An exploration of factors affecting the use of community pharmacy services by South Asians in Leicester

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Volume 2: Appendices

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# APPENDICES (VOLUME 2)

**Appendix 1**  
An initial appraisal of selected literature relating to South Asian health or pharmacy use cited in Chapter 3

**Appendix 2**  
Ethics approval documentation

**Appendix 3**  
Examples of literature search strategies

**Appendix 4**  
Phase 1 topic guides and letters

Phase 2  focus group participant demographics, topic guides, consent forms, patient information letters

**Appendix 5**  
Case vignettes

**Appendix 6**  
Proposal for major intervention study (Phase 3)

**Appendix 7**  
Executive summary Phase 1

**Appendix 8**  
Further statistics on BME population in the East Midlands

**Appendix 9**  
Major websites for information on ethnicity and diversity since 2004

**Appendix 10**  
Themes and Categories used for the Reconfirmation exercise 2008

‘Knowledge’ and its associated findings

‘Professionalism’ and its associated findings

‘Communication’ and its associated findings
APPENDIX 1

An initial appraisal of a selection of the literature relating to South Asian health or pharmacy use cited in Chapter 3
An initial appraisal of literature relating to South Asian health or pharmacy use (as cited in Chapter 3)

<table>
<thead>
<tr>
<th>Reference</th>
<th>Title</th>
<th>No. of participants in study</th>
<th>Research design and methodology</th>
<th>Results and conclusions</th>
<th>Critique and relevance to PhD study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bhopal I (1986)</td>
<td>The inter-relationship of folk, traditional and Western medicine within an Asian community in Britain</td>
<td>65 South Asian patients, 57 GPs, 15 Health visitors</td>
<td>Quantitative and qualitative methodology</td>
<td>Among Asians, knowledge of herbal remedies, the Asian healer and cultural concepts such as the 'hot/cold' theory was high. They frequently used culinary ingredients to treat common diseases such as abdominal discomfort, earache and toothache. The use of metal-based medications was rare, application of the 'hot/cold' concept was not of nutritional significance and Asian healers were infrequently consulted except during visits to India and Pakistan. Among health professionals awareness of Asian medicine was low. None had encountered morbidity resulting from its remedies while 50% felt that such remedies should be encouraged unless shown to be harmful. Traditional medicine was found to play a modest but not insignificant role within the context of total health care. There was little evidence that is use comprises a significant health threat. Opportunities for further research and a prediction of the future of Asian medicine in Britain are presented.</td>
<td>A robust methodology was adopted for this study, highlighting the importance of the use of bi-lingual research associates, and the themes of the qualitative study could be explored further in this PhD study. This study gives a more rounded view of the factors that could affect the use of traditional remedies and their clinical consequences. Community pharmacists were not interviewed, but the study findings contradict the findings by Aslam et al (1992 and 1997). The findings of the study by Jesson et al concur with the findings of this study. The themes could be further explored in this PhD study to affirm these findings.</td>
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<td>Partop et al (1986)</td>
<td>A survey of patients from ethnic minorities: do they use community pharmacies effectively?</td>
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<td>204 Asian consumers using 6 pharmacies in Birmingham</td>
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<td></td>
<td>The majority of Asians included Muslims, Sikh and Hindus</td>
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<td>Structured questionnaire</td>
<td>Interviews conducted in the pharmacy when patients picked up their prescriptions</td>
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<td>41% required a translator to administer the questionnaire</td>
<td>96% of consumers participated.</td>
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<td>^3% of respondents preferred to speak to a pharmacist who spoke an Asian language</td>
<td>Less than 50% demonstrated that they know who the pharmacist was and it was concluded that their knowledge of pharmacists role was poor</td>
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<td>60-80% of respondents acknowledged that the doctor knew more about medicines, and that they would ask the doctor for advice about medicines</td>
<td>82% respondents visited the same pharmacy because it was conveniently located</td>
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<td>No respondents acknowledged they had been given advice other than that for medication</td>
<td>71% of patients preferred leaflets in other languages.</td>
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<td>There was no mention of how the patients were sampled.</td>
<td>There was a wide variation amongst the respondents as to who could comprehend and read their first language, as over half the respondents could also read and write English</td>
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<td>These themes were further explored in the study by Jesson et al (1994) and could be explored again in this PhD study using a different methodology.</td>
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<td>Kaur and Dobranzki (1988) Pharmacy Counselling for patients of Indian/Pakistani origin 52 patients (45 Pakistani, 6 sikh and 1 Hindu)</td>
<td>Quantitative study Questionnaire administered by a member of pharmacy staff fluent in South Asian languages Hospital study</td>
<td>Nearly 75% of the patients in the study understood either very little or no English and were ill equipped to read pharmacy labels. Most patients could not read or write their own language A booklet listing usage principle dosage directions was translated into Punjabi using phonetic phrases. A tape recording of the various phrases in the booklet was also prepared as a pronunciation guide. Both methods were evaluated. The translated instructions were not understood by some patients, and theses was more clear when the phonetic versions were used. A pronunciation guide (phonetic) has been produced, but complex instructions were deemed to be problematic. The study concludes that a bi-lingual pharmacist should be employed in cities where there are large numbers of minority ethnic groups.</td>
<td>Small study in a hospital setting. Outcomes could be explored in this PhD study. Methodology was not well explained in the study and sweeping assumptions were made. The understanding of medicines directions on labels can be explored in this PhD study.</td>
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<td><strong>Gillam et al (1989)</strong></td>
<td><strong>Ethnic differences in consultation rates in urban general practice</strong></td>
<td>Seven practices. Group general practice in the London borough of Brent with a list size of 10,877 patients</td>
<td>The study set out to determine the patterns of consultations with the general practitioner among different ethnic groups and the outcome of these consultations. A retrospective analysis of data from one urban group general practice was examined. Ethnic state, sex and social class distribution, and diagnosis of patients consulting and frequency of consultations analysed as standardised consultation ratios and standardised patient consultation ratios. Ethnic differences in consultation rates were apparent.</td>
<td>Compared with other ethnic groups, male Asians (including those born in Britain and those originating from the Indian subcontinent and east Africa) had a substantially increased standardised patient consultation ratio. Consultation rates for mental disorders—in particular, anxiety and depression—were reduced in all groups of immigrant descent. West Indians consulted more frequently for hypertension and asthma, and their children less frequently with otitis media. Asians consulted more frequently with upper respiratory tract infections and non-specific symptoms. Native British patients were more likely to leave the surgery with a follow up appointment, prescription, or certificate. Limitations of this study were acknowledged by the authors and the authors relied on the self reporting of ethnicity status for this study. The resulting themes warrant further exploration for this PhD study.</td>
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<td><strong>Wiggins (1990)</strong></td>
<td><strong>Meeting the needs of ethnic minority patients</strong></td>
<td>28 patients from different South Asian ethnic backgrounds and a number of GPs and community pharmacists (number not specified).</td>
<td>A survey to assess patients’, practitioners’ and pharmacists’ viewpoints on the provision of healthcare services, particularly pharmaceutical services for Asian communities in East London. Methodology specifies ‘interviews’. Analysis technique mentions ‘quantitative methodology and relies heavily on anecdotal information. The main results of the study were published as a result of patients’ interviews which elicited direct information and were quantitative in nature. Several areas for improvement were identified including the use of plain English when labelling medication, and the translation of Patient Information Leaflets into Asian languages. Herbal medicine and folk medicine used by Asian communities are also discussed. Limitations of this study were acknowledged by the authors and the authors relied on the self reporting of ethnicity status for this study. The resulting themes warrant further exploration for this PhD study.</td>
