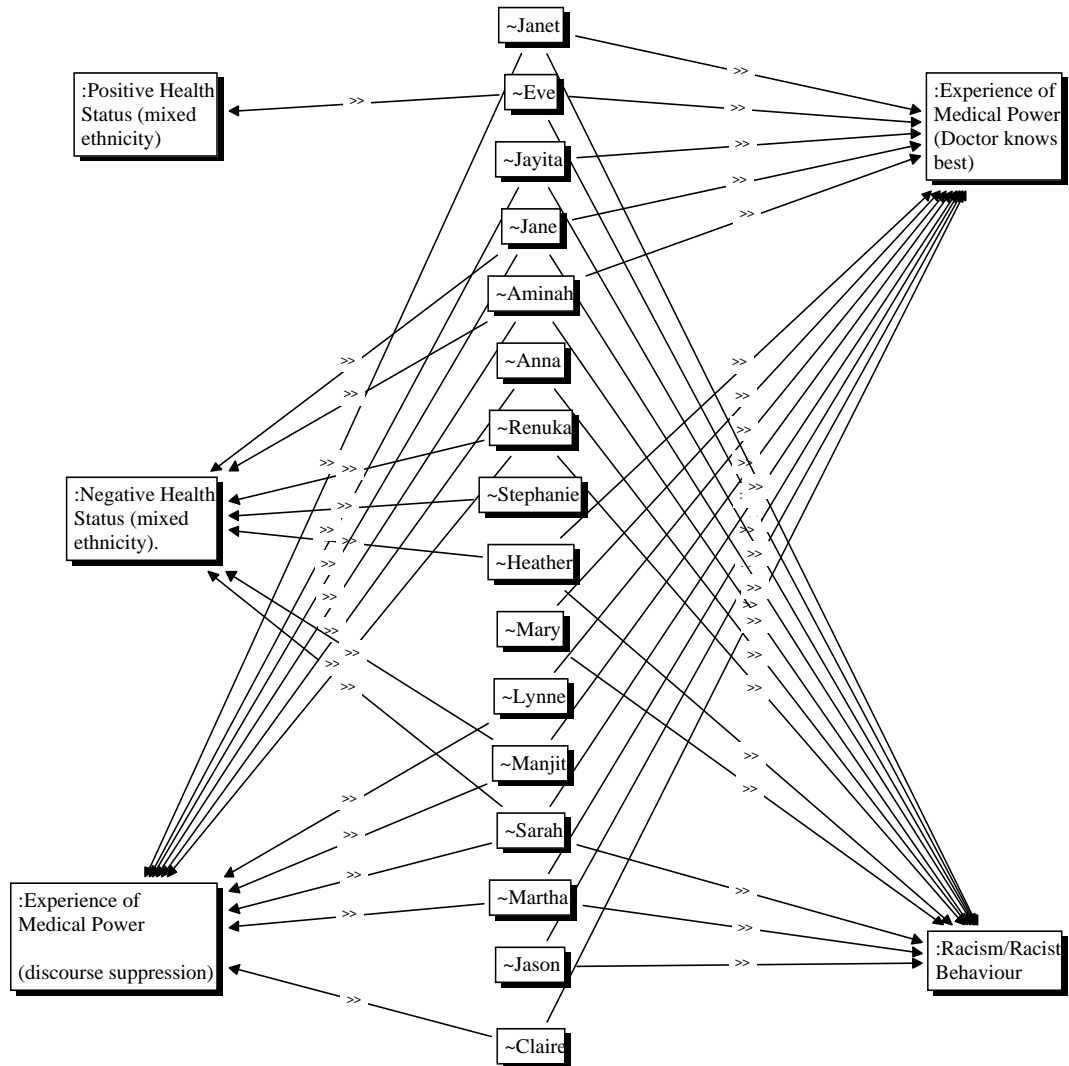
Sometimes, I think I am wasting my time because some non-white patients will not follow my orders.

4.4.3. The patient's story I: mixed ethnicity and health status

The research question which has driven this research contained the hypothesis that people of mixed ethnicity have significantly poorer health status, because of their ethnicity, than the majority white population. In part, this issue has been addressed in Chapter 2.4. However, that relied on the secondary analysis of others' data and includes little qualitative material. This relatively short, but quite complex, metanarrative is concerned with the story of mixed ethnicity and health status as perceived by the narrators.

For this story 5 analysis categories have been selected; these, inevitably, there is considerable overlap with the previous metanarrative 'The Patients' Story: mixed ethnicity and healthcare experiences', since the topics under examination are closely allied. The selected categories are: 'Positive Health Status (mixed ethnicity)', 'Negative Health Status (mixed ethnicity)', 'Experience of Medical Power (discourse suppression)', 'Experience of Medical Power (doctor knows best)' and 'Racism/Racist Behaviour'. The 2 categories concerned with the experience of the exercise of medical power and the category concerned with racism or racist behaviour were also used in the previous metanarrative. They are included here because they help to illuminate, and provide illustrations and examples of, the healthcare experience viewed from a patient's perspective.

Fig: 4.4.3.1. - Network of Linkages: The Patients' Story I: Mixed Ethnicity and Health Status.



While this network diagram indicates the linkages between analysis categories and the individual narratives, like the one that precedes it, it is difficult to quantify these linkages and relate them to the complexity of individual narrative structures. This is accomplished more clearly in the table below.

Table: 4.4.3.1. - Linkages: The Patients' Story I: Mixed Ethnicity and Health Status.

Link Type	No. of Stories
1 link to : <i>Negative Health Status (mixed ethnicity).</i>	1
2 links to: <i>Experience of Medical Power (discourse suppression) + Racism/Racist Behaviour.</i>	1
2 Links to: <i>Experience of Medical Power (doctor knows best) + Racism/Racist Behaviour.</i>	2
2 links to <i>Experience of Medical Power (discourse suppression + Experience of Medical Power (doctor knows best).</i>	2
3 links to: <i>Experience of Medical Power (discourse suppression) + Experience of Medical Power (doctor knows best) + Racism/Racist Behaviour.</i>	3
3 links to: <i>Positive Health Status (mixed ethnicity) + Experience of Medical Power (doctor knows best) + Racism/Racist Behaviour.</i>	1
3 links to: <i>Negative Health Status (mixed ethnicity) + Experience of Medical Power (discourse suppression) + Racism/Racist Behaviour.</i>	1
3 links to: <i>Negative Health Status (mixed ethnicity) + Experience of Medical Power (discourse suppression) + Experience of Medical Power (doctor knows best).</i>	1
4 links to: <i>Negative Health Status (mixed ethnicity) + Experience of Medical Power (discourse suppression) + Experience of Medical Power (doctor knows best) + Racism/Racist Behaviour.</i>	4

In a similar manner to the preceding metanarrative, there are clear indications that the individual stories have many issues and topics in common. In this instance, 13 narratives link to the 'Experience of Medical Power (Doctor knows best)' category, 12 to the 'Racism/Racist Behaviour' category and 11 to 'Experience of Medical Power (discourse suppression)'.

The doctors' stories have been excluded from this metanarrative construction. In part, this is because 2 of the GPs are white, but the remaining doctors have been excluded so as to obtain a metanarrative that is particular to the patients' viewpoint. It is acknowledged that doctors are themselves, inevitably, healthcare system users, but it is contended that they may have a specific 'doctor-oriented perspective', which will be different from that of other service users.

The presence of this orientation would serve only to confuse the patients' story. It would be interesting to follow-up this assumption in later research.

How the narratives begin

The component stories for this metanarrative begin in 2 distinct ways. The narrators either argue that their mixed ethnicity has a negative impact or no impact on their personal health status. Comments include:

Well, I'm not sure that people of mixed ethnicity – and I don't like that term very much – have special health needs. (Manjit: 7-9.)

...do people of mixed ethnicity have special health needs because of that ethnicity? I would say yes and no. I would go with 'yes' for specific reasons around personal needs and personal health. And I'll start with personal health first, that is particularly about haemoglobinopathies – I want a tick for that – and sickle cell disease, yes these are special health needs. The other side of the coin, in terms of personal needs, it's your social side and that social side does affect your health, your social life, so to speak, does affect your health, the sociological processes matter. (Anna: 402-418.)

I think there are links between race and mixed-race and disease too. (Martha: 45-46.)

I don't think that, for me, ethnicity, or my ethnicity anyway, particularly has any impact on health, umm, for me personally ... (Claire: 220-223.)

It doesn't [impact on my health]. Not at all. (Jayita: 141.)

I don't think being a Pakistani has any effect on my health, not at all. Not a thing. (Renuka: 110-111.)

I haven't really had any personal experiences with ethnicity and health, not me nor the kids. (Lynne: 52-54.)

The narratives then progress to stories about particular health status issues, which are nearly always associated with either racism or the doctors' failure to take into consideration, or interact with, the patients' ethnicity. Sometimes the narrators themselves make comments which can be interpreted as racist, about people of other ethnicities or from different

countries. The nature of racism is defined in Chapter 2.1 and, while the statements below are not necessarily intentionally or overtly racist, they are perceived as reinforcing negative stereotypes and assumptions, in this case that people who are 'others' are the source of disease:

I know at the moment there's been some talk about the need to have children that have got any Caribbean parents to have TB injections or something, but I haven't really followed that one through, ... some are being told that you've definitely got to have your TB ... your child immunised. (Jane: 187-194.)

Well, I know about West Indians that have sickle cells(Sic) and a lot of other things ... I mean, most Asians, they have TB.. (Renuka: 163-165.)

Main issues, I suppose, for diabetes, are that sometimes the families, Asian families, don't take it seriously, they often ignore the fact that they've got diabetes and carry on regardless. Because they believe that it'll go away, that's very, very common. (Stephanie: 151-155.)

... as soon as they were born they had to have err, what injection was it? Ooh, I can't remember what it was now, it's for mixed-race children... Anyway, it's for TB. (Lynne: 58-61.)

... people that came from India often didn't have enough vitamins, so they've got rickets and so on. (Martha: 46-47.)

It seems that people are not well informed about the ethnic component of health status. That some specific conditions are more prevalent in minority ethnic populations is clear (see Chapter 2.4.), but it is apparent that the information is not being disseminated sufficiently. For example:

... after all, what do GPs know? I mean [my husband who is a doctor] doesn't know about sickle cell trait and people from the Mediterranean. (Stephanie: 224-225.)

I didn't find out about this [sickle cell disease] from the doctor, I found out from my friend ... (Lynne: 64-66.)

I learnt about sickle cell off my friend, not from the GP – I mean I never had anything off him, no. Not from the midwife or nothing. Janet: 73-76.)

Many narrators made reference to particular issues concerning health and ethnicity. These were often focussed on conditions known to affect people from minority ethnic populations. There was frequent concern over sickle cell disease, which seems to be compounded by ignorance on the part of the patient (or parent) and the doctor.

One time when [my daughter] was really little, she had these pains in her wrist and elbow and, even though my husband hasn't got sickle cell, I was, sort of worried, you know? I suppose I just wanted the GP to tell me it was OK, really, you know, but instead he was looking for injuries and he just wouldn't listen to what I was scared about ... still, I think he was right that time, you know, but it still worries me and I'd still like a doctor to talk to me about it. (Lynne: 352-364.)

Going back to health and ethnicity, doctors are so ignorant! I mean, you know, most GPs have no idea about, say, thalassaemia – even when they've heard of it, they don't know anything about its incidence. They say things like, your background must include the possibility ... some doctors are switched into this, so I'm always asked, you know, is this an issue? But really, all they're doing is showing their ignorance! I tell them that I don't think so and invite them to check and they don't know how to. (Manjit: 374-387.)

Though there is significant comment principally about negative health status, there is little mention of positive factors, though one narrator (Eve: 87:88) regarded her health as being better than the norm because of her ethnicity.

Most individual narratives move rapidly away from telling of health status in favour of discussing experiences of healthcare. Whilst this is, clearly, of great interest, such accounts form part of the next metanarrative.

Surprisingly, there was no mention in the narratives of the effects of socio-economic status on health status. Though the narrators were predominantly middle class, some were working class and several were living in inner-city areas. Others worked, for example as health professionals or as a housing officer, in areas that experience marked social deprivation and it is unlikely that they do not appreciate that deprivation and negative health status have clear

links (see for example, Townsend and Davidson, 1992). It might be argued that the individual narrators were focussed on health and ethnicity, rather than the causes of negative health status. Even so, the majority of Britain's non-white population lives in inner cities (see Chapter 2.3) and it is widely known that these are the areas where deprivation is most apparent. Overall, the reason for omission of these issues is not clear.

The metanarrative

This metanarrative is very strongly linked to both preceding and following metanarratives. It could, perhaps, have formed part of either of these rather than being separated. However, this separation has shown that, for the majority of narrators, it is not health status that is of prime importance, instead it is the nature of the healthcare experience.

The metanarrative is exclusively from the patient's point of view. It is quite short and has only 3 main phases. There is less agreement between the 'voices' that contribute to this metanarrative; in particular, phase I consists of conflicting voices.

PHASE I – MIXED ETHNICITY AND HEALTH STATUS: MY HEALTH

I think that there are links between mixed ethnicity and health status.

I am not sure, however, that most people of mixed ethnicity have special health needs, though there are exceptions.

I want my doctor to take my ethnicity into account when treating me.

I do not think that my health is adversely affected by my ethnicity.

PHASE II – WHAT I KNOW ABOUT SPECIFIC HEALTH ISSUES

Though I think that there may be links for some between mixed ethnicity and health status, these are about specific diseases, not general health.

The specific diseases I know about include sickle cell disease, tuberculosis, thalassaemia and diabetes.

I think that immigrants from the developing world are less healthy than I am.

Sometimes I think that immigrants bring disease into this country.

I think that Tuberculosis is a particular issue and concern for mixed ethnicity children.

PHASE III – WHAT I THINK DOCTORS KNOW/HOW I GET INFORMATION

I don't think that doctors know enough about the possible effects of mixed ethnicity on health status.

I don't feel that I have been well informed about the relationship between my ethnicity and my health status.

I am most likely to get information about health and ethnicity issues (for example, sickle cell disease) from my friends rather than my doctor.

Doctors don't take ethnicity into account when they are treating me or my children. They should.

4.4.4. The patients' story II: mixed ethnicity and healthcare experiences

This complex metanarrative deals with the healthcare experiences of patients, concentrating on the impact of ethnicity on those experiences. In general, this metanarrative is concerned with the social rather than the medical aspects of this experience though, inevitably, there is some comment about medical aspects of health. The issues of health status and mixed ethnicity were addressed in the previous metanarrative.

Of the 20 narratives, 17 contribute to this metanarrative. Their narrators comprise 2 groups of people; first, those who have self-defined as being of mixed ethnicity and, second, those people with mixed ethnicity children, regardless of the narrator's ethnicity. All the contributors' stories included elements concerned with the experience of the healthcare system leading to the selection of 6 analysis categories for the metanarrative construction. These categories were: 'Experience of Medical Power (Doctor knows best)', 'Experience of Medical Power (discourse suppression)', 'Positive Healthcare Experiences (mixed ethnicity)', 'Negative Healthcare Experiences (mixed ethnicity)', 'Racism/Racist Behaviour' and its associated sub-theme 'The RIGHT to be treated as white'.

In this analysis, as in the first metanarrative, manner, tone and structure of the individual narratives can be used only as a general guide, though the exclusion of Andrea's and George's stories had greatest impact on reducing the 'dominant' category by half and the 'informing' category by two-thirds.

The initial diagram of linkages is extremely complex.

Fig: 4.4.4.1. - Network of Linkages: The Patient's Story II: Mixed Ethnicity and Healthcare Experiences.

