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Report

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Foreword

We live in a period of rapid social change. One of the most striking features of this process of transformation is the coexistence of different cultural backgrounds, ways of life and traditions within one single context. Different communities hold a range of health beliefs. These not only express the social context that shaped them, but themselves play a key role in shaping a community's social identity and cultural profile. They profoundly influence the ways in which people view their own health and illness as well as the use they make of health services. These issues place new demands on health intervention related to ethnic groups. Sensitivity to such a context is one of the great challenges confronting health education programmes.

The Health Education Authority (HEA) has been at the forefront of research on the health needs of ethnic communities in England. We have already undertaken two national 'Health and Lifestyle' surveys which focussed on the Indian, Pakistani, Bangladeshi and African-Caribbean populations in England. These surveys have made a major contribution to understanding the health and information needs of the minority ethnic population in England. The HEA now launches a third national health and lifestyle survey as part of a wider research programme on the health of the Chinese community.

Although Chinese people have been part of the British demographic landscape for more than a century and constitute one of the largest ethnic groups in England, very little is known about the community. So far, research on the Chinese community has been piecemeal and left largely to the initiative, goodwill and resources of local community groups and isolated researchers up and down the country. However, recent changes in the global political and economic environment – with the hand-over of Hong Kong to the People's Republic of China – suggest that the make-up of the Chinese community in Britain is likely to change. This will present yet more challenges to health practitioners.

It is precisely to offset the scarcity of knowledge about the Chinese community and to meet these new demands more successfully that the HEA has initiated a major research programme on the health of the Chinese population. The programme brings together existing information on the health needs of the Chinese community and provides an integrated framework to survey the health needs and health beliefs of this population at a national level. Thus this research

report is part of a wider strategy. It examines the health beliefs of the Chinese community and explores how these impact on the one hand, on the acquisition of knowledge and, on the other, on the use and evaluation of health services. The overall approach set out in the study adds depth and breadth to the descriptive knowledge which the national survey will make available. It provides a community-based analysis of health beliefs and, through a detailed qualitative analysis of individual interviews and focus groups, shows how health beliefs function in everyday life. This makes the present work a valuable tool both for researchers and for health practitioners.

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1 The research: health beliefs among the Chinese community in England

1.1 Introduction

This study was commissioned by the HEA to explore the health beliefs of the Chinese community in England.

There has been increasing interest over the last decades in how notions of health and illness are constructed by different communities of people and in how this variation affects health-care delivery. Despite the dominance of the biomedical[1] model in the Western world, there is ample evidence that a variety of modes of health knowledge and practices coexist in any society. Attention to this plurality is crucial to improve the quality of health-care and to challenge patterns of communication between providers and users of health services. Recognising that issues of health and illness are grounded in cultural frameworks enables us to understand how people use, make sense of, and comply with health-care.

In multicultural societies, where different ethnic communities live side by side with the cultural system of the host society, cultural backgrounds and the corresponding representations they entail about health and illness emerge as key factors in the planning of health-care delivery. Awareness and sensitivity to cultural diversity produces medium and long-term gains at the level of both costs and quality of health care (Chi, 1994). Moreover, since the Thirtieth World Health Assembly in 1977, the World Health Organization (WHO) has officially recognised the importance of integrating traditional medicines into health-care systems. This policy change was based on the understanding that the traditional medical knowledge, which permeates lay thinking, can work as an added resource for health-care delivery (WHO, 1978).

[1]Following Currer and Stacey (1986) we use the terms 'biomedicine' or 'biomedical model' to refer to the institutionalised system of health beliefs and practices which developed mainly in the West. It is based on a biological understanding of the human being, dominates the advanced industrial societies, and has now spread throughoput the world. We prefer these terms to other frequently used adjectives such as 'modern' (which implicitly excludes the traditional beliefs and practices that survive in contemporary societies), 'scientific' (which may imply that other knowledge systems are less rational and less legitimate), or 'Western' (which does not fully acknowledge the diffusion and potency of biomedicine throughout the world), although these may also be used in particular contexts.

Besides, contemporary societies live in a period of increasingly rapid change. Very few societies, if any, have been immune to this pace of transformation. One of the most striking features of this process is the coexistence of different cultural backgrounds, different ways of life and different traditions within a single context. People, perhaps more than ever before, must face the displacement of taken-for-granted beliefs and open themselves up to other ways of life. These issues place new demands on health intervention related to ethnic groups. Sensitivity to such a context is one of the great challenges confronting health education programmes.

Yet there remains a tendency to ignore these factors, as if notions of 'culture' and 'beliefs' were too distant from the practicalities of everyday health care. In some cases lay knowledge stemming from cultural traditions is ignored; in others, it is considered an obstacle both to educational campaigns and to compliance with treatment; and in more extreme situations it is treated as pure 'superstition'. As Koo (1987: 405) has pointed out, to consider socio-cultural factors only as barriers to proper treatment can 'delay treatment by Western health-care systems, interfere with the patients' compliance in taking Western medication, or even cause and exacerbate existing health problems.'

Culture and traditional knowledge shape how people think, feel, perceive and socially represent questions of health and illness. This is not a trivial issue, considering that it is in the lay, popular, non-professional sector of society that the vast majority of health-related decisions are made. Indeed, it is estimated that between 70 and 90 per cent of all health-related decisions are made in the popular domain in Western and non-Western societies alike (Kleinman, 1986). The popular arena comprises mainly the family but it also includes social networks and community activities. Ill health is first recognised, defined, labelled and explained by lay members of society in the course of their everyday life. On this basis, health-care activities are initiated. These include all the therapeutic options that people utilise informally, without payment and without consulting folk healers or medical practitioners (Kleinman, 1986; Helman, 1994). All such decisions are based on socially-transmitted lay beliefs about the structure and function of the body, about the origin and nature of ill health, about the behaviours deemed appropriate to keep healthy and to avoid illness: they are based on social representations of health and illness.

The above considerations guided the study we report here. Perhaps more than any other minority ethnic groups in the UK, the Chinese can draw upon a long and well-established medical tradition in order to construct health beliefs and make choices related to health. And yet, as any other displaced community, the Chinese are exposed to

a tradition that differs from their own in fundamental ways. The clash between different ways of conceiving issues of health and illness produces a number of practical consequences, the most important one being the difficulty in communicating and, therefore, in implementing effective health-care. Do the Chinese maintain their traditional beliefs, do they reject Western biomedical systems, or do they combine both knowledge systems? In which ways do these different strategies guide health behaviours? Can they help us to make sense of the experience Chinese people have when using health services?

These questions become all the more important if we consider that there is ample evidence to suggest that Chinese people underutilise health-care facilities. The House of Commons Report (Home Affairs Committee, 1985) first alerted the nation to this fact. Since then, what little research there has been on the Chinese community in England reveals that the uptake of health services by Chinese people is still considerably lower than for the white and other minority ethnic populations, both in terms of GP and outpatient services (Smaje, 1996).

In a small-scale study conducted in Hull, Watt & Chui (1994) interviewed GPs with a substantial number of Chinese patients on their registers. The findings highlight three distinct issues. First, Chinese people were perceived as having higher and different expectations of the primary health-care services than the white and other ethnic populations. Second, doctors reported that Chinese patients tried to postpone or avoid consulting them altogether unless medical attention was absolutely necessary. This was manifest in the way Chinese people tried to keep consultations to a minimum by requesting repeat prescriptions both for themselves and for relatives and friends. And third, the GPs interviewed were agreed that their Chinese patients made very limited use of preventive care. Watt & Chui (1994) also report that uptake of ante-natal care among Chinese women in Hull is remarkably low in spite of a relatively high awareness of the ante-natal classes. Williams, Watt & Chui (1994) corroborate this: in the North of England, they found that 79 per cent of Chinese women were aware of the availability of such classes, but that only 21 per cent actually used the service (in comparison, only 56 per cent of Muslim Asian women were aware of the classes, but a considerable 43 per cent actually attended the classes).

While these findings are extremely useful in providing an initial diagnosis of the community's use of National Health Service (NHS), the need remains to make sense of these patterns of behaviour and to explain why they are produced and how they can be changed. In this sense, the present study had as its main objectives:

- to explore the social representations of health and illness held by the Chinese community and to investigate how these representations affect health-related practices;
- to examine how lay knowledge impacts on the acquisition and use of, and resistance to, new information and knowledge;
- to identify the main concerns associated with the experience or use of health services in England.

To pursue these objectives we took as a starting point the larger social context that frames the life of the Chinese community in Britain and approached their health beliefs by placing emphasis on:

- the ways in which Chinese people handle concrete health issues in everyday life;
- the practical situations facing the Chinese community when using health resources (NHS or other).

This study focuses on the experience of being a Chinese person living in Britain, on the problems and difficulties associated with the use of health-care, and more generally on how Chinese people think and act in relation to health and illness. This focus aims to bring to light the variety of factors which constitute the overall situation of the Chinese in Britain as they are experienced, talked about and lived by the community itself.

1.2. A social psychological perspective on health and illness

Traditionally, research about health beliefs and behaviour has been informed by approaches that consider the individual person as the main focus of analysis and intervention. The limitations of such approaches are discussed extensively in the social scientific literature and it is not our intention to review them in here (for a comprehensive review, see Ogden, 1996). We want to note, however, that models such as the health locus of control model (Wallston & Wallston, 1982), the health belief model (Becker, 1966; Janz & Becker, 1984; Rosenstock, 1966), self-efficacy theory (Bandura,1977; Schwarzer, 1992), and the theory of reasoned action (Azjen, 1985; Azjen & Fishbein, 1970; Terry, Gallois & McCamish, 1993), to cite but the most influential ones, all rest on a number of assumptions which are now recognised to be problematic. At the most basic level, they conceive of individuals as though they function in isolation, rather than as social beings engaging in group life and deriving their knowledge and values from the latter. Thus these models assume that knowledge is acquired in isolation and from direct experience, rather than through communication and social interaction. Furthermore, these models tend to endorse a somewhat limited

understanding of the complex relationships between knowledge, attitudes and behaviour. Put simply, it is assumed that the link between knowledge, attitudes and behaviour is direct and that, once proper information is given, the desired behavioural change will occur.

This dominant conception, which conceives health-related behaviour as the outcome of the joint effect of health-related attitudes and information, has yielded considerable knowledge over the years. It is readily amenable to systematic research and large-scale surveys which, in turn, generate valuable descriptive data. Yet we believe that it carries serious theoretical problems and may also have undesirable practical consequences. The assumption of an autonomous individual leads to a burden of responsibility being placed on the shoulders of people as though they could be made entirely responsible for their lifestyle choices and health (Crawford, 1977; Ichheiser, 1949). It also dangerously underestimates the larger societal, political, economic and cultural determinants of health. We now know, however, that such factors profoundly shape how individuals relate to their own body, how they deal with issues of health and illness, what sense of agency they have when facing health problems, which resources they will use in the case of illness or disease, and so on. And we also know that notions of health and illness are structurally bound up with how people think of themselves, of others and of society to which they belong, as well as with a range of moral issues, such as what is considered 'good' or 'proper' or 'natural' (Herzlich, 1973). Clearly the notion that greater and better individual knowledge will suffice to modify inadequate health-related behaviour is too simplistic to account for the complex psychological dynamics involved in the relations between knowledge and behaviour.

Successful health intervention must be geared towards the total environment in which people live. Social psychologists have made important contributions to developing this radical change in perspective. Indeed, in opposition to an individualistic approach, current developments in social psychological theory and research have produced a large body of evidence showing precisely that it is not individual knowledge, but social knowledge, which impinges on the ways in which individuals make sense of their environment and adopt strategies of behaving towards it (Campbell, 1997; Crawford, 1994; Farr & Marková, 1994; Herzlich & Pierret, 1986; Jodelet, 1984; Naidoo, 1986). These new perspectives focus on how culture, shared meanings and the social environment permeate individual experience, establishing the frameworks within which and against which people act. They show how knowledge is rooted in social life, expressing and structuring the identity and social conditions of those who share it. The theory of social representations, as developed by Moscovici (1984) and Jodelet (1984;

1991) is one such approach. Its theoretical and methodological assumptions have informed the study reported here.

Within the social representational approach, health beliefs and practices are constructed against a background of constant social interaction and negotiation, where allegiances to social identity, group norms and cultural traditions play a major role. In this context beliefs about health and illness express larger social psychological factors which shape the choices people make about health-related behaviours and practices. These factors range from concrete living conditions to the particular patterns of interaction and communication within any given community, via the lay and cultural bodies of knowledge that guide the interpretative frameworks used to make sense of what health and illness are.

Instead of an 'either, or' logic, the focus is both on individual and social reality simultaneously. The emphasis on the relationships between the individual and society enables us to uncover how social beliefs operate on a practical level, shaping personal choices and behaviour, as well as examining how individuals take on and manipulate these beliefs in everyday contexts. As Sapir (1967: quoted in Jodelet, 1991:16) has pointed out, health-related practices and beliefs are examples of the subtle interactions between the 'systems of ideas which have their roots in global culture and those which the individual creates for himself as a result of his special spheres of participation. The more we examine these interactions, the more difficult it becomes to distinguish between society as a cultural and psychological entity and the individual member of society whose culture he must espouse.' Thus a complete account of these beliefs and practices that is both theoretically and practically useful must explain, at one and the same time, the personal and social.

The recognition of these issues can enable health education campaigners to go beyond the imparting of information about health and illness to target populations. By considering health as a cultural system grounded in the shared meanings, values, representations and experiences of a particular community, and by acknowledging that what it is to be healthy is equally central to the identity of a culture and to that of an individual, health promoters can set and achieve more strategic goals. They can identify the knowledge and the cultural profile of a community as a resource they can engage with and develop. Instead of clashing with or discarding or, as in so many cases, simply ignoring existing beliefs, values and experience, health campaigners ought to take them into account and establish collaborative dialogues with their target populations.

No society could function adequately without common knowledge that makes sense of physical and mental well being and ill health.

This cultural system not only expresses the social context that shapes it, but itself plays a key role in shaping a community's social identity and profile. Current social psychological research on health highlights the fallacies of old individualistic approaches. It also proposes a strong vision according to which understanding health and health-related practices demands sensitivity to culture, context and ethnic group. Health beliefs and behaviours are largely dependent on cultural backgrounds and people carry with them the assumptions, values and knowledge that belong to their communities and give them a social identity. These cannot simply be transposed from one context to another: as with different languages, literal translations are often meaningless.

Drawing on this theoretical perspective, the present study will link representations of health and illness to the Chinese culture and way of life.

2 Methodological issues

2.1 Research design

Given the scarcity of research on Chinese health beliefs and practices in England, and considering the complexity of the issues involved, we favoured qualitative methods of data collection and analysis. Open-ended and flexible research methods – in this case, in-depth individual interviews and focus groups – are well suited to delineate how people think about their health or ill health *in their own terms*. They also generate valuable information to direct further research and intervention.

The present research design combines three different data sources: interviews with experts on the Chinese community in England, individual interviews with lay people and focus group discussions with lay people. All the interviews and group discussions were tape-recorded, translated when necessary and transcribed verbatim for analysis. The data were collected between December 1996 and April 1997.

The subjects in this study were not randomly selected so as to be 'representative' of the Chinese population in the statistical sense. Instead we approached potential interviewees on the basis of their typicality and diversity (Patton, 1980). However, the 1991 Census data (Cheng, 1996; Owen, 1992, 1994) in part guided the selection. (The reader can consult Appendix 1 for descriptive information pertaining to the countries of origin, the age distribution and the geographical distribution of the Chinese ethnic group in Great Britain.) We chose participants from the two main regions where the population is most concentrated – Greater London and the North-West of England – and from the age groups which comprise the bulk of the adult Chinese population in England. These age groups correlate with different waves of migration and modes of participation in British society. We did not include a third, older generation in this research because we assumed that the social representations of health and illness of the elderly population would have remained essentially traditional. There is sufficient literature on the health beliefs of the Chinese in traditional Chinese cultures.

We also selected participants of different national origins, the majority being from Hong Kong, Mainland China and Malaysia, in conformity with the Census (Cheng, 1996; Owen, 1992, 1994). UK-born subjects are somewhat under-represented, but this is due to to the age structure of the Chinese population itself. Indeed the age pyramid for the second generation shows that only a tiny proportion of this group are above age 20 and that virtually no one age 35 and over was born in the UK (Cheng, 1996). Diversity and typicality with respect to occupations suggested the selection of participants from four different groups: students, professionals, workers in the catering trade and unemployed respondents (often housewives). Tables summarising the socio-demographic characteristics of lay subjects can be found in Appendix 2.

Interviews with expert informants

In the initial stage of the empirical research we aimed to map out the key issues as perceived by Chinese expert informants who work closely with their community. To this end interviews with six experts were conducted (four in London and two in Manchester). This kind of interviewing is useful for tapping into reflexive knowledge, that is, the critical knowledge one possesses about oneself and one's community. The expert informants were initially recruited through associations dealing with Chinese health and social matters and then through snowballing. We ensured that informants had varied spheres of expertise. The resulting sample comprises respondents trained in biomedicine, either as doctors or nurses; trained researchers and social scientists; and managers of Chinese community centres and associations. The expert interviews were all conducted in English.

The themes addressed in the expert interviews included (see Appendix 3 for full details):

- the characteristics of the Chinese community: perceptions of homogeneity/heterogeneity, cohesion/fragmentation and integration/exclusion;
- the main health-related concerns of the Chinese community in England;
- the experience of health and illness in everyday life;
- the differences and similarities between Chinese and Western medicine;
- the availability and adequacy of service provision.

Individual interviews with lay Chinese people

We also conducted twelve in-depth individual interviews with lay members of the Chinese community. In-depth individual interviews are advocated to circumvent some of the problems traditionally associated with more highly-structured methods of data collection (Bourdieu, Passeron & Chamboredon, 1991). They enable us to gain access to the social representations of health and illness of the Chinese, as these are constructed in discourse, without imposing our own views, concepts and presuppositions on the population being investigated (Farr, 1993). Indeed, individual interviews provide subjects with a great deal of freedom to explore the issues that are most relevant to them, and the meanings which they themselves attribute to health and illness (Herzlich, 1973). Such interviews are ideally suited to our objectives. Four of the twelve individual interviews with lay Chinese people were conducted in Chinese with the mediation of an interpreter. The four subjects who spoke little or no English were all originally from Mainland China and belonged to the older age group. They were involved in the catering industry. Three of them were women.