<td>The methodology of this study was poorly explained and has many omissions within the datasets collected. Results of the interviews with GPs and pharmacists was not clarified or commented on other than that the results ‘yielded many personal experiences and opinions of both the needs of minority ethnic groups and the present state of pharmaceutical services. The study provided themes further exploration of themes that could warrant further exploration for this PhD study.</td>
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<td>Authors (Year)</td>
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<td>Sample</td>
<td>Methodology</td>
<td>Findings</td>
<td>Implications</td>
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<td>Ahmad et al. (1991)</td>
<td>Patients’ choice of general practitioner: importance of patients’ and doctors’ sex and ethnicity</td>
<td>1633 consultations at a health centre in Bradford, with a mixed ethnic list,</td>
<td>Survey, Quantitative. Examined over a four week period to test the relative importance of these variables. Patients had the choice to consult any one of: a male Asian, a male white or a female white doctor. The family practitioner committee register for the practice was used to construct an age-sex profile by ethnic origin, with ethnicity defined on the basis of name. The authors acknowledge the limitations of defining ethnic group on this basis; however as ethnicity was not routinely listed on patient records the authors commented that at the time, there were no better alternatives for such studies. Results statistically analysed. Asian patients, irrespective of sex, were significantly (P less than 0.001) more likely to consult the Asian doctor then either of the other two doctors, though a greater proportion of Asian women than men consulted the female white doctor.</td>
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<td>Relative influence of doctor’s characteristics on a patient consultation further area that could be explored in this PhD study. The study also highlights the need to explore whether patients ethnicity is captured on GP databases.</td>
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<td>Abbas et al. (1992)</td>
<td>Drug utilisation among elderly Asian women</td>
<td>75 elderly Asian women</td>
<td>Structured interview was used to obtain details of demographic status, language and literacy skills, drug use, knowledge of drug regimen and medication taking behaviour. Age ranges of women: 65-96, from Muslim, Hindu and Sikh backgrounds. This study was conducted by a pharmacy student. Patient communication between both doctors and pharmacists was restricted, mainly due to language problems and illiteracy on the patients’ side. Most of the patients taking medication had to rely on memory, or other family members to remind them, of the correct directions for their medications.</td>
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<td>Quantitative study with a small number of patients for statistical analysis to have any meaning, The description of methods and methodology was poor. The findings were published as a research supplement and not extensively reviewed. The study could not be adequately appraised and the results could not be used for further exploration in this PhD study.</td>
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<td>Bhatt and Dickinson (1992)</td>
<td>An analysis of health education materials for minority communities by cultural and linguistic group</td>
<td>An analysis of the HEA catalogue 1990 catalogue of health education materials available for minority ethnic populations</td>
<td>Examines the perceptions of needs and priorities in health education for minority communities (South Asian, Chinese, and Caribbean) as reflected in the 1990 Health Education Authority catalogue of health education materials. The paper also examines the distribution of leaflet and non-leaflet materials amongst the cultural and linguistic groups within these communities. A comparison is made with the previous catalogue published in 1987 to identify shifts in emphasis in health education materials for minority communities.</td>
<td>There was a noticeable increase in information leaflets on accidents, headlice, use of health services, breast and cervical cancer, language, heart health, old age, mental health and race relations. Particularly noticeable was the increase in leaflets concerning women’s health and the use of health services. For South Asians, the topics covered were ‘food’-diet and healthy cooking. Non-leaflet health education materials included posters on food hygiene, and videos mainly on pregnancy. The authors emphasise that literal translations may not be fully understood or relevant to different cultural groups. There are clear gaps, anomalies, over emphases and unequal attention to both topics and groups within the minority communities. Some of the pitfalls for ‘literally translated’ leaflets have been highlighted, emphasising the need for information in leaflets to be more sensitive to cultural content and to language used within these. The use and uptake of health information leaflets will be explored in this thesis.</td>
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<td>Rashid and Jagger (1992)</td>
<td>Attitudes to and perceived use of health care services among Asian and non-Asian patients in Leicester</td>
<td>Quantitative study. Random samples of 1000 patients (500 from each group) initially chosen and 89.6% responded and were interviewed. Personally administered questionnaire (closed questions) in patients preferred language. The study did use trained translators and interpreters. Attitudes to and perceived use of health care services in Leicester explored. Age, education attainment and social class distributions of sample population included in the results. Practical difficulties identified to make contact with interviewees (e.g. inaccuracies of addresses on computer).</td>
<td>Data was coded and statistically analyzed. Communication barriers: no significant findings between Asian and non-Asian patients. Barriers to access to general practitioners: Asian patients reported difficulties (waiting times, appointments and receptionists) Access to hospital services: Asian patients preferred direct access to hospital consultants Telephone advice from GP: Asian patients did not prefer this method Home visits: Asians preferred this throughout the day Deputizing services not liked by Asian patients. 24 hr surgeries preferred by Asian patients. Study concludes that Asian patients do use a different approach to health care delivery demanding more personal care, with greater emphasis on continuity and improved access.</td>
<td>Samples not identified by ethnicity or religion. Samples divided into two groups by name recognition which could have introduced bias. No questions asked on cultural sensitivities. The paper demonstrates the difficulties that could be encountered using a quantitative methodology confounded by lack of data of ethnicity being recorded in the patients' records. Closed questions were used and did not allow further exploration. Study results and outcomes highlighted themes that could be further explored in the PhD study.</td>
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<td>Authors</td>
<td>Title</td>
<td>Sample Size</td>
<td>Methodology</td>
<td>Findings</td>
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<td>Spencer and Edwards (1992)</td>
<td>Pharmacy beyond the dispensary: general practitioners’ views</td>
<td>1087 GPs</td>
<td>Quantitative study aimed to ascertain general practitioners’ attitudes to an extended role for community pharmacists. A Postal questionnaire was sent to a 1 in 6 sample of general practitioners in the Northern, West Midlands, and Oxford regions (total sample size 1087). Attitudes towards specific extended roles, pharmacist prescribing of particular drugs, the role of the pharmacist, and the relationship between the professions.</td>
<td>744 questionnaires were returned an overall response rate of 68.4%. Attitudes varied, from a majority in favour of pharmacists reporting adverse drug reactions to a majority against their supervising repeat prescriptions (81% and 36% in agreement respectively). A similar range of attitudes was shown to pharmacist prescribing, from 84% in agreement with their prescribing nicotine chewing gum (deregulated since the survey) to 11% agreeing to their prescribing cimetidine. About half the respondents thought general practitioners should be allowed to dispense and a third that pharmacists “should stick to dispensing.” 27% agreed that pharmacists were too influenced by commercial pressures to give unbiased advice. Most doctors would favour an extension of the activities of community pharmacists but worry about their role in screening and counseling patients and in prescribing. Despite relationships being generally felt to be good, there may be a need for better communication and cooperation locally and for proper evaluation of initiatives to extend the role of the pharmacist.</td>
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A robust study highlighting themes that should be explored with all participants in this PhD study. Some of the findings are confirmed by a further study by Hughes and Mcann (2003).
Williamson et al (1992)  

Public views on an extended role for community pharmacy

133 active elderly people, mothers of young children, carers of people with disabilities, and people employed full time. Study conducted in England

Quantitative survey in white population

Response rate was 100% as these were face to face interviews using a structured questionnaire.

Results demonstrated support for the development of new community pharmacy services.

The majority of respondents supported the provision of more information on prescribed medicines, opportunity to discuss minor symptoms with the pharmacist, medicine delivery services, and the holding of patient medication records.