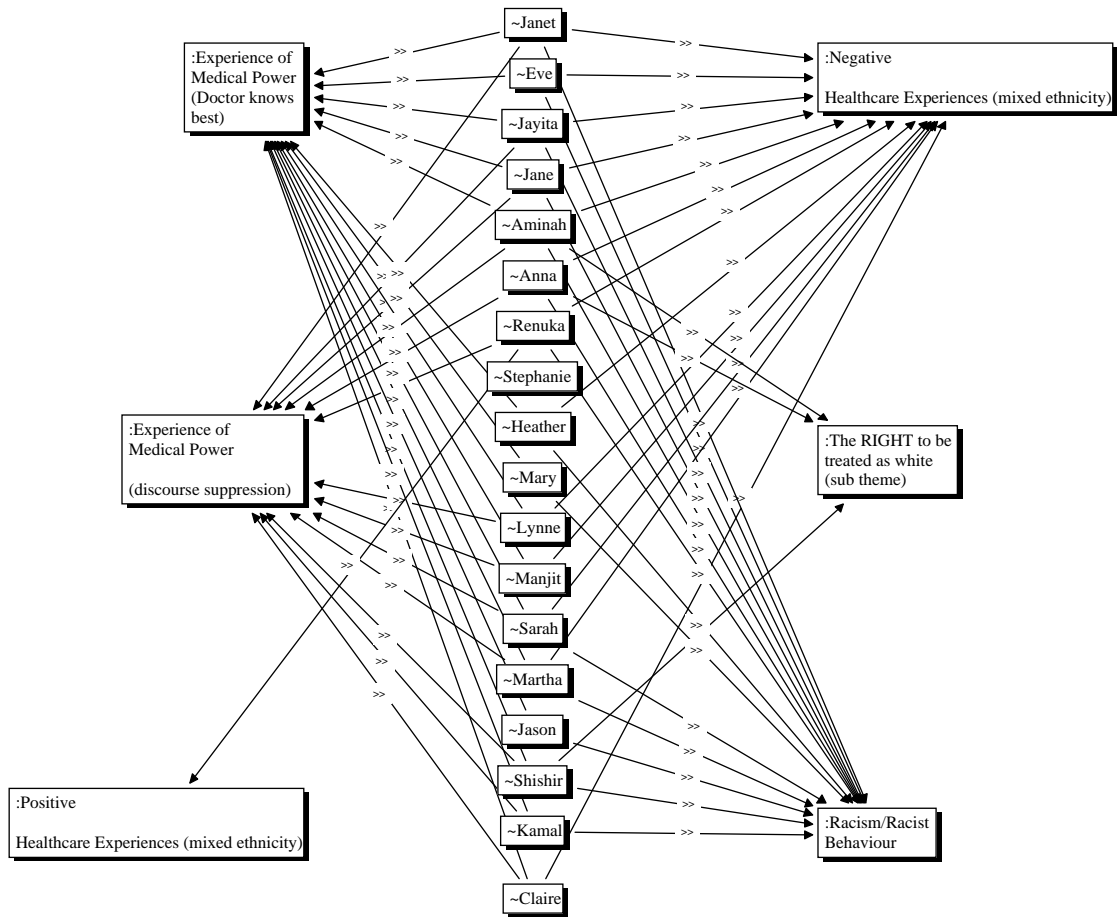


Table: 4.4.4.1. - Linkages: The Patient’s Story II: Mixed Ethnicity and Healthcare Experiences.

Link Type	No. of Stories
2 links to: <i>Experience of Medical Power (doctor knows best) + Racism/Racist Behaviour.</i>	2
3 links to: <i>Experience of Medical Power (doctor knows best) + Negative Healthcare Experiences (mixed ethnicity) + Racism/Racist Behaviour.</i>	2
3 links to: <i>Experience of Medical Power (doctor knows best) + Experience of Medical Power (discourse suppression) + Negative Healthcare Experiences (mixed ethnicity).</i>	3
3 links to: <i>Experience of Medical Power (doctor knows best) + Experience of Medical Power (discourse suppression) + Racism/Racist Behaviour.</i>	1
4 links to: <i>Experience of Medical Power (doctor knows best) + Experience of Medical Power (discourse suppression) + Negative Healthcare Experiences (mixed ethnicity) + Racism/Racist Behaviour.</i>	5
4 links to: <i>Experience of Medical Power (discourse suppression) + Negative Healthcare Experiences (mixed ethnicity) + The RIGHT to be treated as white + Racism/Racist Behaviour.</i>	1
4 links to: <i>Experience of Medical Power (discourse suppression) + Positive Healthcare Experiences (mixed ethnicity) + Negative Healthcare Experiences (mixed ethnicity) + Racism/Racist Behaviour.</i>	1
4 links to: <i>Experience of Medical Power (doctor knows best) + Experience of Medical Power (discourse suppression) + The RIGHT to be treated as white + Racism/Racist Behaviour.</i>	1
5 links to: <i>Experience of Medical Power (doctor knows best) + Experience of Medical Power (discourse suppression) + Negative Healthcare Experiences (mixed ethnicity) + The RIGHT to be treated as white + Racism/Racist Behaviour.</i>	1

It is apparent from the network and table that there is considerable common ground within the various narratives. In particular, 15 individual narratives make links to ‘Experience of Medical Power (doctor knows best)’, 14 stories link to ‘Racism/Racist Behaviour’ and 13 stories links to ‘Experience of Medical Power (discourse suppression)’ and ‘Negative Healthcare Experiences (mixed ethnicity)’.

3 stories have been excluded from this metanarrative. Andrea and George were disqualified, partly because they are GPs, but mostly because they are white with no personal links to

people of mixed ethnicity. Stephanie's story, which would otherwise have been included, made no links with the analysis categories, dealing with the issues only in an impersonal and disengaged manner; while neither of these narrators has directly contributed to the metanarrative, some remarks they made are quoted for illustration. 2 doctors were included as contributors to this metanarrative, because they both self-identify as being of mixed race. Though there is a risk, mentioned in the previous metanarrative, of the potential problems with the particular doctors' perspective, care has been taken to select the remarks made by the doctors when speaking of themselves as service users.

How the narratives begin

When narrators begin to talk about their experiences of the health care system, they normally do so by telling of some specific event which appears to have influenced their opinions of the ways in which they are treated. The overwhelming majority of the experiences that are discussed are negative, and range from perceptions that the doctor has too little time to listen to them (see for example: Balint and Norell, 1990), to events which the narrators attribute to racism and ignorance. Only one narrator, Renuka, suggests that her ethnicity has led to any positive healthcare experiences. Unfortunately, her story makes only a passing reference, rather than giving details that could be included in the metanarrative, she says:

... I like going to see my doctor. (Renuka: 210.)

This could be interpreted as the narrator liking and respecting her doctor rather than evidence of positive experiences.

When talking about the time spent with doctors. for example, some narrators said:

... they tell us they're all pressurised and the rest of it. I think that they don't want to spend more time with patients 'cause it's just nice and convenient to fit us all in our nice little boxes. (Sarah: 237-239.)

... they just want to fob you off, like they don't have enough time, they allocate probably five minutes or ten minutes and if you're chatting they'll look at their clock and say 'you time's up', you know what I mean? (Janet: 154-157.)

It is not necessarily apparent from these statements that they have a direct connection with issues of ethnicity. However, in context, the connections become clearer. Janet, for example, had also said:

You see the Asians go in and they're in there for ages ... (Janet 149-150.)

The stories then move on to tell about the perception that the doctor knows what is best for his or her patient, and the manner in which this information is conveyed. The first comment suggests that doctors may make erroneous assumptions of children's health based on their perceptions of parental ethnicity:

I phoned the doctor and asked if my son could be tested [for sickle cell disease], and the doctor was really saying to me don't be stupid – you know – you're white there's no way he can have any trace of sickle cell. (Janet: 42:44.)

Other statements speak more generally of the manner in which doctors interact with their patients. Some of the accounts are not, at first sight, exclusive to issues of mixed ethnicity, but because of the context from which they are taken, do so relate:

... doctors do like to think that they know everything ... (Jason: 312-313.)

The GP I work for, she takes everybody's feelings into consideration, she's really, really good like that, but she sometimes says to do something that Muslims don't like for their own good – she's a doctor and she knows what's good for people. (Renuka: 260-264.)

... my father is diabetic, and he's had lots of treatment, but he believes that doctors and health professionals know everything so he won't question the treatment he's given and he won't complain and he won't ask questions. He won't ask for an explanation of the way that he's being treated ... he's just passive and he lets doctors do whatever they want to him because they know best. ... He thinks that doctors won't value his opinions. (Heather: 68-77.)

... better to keep them quiet and not let them talk about their problem – after all, doctor knows best ... (Heather: 124-126.)

... you need to be able to follow your doctor's orders so you will get well again. (Kamal: 140-142.)

The stories then progress to the discussion of the way that doctors treat patients of mixed ethnicity. Some narrators reported that they felt that their doctor ‘treated them as if they were white, but commented that this attitude had to be ‘earned’:

... my doctor treats me as if I was white ... (Renuka: 258-2569.)

I think my family doctor treats me like I was white, but I think I’ve had to earn that. (Aminah: 388-389.)

Perhaps more significantly, many patients felt that their doctors do not seem willing to either discuss the impact, or non-impact, of ethnicity on health with their patients, sometimes to the extent that they will suppress any attempt for a patient to raise this as an issue. This stance fits with the Foucauldian perspective that the creations of epistemes and discourse not only enable, but also limit, that which may be said. Doctors’ attitudes suggest that they have rationalised and internalised this position so that it is in keeping with their image of ‘all-knowing and all-powerful’. They then reproduce this behaviour as an episteme that suppresses the ‘mixed ethnicity and health’ discourse and, thus, acts to maintain their powerful position.

For example, they said:

I don't let the idea of race get in the way of my diagnosis ... (Kamal: 92-93.)

... I have no idea how many mixed-race people there might be in the area, and frankly, I'm not that interested. (Andrea: 81-82.)

I don't want to talk to people about their ethnicity. It's not something that matters, as far as I'm concerned. I'm going to treat everyone the same anyway. (Shishir: 207-209.)

Patients noted this behaviour too. They commented:

... mine just try to fob me off... (Janet: 143.)

And he dismissed it all [the possibility that her son had sickle cell disease] and made me feel I was an idiot for asking. (Jane: 51-52.)

Though not part of the planned methodology, a short discussion took place with one narrator, a GP, after the narrative data collection. When speaking of the detection of sickle cell disease in children with white parents, the respondent said:

I think that response was entirely correct. I mean, medicine is all about probabilities, isn't it? So it wasn't likely that a white mother would have a son with sickle cell, so the doctor's response was correct. I wouldn't have checked, and I don't think any other doctor would either, it's just not necessary. (Kamal: 188-194.)

There was considerable comment by many narrators concerning the perceived suppression of information exchange concerning ethnicity and health. Narrators said:

At one point, I saw my GP quite a lot, when I was trying to conceive, and it was clear that he wasn't interested in the possibility of my child being of mixed ethnicity – or at least that was the impression I had – he really didn't want to talk about it and really wouldn't let me either. (Sarah: 227-231.)

It seems to me that GPs don't know – and don't want to know – about any link between ethnicity and health. Maybe they believe that it'll just go away as the races mix? ... it's much easier to diagnose a patient without actually letting them speak – that only complicates the issue with the patient's feelings and knowledge. Much better to keep them quiet and not let them talk about their problem ... (Heather: 117-125.)

he's quite good actually, quite a good GP, but he doesn't tell you much. (Lynne: 81-82.)

It's just like, if they don't, you know, talk about it, then it'll go away. (Manjit: 176-177.)

One narrator, not a doctor, told of a friend's experience, saying,

... the doctor that she saw when she was first pregnant was suggesting that she ought to have an AIDS test. And, you know, that was also really despicable but, you know, there is a sort of whole assumptions that because she was married to a Nigerian ... (Jane: 72-76.)

Another noted:

I worked in [an inner-city district of Birmingham], it's full of Asians, Muslims. The GPs I worked for, there was one, an English doctor and one a Muslim doctor, the English doctor would only see the English patients. (Renuka: 238-241.)

Some narrators thought that the refusal of doctors to engage with the notion that mixed ethnicity could be perceived as having an impact on health was part of a general racialised attitude exhibited by doctors. Narrators indicated that they thought that these attitudes were based in medical power and the belief that doctors know what is best for a patient, even though they are not in possession of all the necessary facts. They said:

When I tried to raise it with one of the GPs, he was one of the white ones, he told me, basically, not to be silly that race and where you come from hasn't got anything to do with your health. (Sarah: 149-152.)

Attitudes which could be perceived as racist, or which at least caused concern, were noted by the narrators, who stated:

When I went to Bangor, I used to get throat infections that were related to the thyroid gland condition I had and my doctor would not, he would not prescribe me any antibiotics. He said this was because I was a smoker, but I always wondered if it was to do with my race. (Jayita: 171-176.)

Of course, GPs have a licence for power, but they use that power to make life easier for themselves, for example, it's much easier to diagnose a patient without actually letting them speak – that only complicates the issue with the patient's feelings and knowledge. Much better to keep them quiet and not let them talk about their problem – after all, doctor knows best (laughs). I do think it's a real shame that GPs and, I suppose hospital doctors too. Don't use their strong position to modify and improve services for all populations. (Heather: 120-128.)

Sometimes I look at [my doctor] and think why do you treat me like this? You see the Asians go in and they're in there for ages and then you go in and he says 'Ah, I'll give you some pills' and that's it. (Janet: 148-151.)

And he dismissed it all [the possibility of an ethnically-specific condition] and made me feel I was an idiot for asking. (Jane: 51-52.)

I don't think my doctor does take any account of my kids race, you know, them being mixed race. In fact ... I think he wants to ignore that. (Lynne: 346-352.)

... even though my husband hasn't got sickle cell, I was, sort of worried, you know? I suppose I just wanted the GP to tell me it was OK, really, you know, but instead he was looking for injuries and he just wouldn't listen to what I was scared about. (Lynne: 354-60.)

When discussing this perceived racism, 1 narrator commented:

Perhaps this sort of thoughtless racism and the making of assumptions is the most dangerous sort, particularly if you're from a mixed background and you don't fit properly anywhere. It's not as if people are even being deliberately discriminating... (Martha: 323-326.)

The doctors involved in these exchanges may not feel that they are acting in a racist manner.

Nevertheless, this is how their conduct is perceived by their patients, the narrators.

One specific health issue, Mongolian Blue Spot, is worthy of note, though it occurred in only 3 of the contributing narratives. It is not directly a 'health' issue, however, it is seen as being indicative not only of the way in which some people of mixed ethnicity feel they are treated by the NHS, but also that doctors are powerful, even in fields where their knowledge may be limited. Mongolian Blue Spot, is a 'birthmark' discolouration of the skin commonly found in children of mixed ethnicity. One of the doctors who participated in this research described it, in a discussion that took place after the data collection session, as:

... a birthmark that children from the Far East sometimes get, ... it doesn't look very nice, but I don't think any other groups get it. I've never seen it at all in my patients, so I don't really know. (Kamal: 166-170.)

A large portion of 1 narrative, and supporting sections from 2 others are reproduced below:

I must tell you about an incident, when ... have you heard of Mongolian Blue Spot that sometimes affects people who are mixed race? My daughter ... she's got it, obviously, on her back, she'd got a little bit round her ankle and round her neck, this blue spot. I always remember taking her to the health visitor, the health centre where you have them weighed and everything. Well, there was a new health

visitor there and I was, like, aware that people had looked and so I was a bit funny, like, about getting her undressed until other people, like, knew about birthmarks and things. Anyway, so I undressed her and put her on the scales. You know, about an hour and a half later, I'd just got in, just done dinner, bang, bang, bang at the door. It was a social worker, health visitor and a policeman! The health visitor thought the spots were bruising. Yeah. I was absolutely gutted. And I said, for goodness sake, she's mixed race you know, it's the Mongolian blue spot. They didn't believe me though – you could see it in the social worker's face, I think she wanted to arrest me! What they had to do was to go back to the hospital records, where it [the blue spot] was listed there. And it was only then that they'd believe me. I felt terrible. I felt like a bad mother and I felt as if I was the guilty one, you know? And now, my little boy it's got, like, darker and like, at the doctors I found I was, sort of, explaining myself, before I was taking his clothes off. I have to say, that's his birthmark, it looks like a bruise --- I don't think I should have to feel like that, but, like, people are always looking, you know? You do what you can, but you have to try to defend yourself before you've done anything. But when she said [talking of the social worker] this is Pauline, from child protection service, I was thinking, what have I done? Then they said that he's got bruises all over him and I said, no, that's his birthmark and I was really relieved, but then I didn't think they were going to believe me and I thought they were going to take my children away. But it wasn't even a good way of doing it, because if it had been bruises they should have done something at the health centre, not waited. They should've done it immediately.. (Lynne: 381-442.)

I had been reading about mixed-race children, and I came across a condition that affects skin pigmentation --- it's called blue-spot. And I asked my doctor if he's heard of it and whether it was likely that my son would be affected, and he had no idea what I was talking about. He even, sort of you know, implied that I had made it up and what were you worrying about, you silly woman. Just like he knew what was best for me and, if he didn't know about it, then it wasn't worth knowing about. I, sort of, also had the feeling that, because he'd never heard of it, he really didn't want me to talk about it, you know, as if he wanted to hide his ignorance. Now, I don't mind GPs not knowing everything, I mean, they can't, can they? But he should have realised that I was a health professional and had an idea of what I was talking about. (Sarah: 282-296.)

I want to tell you about my sister. She's in a mixed-race relationship and she's got a child and the child has a birthmark that lots of mixed-race kids get called Mongolian Blue Spot. Now, she went to the clinic for one of the regular checks and, while she was there, the doctor called the child protection social worker because she thought this birthmark was bruising. Now I know that it's really important to protect the child, but that doctor should have had more knowledge. It's not hard to tell the difference between a birthmark and a bruise, you know. Still, the doctor was white and had probably never heard of it. (Shishir: 201-220.)

This suggests that family doctors are not only unaware of some relatively well-known skin pigmentation issues, but that they make erroneous assumptions of parental behaviour when they discover such issues. Though doctors' duty of care towards all their patients is well-established, the appropriateness of their actions in this situation should be questioned.

