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# GPs' perceptions of the service needs of South Asian people with chronic pain

## A qualitative enquiry

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### Abstract

This qualitative study describes GPs' experiences of and needs for management of people from a South Asian community who have chronic pain. Semi-structured interviews were conducted with 18 GPs from practices in two PCTs in Leicester. The data was analysed using grounded theory. The results indicate that managing patients from a South Asian community with chronic pain can be challenging due to differing pain expression and presentation. Emerging themes refer to shortages of services for these patients including the need for CBT, counselling, community support and GP education and training. Potential implications of the results for service provision are discussed.

### Keywords

- *chronic pain*
- *culture*
- *ethnicity*
- *general practice*
- *qualitative research*

## Introduction

In a society where ethnic diversity is rapidly increasing, clinicians are under pressure to offer culturally appropriate healthcare. To do this, practitioners need to understand how culture and ethnicity influence health and illness related behaviours. Cultural factors influence beliefs, behaviours, perceptions and emotions, all of which affect health and healthcare (Helman, 2007). Culture influences illness behaviour in a number of ways including, the perception of 'normal' and 'abnormal' illness behaviour, the causes of illness, the need to engage in health seeking and preferences regarding personal decision-making and control in healthcare settings. In order for general practitioners (GPs) to maintain a close relationship with their patients and to ensure effective treatment, cultural mismatch in the doctor's and patient's understanding of the condition presented needs to be avoided (May, Dowrick, & Richardson, 1996).

Chronic pain is common, affecting approximately one in five adults in Europe, resulting in substantial healthcare costs (MunidiPharma International Ltd, 2003). Despite this, only a relatively small proportion of patients are managed in specialist pain clinics; the majority are managed by their GP in primary care (Elliot, Smith, Penny, Smith & Chambers, 1999; Smith, Elliott, & Hannaford, 2004). Although research has shown that South Asian people attend General Practices more frequently than White people (Atri, Falshaw, Livingstone & Robson, 1996; Njobvu, Hunt, Pope & MacFarlane, 1999) the uptake of outpatient services among South Asians remains significantly lower (Cooper-Patrick et al., 1999; Morris, Sutton & Gravelle, 2005).

Cultural differences in behavioural expression of pain have been reported in the literature (Allison et al., 2002; Edwards, Fillingim & Keefe, 2001; McCracken, Matthews, Tang & Cuba, 2001; Riley et al., 2002). There is evidence that people from ethnic minority groups may receive less medication or treatment for pain than the local population of the country (Green et al., 2003; Laditka, Laditka, & Mastanduno, 2003). Some of this treatment disparity has been attributed to communication difficulties between healthcare practitioner and patient. Other explanations offered suggest medical staff may believe that people from some ethnic groups exhibit exaggerated pain behaviour; that is, the pain behaviour is disproportionate to the actual pain experienced. Second or third generation immigrants often

have better health and healthcare. This is partly attributed to acculturation, which is defined as 'the extent to which an individual, who migrates from the country of birth, adopts the values, beliefs, cultures and lifestyles of their host country' (Watson, Latif, & Rowbotham, 2005, p. 198). In addition, improved socio-economic status (Edén et al., 1994; Nazroo, 2003) and communication with the GP and a better understanding of the healthcare system may have a role to play.

South Asians form the largest minority group in the UK (Census, 2001). The city of Leicester has a growing South Asian population and at the last census 25.7 per cent of residents in the city described themselves as Asian or Asian British Indian (Census, 2001). A previous paper (Patel, Peacock, McKinley, Clark-Carter, & Watson, 2008) examined how GPs manage chronic pain in this population. If the treatment of ethnic groups is to be more equitable, GPs need to identify their training needs or identify support services that might improve the care offered to this patient group. This article is therefore concerned with GPs' perceptions of the services and additional training that might be required to meet the needs of this population.

## Methods

The study was granted ethical approval by the Leicestershire, Rutland and Northamptonshire LREC.

## Participants

General practitioners were recruited from two strategically selected primary care trusts (PCTs) in Leicester. The first of these PCTs had practices in areas densely populated by South Asian patients (defined as anyone of Indian subcontinent origin, India, Pakistan, Bangladesh or Sri Lanka). The second PCT had practices in areas densely populated by White patients but GPs still had experience of South Asian patients consulting with chronic pain. Using purposive sampling, we recruited White British and South Asians, those who spoke South Asian languages and those who did not and male and female GPs. We also recruited GPs from large group practices and single-handed practices. This enabled us to explore a broad range of GP experiences.