There was less support for discussing health promotion with the pharmacist.

Cost was found to be a major obstacle to the acceptability of diagnostic testing.

The elderly found all aspects of the extended role less acceptable than did other respondents.

It was concluded that there is a need to market new community pharmacy services more effectively.

No mention was made if South Asians were interviewed in the study.

The themes could be further explored with South Asians in this PhD study, particularly the knowledge and acceptability of extended services for the South Asian population.
<table>
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<tr>
<th>Morrow et al (1993)</th>
<th>Consumer perceptions of and attitudes to community pharmacy services</th>
<th>261 members of the public</th>
<th>College of Health survey consumer opinions of and reactions to community pharmacy services using a communication audit approach that involved obtaining consumers' views on communication with pharmacists and how it could be improved.</th>
<th>Over two-thirds of consumers would go first to their doctor for advice on health problems. Loyalty to a particular pharmacy increased with increasing patient age. The majority would like to see pharmacists being health-oriented rather than business-oriented, yet one-third felt they were primarily business people at present. In terms of interpersonal contact with pharmacists, 56% of the sample felt comfortable about asking pharmacists for advice, although an additional 30% wished this to be the normal standard of practice. The survey also indicated that customers would like to have more direct involvement from the pharmacist when purchasing over-the-counter as well as dispensed medication.</th>
<th>No further explorations of views through qualitative study. The survey was conducted in a white population in Northern Ireland. The themes of loyalty, the advisory role of the pharmacist and 'business' image could be explored with the South Asian population for this PhD study.</th>
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<tr>
<td>Jessa (1994)</td>
<td>Are TB patients misunderstood? An evaluation of a translated antituberculosis patient information leaflet within the Pakistani community and a study of TB compliance during Ramadan</td>
<td>32 Pakistani patients</td>
<td>A questionnaire survey of patients receiving tuberculosis treatment at a hospital in the UK and particularly looked at their understanding of an information leaflet translated into Urdu, Punjabi or Gujerati. The impact of Ramadan on compliance tuberculosis therapy was also explored. The study was conducted by pharmacy student.</td>
<td>18.7% could read English, although 30% could understand spoken English clearly. Only 37.5% could read their own language, and half of these could read English also. The study concluded that more trained interpreters were needed.</td>
<td>Small sample of patients so generalisations could not be made. The study was conducted in a hospital setting and as such cannot be generalisable to the community pharmacy setting.</td>
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<td>Study (Year)</td>
<td>Title</td>
<td>Population</td>
<td>Methods</td>
<td>Findings</td>
<td>Conclusion</td>
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<td>Tuffnall et al (1994)</td>
<td>Use of translated written material to communicate with non-English speaking patients</td>
<td>1000 non white patients in Bradford hospitals</td>
<td>10 liaison workers gathered information on 1000 non-white patients who either attended a clinic or were helped as inpatients. The inpatients were mostly non-English speaking, but the outpatients were a true population sample. Data was gathered on the patients’ first language, English, and any other languages they understood. Ability to read and write was graded as fluent, partial, or absent. Length of residence in Britain was also asked for. 425 obstetric patients’ data was separately analysed.</td>
<td>The overall rate of complete illiteracy was 58.8% but varied among language groups. In the obstetric patients the rate was 58.1% (247/425). In all, 57 of the 176 (32.4%) patients who had some understanding of written English had partial understanding (44 of the 57 (77.2%) obstetric patients). Of the 205 patients who had some understanding of written information, but not in English, 73 (35.6%) had partial understanding (47 of 118 (39.8%) obstetric patients). The average length of residence in Britain for the patients who were illiterate was 11.82 years (range 0.1-40).</td>
<td>The authors concluded that leaflets in English may not be read and that other means of communication need to be sought for patients whose first language is not English (e.g. audio-visual material as opposed to translated leaflets). The authors endorse better use of resources for this activity. The findings highlight that data needs to be gathered about the preferences for communication methods and if patients’ first language is not English in order to determine if current communication methods (e.g. leaflets, translated or otherwise) would be appropriate. Some of these findings correlate well to the findings by Kaur and Dorbranski (1988) which was also set in Bradford.</td>
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<td>Gill et al (1995)</td>
<td>The effect of patient ethnicity on prescribing rates</td>
<td>180,587 participants from the GHS survey 1983-91</td>
<td>Quantitative study with retrospective analysis of data. Respondents asked how many times they had consulted a GP within the preceding 14 days. For each consultation they were asked if they received a prescription. Results presented only for age groups 0-15, 16-44, 45-64 and for the following groups: white, Indian, Pakistani and West Indian. This study confined to respondents aged less than 65 years</td>
<td>Results statistically analyzed. Higher proportions of Pakistanis and Indians are given a prescription compared with white and west Indian people.</td>
<td>Methodology poor and acknowledged by authors and that further research needed to explore the reasons behind the differences in prescribing rates. It would be interesting to explore if a qualitative approach would yield a better insight into whether this phenomenon is valid amongst the GP practices in Leicester.</td>
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<td>Authors</td>
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<td>Methodology</td>
<td>Findings</td>
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<td>Rashid, Jagger et al</td>
<td>Views of Asians and non-Asians on sources of drug information and the desirability for medication to be made OTC</td>
<td>Quantitative study-part of a larger study (Rashid and Jagger 1992) Retrospective analysis of randomized data comparing opinions of Asians and non-Asians with respect to 12 selected classes of medicines, whether they should be made available over the counter and the provision of information regarding these.</td>
<td>Results statistically analyzed. Asians desired less availability for OTC medication than non-Asians. Asians desired more information than non-Asians, although the overall percentage requiring further information was below 30%. Most respondents wanted drug information on the 12 classes of medicines to be given by the doctor, with smaller numbers favouring the pharmacist and smaller still the media. Authors concluded that some effort may be needed to persuade patients to self medicate and seek the advice of a pharmacist for minor problems.</td>
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<td>Duran-Tauleria, Rona et al</td>
<td>Influence of ethnic group on asthma treatment in children in 1990-1: national cross sectional study</td>
<td>Cross sectional survey in England and Scotland on 17667 children aged 5-11. The inner city sample included 7049 children from an ethnic minority (69%) inc. Indian sub-continent.</td>
<td>Quantitative study using self – administered questionnaire which was also available in dual languages. Parents asked to complete questionnaires The questions relied on memory and the discussion comments that only an acute attack of asthma might be remembered but not much importance made on commenting on episodes of wheeze. Afro-Caribbean group had the worst response rate for completing questionnaire. Children from the Indian subcontinent and those from other ethnic groups were more likely to be prescribed antitussives and antibiotics than the white representative sample. Higher proportions of children with persistent wheeze in ethnic minority groups are likely not to be diagnosed with asthma and are hence undertreated. Qualitative studies in ethnic minority groups could help identify reasons for the deficiencies in the treatment of asthma, and this could be explored for other conditions in this PhD study. This study highlights the further need of the utilisation of qualitative methodology for this PhD study, and to further explore if the management of somatic symptoms was more prevalent in this population.</td>
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<td>Fasil J. (1996)</td>
<td>Primary Health Care for Black and Minority Ethnic People. A Consumer Perspective</td>
<td>Exploratory report for the NHS Ethnic Health Unit on Primary Health Care for Black and Minority Ethnic People.</td>
<td>Qualitative study. Focus group discussion with members of the public that included a South Asian focus group. A mixed group (male and female) with a varied group profile. The group was not further subdivided into religion. There was a separate Bengali group (women only). Issues surrounding the experiences of the groups and individuals around primary health care service provision were explored. Focus groups were in London.</td>
<td>7 key recommendations made which are highlighted in Chapter 2. Many areas and themes generated for inclusion into the topic guides for this study. The methodology used was robust as trained interpreters and moderators used. This was published as a report and did not highlight the details of how the groups were conducted or analysed. Results and comments indicate further research using a similar methodology for this PhD study.</td>
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<td>Eccles and Kohli (1996)</td>
<td>Primary Health Care for Black and Minority Ethnic People- A GP Perspective.</td>
<td>Exploratory report for the NHS Ethnic Health Unit on Primary Health Care for Black and Minority Ethnic People.</td>
<td>Qualitative Study. 3 focus groups in Leicester, Newham and Bradford. Focus group discussions involved 50 GPs, 5 practice nurses and 16 other people who were divided into 12 small working groups. Issues and themes identified are included in the main text (Chapter 2). Overall 6 key recommendations made. Methodology for the 3 groups not the same hence different groups explored different areas. Some groups focused on topics given by the organisers of the groups but others were more open ended. This could give rise to heterogeneous representation of results and hence recommendations, although robust, cannot be generalised. A common topic guide would have been useful. However the insight given by the report findings would be interesting to explore these in this PhD study.</td>
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Webster et al (2002) The experiences and needs of Gujarati Hindu patients and partners in the first month after a myocardial infarction