The metanarrative

This metanarrative is closely associated with 'The Patient's Story I: mixed ethnicity and health status' which precedes it; this is inevitable, as it is almost impossible to separate health status from healthcare experiences. However, though narrators spoke earlier about their health status, this metanarrative is concerned with the doctor/patient relationship, patient experiences, feelings and perceptions of how they were treated by doctors because of their ethnicity. The metanarrative suggests that, for this group of narrators at least, the experience of the healthcare system is overwhelmingly negative, because of their ethnicity, or the ethnicity of their children.

PHASE I – GENERAL IMPRESSIONS OF THE HEALTHCARE EXPERIENCE

I don't think that my doctor treats me well. He/she never has time for me.

I sometimes think that this is because of my ethnicity, or the ethnicity of my children.

PHASE II – DOCTORS DON'T HAVE ENOUGH TIME

I don't think that doctors spend enough time with me.

This makes me feel undervalued and, sometimes, I think that the doctors spend more time with people of other ethnicities.

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PHASE III – DOCTORS SAY THEY KNOW BEST

Doctors say that they know what is best for me and that I need to follow their instructions.

However, I think they are often ignorant of the ethnic factors that I think may affect my health.

I also think that they do not care about the way that I feel or understand that I care and worry about my children.

I believe that doctors think that they know more than I do, and don't mind telling me so.

Mostly I defer to my doctor, partly because I know he/she could make my life difficult or unpleasant if I don't.

PHASE IV – HOW I FEEL ABOUT THE WAY I AM TREATED BY DOCTORS

Though I'm not sure, I sometimes feel that doctors treat me, or my children, differently because of my ethnicity.

At times, I think the doctor treats me as though I was white, but I've had to 'earn' this by being a model patient and I'm not sure that the assumption that it is better to be treated this way is correct.

I feel that doctors don't think that ethnicity matters in health or makes any difference to the way I feel about my health.

Doctors don't want to listen to my point of view and stop me talking about my ethnicity, even though I sometimes think it may be important. I think they do this for a variety of reasons, including:

They don't know much about race and ethnicity and don't want me to know about their ignorance.

They think that if they ignore these issues, then they'll go away.

Maybe they don't care.

Doctors are racist, perhaps unthinkingly.

PHASE V – MY EXPERIENCES WITH CHILD SAFETY ISSUES/MONGOLIAN BLUE SPOT

Sometimes, I get the feeling that the doctor thinks that I am a bad parent because of my ethnicity

This is a specific issue that affects my children. It is not really about health, but is about the knowledge and attitudes of doctors.

I think doctors should know about this condition, how to recognise it and how it is different to bruising.

I think I have been treated badly in connection with this condition because:

It's not my fault that doctors don't know about it; I shouldn't have to explain all the time.

A doctor should be able to tell the difference between child abuse and a birthmark, particularly when the condition is widespread among mixed ethnicity children.

Though I think it's good for doctors to protect children from abuse (and I want mine to be safe), they should take more care because:

If there's a need to protect a child, then they should do it at once, not wait until I go home.

There is no need to make me feel as though I'm a bad parent and, somehow, it's all my fault.

4.5. Summary and discussion

This chapter is a brief discussion of the findings from the metanarrative analysis, presented before proceeding to a conclusion. In particular, there will be a discussion of the context of the narrative data collection sessions with particular reference to the contributors, a summary and interpretation of the content of the 4 metanarratives, a short evaluation of the effectiveness of the narrative research method (for a full discussion of the nature of narrative research, see Chapter 3.3) and some discussion of changes that might be made if this research was to be repeated or extended.

The context of the narrative collection/sessions.

The participating narrators are clearly central to this research; it is their views, beliefs, feelings and experiences that comprise the findings. It follows that it is important to know the narrators' backgrounds since it is certain that the choice of a different set of narrators would result in a different set of stories and perhaps result in other analytical metanarratives.

The majority of the narrators who contributed to this research were drawn from the West Midlands Conurbation. Of the 20 people who participated, 15 were female and 5 male. Their ages ranged from 19 to 51 years with a mean age of 34.4 years; the median age was 33 years. The narrators all defined their own ethnicity during the research process (see Appendix 3), but in broad terms, 13 were of mixed ethnicity, 6 were white and 1 was black. Of the 6 ethnically white people, 4 had mixed ethnicity children; the remaining 2 were GPs who contributed to the research mainly from that perspective.

Country of birth information was recorded and is shown in the table below:

Table: 4.5.1. – Narrators’ Country of Birth

Country of Birth	No. of Narrators
United Kingdom	13
Pakistan	3
Jamaica	2
Canada	1
Malaya	1

Though no social class data or opinion of class position was sought, the researcher formed clear ideas of individual’s class position, based upon background data (see Chapter 4.1) and a number of observed characteristics such as appearance and language use. The result of this quasi-formal assessment process suggests that, of the 20 narrators, 5 could be construed as ‘working class’ and the remainder as ‘middle class’. 60% of the narrators work for the NHS, either as employees or contractors.

Only one narrator was unemployed. Of the remainder, 2 were employed part time and the balance, including 2 students, were full-time employed. In terms of educational attainment, 3 narrators had no qualification, 8 had (or were undertaking) undergraduate degrees or professional qualifications, 2 had professional qualifications, 5 had masters degrees (some with a professional qualification), and 2 had higher research degrees.

The narrators were all made aware of the research topic by means described elsewhere (see Chapter 3.3.) and for the most part, remained focused on these issues.

The metanarrative content.

4 metanarratives, informed by the research questions, were produced from the 20 individual narratives (see Chapter 4.4.). Other metanarratives could, undoubtedly, have been constructed

from the collected narrative data. The choice made to restrict the process to 4 metanarratives was based on the preliminary analysis (see Chapter 4.2.) which indicated the pertinent themes. The metanarratives are composite creations based on the transcripts of the narrative data collection sessions. They can be thought of as the statements that might have been made if the contributing narrators had been participants in a focus group.

In general terms, the narrators spoke about themselves and their families' health status and health care experiences, which they illustrated with frequent examples. Sometimes they spoke of matters that were less closely related to the research issues. This is discussed in Chapter 3.3.

What was in the metanarratives?

1: The mixed ethnicity and identity story: choice and fitting-in.

This metanarrative is centred around the notion of identity, strongly linked to the concept of mixed ethnicity. The contributing narratives list 27 narrator definitions of 'ethnicity' and 59 definitions of 'mixed ethnicity' (see Appendix 3). The hypothetical metanarrator self-identifies as a complex person who has ascertained their 'place' in the world by means of multiple ethnic characteristics and making sometimes difficult choices. The selection of the metanarrator's 'place' in society is predicated on a perceived need to fit into the social order, because not to do so is painful.

There is an acknowledgement that, whatever choices an individual makes, choices made by others will be important too, though the reasons for others' choices are not always apparent. It is clear though, that the metanarrator perceives a feeling that there is an implicit message in the minutiae of daily living that people would prefer that he/she self-define as white rather than 'black', because this would make everything easier. People of mixed ethnicity reject this.

2. The doctors' story; health and ethnicity, power and 'professional ethnicity'.

This metanarrative is focussed on doctor's identity, together with a concept of 'professional ethnicity' which is bound up with notions of identity, and the medical power that they wield over their patients. The concept of 'professional ethnicity' is contested and is included to indicate that there are dimensions of doctors' professional identities that are mediated by their own and their assumptions of others' ethnicities.

The 'doctor metanarrator' is clear that her/his prime identification is that of 'doctor' and that other characteristics, such as gender and ethnicity are seen as less important. The metanarrator doctor is clear about his/her perceived high status and intelligence and aware that his/her time is self-perceived as a valuable resource which should not be wasted. There is a perception that patients should simply follow doctors' instructions because 'doctor knows best'.

In terms of health and ethnicity, the 'doctor metanarrator' has some broad knowledge of specific health issues but, in general, does not think that ethnicity has a significant impact on health or the healthcare experience. Linking to the notion of the value of doctors' time, this metanarrative acknowledges that people from minority ethnic populations may have different understandings of health and illness than the general population. There is an implication, however, that they should try to overcome this.

3. The patients' story I: mixed ethnicity and health status.

The 'metanarrator patient' has a clear belief that ethnicity impacts on health status, but for the most part, shares the doctors' view that this is about specific conditions or disease prevalence rather than some generalised belief that being of mixed ethnicity implies having a more negative health status than the general population. The metanarrator has some knowledge of specific conditions that have ethnic links, but feel that doctors do not know about the

relationship between ethnicity and health and do not take sufficient account of it when treating patients.

4. The patients' story II: mixed ethnicity and healthcare experiences.

This metanarrative focuses on healthcare experiences, which it suggests are predominantly negative in character. There is an opinion that doctors do not spend enough time with their mixed ethnicity patients, coupled with a suspicion that this is because of their ethnicity. These experiences mean that mixed ethnicity patients feel undervalued and disempowered, especially as doctors continually tell them that they, the doctor, knows what is best for them.

The metanarrator describes their feeling that doctors do not care about the way she/he feels, but feels trapped by the doctor's power and fears that resistance could result in the doctor making life difficult in the future.

This metanarrator feels also that doctors do not allow discourse or interaction around the concept of mixed ethnicity and that this may be for a variety of reasons including the notions that doctors are racist, that they do not care about the feelings of their patients and that, if they ignore these issues, they will go away.

Finally, the metanarrator talks about a specific skin condition, Mongolian blue spot, and their entirely negative healthcare experiences with regard to doctors failure to recognise the condition and then to respond inappropriately and pathologically.

What was missing from the metanarratives?

Several issues, principally described as socio-economic, which might have been expected to be present in the various metanarratives were absent. This is, perhaps, surprising, in view of the educational and class backgrounds of the majority of the narrators who contributed to this

project, who might be expected to be aware of societal and economic factors relevant to the topic of health.

For example, it is widely acknowledged (see for example Townsend *et al*, 1992, or Acheson, 1998) that socio-economic factors have a significant impact on both health status and some health care experiences such as the ability to access primary health care services. In particular, there is a demonstrable, though complex, link between poverty and ill-health. However, there was no mention of this or similar issues in the narratives.

In the same way, there are suggestions (see for example, Nazroo, 1997, or Fernando, 1991) that being a member of a minority ethnic population in Britain may, in itself, lead to worsened health because of the stresses of racism. While many narrators describe racist experiences, none link these to the notion of increased morbidity.

There was little mention of environmental or housing factors which might impact on health status or health experiences, though there were hints of some of the difficulties that might be experienced in living in inner-city areas. For example, some narrators spoke of difficulties encountered with the GP with whom they were registered, and noted the absence of choice, or discussed the difficulties associated with the use of public transport.

There was some slight mention of the role of education in understanding ethnicity in health, Erica for example, suggests in her narrative that there should be changes to NHS provision and that a part of these changes would be dependent on education. However, this appears to be limited to the notion of educating doctors, rather than the implication that educational level may have an impact on the healthcare experience and that this level may be influenced by external factors.

Discussion

The individual narratives and metanarratives fall into 2 distinct groups, doctors and patients. This is, perhaps, unsurprising in respect of the metanarratives since they were intentionally constructed in this way. However, with the exception of the doctors' story, individuals were not excluded from the metanarratives because of their professions. This dichotomy is interesting with regard to the individual narratives, especially because more than a third of the narrators work in the NHS.

2 particular issues were noted. First, as far as these narratives are concerned, doctors do not appear to see themselves as patients even though it seems inescapable that everyone will, from time to time, be a user of healthcare services. Second, the patient/doctor dichotomy seems to be antagonistic or, at least, adversarial. There are a number of matters arising and while it might be argued that some of these issues are not centred on or related directly to mixed ethnicity or ethnicity, research on power relationships (see for example Barnes, Bowl and Fisher, 1990 or Bhavnani, 1997) has demonstrated that connections do exist. The issues include:

- Doctors believe that their time is so valuable that it should not be 'wasted' by considering issues, such as mixed ethnicity, that are tangential to health status.
- Doctors believe, and patients perceive this belief, that they know what is best for patients, that ethnicity is an irrelevancy, and that patients should follow their orders without need for explanation.
- Doctors feel that all patients, but particularly patients from minority ethnic populations, should learn to present their symptoms in a manner that they doctor will understand, even though it is acknowledged by doctors and patients that there are

cultural differences in both the perception and experience of health and illness as well as in the way that symptoms may be described.

- Doctors are perceived as treating patients of mixed ethnicity less favourably than other groups. Some mixed ethnicity patients believe that GPs are racist.
- People of mixed ethnicity feel that, because of their ethnicity, they are undervalued and disempowered by doctors.
- Doctors are perceived as wishing to prevent discussion or interaction around issues of ethnicity because they know little about these matters and hope that this lack of knowledge will not be exposed to their patients.
- Mixed ethnicity patients are likely to know more about how their ethnicity affects their health status than GPs, though this may not be unusual since GPs are, intrinsically, generalists and cannot be expected to know everything. However, this would be a matter for less concern if doctors did not assert that they know what is best for their patients.
- Patients report that doctors sometimes do not seem to have specific knowledge, for example the ability to distinguish between Mongolian Blue Spot and bruising, that leads them to react inappropriately. This, and other events, make the parents of mixed ethnicity children feel that they are blamed for their children's illness and treated as 'bad parents'.

The concept of mixed ethnicity proves to be of extreme complexity. It does not seem feasible that a single definition could be made that would be acceptable to everyone. Indeed, it does not seem desirable that such a definition should be attempted because:

- To create a single definition would be to lose the diversity and complexity inherent in the concept of mixed ethnicity and would result in an assumption that everyone defined as ‘mixed’ was the same.
- The creation of a single definition would not be helpful in the utilisation of official statistics, since it would not reflect possible different needs resulting from different ethnic mixes.
- It is, anyway, inappropriate to attempt a fixed definition of ‘mixed ethnicity’ because this would be resistant to change in the future.

Narrators contend that their self-definitions of their ethnicity are the only ones that should be accepted because:

- They are based on choices that each mixed ethnicity individual has to make if they are to decide where they fit in the social world.
- Individuals may identify themselves in very complex ways and may choose to change that identification to suit particular circumstances.
- They reflect personal struggles with identity that often have to reject proposed categorisations suggested by others based on the implicit understanding, implied by the dominant white population that it is intrinsically better, and the individual’s life will be enhanced, if they choose to be white.

Evaluation of the analysis processes

The creation of metanarratives from narrative data has proved to be a useful analytical process. It has been particularly useful in this exploratory research because it has enabled narrators to identify the issues that are important to them. It is not without its limitations, however. Whether it can be utilised depends to a large extent on the data collection strategy. It

would, for example, be of little use if the data were not the words of the narrator, so it would be difficult to employ the results of more structured interviewing techniques. The output of unstructured or semi-structured interviews could be used, but may yield very different results, since there will be no narrative structure to be analysed in the manner of this research.

Analysis by metanarrative requires that the narrative data be transcribed verbatim, which is a lengthy and demanding process. It is not possible to move directly from transcribed data to metanarrative construction. There must first be a process of ascertaining what themes are contained in the narratives and what importance the narrators seem to attribute to them (this process is described and discussed in detail in Section 3). Even when this has been accomplished, the concept of choice is omnipresent. A collection of individual narratives may permit the construction of a huge number of metanarratives and, if a manageable number of metanarratives is to be created, the researcher's choices must be justified and explained. In this research, the choices have been made around themes identified in the research questions and the individual narratives themselves. That there are other metanarratives present in this data is certain; though they are outside the scope of this study, it would be interesting to pursue them in future work.

There are some issues to consider about the choice of contributors to this research. The participants were selected by means of snowball sampling since there was no sampling frame extant and the population is effectively 'invisible'. It is likely that this process has resulted in a group of narrators who do not represent the general population. Nevertheless, since this research is exploratory and is not intended to produce generalisable results this is not of major significance. However, as stated above, 15 out of 29 narrators were female. Additionally, 12 work within the NHS, mostly in clinical occupations. It is not apparent whether the contributions from men and women are significantly different in this sort of research. Only a

larger study can prove this. However, it is likely that the high proportion of health care workers has made some impact on the study. The inputs from individuals working within the NHS were examined separately for the construction of the metanarratives, and this separation is indicated in those chapters (see Section 4.). Overall however, it appears that narrators spoke predominantly of their own, or their children's healthcare experiences, using their professional backgrounds for illustration and example.

Researcher reflections

While carrying out the narrative research, I kept a diary to record personal issues that arose, some of which are briefly mentioned here. My overriding feeling was one of being honoured that individuals were willing to share the most personal and intimate details of their history and lives with no thought of reward. There was, too, a feeling, sometimes intense, of frustration that an interesting issue was being recounted by the narrator which I wanted to pursue in greater depth and detail. This is not possible, however, when using narrative research methods because to interrupt is to halt the flow of the story which when, or if, recommenced will be a new story rather than a continuation of the old. I have also experienced feelings of great satisfaction based on the collection of a large amount of data and the discovery of resonance between the findings from this data and contemporary discussions focused on identity, in academia in general and, for example, in some television documentaries such as, *Black Britain* (2001).

Overall, the narrative research method has been an excellent tool for discovering people's stories and the metanarrative method of analysis has engendered a fascinating way of uncovering the issues that produce these stories. Some issues arise from this that should be noted. I have endeavoured to produce the metanarratives in words which might be those used by the contributors rather than my own; this has not been an easy task and it is possible that

the tone of the metanarratives has been altered by my analysis. However, I have striven to ensure that it is not my voice that the reader will hear.