The individual interviews with lay participants focused on the following themes (See Appendix 4 for full details):

- the experience of being a Chinese person living in Britain: dynamics of identity, integration/exclusion, advantages/disadvantages;
- general aspects of Chinese representations of health and illness;
- health and lifestyle: emphasis on working conditions;
- health beliefs and health-related practices;
- experiences of ill health: symptoms, resources, cure, explanations offered for the condition, effects on family, communication with health professionals, knowledge and use of resources, for example;
- relationship between Western (British) and Chinese health beliefs and practices: combination/separation.

Focus group discussions with lay Chinese people

Four focus groups with lay members of the Chinese community were also convened. Focus groups overcome some of the limitations associated with individual interviewing. They are an effective way of rapidly gathering a wide array of views and opinions and of providing information about both consensual and conflicting beliefs. Group interviewing makes use of group dynamics to generate data and insights which would otherwise be less accessible (Morgan & Krueger, 1993). It provides data on interactions, on realities as defined in a group context, and on interpretations of realities that reflect the group's dynamics; it

also shows how identities, social representations, beliefs, and shared cultural norms, all structure interaction and social communication (Burgess, Limb & Harrison, 1988). Focus groups aim to replicate, in so far as this is possible in a research design, the social settings in which people live and the conditions under which they would normally interact (Morgan, 1988; Morgan & Krueger, 1993).

Notwithstanding the considerable problems and costs encountered in setting up the groups in the first place, this method of data collection proved the richest. It revealed very specific patterns of communication among Chinese participants in terms of mutual respect, discipline in turn-taking, modes of conflict resolution, deference to authority and hierarchy, for example. The moderator hardly had to moderate at all since interactional patterns were so finely tuned. The groups were also an ideal means of eliciting latent beliefs and practices that are taken for granted. The very process of accounting for their private beliefs and habits in the common space of the group prompted the subjects to realise that what they had assumed to be their own isolated experience was in fact shared by most and grounded in cultural frameworks. Thus, by fostering a heightened self-awareness, the focus groups had an almost therapeutic nature and actually served to empower the participants.

The four groups were set up to reflect expected gender and generational differences (20–27- and 37–44-year-olds, male and female). The participants were recruited in the Greater London area. The two groups of young subjects comprised students of diverse nationalities and discussions were conducted in Central London. The two groups of older subjects included participants from a range of socio-economic backgrounds. The discussion with older women was held in a private home in Norbiton and the one with older men was convened in a Chinese restaurant in Greenwich. The discussions were in English which was often the only common language between the participants. Both researchers were present for all the focus groups, one moderating, the other mainly observing. No particular stimulus material was used.

The group discussions focussed on the following issues (See Appendix 5 for full details):

- the dynamics of mixed identity: being Chinese in England;
- characteristics of the Chinese community;
- health and lifestyle: health beliefs and health-related practices at home;
- attitudes towards Chinese traditional medicine and Western biomedicine;
- shared or particular experiences of contact with health services in England.

Data integration and analysis

The data were analysed according to two distinct but inter-related dimensions: content and processes. Bearing in mind the three-fold objective of our study, we extracted themes and sub-themes from the interviews and group discussion transcripts. This allowed us to identify the main issues emerging from the data and to establish how these are structured by identity and cultural processes. All the interviews and focus groups were content analysed in terms of their sequential structure. We identified the themes and sub-themes which evoked and generated one another (content), and stressed how these were linked by the reasoning and the identity positioning of the participants (processes). This strategy enabled us to derive deeper levels of belief and experience from the thematic content of the data, for as the interviews progressed and as rapport became more firmly established, the respondents felt more at ease in disclosing the complex reality of holding on to Chinese beliefs and cultural identity in British society. The quotations selected to appear in the report were chosen on the basis of their representativeness in relation to the entire corpus of data. The criterion was qualitative: quotations represent the overall trend of the analysis.

2.2 Researching the Chinese community

For a variety of reasons, Chinese people in England constitute a 'hard-to-reach' population (Li, 1992; Song & Parker, 1995; Tso & Chung, 1996). Barriers to access are not linked exclusively to the fact that the researchers are not Chinese. Even those most directly involved with the Chinese community (Tso & Chung, 1996) comment that elderly Chinese people in Manchester were 'very reluctant indeed to take part' in one of their studies and that they seemed 'quite unwilling to disclose information'. Experts recognise that the community is difficult to access. They are adamant that the solution lies in getting a strong footing in the community through its main organisations.

Accessing a 'hard-to-reach' population

We used existing community resources (see Appendix 6 for a list of Chinese community resources and associations in the UK) and worked closely with a Chinese research assistant. Of course this strategy entails many potential pitfalls and biases. It only allows access to people who use community centres and resources; they are a very distinct segment of the Chinese population. They tend to be more traditional and probably either less or more vocal than the average Chinese person. They may also end up being over-researched. Moreover, the pre-selection of subjects by community workers will often be made on the basis of unknown criteria. In our experience, these may range from sheer pragmatism – for

example, availability, previous acquaintance, geographic proximity, and so on – to the subtle, and perhaps unconscious, recruitment of people who conform to organisers' views about the needs of the community. Of course, the nature of the associations and organisations also reveals something about the subjects who attend them or use their services. However, in spite of these limitations, this seems to be the most viable way of approaching members of the Chinese community.

Advantages and disadvantages of using non-Chinese researchers

The two main researchers involved in this project are not Chinese themselves. The issue of whether or not they should be matching identity between researchers and the communities they investigate is a highly contentious and debated one among social scientists doing qualitative research. The requisite of matching ethnic and gender identity (among other possible sources of matching identification) between the researcher and the object of study is, in our view, a misguided conception. Difference does not preclude understanding, and empathy can go hand in hand with a critical stance. In fact, there are advantages and limitations in any choice one makes. The balance of these in relation to the objectives of the research is the real issue to be considered.

In our experience of researching the Chinese community we found that not being Chinese ourselves was a limitation in terms of gaining entry into the community. Being Chinese, or at the very least speaking Chinese, no doubt helps to overcome the reluctance to speak to outsiders. It was disadvantageous also in that interviews with only Chinese-speaking subjects had to be conducted through interpreters, a situation which fundamentally changes interactional dynamics and impinges on what is being expressed. More subtly, not sharing the same language and culture means, for example, that inter-cultural barriers could come into play during the interviews, that the interviewees could feel less comfortable in the interview situation and that some elements of the Chinese cultural universe which may not be easy to express in English could be lost altogether. Bearing such issues in mind, it is not surprising that the literature on minority ethnic health issues tends to stress the benefits of 'matched' interviewer-interviewees, both with respect to ethnicity (Blauner & Wellman, 1973; Stanfield & Routledge, 1993) and to gender (Stanley & Wise, 1983).

However, these very 'limitations' can also be advantageous. Song & Parker (1995) have devoted a paper to *rapports* between researcher and participant during interviews with UK Chinese subjects. The authors – one English-Chinese, the other Korean-American – showed how different identities came to the fore at different moments in the

interviews, with no predictable patterns. Each positioning, either as a 'pure' or 'mixed' Chinese person, made certain disclosures possible and impeded others. Generally however, the authors noted that assumptions of differences between interviewer and interviewee often prompted clarification, whilst assumptions of similarity tended to facilitate intimacy but also to engender anxieties if the subjects felt that they deviated from an assumed shared Chinese 'norm'.

Thus it would appear that the perception of cultural differences often compels interviewees to be more explicit about their beliefs. Non-Chinese researchers are also more likely to identify tacit assumptions in Chinese belief systems since they do not share them. It should also be borne in mind that the very reluctance or difficulties experienced by Chinese respondents in engaging with non-Chinese people are themselves part of the phenomena we are investigating; they give us insights into the reality of being Chinese in Britain.

It is perhaps in interviews with only Chinese-speaking subjects that the advantages and drawbacks of not being Chinese ourselves were most obvious. We had recourse to interpreters during the interviews and then, as a means of quality control, asked a Chinese research assistant to transcribe them, providing clarifications and, for example, noting erroneous translations, distortions, biases, uninvited interventions by the interpreter and segments of text which were edited out. This research strategy allowed us to gain insight into the power relations which are enacted during interpreter-mediated interviews: shifting allegiances are formed between the researcher and the interpreter, and between the latter and the interviewee, which shape the data in important ways. For instance, questions which may be interpreted as politically sensitive tended to be edited out. Answers which were thought by the interpreter to reflect badly on the Chinese community were either omitted by the interpreter or prefaced by some mechanism of distancing themselves. Often the two Chinese-speaking people would converse among themselves about health beliefs and practices, thereby blurring the boundaries between the interviewee's own views and those of the interpreter. There is no space to discuss these issues in greater detail; they ought to be researched systematically. However, this research strategy shows that the use of interpreters is no panacea. Interpreters ought to be fully trained and made aware of their potentially oppressive position.

3 The importance of Chinese culture in understanding health beliefs

Chinese culture is highly complex and far from being homogeneous. To attempt to summarise it in a few paragraphs is very bold. However, considering the paucity of knowledge of Chinese culture, even a broad overview may be better than nothing at all. It should help us to understand and respect attitudes and behaviours which may otherwise be puzzling, and to tailor policies which take account of cultural realities and social structures. If health beliefs and practices are indeed intrinsically related to cultural norms, values and identities, one must take account of the latter in addressing the specific issues revolving around health and illness *per se*. Cultural norms and social structures also shape research (for example, in terms of gaining access to people and in terms of the dynamics of disclosure in interviews and group discussions, and in terms of the suitability of particular research techniques and data interpretation); they must be taken into account throughout the research process.

3.1. Common characteristics of Chinese communities

Chinese scholars from the People's Republic of China, Hong Kong, Taiwan and Singapore as well as from overseas Chinese communities (Tseng & Wu, 1985; Tu, 1994) are agreed that despite the diversity of Chinese communities there persist some shared characteristics. These derive largely from the pervasive influence of Confucian philosophy on Chinese culture (King & Bond, 1985), and they are at the very core of Chinese identity. Indeed, since Confucian thought has dominated the Chinese way of life for 2000 years it is unlikely to cease its influence on Chinese migrants, even after two or three generations of participation in British society.

The contributions we reviewed emphasise the importance of the family, the hierarchical structure of social life, the cultivation of morality and self-restraint and the emphasis on hard work and achievement. Various researchers also stress the pride which Chinese people take in their culture (Wu, 1994), as well as the fact that Chinese culture and society can be defined as 'collectivist' (Hui & Triandis, 1986). Drawing upon the

data we collected, we shall explore the influence of Chinese culture on the contemporary experience and everyday reality of Chinese people living in England.

The family as the fundamental unit of society

> *W: ... I think for us there are certain things that we hold very strong. We were brought up in that environment since we are young, that I think there's no way that we will compromise on those issues. Even though we might be staying here for the rest of our lives, I think I'll still hold very strong on those sorts of things. Especially like family. I think for the Chinese, everything can be summarised from the family, your cultural value.* focus group, young men

It is consistently reported by scholars studying overseas Chinese communities that while many traditional Chinese values may erode under Western influences, the sense of obligation and responsibility towards one's family remains a core value, structuring both social relations and people's sense of identity. The boundaries of the family unit are not strictly defined: they may or may not extend beyond the nuclear family. But all learn to distinguish between different degrees of proximity in order to show the proper amount of deference and obedience. Filial piety constitutes the ideological basis of traditional Chinese society, the basic ideal against which one must be judged. It is not surprising, therefore, that much of the struggle faced by Chinese immigrants in the UK should revolve and crystallize around the education of children.

In many ways the family unit takes precedence over its individual members. Interactions and social communications within the family are not reciprocal in the sense that children learn not to initiate conversation or to answer back to their parents or other elders. It is assumed that the family as a whole will thrive and prosper if harmony prevails at home, that is, if basic rules of obedience, moderation and self-restraint amongst family members are observed.

Of course families differ in the extent to which decision-making is shared, in the quality of inter-personal communication, in the degree to which families favour the individualisation of their members, as well as in the types of contact they have with the outside world. All such factors are likely to increase in importance as Chinese people in England get acculturated in the mainstream culture. Yet family life at home and often in the work place remains the stronghold of traditional Chinese values. This dichotomy between the private domain – where traditional Chinese values are passed on and enacted – and the public domain – where contacts with non-Chinese people promote change, challenge traditions, generate struggles but can also prove emancipating – is

abundantly present in our data. Home is the place where health beliefs are transmitted.

Expectations related to family life account for many of the difficulties faced by Chinese immigrants. The second generation find themselves caught between the contradictory demands of meeting their parents' expectations and often looking after them at home, on the one hand, and of fulfilling their own potential and enjoying upward mobility by opting out of the catering business, on the other (Cheng, 1996; Parker, 1993, 1995). And the first generation feels unable to shape their children's way of life, stripped of their traditional position, deprived of respect, abandoned and isolated. Guilt on the children's part, and shame on the parents', often result.

Hsu (1985: 101) also argues that 'as a result of strong family orientation and ties, the Chinese are less enthusiastic about participating in non-kinship organisations that work towards a common cause'. Here we may find one of the roots for the minimal demands which the community has put on social services and other forms of assistance in the UK (Home Affairs Committee, 1985). Jones (1987) also reports that, traditionally, the Chinese have been reluctant to seek help outside their own communities and Li (1992) suggests that reaching beyond the community for assistance may be regarded as shameful. Clearly, in a multi-cultural context, this situation may be pathogenic since problems which emerge and manifest themselves within the family unit may not always be resolved in that same realm. However, the fact that more Chinese are now beginning to voice their needs may itself be taken as a positive sign of their integration within the UK and of their desire to participate in the host community, whilst retaining their own identity.

Finally, it must be borne in mind that much of the clinical communication with Chinese patients takes place in the context of the family rather than in the dyadic relations which are the norm with English patients. Children are often present, acting as interpreters for their parents from a very young age (Li, 1992). Moreover, clinical diagnoses often have consequences for the entire family – and sometimes even for the broader community – and not only for the 'diseased' individual (Davis & Horobin, 1977; Mares, Henley & Baxter, 1985).

The hierarchical order of social life

W: I think the thing that I like best is one of the things I detest most as well. It's hard to say, there's a sense of hierarchy. Traditional family, father on top, mother below, then the children come in. And even amongst them there's a very strong sense that you are the eldestest (sic), I'm the eldestest, you're the younger one, you listen to me, and since you're the younger one, I'll have to take care of you, and all that. In my family, the hierarchy is very strong. You know, it's like, if I want to do something I will turn to my elder sister for support. If my elder sister says no, I'll turn to my mother, if my mother says no, I'll turn to my father, you know. ... And if my father says yes, then what my mother says and what my sister says doesn't count. He's the ultimate, ultimate decision-maker. focus group, young women

In traditional Chinese social life the distribution of authority is based on generation, age and gender, on a hierarchical system of roles and expectations. In many ways, this traditional structure is being challenged as contacts with outsiders multiply. In Western societies most informal encounters are assumed to have an egalitarian, rather than hierarchical, quality. This dominant feature of social life makes it difficult for traditional Chinese people to know how to engage with equal partners. King and Bond (1985) argue that a certain unease characterises Chinese relations with strangers which owes in part to the complete absence of prescriptions concerning such relations in Confucian social philosophy. The stranger, as a role category, is too ambiguous to be placed within a role structure. This pattern of social relations will impinge on Chinese people's relationships with health professionals, especially among the most traditional, elderly population. Moreover, because such a pattern is deeply engrained and simply taken for granted, the portrayal of health professionals in health promotion material should follow established gender, age and occupation differentials. For instance, medical doctors – whether they are Chinese or white – are more likely to be recognised, respected and trusted if they are represented as older men.

The cultivation of morality and self-restraint

W: ... I feel in London, it's a very big change because back home we are always controlled or protected by the family. When we are here, we could have done whatever we want, I mean, even if we don't go to lectures, the lecturer wouldn't know and I think family value is one of the most important things that keep us going here and stick to our own values ....

R: Yeah, it makes me more self-disciplined here because we are uncontrolled on our own, nothing controls us so we have to ....

W: Self-control.

R: We have to borrow these family values to control our daily lives, to self-discipline us.
focus group, young men

The Chinese in England have a reputation for being a law-abiding, self-restrained community which 'keeps itself to itself' (Home Affairs Committee, 1985; Jones, 1987). These attributes are closely linked to cultural demands of high morality and self-control. Of course, morality itself is a cultural construct. In addition to general displays of honest and proper behaviour, Chinese morality also expresses itself in matters which directly impinge upon people's health. For instance, being moral entails having a firm control over one's sexuality – sexual relationships are traditionally engaged in only in married life. In this respect there is a widespread feeling that Westerners are 'loose' and engage in 'casual' and immoral sex. Morality, perhaps more surprisingly, also extends to such practices as smoking and drinking. To smoke is considered unusual and sometimes unacceptable as far as women are concerned. Moreover, the Chinese in our sample believe that they drink less frequently and less heavily than the English population. Social drinking, such as takes place at the pub, is not enjoyed by the Chinese, whose recreational activities traditionally involve eating and gambling. This difference is frequently cited to explain the difficulties experienced by the Chinese in mingling with the general population.

Chinese people tend to keep more to themselves but English people like to go to pubs and discothèques. The Chinese people like to be to themselves; they like to stay close to their community or something so they can do things together but not so wild. I guess if you go to the pubs you rarely find any Asian or Oriental people there because that's not their interest. When we Chinese people get together and we try and talk and think how we can actually try to get to know English people better, there's one thing which keeps coming into our conversation is, if you don't go to a pub with them, you can't be friends with them because that's the only way that you can actually get to know them ....
lay participant, female, 22 years old

Morality is intrinsically related to self-restraint and to the concomitant avoidance of excessive emotions and behaviours. Chinese children are trained to control emotions which are considered adverse and which might threaten harmonious relationships both in the family and in public life. Again, these cultural attributes are not unrelated to health beliefs. The Chinese believe that excessive displays of emotions (be they sadness, fear or joy) may cause organ damage and therefore endanger health. Such feelings perturb normal functioning and are believed to be linked to changes in energy flow (Hsu, 1985). We also have evidence of such beliefs in our data (see Chapter 5).