Inclusion criteria were that participants who were vocationally trained GPs, with at least 12 months

experience of providing treatment for pain to English speaking and non-English speaking South Asian patients in Leicester. GPs were excluded if they had been practising for less than 12 months in Leicester or felt they had insufficient experience of South Asian patients to draw upon.

### *Data collection and analysis*

Letters of invitation were sent to GPs that were followed up, one week later, with a telephone call from the researcher to discuss participation. One-to-one semi-structured interviews were conducted with GPs either over the telephone or at their practice. The interviews lasted between 30 and 60 minutes and, with consent, were tape-recorded for later transcription. All interviews were conducted by (SP) a South Asian research health psychologist with experience of qualitative research in the field of chronic pain.

An outline interview schedule was developed. All interviews started off broadly asking GPs about their experience of treating South Asian patients with chronic pain. From this question the interviewer was able to explore aspects GPs found challenging, examples of cases where they have found managing patients from this community difficult and following on from that, GPs thoughts on existing services for this population and ideas for any future service requirements.

The recorded interviews were transcribed verbatim. The data were microanalysed using the constant comparative method of grounded theory (Strauss & Corbin, 1998), a process involving repeatedly comparing, contrasting and reviewing information across the interviews. By means of axial coding, codes were refined to categories and then to core categories. A 'field diary' was kept by the researcher to note additional information on theoretical explanations and thoughts on themes and operational issues. To help manage the data systematically NVivo (QSR International Pty Ltd, 2002), a qualitative data software package, was used to help code each transcript, a process whereby a theme or themes were assigned to segments of text.

Interviews were coded by the interviewer. The themes and possible meaning and interactions were discussed with the multidisciplinary research team. A research team from different professional and ethnic backgrounds has the advantage of providing insight into the data, challenging assumptions arising from the respective experiences and disciplinary affiliations of individuals.

## **Results**

A total of 19 GPs agreed to participate and gave informed consent. One GP was excluded as she had not practised as a GP within Leicester for at least 12 months. Of the 18 included GPs, 11 were South Asian and 7 White British, 11 males and 7 females. The mean age of GPs was 46 years and on average GPs had been qualified for 13 years. Three GPs practiced in single handed practices while the remaining 15 in partnered and larger practices.

The main themes emerging from the GP interviews presented in this article focus around perceived service and educational requirements. Additional emerging themes including the consultation process, clinical management of pain, patient expectations and acculturation are presented elsewhere (Patel et al., 2008). From the interviews we found GPs felt the additional services required for South Asian patients with chronic pain included counselling, cognitive behaviour therapy (CBT), and local community support. Some GPs also identified gaps in their own education and felt specific training may be useful. The challenges of secondary care pain management and a mismatch between GPs' understanding of services and the actual availability was also highlighted.

### *Addressing patients psychosocial needs via counselling and CBT*

A number of GPs felt the underlying issues for patients with chronic pain were often psychosocial and as a result felt there was a need for more culturally specific psychological services. Some felt access to language specific counselling services may be beneficial in helping address some of these barriers. Despite this suggestion GPs were aware that there are not enough trained counsellors with South Asian language skills and a thorough cultural understanding; therefore this would be difficult to achieve. As a consequence, GPs felt they have little option but to manage patients who may benefit from these services themselves:

I think there isn't enough counsellors, for example, with, erm, south Asian language skills or even an understanding of the culture. I think a lot of these patients would be suitable for counselling, erm, but, you know, a lot can't access that support, because it isn't available or there's a big shortage of training counsellors or available counsellors. So, I think there is an issue there. (South Asian male GP3)

I think number one is that we need to get an Indian counsellor, we do not have enough South Asian language speaking counsellors, we don't have any available in my PCT. (South Asian female GP19)

The GPs acknowledged that there are counselling services available in English but felt using interpreters for counselling would be inappropriate. They perceived counselling to be a complex interaction between the counsellor and the patient therefore requiring the counsellor to communicate fluently in the patient's own language:

The trouble is, er, the counsellors we've got here are all English speaking, so I don't think they'd be able to first of all speak to them, counselling, you need quite a complex level of language skills really, you can't just speak a few words. (South Asian male GP3)