5. CONCLUSION AND RECOMMENDATIONS

This exploratory study has been concerned with investigating the health status and experiences of a particular population group; people who define their own, or their children's, ethnicity as 'mixed'. It has accomplished this by creating a series of research questions, within a theoretical framework, and by collecting narrative data which has been analysed by metanarratives to provide answers. The research questions are discussed in detail in Chapter 3.2. In addition, this chapter reflects on the research methods and possible policy implications.

5.1. Responses to the research questions.

The research undertaken for this thesis was based on an initial hypothesis that, because of their ethnicity, people of mixed ethnicity experience significantly worse health status than the white majority population. Chapter 3.2. describes the processes which developed the initial hypothesis into a series of 4 research questions. In their final form, these questions asked:

1. Do people of mixed ethnicity, because of their ethnicity, have significantly poorer health status than the white majority population?
2. Do people of mixed ethnicity, because of their ethnicity, have predominantly negative healthcare experiences?
3. Do people of mixed ethnicity, because of their ethnicity, suffer from the suppression of the discourse of mixed ethnicity and health because of the exercise of medical power by doctors?
4. How do people who define themselves as being of mixed ethnicity describe and define their ethnicity and identity?

This section of the thesis will, initially, state the 'answers' to these questions and then discuss the implications for possible future policy change. The issues identified in this chapter are, necessarily of great complexity as well as being inextricably interlinked. Other categorisation processes than the ones reported here are, therefore, possible.

How do people who define themselves as being of mixed ethnicity describe and define their ethnicity and identity?

Even though this question was the last to be formulated, I have chosen to answer it first in order to explain my initial understanding of the definitions of mixed ethnicity that inform the subsequent answers.

I was aware at the commencement of this research that the term ‘mixed ethnicity’ was, at best, contested. Nevertheless, it seemed possible that a coherent population grouping existed that could be classified as being of mixed ethnicity and that this group might have consistent characteristics which could be used as variables within this project. This has proved not entirely to be the case, as evidenced by the appropriate metanarrative (Chapter 4.4.1).

Mixed ethnicity can be described in many ways. In terms of Official Statistics, the 1991 Census made no real provision for a ‘mixed’ category and, in any event dealt with the data in an idiosyncratic manner that resulted in the loss of much information on diversity (see Chapter 4.3). The Census of Population 2001 provides 3 predefined ‘mixed’ categories and makes provision for the subject to write-in any other mixed background. The 3 predefined categories are: White and Black Caribbean: White and Black African: White and Asian. Though this is undoubtedly a positive development, it still fails to capture the richness and diversity that is inherent in the notion of mixed ethnicity, and may serve to limit the way in which service providers think and assess need.

The conclusion of this story is that there is no coherent group of people in Britain whose ethnic composition can truly be captured by the simplistic phrase ‘mixed ethnicity’. The Mixed-ethnic Metanarrator makes it clear that, first, the concept is extremely complex and second, that only people of mixed ethnicity can define what they, as individuals, mean by that

term, though there is little agreement between individuals. The Metanarrator notes that there is rarely an appropriate box to be ticked on ethnic monitoring forms.

It is apparent from the metanarrative that many people of mixed ethnicity make conscious choices about their identity. There are indications that, for some people, these choices do not necessarily result in a static identity, but rather in a more flexible form which is capable of change to suit different circumstances. However, the most common choice expressed by the mixed ethnicity individuals who contributed to my research was between being 'black' or 'white'. These choices are difficult for some and relatively easy for others but, even when choices have been made the perceptions of others still have an important impact on the individual. No matter what the choices are made by a person of mixed ethnicity, some other people will make decisions based on appearance which can cause difficulty and disadvantage.

Identity is extremely complex and it was never the intention of this research to investigate its formation in detail, rather the need to comment upon it arose from within the study. There is a considerable literature on identity formation, but the studies which have informed this research (see for example Foucault, 2000 or Hall, 2000) suggest that identity is contested, but that it is the product of discourse. Additionally, Breakwell (1986) argues that concepts of identity are continually challenged by both internal and external forces. The conclusion, therefore, is that though individuals can make choices about their identity, these choices cannot be wholly internal, but will in part at least be constrained by others reactions to them.

The absence of a consistent homogeneous population grouping that can be identified by the term 'mixed ethnicity' does not mean that the concept is useless for analytical or practical purposes. The diversity that is apparent in this population sector may simply indicate a requirement for a more flexible and adaptable policy making and implementation framework

that takes account of individual's choices of identity when assessing, for example, the need for health provision for a particular minority ethnic group.

To some extent, the absence of numerically large groups of mixed ethnicity people suggests that a process may exist whereby individuals, by means of self-definition, generate the potential for new ethnicities. Hall (1989) suggests that these new ethnicities are likely to be fluid and flexible, but largely under the control of the individual. My research concludes that the possibility exists for the currently understood minority ethnic groupings to become outdated and replaced by multiple, diverse and changing ethnicities. My research suggests (see Chapter 4.4.1.) that these potential new ethnicities are based on a series of complex factors which include individuals' decisions and choices about their own ethnicity and identity mediated by a perceived need to 'fit-into' society. In time these new ethnicities may lead to the development of 'new' ethnic groupings which may become numerically significant, even though they will be affected by the choices and perceptions of people outside them.

An additional dimension to the attempt to define the nature of mixed ethnicity appears to be that, while the notion of 'blackness' is usually a component, the notion of 'whiteness' frequently is not. Indeed, some narrators, for example Jason, who self-defined as being of mixed ethnicity, asserted that the notion, for him, excluded whiteness. To a major extent, this may be because 'white' is rarely regarded as an ethnic group in Britain, simply being perceived as the norm against which ethnicity, in terms of skin colour at least, is judged (see for example, Roediger, 1994). The notion of whiteness not only as a norm but as a normative force, is shown in this research by the repeated assertion by mixed ethnic narrators that they continually receive the message that 'white is best; choose to be white'.

To conclude this section, there is no doubt that the nature of mixed ethnicity is extremely complex and that imposed definitions lead to a loss of diversity. Therefore, the only valid definitions of mixed ethnicity are self-definitions. The evidence from this research is that such self-definitions are the outcome of a series of, often difficult, personal choices and decisions in interaction with the responses of others.

Do people of mixed ethnicity, because of their ethnicity, have significantly poorer health status than the white majority population?

Little data is collected concerning the health status specifically of people of mixed ethnicity.

Though a considerable volume of data exists for people from minority ethnic groups, the collection of this data has been inconsistent with categories changing significantly in relatively short periods of time. In some instances, these changes could be considered to be attempts to move towards politically correct, or at least less offensive, modes of speech, for example the way in which black people whose families 'originate' in the islands of the Caribbean, have in the 20th Century alone been described by the dominant population in Britain as; 'Nigger', 'Negro', 'West Indian', 'Afro-Caribbean', 'African-Caribbean' and 'Black'. However, disparate descriptions cause analytical problems. For example, Anionwu (1992) employs 'Asian' as an analytical category while others (Rudat, 1994, Nazroo, 1997 and Erens, 2001) use such terms as 'South Asian', 'Indian', 'Pakistani', 'Bangladeshi' and 'Sikh' to subdivide the populations. Nor is it always clear how these distinctions are made. Where, for example, do Chinese people fit into the 'Asian' categorisation? A further difficulty in comparison is the current trend (see for example, Erens, Primatesta and Prior 2001) to use 'general population' as a category. It is unclear whether this category is intended to include all groups, all white groups, or all groups other than ethnic minority groups. For the purposes of this analysis, it has been assumed that it is intended to refer to the white population.

There are other important issues connected with the collection of 'ethnic' health, and other, statistics. Again, little information is gathered about people of mixed ethnicity and much of the data that is collected is processed in such a way as to render it of little use to the social scientist (see Chapter 2.3). The politics of ethnic data collection are complicated too, with evidence that significant numbers of people from minority ethnic populations are concerned that such data might, at some future time, be used to their disadvantage.

These reservations notwithstanding, it seems reasonable to suggest that the health status of people of mixed ethnicity will be influenced by the health status of their recent antecedents. It is often accepted as a given (see for example Nazroo, 1997: 21 or Ahmad, 1993: Ch. 1), that the health status of people from minority ethnic groups is worse than that of the general population. However, the data is somewhat ambivalent on this. With the exception of some specific conditions, 'ethnic' indicators of health are ambiguous at best. In many instances, people from minority ethnic populations experience better health than the white population and for some groups, especially Chinese people, their health is much better. In addition, there is evidence that the perception of minority ethnic health is grounded on the perceived health of immigrants, though the growing body of empirical evidence suggests that the health of immigrants is a reflection of socio-economic issues and levels of healthcare provision in their countries of origin and in the UK, rather than an indication of innate causative factors. If this is, indeed the case, then the health status of minority ethnic people will continue to change until it reflects other patterns of health status that depend on differentially experienced socio-economic status (see for example Townsend, Davidson and Whitehead, 1992 or Acheson, 1998).

What the doctors say

In my research, the doctors who contributed and whose input directed the creation of the metanarrative, suggest that they do not believe that ethnicity and mixed ethnicity have a significant impact on, or link to, health status. These doctors were knowledgeable about some of the specific conditions that are more prevalent in some ethnic groups, but unclear as to whether these, or other conditions, might be of particular importance to people of mixed ethnicity, or indeed if these conditions could occur in people of mixed ethnicity.

I suggest that it is apparent from the metanarrative, supported by evidence from the individual narratives, that the contributing doctors have subsumed their own ethnicities into something that I call 'professional ethnicity'. Though it could be argued that professional ethnicity is the same as professional identity, it is my contention that it is different. This argument is based on the way in which the contributing doctors viewed the ethnicity of their patients as either an irrelevancy or as a problem to be overcome, especially in terms of the ways in which patients report their symptoms and follow doctors' directions, and at the same time ignored their own ethnicity.

In addition, most of the doctors' narratives contain statements that I perceive as racist. This is exemplified by the common assertion that the best possible manner of treatment is to treat individuals of any ethnicity as 'white'. This can only reinforce the white supremacy paradigm to the detriment of all other groups. There were other descriptions of treatment and diagnosis which I interpret as racist, for example doctors frequently suggested that they imposed specific treatment regimes on South Asian patients who had recently visited the Indian sub-continent. They made no such reference to white patients who had been to similar locations.

What the patients say

The contributions of the patients to the research on health status paint a quite different picture to those of the doctors. Mixed ethnicity service users are adamant that there are links between their ethnicity and their health status, though they are not necessarily able to describe the nature and importance of these links. I conclude from this that they experience health as a part of their identity in the same way that they experience mixed ethnicity. Overall, the patient narrators believe that their general health is not adversely affected by their ethnicity.

However, the patients' knowledge of specific conditions that they were likely to experience was similar to that of the doctors, but their understandings were not necessarily the same. For example, patients frequently suggested that tuberculosis could be a problem for mixed ethnicity children, though this was not mentioned by the doctors.

Overall, the patients' metanarrative (Chapter 4.4.3) suggests that patients feel that doctors do not take account of ethnicity when treating them, or their children, but that they should do so. There are also issues around specific knowledge of and information about the possible affects of mixed ethnicity on health. Patients do not feel that they have enough information and are concerned that this information is not, in their experience, promulgated by doctors; rather it is likely to be circulated among friends or associates. Based on the analysis of this metanarrative, I conclude that, for the majority of narrators, it is not health status that is of prime importance, instead it is the nature of the healthcare experience that matters.

Discussion

I was surprised that, during the data collection, none of the narrators suggested that health status might be influenced by socio-economic status. The majority of the narrators were highly educated and middle class. Many worked as health professionals in inner-city and deprived areas and it does not seem likely that they are ignorant of the links between

deprivation and morbidity. My assumption is that the narrators were focussed, by the research, on issues of health and mixed ethnicity, rather than health and socio-economic factors, but the real reason for this omission remains unclear. An alternative explanation is that their narratives reflected their experience as healthy, middle-class professionals.

There are 2 main ways in which the collection of ethnic statistics can be useful. First, they can, for example, assess specific need or measure the effectiveness of a service delivery; second, they can be used to compare and track progress of such initiative over time. However, the problems of changing categories limits the effectiveness of the second usage. I conclude that it would be wrong for people of mixed ethnicity to be forced to choose a 'mixed' categorisation and that, in any event, such a categorisation would have little meaning and would be insufficiently flexible to be useful, since it cannot represent any coherent grouping of people or characteristics. The only practical manner in which to categorise mixed ethnicity is to let individuals choose for themselves the manner in which they wish to be identified.

There is insufficient evidence, either from this project or from other research, to say categorically that mixed ethnicity affects, or does not affect, an individual's health status.

However, an individual's ethnicity is important to that individual as a patient as part of their identity and the resources that they can access in any specific situation. It may be for this reason that it is my perception that doctors assume a 'professional ethnicity', this assumption being based on the doctors' use of power to prevent the discourse of health and mixed ethnicity by denying it the possibility of existence and, thus, limiting what can be said. This can be seen as doctors deliberately placing themselves in the position of an external limiting control on the discourse of health and mixed ethnicity.

Do people of mixed ethnicity, because of their ethnicity, have predominantly negative healthcare experiences?

It is not possible to isolate the players in this metanarrative as clearly as in others. Some crossover occurs since 2 of the contributors to The Patients' Story II are doctors. For the most part, the doctors have contributed to both metanarratives as doctors rather than as service users, except in one case where a doctor's story describes the healthcare experiences of a relative who is not his patient.

What the patients say

The vast majority of patients who contributed to the relevant metanarrative, 16 out of 17, expressed the view that they were not treated well by their family doctors who, they felt, did not want to spend time with them. These patients also expressed the belief that this was, in part at least, because of doctors' perception of their ethnicity or their children's ethnicity; a process which some considered racist. The impression that doctors do not spend enough time with their mixed ethnicity patients leads these patients to feel undervalued, especially when this notion is associated with the belief that doctors spent more time with people of other apparent ethnicities. This suggests that people of mixed ethnicity believe that they receive a 'worse' service from their GP, which diminishes the quality of their healthcare experience.

The Patient Metanarrator comments, too, on the exercise of medical power as a factor that damages the healthcare experience. This exercise of power manifests itself as the perception that doctors believe that they are more knowledgeable than their patients and do not mind letting the patients know that this is the case. There is also an inference, expressed by the Patient Metanarrator, that GPs do not know, or care, whether ethnicity has an impact on either health status or healthcare experiences. However, it is in the self-interest of people of mixed ethnicity to know if there are health implications linked to their ethnicity and, for many of the narrators in this project, this was, indeed, the case.

The Patient Metanarrator talks at length about the way that mixed ethnicity patients are treated by their doctors. The predominant perception, discussed above, is that doctors do not want to consider the influence of mixed ethnicity on health and are unwilling or unable to impart useful information. Patients believe that this is partly because doctors are ignorant of any relevant issues, partly because doctors either do not care or hope that if they ignore the issues they will disappear and partly because the Patient Narrator feels that the GP is, perhaps unconsciously, racist.

The specific issue of Mongolian Blue Spot is a useful, though perhaps extreme, example of both the way in which doctors treat their mixed ethnicity patients and the level of GPs' knowledge about some specifically ethnically-linked health issues. This issue is discussed more fully in Chapter 4.4.4, but can be summarised by stating that a specific condition has resulted in some people of mixed ethnicity having significantly negative healthcare experiences that could have been avoided had the doctors been better informed and willing to accept that there can be an ethnic dimension to health and healthcare. It follows that similar assumptions will impinge on issues unconnected with healthcare.

What the doctors say

A little to my surprise, the Metanarrator Doctor acknowledged that she/he was powerful and felt that his/her time was precious. The doctors were aware, and apparently comfortable with, the notion that they were powerful, intelligent and respected and seem to believe that they know what is best for all their patients.

In terms of the healthcare experience, it is not apparent from this research that doctors feel that a positive healthcare experience is necessary or, perhaps, even desirable. They are more interested in their patients following instructions.

I conclude that the attitudes expressed by the Metanarrator Doctor in my research exhibits distinct racist tendencies and that these may be focussed on people of mixed ethnicity. In particular, doctors believe that they can tell an individual's ethnicity by simple observation and feel that some minority ethnic groups, particularly people of mixed ethnicity and African-Caribbean people, are less likely to follow doctors' instructions. This may result in the Metanarrator Doctor treating these groups of people as a potential 'waste of time and effort'.

Discussion

Much is known about the ethnic components in health status. But it seems that this information is not being disseminated to the people that need it, be they doctors or health service users. In addition, it seems that there is a perception of considerable misinformation in circulation, some of it racist or prejudicial, about people from minority ethnic groups.