3.2 Collectivism and individualism

I think in English or Western [cultures], it's more sort of individual, you know, more how would you say it, sort of more outward. And I remember trying to tell my elder daughter this story we all heard about this family, this little boy and the father asked this little boy to choose a bowl of fruit, pear and the little boy chose, he's the smallest, he chose the smallest one. I was trying to tell this story to my daughter but my [English] husband got so upset, 'Why do you do that?' he said. I ask my daughter, which one would you choose? She said, 'Oh, I would choose the big one.' I said: 'oh no no no, you don't choose the big one, you choose the small one because you're the smallest, you should, the little boy chose the smallest because he had to give the big one to dad, yes?' So I try to influence her but the Western culture is not like that, you go for the best one yourself, you know. Then I'm all confused. focus group, older women

Many of the characteristics of Chinese culture discussed above can be best understood as part of the more encompassing ideology of 'collectivism', which is generally contrasted with that of 'individualism' (Hui & Triandis, 1986). These two ideologies entail very different senses of identity, relationships to others, approaches to knowledge and traditions, and ways of life.

Open acknowledgement of the role of others (especially family) in shaping one's life is a central feature of collectivist cultures. One's actions are evaluated first and foremost with respect to their consequences for the well being of the group, rather than that of the individual. Dependency on the group is manifest in every generation, albeit in different ways, and in the sphere of economic as well as private life (the two are often linked). The primacy of collective goals over individual needs and desires also means that there is greater emphasis on obedience, harmony, respect, reliability and self-discipline, than there is on creativity, self-reliance, independence, and self-fulfillment. These values, as we have seen, are supported by a social system where power-distance and hierarchy take precedence over egalitarianism: roles are clearly defined.

Unlike individualist cultures, collectivist cultures tend to favour traditional knowledge and practices over the pursuit of novelty. The value placed upon tradition and experience accounts for the predominant role usually ascribed to elderly people. It also shapes both the content of knowledge and its modes of transmission across generations. The subjects in our sample, for instance, often declared themselves unable to *explain* why they were avoiding certain foods or eating others; yet, they all *described* very similar practices which obviously expressed some common principles unknown to the very people who enacted them. Knowledge is passed on through gestures,

habits and rituals. It is less important to understand *why* one does something than to know *what* to do and *how* and *when* to do it. Invoking traditions, 'the way it has always been done', is sufficient to explain. Interestingly, it is assumed that knowledge will almost automatically come with age. Again, the respect for tradition characteristic of Chinese culture has immediate bearing on people's health beliefs and choice of health-care system.

3.3 Pride in Chinese civilisation

> *For my race, I think we are advantaged because we got a very long civilisation, so we can draw upon that. That gives people a lot of reassurance.* expert

In order to cope with Western ideas and foreign concepts – and with the conditions of modern life more generally – the Chinese across the diaspora will have to redefine their national and cultural identity (Chen, 1979; Schwarcz, 1994; Wu, 1994). As some respondents noted, China traditionally represented the Middle Kingdom, that is, the country at the centre of the world. Such a view is at the core of the consciousness of ordinary Chinese people. According to Wu (1994: 149), 'this anthropocentric view is based on a deep-rooted sense of belonging to a civilization that can boast several thousand years of uninterrupted history. Such a sense of unity and continuity was, until recently, common among all Chinese, even among those who had moved abroad recently to settle among non-Chinese people'.

Traditional Chinese medicine is based on two millennia of trials and errors. It has generated a colossal body of knowledge which cannot be easily either refuted or proven because it easily tolerates notions which, from a Western perspective, would appear contradictory. That it should have survived for so long and still be endorsed by one's family and community is enough to endow it with legitimacy and to guarantee some degree of trust. Traditional medical beliefs seem to belong to a sphere which is distinct from scientific, biomedical knowledge and the health-care system which is derived from the latter. Indeed, the subjects in our sample would use Chinese remedies and Western medicine either in parallel or alternatively, with no apparent clash. We shall see later how the content of Chinese health beliefs supports this juxtaposition.

4 A portrait of the Chinese community

4.1 Describing the Chinese community

In the current climate, 'describing' the Chinese community is a political act. The fact that, for the very first time, the 1991 Census provided data on the ethnic groups of the people surveyed was the result of intense political negotiations. This new criterion for data collection in turn meant that hard data were available to policy makers and that research on previously ill-identified groups, such as the Chinese, would now be encouraged. The political nature of this 'description' is also noticeable in the scientific or expert literature. For instance, some sources emphasise the *ranking* of this ethnic group and claim that the Chinese constitute the third largest ethnic group – after the black and Asian groups – in the United-Kingdom (Home Affairs Committee, 1985; Li, 1992); others draw attention to the demographic *size* of the community and insist that it is the smallest ethnic group identified in the Census (making up a mere 4.9 per cent of the minority ethnic population and 0.3 per cent of the general population), with a population of approximately 157,000 (Cheng, 1996). Some stress the long-term entrenchment of the Chinese community in British social and economic life stating that the Chinese have lived in the UK for 'nearly two hundred years' (Parker, 1994); others focus almost exclusively on the recent history of the community, following the large influx of Chinese migrants in the 1960s. Clearly, there is more than one way of describing the Chinese community.

These debates are not matters for experts or academics only. They raise issues which are at the very heart of how the Chinese community thinks of itself in relation to the host society, how it strives for recognition and tries to mobilise resources. Defining one's community and finding one's position in it is precisely what constructing identities is about. Community is the root of identity: people draw on community membership in making sense of themselves, of their actions and their beliefs. In forming an identity – that is, in developing a sense of what one shares with others, as well as of what differentiates one from others on both an interpersonal and intergroup level – people draw on their history and relate it to the present. Traditional beliefs and practices are confirmed, elaborated, modified or abandoned.

4.2 How do the Chinese describe their community?

As soon as one seeks to define the Chinese community its diverse nature becomes apparent. There are generational differences, class and occupational differences, educational differences and a whole tapestry of personal histories and circumstances to consider. Research on ethnic communities often underestimates the variety which exists within these groups (Johnson, 1996). For instance, very few of the people we spoke to – including the experts – would recognise the portrait of the community painted by Cheng (1996) in his discussion of the most recent Census data.

> *The profile of the Chinese community in Britain is one of a successful ethnic minority. It is small in size, young in age, balanced in gender and its arrival was one of the most recent on the British scene. The Chinese are well educated, the proportion of college educated and above surpassing that of the White population. They have a lower unemployment rate and are disproportionately over-represented in professional and skilled occupations. In education and occupation, the Chinese have out-performed the Whites.* Cheng, 1996:178

Such a picture rightly stresses the remarkable achievements of this relatively new ethnic group in Britain. Yet, in doing so, it also runs the risk of masking the internal diversity which characterises the Chinese community and, therefore, of hiding real difficulties and needs.

Heterogeneity and homogeneity

The Chinese are not a homogeneous group although they do partake of a common culture. It is therefore necessary to distinguish between sub-groups of this population. Essentially the community can be divided into three age groups, each with different patterns of migration and comprising individuals with radically different life experiences.

The Chinese settlers: homogeneity and isolation

The older age group includes people aged 60 and above. Most of these now elderly Chinese people arrived here some 30 or 40 years ago as a result of the Communist take-over of China and of declining economic conditions in rural Hong Kong (Jones, 1987; Shang, 1984). Post-war prosperity in the UK and more favourable immigration policies (the 1948 British Nationality Act) resulted in a sudden influx of Chinese immigrants from the New Territories. These early migrants were generally poorly-educated men, usually farmers and factory workers,

who spoke, read or wrote little or no English. Nevertheless, they successfully established themselves in the catering trade (Watson, 1977) where, encouraged by immigration policies, their wives and families soon joined them. 'Take-aways' began to spring up everywhere, mainly because they could be run as a family business. A decade ago, it was estimated that some 90 per cent of the Chinese population in the UK was involved in the catering trade (Home Affairs Committee, 1985). Although this proportion is rapidly declining (Owen, 1994), the consequences of such early specialisation are still acutely felt.

The older age group also includes the parents of subsequent Chinese immigrants who called upon their elders to join them in Britain and to act as child-minders whilst they themselves worked long hours in the family business.

> *I was born here, I grew up in the community. I have seen [this pattern] everywhere. Normally what happens now is the father goes out working, the children, the younger children are left with the grandparents who look after them, and in most cases the grandparents have come from Hong Kong or China; they are brought here by their children to look after their grandchildren. After a few years, the grandchildren grow up, they don't need caring for anymore, so the grandparents just sit there ....*
>
> ***I: They've lost their function?***
>
> *Yes, they've lost their function but they are still within the family because that is the traditional aspect of the Chinese culture.* expert

For reasons highlighted earlier we did not interview members of this age group. However, they were present in our study through the voices of their children and grandchildren, as well as those of the experts. All claimed that elderly Chinese people are the most traditional: they have been socialised in Chinese cultures, are poorly educated, came here in adulthood, and cannot communicate easily in English. Older Chinese people find themselves isolated by a Western individualistic lifestyle which excludes them. Yet, in spite of difficult life circumstances and presumably poorer health than that of their younger counterparts, they make comparatively little use of the NHS (Watt & Chui, 1994; Williams, Watt & Chui, 1994). Again, experts note a sense of 'gratitude' towards the host community for providing improved life conditions compared to those prevailing in their country of origin. This combines with the traditional preference to 'keep themselves to themselves' and to deal with private matters inside the community and explains, in part, the frequently noted fact that the Chinese community does not voice its needs. It is also related to the greater use which elderly people make of traditional health professionals such as herbalists, Chinese doctors or acupuncturists.

The middle generation: diversity and hybridity

The second age group, which includes people aged between 30 and 60, is much more diverse. Here we find the now grown-up foreign-born children of the first generation of settlers (most of whom are originally from the poorer, rural parts of Hong Kong), who arrived in England in their youth or teenage years. Some of them are still involved in the catering industry but many have pursued higher education and are now working in a wide range of professions. But the middle generation also comprises very different groups of newcomers and includes among others: professional and wealthy immigrants who have recently emigrated from cosmopolitan Hong Kong as a result of the hand-over of the former British colony back to China; scholars and intellectuals from Mainland China who left after the crushing of the democratic movement in Tiananmen Square in 1989; many women from Malaysia who came here some 20 years ago, often to train as nurses, and who stayed after completing their training; and Vietnamese Chinese who escaped from Vietnam, via Hong Kong, and entered the UK as political refugees. Many of these more recent migrants are highly educated. The expansion of this group will impact on the socio-economic make-up of the Chinese community in Britain in due course (Cheng, 1996). It will probably change the community's identity and its relations with the host population as well.

> *The second group are the ones that were born in Hong Kong or China, and came to England at a very early age or in their teenage years. I would say half speak some English and the other half speak little or no English. If they came to England at a very early age they would have been educated into English schools to a certain level. They would have become the professionals, the ones that actually had jobs outside of catering. But the ones that didn't manage would have dropped out at 16 or something, went straight into catering trade, and got stuck there until they retired. This group would speak some English, they would be able to fend for themselves in very basic matters. The third group came to England at the age between 10 and 15, and these are the ones that have been put into schools and couldn't manage. So they dropped out, went straight into the catering system. These are the ones that do not speak English, or speak very little English. Today, they are 40, 50 years old, and they really need help. All they know is the circle of friends within the catering trade or relatives within the catering trade.* expert

Then you get people like me who are age 30 upwards, who came into this country in the seventies because mother and father have gotten here, now they bring their children or mother over. So we've had exposure to the Hong Kong culture and most of us are bilingual. We definitely can speak but might have difficulties in reading. So we're into the culture and we understand both worlds largely. Most of us feel we're hybrid but happy with the fact that we're hybrid. We're fairly well integrated into the British society and still have an understanding of where our parents came from, but it doesn't mean we don't get into conflicts with the first generation. Many will not be in the catering trade, have no wish to be, have been educated here and because education is valued in the Chinese culture, most of us are doing reasonably well. expert

The considerable differences in life experiences among members of this second generation of immigrants are recognised by experts and lay people alike but there is a consensus that, in spite of these differences, people are somehow united by a common Chinese culture.

The young generation: children, students and ... 'banana split'

Finally, one finds the younger generation aged below 30. This group encompasses mainly three sub-populations. First, foreign students, especially from Hong Kong, Singapore and Malaysia, who are here temporarily to acquire a British education but who intend to go back to their respective countries. Then there are the children, adolescents and young adults who were born abroad and recently emigrated to England to join their families. They are currently struggling with the language and the culture of the host society. And last, there are the British-born Chinese (Lambeth Chinese Community Association, 1992; Parker, 1993, 1995). This group craves for cultural recognition and wrestles with the problems of belonging in British society whilst holding onto a Chinese culture which they only know indirectly through their family and through the occasional visit to their parents' country of origin.

Then you get the youngsters who are born here. The teenagers, kids, right up to about 20 or so, who really are born and bred in Britain, who find it very difficult to speak Cantonese or whatever dialect they speak at home. They probably have more problems adjusting than we have because they don't have the exposure or access to the culture like we did. So they're having to be raised by a family out of context with expectations which they've no understanding of, using terms they don't understand. They look totally different to their white contemporaries. They are British but it doesn't mean they don't suffer discrimination. And yet they can't fall back on another culture and be proud of that because they don't know what it is. expert

Maintaining a Chinese identity in an English land

I: In a way you were saying that you keep very much alive the things you were taught by your parents. You're living here a long time, you're in Britain but you keep your Chinese upbringing, your Chinese culture. And you try to do this with your own children?

YW: Yes. Well you try.

SK: It's very difficult.

JE: I would say, isn't it?

SK: They go to school, they mix with their friends who are mostly Western, and they bring back Western ideas.

JO: It's your decision to bring up children in this country!

J: Yes. They're individuals so I let them be. They may look Chinese but their thinking's really Westernised already. So when they grow up I have this fear that people will think they're Chinese but they are actually very Westernised inside. So if they should be rejected when they are grown up they will be in a crisis of how they handle the problem.

JO: Where will they be rejected?

J: I don't know. It's a hypothetical situation.

JO: Because I was born here, Okay? I still believe in the Chinese culture and then I married an English and then I realised I was more Chinese because I thought I would adapt to marrying an English but I'm very Chinese.

IO: I think the value, it's a certain kind of value. I think, for you, your husband is English and you are Chinese; maybe the children will mix up together both cultures. But mine, my children are more than your children ....

JO: More Chinese.

IO: Yes, I do believe that.

J: But don't forget, they've only lived here for four years. Give it another ten years, do you think that your children will still be able to balance the two cultures? Or they will tend to be more English than Chinese?

SK: They will question, they will question, start questioning.

JO: Like I did.

IO: Hang on, like what kind of things? I mean like certain kind of values. I do think we can have a pretty even balance.

YW: Well I do hope so because I am a failure really, I can't even teach them to speak Chinese no matter how hard I try and I ....

IO: My son does reject. Sometimes he will say why can't I do that? Why ....

SK: Yes, they question you a lot.

IO: Yes, but finally, you can see that he will follow you. I do believe that.

focus group, older women

This group is referred to as 'the bananas' – yellow on the outside and white on the inside. This somewhat pejorative label comes from the more conservative section of the community which powerlessly watches the youth becoming acculturated in British society, but it is accepted by those to whom it refers. Being a 'banana' entails being split between the expectations and aspirations of two cultures; it is infinitely more complex than simply 'looking' Chinese but 'being' white. One of our respondents clearly conveys the experience of, and meaning attached to 'being a banana', together with the particular social relations which this makes possible but also impedes:

> *In Hong Kong I felt more freer because I was part of a society who looked like me. If you're on the street, you look Chinese and stuff like that. But whenever I encountered conversation and reading, that's when it struck on to me that I was an English. But when I didn't have to communicate with anyone, I was just part of Hong Kong, you know, part of the community. But being involved in it is completely different. They saw me as an English person. It's quite funny though because there's a saying – not a saying – there's a description of me. I'm called a banana. Because I'm yellow on the outside and white on the inside. And that's a perfect description of what I am basically. And that's what they saw.* lay participant, male, 23 years old

Clearly, the segmentation of the Chinese community is intrinsically related to social, economic and political circumstances (both in the country of origin and in the host society), to changes in immigration policies and to the traditional Chinese family structure and cultural values. Clearly too, the variety of life experiences described above makes for a complex and heterogeneous community with different ways of life, degrees of traditionalism, aspirations, beliefs and needs. And yet, independently of their country of origin, age, generation, religion and socio-economic background, everyone in our sample was acutely aware and proud of being Chinese. Such shared feelings and sense of identity are no doubt reinforced by the experience of being abroad and the difficulties of integrating in a very different society and culture.