GPs had some degree of understanding of how CBT could play a role in helping these patients manage their pain. However they felt the current health service provision was limited and for this patient group or either inadequate or culturally inappropriate:

I think the biggest thing is this cognitive behaviour therapy, making it much more accessible, making that suitable, if you like, for Asian patients, because for cognitive behaviour therapy at the moment, you need to have an English speaker who speaks reasonably good English, who can understand the concepts in English and so on whereas not many of the patients fit that category, so cognitive behaviour therapy geared to deal with some of the patients who don't speak much English. I think that would be worthwhile. (South Asian male GP4)

GPs were positive about the availability of CBT but were not fully aware of the details and the services that are or will be available:

Now, I know there is some mention of CBT in trying to help patients with chronic pain. I think the service is just being developed, as far as I'm aware, in Leicester, er, as to how much patients with language difficulties and so on, how their needs will be met. I'm not even sure. But that's something I'm looking forward to, if the service is up and running. (South Asian male GP10)

### *Provisions required for community support*

GPs perceived some patients to be isolated within their community and, for some, interacting outside

of their community was not possible or even culturally acceptable. Many described the South Asian patient with pain being someone who is elderly with restricted physical mobility. It was suggested that having community nurses with the language and cultural skills to visit patients in their homes might be useful:

I think, erm, it wouldn't be bad to have somebody like a sort of a health visitor or a Macmillan nurse, shall we say, someone who can visit people in their homes, who've got, who are of the same ethnic background, who will be able to understand the nuances and be able to, you know, share and get a better understanding as to how the condition's affecting them physically and psychologically and then work with the GP and other agencies to support them. (White British male GP6)

Despite these suggestions GPs identified challenges that would need to be overcome, one such was the applicability of service delivery models across the different faith groups:

I think the difficulty with that is there are an infinite variety of ethnic backgrounds, not an infinite but a large, so you can't have a person who will relate as well to the Hindu population as to the, erm, to the Muslim population. (White British male GP6)

GPs suggested community support groups could offer a valuable service to these patients. This was envisaged as a group of culturally similar South Asian patients with chronic pain meeting up on a regular basis to provide support to each other. This would offer patients an opportunity to share their pain experience with others suffering from similar pain. There are currently a number of organizations that have support groups of this nature to aid self-management. However, many of these are restricted to those with English language skills:

I think it'd be nice to have chronic pain anonymous kind of service like an alcoholics anonymous service where you have people, lots of people getting together with their pain so it's like an association ... I think if there was one for Asians which keyed into what they really felt the Asian people wanted, then that'd be useful I think. I think it'd be useful for them to meet up with other people who have similar problems to understand. (South Asian male GP7)

Some GPs felt the community groups could offer more than just social support. There was feeling

that these groups could be an important source of information:

... if somebody was to, sort of, discuss with them that maybe sometimes pain is not just physical pain, it can be pain because of psychosocial issues, if somebody could, sort of, talk to them or put that sort of idea across to them, maybe they might find it helpful. (South Asian female GP8)

### *Opportunities for increasing practitioners' understanding of pain in a multicultural community*

Many GPs felt they had learnt a lot of their strategies for managing chronic pain in South Asian patients through their experience of treating patients. They perceived that there is limited research on chronic pain among South Asian patients upon which they can draw to help inform their practice. There is thus a perceived need for more research:

Erm, part of it, I think, is an education thing in that the GPs need to be aware of the problems, which obviously, it'd be useful to find out from what your study shows in the end because we've all got our own individual prejudices and while we try not to let them influence things, they're bound to, to some extent, so we need to know more about culturally how people present, erm, and knowing that what body pain might mean to somebody. (White British female GP5)

Erm, I think in terms of helping GP's, everyday kind of management of it, erm, we are perhaps still at the stage of trying to understand what it is, when we talk about chronic pain ... until we've got a conceptual framework for working with chronic pain, it seems to me, difficult to be critical of services out there that are trying to meet undifferentiated demands. (White British male GP16)

GPs seemed happy with receiving information on culture and ethnicity and found the information useful. There may be a need for information like this to be further developed and sent to GPs to increase their awareness of and provide tips on managing pain in a multicultural community:

Every now and then, we get the odd information leaflet about how, you know, what Hindus, Sikhs, Muslims, little tips on what their culture and the things they do health wise, which do help. (White British male GP17)