The issue of doctors not spending enough time with their patients is complex. Undoubtedly, doctors are busy professionals. There is ample evidence (for example, Balint and Norell, 1990) that they spend as little time as possible with each patient. The patients' perception that this is due to their ethnicity is a cause for concern, and is supported by statements made in the narratives. This is linked to the assertion that doctors sometimes act in a racist manner towards their mixed ethnicity patients. Even if this racism is unconscious or unthinking, it is inappropriate to treat individuals of different ethnicities in the same manner, since this can be seen as accepting the assumption that not only is it appropriate to treat everyone as if they are white, but that this is the best way that people can expect to be treated. It could, of course, be argued that doctors may not believe that they are acting in a racist manner, however, this is how their behaviour is perceived by their patients.

The evidence from the patients, and my interpretation of the doctors' narratives, suggests strongly that doctors are sometimes racist in their treatment of people of mixed ethnicity. At

best, their attitude that it is appropriate to treat everyone as if they are white should be addressed. This is epitomised by the extreme example of Mongolian Blue Spot which suggests that family doctors are not only unaware of some relatively well-known skin pigmentation conditions, but that they make erroneous assumptions of parental behaviour when they discover such conditions. Though doctors' duty of care towards all their patients is well-established, the appropriateness of their actions in this situation should be questioned.

I conclude that it is irrelevant whether the mixed ethnicity healthcare experience is 'really' more negative than that of other groups. If patients feel that it is negative, then it is.

Do people of mixed ethnicity, because of their ethnicity, suffer from the suppression of the discourse of mixed ethnicity and health because of the exercise of medical power by doctors?

In discussing the 'suppression of discourse', this third question uses 2 definitions of 'discourse'. First, it is used to describe the simple dialogue between patient and doctor (see for example Macdonnell, 1986: 1) and includes the implication that this dialogue takes place within a binary power structure where the doctor is the most powerful participant. By implication, doctors may use their position of power to decline engagement with particular issues for a multiplicity of reasons. Second, 'discourse' is also used in the Foucauldian sense of a productive process that enables, but also constrains, that which can be said. When using Foucault's assertion that power is an omnipresent productive force, it can be argued that the patient, though in an inferior position in a binary power structure, can also suppress discourse, for example by not describing to the doctor her/his belief that mixed ethnicity contributes to their health status or healthcare experiences.

All of the metanarratives contribute to the issues addressed by this question, and it is difficult to divide them into the doctor/patient dichotomy exploited in the 2 previous chapters.

However, the narratives confirm the existence of a mixed ethnicity and health discourse, at

least for those who identify themselves as patients in this project. I conclude that there is evidence that doctors commonly try to suppress this discourse, often by a process of denying its existence. That doctors are able to do this confirms their powerful position in society and fits well with the Foucauldian position that power and knowledge govern what can be said. I suggest that this exercise of medical power in this specific manner confirms the existence of a 'professional ethnicity', though it might be argued that doctors have chosen to subsume their ethnicity within their professional identity. I suggest that this exercise of power confirms that GPs are sometimes perceived as racist in their dealings with people of mixed ethnicity and people from minority ethnic populations and I conclude that this suppression of discourse contributes to the predominantly negative healthcare experiences encountered by people of mixed ethnicity.

5.2. Reflections on the findings and the research process.

The use of a Foucauldian theoretical framework has been of particular use in this exploratory research, because it has permitted analysis of subjective truth rather than simply objective fact. Had this not been the case, the narrators' stories would, potentially, have been evaluated as either 'true' or 'false'. Though not without latent utility, such a process would not have yielded the depth of feelings, perceptions and beliefs that this project has achieved. This is not to say that objective fact is without value. 'Facts' can be used in some instances as initial hypotheses or as benchmarks against which to measure progress towards a goal. Nonetheless, the subjective truths of this research should not be seen as being diametrically opposed to fact, because facts are not at issue. The value of the research reported in this thesis is that it has uncovered people's feelings, beliefs and attitudes and has given the narrators not only the opportunity to have a voice, but to explain how they have rationalised their experiences and created understandings of the social world in which they live.

Though the process of narrative data collection has proved particularly fruitful, it is not without some drawbacks. In particular, the necessity for the process to be continuous and uninterrupted means that it is not possible to check-back with narrators to ensure that what they say is what is heard by the researcher (see Chapter 3.3 for a more extensive discussion of this issue). In addition, the narrators who participated in this research have proved to be a particularly geographically mobile group with whom it has, for the most part, been impossible to maintain contact. Though the narrative methods utilised in this study were extremely productive, the majority of the narrators in this project were middle-class, well educated and articulate. 3 narrators were working-class, but were no less articulate. It is conceivable that narrative methods would be of considerably less utility with different groups of narrators.

There are other possible explanations for the negative health experiences of mixed ethnicity people discussed in this thesis. In particular, the source of these experiences which both the narrators and I attribute to others perception of ethnicity, could be the result of other social divisions, for example class or social deprivation. Because of the exploratory nature of this study, investigation of these issues was outside the scope of this research.

If this research was to be duplicated or extended in the future, it would be useful if the number of contributors could be greater and be drawn from different geographical areas. An attempt made to ensure that the gender composition of the contributing group was more balanced than is the case in this research would likewise be useful. Alternatively, it would be interesting to establish why more women than men, a ratio of 3:1 in this project, were willing to participate in order to establish whether there is a gender-specific characteristic involved in the self-identification of people of mixed ethnicity. Other interpretations are possible, for example that women are more interested in health.

Further research based on this study would have the benefit of starting from a position where the nature of mixed ethnicity is already established, though without a discrete definition, and would be able to concentrate on the nature of healthcare experiences rather than the need to establish the important themes.

The Metanarrative Construction

The intricacy and interconnectedness of the issues identified in this research have made analysis complex. The great volume of data collected, more than 80,000 words of transcribed narrative, would have been very difficult to analyse by manual methods, especially as the nature of the narrative process demands that stories should remain intact and the narrators' voices heard. The use of ATLAS.ti qualitative analysis software has made this project manageable, and because of the software's non-hierarchical construction, its use has had a minimal impact on the analysis, with the exception of the creation of the network diagrams. Though these diagrams could have been created manually, the software rendered this portion of the process relatively easy. Additionally, the flexibility of the program ensured that networks could be amended as and when required. It was the construction of these networks that permitted the production of the metanarratives which have been central to the data analysis. ATLAS.ti does not, of course, actually carry-out qualitative analysis. It merely provides a convenient way of organising and accessing data and some tools which support the researcher's cognitive processes.

However, the innovative production of metanarratives has rendered the data accessible and illuminated not only the themes and issues therein, but also given access to the narrators' experiences, thoughts, feelings and beliefs. The justification for the production and analysis of the 4 metanarratives in this thesis is discussed in detail in Chapter 4.3. However, because of the complexity of the themes and issues identified, as well as the manner in which they

interlink, it would be possible to produce other metanarratives from the same data. However, the 4 metanarratives used in the analysis have focussed on the themes thought to be most significant by the narrators.

5.3. Policy-making and implementation: recommendations

In recent years, there has been considerable development and growth in policy initiatives concerned with the health of Britain's minority ethnic population. Some of the major initiatives in the last 5 years include:

- 1996: Summary of Work in the Directorate of Health Policy and Public Health Relating to Black and Minority Ethnic Issues. (Lambeth Lewisham and Southwark Health Authority, 1996.)
- 1996: Responding to Diversity. (Office for Public Management, 1996.)
- 1997: Reaching Out – A study of Black and Minority Ethnic single homelessness and access to primary health care. (Small and Hinton, 1997.)
- 1997: The New NHS Modern Dependable. (Cm. 3807, 1997.)
- 1997: Creating Cultural Competence: Equal Access to Health Services. (Sandwell NHS Trust, 1997.)
- 1997: Ethnicity and Commissioning. (Lambeth Lewisham and Southwark Health Authority, 1997.)
- 1998: Our Healthier Nation. (Cm. 3854, 1998.)
- 1998: The Acheson Report, Independent Report into Health Inequalities. (Acheson, 1998.)
- 1998: Modernising Social Services. (Cm. 4169, 1998.)
- 1998: Directory of Asian Initiatives. (Bahl, 1998a.)
- 1999: Study of Black Asian and Ethnic Minority Issues. (Alexander, 1999.)
- 1999: Saving Lives: Our Healthier Nation. (Cm. 4386, 1999.)

- 1999: With Respect to Old Age: Long Term Care – Rights and Responsibilities. (Cm. 4192, 1999.)
- 1999: Minority Ethnic Homelessness in London – Findings from a Rapid Review. (Chahal, 1999.)
- 2000: The NHS Plan: A plan for investment: A plan for reform. (Cm. 4818, 2000.)
- 2000: Minority Ethnic Issues in Social Exclusion and Neighbourhood Renewal. (Cabinet Office, 2000.)

Some of the initiatives discussed above are concerned with issues much broader than those of health and ethnicity. In particular, ‘The New NHS Modern Dependable’, ‘Our Healthier Nation’, ‘Saving Lives: Our Healthier Nation’, ‘With Respect to Old Age: Long Term Care – Rights and Responsibilities’ and ‘The NHS Plan: A plan for investment: A plan for reform’. However, it is reasonable to argue that these policies which will make significant changes to the way in which social and healthcare services are delivered, should make appropriate provision for people of mixed ethnicity.

All of the above policy initiatives all treat minority ethnic populations in a similar way. That is, they perceive them to be communities. Though some (for example Ahmed, 1998: Ch. 22) acknowledge that there is diversity within, for example ‘Asian’ communities, there is still a tendency to treat these groups as homogenous. This is shown below in a discussion of the content of a selection of policy documents.

Summary of Work in the Directorate of Health Policy and Public Health Relating to Black and Minority Ethnic Issues.

This document summarised and commented on the on-going black and minority ethnic health initiatives in the Lambeth Lewisham and Southwark Health Authority. It identified a number of issues, for example the over-representation of African-Caribbean people in higher security level psychiatric units and communication problems in prescribing drugs. Though it makes

recommendations for policy change to reflect ethnic diversity, only ‘mainstream’ ethnic groups are identified (for example, Indian, African-Caribbean, Pakistani). There is no mention of people of mixed ethnicity and no assessment of their health needs.

Responding to Diversity.

This document identified the need to consider ethnic issues in commissioning health care (part of the process of the NHS internal market). It identified a number of issues relating to ethnic-based inequalities in health and set out a strategy to develop effective purchasing for people from minority ethnic groups. Though its recommendations appear sound, it concentrates on the ‘minority ethnic community’ as the analytical unit. Since my research has concluded that there is no community of people of mixed ethnicity that can be utilised in this way, the strategy outlined in the document would require further refinement if the needs of this population sector are to be addressed.

Reaching Out – A study of Black and Minority Ethnic single homelessness and access to primary health care.

This is one of the few studies that attempted to assess the needs of people from all minority ethnic groups. Unfortunately, for the reasons discussed in Chapter 2.3, it relied upon the flawed ethnic categorisations used in the 1991 Census. The recommendations from this report are, again, centred on the community as the analytical unit and, therefore, share the difficulties discussed above.

The New NHS Modern Dependable.

This important document was the first health-related White Paper produced by the 1997 New Labour Government. It contains a number of important initiatives which impact on the health of minority ethnic populations. For example, it required Health Authorities, in partnership with NHS Trusts, Primary Care Groups and others, to assess the health of their populations

and then to prepare ‘Health Improvement Programmes’ (Cm 3807: Ch. 4) covering their population’s health needs and healthcare requirements. There is, however, an incompatibility between this laudable intention and later Government statements (see for example DoH, 2000) to the effect that there would be an expectation that all treatments should be available to all patients regardless of where they live.

The White Paper also introduced the concept of Health Action Zones (HAZs) which are intended to,

... make real changes in people’s experience of health services and will begin to make real progress on tackling inequalities. (Department of Health, 1998: 2.)

The White Paper makes passing references to,

‘... the special health needs of black and minority ethnic patients’ (Cm 3807: Ch. 5 and *passim*).

However, it does not acknowledge the existence, or the possibility of special health needs, of the mixed ethnicity population sector. HAZs have begun important initiatives that will, in time, address many issues of minority ethnic health, (see for example, Sayce, 2001), but since their terms of reference are informed by the White Paper and the Acheson Report (Acheson, 1998), they do not include people of mixed ethnicity as a separate category for the implementation of positive change, again relying on the concept of community.

Study of Black Asian and Ethnic Minority Issues.

At first sight, this report would seem to be the obvious impetus for new health initiatives for everyone. However, the data in the report is drawn from a variety of sources and suffers from the problems of categorisation referred to elsewhere in this thesis. It is likely that this is because the entire project took only 6 months to complete. I conclude that it has failed to address ethnic health issues other than those of the ‘main’ minority ethnic groups, as indicated

by the categories used in the title. Though it makes an attempt to utilise updated demographic information, it does not engage with the notion of ‘mixed ethnicity’, other than noting that children of mixed ethnicity aged under 5 years were more likely to be in care (Alexander, 1999: 33).

The NHS Plan.

This White Paper (Cm. 4818, 2000) sets out the Government’s plans and policies for the future of the NHS. Crucially, it describes 10 NHS core principles. Of particular interest for this thesis are principles 3, 4 and 9 which state:

3. The NHS will shape its services around the needs and preferences of individual patients, their families and carers. The NHS of the 21st century must be responsive to the needs of different groups and individuals in society, and challenge discrimination on the grounds of age, gender, ethnicity, religion, disability and sexuality.

4. The NHS will respond to the needs of different populations.

9. The NHS will help keep people healthy and work to reduce health inequalities. The NHS will focus efforts on preventing, as well as treating ill-health. ... It will work with others to reduce health inequalities. (Cm. 4818, 2000: 3-5. Original emphasis.)

Clearly, the application of these principles should be advantageous to people from ethnic minority populations, though the word ‘ethnic’ occurs a mere 6 times in the entire 144-page document. There is, as ever, no mention of people of mixed ethnicity. Yet again, the policies and initiatives are targeted at communities (see for example Cm. 4101, 2000: Sec. 8.7, 13.2, 13.8, 13.15 and 15.1) and seem unable to cope with the health needs and experiences of people who do not fit into these convenient categories.

This process continues throughout the remainder of the policy initiatives and is present too in health promotion strategies (for example Bahl, 1987 or Douglas, 1998: Ch. 7). People from minority ethnic groups or communities are targeted. People of mixed ethnicity, because they

do not belong to these communities, are ignored, presumably on the erroneous assumption that their healthcare needs and expectations can be addressed by homogenisation with larger, more coherent groupings.

I conclude that, in terms of health-related policy, the mixed ethnicity population sector is to all intents and purposes invisible and ignored and that the notion of using ‘minority ethnic community’, as the population grouping utilised to plan and deliver health services, disadvantages and excludes people of mixed ethnicity.

This research did not identify a more negative health status for people of mixed ethnicity, and, therefore, no ‘special’ healthcare needs, when compared either to the white population or the whole population of Britain. It did identify a different, and negative, perception of the healthcare experience for this population sector and a belief among people of mixed ethnicity that there is a link between their ethnicity, their identity and their health. These findings suggest that there is a need for GPs and other healthcare professionals, to understand that people of mixed ethnicity see themselves predominantly as individuals rather than as members of minority ethnic communities and that this affects individuals’ and doctors’ understanding of health care needs.

I conclude that there is a need for health policy initiatives to specifically address the issues of the mixed ethnicity healthcare experience identified in this research, whether these are in terms of medical treatment, health promotion or the manner in which doctors, and perhaps other health professionals, treat their mixed ethnicity patients.

REFERENCES

- Abercrombie, N, Hill, S and Turner, B S, (1994), *Dictionary of Sociology* (3rd Ed.), London, Penguin.
- Abma, T A, (1998), 'Storytelling as Inquiry in a Mental Hospital', *Qualitative Health Research*, 8(6): 821-838.
- Acheson, Sir Donald (Chair), (1998), *Independent Inquiry into inequalities in health: Report*, London, The Stationery Office.
- Ahmad, W I U, (1993), *'Race' and Health in Contemporary Britain*, Buckingham, Open University Press.
- Ahmad, W I U (Ed.), (1992), *The Politics of 'Race' and Health*, Bradford, University of Bradford, Bradford & Ilkley Community College.
- Ahmad, W I U and Atkin, K, (1996), *'Race' and Community Care*, Buckingham, Open University Press.
- Ahmad, W I U, Kernohan, E and Baker M, (1991), 'Patients' choice of general practitioner: importance of patients' and doctors' sex and ethnicity', *British Journal of General Practice*, Vol. 41: 330-331.
- Alexander, Z, (1999), *Study of Black, Asian and Ethnic Minority Issues*, London, Department of Health.
- Alibhai-Brown, Y and Montague, A, (1992), *The Colour of Love: Mixed Race Relationships*, London, Virago Press.
- Althusser, L, (1976), *Essays in Self-Criticism* (Trans. G Locke), London, New Left Books.
- Althusser, L, (1984), *Essays on Ideology*, London, Verso.
- Amin, K, Gordon, P and Richardson, R, (1991), *Race Issues Opinion Survey 1991: preliminary findings*, London, The Runnymede Trust.
- Anionwu, E N, (1993), 'Sickle cell and thalassaemia: community experiences and official response', in Ahmad W I U (Ed.), *'Race' and Health in Contemporary Britain*, Buckingham, Open University Press.
- Anionwu, E N, (1996), 'Ethnic origin of sickle and thalassaemia counsellors: does it matter?' in Kelleher, D and Hillier, S, *Researching Cultural Differences in Health*, London, Routledge.
- Anthias, F, (1992), *Ethnicity, Class, Gender and Migration: Greek-Cypriots in Britain*, Aldershot, Avebury.
- Anthias, F, (1998), 'Rethinking social divisions: some notes towards a theoretical framework', *The Sociological Review*, Vol. 46, No. 3, Aug 1998: 505 – 535.