Table 4.1 Characteristics of the Chinese community by generation: integration, identity, health beliefs and use of services

Generation	Integration	Origins, attributes, identity, health beliefs and use of health services
Older generation: (60-year-olds and over) • Chinese settlers • Parents of middle generation	Low integration Isolation	• Origins: rural Hong Kong (New Territories) • Attributes: no English, catering trade, lower education, cultural homogeneity • Identity: strong traditional Chinese (self-contained in the community) • Health beliefs: traditional, folk, superstition • Use of traditional Chinese doctors and herbalists, traditional tonics and food • Difficulty using NHS: language, culture, mobility, lack of knowledge about the NHS
Middle generation (30–60-year-olds) • Chinese settlers • Newcomers	Low integration	• Origins: Hong Kong, Mainland China, Vietnam (refugees) • Attributes: little English, catering trade, lower level of education • Identity: strong traditional Chinese (self-contained in the community) • Health beliefs: traditional, folk, superstition • Difficulty using NHS: language/culture, lack of knowledge about NHS, opening hours
	High integration	• Origins: Britain, urban Hong Kong, Malaysia, Singapore, China • Attributes: bilingual, mixed professions, high level of education • Identity: negotiating Chinese and Western (conflicts, confusion, self-awareness) • Health beliefs: traditional health beliefs deeply mixed with biomedicine • Full use of NHS; partial satisfaction
Young generation (0–30-year-olds) • Children • Foreign students • Newcomers	High integration	• Origins: British-born Chinese • Attributes: English with some knowledge of Chinese or parents' dialect, (high) education • Identity: negotiating Chinese and Western (conflicts, confusion, self-awareness) • Health beliefs: combination of Chinese and biomedical knowledge • Full use of NHS
	Functional integration	• Origins: Chinese Diaspora, including Britain • Attributes: students, higher education, young children, bilingual • Identity: predominantly Chinese identity subjected to questioning or in stage of identity formation • Health beliefs: combination of Chinese and biomedical knowledge • Full use of NHS

5 Representations of health and illness among the Chinese community in England

In this chapter we report the findings related to the content and dynamics of the representations held by the Chinese community about issues of health and illness. The data are presented around the general themes that emerged in the focus groups and interviews and are explained in terms of the processes associated with the representations. In spite of the generational diversity identifiable in the data, there is a *common system of representations about health and illness* that permeates all our findings. These representations appear in the data as an articulated system of knowledge with power to explain and interpret not only issues of health and illness but also the existential grounding of Chinese people living in a foreign country. The way in which the respondents make use of these common representations varies mainly as a function of their age and degree of acculturation in British society.

Before we present our findings it is important to say that the following representations did not appear as a fully articulated corpus of notions in the data. They emerged through story telling and the description of everyday experiences and practices. They were often expressed in a patchy and fragmented form. This is in part due to the fact that knowledge transmission in Chinese cultures relies more on rituals and on gestures than on explanation; knowledge is mainly passed on through observation and without the mediation of language. But it is also due to the fact that everyday knowledge – in any culture – operates as a *resource* to be drawn upon to make sense of empirical diversity: it is first and foremost knowledge *to be used*, which explains why it often appears in a contradictory and fragmented form.

In what follows we discuss in more detail the content of the representations of health that emerged in our study and the processes that sustain these representations in the context of the Chinese community in England. Both content and processes are crucial to understand how and why they are produced by the Chinese community.

5.1 Balance and harmony: health as a world view

It is clear from our data that traditional Chinese concepts of health and illness dominate the representations held by the Chinese community in England. Whatever biomedical knowledge they possess, this information has been mainly integrated and reformulated, insofar as it is compatible with their already-existing and highly-structured world view and cultural identity. The notions of balance and harmony are central to representations of health and illness. The healthy working of the body is thought to depend on the harmonious balance between elements and forces within the body and between the latter and the social, natural and supernatural environment.

Balance and harmony give structure and meaning to the understanding of the complementary and yet antagonistic forces by which everything that exists is formed. The Chinese see the human body, the natural surroundings, the social relations that organise society and the supernatural world as elements linked and regulated by the adequate management of opposites and similarities. Thus the binaries hot/cold, wet/dry and yin/yang – just to cite the ones most frequently referred to by our subjects – operate within and across each existing domain. The principle of similarity – the idea that 'like helps like' or 'like fights like' – also organises the internal structure of each domain and its relation to other domains.

It is through this world view that the Chinese community constructs a representational system capable of defining what health is, how it can be jeopardised by illness and how the latter can be treated. To put it more directly, the Chinese possess an articulated system of knowledge which is competent firstly to define health and illness, secondly to explain the aetiology of disease and thirdly to devise appropriate therapeutics to handle it. Our data suggest that this system of everyday knowledge is linked in some fundamental ways to the maintenance of a cultural identity.

5.2 Health and illness: balance and disruption in the flow of energy

It is widely known that Chinese medicine is based on a system of thought which sees the human organism as a microcosm corresponding to and mirroring the structure of society, the image of nature and the macrocosm of the universe (Anderson, 1987; Chan, 1991; Kleinman *et al*, 1975; Unschuld, 1985, 1987). Underlying this system of thought are the well-known yin-yang principles. These principles dictate the particular relations between various parts of the human organism and external, climatic conditions. 'Balance and harmony are basic to health –

not only within the body, but also in social relations, in relations with the landscape and nature, and in relations with the supernatural' (Anderson, 1987: 33). Traditional Chinese medicine is based on the idea that vital force or energy (*ch'i*) irrigates the human organism. Health results from sufficient and adequately distributed energy. Illness, on the other hand, is the symptomatic manifestation of energy disequilibrium or insufficiency. Energy imbalance can be caused either by internal or external factors:

- **Internal factors:** these include one's hereditary proneness to having a yang- or yin-dominated personality, age, poor diet, infections, accidents, fatigue, or excessive emotions such as joy, anger, fear, or sadness.
- **External factors:** these relate to natural or meteorological conditions such as temperature, humidity and volume of rainfall, atmospheric pressure, wind speed and direction, together with the movement of celestial bodies. Environmental irritants, germs, viruses and bacteria were also mentioned. Of these external factors, windy, cold, wet, hot, or dry weather conditions seem to be the most salient dimensions used by the Chinese in England to explain the cause of illness.

***Figure 5.1 Health and illness as the flow of* Ch'i**

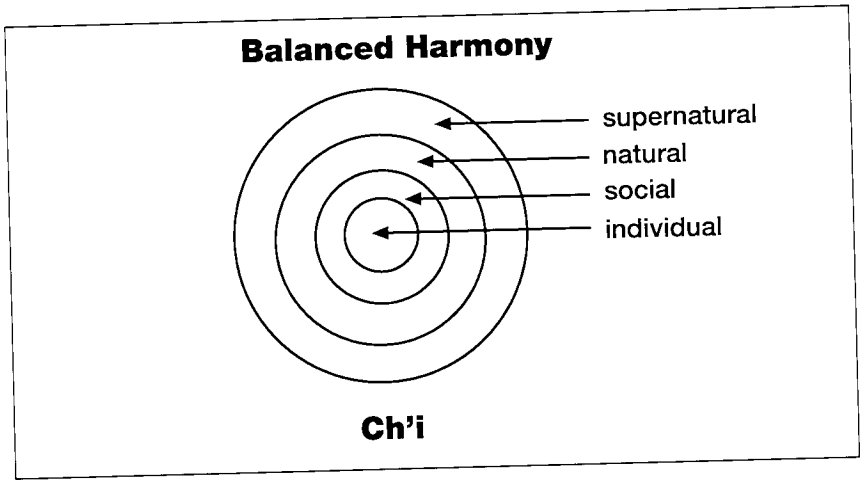

Figure 5.1 helps to visualise how vital energy (*ch'i*) controls the self (mind and body), nature, society and the supernatural. This conceptual scheme, which is found in classical Chinese medicine, was prevalent in our data mainly through the notions of balance and the complementary notions of hot/cold, wet/dry, yin/yang. Vital energy circulates through the human body according to a regular pattern that needs to be kept in balance. The human body comprises parts (organs) which fulfil certain functions, and networks which link these organs, distributing, storing,

absorbing and discharging energy. The rhythm of the seasons, equilibrium in dealing with time through routine and the proper timing of meals, and climatic conditions are crucial to the balance of vital energy (*ch'i*). Fresh food, such as freshly killed chicken and fish, fresh fruits and vegetables, and the correct preparation of these through the choice of a suitable cooking method allow the management of hot/cold, wet/dry and yin/yang conditions and guarantee good health. Harmony within the family and respect for its hierarchy and fundamental values, the primacy of collective goals over individual needs and desires, obedience to authority and self-discipline, all maintain the self in balance with society and give to the Chinese definition of health a breadth that goes far beyond bodily conditions. These are in turn part of the flow of energy that links one's ancestors and the health of future generations. Transmission of this knowledge through rituals of food preparation perpetuates ancestor worship and allows for good health both in one's life and for future generations of kin. In this way *ch'i* flows through generations while endorsing the survival of the Chinese way of life. The need to keep just about everything balanced and to make proper use of the oppositions found in different domains was clear in our data. The Chinese refer to it as a 'way of life'.

KW: To the Chinese when you're sick it's more than just either you have a virus in there or anything like that. It's got something probably to do with the way you handle yourself, the way you eat, whether you drink enough water and all these sorts of things. I mean, to us, sick is more than just medicine can get rid of it. It's a whole way of life. Chinese always have the idea of like, your body is too heated or too cold.

CS: Yes.

KW: This sort of thing that can't be explained by Western ... You don't have the idea of body, whether your body is hot or cold. It's not measured in terms of your temperature. I mean, it wouldn't show up on your thermometer whether your temperature is too high but to a Chinese, this just, it blends into the way of your ....

W: It's just your life.

KW: ... the food we take, there are two kinds of food we take. The heating kind and the cooling kind so when a friend sometimes he might say he has diarrhoea, I say, oh you ate too much cooling stuff, papaya, watermelon, drank too much chrysanthemum tea.

focus group, young men

You have to have a balance. That is the Chinese point of view. That is why the country is called China. China is called the Middle Kingdom. We believe we're in the middle of the world, of the earth. Everything must be nicely balanced. So, for example, if you have dry lips, blisters or ulcers, you must be hot. In order to balance that, then you must take

something, not necessarily medicine but soups and other remedies which have the cold properties in order to balance it. expert

Conversely, excess, disequilibrium and imbalance are at the origin and define the nature of ill health. Illness is always a state of disruption in the balance of opposites and in the flow of *ch'i*. Emotional and physical excesses, exposure to climatic perturbations or pathogenic agents (such as viruses or bacteria), absence of routine, lapses in self-restraint and discipline and lack of a proper diet are the elements that conspire to debilitate health and to bring about illness. The treatment for imbalance/disease consists in restoring the optimal equilibrium between humours or elements, either by removing excess or by compensating for the deficiency through supplementary intake of foods or medications containing the missing element or its equivalent.

5.3 'You are what you eat': the role of food

Eating is an eminently social business. No culture consumes all the foods which are potentially available to it. Foodstuffs found in local environments are subjected to complex classifications and they are surrounded by ritualistic practices concerning who eats what, when, how, and for what purpose. Everywhere food beliefs reproduce and protect a symbolic order and foster solidarity between those who share them (Douglas, 1966). Everywhere they are also closely intertwined with ideas about health and illness.

Nowhere is this truer than in Chinese cultures. Since health is conceived as the product of sufficient and adequate flow of energy through the body, and since food is an important source of energy, the proper selection of food and drinks, as well as the disciplined timing of meals, are thought to be integral to good health. The manipulation of nutrition remains the first and major recourse of almost all Chinese families today in order to maintain good health and prevent or cure illness (Anderson, 1987; Ho, 1985; Kleinman *et al*, 1975; Koo, 1984, 1987). There was not a single participant in this research – expert or lay, foreign or British-born, young or old – who did not mention the importance of food in relation to health. Our data suggest that dietary prescriptions and proscriptions articulate the complex interactions between individual, social and natural conditions. They link each individual to the family and to Chinese culture as a whole. Together with language, food is probably the most important vehicle for the transmission of traditional health beliefs. The Chinese have a long history of using food, herbs, animal parts and insects to maintain health and to treat illness.

The classification of food

Food is evaluated according to a number of criteria which seem to be involved simultaneously in allocating ingredients to a particular category. Underpinning the categorisation of food is again the notion of balance between the forces of yin and yang. Thus foodstuffs are classified primarily according to their properties as either 'hot' (yang), 'cold' (yin) or, less frequently, 'neutral' (yin-yang). These properties refer to the effects of the body that are attributed to them, not exclusively to bodily temperature. Although 'hot', 'cold' and 'neutral' are discrete categories, Chinese people in England seem to distinguish between various degrees of 'yin/cold' and 'yang/hot' properties.

The allocation of items to a category is by no means uniform. However, 'hot' foods tend to be spicy, high-calorie, protein-rich and oily; they generally have a sharp or intense flavour and would often be red, orange or yellow in colour. Foods which our informants considered to have 'heating' properties include meat, herbs, wines, ginger, garlic, chillies, brown sugar, spices and oils. Interestingly, considering that alcohol is usually classified as 'hot', beer was deemed to be cooling by the Chinese subjects in our sample. This surprising categorisation allows them to make sense of British dietary rules and behaviours. English people may eat remarkable quantities of 'heaty' food at irregular times but beer cools them down, thereby counter-balancing the dangerous effects of a 'hot' diet and explaining why, in spite of an unbalanced diet, they are nevertheless healthy on the whole. We see here how the flexibility of the system (Anderson, 1987; Manderson, 1987) allows them to make sense of new realities without calling the system itself into question.

> *When we have heat in us, we take the cooling tea. When English people have the heat in them, they take beer.*
>
> lay informant, male, 44 years old

> *English people they eat a lot of hamburger, you know, but they drink a lot of beer. Beer balances with the yang. It's a cool thing, see? Even in hot weather when you drink beer you feel good. Beer contains a lot of yin to balance the yang. So the English eat a lot of burger, eat a lot of fried thing but they drink beer a lot so it's balanced.*
>
> focus group, older men

Foods with 'cooling' properties, on the other hand, tend to be rather bland, watery, crisp and fresh, to yield low energy and to be green or white in colour (Anderson, 1987). Subjects mentioned that most fruits and vegetables such as Chinese cabbage, water chestnuts, spinach, watermelon and bananas, would fall in this category, but honey, white sugar, tea and various herbs were also generally categorised as cooling. For instance, older men were discussing the use of soups to cool the body down after having ingested too many 'hot' foods.

S1: The body, you eat too much hot thing like a chilli or a curry, you need a cold thing like a soup, or Chinese vegetables. Something like that, yeah, a bit cooler.

I: But the soup is hot?

S1: No the soup is hot but the soup is not hot.

S2: The thing in there, the ingredients in there, they contain the medicine, the herb. Some people they use the herb to cook the soup. The herb contains the ingredients to cooling down the temperature of the body ....

S1: The green in the tea.

S5: The green herbs and vegetables, they are cooling down your body and it is neutralised. It neutralises the body system.

S2: You eat too much the fried thing, you use the spinach, okay?

focus group, older men

The only foods widely recognised as having 'neutral' properties were rice and wheat noodles, although some subjects included either pork, chicken and fish in this category. Thus 'hot', 'cold' and 'neutral' refer to properties other than temperature.

It is important to note that the method of cooking can modify or enhance the properties of food. For instance, boiling is believed to add more yin, whereas deep-frying, stewing, grilling or roasting are said to accentuate the yang qualities. Stir-frying and steaming are the most ambiguous methods: some assert that they enhance yang properties, others that they add yin, and others still that they are neutral.

Other relevant qualities attributed to foodstuffs are their 'tonic' and 'poisonous' characteristics.[1] Chinese 'tonics' are part of the normal diet of many Chinese people and many everyday ingredients are thought to have tonic or invigorating qualities, that is to increase one's level of energy. The most frequently mentioned foods of a 'tonic' nature are meat, poultry, sea food, eggs and internal organs. But tonics also come in the form of root extracts (such as ginseng), wines and herbs. Many patented herbal prescriptions recommended by Chinese herbalists are also classified as having 'tonic' properties. There would appear to be a considerable overlap between 'hot' and 'tonic' foods. 'Poisonous' foods

[1]Koo (1984: 758) identified two further energy qualities, 'irritating' and 'stimulating', to be salient among Taiwan and San Francisco Chinese with respect to food. Her informants believed that 'irritating' foods disturbed the circulation of energy, by causing it to flow too much or too quickly in some parts of the body, and too little or too slowly in others. And 'stimulating' foods encouraged the forced expenditure of energy in the body, later exhausting the body's resources. The logic behind these properties is entirely congruent with the overall representations of the body and of health held by the Chinese we interviewed in England, even though we did not find direct evidence of these means of food categorisation in our data.

are called thus on the basis of the observation that scaly animals like snakes and scorpions were known to be poisonous (Koo, 1984). By extension, some seafood and shellfish are also called 'poisonous', although they are known to be perfectly safe and eaten by most, and are believed to affect one's skin.

S5: Shrimp doesn't do any harm for the body but we believe it is something sensitive to the skin. It's just like seafood, all the shellfish, it's sensitive to the skin.

S2: It's poisonous. focus group, older men

The actual items which are included under each category – 'hot', 'cold', 'tonic' or 'poisonous' – may vary slightly from one Chinese society, region, family or even individual to the next, but the classification itself holds. The simplicity, flexibility and malleability of the system, far from betraying its weakness and signalling its eminent demise, are the very qualities which serve to ensure its survival and widespread diffusion.

The use of food in prevention and cure

We Chinese people know that when you have an ulcer or blisters in your mouth, then you have got too much fire in you, you got too much heat in you. So you've got to take something cold to counter-balance that. So when you take cold things, then that ulcer goes away and then you know that you got rid of the heat. lay participant, male, 44 years old

Food is the key to prevention and it plays a fundamental role in curing disease. Our respondents referred to food as a general regulator in everyday life; the right use of food is the major source of health prevention. The whole concept of cooking and eating a 'nice meal' contains the elements that can preserve good health: the foodstuffs used, the way of cooking and the time and ritual of eating in a communal situation. These are the crucial ingredients that produce a healthy life and they are engrained in the Chinese community as cultural practices.

... feeling well or healthy is very much tied up with using a good diet [...] Eating the right things, the right foods, drinking the right soups, when you eat your food, how many times you need to eat it, in what time of year it's best to eat what .... expert

Food has also curative properties and there was widespread reference across the data to the various ways in which food can cure illness.

I: Do you change your diet if you are ill?

S2: Yes.

S5: Very important.

I: Tell me about that a bit.

S5: It depends what sort of illness you got ....

S2: For flu, some people they drink a lot of ginger. They bang the ginger and they get the juice of the ginger, the drink of the root flowing out. But not nowadays, in modern days, because you can get some aspirin. It's quicker, you know.