It was interesting that not all the GPs felt that there were services or provisions that may be helpful to them in managing these patients. Some GPs felt that there is little that can help them manage these patients; it is just something they have to understand, accept and manage:

I'm not really sure that there is anything extra that can be done. Perhaps I'm being a bit pessimistic, but I'm not aware of anything else that can be done. I think you know, these things are probably, to an extent, culture, erm, it's a low pain threshold, which I'm not sure you can actually do anything about it. (South Asian male GP1)

As long as you understand that way of responding, you understand where they're coming from. I don't think that a service could fix that for you. Because, that's the individual and how they express themselves. (South Asian female GP11)

From a healthcare perspective, even if practitioners feel there is nothing that can be done to help these patients, it is still important for them to be aware of the full range of services available. It became apparent that some GPs were unfamiliar with the pain management services available:

Well, I think the pain management is good, but yeah, I don't quite know whether there is a lot of psychological input there. (White British female GP9)

Looking specifically at the possible means of addressing GP education, it was suggested that informal learning opportunities possibly in the form of a chronic pain network might be valuable. This would provide GPs with the opportunity to liaise with more experienced colleagues about pain management in general as well as specific issues related to ethnicity:

Well, I like to learn more and more, because I get lazier as I get older, by conversation, informed dialogue with experienced colleagues. I don't think that kind of dialogue goes on in relation to primary care, understanding chronic pain, you don't see, for example, erm, education sessions on managing chronic pain in South Asian patients. That's not the way that should be handled, but it's a reflection of the fact that we don't have a dialogue about it ... If I see somebody that completely confuses me or I feel I might have missed it, I will talk about it with a colleague ... there's no chronic pain network, if you like, that one can tap into. (White British male GP16)

### *The challenges of secondary care services*

Some GPs were very happy with the services provided by secondary care. The only negative aspect was the applicability of these and the availability of these services to those whose first language is not English as the availability of translators is limited:

The services are excellent of what is available with regard to pain management, er, control, from the educational programmes to the acupuncture and those sort of things and self help etcetera. But obviously, any clinic, there's room for improvement and from the Asian point of view, particularly if you're dealing with an elderly Asian, it's the translation of those services which is important. Patients that I've referred on, you know, we've asked for interpreters or we've asked patients to take somebody who can interpret but again, it's very difficult. If the person who's going with, er, a relative of the person who's going and isn't very au fait with what the services are, they're not very good translators either so you're probably better to use hospital-based translators who can get that information across. (South Asian male GP12)

Many GPs felt it would make it easier for them to manage patients if secondary care referrals were managed faster than they currently are:

I suppose the only thing that would help would be being able to, if you decide the patient needs an investigation or a second opinion, being able to get that promptly ... Each time you want to do something, there's a wait involved, so, you sometimes have to resist the temptation to refer people earlier. (White British female GP18)

That's a big problem, so, if you tell them, 'I'll refer you', at one stage, it used to be about nine months waiting time. Now, I don't know whether the 13-week wait is adhered to now, I'm not sure, because certainly, in the last six to eight months, perhaps a year even, I've not referred anyone to the Pain Clinic. So, that is an issue. (South Asian male GP10)

There was some feeling that service provided in secondary care could just as easily be provided in primary care by GPs this would avoid the delays currently experienced:

Chronic pain management itself, erm, I feel that if the services are available in the secondary care, or even if it's community based, some of the services, like acupuncture, being available directly, a lot of these alternative strategies, we could implement

here. So, you know, the system itself holds some barriers in delaying the management of some of these patients. (South Asian male GP12)

### *Expectation mismatch*

Some GPs felt the services offered in secondary care such as physiotherapy could be better. This could partly be attributed to an expectation mismatch between what the GP feels should be provided and what the actual service provides:

They accept the referral, but they don't often go and if they go, I think they only go once, but physiotherapy in Leicester, it's not, I don't know, I don't want to damn the service, but, it's much more about giving patients education and exercises to do at home, rather than actually a therapy, as in some palpation or manipulation or ultrasound, so, I think people's satisfaction with the physical therapies they're offered is not at high as it used to be. (White British male GP18)