40 Gujarati Hindu coronary patients in Leicester

Qualitative: Semi-structured interviews exploring experiences and health care needs. Interviewees preferred to speak in Gujarati even though they could speak English. Partners and family members or carers were invited to participate and this could have introduced bias into the analysis. Areas of interviewer bias also identified. Problems experienced with access to the sample despite postal reminders and telephone confirmation. Sample warmed to interviewer after 'interviewer rapport' was established.

Qualitative: Validation of standardized measures for assessing anxiety, depression and health-related QOL were used. Study highlighted the pitfalls of using quantitative methodology with South Asian patients. Patients and family members found difficulty in completing questionnaires, even though they were in the preferred language of the patient. Questions needed to be more structured and focussed.

Quantitative: questionnaires were not filled in appropriately

Qualitative: three themes identified: experiences, health care needs and cardiac rehabilitation. Many barriers and flaws in research methodology identified. (see comments)

A number of categories emerged from the data which pertained to a lack of information and advice, poor performance of activity, little lifestyle adjustment, poor expectations, lack of future plans, strong family support, dissatisfaction with the family doctor, and a significant belief in fate.

Experiences and health care needs of Gujarati Hindu patients with myocardial infarction appear different to those of non-Asians. Cardiac aftercare and rehabilitation services should take account of such information

The paper highlighted further insight into the intricacies of using both types of methodologies with south Asian patients.

This study confirmed the need to a more detailed qualitative study for this PhD study with further insight into the use of appropriate techniques in minimising bias in the execution of the study and analysis of the findings.

The findings also confirmed the need for exploration of socio-psychological issues underpinning health seeking patterns which could pertain to community pharmacy, as highlighted by for e.g. Hassall et al (2000).
Lindesay, Jagger et al (1997), Knowledge, uptake and availability of health and social services among Asian Gujarati and white elderly persons

405 Hindu Gujaratis and 381 whites aged 65 years and over residing in Leicester

Quantitative survey using bi-lingual workers
Participants were randomly sampled from the Leicestershire District FHSA list by a computerized method based on linguistic analysis of the patient's name. 150 Hindu Gujaratis and 152 whites were interviewed with response rates of 72% for the Asian Gujaratis and 80% for the white groups. The outcome measures were the activities of daily living (ADLs), incontinence, auditory/ visual deficits, cardiovascular disease, cognitive impairment (measured by the Mini- mental State Examination), depression, use of GP and hospital services, knowledge of community health and social services, willingness to use these services, suitability and cultural accessibility Bi-lingual health care workers were used to administer the questionnaire.

Results statistically analysed
Results showed a poorer uptake of services by elderly Asian Gujaratis and this could not be explained by assuming 'better health'. They were significantly more likely to be dependent in six of the 14 Activities of Daily Living scores and had higher rates of diabetes and impaired vision. Significantly more Asian Gujaratis than whites lived with others (84 versus 52%, p < 0.0001) with a greater availability of alternative sources of help and support. The knowledge and understanding of services were significantly poorer in the Gujarati group; fewer Asian Gujaratis knew how to apply for services and of those applying, fewer had been successful.

Where services had been obtained, the levels of dissatisfaction were higher in the Gujarati group. The literacy rates were low in the Gujarati sample with 78% being unable to read or write in English and 27% unable to read or write in their mother tongue.

The researchers concluded that the lower uptake of services by elderly Asian Gujaratis is not the result of better health but may be explained by greater family support together with a lack of knowledge of and dissatisfaction with what is available.

The researchers surmise that health services would need to be reappraised and revised if they are to cater adequately for this growing population with many needs as yet unmet.

This was a sound study and the methodology was clearly explained. The sample size was robust for statistical analysis of the results.

Themes such as communication, awareness of services, and the ability of South Asians to read and write in their mother tongue could be explored in this PhD study.

Although the research methodology was sound, the funding of this PhD study would have been exhausted if this methodology was adopted.
<table>
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<tr>
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<tbody>
<tr>
<td><strong>Methods</strong></td>
<td><strong>Results</strong></td>
</tr>
<tr>
<td>276 single handed GPs, including those from a South Asian background</td>
<td>Quantitative study design. Data collected by questionnaire and from routine sources in general practices in England. These included 155 single handed general practitioners: 42 Asian doctors qualified in United Kingdom (group 1), 58 white doctors qualified in United Kingdom (group 2), and 55 Asian doctors qualified in Indian subcontinent (group 3). Study tested whether Asian general practitioners who qualified in the Indian subcontinent prescribe items more often, more expensive items, and fewer generic drugs than their British trained Asian and non-Asian counterparts.</td>
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<td>The methodology and analysis of the findings of this study were robust and well explained. The study highlights that no data on the ethnicity of GP prescribers was available. The authors confirmed the confounding factors that could affect the study, including bias and that the study could not be generalisable to the wider population of GPs. It is important that for this exploratory PhD study, a suitable sample of GPs is chosen for interview.</td>
</tr>
<tr>
<td>Hassell et al (1997)</td>
<td>A pathway to the GP: the pharmaceutical 'consultation' as a first port of call in primary health care</td>
</tr>
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</table>
Morris, Cantrill et al (1997)  

| One simple question should be enough: consumers’ perceptions of pharmacy protocols | 40 consumers from 2 community pharmacies. No mention of where the study was conducted, and was presumed to be in the Manchester area. | Qualitative study to determine consumers’ views about over-the-counter (OTC) medicine purchases. Consumers’ views and spontaneous comments were obtained regarding their expectations when making their most recent OTC medicine purchase. 

Their awareness of the need for questioning, and their willingness to answer questions about minor ailments were explored using telephone interviews. | The majority of consumers had a degree of awareness of why pharmacy staff might require information 

25 consumers expected to make their most recent purchase without being questioned. 

Consumers’ attitudes to unsolicited questioning appeared to be affected by their perception of whether questioning was necessary. 

The majority of consumers seemed to view decisions about medicine purchase as their sole responsibility, rather than perceiving pharmacists to have a professional role. 

The results also suggested a wide variation in the needs and preferences of individual consumers. | Study methodology was robust and analysis methodology well explained, with confounding results and explanations for bias mentioned. 

No South Asians were interviewed in this study. 