- Anwar, M, (1990), 'Ethnic Classifications, Ethnic Monitoring and the 1991 census', *New Community*, 16 (4) (July): 607-615.
- Appadurai, A, (1996), *Modernity at Large: cultural dimensions of globalization*, Minneapolis, University of Minnesota Press.
- Arber, S, (1993), 'Designing Samples' in Gilbert N (Ed.), *Researching Social Life*, London, Sage.
- Atkinson, R L, Atkinson, R C, Smith E E, Bem, D J and Nolen-Hoeksema, S, (1993), *Introduction to Psychology* (11th Ed.), Forth Worth, Harcourt Brace Jovanovich.
- Bahl, V, (1987), *Asian Mother and Baby Campaign: Report by the Director*, London, Department of Health.
- Bahl, V, (1998), 'Ethnic minority groups: The national Experience' in Rawaf, S and Bahl, V, *Assessing Health Needs of People From Minority Ethnic Groups*, London, Royal College of Physicians.
- Bahl, V, (1998a), *Directory of Asian Initiatives*, London, Department of Health.
- Balarajan, R and Raleigh, V S, (1992), 'The ethnic populations of England and Wales: the 1991 Census', *Health Trends*, Vol. 24, No. 4.
- Balarajan, R and Raleigh, V S, (1995), *Ethnicity and Health in England*, London, HMSO.
- Balchin, P, (1995), *Housing Policy: an introduction*, London, Routledge.
- Balint, E and Norell, J S (Eds.), (1990), *Six Minutes for the Patient: Interactions in General Practice Consultation* (2nd Ed.), London, Routledge.
- Ball, T and Dagger, R, (1991), *Political Ideologies and the Democratic Ideal*, New York, Harper Collins.
- Banton, M, (1967), *Race Relations*, London, Tavistock.
- Banton, M, (1983), *Racial and Ethnic Competition*, Cambridge, Cambridge University Press.
- Barnes, M and Bowl, R, (2001), *Taking Over The Asylum: Empowerment and Mental Health*, Basingstoke, Palgrave.
- Barnes, M, Bowl, R and Fisher, M, (1990), *Sectioned: Social Services and the 1983 Mental Health Act*, London, Routledge.
- Benedict, R, (1943), *Race and Racism*, London, Routledge & Kegan Paul.
- Berrington, A, (1994), 'Marriage and family formation among white and ethnic minority populations in Britain', *Ethnic and Racial Studies*, 17: 517-546.

- Berrington, A, (1996), 'Marriage patterns and inter-ethnic unions', in Coleman, D and Salt, J, *Ethnicity in the 1991 Census: Volume One: Demographic Characteristics of the ethnic minority populations*, London, HMSO.
- Berthoud, R and Nazroo, J, (1997), 'The mental health of ethnic minorities', *New Community*, Vol. 23, No. 3: 309-324.
- Bevir, M, (1999), 'Foucault, Power, and Institutions', *Political Studies*, XLVII: 345-359.
- Bhat, A, Carr-Hill, R and Ohri, S, (1988), *Britain's Black Population*, Aldershot, Gower.
- Bhavnani, K K, (1997), 'Feminist Theory' in Robinson, V and Richardson, D, *Introducing Women's Studies: Feminist Theory and Practice*, Basingstoke, Macmillan.
- Bhopal, R and White, M, (1993), 'Health promotion for ethnic minorities: past present and future', in Ahmad W I U (Ed.), *'Race' and Health in Contemporary Britain*, Buckingham, Open University Press.
- Bhrolchain, M, (1990), 'The ethnicity question for the 1991 Census: background and issues', *Ethnic and Racial Studies*, Vol. 13, No. 4: 542-567.
- Black Britain, (2001), *All Mixed Up* (producer: Petal Felix), London, BBC Television, 19 March.
- Bolt, C, (1971), *Victorian Attitudes to Race*, London, Routledge & Kegan Paul.
- Booth, H, (1988), 'Identifying ethnic origin: the past, present and future of official data production', in Bhat, A, Carr-Hill, R and Ohri, S, *Britain's Black Population*, Aldershot, Gower.
- Borland, K, (1991), 'That's Not What I Said' in Gluck, S B and Pattai, D, *Women's Words: The Feminist Practice of Oral History*, London, Routledge.
- Bouma, G D and Atkinson, G B J, (1995), *A Handbook of Social Research: A comprehensive and practical guide for students* (2nd Ed.), Oxford, Oxford University Press.
- Bowler, I, (1993), '"They're not the same as us": Midwives' stereotypes of South Asian descent maternity patients', *Sociology of Health and Illness*, Vol. 15(2): 157-158.
- Braham, P; Rattansi, A and Skellington, R (Eds.), (1992), *Racism and Antiracism: Inequalities, Opportunities and Policies*, London, Sage.
- Breakwell, G, (1986), *Coping With Threatened Identities*, London, Methuen.
- Bremer, K, Roberts, C, Vasseur, M, Simonot M and Broeder, P, (1996), *Achieving Understanding: Discourse in Intercultural Encounters*, London, Longman.
- Browne, D, (1995), 'Sectioning: the black experience' in Fernando, S, *Mental Health in a Multi-ethnic Society*, London, Routledge.

- Brozovic, M, Davies, S and Henthorn, J, (1989), 'Haematological and clinical aspects of sickle cell disease in Britain', in Cruikshank, J and Beevers, D, *Ethnic Factors in Health and Disease*, Sevenoaks, Wright.
- Bruner, J, (1981), 'Life as Narrative', *Social Research*, 54(1): 11-32.
- Burney, E, (1967), *Housing on Trial: A Study of Immigrants and Local Government*, Oxford University Press, Oxford.
- Burns, R B, (2000), *Introduction to Research Methods* (4th Ed.), London, Sage.
- Bywaters, P and McLeod, E, (1996), *Working for Equality in Health*, London, Routledge.
- Cabinet Office, (2000), *Minority Ethnic Issues in Social Exclusion and Neighbourhood Renewal*, London, The Cabinet Office.
- Cashmore, E with Banton, M, (1994), *Dictionary of Race and Ethnic Relations* (3rd Ed.), London, Routledge & Kegan Paul.
- Central Office of Information, (1993), *Immigration and Nationality*, Aspects of Britain Series, London, HMSO.
- Central Office of Information, (1997), *Ethnic Minorities* (2nd Ed.), Aspects of Britain Series, London, The Stationery Office.
- Centre for Contemporary Cultural Studies, (1982), *The Empire Strikes Back: Race and Racism in 70s Britain*, London, Hutchinson.
- Chahal, K, (1999), *Minority Ethnic Homelessness in London – Findings from a Rapid Review*, London, NHS Executive.
- Cheek, J and Rudge, T, (1997), 'The Rhetoric of Health Care? Foucault, Health Care Practices and the Docile Body – 1990s style', in O'Farrell, C, (Ed.), *Foucault: The Legacy*, Kelvin Grove, Queensland University of Technology.
- Cm. 1986, (1993), *The Health Of The Nation: A strategy for health in England* (2nd Ed. with corrections), London, HMSO.
- Cm. 2151, (1962), *Commonwealth Immigrants Act*, London, HMSO.
- Cm. 2739, (1965), *Immigration from the Commonwealth*, London, HMSO.
- Cm. 3064, (1966), *Commonwealth Immigrants Act 1962: Instructions to Immigration Officers*, London, HMSO.
- Cm. 3807, (1997), *The New NHS: modern, dependable*, London, The Stationery Office.
- Cm. 3854, (1998), *Our Healthier Nation: A Contract for Health*, London, The Stationery Office.
- Cm. 4169, (1998), *Modernising Social Services*, London, The Stationery Office.

- Cm. 4192, (1999), *With Respect to Old Age: Long Term Care – Rights and Responsibilities*, London, The Stationery Office.
- Cm. 4253, (1999), *The 2001 Census of Population*, London, The Stationery Office.
- Cm. 4262, (1999), *The Stephen Lawrence Inquiry: Report of an Inquiry by Sir William MacPherson of Cluny*, London, The Stationery Office.
- Cm. 4386, (1999), *Saving Lives: Our Healthier Nation*, London, The Stationery Office.
- Cm. 4818, (2000), *The NHS Plan: A plan for investment: A plan for reform*, London The Stationery Office.
- Coffey, A and Atkinson, P, (1996), *Making Sense of Qualitative Data*, London, Sage.
- Cohen, P and Bains, H S, (Eds.), (1988), *Multi-Racist Britain*, Basingstoke, Macmillan.
- Coleman, D and Salt, J, (1996), *Ethnicity in the 1991 Census: Vol. one. Demographic characteristics of the ethnic minority populations*, London, HMSO.
- Commission for Racial Equality, (1978), *Fact Paper 4: The language barrier in employment*, London, Commission for Racial Equality.
- Commission for Racial Equality, (2000), *Amendment Act 2000*, London, Commission for Racial Equality, <http://www.cre.gov.uk/law/rra2000.html> (accessed 4/2/01).
- Comte, A, (1974, 1st published 1830), *The Positive Philosophy*, New York, Ams Press.
- Corbin, J and Strauss, A, (1990), 'Grounded theory research: Procedures, canons and evaluative criteria', *Qualitative Sociology*, Vol. 13: 3-21.
- Cousins, M and Hussain, A,(1984), *Michel Foucault*, Basingstoke, Macmillan.
- Cruikshank, J and Beevers, D, (1989), *Ethnic Factors in Health and Disease*, Sevenoaks, Wright.
- Daudi, P, (1986), *Power in the Organisation: The Discourse of Power in Managerial Praxis*, Oxford, Basil Blackwell.
- Davis, A, (1992), *Who needs user research? Service users as research subjects or participants, implications for user involvement in service contracting*, Leeds, Nuffield Institute for health Studies.
- Deakin, N D, (1975), 'Harold Macmillan and the control of Commonwealth Immigration', *New Community*, Vol. 4 (2): 188-190.
- Deakin, N, with Cohen, B and Mcneal, J, (1970), *Colour, Citizenship and British Society*, London, Panther Modern Society.
- Denzin, N K and Lincoln, Y S, (1998), *Collecting and Interpreting Qualitative Materials*, London, Sage.

- Denzin, N K and Lincoln, Y, S, (1998), *The Landscape of Qualitative Research: Theories and issues*, London, Sage.
- Department of Health, (1993), *The Health of the Nation: Key Area Handbook: Coronary Heart Disease and Stroke*, Leeds, Department of Health.
- Department of Health, (1998), *Frank Dobson Gives The Go-Ahead For First Wave Of Health Action Zones*, Press Release 98/120, London, Department of Health.
- Department of Health, (2000), *Nice Issue First Set On Guidance To Tackle Unacceptable Variations In Care*, Press Release 2000/0178, London, Department of Health.
- Dominelli, L, (1997), *Anti-racist Social Work* (2nd Ed.), Basingstoke, Macmillan.
- Donald, J and Rattansi, A, (1992), 'Race', *Culture and Difference*, London, Sage.
- Douglas, J, (1998), 'Health Promotion - the Sandwell experience' in Rawaf, S and Bahl, V, *Assessing health needs of people from minority ethnic groups*, London, Royal College of Physicians.
- Douglas, J, (1998), 'Developing appropriate research methodologies with black and minority ethnic communities. Part I: reflections on the research process', *Health Education Journal*, Vol. 57: 329-338.
- Douglas, J, (1996), 'Developing with Black and Ethnic Communities, Health Promotion Strategies which address social inequalities' in Bywaters, P and Mcleod, E, *Working for Equality in Health*, London, Routledge.
- Dreyfus, H L and Rainbow, P, (1982), *Michel Foucault: Beyond Structuralism and Hermeneutics*, Brighton, Harvester Press.
- Dudley, E and Novak, M (Eds.), (1972), *The Wild Man Within: An Image of Western Thoughts from the Renaissance to Romanticism*, Pittsburgh, Pittsburgh University Press.
- du Gay, P, Evans, J and Redman, P, (2000), *Identity: a reader*, London, Sage.
- Durkheim, E, (1970), *Suicide: A Study in Sociology*, London, RKP.
- Dyer, R, (1988), 'White', *Screen*, 29: 44-64.
- Edwards, A and Talbot, R, (1999), *The Hard-pressed Researcher: A research handbook for the caring professions* (2nd Ed.), London, Longman.
- Erens, B, Primatesta, P and Prior, G (Eds.), (2001), *Health Survey for England – The Health Of Minority Ethnic Groups*, London, The Stationery Office.
- Fernando, S, (1991), *Mental Health, Race and Culture*, Basingstoke, Macmillan.
- Fernando, S, (Ed.), (1995), *Mental Health in a Multi-ethnic Society*, London, Routledge.
- Fitzherbert, K, (1967), *West Indian Children in London*, London, G Bell.

- Foot, P, (1969), *The Rise of Enoch Powell*, London, Cornmarket Press Ltd.
- Foucault, M, (1970), *The Order of Things: An Archaeology of Knowledge*, (Trans. Alan Sheridan), London, Tavistock.
- Foucault, M, (1973), *The Birth of the Clinic: An Archaeology of Medical Perception*, (Trans: A M Sheridan Smith), London, Tavistock.
- Foucault, M, (1977), *Discipline And Punish: The Birth of the Prison*, London, Allen Lane.
- Foucault, M, (1980), *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*, London, Harvester Press.
- Foucault, M, (1981), 'The Order of Discourse' (trans. I McLeod) in Young, R, *Untying the Text: A Post-Structuralist Reader*, London, Routledge & Kegan Paul.
- Foucault, M, (1982), 'Afterword: The Subject and Power' in Dreyfus, H L and Rainbow, P, *Michel Foucault: Beyond Structuralism and Hermeneutics*, Brighton, Harvester Press.
- Foucault, M, (2000), 'Introduction to 'The Use of Pleasure'' (1st published 1984) in du Gay, P, Evans, J and Redman, P, *Identity: a reader*, London, Sage.
- Francis, E, (1993), 'Psychiatric racism and social police: black people and the psychiatric services', in James, W and Harris, C, *Inside Babylon: The Caribbean Diaspora in Britain*, London, Verso.
- Freundlieb, D, (1994), 'Foucault's theory of discourse and human agency' in Jones, C and Porter, R, (Eds.), *Reassessing Foucault*, London, Routledge.
- Frow, J, (1985), 'Discourse and Power', *Economy and Society*, Vol. 14, No. 2, May: 192-214.
- Fryer, P, (1948), 'Five Hundred Pairs of Willing Hands', *Daily Worker*, No. 5226: 23 June.
- Fryer, P, (1984), *Staying Power: The history of black people in Britain*, London, Pluto Press.
- Fyfe, C, (1994), 'Using race as an instrument of policy: a historical view', *Race & Class*, Vol. 36, 3: 69-77.
- Gabe J, Kelleher D and Williams G (Eds.), (1994), *Challenging Medicine*, London, Routledge.
- Gee, J P, (1985), 'The Narrativization of Experience in the Oral Style', *Journal of Education*, 167(9): 9-35.
- Gergen, K J, (1994), *Realities and Relationships: Soundings in Social Construction*, Cambridge, MA, Harvard University Press.
- Gilbert, N (Ed.), (1993), *Researching Social Life*, London, Sage.
- Glaser, B G, (1992), *Basics of Grounded Theory Analysis*, Mill Valley, Ca, Sociology Press.