Communication difficulties, primarily the language barrier, add to the challenges and complexities of managing patients from this community with pain. Most patients bring a friend or family member as an interpreter, which can be beneficial and to some degree GPs rely on when there are no alternative interpretation services available. However, at times, the three-way conversation with uncertainty over accuracy can be difficult, therefore GPs should not expect absolute accuracy and to some degree need to be able to identify non-verbal cues:

I've seen patients who come in and maybe they think I don't speak their language and so I'll talk to them and they'll say something to the person who's supposed to be interpreting, which I understand completely and then their interpreter will tell me in English and I'll think, well, that's not what she just said. (South Asian female GP8)

Erm, I think they express themselves in a different way and I can't think of an example they, erm, they don't seem to use the language in exactly the same way as I would use it. The nuances of what we talk about, our facial expressions and things like that, that betray what we're feeling, seem to be different. (White British male GP6)

## **Discussion**

In this article we focused on GPs' experiences of managing patients with chronic pain from a South Asian community, in particular on GPs' perceptions

of the support services required and their own learning needs. From the interviews we found that GPs perceived that there is a lack of culturally specific psychological therapies and community support for this group of patients. GPs recognized that they have learning needs with respect to managing chronic pain in South Asian people but that there may be little evidence to inform their learning and practice. GPs felt there is a need to focus on the challenges and provisions of secondary care pain clinics to limit delays in pain management.

Managing chronic pain in any community can be a difficult and frustrating experience for GPs. Our findings give insight into what GPs feel they need to help them manage patients more effectively in primary care. GPs seemed particularly interested in having access to more culturally relevant psychological services including counselling and CBT. Most current pain management programmes are derived from a CBT approach that has been shown to be effective (Flor, Fydrich, & Turk, 1992; Morley, Eccleston & Williams, 1999) and have been described as the treatment of choice for patients coping with pain-related disability (McCracken & Turk, 2002; Turk, 1996). However, it is important to bear in mind that these research data come almost exclusively from European populations, people of European descent or western countries.

The literature suggests cultural factors influence beliefs, behaviours, perceptions and emotions, all of which affect health and healthcare (Helman, 2007). Therefore, the cultural background of the GP may play a role in how chronic pain is perceived. Research indicates that GPs are more likely to perceive South Asian patients as having an underlying psychological basis to their pain, which could result in the treatment disparities such as less referral to outpatient services (Cooper-Patrick et al., 1999; Morris et al., 2005) and receipt of less medication or treatment for pain (Green et al., 2003; Laditka et al., 2003). Before the provision of culturally relevant counselling and CBT services with appropriately trained staff is contemplated, further research is required to determine the suitability of CBT for South Asian people and the content of such a programme. Furthermore, it is important to note that when we talk about South Asian people we are grouping a large number of faiths and cultures together as one, ignoring significant cultural variation. Although this is an important point it was beyond the scope of this study to evaluate each subgroup due to small numbers in each group making

it difficult to draw upon key emerging themes. In addition, it remains unclear if GPs actually make such fine distinctions between groups.

GPs felt that local community support groups might be a way of supporting patients. Although support groups can provide an opportunity for patients to share experiences and concerns, little research has been published on the use of support groups for people with chronic pain (Arthur & Edwards, 2005; Subramaniam, Stewart, & Smith, 1999), and the data are contradictory (Arthur & Edwards, 2005; Fordyce, 1976; Linton, Hellsing & Larsson, 1997; Peacock, Cascone, & Porter, 2007). In an RCT looking at the effectiveness of lay led self-management programmes for South Asians positive improvements were seen in self-efficacy and self-care; limited effects were seen on health status (Griffiths et al., 2005). Recruitment and attendance was only moderate despite provision of incentives, this compares poorly with other groups in similar studies (Lorig, Ritter, & Gonzalez, 2003; Lorig, Sobel, & Stewart, 1999). Limited trials have been conducted on minority groups and therefore these groups are under-represented (Sheikh, Netuveli, Kai, & Panesar, 2004). Despite this, it is possible to draw on the broader literature around chronic condition interventions tailored for South Asians for coronary heart disease (CHD) and diabetes. Project Dil (Farooqi & Bhavsar, 2001) aimed to improve the prevention of CHD by implementing training for healthcare professionals and increasing awareness within the community has helped engage and drive forward CHD management in primary care. From the diabetes literature we find specialist led primary care clinics for South Asians failed to improve 'knowledge awareness' and 'self management' (Vyas et al., 2003). Whereas a lay led self-help programme found those who attended showed a decrease in HbA1c levels and increase in 'knowledge' (Simmons, 1992). Hawthorne and Tomlinson (1997) found one to one teaching with picture flashcards with Asians with diabetes helped to improve knowledge and self-care skills at six month follow-up. These studies indicate careful consideration needs to be taken when deciding how to implement health information to a South Asian population.