Findings could be explored with South Asians in this study. |
### Vallis et al (1997)

**Users’ views and expectations of community pharmacists in a Scottish commuter town**

- **Participants:** 1050 participants
- **Methods:** 50 qualitative, semi-structured interviews were conducted with a random sample of adults; these were followed by a postal questionnaire to a further 1000 people.
- **Response Rate:** 60% response rate for postal questionnaire

The findings from qualitative interviews showed that respondents had high regard for community pharmacists, although many expressed low expectations of pharmacists’ diagnostic and therapeutic roles.

In the postal survey, pharmacy and dispensary services were more highly supported than the therapeutic and advisory roles of the community pharmacist.

Health professional aspects of pharmacy services were more highly valued than the consumerist aspects.

It was concluded that this study confirms the importance of considering users’ views in planning future community pharmacy services.

No mention of South Asian or ethnicity data in the study. The sample size was robust, and the quantitative findings were complemented by the qualitative findings of the study.

The paper did not mention how the focus groups were conducted and no details were given on how these were analysed.

The themes could be explored with South Asians in this PhD study.
Cooper et al (1998)  | Use of health services by children and young people according to ethnicity and social class: secondary analysis of a national survey (General Household survey).  

| 20,473 children and young people aged between 0 and 19 years were included in this analysis.  


The authors included consultations with a general practitioner within a two week period, outpatient attendances within a three month period, and inpatient stays during the past year.  

The authors assessed whether equity is achieved in use of general practitioner, outpatient, and inpatient services by children and young people according to their ethnic group and socioeconomic background.  

The study revealed no significant class differences in the use of health services by children and young people, and there was little evidence of variation in use of health services according to housing tenure and parental work status.  

South Asian children and young people used general practitioner services more than any other ethnic group after controlling for socioeconomic background and perceived health status.  

The use of hospital outpatient and inpatient services was significantly lower for children and young people from all minority ethnic groups compared with the white population. Indian children and young people are more likely to consult a general practitioner than any other ethnic group.  

A child or young person’s ethnic origin, was clearly associated with use of general practitioner and hospital services, which could imply that children and young people from minority ethnic groups receive a poorer quality of health care than other children and young people.  

These ethnic differences have important implications for the quality of health care received by children and young people  

The General Household survey does not explore the use of community pharmacy services  

This study was a retrospective analysis of a major national survey. The themes could be further explored in the PhD study.
<table>
<thead>
<tr>
<th>Stone, Patel, Panja et al. (1998)</th>
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<tr>
<td>Reasons for non-compliance with screening for infection with H Pylori, in a multi-ethnic community in Leicester, UK.</td>
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<td>600 patients (400 Asian and 195 non-Asian) in Leicester, aged 21-55 registered with a single practice.</td>
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<td>Quantitative study. Patients matched for sex and age group. Phase 1: 200 Asian and 200 non-Asians invited for screening test via mail. A screening patient information leaflet and letter only sent in English. All people who did not attend were interviewed using a structured questionnaire (a question with a list of possible answers) for reasons for non-attendance. Phase 2: A further 200 Asians (matched as before) sent out screening patient information leaflet and letter in both Gujerati and English. Non-attendees were not interviewed, but house-house enquiries made to identify those who had changed address. No computerised records held by practice. Asian and non-Asians were identified by name. Inadequate record keeping by the Health Authority was highlighted by the authors.</td>
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<td>Quantitative results analysed and showed no significant differences in attendance for screening between groups. For both Asians and non-Asians, females took up the test better than males. Significant differences between reasons for non-acceptance of the test were family reasons for the Asians and holiday commitments for the non-Asians. Other results cited but comparable for both groups included letter not read or fully understood, too busy (work commitments) etc. Language difficulties and leaflets in other languages are not considered to help in the uptake of screening tests. There needs to be other methods where the value of preventative medicine are effectively promoted and properly appreciated in South Asian patients.</td>
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<td>It was uncertain how the questionnaire and interview schedule was designed as to how 'open' or 'structured' the questions were actually were. Non-English speaking patients accompanied by family members for interpretation which could lead to bias, and it was noted that the Asians were more likely not to have fully read or understood the letter. Factors including a further exploration of how South Asians view screening services generally and how they are accessed are warranted by a further exploratory study, as the 'expanding' role of pharmacists includes the screening of patients and preventative health care. The use of translated methods for invitation and information also warrant further exploration in this PhD study.</td>
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<td>Abu-Omar, S et al (2000)</td>
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<td>Bell et al (2000)</td>
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<td>Farooqi, Nagra et al. (2000)</td>
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<td>Whittington et al. (2001b)</td>
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<td>Hassell et al. (2001)</td>
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| Beney, Bero and Bond (2001) | Expanding roles of outpatient pharmacists: effects on health services utilisation, costs and patient outcomes (Cochrane review) | Review using 25 studies with 40 pharmacists and 16,000 patients. | Selection criteria included RCTs, controlled clinical trials, controlled before and after studies and interrupted time series examining the following:
1. Pharmacist services targeted at patients vs. no services delivered by other health professionals
2. Pharmacists services for patients vs. no comparable service
3. Pharmacy services for health professionals vs. other services provided by health professionals
4. Pharmacist services for health professionals vs. no comparable service | For no.1-service utilisation increased whereas hosp. and A&E admissions decreased.
For no.2-pharmacist services decreased use of non-scheduled health services, specialist visits and the no/cost of drugs. There was an improvement in patient condition but no improvement of QOL.
For no.3-pharmacists peer education did better than pharmacy education to decrease inappropriate prescribing
For no.4-pharmacist intervention produced intended effects on physician prescribing but unable to show a difference in patients QOL.
Only 2 studies compared pharmacy services with other health professional services.
Both had bias and the reviewers could not draw conclusions for criteria 1 and 3.
Doubts were also cast on the generalisability of all the studies, poorly defined interventions and the lack of cost assessment and patient outcome data.
It was concluded that more rigorous research needs to be done, especially to document the effects of pharmacist interventions. | The studies was done in a hospital setting so would not be applicable to this PhD study. However, themes have been identified to further explore the barriers and use of extended roles with GPs, community pharmacists and service users, including the use of peer education in a health care setting and the impact of health care education for a South Asian patient. |
| Morris, Cantrill et al. (2001b) | GPs' attitudes to minor ailments | Study of 759 GPs in eight English health authorities. | GP’s experiences and perceptions of minor ailment consultations and their attitudes towards minor ailment management. An attitudinal statements were analysed using factor analysis. Questions for the quantitative study were derived from a series of 20 qualitative interviews with practicing GPs. A quantitative study using a questionnaire survey. The survey was sent to one GP randomly selected from each practice. Attitudinal statements were analysed using factor analysis. A poor response rate was obtained and this was acknowledged by the authors. 414 GPs (54.5%) completed and returned the questionnaire. Respondents were consulted regularly about minor illness or symptoms, with almost all (95.6%) having experienced a minor ailment consultation in the previous week. Statistical factor analysis suggested four issues to be of importance in determining GP’s attitudes to minor ailment management. These were attitudes towards pharmacists, attitudes towards patient empowerment, frustration with minor ailment consultations and attitudes towards caution/risk. GPs are clearly frustrated by the level of minor ailment consultations; this study suggests that there may be complex factors which influence their attitudes. The study highlights that for the optimal management of minor ailments, inter-professional relationships potentially are of great importance. With increasing patient demand, it is essential that finite health care resources are accessible, appropriate and used in an optimal way. Robust study methodology adopted including attitudinal statements. There was no mention of the ethnicity of GPs surveyed or their population demographics. Attitudes of GPs for minor ailments could be further explored in this PhD study, including that of professional collaboration and the need for exploration of local GPs views to the pharmacist management of minor ailments and their views of patient factors affecting minor ailments and their management. |
| Partidge and Hussein (2002) | Perceptions of asthma in South Asians and their views on educational materials and self-management plans: a qualitative study | 60 participants of South Asian origin | A qualitative study with 60 participants (12 participants with asthma for semi-structured interviews and 48 participants for focus groups) was designed to explore knowledge about asthma, attitudes, perceptions, health beliefs and health needs of those from Pakistan and India (South Asians). | Overall, most of the patients with asthma were aware of the symptoms and trigger factors of asthma and were well informed about the ‘reliever’ and ‘preventer’ properties of their inhalers.