- Glaser, B G and Strauss, A L, (1967), *The Discovery of Grounded Theory*, London, Weidenfeld and Nicolson.
- Gluck, S B and Patai, D (Eds.) (1991), *Women's Words: The Feminist Practice of Oral History*, London, Routledge.
- Goodman, R, (1997), 'The Strengths and Difficulties Questionnaire: A Research Note', *Journal of Child Psychology and Psychiatry*, 38: 581-586.
- Gordon, P, (1996), 'The Racialisation of Statistics' in Skellington, R with Morris, P, 'Race' in *Britain Today*, (2nd Ed.), London, Sage.
- Gordon, T, (1982), 'Further mortality experience among Japanese Americans' *Public Health Reports*, Vol. 97: 973-984.
- Government Statistical Service, (1993), *1991 Census: Ethnic Group and Country of Birth*, London, HMSO.
- Grbich, C, (1999), *Qualitative research in Health: An Introduction*, London, Sage.
- Gurevitch, M, Bennett, T, Curran, J and Wollacott, J (Eds.), (1982), *Culture, Society and the Media*, London, Methuen.
- Hakluyt, R, (1972), *Voyages and Discoveries*, Harmondsworth, Penguin.
- Hall, S, (1996), 'Race, Culture and Communications: looking backward and forward at cultural studies' in Storey, J (Ed.), *What Is Cultural Studies*, London, Arnold.
- Hall, S, (1982), 'The rediscovery of ideology' in Gurevitch, M, Bennett, T, Curran, J and Wollacott, J (Eds.), *Culture, Society and the Media*, London, Methuen.
- Hall, S, (1989), *New Ethnicities*, London, ICA Documents 7, Black Film, Black Cinema.
- Hall, S (2000), 'Who needs 'Identity'?', in du Gay, P, Evans, J and Redman, P, *Identity: a reader*, London, Sage.
- Harris, H W, Blue, H C and Griffith, E E H (Eds.), (1995), *Racial and Ethnic Identity: Psychological development and creative expression*, London, Routledge.
- Hartley, J, (1994), 'Culture' in O'Sullivan, T, Hartley, J, Saunders, D, Montgomery, M and Fiske, J, *Key Concepts in Communication and Cultural studies*, (2nd Ed.), London, Routledge.
- Haskey, J, (1997), 'Population Review: (8) The ethnic minority and overseas-born populations of great Britain: Population Trends', *Population Trends*, Summer 1997: 13-30.
- Health Information For Newtown Teenagers, (2000), *The I.D. Project*, Birmingham, HINT.
- Henley, A, (1991), *Caring For Everyone: ensuring standards of care for black and ethnic minority patients*, Cambridge, National Extension College.

- Henriques, J, Holloway, W, Urwin, C, Venn, C and Walkerdine, V, (1984), *Changing the subject, Psychology, Social Regulation and Subjectivity*, London, Methuen.
- Hill, A, (1989), 'Molecular markers in ethnic groups', in Cruickshank, J, and Beevers, D, *Ethnic Factors in Health and Disease*, Sevenoaks, Wright.
- Hindess, B, (1996), *Discourses of Power: From Hobbes to Foucault*, Oxford, Blackwell.
- Hindess, B and Hirst, P, (1977), *Mode of Production and Social Formation*, London, Macmillan.
- HMSO, (1871), *Census of Population*, London, HMSO.
- Hobbes, T, (1968: 1st published 1651), *Leviathan*, London, Penguin.
- Home Affairs Committee, (1983), *Ethnic and Racial Questions in the Census: report and minutes of evidence, Vol. 2:(HC 33)*, London, HMSO.
- Horrocks, C and Jevtic, Z, (1997), *Foucault for Beginners*, Cambridge, Icon Books Ltd.
- Hoy, D C (Ed.), (1986), *Foucault: A Critical Reader*, Oxford, Basil Blackwell.
- Hughes, J and Sharrock, W, (1997), *The Philosophy of Social Research*, (3rd Ed.), Harlow, Addison Wesley Longman.
- Husband, J, (1996), 'Defining and Containing Diversity: community, ethnicity, citizenship' in Ahmad W I U and Atkin, K, *'Race' and Community Care*, Buckingham, Open University Press.
- Illich, I, (1990), *Limits to Medicine. Medical Nemesis: The Expropriation of Health*, Harmondsworth, Penguin.
- James, W and Harris, C, (1993), *Inside Babylon: The Caribbean Diaspora in Britain*, London, Verso.
- Jenkins, R, (1997), *Rethinking Ethnicity: Arguments and Explorations*, London, Sage.
- Jenks, C, (1998), *Core Social Dichotomies*, London, Sage.
- Jones, C, (1977), *Immigration and Social Policy in Britain*, London, Tavistock.
- Jones, C and Porter, R (Eds.), (1994), *Reassessing Foucault*, London, Routledge.
- Jones, K, (1967), 'Immigrants and the Social Services', *National Institute Economic Review*, No. 41: 28-40.
- Jones, K, (1991), *The Making of Social Policy in Britain: 1830 - 1990*, London, Athlone Press Ltd.
- Jones Finer, C (Ed.), (2001), *Comparing the Social Policy Experiences of Britain and Taiwan*, Aldershot, Ashgate.

- Jowell, R, Curtice, J, Park, A, Brook, L, Ahrendt, D with Thomson, K, (1995), *British Social Attitudes: the 12th Report*, Aldershot, Dartmouth.
- Kelleher, D and Islam, S, (1996), 'How Should I Live? Bangladeshi People and Non-Insulin Dependent Diabetes' in Kelleher, D and Hillier, S, *Researching Cultural Differences in Health*, London, Routledge.
- Kelleher, D and Hillier, S (Eds.), (1996), *Researching Cultural Differences in Health*, London, Routledge.
- Kendall, G and Wickham, G, (1999), *Using Foucault's Methods*, London, Sage.
- King, M, Coker, E, Leavey, G, Hoare, A and Johnson-Sabine, E, (1994), 'Incidence of psychotic illness in London: comparison of ethnic groups', *British Medical Journal*, Vol. 309: 1115-1119.
- Knowles, C and Mercer, S, (1992), 'Feminism and Antiracism' in Donald, J and Rattansi, A, 'Race', *Culture and Difference*, London, Sage.
- Koch, T, (1998), 'Story telling: is it really research?', *Journal of Advanced Nursing*, 28(6): 1182-1190.
- Koch, T and Harrington, A, (1998), 'Reconceptualizing rigour: the case for reflexivity', *Journal of Advanced Nursing*, 28(4): 882-890.
- Kritzman, L D (Ed.), (1988), *Michel Foucault: Politics, Philosophy, Culture: Interviews and other Writings 1977-1984*, London, Routledge.
- Lambert H and Sevak, L, (1996), 'Is "cultural difference" a useful concept?' in Kelleher, D and Hillier, S (Eds.), (1996), *Researching Cultural Differences in Health*, London, Routledge.
- Lambeth, Lewisham and Southwark Health Authority, (1996), *Summary of Work in the Directorate of Health Policy and Public Health Relating to Black and Minority Ethnic Issues*, Internal Policy Document, London, Lambeth, Lewisham and Southwark Health Authority.
- Lambeth, Lewisham and Southwark Health Authority, (1997), *Ethnicity and Commissioning*, Internal Policy Document, London, Lambeth, Lewisham and Southwark Health Authority.
- Langellier, K M and Sullivan, C F, (1998), 'Breast Talk in Breast Cancer Narratives', *Qualitative Health Research*, 8(1): 76-94.
- Layton-Henry, Z, (1992), *The Politics of Immigration: Immigration, 'Race' and 'Race' Relations in Post-war Britain*, Oxford, Blackwell.
- Lewis, G, Gewirtz, S and Clarke, J, (2000), *Rethinking Social Policy*, London, Sage.
- Lieblich A, Tuval-Mashiach, R and Zilber, T, (1998), *Narrative Research: Reading, Analysis and Interpretation*, Applied Social Research Methods Series, London, Sage.

- Littlewood, R and Lipsedge, M, (1982), *Aliens and Alienists, Ethnic Minorities and Psychiatry*, Harmondsworth, Penguin.
- Lloyd, I, (2001), *A Race Odyssey*, www.pih.org.uk.
- Lukes, S, (1974), *Power: A Radical View*, Basingstoke, Macmillan.
- Macdonnell, D, (1986), *Theories of Discourse*, Oxford, Basil Blackwell.
- MacLaclan, M, (1997), *Culture and Health*, Chichester, John Wiles & Sons.
- Malik, K, (1996), *The Meaning of Race: Race, History and Culture in Western Society*, Basingstoke, Macmillan.
- Malpass, P and Murie, A, (1990), *Housing Policy and Practice*, (3rd Ed.), Basingstoke, Macmillan.
- Mama, A, (1992), 'Black Women and the British State' in Braham, P, Rattansi, A and Skellington, R (Eds.) *Racism and Antiracism: Inequalities, Opportunities and Policies*, London, Sage.
- Mares, P, Henley, A and Baxter, C, (1985), *Health Care in Multiracial Britain*, Cambridge, Health Education Council.
- Marx, K, (1970), *The German Ideology*, London, Lawrence and Wishart.
- Mason, D, (1995), *Race and Ethnicity in Modern Britain*, Oxford, Oxford University Press.
- Mason, J, (1996), *Qualitative Researching*, London, Sage.
- Matthews, R N, (2001), 'Current Themes and Issues in Britain's National Health Service' in Jones Finer, C (Ed.), *Comparing the Social Policy Experiences of Britain and Taiwan*, Aldershot, Ashgate.
- May, T, (1998), 'Reflections and reflexivity' in May, T and Williams M, (Eds.), *Knowing the Social World*, Buckingham, Open University Press.
- May, T and Williams, M (Eds.), (1998), *Knowing the Social World*, Buckingham, Open University Press.
- McGovern, D and Cope, R, (1987), 'First psychiatric admission rates of first and second generation Afro-Caribbeans', *Social Psychiatry*, Vol. 22: 139-149.
- McHoul, A and Grace, W, (1993), *A Foucault Primer: Discourse, Power and the subject*, Melbourne, Melbourne University Press.
- Megill, A, (1985), *Prophets of Extremity: Nietzsche, Heidegger, Foucault, Derrida*, Berkeley, University of California Press.
- Michels, R, (1959), *Political Parties*, New York, Dover.

- Miles, M and Huberman, A, (1984), *Qualitative Data Analysis*, London, Sage.
- Miles, R, (1982), *Racism & Migrant Labour*, London, Routledge & Kegan Paul.
- Miles, R, (1989), *Racism*, London, Routledge.
- Miller, J B, (1976), *Towards a New Psychology of Women*, Boston, Ma, Beacon Press.
- Mills, S, (1997), *Discourse*, London, Routledge.
- Mishler, E G, (1984), *The Discourse of Medicine: Dialectics of Medical Interviews*, Norwood, NJ, Ablex.
- Modood, T, Bethoud, R, Lakey, J, Nazroo, J, Smith, P, Virdee, S and Beishon, S, (1997), *Ethnic Minorities in Britain: Diversity and disadvantage*, London, Policy Studies Institute.
- Modood, T, (1992), *Not Easy Being British: colour, culture and citizenship*, London, Runnymede Trust and Trentham Books.
- Mosca, G, (1939: 1st published 1896), *The Ruling Class*, New York, McGraw-Hill.
- Moser, C A and Kalton, G, (1971), *Survey Methods in Social Investigation*, Aldershot, Gower.
- Mosse, G, (1985), *Towards the Final Solution: A History of European Racism*, Madison, University of Wisconsin Press.
- Mullard, C, (1973), *Black Britain*, London, George Allen & Unwin.
- Nanton, P, (1992), 'Official statistics and problems of inappropriate ethnic categorisation', *Policy and Politics*, Vol. 20, No. 4: 277-285.
- Nazroo, J Y, (1998), 'Genetic, cultural or socio-economic vulnerability? Explaining ethnic inequalities in health', *Sociology of Health & Illness*, Vol. 20, No. 5: 710-730.
- Nazroo, J Y, (1997), *The Health of Britain's Ethnic Minorities: Findings from a national survey*, London, Policy Studies Institute.
- NHS Executive, (1998), *The new NHS: Modern and Dependable: A National Framework for Assessing Performance*, London, Department of Health.
- Nola, R, 1998, 'Knowledge, Discourse, Power and Genealogy in Foucault' in Nola, R (Ed.), *Foucault*, Ilford, Frank Cass.
- Nola, R (Ed.), (1998), *Foucault*, Ilford, Frank Cass.
- Norman, A, (1985), *Triple Jeopardy: growing old in a second homeland*, London, CPAG.
- Oakley, A, 1981, 'Interviewing women: a contradiction in terms' in Roberts, H (Ed.), *Doing Feminist Research*, London, Routledge & Kegan Paul.

O'Farrell, C (Ed.), *Foucault: The Legacy*, Kelvin Grove, Queensland University of Technology.

Office for National Statistics, (1997), *Key Statistics for new health areas England and Wales*, London, The Stationery Office.

Office for National Statistics, (1998), *2001 Census: Update*, London, ONS, <http://www.ons.gov.uk/census/1997test/updtate.htm>.

Office for Public Management, (1996), *Responding to Diversity: A study of commissioning issues and good practice in purchasing minority ethnic health*, London, OPM.

OPCS, (1993), *1991 Census: Ethnic group and country of Birth Report: Great Britain, (Vol. 2)*, HMSO.

OPCS, (1993a), *1991 'Census, Ethnic Group Flowchart and Index* (OPCS internal document) in Owen, D, *Towards 2001: Ethnic Minorities and the Census*, Warwick, Centre for Research in Ethnic Relations.

O'Sullivan, T, Hartley, J, Saunders, D, Montgomery, M and Fiske, J, (1994), *Key Concepts in Communication and Cultural Studies*, (2nd Ed.), London, Routledge.

Owen, C, (1993), 'Using the Labour Force Survey to estimate Britain's ethnic minority populations', *Population Trends*, No. 72, Summer 1993: 18-23.

Owen, D, (1994), 'Spatial variations in ethnic minority group populations in Great Britain', *Population Trends*, No. 78, Winter 1994: 23-33.

Owen, D, (1996), *Towards 2001: Ethnic Minorities and the Census*, Warwick, Centre for Research in Ethnic Relations.

Owen, D, (1996a), 'Black-Other: the melting pot' in Peach, C (Ed.), *Ethnicity in the 1991 Census: Volume Two, The ethnic minority populations of Great Britain*, London, HMSO.

Owen, D and Johnson, M, (1996), 'Ethnic Minorities in the Midlands' in Ratcliffe, P (Ed.), *Ethnicity in the 1991 Census: Volume Three, Social Geography and ethnicity in Britain: geographical spread, spatial concentration and internal migration*, London, HMSO.

Panayi, P, (1994), *Immigration, ethnicity and racism in Britain 1815 - 1945*, Manchester, Manchester University Press.

Pareto, V M, (1963), *The Mind and Society: a treatise on general sociology*, New York, Dover.

Parker, D, Li, J and Fan, J, (1996), *The Needs of Young People of Chinese Origin in Birmingham*, Birmingham, Birmingham Chinese Youth Project.

Pascoe, L C (Ed.), (1968), *Encyclopaedia of Dates and Events*, Sevenoaks, Hodder and Stoughton.

- Patterson, S, (1969), *Immigration and Race Relations in Britain 1960 - 1967*, London, Oxford University Press.
- Peach, C (Ed.), (1996), *Ethnicity in the 1991 Census: Volume Two, The ethnic minority populations of Great Britain*, London, HMSO.
- Pêcheux, M, (1982), *Language, Semantics and Ideology: Stating the Obvious*, (Trans. H Nagpal), Basingstoke, Macmillan.
- Petersen, A and Bunton, R (Eds.), (1997), *Foucault: Health and Medicine*, London, Routledge.
- Petersen, W, (1980), 'Concepts of Ethnicity' in Petersen, W Novak, M and Gleason, P, *Concepts of Ethnicity*, London, Belknap Press.
- Petersen, W, Novak, M and Gleason, P, (1980), *Concepts of Ethnicity*, London, Belknap Press.
- Phillips, M and Phillips, T, (1999), *Windrush: The Irresistible Rise of Multi-Racial Britain*, London, Harper Collins.
- Phoenix, A, (2000), 'Constructing Gendered and Racialized Identities: Young Men, Masculinities and Educational Policy' in Lewis, G, Gewirtz, S and Clarke J, *Rethinking Social Policy*, London, Sage.
- Phoenix, A, (1994), 'Early Motherhood and Black Women', in Wilson, M, (Ed.), *Healthy and Wise: The essential health handbook for black women*, London, Virago.
- Pieterse, J N, (1992), *White on Black: Images of Africa and Blacks in Western Popular Culture*, London, Yale University Press.
- Pinderhughes, E, (1989), *Understanding Race, Ethnicity and Power: The Key to Understanding in Clinical Practice*, New York, The Free Press.
- Prior, L, (1997), 'Following in Foucault's Footsteps: Text and Context in Qualitative Research', in Silverman, D, *Qualitative Research: Theory, Method and Practice*, London, Sage.
- Punch, K F, (1998), *Introduction to Social Research: Quantitative & Qualitative Approaches*, London, Sage.
- Rashid, A and Jagger, C, (1992), 'Attitudes to and perceived use of health care services among Asian and non-Asian patients in Leicester', *British Journal of General Practice*, Vol. 42: 197-201.
- Ratcliffe, P (Ed.), (1996), *Ethnicity in the 1991 Census: Volume Three, Social Geography and ethnicity in Britain: geographical spread, spatial concentration and internal migration*, London, HMSO.