There is a need to manage the communication process more effectively in order to progress with the clinical management of patients. Neal et al. (2006) reported there were no differences in verbal domination when White and South Asians consulted with a White GP. White patients had more emotional



consultations where both the patient and GP played an active role. GPs spent more time asking questions to those less fluent in English. Interestingly they spent less time giving information to those South Asians fluent in English than White patients. This discrepancy is particularly concerning. For those who do not speak the local language translation services need to be more accessible in primary care (Jones & Gill, 1998). There may be scope to train medical students on how to most effectively use interpreters including family members during the consultation process (Free, Green, Bhavnani, & Newman, 2003; Phelan & Parkman, 1995), as it is not always feasible to have interpreters available when patients consult.

Our results and those of other studies suggest GPs are interested in receiving relevant training for chronic pain management (Stannard & Johnson, 2003). Recent literature has focused on improving the informed shared decision-making process within the consultation (Frantsve & Kerns, 2007). Allen et al., (2008) describes an Internet-based health coaching intervention to help improve patient–clinician communication. To aid the consultation process practitioners may benefit from easily accessible training and education on the influences of culture and ethnicity on pain, which currently does not exist. The availability of online training resources including access to relevant research papers, links to related organizations and a forum for discussion may be a useful resource. There is support for the use of online resources in improving knowledge, attitudes and beliefs about chronic pain (Harris et al., 2008).

### *Strengths and Limitations*

The strengths of this study are the broad and purposive sampling frame, which ensured we could access the accounts of a wide range of GPs with experience of South Asians with chronic pain. Our analysis was rigorous incorporating transcription of interviews, careful reading and re-reading of the text with generation of codes from the data and active search for negative cases. Rigor was maintained at every stage of the analysis to minimize any potential investigator bias by the first author (SP) regularly consulting co-authors for clarification over interpretation throughout the analysis process. We actively sought and achieved saturation of the data with no new themes emerging from the final cases. This helps to ensure that the results are generalizable. Nevertheless caution must be

taken against over generalizing these data as they are situated in a single English city that, although it has a large and varied South Asian community does not fully represent South Asian people in the UK.

These data extend our previous findings that GPs face a range of challenges when managing South Asian patients with pain particularly during the consultation process (Patel et al., 2008). To summarize, GPs found there were considerable gaps in the services available to South Asian patients with chronic pain. They felt access to healthcare in particular psychological therapies including pain management were limited or were culturally or linguistically inappropriate. Suggested service improvements included the provision of better psychological/counselling support both professionally and through support groups as well as faster access to secondary care. Practitioners feel the ability to refer to multi-disciplinary teams including counsellors and personnel trained to deliver CBT would be a valuable resource but the cultural transferability of such programmes requires attention. Access to psychological services is limited in general therefore this may not be specific to this population. It would therefore be important to explore patients' experiences, perceptions and likely acceptance of such services.

### **References**

- Allen, M., Iezzoni, L. I., Huang, A., Huang, L., & Leveille, S. G. (2008). Improving patient-clinician communication about chronic conditions: description of an internet-based nurse E-coach intervention. *Nursing Research, 57*(2), 107–112.
- Allison, T. R., Symmons, D. P., Brammah, T., Haynes, P., Rogers, A., Roxby, M., & Urwin, M. (2002). Musculoskeletal pain is more generalised among people from ethnic minorities than among white people in Greater Manchester. *Annals of the Rheumatic Diseases, 61*, 151–156.
- Arthur, A. R., & Edwards, C. (2005). An evaluation of support groups for patients with long term chronic pain and complex psychosocial difficulties. *European Journal of Psychotherapy, Counselling and Health, 7*, 169–180.
- Atri, J., Falshaw, M., Livingstone, A., & Robson, J. (1996). Fair shares in health care? Ethnic and socio-economic influences on the recording of preventive care in selected inner London general practices. *British Medical Journal, 312*, 614–617.
- Census (2001) National Report for England and Wales. London: Stationary Office, 2003.
- Cooper-Patrick, L., Gallo, J. J., Gonzales, J. J., Vu, H. T., Powe, N. R., Nelson, C., & Ford, D. E. (1999). Race,