S5: Well, let's say you have a sore throat. You have to change your diet straight away. You have to cut down the greasy food, the deep-fried, the meat, all that and go on a diet like on more vegetables, soup, more fish and that will cure the problem. focus group, older men

Through food the principle of 'like helps like' can be enacted and our respondents referred to how they use animal parts to remedy specific problems. Headaches and migraines can be alleviated by eating pigs' brains, and properties attributed to some animals are thought to be absorbed by the human body through eating and drinking. Women wishing to become pregnant or being in the early months of their pregnancy, for instance, would eat the placenta of mammals in order to benefit from its association with fertility. Similarly, the strength of the tiger is believed to be passed to men when they ingest some of its organs. The workings of this principle are illustrated in the following quotations:

I: What about rheumatism and arthritis, when your joints hurt, what do you do about that?

S5: We have a kind of medicine oil, made from the gall bladder, a piece of a snake and put into the wine, the white spirit or wine, and rub it all over our body and let the spirit go into all the bones and joints.

S2: You have to buy the piece of snake and put it in the alcohol ... It's good medicine to treat the joints. I mean the snake body contains some medicine. The Chinese people believe that it could kill the joint ache, you know? So the pieces in the alcohol, drink that alcohol and even like, you know, the bone of tiger should make them strong to cook with the medicine or to put in the alcohol. Tiger is good to make you strong. Part of the animal can treat part of the self, you know? So you have to get that part of the animal. [....]

S5: Some of the food damages a part of the body and some of the food enriches a part of the body. And most Chinese people, you eat the pig liver and it's good for your liver ... and pig's brains will take your headache away. That's what we believe and are brought up with.

focus group, older men

My mother suffers very badly from migraine and my grandmother would cook up pig's brain for her, you know, with herbs and things to get rid of the migraine which it seems to do for years at a time but then it comes back again, never completely. And then, if you have chicken pox, you bathe in some feathers.

expert

Food, thus, is a major vehicle for health beliefs in the Chinese community. It comprises the objectification of a number of concepts and rituals that keep the cultural system of the community alive and provide for each of its individual members a clear sense of identity and belonging. It is extremely important not only in relation to what one eats (the properties of foodstuffs), but also in relation to how one eats (the rituals of preparing, timing and socially organising food intake). It was in discussing the properties of food and the various rituals associated with preparing and eating it that the participants revealed their representations of health and illness.

S1: Well, it's a kind of a way of living ... I know from own family life, you had certain soups in summer and certain soups in winter and you eat certain things at certain times. Not because the doctor asked you to do them but because it's just part of your culture ....

S2: Yeah, part of your life as such.

S1: ... a bit like taking cod liver oil everyday, you know, that kind of stuff. And I think a different thing is that it's not seen as medicine; it's actually part of your life. So you have it as part of your meal. So although the soup is medicinal, it's actually part of the feast.

experts

This is of major significance for communication between Chinese people and Western health workers. Through food the Chinese pass on traditional knowledge, express care and maintain fundamental kinship relations. The Chinese table is a microcosm of a whole cultural system where health is one among many other elements that combine to perpetuate and defend a way of life.

5.4 The reproduction of knowledge through observation of practices

We have observed that most participants have little *reflexive awareness* of their own practices: there is hardly any questioning of the reasons or explanations that lie behind the practices in which people otherwise engage. The Chinese people in our sample could describe what they themselves or their relatives do, the remedies they ingest, the symptoms they suffer from; but few, if any, had actively thought about the principles underlying their behaviours. Everyone knew and made use of the very general notions of balance and harmony, of yin and yang, hot and cold and dry and wet but without being able to explain how these and other principles function. In fact it is not necessary or even desired for the Chinese to be able to explain their practices. Most of the time, for children to question the way things are is interpreted as challenging parental authority. There is nothing surprising about that: people's relations to knowledge are themselves socially constructed. Being expected to give an account is a Western, modern phenomenon, deeply tied in with a particular kind of public sphere and democratic values. In most traditional societies, being able to reproduce the system of knowledge through the observation of wise and knowledgeable elderly people is what is expected. As one of the most self-critical and thoughtful of the experts interviewed said:

> *S1: I think all this explaining to children is a very Western concept anyway. You know, well, that's what my mother thinks, that here they're all very badly brought up because they do too much talking to them [...]. I mean this kind of explanation and sort of taking you through why people do things and why it could be good for you, I just don't remember that as part of our lives ....*
>
> *S2: I don't remember that either.*
>
> *S1: Not at all. A lot of it is also observation, you see? It's in the doing, you know, because you're around, I mean I was around lots of women, my grandmother, my mother, my aunts, and so you would see them and you would hear when one of them was ill and what they did and stuff. It just gets stored somewhere, drenched out again when we see people like you.* experts

The transmission of knowledge takes place through socialisation and community rituals of all kinds, the most important ones occurring within the family. In this sense, it is a deeply-engrained knowledge, most of the time taken for granted and objectified in the most basic elements of everyday life: language and food. Whenever the Chinese language is spoken and food is prepared, traditional knowledge about health is being transmitted.

When asked to explain how they have come to acquire the rich knowledge they have about health and illness people typically shrugged their shoulders and answered:

S5: It's our culture. It's our culture. It's so simple. Everyone knows. It's like your left hand and your right hand when you are born. Everyone should know.

S2: You know from your grandmother, your grandfather, and before they teach the grandson. focus group, older men

5.5 Health beliefs and identity: maintaining and questioning cultural inheritance

The representations of health and illness uncovered in our study are deeply intertwined with issues concerning the maintenance, the transmission and the transformation of a cultural identity. The Chinese abroad, as with other ethnic groups, 'seek to create some continuity between past and present, between old selves imprinted by the mother tongue and the new ones invented with painful freedom' (Schwarcz, 1994). They do not simply establish and develop an identity (or various related identities) in isolation from the influences and pressures of wider society. There is a complex interaction between, on the one hand, the shared history, social memory and common practices of the Chinese and, on the other, the new social knowledge and conventions that they are exposed to and, at times, appropriate.

Representations of health and illness are not just about being healthy and avoiding illness. They are first, and perhaps foremost, about being Chinese or not, about being able to state a Chinese identity and have it recognised, about remembering and performing the stock of symbols and practices handed down through generations of Chinese people, and about deciding how to cope with the differences between 'the Chinese way' and that of the host society. Our findings provide ample evidence of how different health beliefs and practices (Chinese and Western) are combined as Chinese people negotiate their identity in non-Chinese society.

From isolation to integration: the negotiation of identity

The different groups identified in the portrait of the community have different ways of making sense of Chinese beliefs and customs in a non-Chinese society. These differences can be put on a continuum. At the one end, there are the 'isolated' Chinese; at the other, the 'integrated' Chinese. In reality there are no extreme examples: however cut-off from

the wider society, living in Britain challenges everyone's identity in some way; and however determined to embrace British culture, there is always a link to a Chinese identity, not least because of one's appearance. There are though, degrees of isolation and integration that do not conform perfectly to generational differences; rather, they can be better explained through the ability to use English and the willingness to engage with English culture. These are central to a clear understanding of how the community draws upon resources from the host society and how its different needs can be met.

The more isolated Chinese people are from the host society, the more they will rely on Chinese health beliefs and draw on Chinese networks for help. The least integrated members of the Chinese community tend to be elderly people, or people working in the catering industry. They are less educated and are united by the fact that they do not speak English. Age is not the only variable in determining their level of integration. Competent use of the English language is crucial in order to participate fully in the host society and to use mainstream health services. As things are this group must rely on their community network when they seek medical attention or need to use the NHS. However, although the least integrated, they experience virtually no identity-related problems – they feel Chinese and are perceived as such by others – but they need more from the host society and from the NHS. They do not have the means of identifying the resources that are available to them, and accessing Western care appears to be highly problematic, not least because they have to *ask* for help, something that, we consistently found, the Chinese do not like to do.

Traditionally the Chinese do not bother other people with their problems and to do so would affront their Chinese identity and values. Thus if going to see a GP requires asking someone to interpret on their behalf, they will try to avoid it. It is here that we can clearly understand the widespread practice among the Chinese of using their children as interpreters in medical consultation. The problems involved in this practice have been neatly summarised by Li (1992). Our data suggest that Chinese parents who are unable to speak English use children as interpreters in order to avoid asking for help outside the private home. Such finding reinforces the need for the mainstream primary health care system to offer help, rather than forcing the less integrated members of the Chinese community to ask for it. The onus is on the health authorities to widen the scope of their services. It is important to understand that this group holds strongly to a Chinese identity and therefore its use of resources will be confined within the boundaries of the Chinese community.

When they found out about the tumour it was too late

I had one patient who went to the GP complaining of pain in the stomach. And the GP, without any interpreter, said he was attention-seeking. The patient was a Chinese gentleman. Attention-seeking? The saddest thing is this gentleman had children who work in the Chinese community, who are community workers but they don't live with him. They're totally bilingual but they're not able to interpret for their dad. And as a result when it was actually found out he got a tumour, it was too late.

expert

For the other groups, who hold mixed identities and can speak English, to integrate Chinese and British cultures, to combine different knowledges, beliefs and practices is not only necessary and possible, but also advantageous. In these groups, personal experiences are grounded in Chinese culture, values and traditions, which provide the background upon which their lives in Britain unfold. But as they meet new styles of thinking and relating they are thrown into the task of rethinking themselves and negotiating new identities. In our study this is true not only for the young generation but also for those who came to Britain as teenagers and grew up knowing both worlds in detail. Incidentally, the negotiation of identity is more salient among women than men in our study. We might tentatively suggest that women are more prone to being questioned by their acculturated children and that, through them, they are more exposed to the host society. It is also likely that their position in the traditional social hierarchy facilitates the questioning of Chinese values. In any case mixed identities lead to mixed representations of health and illness and to the ability to use both systems of knowledge as resources to fit their needs. In this group there is no salient problem related to the use of NHS resources which will be combined with old family recipes and traditional Chinese medicine.

It is important to note however that integration does not come easily. There is an acute awareness of the sometimes drastic differences between cultures, and the psychological pain associated with each of the choices made may be considerable. Feelings of 'split-personality', guilt, loneliness and of 'being torn' were very apparent among all those who described the task of 'integration'. Many in our study spoke of the painful experience of racial harassment as crucial in defining the sustenance of their cultural inheritance. Integrating involves choices which redefine one's sense of self and shake community ties in a community where social links and belonging are most cherished values.

I had to seek help to go through that

I have gone through, I had a depression period. It's due to a lot of things. Basically my life experience and the confusion with the mixed culture and mixed marriages and identity. I don't know where I am and I feel, I see different things in a different way and I could see I'm torn between. There's a conflict between the two cultures. I've gone through that and I did, I sought help. I needed to seek help and yes, I got through it. It's also the family values: you're torn between. You respect your parents, which is the way you've been brought up and raised, and you feel guilty when you can't be able to do that and of being a Chinese. And living in here, in this society ... It's different, you see, and you feel very unhappy yourself. That's why I say I try to be an individual and I try to do things that ... I feel good and I feel comfortable. I honestly try not to feel guilty anymore, you know, not being able to see to my parents and see to their needs and you know, if they have someone, they have their problems, because they have communication problems, you know, I mean, they can't communicate and I feel I could communicate but I live away from them. I can't help them that much, you know? And I have to live with that and I sort of, you can only do what you can. You can't spend your life living other people's lives because everybody has problems. But I had to seek help to go through that ....

focus group, older women

5.6 'Sitting a month': an illustration of Chinese health beliefs at work

Perhaps the logic of the Chinese complex conceptual system is best illustrated through an empirical example. The so-called practice of 'sitting a month' – that is, of staying indoors and of engaging in ritualistic food behaviours for a whole month after child delivery – allows us to understand better how Chinese people conceive of the body, its functions, and its needs. It shows how one's health is intrinsically related to food and to environmental conditions. It also illustrates the importance of others in the maintenance of health beliefs. Moreover, this example allows us to explore the links between health beliefs and health practices and to understand why some health beliefs can be maintained in the face of apparent lack of congruence between the latter and empirical reality. Finally, the case of 'sitting a month' clearly highlights the diversity of approaches to health and health-care which characterises the Chinese community in England.

It is widely believed that Chinese women should be confined at home for 30 days after giving birth (Tann & Wheeler, 1980). During this period of relative rest women must protect themselves against the malevolent effects of exposure to wet and windy conditions by respecting a number

of prohibitions concerning wind and water. Staying indoors (to avoid contact with rain, snow, humidity and wind), avoiding contact with water (by keeping baths, showers and shampoos to a strict minimum), and avoiding sitting in a draught (by keeping windows shut during the whole period) are the main prescriptions to prevent 'wet/wind' conditions which would damage the mothers' own health and, through breast-feeding, that of their babies.

'Sitting a month' also comprises a number of food rituals intended to allow women to recuperate from the trauma of childbirth. Childbirth is deemed very traumatic because it entails a massive expenditure of energy and an important 'loss of blood' (which irrigates the body and, as such, is central to good health). It is therefore imperative to 'bring up' the level of yang energy and restore the body's balance by changing the diet so as to take more 'tonics', to ingest nutritious 'hot' foods cooked at high temperature with oil, and to avoid 'cooling' foods such as fruit and vegetables.

YW: You're supposed to eat the food with just a ginseng and to add some Chinese wine to cook the meat. And a lot of ginger, a root ginger ...

SK: That's to enrich the blood that you lost.

JE: Or garlic. That's something else that enriches your blood.

SK: Ginger is full of fibre, you see? You must remember I was told not to eat fruits during the first month because it's something to do with the flow of the yin yang in your body. Your body is very down after birth so you must eat all this wine and chicken.

JE: Things to boost it.

SK: Bring it up.

YW: Your circulation.

IO: Also heaty food like fried food, greasy food and baked, you know, things like that. Ginger is good. And some vegetables.

SK: No they are not, not at this time. focus group, older women

S5: We believe [women] lose a lot of blood [during delivery], they lose a lot of yang already so they have to bring it back to the neutral. That's why we have to be careful, that's why you have to sit in the home, don't do anything and keeping back whatever they lose, on a special diet. Before the baby birth, it sees that there is enough energy for the baby and the mother as well, and some people give them ginseng.
focus group, older men

Of course, keeping up such practices requires the presence of relatives to handle everyday chores around the house, to tell the young mother what

to do, what to refrain from and when to eat what. Relatives must go out and buy the ingredients and prepare the food according to the principles indicated above. Chinese mothers abroad rarely have the luxury of such conditions. The basic ingredients are not available everywhere and relatives do not always live in the same house, the same town or even the same country as the new mothers. Moreover, some women in our sample were married to Englishmen who were challenging the validity of these practices on the basis of their own Western health beliefs. Compromises must be reached but this is achieved at a huge psychological cost. Chinese mothers feel that they do not provide their babies with the best conditions to start their new lives. And they experience all the symptoms which they know will ensue when one does not follow the prescribed 'Chinese way'.

YW: According to Chinese culture, you're not supposed to go out at all the first month and with me it's a bit difficult because my [English] mother-in-law came to stay with me for two weeks and so my husband wants to take his mum out and they did believe that I should take the baby out. The Chinese way, you shouldn't take a baby out. So I was torn between these two cultures and in the end I think I go out with them, after two weeks. It was in July but I was feeling cold and weak, believe me, and that was only after going out for an hour or two, and then I thought that's why the Chinese think you shouldn't go out because you're body's not quite prepared for it. And in July I have a jacket, I'm still feeling so cold and after an hour walking my legs were so weak, you know, I was almost want to sit down, so tired.

SK: Childbirth is very traumatic. It takes a lot out of you.

YW: Yes but I mean at that time I thought, you know, I should go out with them because they were all excited about taking the baby. Because you don't have the experience, you don't have a mum to advise you. I thought I have had a good two weeks rest, I should be able to go out. But not until I go out, then I realise how stupid I am.

focus group, older women

Even the mothers who did not completely follow 'the Chinese way' did not fundamentally revise their trust in Chinese prescriptions. One British-born Chinese woman in the focus group with older people had gone out herself just two days after the birth of her child, refusing to believe what her mother had 'tried to drum into her'. Yet even she would exclaim: 'Look at her! That's the Chinese way and ginger!', pointing to a youthful and healthy-looking mother of four in the group. Thus, the belief system is maintained.

A study of breast-feeding patterns among twenty Hong Kong Chinese women in London (Tann & Wheeler, 1980) also warns against the danger of interpreting changes in practices as some straightforward and

unproblematic reflection of changes in health beliefs. Tann & Wheeler (1980) report that all but one of the women bottle-fed their children, although nearly 60 per cent of mothers breast-feed in Hong Kong. The mothers claimed that it was 'inconvenient' to breast-feed. However, a deeper analysis revealed that, not having the privilege of 'sitting a month' in London with a properly 'nutritious' diet, the women thought that they were not sufficiently well-nourished themselves to produce high quality milk for the babies. Not having their traditional diet of meat cooked in Chinese wine and ginger with herbs and other special spices, they preferred to opt for bottle-feeding. Thus, far from being inoperative, it was precisely the potency of traditional health beliefs which led to apparently 'modern' behaviours.

How do Chinese people living in England reconcile their belief in the importance of 'sitting a month' with the routine observation that the rest of the British population do not engage in similar practices and nevertheless seem healthy? Many strategies are invoked which all draw on different aspects of traditional Chinese knowledge. For instance it is traditionally thought that the effects of exposure to excess 'wet-wind' conditions on the body may not manifest themselves at all if the people exposed are somehow resilient, either because they have a yang-dominated personality which predisposes them favourably, or because they maintain a balanced diet and orderly lifestyle which make them less vulnerable to these conditions. Wet-wind conditions are also thought less likely to affect young people because they have a more 'fiery' nature than older people, independent of each individual's own hereditary predisposition. Thus if any of the above explanation is correct, the signs of illness traditionally associated with exposure to wet and windy conditions (such as rheumatism and arthritis) may either not manifest themselves at all or they may only appear much later in life.