They were also well informed about alternative/complementary therapies and were willing to try them should the treatment provided by their general practitioner (GP) fail to resolve their symptoms.

Most were dissatisfied with the asthma care provided by their GPs e.g. delays in making the diagnosis and deficiencies in providing both verbal and written information on asthma.

It was concluded that improved dissemination of written and verbal information on all aspects of asthma and increased awareness, training and support for adoption of written self-management (action) plans is needed to provide a more efficient and effective service for South Asian patients with asthma. | Methodology for this study well explained. Communication as a main theme warrants further exploration in for this study |
| Hibbert et al (2002) | Consumerism and professional work in the community pharmacy | Consumers, pharmacists and counter assistants from 10 community pharmacies in NW England | Observation study in community pharmacies followed by interviews and with 10 pharmacists; 4 focus groups with counter assistants; 94 interviews and 7 focus groups with consumers. The study methodology and analysis was fully described. 5% of the focus group participants were Pakistani. | Themes identified from consumers include:  
The importance of lay expertise, conveyed a strong sense of consumers’ ability to self-manage specific conditions using purchased medicines.  
Consumer views of purchased medicines for any insights that these might offer for the consumer-professional interaction.  
Themes identified by the counter staff and pharmacists include:  
The professional response to consumer expertise e.g. Respondents reported negative reactions from consumers when attempting to ask questions or provide simple advice about medication use.  
One outcome indicates that consumers were reluctant to be questioned, and generally felt they had sufficient knowledge through their experience of the treatment of the particular minor ailment. The focus was on buying a product rather than obtaining a professional service. In the examples discussed there seemed to be relatively little scope for a professional contribution, in terms of tailoring the treatment. | This study gives useful insight into some of the sociological explanations of health seeking behaviors of consumers in relation to minor ailments and the perceptions of community pharmacy and pharmacy staff towards the perceptions of consumers requesting advice for minor ailments.  
It would be interesting if these themes also resulted from the focus groups with South Asian patients in this PhD study.  
The two-strategy study methodology for this paper was noted as this could add to the findings of this PhD study if this method was adopted. This was a limitation of this PhD study. |
Schafheutle et al. (2002)  

Access to medicines: cost as an influence on the views and behaviour of patients  

3 community pharmacies used  
31 participants  
Study in the North west of England  
Qualitative methodology including focus groups  
Majority of focus group participants were non exempt from prescription charges  
The management behaviour of those participants who had to pay for their prescriptions, particularly those from less-affluent or deprived backgrounds, was influenced by cost.  
Factors such as symptom or disease severity, effectiveness, or necessity of treatment also identified  
Participants felt that paying for prescriptions was their problem.  
There was a belief that discussing cost issues could jeopardize the doctor-patient relationship.  
Medication cost influenced participants when deciding how to manage their condition.  
Awareness of the existence of prepayment certificates, which can be bought by patients who require regular medication,  
Current level of the prescription charge is still a barrier to obtaining prescription medicines under the NHS to those on lower incomes.  
Ethnicity profile or demographic profile was not captured  
Thematic analysis of the findings was mentioned, though no mention of precise methodology for rigour and neutrality in the interpretation of the findings  
Themes re cost and awareness of other routes of obtaining medicines need to be explored with South Asians for this PhD study
| Jackson and Peters (2003) | Introducing touchscreens to black and ethnic minority groups—a report of processes and issues in the Three Cities project | Intervention study | This study aimed to improve access to health information for ethnic minority groups by providing this in their own language, in an audio and visual format through a touchscreen computer. The study was led by health promotion and public health workers informed by advisory panels of representatives from local black and ethnic minority groups in the cities of Nottingham, Sheffield and Leicester. Discussion within the advisory panels and local epidemiological data helped to identify groups to be targeted and priority health issues to be addressed. Other issues covered during development included interface design, language translation and identification of accessible locations. | A number of problems were addressed in establishing appropriate touchscreen facilities, mainly relating to producing information in an electronic format for multiple languages and populations not necessarily computer-literate. Three touchscreens, containing information on 10 health topics, translated into five languages are currently installed, one in each city. They are being rotated through a series of locations including a library, GP practice, and a temple. Their use, and satisfaction with use, is being evaluated over a 2-year period, by statistical analysis of computer logs and the collection of qualitative information by bi-lingual interviewers with users, over an 18-month period. | As this study is on-going, the use of alternative communication methods (such as those highlighted in this study) will be explored in this PhD study. |
| Hughes and McCann (2003) | Perceived interprofessional barriers between community pharmacists and general practitioners: a qualitative assessment | Three locality areas of a health and social services board in Northern Ireland. | GPs and community pharmacists participated in uniprofessional focus groups; data were analysed using interpretative phenomenology.  

Twenty-two GPs (distributed over five focus groups) and 31 pharmacists (distributed over six focus groups) participated in the study.  

Limitations and potential bias in the findings were acknowledged by the authors | The 'shopkeeper' image of community pharmacy emerged as the superordinate theme, with subthemes of access, hierarchy and awareness.  

The shopkeeper image and conflict between business and health care permeated the GPs' discussions and accounted for their concerns regarding the extension of prescribing rights to community pharmacists and involvement in extended services.  

Community pharmacists felt such views influenced their position in the hierarchy of healthcare professionals.  

Although GPs had little problem in accessing pharmacists, they considered that patients experienced difficulties owing to the limited opening hours of pharmacies.  

Conversely, pharmacists reported great difficulty in accessing GPs, largely owing to the gatekeeper role of receptionists.  

GPs reported being unaware of the training and activities of community pharmacists and participating pharmacists also felt that GPs had no appreciation of their role in health care.  

A number of important barriers between GPs and community pharmacists have been identified, which must be overcome if interprofessional liaison between the two professions is to be fully realised. | A robust study identifying good methodological qualities.  