- Rawaf, S and Bahl, V (Eds.), (1998), *Assessing health needs of people from minority ethnic groups*, London, Royal College of Physicians.
- Reissman, C K, (1993), *Narrative Analysis: Qualitative Research Methods Series: 30*, London, Sage.
- Rex, J, (1983), *Race Relations in Sociological Theory*, (2nd Ed.), London, Routledge & Kegan Paul.
- Rex, J and Mason, D (Eds.), (1986), *Theories of Race and Ethnic Relations*, Cambridge, Cambridge University Press.
- Richardson, R, (1992), 'Introduction', in Modood, T (Ed.), *Not Easy Being British: Colour, culture and citizenship*, London, Runnymede Trust and Trentham Books.
- Roberts, H (Ed.), (1981) *Doing Feminist Research*, London, Routledge & Kegan Paul.
- Robinson, L, (1998), 'Race', *Communication and the Caring Professions*, Buckingham, Open University Press.
- Robinson, R, (1992), 'Introduction', in Modood, T (Ed.), *Not Easy Being British: Colour, culture and citizenship*, London, Runnymede Trust and Trentham Books.
- Robinson, V and Richardson, D, (Eds.), (1997), *Introducing Women's Studies: Feminist Theory and Practice*, Basingstoke, Macmillan.
- Roediger, D, (1994), *Towards the Abolition of Whiteness*, London, Verso.
- Rooney, B, (1987), 'Racism and resistance to change' in Torkington, N P K, (1991), *Black Health: A Political Issue*, London, Catholic Association for Racial Justice.
- Rose, E J B in association with Deakin, N and Abrams, M, Jackson, V, Preston, M, Vanags, A H, Cohen, B, Gaitskell, J and Ward, P, (1969), *Colour and Citizenship: A Report on British Race Relations*, London, Oxford University Press.
- Rose, K and Webb, C, (1998), 'Analyzing Data: Maintaining Rigor in Qualitative Study', *Qualitative Health Research*, 8(4): 556-562.
- Roth, I (Ed.), (1990), *Introduction to Psychology*, Buckingham, Lawrence Erlbaum Associated Ltd in association with the Open University.
- Rudat, K, (1994), *Health and Lifestyles: Black and Minority Ethnic Groups in England*, London, Health Education Authority.
- Runnymede Trust and the Radical Statistics Race Group, (1980), *Britain's Black Population*, London, Heinemann Educational Ltd.
- Runnymede Trust, (2001), *Multi-ethnic Britain: Key Facts*, www.blink.org.uk/reports2/kfacts.htm.

Sandelowski, M, (1991), 'Telling Stories: Narrative Approaches in Qualitative Research', *IMAGE: Journal of Nursing Scholarship*, 23(3) Fall: 161-166.

Sandwell Healthcare NHS Trust (2001), '2001: More Nurses from the Philippines', *In Trust*, Issue 20, Spring 2001: 1.

Sandwell NHS Trust, (1997), *Creating Cultural Competence: Equal Access to Health Services*, Internal Policy Document, Sandwell, Sandwell NHS Trust.

Sayce, L, (2001), *HAZ Projects*, Lambeth, Southwark and Lewisham HAZ:
www.lslhaz.org.uk.

Scarman, Lord, (1981), *Report to the Right Honourable William Whitelaw CH, MC, MP, Secretary of State for the Home Department, on the Brixton Disorders of 10 - 12 April 1981*, London, HMSO.

Seale, C, (1998), 'Normal/Pathological' in Jenks, C, *Core Social Dichotomies*, London, Sage.

Seidman, S, (1998), *Contested Knowledge: Social Theory in the Postmodern Era*, (2nd Ed.), Oxford, Blackwell.

Sheldon, T A, (1992), 'The use of 'Ethnicity' and 'Race' in Health Research: A cautionary note', in Ahmad, W I U, *The Politics of 'Race' and Health*, Bradford, University of Bradford & Ilkley Community College.

Sheldon, T A and Parker, H, (1992), 'Race and ethnicity in health research', *Journal of Public Health Medicine*, Vol. 14, No. 2: 104-110.

Silverman, D, (1997), *Qualitative Research: Theory, Method and Practice*, London, Sage.

Skellington, R with Morris, P, (1996), *'Race' in Britain Today*, (2nd Ed.), London, Sage.

Smaje, C, (1995), *Health, 'Race' and Ethnicity: Making sense of the evidence*, London, King's Fund Institute.

Smaje, C, (1996), 'The Ethnic Patterning of Health: New Directions for Theory and Research', *Sociology of Health & Illness*, Vol. 18, No. 2: 139-17.

Small, C and Hinton, T, (1997), *Reaching Out: A study of Black and Minority Ethnic single homelessness and access to primary health care*, London, NHS Ethnic Health Unit.

Smith, M, (1986), 'Pluralism, Race and Ethnicity in Selected African Countries' in Rex, J and Mason, D (Eds.), *Theories of Race and Ethnic Relations*, Cambridge, Cambridge University Press.

Smith, S J, (1989), *The Politics of 'Race' and Residence: Citizenship, Segregation and White Supremacy in Britain*, Cambridge, Polity Press.

- Solomos, J, (1992), The Politics of Immigration since 1945 in Braham, P, Rattansi, A and Skellington, R (Eds.) *Racism and Antiracism: Inequalities, Opportunities and Policies*, London, Sage.
- Solomos, J, (1993), *Race and Racism in Britain*, (2nd Ed.), Basingstoke, Macmillan.
- Solomos, J and Back, L, (1996), *Racism and Society*, Basingstoke, Macmillan.
- Spencer, I R G, (1997), *British Immigration Policy Since 1939: The Making of Multi-racial Britain*, London, Routledge.
- Stillar, G F, (1998), *Analysing Everyday Texts: Discourse, Rhetoric and Social Perspectives*, London, Sage.
- Storey, J (Ed.), (1996), *What Is Cultural Studies*, London, Arnold.
- Strauss, A and Corbin, J, (1998), *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*, (2nd Ed.), London, Sage.
- Thomas, K, (1990), 'Dimensions of Personality' in Roth, I (Ed.), *Introduction to Psychology*, Buckingham, Lawrence Erlbaum Associated Ltd in association with the Open University.
- Tizard, B and Phoenix, A, (1993), *Black, white or mixed race? Race and racism in the lives of young people of mixed parentage*, London, Routledge.
- Torkington, N P K, (1983), *The Racial Politics of Health - A Liverpool Profile*, Liverpool, Liverpool University.
- Torkington, N P K, (1991), *Black Health: A Political Issue*, London, Catholic Association for Racial Justice.
- Townsend, P, Davidson, N and Whitehead, M, (1992), *Inequalities in Health*, Harmondsworth, Penguin.
- van Dijk, T A, (1998), *Ideology: A Multidisciplinary Approach*, London, Sage.
- Wallman, S, (1979), *Ethnicity at Work*, Basingstoke, Macmillan.
- Walvin, J, (1984), *Passage to Britain: Immigration in British History and Politics*, Harmondsworth, Penguin Books Ltd.
- Ward, R, (1992), 'Race, housing and wealth', *New Community*, Vol. X, No. 1: 3-15.
- Weissman A, (1989), '“Race-ethnicity”: a dubious scientific concept', *Public Health Reports*, 195 (1): 102-103.
- White, H, (1972), 'The forms of wildness: Archaeology of an idea' in Dudley, E and Novak, M (Eds.), *The Wild Man Within: An Image of Western Thoughts from the Renaissance to Romanticism*, Pittsburgh, Pittsburgh University Press.

Wilkinson, R G, (1996), *Unhealthy Societies: The Afflictions of Inequality*, London, Routledge.

Williams, F, (1989), *Social Policy: A critical introduction* Cambridge, Polity Press.

Wilson, M, (Ed.) (1994), *Healthy and Wise: The essential health handbook for black women*, London, Virago.

Wright, P, (1968), *The Coloured Worker in British Industry*, Oxford, Oxford University Press for the Institute of Race Relations.

Young, R, (1981), *Untying the Text: A Post-Structuralist Reader*, London, Routledge & Kegan Paul.

Zack, N, (1993), *Race and Mixed Race*, Philadelphia, Temple University Press.

Zimbardo, P G, (1988), *Psychology and Life*, (12th Ed.), New York, Harper Collins.

APPENDICES

**CHRONOLOGY OF NEW COMMONWEALTH IMMIGRATION AND
'RACE' EVENTS AND LEGISLATION**

- 1945** W.W.II ends. Attempts are made to repatriate colonial workers, but many remain. Substantial Irish immigration continues.
- 1947** Polish Resettlement Act.
- 1948** British Nationality Act.
- SS Empire Windrush* and *SS Orbita* bring immigrants from West Indies.
- 1950** First attempt to introduce legislation against race discrimination (Reg Sorenson, Private Member's Bill) fails.
- 1954** Immigration Control Act drafted (NOT presented to parliament).
- 1956** Fenner Brockway's private member's bill to outlaw discrimination in public places fails.
- 1961** Large rise in immigration, partly caused by campaign for immigration control. Commonwealth Immigrants Bill introduced.
- 1962** Commonwealth Immigrants Act requires immigrants to have an employment voucher before being allowed entry.
- 1964** Labour Government renews immigration control legislation.
- 1965** White Paper on control of Commonwealth Immigration reduces number of entry vouchers to 8,500 (1,000 are reserved for Maltese citizens).
- First Race Relations Act.
- Race Relations Board and National Committee for Commonwealth Immigrants

instigated.

1967 Founding of the National Front. Establishment of Joint Council for the Welfare of Immigrants.

1968 Commonwealth Immigrants Act (controls entry of East African Asians).

Enoch Powell's 'Rivers of blood' speech.

Second Race Relations Act

Establishment of Parliamentary select committee on Race Relations and Immigration.

1969 Immigration Appeals Act.

A major survey of British race relations *Colour and Citizenship* published.

1971 Immigration Act replaces Aliens Restriction Act 1914 and Commonwealth Immigrants Acts, 1968 and 1962.

1972 Asians expelled from Uganda. 27,000 admitted to UK.

1973 Pakistan leaves Commonwealth. Pakistan Act passed.

1976 Third Race Relations Act. Establishment of Commission for Racial Equality.

Notting Hill carnival: black people clash with police.

1978 Conservatives propose stronger anti-immigration law.

1980 St Paul's riot, Bristol.

1981 Nationality Act.

Brixton and Toxteth riots.

Select Committee report on racial disadvantage.

Home Office report on racially motivated attacks.

1985 Handsworth riots.

Visa controls imposed on visitors from Sri Lanka.

1986 Visa controls on visitors from India, Nigeria, Ghana, Pakistan, Bangladesh.

Home Office report on racial attacks.

Immigration Act. Immigration (Carrier's Liability) Act.

1988 Immigration Act – restricts immigrant's rights.

1989 Government grants full British citizenship to 225,000 people from Hong Kong.

1990 British Nationality (Hong Kong) Act.

1991 Asylum Bill Published.

1996 Asylum and Immigration.

1999 Immigration and Asylum Act.

2000 Race Relations (Amendment) Act.

APPENDIX 2

SUBJECTIVE/DESCRIPTIVE CODES

INTERNAL (Describing) CONTROLS (Subjective/Descriptive) Event Code	CODE IDENTIFIER	NOTES
I need you to listen.	EACCESS	Description/Evidence of Access problem.
Doctor knows best!	EDEFER	Evidence/example/description of deference to GP.
I don't feel accepted.	EDISCRIM	Evidence/Example of discrimination. Power + Prejudice.
I just give up	EDISEMP	Evidence/Example of Disempowerment. May link to the exercise of medical power.
Individual descriptions of ethnicity.	EDISETHNIC	Description of ethnicity.
He won't let me talk.	EDISPRES	Evidence/Example of discourse suppression.
You've got to protect your kids.	EFEAR	Experience of fear because of the individual's ethnicity
I think/don't think that my ethnicity affects my health.	EHEALTH	Potential link between ethnicity and health.
Doctors don't understand about ethnicity.	EIGNORE	Evidence/Example of GP ignorance. Relates to medical power, Dr exhibits ignorance or condition/ethnicity connection/etc.
'Half-caste' and other terms.	ENONPC	Non-PC language? To indicate the way the subject thinks about ethnicity?
Doctors treat me badly.	EPOWER	Evidence/Example of exercise of GP Power. Binary Positional power.
They see me as different.	EPREJ	Description/Example of prejudice/stereotyping. Manifestation of discrimination.
Black is a colour not a race.	ERACE/ETHNIC	'Race'/Ethnicity confusion. Use of 'race' when does not fit with my take on 'race'/ethnicity.
Everyone who's not white has experienced racism.	ERACISM	Evidence/Example of Racism. Power + Prejudice + colour?
I want to have my say.	ERESIST	Evidence/description of Resistance The process of challenging medical power
How do I cope?	ESTRESS	Evidence/Example of stress.
Choosing my identity gives me access to a support group	ESUPPORT	Identity/ethnicity and choice.

CONCEPT/THEORY CODES

EXTERNAL (Defining) CONTROLS Concept/Theory Code	CODE IDENTIFIER	Notes
Racism.	RACISM	Power + Prejudice + colour?
Discrimination.	DISCRIMINATION	Power + Prejudice.
Medical power.	MEDICAL POWER	Binary Positional power.
Medical Ignorance.	MEDICAL IGNORANCE	Relates to medical power, Dr exhibits ignorance or condition/ethnicity connection/etc.
Discourse suppression.	DISCOURSE SUPPRESS	
Action on prejudice/stereotyping	PREJUDICE	Manifestation of discrimination.
Ethnicity.	ETHNICITY	
'Race'/Ethnicity Dichotomy.	RACE/ETHNICITY	Use of 'race' when does not fit with my take on 'race'/ethnicity.
Internalisation of 'racialised' position?	INTERNALISED RACE	To indicate the way the subject thinks about ethnicity?
Stress.	STRESS	
Access to services.	ACCESS	
Hierarchy of Power	POWER	
Resistance	RESISTANCE	The process of challenging medical power
Disempowerment	DISEMPOWER	May link to the exercise of medical power.
'Race'	'RACE'	
Gatekeeping	GATEKEEPER	
Identity	IDENT	Professional identity.

NARRATORS' DEFINITIONS OF 'ETHNICITY'

Ethnicity as language usage.

Ethnicity as limited choices.

Ethnicity as misunderstanding social exclusion.

Ethnicity as nationality + skin colour.

Ethnicity as nomenclature.

Ethnicity as obesity?

Ethnicity as pain.

Ethnicity as parental place of birth.

Ethnicity as perceived skin colour.

Ethnicity as perspective.

Ethnicity as political correctness.

Ethnicity as potential income.

Ethnicity as preference for doctor's ethnicity.

Ethnicity as professional membership.

Ethnicity as Race.

Ethnicity as rejection of ethnic position.

Ethnicity as religion.

Ethnicity as sexuality?

Ethnicity as Social Class.

Ethnicity as socio-economic position.

Ethnicity as specific health issues.

Ethnicity as statistics.

Ethnicity as susceptibility to disease.

Ethnicity as the inability to describe symptoms in the way doctors want.

Ethnicity as the need for cultural sensitivity.

Ethnicity as where you live.

Ethnicity as whiteness.

NARRATORS DEFINITIONS OF 'MIXED ETHNICITY

Mixed Ethnicity as who am I?.

Mixed Ethnicity as a burden

Mixed ethnicity as a guest.

Mixed Ethnicity as accent.

Mixed Ethnicity as accepting people.

Mixed Ethnicity as adopting a country

Mixed Ethnicity as an Internalised View.

Mixed ethnicity as an unusual mix!

Mixed Ethnicity as ancestry.

Mixed Ethnicity as assimilation.

Mixed Ethnicity as assumptions about
behaviour.

Mixed ethnicity as assumptions about
names.

Mixed ethnicity as becoming white.

Mixed Ethnicity as better?

Mixed Ethnicity as black.

Mixed Ethnicity as changed moral values.

Mixed Ethnicity as choice not always for
all.

Mixed ethnicity as choice of identity.

Mixed ethnicity as choice.

Mixed Ethnicity as choosing black.

Mixed Ethnicity as defining by skin colour.

Mixed Ethnicity as diet.

Mixed ethnicity as difference.

Mixed ethnicity as difficulty in completing official forms.

Mixed ethnicity as diluting 'race'.

Mixed Ethnicity as doctors don't care?

Mixed Ethnicity as expectations of appearance.

Mixed Ethnicity as family names.

Mixed ethnicity as family structure.

Mixed ethnicity as feeling white.

Mixed Ethnicity as fitting-in (or not).

Mixed ethnicity as hair care.

Mixed ethnicity as half-and-half.

Mixed Ethnicity as half-breed.

Mixed ethnicity as having no choice?

Mixed ethnicity as hybrid vigour.

Mixed ethnicity as identity crisis.

Mixed Ethnicity as inherited characteristics.

Mixed Ethnicity as intermarriage.

Mixed Ethnicity as labelling.

Mixed ethnicity as lack of choice of identity.

Mixed Ethnicity as maternal identity.

Mixed Ethnicity as medical ignorance.

Mixed Ethnicity as mixed cultures.

Mixed Ethnicity as multi group membership.

Mixed ethnicity as nomenclature.

Mixed Ethnicity as not appearing Black.

Mixed ethnicity as not interesting.

Mixed ethnicity as not standing out.

Mixed Ethnicity as parental issues.

Mixed ethnicity as person of many nations.

Mixed ethnicity as place of birth.

Mixed ethnicity as rejection of parental culture.

Mixed ethnicity as skin colour.

Mixed ethnicity as there's no-one like me.

Mixed ethnicity as two cultures.

Mixed Ethnicity as two histories.

Mixed Ethnicity as white = good.

Mixed ethnicity as who