Conversely, according to the group of older men in our sample, the long-term consequences of not 'sitting a month' can be observed among older English women: their legs and feet are swollen. A Vietnamese Chinese father of twelve (S6), whose wife has followed all the prescriptions of the Chinese way, discusses with older men:

> *S6: I think English people, when the baby come, they stay in hospital one day or two days, and go out shopping, yeah? Then all the feet very bigger. Chinese people stay in one month and no open window. No open window because the wind it can affect in the future.*
>
> *S5: Not straight away, but when you are getting older, there will be problems.*
>
> *S1: If, in England, an old woman is 50 or 60, old, old lady, you see the foot it's big, isn't it? The Chinese people are never like that, never see that the foot is so big.*

I: Why do you think that is?

S2: The English women as they are getting older, their feet are getting swollen, you know? Because the thing is, the English woman having to give birth to the child and not diet good or stay at home ....

I: What causes the legs to become swollen like that?

S2: The Chinese people call it wet and wind.

S5: Wet and wind, and when you become old, we believe that all these things just come down your legs. When you are young, all the blood pressure go up to your head, when you get old it go down and that's why your legs are getting all the pressure. Different age, different attitude. focus group, older men

Thus, the effects of exposure to adverse weather conditions can be delayed by some thirty or forty years according to Chinese health beliefs. This means that the latter simply cannot be invalidated by reference to the empirical. Traditional medicine is acknowledged by all the Chinese in our sample to belong to a realm of knowledge (tradition, experience, wisdom) which, unlike biomedicine, cannot be proven or invalidated.

The social representations of health and illness which we have reported in this section are consensually shared. They belong to the stock of common sense knowledge which all Chinese people possess. Of course, some respondents were highly self-aware and others not. Some openly distanced themselves from Chinese 'superstitions', whilst others bestowed their unshaken trust upon 'the Chinese way'. Some held a very rich, detailed and finely articulated knowledge; others could hardly put into words the complex belief system which nevertheless sustained and gave meaning to their daily practices. In making sense of this empirical diversity, we have chosen to focus and to report on those aspects which were dominant across our data set and which were of a more direct practical import, especially in accounting for people's patterns of use of health services. These are the issues to which we now turn.

6 Choice and evaluation of health services

To what extent do the health beliefs we have uncovered map onto behavioural choices and evaluations in relation to health services? Is there a direct correspondence between beliefs about disease causation (whether they agree with Western biomedicine, or with classical Chinese medicine or are based on folk observations) and choice of therapeutic intervention? How do patients experience and evaluate the adequacy of the care they receive? What are the barriers to the use of NHS services by Chinese people in England?

To answer these questions it is essential to bear in mind that medical systems do not only deliver health care. They are complex *social* and *cultural* systems, in that they imply systems of meanings and behavioural norms but also institutional settings and social relationships within which these norms and meanings are enacted (Kleinman, 1986). Medical systems cannot be divorced from the wider society and culture from which they stem and which they sustain. Thus, when people seek medical help in multicultural societies they choose services and health personnel in the health-care system which not only best address their own lay assessments of their conditions, but which assume and reflect their culture. Choices of health-care and evaluations of individual experiences of health services are therefore shaped by social and cultural understandings. 'The health care system articulates illness as a cultural idiom, linking beliefs about disease causation, the experience of symptoms, specific patterns of illness behaviour, decisions concerning treatment alternatives, actual therapeutic practices and evaluations of therapeutic outcomes' (Kleinman, 1986: 31–32).

The choice and evaluation of health services made by lay Chinese people in our study are based on three inter-related sets of factors:

- the structure and content of their health beliefs *per se*;
- the quality of their encounters with health professionals in terms of the latter's perceived competence, of social dynamics and mutual understanding or misunderstanding;
- the availability (in terms of cost, opening time and location, for example) of relevant services.

We therefore find psychological, socio-cultural and purely practical factors interacting. Before we look more closely at the factors and the principles which determine choices concerning health services, we must briefly describe the professional and folk resources to which Chinese people in the UK may have recourse.

6.1 Professional and folk health resources

In addition to health support in the popular domain (such as family, friends and clans, for example), members of the Chinese community have a wide array of *professional* and *folk* resources to draw upon when they feel unwell. The components of these professional and folk arenas are:

- **Western-trained biomedical health professionals:** these include hospital doctors and GPs (private or NHS), nurses, pharmacists, dentists, midwives, physiotherapists, clinical psychologists, social workers, for example. They may be white or Chinese. It should be emphasized that most of these health professionals (perhaps with the exception of social workers and psychologists) are widely consulted in all Chinese cultures where biomedicine is relatively developed. They therefore do not constitute a novel social group for the Chinese in England.
- **Traditional, classically-trained Chinese doctors:** these are specialists who have undergone expert training in classical Chinese medicine. They would include bone setters, acupuncturists and some herbalists, for example.
- **Herbalists:** the practice of herbalism may or may not be combined with that of Chinese medicine. Herbalists may be different from Chinese doctors. Their role is to provide herbs, roots or plant extracts involved in the management of health problems and to advise people on health matters. Their practice is not clearly regulated.

In addition, there is of course a plethora of healers to which the Chinese, like the general population, may choose to have recourse (see Helman, 1994). Each of these professional and folk healers proposes and legitimises a particular form of social reality (such as communicative practices and role structure), understanding of health and illness (such as diagnosis and aetiology) and set of therapeutic interventions (such as drugs, surgery and diet change).

6.2 Representations of health and illness, and health services: the principles guiding choice

The Chinese in our sample do not generally consider that their traditional medical knowledge and beliefs clash with Western biomedicine. On the contrary, they constantly strive to integrate the two medical systems, drawing on what they think to be their respective strengths. This is constantly reported about Chinese communities across the diaspora (Anderson, 1987; Ho *et al*, 1984; Koo, 1987; Quah, 1989) and it was no different in our study.

> *I think most of us look at traditional Chinese medicine and Western medicine as coexisting quite nicely. I think on the whole most of us would try anything as long as it works. You'll find that sometimes [the Chinese] go to both. They see the Western medical doctor and then toddle off to a herbalist to get herbs and then they'll use the two together. They wouldn't see the conflict.* expert

> *CS: Western medicine isn't always the best method of actually treating something. You don't always have to take aspirins to treat a headache or something. So it's basically looking at the options that are available to you and saying Okay, if something works for you, then well and good, but if it doesn't, then you can try something else.* focus group, young men

This can be interpreted as yet another instance of the often-quoted Chinese 'pragmatism'. It is frequently noted that the Chinese alternate between systems of health-care and will try anything in no particular order until they feel better. Koo (1987) has described the common Chinese practice of 'doctor shopping' in Hong Kong and she has begun to identify the reasons behind the apparent 'as long as it works' approach. Indeed, the combination of health-care services is not random: it is governed to a large extent by deeply-engrained health beliefs. We describe them in detail below.

Minor/major, root/symptom, slow/fast: the logic of combination

As a general rule, and at the level of *conscious awareness*, Chinese people in England use the following basic principles in choosing health services and therapeutic interventions.

Folk or classical Chinese remedies and interventions are advocated:

- for *minor* conditions;
- in order to treat what they believe to be the *root* or the cause of the problem;
- if the intervention is *not urgently needed.*

Conversely, over-the-counter medicine and consultation of Western-trained medical personnel will be advocated in the case of:

- major or *severe* conditions;
- when it suffices to deal with the *symptoms* of illness;
- to alleviate acute pain quickly.

On the basis of such health beliefs it seems perfectly logical to use both Western and Chinese therapeutics simultaneously: the former only offers a 'quick fix' but promptly rids you of painful symptoms, whilst the latter really tackles the root of the problems and provides a long-term solution but may leave you suffering unnecessarily. Rather than being contradictory Western and Chinese health practices and health services become complementary. We can observe this logic at work across the entire community.

> *S5: We find that all the English medicine that you can buy in the chemist only help you to feel more relaxing, it doesn't kill your problems. If you have a sore throat, headache, and take aspirin, it doesn't kill your headache. It just make you go to sleep.*
>
> ***I: So it deals with the symptom but not with the cause?***
>
> *S5: Really, the symptom. Most of the things at the chemist, you just drug yourself. You drink all the medicine; they are more like drug than actually the cure for the germs or anything. We find that in this country the health, the doctors, they never give you anything which is cure. They only help you to get more relaxing. That's all we believe in this country that doctors do.*
>
> focus group, older men

> *If you want to get well completely, to get rid of the root of the illness as such, you'll have to take the Chinese medicine because only Chinese medicine could get rid of the root of your illness. If you want just to relieve the symptom for one day, then you can take the Western medicine. But if you want to get to the root, you have to take the Chinese medicine. But anyway, they [Chinese people running a Western pharmacy] gave me this Western medicine which is about ten little tablets. It was quite expensive as well, it was a few pounds. So I took one and the symptom went. But then it came back again. So at the same time, I took the Chinese medicine and when it got worse, I took the Western medicine. By the end of one week, it went completely.*
>
> lay participant, male, 44 years old

Chinese people will use traditional remedies for minor health problems causing temporary and slight discomfort such as colds and flu, headaches and oral ulcers – as well as for more serious or chronic ailments – such as asthma, rheumatism and arthritis, and peptic ulcers – with which they are familiar because they have a predominantly traditional or folk aetiology. They will prefer Western medicine for

lesser known, life-threatening conditions, for which traditional aetiology is unclear (such as cancer or strokes).

> *From my own experience of the Chinese community, Western medicine seems to be used as a last resort. In fact, my family came over here with hoards of Chinese medicines from home that they bring over because it's so expensive to buy them here. In fact, I have a cabinet, I only treat myself with Chinese medicine. I don't take Panadols and things like that. But I know from my own experience, from my family, we prefer Chinese medicine, including acupuncture and things like that before we go to a Western doctor. Having said that, I think it's about degrees of illness. My mother has cancer and she wouldn't dream of treating herself with Chinese medicine because it doesn't feel powerful enough as she would see it. So she sees a [Western] doctor here.*
>
> expert

For ailments with a traditional aetiology (whether mild or acute), the participants always recommended some form of dietary change in order to counter-balance hot/dry or cold/wet excesses. This often included the use of 'tonics', animal parts, herbs and teas, root extracts and alcoholic drinks either bought at herbalist shops in England or sent over from relatives and friends 'back home'. These traditional treatments could be combined, or not, with the use of over-the-counter (OTC) medicine and, if it could be arranged promptly enough, with a visit to the GP.

Interestingly however, traditional beliefs about disease causation are not systematically associated with the use of traditional Chinese remedies (apart from change of diet). For instance, an older woman suffering from a peptic ulcer attributed her severe stomach pains to the irregular eating schedule so common in the catering industry.

> *I got very very bad stomach aches because when I'm working, I can't eat when I'm hungry. Previously I never had any gastric pains. But now, because of irregular meals – you know how hard the Chinese people usually work – I have the pains. It seems unreasonable for you to go off for a meal when everyone else is working. I've worked in the kitchen for more than six years now so it's getting really, really bad.*
>
> lay participant, female, 44 years old

She went on to explain that irregular meals are dangerous because when the 'stomachs are empty they grind against each other and eventually they will have a hole in them'. But the same woman declared:

> *I never really believed in Chinese medicine. I really believe in Western medicine [....] So I took the pain-killers for about six or seven weeks and also during that time I changed my diet as well. I tried to eat things that are more easily digestible. I ate congees and also I ate a lot of potatoes. I didn't eat anything else. I didn't even eat meat.*
>
> lay participant, female, 44 years old

From a methodological point of view, it is important to note that in a survey, this subject (like so many others) would almost certainly have answered that she trusts and uses Western medicine rather than Chinese medicine. Clearly, such a response would fail to convey the complexity of her understandings of health and illness and would give a highly distorted and inaccurate portrayal of her approach to health matters. Only open-ended research strategies allow us to tap into, and to make sense of, such complex beliefs.

There are different patterns in the ways in which the Chinese combine health services. But the dichotomies minor/major, root/symptom and slow/fast are consensually shared.

Maintenance of health and prevention of illness versus cure of disease

It should also be apparent by now that Chinese people will generally use Chinese medicine, tonics and herbs in order to maintain good health and to prevent illness, whereas they will have recourse to biomedicine in order to deal with serious diseases. However, it is worthy of note that the meaning of prevention for Chinese people differs considerably from the concept of prevention afforded by Western medicine and diffused throughout Western societies. Prevention is a matter for everyday life and *it does not belong to the realm of illness*. One keeps well by balancing the social, individual, natural and supernatural realms; prevention is a matter of achieving a harmonious life. A medical doctor clearly expressed the difference:

> *Yes, prevention is quite a new concept. No, that's not true. It's always in the culture because of the soups and all the stuff that they have to eat in order to keep themselves well. That is a thinking about prevention but what I'm trying to say is that the Western approach to prevention is alien. That's to be expected because it's not something that, in Hong Kong, they would have been exposed to it. Because it's all about fee-paying. And you don't earn any money if you prevent. So the doctors do not have the incentive to prevent, they have to cure. So that generation has been raised with that medical culture, so when we talk about prevention, it's about maintaining good health, not about preventing disease. So they do a lot of things to maintain themselves healthy [but] cervical screening, they couldn't understand it. So the uptake on the whole is very low. So is breast screening. But the sale of ginseng has maintained its value throughout the years. So it's about maintaining health. They think about health; they don't use the word disease. It's what you can do to make yourself healthy. But when they do have a disease and they don't feel well – they're looking for cures.* expert

This concept of prevention can cast light on the findings reported earlier (Watt & Chui, 1994; Williams, Watt & Chui, 1994) according to which

ante-natal classes failed to attract a significant number of would-be parents in the Chinese community. It also means that health education programmes need to take account of the specific Chinese concept of prevention.

Trust in Western technology and belief in Chinese medicine

Chinese people also turn to the primary health service in England when they believe that Western technology can enable them to find out what their *real* condition is. It is as though modern technology allows people to see how their body functions and the state which it is in, so that they are then empowered to make decisions about their health based on traditional Chinese principles. Blood pressure checks, urine samples, X-rays, electrocardiograms (ECGs) and other diagnostic procedures seem to be welcomed by Chinese patients.

> *In a sense I prefer the Western way. At least you can align the bones together by doing an X-ray and if you don't use an X-ray sometimes you don't know how far the bone in broken. You can manipulate by touch but you need to see it precisely first.*
>
> lay participant, female, 44 years old

> *My GP was very good and my GP always gives me something to take and keeps on telling me that I shouldn't be nervous. [....] He took my blood sample and urine sample, everything that he should check, he checked for me.*
>
> lay participant, female, 44 years old

This attitude is probably more prevalent among less educated older respondents who want to see specific activities carried out, but it is also widespread among the younger and the highly educated respondents in our sample. As we discuss below it is also directly related to the form which medical encounters take in Chinese cultures:

> *People expect things to be done to them.*
>
> expert

> *For the people I've come across who come to use the Sunday surgeries at the Centre, it's all about physical conditions, it's all about 'what can you do to get rid of it, doctor?', 'what treatment you're going to give me?', 'what tablets are you going to give me?' – nobody came and talked to me about yin and yang or treating my whole body. It's about 'this bit hurts, can you deal with that?' They love blood-pressure checks, you know, things you can do to them.*
>
> expert

It is crucial for health practitioners to be aware that health beliefs are neither always expressed in language nor disclosed in the doctor-patient encounter. What may appear as a perfectly standard request for diagnostic testing will often be interpreted by the patient, outside the clinic, in terms of traditional beliefs.

In any case, none of the respondents in our sample objected to Western treatment and technology in the case of severe and life-threatening conditions. Even the most intrusive forms of surgery and chemical therapy would be used if necessary, although such forms of intervention are alien to classical medicine.

> *I think all the acute illnesses in the modern world, Chinese medicine take too long. If you have appendicitis, it can't be treated by Chinese medicine. You'll kill the person. They require surgery. Sometimes you require a quick decision. Chinese medicine can't act upon that, not that fast.* lay participant, female, 44 years old

Use of traditional Chinese doctors

Chinese doctors are considered to be the best resource when the problem is muscular or bone related. In spite of the availability of free Western technology, of the high cost of consultations with Chinese doctors and of the considerable pain caused by Chinese medical intervention in bone and muscle injury, our study shows that Chinese people will rely on Chinese doctors for such ailments. They trust the knowledge and ability of Chinese medicine in this area and believe that it is the best treatment. In fact they cannot understand the failure of the biomedical model to recognise the evidence provided by more than 2000 years of successful Chinese therapy.

> *... like I had sprained ankle, it bugged me for a while and then he [the Chinese doctor] wrapped me in a very painful manner but it got well fast. If I had gone to a medical doctor he would just say wrap it up, don't go out, no don't play games for six months. But I think that helped me heal faster, I mean, I did not play games for a while but not as long.* focus group, young man

Interestingly, bone setters and acupuncturists are said *both* to work fast and to tackle the cause of the problem. This is surprising since fast treatment is usually associated with Western care. No doubt this conjunction of factors ensures the credibility and legitimacy of traditional Chinese doctors.

Supernatural causes

Although the correspondence between beliefs in causation and treatment is usually unclear, there is an exception when the cause of illness is thought to be of a supernatural order. If a condition is believed to be the result of a bad omen or of the malevolent action of ancestral spirits, then a fatalistic outlook is very likely to ensue: natural remedies can do nothing against supernatural causes. Such causes are most likely to be invoked in the case of mental illness – which would be interpreted as

possession by evil spirits – or in the case of life-threatening diseases such as cancer – which would be an expression of the wrath of ancestors. Superstitious beliefs and extreme fatalistic approaches are rare and seem to be found exclusively among the older, less educated Chinese originally from rural areas (the first settlers). The treatment would consist in offerings to appease the spirits. It may also entail going back to the country of origin to seek exorcism.

> *I suppose what I haven't said about is the belief about the ancestors and the impact which they have on the next generation. There is a belief that if, in your previous life you've done bad things, then you'll pay for it in this life. That would appear as you being in poverty or in poor health or coming up with cancer. So there's still ancestor worship. They burn paper money at the right festivals to pay respects to your dead ancestors and to try to do good things in this life so that you don't then go and reincarnate in anything worse. You will definitely find that amongst some of the older groups.*
>
> ***I: And you would locate this only amongst the older groups?***
>
> *Yes, you would be hard pushed to find this amongst any other groups. [....] And to take it to the extreme, there are still a very small number of people who will go back to Hong Kong and get exorcised if they believe they've got spirits inside them that are the cause for the weird behaviour when in fact this person's got schizophrenia! So exorcism, the belief in evil spirits will shape some of the interpretation of illness or feeling unwell.* expert

Not having contacted members of the older generation we have no direct evidence of this attitude in our sample. But four experts spontaneously mentioned it and two lay subjects reported on their parents' superstitious attitude.