- gender and partnerships in the patient – physician relationship. *Journal of the American Medical Association*, 282, 583–589.
- Edén, L., Ejlertsson, G., Lamberger, B., Leden, I., Nordbeck, B., & Sundgren, P. (1994). Immigration and socio-economy as predictors of early retirement pensions. *Scandinavian Journal of Social Medicine*, 22, 187–193.
- Edwards, C. L., Fillingim, R. B., & Keefe, F. J. (2001). Race, ethnicity and pain. *Pain*, 94, 133–137.
- Elliott, A. E., Smith, B. H., Penny, K. I., Smith, W. C., & Chambers, W. A. (1999). The epidemiology of chronic pain in the community. *The Lancet*, 354, 1248–1252.
- Farooqi, A., & Bhavsar, M. (2001). Project Dil: A co-ordinated Primary Care and Community Health Promotion Programme for reducing risk factors of coronary heart disease amongst the South Asian community of Leicester – experiences and evaluation of the project. *Ethnicity & Health*, 6(3–4), 265–270.
- Flor, H., Fydrich, T., & Turk, D. C. (1992). Efficacy of multidisciplinary pain treatment centres: a meta-analytic review. *Pain*, 49, 221–230.
- Fordyce, W. E. (1976). Behavioral methods for chronic pain and illness. St Louis: Mosby.
- Frantsve, L. M., & Kerns, R. D. (2007). Patient-provider interactions in the management of chronic pain: current findings within the context of shared medical decision making. *Pain Medicine*, 8(1), 25–35.
- Free, C., Green, J., Bhavnani, V., and Newman, A. (2003). Bilingual young people's experiences of interpreting in primary care: A qualitative study. *British Journal of General Practice*, 53(492), 530–535.
- Green, C. R., Anderson, K. O., Baker, T. A., Campbell, L. C., Decker, S., Fillingim, R. B., Kalauokalani, D. A., Lasch, K. E., Myers, C., Tait, R. C., Todd, K. H., & Vallerand, A. H. (2003). The unequal burden of Pain: Confronting racial and ethnic disparities in pain. *Pain Medicine*, 4, 277–294.
- Griffiths, C., Motlib, J., Azad, A., Ramsay, J., Eldridge, S., Feder, G., Khanam, R., Munni, R., Garrett, M., Turner, A., & Barlow J. (2005). Randomised controlled trial of a lay-led self-management programme for Bangladeshi patients with chronic disease. *British Journal of General Practice*, 55, 831–837.
- Harris, J. M., Elliott, T. E., Davis, B. E., Chabal, C., Fulginiti, J. V., & Fine, P. G. (2008). Educating generalist physicians about chronic pain: live experts and online education can provide durable benefits. *Pain Medicine*, 9(5), 555–563.
- Hawthorne, K., & Tomlinson, S. (1997). One-to-one teaching with pictures–flashcard health education for British Asians with diabetes. *British Journal of General Practice*, 47(418), 301–304.
- Helman, C. G. (2007). *Culture, Health and Illness*, 5th edn. London: Hodder Arnold.
- Jones, D., & Gill, P. (1998). Breaking down language barriers. *British Medical Journal*, 316, 1476–1480.
- Laditka, J. N., Laditka, S. B., & Mastanduno, M. P. (2003). Hospital utilization for ambulatory care sensitive conditions: Health outcome disparities associated with race and ethnicity. *Social Science & Medicine*, 57, 1429–1441.
- Linton, S. J., Hellsing, A. L., & Larsson, I. (1997). Bridging the gap: Support groups do not enhance long-term outcome in chronic back pain. *Clinical Journal of Pain*, 13(3), 221–228.
- Lorig, K. R., Ritter, P. L., & Gonzalez, V. M. (2003). Hispanic chronic disease self management: A randomised community-based outcome trial. *Nursing Research*, 52, 361–369.
- Lorig, K., Sobel, D., & Stewart, A. (1999). Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalisation: A randomized trial. *Medical Care*, 37, 5–14.
- May, C., Dowrick, C., & Richardson, M. (1996). The confidential patient: The social construction of therapeutic relationships in general medical practice. *The Sociological Review*, 44, 187–203.
- McCracken, L. M., Matthews, A. K., Tang, T. S., & Cuba, S. L. (2001). A comparison of blacks and whites seeking treatment for chronic pain. *Clinical Journal of Pain*, 17, 49–55.
- McCracken, L. M., & Turk, D. C. (2002). Behavioral and cognitive-behavioral treatment for chronic pain. *Spine*, 27, 2564–2573.
- Morley, S. J., Eccleston, C., & Williams, A. (1999). Systematic review and meta-analysis of randomized controlled trials of cognitive behavioural therapy and behaviour therapy for chronic pain in adults. *Pain*, 80, 1–13.
- Morris, S., Sutton, M., & Gravelle, H. (2005). Inequity and inequality in the use of health care in England: an empirical investigation. *Social Science and Medicine*, 60, 1251–1266.
- Munidipharma International Ltd. (2003). *Pain in Europe: A report*. Cambridge: Munidipharma International Ltd.
- Nazroo, J. (2003). The structuring of ethnic inequalities in health: Economic position, racial discrimination, and racism. *American Journal of Public Health*, 93, 277–284.
- Neal, R. D., Ali, N., Atkin, K., Allgar, V. L., Ali, S., & Coleman, T. (2006). Communication between South Asian patients and GPs: Comparative study using the Roter Interactional Analysis System. *British Journal of General Practice*, 56(532), 869–875.
- Njobvu, P., Hunt, I., Pope, D., & MacFarlane, G. (1999). Pain amongst ethnic minority groups of South Asian origin in the United Kingdom: A review. *Rheumatology*, 38, 1184–1187.
- QSR International Pty Ltd, (2002). NVivo version 2.0, <http://www.qsrinternational.com>
- Patel, S., Peacock S. M., McKinley, R. K., Clark-Carter, D., & Watson P. J. (2008). GPs' experience of managing

