Avoiding premature coronary deaths in Asians in Britain

Cultural factors are important

EDITOR,—An improved health service for all minority groups is to be applauded (even if the motives are predominantly economic). It may, however, be simplistic to suggest that the way to prevent coronary heart disease among Asians is to inform them of factors that would increase their likelihood of coronary heart disease and then expect them to change their lifestyle accordingly.¹

The assumption that each person appreciates health risks solely on the basis of information that he or she possesses ignores the large influence of cultural factors on the degree of importance that people ascribe to any risk.² The idea that people then analyse the costs of these risks and change their behaviour accordingly assumes, firstly, that they use an economic cost-benefit conceptual model to determine their behaviour³ and, secondly, that they will be in a position to change it.

The medical profession often assumes that if people do not correct their behaviour then they are not behaving in a reasoned way or are unable to attach appropriate priority to their health, and they may then be held responsible for having brought on their illness.⁴ Categorising a racial group as being at risk of a disease for which they may be blamed will marginalise them. This is particularly unnecessary when we are aware of the limited efficacy of health education campaigns, even among the supposedly rational, "health maximising" white middle classes.

I agree that coronary heart disease among Asians is an important issue that warrants funds for public

information and that we should not avoid our responsibilities as a profession to attend to the health requirements of minority ethnic groups merely because this is a sensitive issue. My point is that if we concentrate solely on the changes that should be made by individuals, from any minority group, to decrease their risk of illness, without regard to the complexity of factors that affect their conceptualisation of risk and behaviour, this will have consequences that may alienate them further.

SANGEETA PATEL
Clinical lecturer

Division of General Practice and Primary Care,
St George's Hospital Medical School,
London SW17 0RE

- 1 Gupta S, de Belder A, Hughes LO. Avoiding premature coronary deaths in Asians in Britain. *BMJ* 1995;311:1035-6. (21 October.)
- 2 Douglas M. Risk is a collective construct. In: Douglas M, Wildavsky A, eds. *Risk and culture: a essay on the selection of technological and environmental dangers*. Berkeley: University of California Press, 1983:186-98.
- 3 Good B. Illness representations in medical anthropology. In: Good B, ed. *Medicine, rationality and experience*. Cambridge: Cambridge University Press, 1994:25-64.
- 4 Lupton D. Power relations and the medical encounter. In: Lupton D, ed. *Illness, disease and the body in Western societies*. London: Sage, 1991:105-30.

Several key facts need to be considered

EDITOR,—Sandeep Gupta and colleagues' urge actions by the "Asian" community (the term "Asian" here is misleading to international readers) and by the Department of Health. What actions? The authors' advice is to control central obesity and increase physical exercise. How much of a dent will these actions make? If central obesity is controlled and all Asians exercise will coronary heart disease in Asians be avoided? Obviously not.

Actions arising from the insulin resistance hypothesis must be components of a strategy.⁵ The influential view that the prevalence of risk factors for coronary heart disease is lower in south Asians in Britain (British residents whose origins lie in India, Pakistan, Bangladesh, or Sri Lanka) than in the white population may be simplistic: when non-biochemical risk factors were studied the balance went against south Asians in Glasgow.⁶ There are several key facts.

Firstly, the cause of coronary heart disease is poorly understood. The reasons why the rates rise and fall over time within populations are unclear. Among the ethnic majority population in Britain coronary heart disease is on the wane. Among ethnic minority groups similar rises and falls will surely occur.

Secondly, mortality from coronary heart disease in south Asians, whose overall socioeconomic status is low, is almost identical with that in members of social class V in Britain.⁷

Thirdly, the key questions for south Asians are why the rates are high and how to reduce them, not why they are higher than in those in the white population.

Fourthly, the priority is the control of risk factors that are agreed to be causal, including smoking, raised blood pressure, raised cholesterol concentration, obesity, and failure to exercise.

Fifthly, maintaining the low prevalence of smoking in south Asian women and Sikh men and reducing smoking in Bangladeshi and Pakistani men⁸ are priorities.

Sixthly, research is needed on the hypotheses based on insulin resistance and the role of uterine

and early childhood adversity and on socio-economic influences including stress.^{9,4} Research must not, however, overshadow preventive activity.

Finally, pending clearer understanding, an inclusive rather than a reductionist strategy is appropriate.

In the 1980s little health education material on coronary heart disease existed for ethnic minority groups.⁷ This deficit is being corrected, and the challenge is to ensure that a credible knowledge base is used for health promotion. In searching for knowledge researchers must explore the byways and cul de sacs; but the public, policymakers, and practitioners should stay on the main roads.

RAJ BHOPAL
Professor

Department of Epidemiology and Public Health,
School of Health Care Sciences,
Medical School,
University of Newcastle,
Newcastle upon Tyne NE2 4HH

- 1 Gupta S, de Belder A, Hughes LO. Avoiding premature coronary deaths in Asians in Britain. *BMJ* 1995;311:1035-6. (21 October.)
- 2 Bhopal RS, Phillimore P, Khali HS. Inappropriate use of the term "Asian": an obstacle to ethnicity and health research. *J Public Health Med* 1991;13:244-6.
- 3 Bhopal RS. The coronary heart disease epidemic in "South Asians". Why? What can be done? *SHARE Newsletter* 1993;6: 4-5.
- 4 Williams R, Bhopal RS, Hunt K. Coronary risk in a British Punjabi population: comparative profile of non biochemical factors. *Int J Epidemiol* 1994;23:28-37.
- 5 Department of Health. *Variations in health. What can the Department of Health and the NHS do?* London: DoH, 1995.
- 6 Health Education Authority. *Black and minority groups in England*. London: HEA, 1994.
- 7 Bhopal RS, Donaldson LJ. Health education for ethnic minorities: current provision and future directions. *Health Education Journal* 1988;47:137-40.

General practitioners should identify risks opportunistically

EDITOR,—I am a general practitioner in Tower Hamlets in east London, an area with a substantial population of Bangladeshi origin, who are at documented high risk of premature coronary death. I support Sandeep Gupta and colleagues' call for the development and funding of an immediate prevention strategy with a strong base in the Asian communities at risk, while research about cause and effective interventions should be continued.¹

I would underline the importance of using consultations in general practice to identify and address risks opportunistically. To be more effective this needs the resources of time and readily available trained health advocates when doctors or nurses do not come from the community concerned. Well person clinics often reach only a small proportion of patients, particularly in deprived areas.

My concern with the editorial is that it quotes the highly speculative hypothesis of adaptation to famine² as an explanation for the excess risk in migrant Asians as if the hypothesis has been proved. This piece of reductionism is ahistorical and antievolutionary and, while not so intended, is open to racist interpretation. There is no reason to suppose differential exposure to famine among south Asians compared with other ethnic groups over an evolutionary timescale.

The current emphasis needs to be on modifiable risk and how to modify it. For example, in some

Advice to authors

We receive more letters than we can publish: we can currently accept only about one third. We prefer short letters that relate to articles published within the past four weeks. Letters received after this deadline stand less chance of acceptance. We also publish some "out of the blue" letters, which usually relate to matters of public policy.

When deciding which letters to publish we favour originality, assertions supported by data or by citation, and a clear prose style. Wit, passion, and personal experience also have their place.

Letters should have fewer than 400 words and no more than five references (including one to the *BMJ* article to which they relate); references should be in the Vancouver style. We welcome pictures.

Letters should be typed and signed by each author, and each author's current appointment and address should be stated. We encourage you to declare any conflict of interest.

Please enclose a stamped addressed envelope if you would like to know whether your letter has been accepted or rejected.

Letters will be edited and may be shortened.