6.3 Social psychological and social factors in the selection of health services

Differences in health beliefs are not the sole determinant in the choice of health services. Our data suggest that one of the most important factors concerns the social psychological dynamics surrounding notions of identity. Choosing to foster health through traditional methods is a powerful means of stating – to oneself and to the community – that one is still Chinese after all. It is also making a statement about the value of an entire civilisation by pointing to the antiquity and validity of its knowledge base. Conversely, for a Chinese person living in England, to privilege Western health care irrespective of the conditions suffered is a way of asserting that one is 'modern'. It is to fight against what is thought to be a stereotypical view of the Chinese people.

Previous experiences of health-care systems also matter: familiarity with a particular system usually means greater ease and trust. Past experiences also determine to a large extent the patients' expectations and therefore their degree of satisfaction with the service. Trust in the qualifications of the medical staff is another factor, especially since Chinese people here often lack the networks to find out about the most competent doctors. Word of mouth is crucial in the choice of a Chinese doctor but this means being part of a community. Thus, fear of 'quacks' or charlatans militates against the use of traditional doctors just as standard qualifications across the NHS instil confidence. We now discuss these factors.

The maintenance and defence of identity

Although one might expect there to exist a direct and linear relationship between, on the one hand, greater level of integration, younger age and higher socio-economic status and, on the other, a more modern identity; and although one might further assume that a 'modern' identity automatically leads to the use of NHS services only, we observed much more complex and subtle patterns among our subjects. At one level, of course, the relationships just described do reflect very real trends in the community. However, the belief in traditional Chinese concepts of balance and harmony between opposites (as well as in some of the therapies associated with them) does not simply disappear. We have listened to many Western-trained Chinese nurses, midwives and health visitors who, in spite of years of professional training in Western medicine, did not fundamentally review their basic Chinese understandings. The latter were suppressed for years but they are now allowed to surface again. The social climate has changed. People themselves have matured and are better able to assert what they believe in.

> *I know certain thing works. And in those days, it was very hard to talk to anybody about herbal medicine – nobody ... They just brush me off. Perhaps what happens now is people are more open-minded. But in those days, in my days, probably they would just laugh it off and say oh! what the hell are you talking about? [....] I might be giving you a conflict view of things but deep down I believe both work. It depends on how you apply it. Chinese medicine worked for thousands of years, yes? And without that probably there wouldn't be such a vast population in China. It must have worked somehow.*
>
> lay participant, female, 44 years old

Scientific medical knowledge itself is moving away from an exclusive focus on the individual to encompass notions such as 'lifestyle', 'environmental irritants' and 'passive smoking', for example. All this helps to lend support to a tradition which stubbornly refuses to die.

The type and quality of previous health-care experiences

For the Chinese who have arrived in England in their teenage years or afterwards, experiences of the health services in the country of origin largely shape their perception of the health services in the host community and of the competence of particular medical staff.

> *Everybody pays for medicine in Hong Kong, so the expectation is that as you pay for something, you get something done to you. If you come to a GP and the GP tells you to give up smoking, you'd claim: 'God, that was a bloody bad doctor. He didn't stab me!' So it's about previous experiences.*
>
> expert

> *The [GPs] are quite good in giving you advice; they always try to tell you that you have, there's nothing wrong, you didn't actually have to come in, you know. If you just leave it for another few days it will just go off by itself, etc. They're reluctant in prescribing medicine to you as well, you know. Maybe it's good practice and maybe it's bad, I'm not sure, but you know, they have a reason why not to do it. But it's frustrating because at home, if you go to see a doctor, you're expecting to get medicine. The doctors definitely will prescribe you this and that. This is for flu, you take how many times a day, you know, it's a general practice, but here in this country, they just do it different. If you go to see a doctor or a nurse, it's basically just to get a consultancy but not to get any medicine, so they don't do anything to your body. So there were a few occasions actually I insisted I wanted some medicine, you know. I said, I can't go on and then they said of course, so they just prescribed me some medicine.*
>
> ***I: And can you trust a doctor who doesn't prescribe anything ...?***
>
> *Well, I mean I'm sure somehow they are doctors. I hope they know what they are doing, although sometimes I feel they don't [....] I wouldn't say I wouldn't trust them but I just have to accept it ....*
>
> lay participant, male, 22 years old

> *It is always difficult to get the doctor to understand that I've got too much heat in me because they can't understand this phenomenon.*
>
> lay participant, male, 44 years old

Examples abound in our data of instances where lay subjects talked about the difficulties they experienced in communicating their preoccupations to the doctor. Actual or anticipated misunderstandings often suffice to deter Chinese people from consulting their GPs. Confidence in the competence of the GP may even decrease if the latter fails to take seriously the lay aetiology and diagnosis put forward by the patients. The Chinese firmly believe in their own understanding, and failure on the part of the health professionals to recognise the validity of

their assessments raises significant communication barriers which may not be easy to overcome.

Was the coil held up in the hands of the baby?

One of my staff had the ridiculous situation of working with a lady from China. She had a coil fitted in. That's for family planning – we all know that. She had a baby delivered while the coil was still in there! Non-communication with the practitioner caused that. Of course the GP who looked after her said, 'Well, you're expecting a baby' but he may not necessarily have known what sort of contraceptive method she was using. It's only afterwards that we found out that there was still a coil inside her. We Chinese can joke about it and say, 'Was it held up in the hands of the baby?' But that's the situation. expert

More generally, health professionals ought to be more sensitive to cultural differences which extend beyond health issues *per se* but shape the type of communication which takes place during the delivery of health-care. A young woman describes how she was shocked to have been 'diagnosed as being in need of a boyfriend' when she was only sixteen. Women in their twenties in one of the focus groups similarly felt ill at ease discussing sexual health issues since they considered the latter to be pertinent only to women with an active sexual life.

6.4 Structural factors involved in the choice of health services

There are a number of factors in the choice of health services that do not pertain directly to health beliefs or cultural differences *per se*. The Chinese community also selects health-care systems and services on the basis of factors such as: the gratuity of services, opening hours (which are a particularly important issue considering the long and anti-social hours during which those in the catering industry work), the location of health services, the possibility of obtaining an immediate consultation (as opposed to having to make an appointment) and the availability of trained interpreters, for example. All existing studies of the health needs of the Chinese community stress the above points (for example Home Affairs Committee, 1985; Li, 1992; Mares, 1982; Tso and Chung, 1996; Williams, Watt & Chui, 1994). They lie outside of our remit but they were singled out often enough both by lay and expert participants in this study to deserve mention here. Table 6.1 summarises the main implicit and explicit criteria which members of the Chinese community use in selecting a system of health-care and particular health services.

Table 6.1 Criteria used by lay Chinese people in the choice of health services and system of health care (traditional Chinese or Western biomedical)

Selection criteria	Traditional Chinese doctors/herbalists	Western biomedical primary health-care
Illnesses	• Mild pain • Minor • Traditional or folk aetiology • Maintenance of health, prevention of illness • Trust in classical Chinese diagnostic procedure • Muscular pain	• Acute pain • Severe • Scientific/biomedical aetiology • Cure of illness • Trust in technology-based diagnostic procedure
Therapeutic intervention	• Gentle • Root/cause of problem • 'Natural' treatment with no side effects: herbs, tonics, teas, manipulation, massage, acupuncture, bandages, etc. • Slow effect • First/last recourse	• Powerful • Symptoms • 'Chemical' medicine with side effects: antibiotics, antihistamines, anaesthetics, etc. • Surgery and operations • Fast effect • First/last recourse
Social psychological and social factors	• Defence and maintenance of Chinese identity • Trust only in some: fear of charlatans and quacks, recommendations through word of mouth • Familiar • Previous experiences • Mutual understanding based on common representations of health and illness	• Establishment and defence of a modern, cosmopolitan identity • Generalised trust established through uniform quality standards • Familiar/unfamiliar • Previous experience • Fear of misunderstanding based on different representations of health and illness • Chinese medicine does not work in the West
Structural factors	• Available in Chinatowns only • Common language • Fee paying/expensive • Immediate consultation • Opening hours • Privacy	• Available everywhere • Linguistic barrier/use of interpreters (children) • Free • Consultation through appointment • Opening hours

7 Conclusions and recommendations

The aims of the present study were manifold. Our explicit and immediate objective had three inter-related dimensions: firstly to explore the structure and content of Chinese social representations of health and illness and to investigate how these shape health practices; secondly to examine how these representations impact on the acquisition and use of new biomedical knowledge; and thirdly to identify the main concerns and difficulties experienced by Chinese people in England when they use various health resources. More generally, we wanted to offset the scarcity of knowledge about the Chinese community and to offer some guidelines, based on in-depth qualitative analyses in order to develop more culturally sensitive policies. The set of representations and practices brought to light in this study illustrates how the Chinese community in Britain makes sense of and relates to issues of health and illness in everyday life. The findings add further support to recent calls from the community to have their needs researched. They suggest both general principles and specific activities through which health-care services and educational campaigns for the Chinese community can be made more effective.

7.1 Main findings

In this concluding section we highlight the findings which relate to our main objectives. We also single out those issues which are of direct import for both researchers and practitioners whose work brings them into close contact with the Chinese community and, more broadly, for anyone interested in the social psychological dimensions of health-related knowledge and practices. Finally, drawing upon this rich research experience, we make a number of recommendations of a methodological nature to facilitate the work of future researchers.

Diversity and unity in the Chinese community

The study highlights both the heterogeneity and the unity of the Chinese community in England. The community comprises three generations, each of them bearers of distinct life experiences. The **older generation** includes the first settlers as well as the parents of the middle generation who later joined their children in England. The vast majority come from the New Territories in Hong Kong. They speak little or no English and live within the confines of the Chinese community. Low integration

and isolation are typical of this group. They hold on to an unquestioned Chinese identity and to traditional understandings of health and illness. The **middle generation** is the most diverse. It encompasses the children of the early settlers as well as newcomers from many Chinese communities. Some members of the second generation are highly integrated in British life (they are fluent in English and are often highly educated professionals), whilst others remain cut-off (they speak little or no English, are often poorly educated and are involved in the catering trade). The former group combine Western and Chinese health beliefs and make full use of NHS facilities. The latter hold on to traditional health beliefs and practices and they are more likely to turn to traditional healers and remedies. Finally, the **young generation** encompasses growing numbers of British-born Chinese (children and young adults) as well as foreign students. All are at least functionally integrated in British society. They speak English and have generally attended English schools. However, for most, reconciling the divergent expectations of Chinese and Western cultures proves a challenge. Their health beliefs and practices reflect this ambivalence and struggle: although they make full use of NHS services, they also combine the latter with traditional health practices.

Researchers, health education agencies, community workers and medical staff ought to recognise this diversity and differentiate between the various segments of the community. This entails becoming aware of the differences in the languages people understand, speak, read and write. For instance, a Chinese person may well speak a particular dialect at home (such as Hakka or Hokkien), but read only Mandarin or Cantonese, and write no Chinese language at all. Sometimes, too, English is the only common language among Chinese people of different national origins. Bearing this in mind, all the material produced for the Chinese community must be bilingual, combining English together with the most suitable Chinese form for the specific target population. This is both an essential mark of respect and a strategic communicational tool. Discrepancies in lifestyles, educational achievements and socio-economic positions must also be acknowledged. Standard, undifferentiated health-care provision is not the royal road to equality of access to health and welfare services. Increased sensitivity to diversity is more likely to result in the efficient use of health resources as well as better community relations. Therefore there needs to be:

- differentiation between sub-groups and profiling of target community;
- sensitivity to linguistic, socio-economic and lifestyle diversity;
- production of bilingual material with appropriate written Chinese form.

Chinese values

The unity found in the Chinese community stems to a large extent from shared values and norms. Indeed, our study corroborates other research on Chinese communities around the world, showing that a number of core values are still very much alive and embody the essence of Chinese culture. These are: first and foremost, the respect and belief in the family as the most important unit of social and individual life; deference for and compliance with hierarchy in terms of age, gender, generation and social role; and the importance of self-discipline, hard work and the maintenance of high moral standards. These values structure the Chinese division of labour both inside and outside the home, placing authority and formal knowledge firmly in the hands of elderly people, men and the educated, and leaving women inside the house responsible for everyday care and the perpetuation of lay knowledge.

This traditional social structure has immediate implications. It suggests that actual medical encounters, as well as health education campaigns, are more likely to be successful if they respect traditional roles, at least among the older and middle generations. It also suggests that health information about specific issues, such as nutrition, smoking, the practice of safer sexual relations and so on, will be appropriated very differently by the various segments of the Chinese population. It probably also accounts for the unreasonable demands put on young children to act as interpreters for their parents and to mediate between the latter and the host society.

This collectivist social structure is also evidenced in the widely held view that the community as a whole ought to be self-reliant and to cater for its members. Thus the relative silence of the community should not be interpreted as a straightforward reflection of some unproblematic state of affairs, but rather as the expression of a people proud of its culture and grateful to the host society. Since reaching out for help is often regarded as shameful, it becomes incumbent on British health authorities to initiate contact with the Chinese community and seek out its views. This could be enacted, for instance, through the development of more extensive networks of visiting nurses, or via the provision of self-help facilities for the community. There needs to be:

- awareness and respect of Chinese cultural heritage and values;
- respect of traditional social roles in health promotion material and medical encounters;
- a proactive approach to seek out the views of the community;
- provision of adequately trained interpreters;
- development and use of community resources.

The structure of Chinese health beliefs

Traditional Chinese medicine holds that good living habits are important in preventing disease and maintaining health because they help the organism to keep an internal balance and to adjust to changes in the natural environment. Such notions form the substantive core of the representations found in our study. The binary oppositions between yin/yang, hot/cold and wet/dry are at the centre of a conceptual system used to explain the nature of health and the causes of illness, as well as to identify adequate treatment. Health is conceived as the harmonious balance of these contradictory forces or conditions, while illness is an expression of disruption in this equilibrium. Balance and harmony must prevail at the level of the individual (body and soul), and between the individual, the social, the natural and supernatural domains. Routine and discipline are essential to good living. Thus Chinese health beliefs are deeply entrenched in a world view.

Perhaps we can learn from these all-encompassing representations of health and illness which intrinsically relate health with lifestyles, social networks and environmental conditions. Less individualistic notions of health and illness are only now becoming accepted in the West. The Chinese have much to contribute to current debates about health-care: openness to their ancestral knowledge and practices may result in better quality service provision and sounder health for all. However, the Chinese representations of health and illness do not foster the take-up of preventive health measures. Considerable educational work will have to be undertaken for the Chinese to integrate Western notions of prevention. The task will be greater still when preventive practices, such as cervical smear tests, are also shrouded in cultural taboos. There needs to be:

- openness to the more holistic Chinese approach to health;
- appreciation that traditional Chinese health knowledge is a resource;
- recognition of lay understandings and diagnoses by medical staff;
- use of notions of balance and harmony in framing health messages;
- education about Western medical preventive measures.

Health and cultural identity

It is clear from our study that, for the Chinese, representations of health and illness cannot be separated from a struggle to maintain a Chinese identity and cultural inheritance. Everyday knowledge about health and illness is learned, transmitted and enacted through the most fundamental dimensions of culture: **language**, **food** and **family**. The ancient knowledge Chinese people possess about keeping well is perpetuated in parallel with the perpetuation of Chinese culture itself. This explains why this knowledge will not disappear: to relinquish traditional health beliefs is virtually impossible without fundamentally threatening one's identity as a Chinese person.

Again, this intrinsic connection between health, the entire Chinese way of life, and the personal and social identity of every Chinese person, calls for increased sensitivity and respect. Disregard for the very long tradition of knowledge that Chinese people have about health and illness is experienced by them as disrespect for themselves and for a rich cultural heritage. It should come as no surprise that even young, educated, acculturated, English-speaking Chinese people should seek to keep alive their traditional health knowledge: it is an important resource to maintain, state or reclaim a Chinese identity when other sources of identification are no longer relevant or available. There therefore needs to be:

- recognition of the meaning of health beliefs in terms of identity;
- recognition of health beliefs and practices as expressions of cultural wisdom and history;
- recognition of the importance of Chinese people in the health service and use of Chinese models in health education posters and videos.

The coexistence of Western and Chinese notions of health and illness

Our study suggests that Chinese people can integrate different systems of knowledge and incorporate new information coming from different traditions. This appears to be a function of the Chinese mode of thinking, which itself can absorb and transform new information without losing its essential features. The idea of complementarity between opposites allows for the simultaneous use of different resources; it empowers the Chinese to cope with an alien environment.

The ability to integrate knowledge varies according to age and degrees of acculturation in mainstream British society but it is present throughout our sample. Chinese people will take on new information and either anchor it into their system of thinking about health and illness or allow it to exist side by side with their prior knowledge. This is made possible because, according to the Chinese way of thinking, Chinese and Western health beliefs belong to different realms and therefore do not compete. One believes and trusts in Chinese medicine. Western medical knowledge, by contrast, is grounded in science: it is open to proof and challenge and, by its very logic, challenges beliefs. Rather than turning these systems into mutually exclusive domains, the Chinese reconcile them in order to suit their different purposes and needs. There needs to be:

- awareness of potentially negative forms of anchoring Western medical knowledge;
- use of potentially fruitful forms of anchoring.