- chronic pain in a South Asian community: A qualitative study of the consultation process. *Family Practice*, 25, 71–77.
- Peacock, S. M., Cascone, A., & Porter, J. (2007). Is it good to talk? Who attends pain management support groups and why? *British Pain Society Newsletter*, Summer Edition.
- Phelan, M., & Parkman, S. (1995). How to work with an interpreter. *British Medical Journal*, 311, 555–557.
- Riley, J. L., Wade, J. B., Myers, C. D., Sheffield, D., Papas, R. K., & Price, D. D. (2002). Racial/ethnic differences in the experience of chronic pain. *Pain*, 100, 291–298.
- Sheikh, A., Netuveli, G., Kai, J., & Panesar, S. S. (2004). Comparison of reporting of ethnicity in US and European randomised controlled trials. *British Medical Journal*, 329, 87–88.
- Simmons, D. (1992). Diabetes self help facilitated by local diabetes research: The Coventry Asian Diabetes Support Group. *Diabetic Medicine*, 9(9), 866–869.
- Smith, B. H., Elliott, A. M., & Hannaford, P. C. (2004). Is chronic pain a distinct diagnosis in primary care? Evidence arising from the Royal College of General Practitioners' Oral Contraception study. *Family Practice*, 21, 66–74.
- Stannard, C., & Johnson, M. (2003). Chronic pain management – can we do better? An interview-based survey in primary care. *Current Medical Research & Opinion*, 19(8), 703–706.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*, 2nd edn. London: SAGE.
- Subramaniam, V., Stewart, M. W., & Smith, J. F. (1999). The development and impact of a chronic pain support group: A qualitative and quantitative study. *Journal of Pain & Symptom Management*, 17, 376–383.
- Turk, D. C. (1996). Biopsychosocial perspective on chronic pain. In J. R. Gatchel, R. J., & D. C. Turk (Eds.), *Psychological approaches to pain management*. New York: Guilford Press.
- Vyas, A., Haidery, A. Z., Wiles, P. G., Gill, S., Roberts, C., & Cruickshank, J. K. (2003). A pilot randomized trial in primary care to investigate and improve knowledge, awareness and self-management among South Asians with diabetes in Manchester. *Diabetic Medicine*, 20(12), 1022–1026.
- Watson, P. J., Latif, K. R., & Rowbotham, D. J. (2005). Ethnic differences in thermal pain responses: A comparison of South Asian and White British healthy males. *Pain*, 118, 194–200.

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