The combination of health practices

The feature of Chinese thought discussed above accounts for the finding that Chinese people combine the health resources available to them irrespective of whether they are rooted in Chinese or Western medical traditions. This result corroborates studies conducted throughout the Chinese Diaspora which describe the so-called 'Chinese pragmatism'. Yet we have found that the combination of practices is not random; it is guided by deeply-held health beliefs. Chinese medicine and folk observations are used in everyday life in order to maintain good health and to prevent illness; they are also used to treat minor conditions or ailments for which traditional or folk aetiology is widely endorsed. Moreover, the Chinese believe that their traditional knowledge is better equipped to handle the roots of disease which, in turn, explains why it works slowly. Conversely, the Chinese will use the Western treatment regimen in order to alleviate acute pain, to reduce symptomatology or to cure severe and life-threatening illnesses. In addition, they will draw upon Western medicine when the aetiology of disease is unclear and not established by classical Chinese medicine. Finally, both systems will be used to compensate for the limitations or failures of either; in other words, they are both used as 'last resort' when the other system does not work. This is a general pattern in our sample. There needs to be:

- explicit inquiry from health professionals into simultaneous health practices.

The transmission of knowledge

One of the most important findings of our study concerns the mode in which knowledge is transmitted in the Chinese community. Although language is deeply involved in the transmission of knowledge by virtue of the conceptual categories it carries, it is not actively used in order *to explain* practices and beliefs. The Chinese objectify: they put what they know and believe into action and language, into community rituals of all kinds, which appear as repositories of the ancestral knowledge and wisdom of the Chinese people. They learn by observing what others in the community do mainly inside the home. Mothers and grandmothers are the main agents through which social knowledge is transmitted: prescriptions and prohibitions concerning diet, behaviour and social relations are handed down and learned through their practices. This has serious implications for the understanding of how the Chinese know: their knowledge system is alive in what they do rather than what they say. Anyone researching the Chinese community should be aware that practices are the best means to understand a conceptual system whose origins and principles are often lost to those who, nevertheless, know how to put it to work. This will be

discussed more extensively below, as we turn to methodological issues. There needs to be:

- selection of the most effective agents (women/men, local/national) for health education;
- focus on practices and actual behaviour rather than abstract explanations.

Use of primary health care services

Although Chinese people do make extensive use of Western health resources, a number of factors still impede the full and most appropriate use of NHS resources by them. Lack of information about the functioning of the NHS and the range of services available is still widespread. This is particularly true for services which, until recently, had no equivalent in Chinese cultures, such as social work, and for services which are associated with cultural taboos, such as counselling and psychotherapy. There is an urgent need to produce basic material which describes and explains the British health-care system in a clear and simple way. Inconvenient opening hours for those who are involved in the catering industry, together with linguistic barriers and a shortage of qualified interpreters, also account for the reported under-utilisation of NHS services.

Notwithstanding the overriding importance of such barriers we need to stress the role of cultural differences in determining the evaluation which Chinese people make of Western health services. Our data suggest that, while the level of satisfaction with Western health services is usually high, lack of sensitivity to cultural realities is relatively common and affects the overall appraisal of the services. For instance, foreign-born Chinese patients are used to a different operational system in the delivery of health-care. Their previous experiences shape what are often unmet expectations: consultations without prior arrangements, the systematic prescription of medicines, thorough bodily examinations by doctors, submission to a battery of tests and time dedicated to the patient, are all part and parcel of patient-doctor encounters in Chinese countries. Not surprisingly Chinese people expect similar practices to take place in England. Failure to behave in expected ways leads to frustration and to negative evaluations of health-care delivery in the UK. Moreover, the participants report important differences both in moral codes and norms and in ways of expressing or describing physical pain and psychological distress. These are often misunderstood, thereby impeding full communication. There needs to be:

- production of educational material describing and explaining NHS services;
- anchoring of services with no formal equivalent in Chinese cultures into similar, already-existing services;

- education of health practitioners about different expectations in medical encounters;
- provision of qualified interpreters;
- opening of clinics at more suitable times where there is a large concentration of Chinese people.

7.2 Methodological recommendations

In addition to the substantive issues summarised above, general methodological guidelines emerge from our study. Some recommendations are very broad and applicable to any research on the Chinese community; others focus more specifically on health issues. Our intention is not to engage in a detailed methodological discussion but only to communicate the fruits of this research experience to others interested in pursuing further some of the issues discussed in this study.

Let us reiterate, first, that there are both advantages and disadvantages in using researchers who do not share with their subjects a common ethnicity, age, gender, religion, socio-economic background or sexual orientation, for example. Complete matching is no more a guarantee of understanding than complete difference is one of objectivity. Empathy and critical stance can coexist. The respective strengths of both similarity and difference ought to be balanced against one another with a clear awareness of their consequences in terms of the research questions themselves. In this case, non-Chinese researchers worked together with a Chinese research-assistant to maximise the validity of field efforts and to minimise the reactivity inherent in each choice of researchers.

It is also important to emphasize the merits of triangulating, or combining, various methods of data collection and analysis. Again, the research design should reflect the theoretical considerations informing the research process, the practical circumstances structuring its execution, the characteristics of the empirical problem and the kinds of analyses which each method can potentially yield. Here, the research design allowed us to tap into both lay and expert knowledge and to do so at the level of the individual as well as that of the group. We were interested in the structure, content and functions of social representations of health and illness; these are to a large extent taken for granted, so a combination of both lay and more reflexive expert knowledge was necessary.

We used open-ended questions which allowed the subjects plenty of scope to explore their own thoughts and feelings, and to expand on the shortlist of themes singled out beforehand in the interview and focus group schedules; but such a research strategy, alone, cannot provide a sufficient basis for policy makers. It ought to inform, and to help make sense of, large-scale quantitative surveys. Conversely, the limitations of

closed questions and coarse survey methods were also clearly alluded to. One may recall the rationale offered by women for giving up the practice of breast-feeding, or the case of this older woman who claimed, on the one hand, that because of irregular eating times, her 'stomachs were grinding', thereby causing ulcers and, on the other hand, that she did not believe in Chinese medicine at all.

In terms of gaining entry into the community it is best to use existing organisations, associations, community centres, churches, student unions and the like, and to build on initial contacts through snowballing and 'foot-in-the-door' strategies. Again, the diversity which is characteristic of the Chinese community ought to be acknowledged and to inform research practices. In addition, in reaching out to the Chinese population, researchers ought to be mindful of the geographical dispersal of the community: because of its continuing involvement in the catering industry, and in order to avoid competition, the community is particularly spread out across the country. Generally, it is highly desirable to prepare bilingual material, with the most appropriate written Chinese form being selected for the specific segment of the Chinese population targeted.

With respect to health issues in particular, the following methodological recommendations are put forward. First, the terminology used in questionnaires and surveys should always be piloted beforehand because Chinese people may refer to the same medical condition in very different ways. For instance, they may refer to 'arthritis' either by using the English word, or by using the modern Chinese literal translation ('inflammation of the joints'), or again by using the classical Chinese terminology ('wind-damp') which already proposes an aetiology of the condition. Second, the emphasis should always be placed on symptoms rather than on more complex diagnoses. There are already many differences in the ways Chinese people describe their physical condition compared to British people. Greater distortions and sources of misunderstandings can be avoided by reducing the scope for interpretation. Similarly, surveys should focus on practices and behaviours rather than on concepts, knowledge or beliefs which, in any case, can be more adequately explored through open-ended research methods such as interviews and focus groups. Finally, we have learned that it is preferable to avoid references to ill health and to emphasize well being instead because older and less-educated Chinese people tend to be superstitious and to believe that talking about poor health could suffice to bring about disease.

7.3 A final word ...

Researching the Chinese community has been an enriching and rewarding experience. Despite the difficulties associated with accessing lay members of the community, and despite the fact that we are non-Chinese researchers, the people we met were prepared to engage with us and to talk about their experiences in an open and genuine manner. They welcomed us, talked to us and even cooked for us, which in itself is indicative of their desire to state what they think and who they are. We invited them to discuss issues largely taken for granted and often embedded in painful life experiences. They took our invitation up and worked through these issues and experiences with us.

The stability and maintenance of the Chinese belief system owes a great deal to its apparent simplicity and to its ability to make sense efficiently and usefully of complex and diverse experiences. As Anderson writes '... it is simple and it encodes or allows for encoding a great deal of useful information. It is easily taught and easily learned. It does serve as a useful vehicle for storing the collective knowledge of a large group of people' (Anderson, 1987: 334). The Chinese health belief system has survived and also continues to thrive because it is linked to the identity and collective memory of the Chinese people. For all these reasons, health professionals and health education agencies must take seriously the Chinese way of thinking about health and illness.

Appendix 1: Country of origin, age distribution and geographical distribution of the Chinese population in Great Britain (1991)

The data are derived from the 1991 Census (Owen 1994). In total, 156,938 respondents (0.3% of the British population) consider themselves to be Chinese.

Table 1 Country of origin of Chinese, Great-Britain (1991)

Country of origin	Number	Percentage
United Kingdom	44,635	28.44
Hong Kong	53,473	34.07
People's Republic of China	20,141	12.83
Malaysia	20,001	12.75
Vietnam	9,448	6.02
Other parts of the world	9,240	5.89

Table 2 Age distribution of the 'Chinese' ethnic group in Great-Britain (1991)

Age group (%)	Chinese male	Chinese female
Population (000s)	77.7	79.3
Aged 0–4	7.3	6.8
Aged 5–15	17.0	15.5
Aged 16–24	18.7	17.0
Aged 25–44	39.2	43.1
Aged 45–64	14.9	11.4
Of pensionable age	2.9	6.0
Median age in years	27.9	29.6

Table 3 Geographical distribution of the 'Chinese' ethnic group in Great-Britain (1991)

Standard region *(Metropolitan county)*	Chinese people (000s)	Chinese people (%)
South East	83.6	0.5
Greater London	*56.6*	*0.8*
South West	6.7	0.1
West Midlands	9.6	0.2
West Midlands MC	*6.1*	*0.2*
East Midlands	7.6	0.2
Yorks & Humberside	8.2	0.2
North West	17.4	0.3
Greater Manchester	*8.3*	*0.3*
Merseyside	*5.6*	*0.4*
North	5.0	0.2

Only the areas where the number of Chinese people is equal to or greater than 5000 have been included in this table.

Appendix 2: Characteristics of participants

Table 1 Participants in individual interviews

Subject	Gender	Age group	Occupation	Origin
01	male	20–27	student	Hong Kong
02	male	20–27	student	UK
03	male	20–27	professional	Malaysia
04	female	20–27	student	Malaysia
05	male	20–27	student/catering	Hong Kong
06	female	20–27	profess/catering	UK
07	male	37–44	catering	China
08	male	37–44	professional	Singapore
09	female	37–44	catering	China
10	female	37–44	catering	China
11	female	37–44	catering	China
12	female	37–44	professional	Malaysia

Tables 2 Participants in focus group discussions

2.1 Men (20–27 years old)

Subject	Country of origin	Length of stay in UK	Occupation
KW	Malaysia	4 years	student
KL	Malaysia	3 years	student
W	Hong Kong	1 year	student
CS	UK	21 years	student
R	Indonesia	3 years	student

2.2 Women (20–27 years old)

Subject	Country of origin	Length of stay in UK	Occupation
W	Malaysia	4 years	student
P	Singapore	2 years	student
WL	Hong Kong	10 years	student
SU	Hong Kong	1 year	student
SA	China	1 year	student
CA	Singapore	3 years	student

2.3 Men (37–44 years old)

Subject	Country of origin	Length of stay in UK	Occupation
S1	Vietnam	16 years	catering
S2	Vietnam	17 years	catering
S3	Vietnam	15 years	catering
S4	Vietnam	17 years	catering
S5	Hong Kong	22 years	catering
S6	Vietnam	17 years	catering
S7	Vietnam	17 years	manual worker

2.4 Women (37–44 years old)

Subject	Country of origin	Length of stay in UK	Occupation
JE	Malaysia	27 years	NHS nurse/secretary
J	Hong Kong	29 years	housewife
SK	Brunai	7 years	biochemist/housewife
YW	Hong Kong	13 years	social worker
JO	UK	37 years	housewife
IO	Hong Kong	4 years	student/housewife

Appendix 3: Interview schedule: expert informants

Section I Characteristics of the Chinese community in England

I. Homogeneity and heterogeneity of the community.

Prompts: immigration patterns, areas of settlement
socio-economic and socio-demographic differences
linguistic abilities/difficulties.

II. Cohesion and fragmentation. Dynamics of identity.

III. Integration in, and exclusion from, mainstream society.

Section II Theories of health and illness

I. Differences and similarities between traditional Chinese and Western biomedical systems.

Prompts: holistic/localistic
focus on person/focus on disease
focus on prevention/focus on treatment.

II. Chinese lay theories of health and illness. Notions of balance and harmony.

III. Relationships between clinical conditions and therapeutic interventions.

IV. Health and lifestyle.

Prompts: health as way of life, cultural values
role of food in prevention and treatment
exercise, smoking, sexual taboos.

Section III Provision and adequacy of health services

I. Chinese patterns in seeking medical help (voicing of demands, self-restraint, trust in biomedical system, combination or segregation of health services, self-medication, etc.).

II. Access to health care (facilitators and barriers).

III. Availability and adequacy of service provisions. Main health-related concerns.

Appendix 4: Interview schedule: lay Chinese people

Section I Personal life

I. Personal introduction

Prompts: length of stay in England
country of origins and reasons for migration
personal circumstances: family situation/relatives, work, linguistic abilities.

Section II Being Chinese in England

I. Feelings of belonging and exclusion.

II. Differences between way of life 'back home' and in England (if relevant).

III. Advantages and disadvantages of mixed identities. Negotiating different cultural demands in the home and outside.

IV. Ease or unease in communicating with English and Chinese people. Linguistic and cultural facilitators and barriers.

Section III Health beliefs and health-related practices

I. In general, would you say that you enjoy good health?

II. What do you do to keep healthy or to avoid being ill in everyday life?

Prompts: food as prevention and treatment (tonics, self-medication)
smoking, exercise, medical check-ups
balanced way of life, avoidance of excesses, weather conditions.

III. What would you say are the main differences between Chinese and Western medicine?

IV. Overall, do you *prefer* traditional Chinese medicine or Western medicine? Why?

V. Overall, do you *trust* traditional Chinese medicine or Western medicine? Why?

VI. In general, would you say that people are healthier now than in your parents' time? Why?/ Why not?

VII. Can one do anything at all to prevent illness?

Section IV Access to, and experience of, health services

I. Have you ever consulted/do you usually consult traditional Chinese doctors? For which conditions?

II. Have you ever consulted/do you usually consult Chinese herbalists? For which conditions?

III. Have you ever consulted/do you normally consult Western-trained GPs? For which conditions? Would you tell your GP that you also see a Chinese doctor/herbalist or use medicinal foods and tonics at home? (if relevant).

IV. Do you feel that adequate health services are available to you?

V. Are GPs, nurses, and other health professionals sensitive to your needs as a Chinese person?

VI. Where/who do you obtain health-related information from?

Appendix 5: Focus group schedule: lay Chinese people

Section I The dynamics of mixed identity

I. What is it like to be a Chinese person living in Britain?

Prompts: do you feel more Chinese?/more British?
does your cultural identity depend on the circumstances?
is England home for you?.

II. You belong to a *particular generation* of Chinese people. Could you tell us about the differences and the similarities between you and your parents/children?

III. What do you value in your parents/children?

IV. What do you reject from (disagree with) your parents/children?

V. What did/do you learn from your parents/children?

Section II Health at home

I. Did your parents teach you about how to be healthy, how to lead a healthy life? What exactly?

Prompts: do/did you eat particular foods to strengthen you?
do/did you eat or drink certain ingredients or herbs to avoid being ill?

II. Among the things which you either value or reject from the way you were brought up, is there anything that concerns health?

Section III Attitudes towards traditional Chinese medicine

I. What do you think about traditional Chinese medicine?

II. Are there conditions for which Chinese medicine is better than Western medicine?

III. Have you ever consulted a herbalist or an acupuncturist, for instance? Why? Why not?

Section IV Access to, and experience of, health services

I. We would like to hear your views about/experiences of the health services. Do you think that they are sensitive to the needs of Chinese people?

Appendix 6: List of Chinese organisations in the UK

Belfast Chinese Welfare Centre
Eblana Street 17
Belfast 7
(01232) 238 220

Birmingham Chinese Community Centre
Unit B 206
Arcadian Centre
Pershore Street
Birmingham B5 4TD
(0121) 622 3003

Birmingham Chinese Youth Project
Unit B205
Arcadian Centre
Pershore Street
Birmingham B5 4TD
(0121) 622 3003

Camden Chinese Community Centre
173 Arlington Road
London NW1 7EY
(0171) 267 3019

Chinese Arts Centre
39–43 Edge Street
Manchester M4 1HW
(0161) 832 7271

Chinese Association of Tower Hamlets
Sailor's Palace
680 Commercial Road
London E14 7HA
(0171) 515 5598

Chinese Health Information Centre
6–8 Houldworths Street
Manchester M1 13J
(0161) 228 0138

Chinese Information Advice Centre
68 Shaftsbury Avenue
London W1V 7DF
(0171) 836 8291

Greenwich Chinese Association
c/o West Greenwich House
141 Greenwich High Road
London SE10 8JA
(0181) 858 2410

Hackney Chinese Community Services
28–32 Ellingford Road
Hackney
London E8 3PA
(0181) 986 6171

Haringey Chinese Community Centre
211 Langham Road
London N15 3LH
(0181) 881 8649

Hounslow Chinese Community Centre
Hounslow United Reform
Church Hall
114 Hanworth Road
Hounslow
Middlesex TW3 1UF
(0181) 577 2034

Islington Chinese Association
33 Giesback Road
Archway
London N19 3DA
(0171) 263 5986

Lambeth Chinese Community Centre
69 Stockwell Road
London SW9 9YP
(0171) 733 4377

Liverpool Chinese Community Advisory Service
Henry Street
Liverpool L1 5BU
(0151) 708 5197

London Chinese Health Resource Centre
Queens House, no 1
Leicester Place
Leicester Square
London WC2H 7PB
(0171) 287 0904

North East Chinese Association
24–25 Stowell Road
Newcastle Uptown NE1 4YB
(0191) 261 8583

Other useful addresses and organisations

Chinese Embassy
49–51 Portland Place
London W1N 4JL
(0171) 636 8845

Hong Kong Government Office
6 Grafton Street
London W1X 3LB
(0171) 499 9821

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