These themes are important for further exploration in this PhD study, particularly in relation to the South Asian population |
| Hammond et al (2004) | Patients’ use of GPs and community pharmacists in minor illness: a cross-sectional questionnaire-based study | This cross-sectional questionnaire study was conducted at 13 general practices in West Sussex, UK. 4232 questionnaires were distributed. A questionnaire was given to all patients attending appointments with their GP in these practices over a 1-week period, asking what the presenting problem was and whether the advice of a pharmacist had been sought. If patients had not sought the advice of a pharmacist, they were asked why not. The GP was then asked to indicate whether, in their opinion, the patient’s problem could have been managed by a community pharmacist. One potential bias in the study is that the patient handed their questionnaire to the GP at the start of the consultation, to maximize the response rate. It could, however, have made patients more likely to select reasons for attending the GP relating to trust in the GP rather than to say, for instance, that they had come for a free prescription. This was acknowledged by the authors. | The response rate was 94% (3984), representing 87% of all patients consulting their doctor during the week of the study. GPs felt that only 7% (280) of these visits could have been managed by a community pharmacist. The proportion of ‘unnecessary’ visits was significantly higher ($P < 0.001$) amongst young adults, those presenting with new medical problems and those consulting about a child’s health. Skin and musculoskeletal problems were the most common causes of ‘unnecessary’ visits to the GP. The majority of patients making ‘unnecessary’ visits (59%) disagreed with the GP and felt that the pharmacist would not have been appropriate for their problem. GPs and patients were, on the whole, in agreement over which conditions were appropriate for GP attention. There is, however, a need for education to increase awareness of the roles of pharmacists, aimed particularly at young adults and at those with children. Authors have illustrated that despite pharmacists having increased involvement in managing minor illness, many patients continue to attend their GP with problems that could be managed by community pharmacists. There is a need for education to increase awareness of the roles of pharmacists. | Limitations of the study is that data on ethnicity was not captured, and that the GPs’ opinions of what could and could not be managed by a pharmacist was taken as the gold standard, with which patients’ views were compared. Although this gave a clear picture of the extent to which GPs believed they were being used, the methodology did not allow exploration of GPs and patients views of what the role of community pharmacists entailed. This paper was published after Phase 1 of this PhD study, and preliminary results of Phase 1 of this PhD study indicate that GPs are unaware of the potential role of the community pharmacist in the management of minor ailments. Cost, poor access and lack of privacy did not appear to be important barriers to visiting a pharmacist (as illustrated by the study by Hassell et al 1998). It was patients’ perceptions of pharmacists that appeared most important in their decision to visit a GP instead; the majority of patients making ‘unnecessary’ visits believed that visiting a pharmacist would not have been appropriate for their problem, or simply had not considered it. |
| Parmentier H et al (2004) | Community pharmacy treatment of minor ailments in refugees | Refugees presenting with minor illnesses were offered a voucher. This voucher could be taken to the pharmacist, who, after a consultation, could exchange the voucher for appropriate OTC medication. Two hundred vouchers for free prescriptions were distributed to the refugees over the 5-month course. The presenting minor ailment and corresponding medication was recorded by the pharmacist. Additional Interpreting services were offered using telephone interpreters who could be contacted on specially purchased hands-free phone sets at the refugee accommodation and at the participating pharmacists. | A total of 200 vouchers were distributed to 184 refugees over a 5-month period resulting in the dispensing of 264 items. The five most frequent minor ailments were: upper respiratory tract infections (37%), headache (14%), musculoskeletal pains (7%), allergy including hay fever (6%), indigestion (6%). The five most frequently dispensed items were: paracetamol (28%), Sudafed (16%), ibuprofen (11%), aspirin (10%) and simple linctus (8%). Only two clients were referred directly to the GP and two advised to attend if symptoms persisted. | This study adds strength to the study by Whittington et al, and could add more value for the scheme to be extended to people whose first language is not English. Recommendations from this PhD study could be enhanced by the findings from this paper. |
APPENDIX 2
Ethics approval documentation
(available from the candidate in written format)
APPENDIX 3

Examples of database searches
IPA Search 1970- August 2007

Search History
#4 ethnic minorities(50 records)
Searches and results below from: IPA 1970-2007/06
#3 ethnic minorities(50 records)
Searches and results below from: IPA 1970-2007/06
#2 ethnic minorities(50 records)
#1 south asian ethnic minorities(0 records)

Search History
#9 ((( community pharmacist )and( consultation ))or( general practitioners ))(1135 records)
#8 ( community pharmacist )and( consultation )and( ethnic minorities )(0 records)
#7 ( community pharmacist )and( consultation )(314 records)
#6 ( community pharmacist )and( consultation patterns )(0 records)
#5 ( pharmacy services )and( ethnic minorities )(3 records)
Searches and results below from: IPA 1970-2007/06
#4 ethnic minorities(50 records)
Searches and results below from: IPA 1970-2007/06
#3 ethnic minorities(50 records)
Searches and results below from: IPA 1970-2007/06
#2 ethnic minorities(50 records)
#1 south asian ethnic minorities(0 records)

#11 ( minor ailments )and( general practitioners )(5 records)
#10 ( minor ailments )and( ethnic minorities )(1 records)
#9 ((( community pharmacist )and( consultation ))or( general practitioners ))(1135 records)
#8 ( community pharmacist )and( consultation )and( ethnic minorities )(0 records)
#7 ( community pharmacist )and( consultation )(314 records)
#6 ( community pharmacist )and( consultation patterns )(0 records)
#5 ( pharmacy services )and( ethnic minorities )(3 records)
Searches and results below from: IPA 1970-2007/06
#4 ethnic minorities(50 records)
Searches and results below from: IPA 1970-2007/06
#3 ethnic minorities(50 records)
Searches and results below from: IPA 1970-2007/06
#2 ethnic minorities(50 records)
#1 south asian ethnic minorities(0 records)

#14 ((( minor ailments )and( community pharmacists ))not( general practitioners ))(25 records)
#13 J-Soc-Adm-Pharm in SO(464 records)
#12 ( minor ailments )and( community pharmacists )(29 records)
#11 ( minor ailments )and( general practitioners )(5 records)
#10 ( minor ailments )and( ethnic minorities )(1 records)
#9 ((( community pharmacist )and( consultation ))or( general practitioners ))(1135 records)
#8 ( community pharmacist )and( consultation )and( ethnic minorities )(0 records)
Database: **CINAHL** <1998 to September 2001>
Search Strategy:

```
1  exp ETHNIC GROUPS/ (5597)
2  (asian$ or indian$ or bangladeshi$ or ethni$ or cultur$ or pakistani$ or
  sikh$ or punjabi$).mp. [mp=title, cinahl subject heading, abstract,
  instrumentation] (7949)
3  1 or 2 (10876)
4  pharmac$.mp. [mp=title, cinahl subject heading, abstract, instrumentation]
  (3408)
5  exp Health Promotion/ (2699)
6  health$ promotion$.mp. [mp=title, cinahl subject heading, abstract,
  instrumentation] (1760)
7  5 or 6 (3486)
8  exp COMMUNICATION/ or exp COMMUNICATION PROTOCOLS/ or exp
  COMMUNICATION
  SKILLS/ or exp COMMUNICATION BARRIERS/ or exp COMMUNICATION SKILLS
  TRAINING/ or
  exp "COMMUNICATION WITH COMMUNITY RESOURCES (OMAHA)="/ or exp
  NONVERBAL
  COMMUNICATION/ (8706)
9  communicat$.mp. [mp=title, cinahl subject heading, abstract,
  instrumentation] (6959)
10 8 or 9 (12535)
11 3 and 4 (80)
12  limit 11 to english (78)
13  from 12 keep 38 (1)
14  from 13 keep 1 (1)
15 3 and 7 (399)
16  limit 15 to english (393)
17  from 16 keep 8, 120 (2)
18  from 17 keep 1-2 (2)
19 10 and 3 (1070)
20 19 not 16 (1031)
21  limit 20 to (english and yr=1995-2001) (990)
22  south$ asian$ ethnic$.mp. [mp=title, cinahl subject heading, abstract,
  instrumentation] (3)
23  south$ asian$.mp. [mp=title, cinahl subject heading, abstract,
  instrumentation] (75)
```
Database: CINAHL <1998 to September 2001>
Search Strategy:

1 exp ETHNIC GROUPS/ (5597)
2 (asian$ or indian$ or bangladeshi$ or ethni$ or cultur$ or pakistani$ or sikh$ or punjabi$).mp. [mp=title, cinahl subject heading, abstract, instrumentation] (7949)
3 1 or 2 (10876)
4 pharmac$.mp. [mp=title, cinahl subject heading, abstract, instrumentation] (3408)
5 exp Health Promotion/ (2699)
6 health$ promotion$.mp. [mp=title, cinahl subject heading, abstract, instrumentation] (1760)
7 5 or 6 (3486)
8 exp COMMUNICATION/ or exp COMMUNICATION PROTOCOLS/ or exp COMMUNICATION SKILLS/ or exp COMMUNICATION BARRIERS/ or exp COMMUNICATION SKILLS TRAINING/ or exp "COMMUNICATION WITH COMMUNITY RESOURCES (OMAHA)"/ or exp NONVERBAL COMMUNICATION/ (8706)
9 communicat$.mp. [mp=title, cinahl subject heading, abstract, instrumentation] (6959)
10 8 or 9 (12535)
11 3 and 4 (80)
12 limit 11 to english (78)
13 from 12 keep 38 (1)
14 from 13 keep 1 (1)
15 3 and 7 (399)
16 limit 15 to english (393)
17 from 16 keep 8, 120 (2)
18 from 17 keep 1-2 (2)
19 10 and 3 (1070)
20 19 not 16 (1031)
21 limit 20 to (english and yr=1995-2001) (990)
22 south$ asian$.mp. [mp=title, cinahl subject heading, abstract, instrumentation] (3)
23 south$ asian$.mp. [mp=title, cinahl subject heading, abstract, instrumentation] (75)
24 21 and 23 (6)
25 from 24 keep 1, 6 (2)
Search for: from 17 [from 16 keep 8,120] keep 1-2
Citations: 1-2

Database: CINAHL <1998 to September 2001>
Search Strategy:

1 exp ETHNIC GROUPS/ (5597)
2 (asian$ or indian$ or bangladeshi$ or ethni$ or cultur$ or pakistani$ or sikh$ or punjabi$).mp. [mp=title, cinahl subject heading, abstract, instrumentation] (7949)
3 1 or 2 (10876)
4 pharmac$.mp. [mp=title, cinahl subject heading, abstract, instrumentation] (3408)
5 exp Health Promotion/ (2699)
6 health$ promotion$.mp. [mp=title, cinahl subject heading, abstract, instrumentation] (1760)
7 5 or 6 (3486)
8 exp COMMUNICATION/ or exp COMMUNICATION PROTOCOLS/ or exp COMMUNICATION SKILLS/ or exp COMMUNICATION BARRIERS/ or exp COMMUNICATION SKILLS TRAINING/ or exp "COMMUNICATION WITH COMMUNITY RESOURCES (OMAHA)"/ or exp NONVERBAL COMMUNICATION/ (8706)
9 communicat$.mp. [mp=title, cinahl subject heading, abstract, instrumentation] (6959)
10 8 or 9 (12535)
11 3 and 4 (80)
12 limit 11 to english (78)
13 from 12 keep 38 (1)
14 from 13 keep 1 (1)
15 3 and 7 (399)
16 limit 15 to english (393)
17 from 16 keep 8, 120 (2)
18 from 17 keep 1-2 (2)

Database: Medline <1993 to Present>
Search Strategy:

1 exp Ethnic Groups/ (21903)
2 (asian$ or indian$ or bangladeshi$ or ethni$ or cultur$ or pakistani$ or sikh$ or punjabi$).mp. [mp=title, abstract, registry number word, mesh subject heading] (187627)
3 1 or 2 (196898)
4 exp Attitude to Health/ or exp Knowledge, Attitudes, Practice/ or exp Patient Acceptance of Health Care/ (60197)
5 3 and 4 (5074)
6 limit 5 to (human and english language) (4756)
7 exp Great Britain/ (62590)
8 6 and 7 (264)
9 from 8 keep 3-4, 6, 9-11, 16, 18, 23... (86)
Ovid Technologies, Inc. Email Service

Search for: from 12 [from 11 keep
3-4,8,20-21,23-25,30-31,35-36,43,47,52,55,57-58,60,62-69,80,83,94-95,97-98,105,108-
109,111-114,117-118,120,122-123,126]
keep 1-46
Citations: 1-46

Database: Medline <1993 to Present>
Search Strategy:

1 exp Great Britain/ (62590)
2 exp Pharmacists/ or exp Family Practice/ or exp Managed Care Programs/ or
exp Community Pharmacy Services/ (46754)
3 minor$ ailment$.mp. [mp=title, abstract, registry number word, mesh
subject heading] (32)
4 exp Ethnic Groups/ (21903)
5 (asian$ or indian$ or bangladeshi$ or ethni$ or cultur$ or pakistani$ or
sikh$ or punjabi$).mp. [mp=title, abstract, registry number word, mesh subject
heading] (187627)
6 4 or 5 (196898)
7 2 or 3 (46776)
8 1 and 7 (3552)
9 limit 8 to (human and english language) (2763)
10 pharmac$.mp. [mp=title, abstract, registry number word, mesh subject
heading] (90030)
11 9 and 10 (126)
12 from 11 keep 3-4, 8, 20-21, 23-25, 30-31, 35-36... (46)
13 from 12 keep 1-10 (10)
14 from 12 keep 1-46 (46)

Ovid Technologies, Inc. Email Service

Search for: from 27 [limit 26 to english language] keep
1-2,9-11,14-18,20,22-25,28-28
Citations: 1-17

Database: Medline <1966 to Present>
Search Strategy:

1 exp Ethnic Groups/ (56757)
2 asian$.mp. [mp=title, abstract, registry number word, mesh subject
heading] (10245)
3 1 or 2 (64027)
4 exp PHARMACY/ (2743)
5 PHARMACY/ or exp COMMUNITY PHARMACY SERVICES/ (3600)
6 3 and 5 (13)
7 limit 6 to english language (13)
8 south asian.mp. [mp=title, abstract, registry number word, mesh subject
heading] (278)
9 comm$ pharm$.mp. [mp=title, abstract, registry number word, mesh subject heading] (1231)
10 pharmac$.mp. [mp=title, abstract, registry number word, mesh subject heading] (231867)
11 9 and 10 (1230)
12 1 or 8 (56969)
13 11 and 12 (3)
14 from 13 keep 1-2 (2)
15 from 13 keep 1-2 (2)
16 exp "Referral and Consultation"/ (31275)
17 minor ailment$.mp. [mp=title, abstract, registry number word, mesh subject heading] (68)
18 limit 17 to english language (59)
19 from 18 keep 6, 13, 20, 46, 51, 54... (7)
20 exp Self Medication/ (2358)
21 self medicat$.mp. [mp=title, abstract, registry number word, mesh subject heading] (2916)
22 20 or 21 (2916)
23 exp PHARMACY/ (2743)
24 community pharmac$.mp. [mp=title, abstract, registry number word, mesh subject heading] (1315)
25 23 or 24 (4000)
26 22 and 25 (45)
27 limit 26 to english language (42)
28 from 27 keep 1-2, 9-11, 14-18, 20, 22-23, 25-28 (17)

Ovid Technologies, Inc. Email Service
---------------------------------------
Citations: 1-2

Database: Medline <1966 to Present>
Search Strategy:
---------------------------------------
1 exp Ethnic Groups/ (56757)
2 asian$.mp. [mp=title, abstract, registry number word, mesh subject heading] (10245)
3 1 or 2 (64027)
4 exp PHARMACY/ (2743)
5 PHARMACY/ or exp COMMUNITY PHARMACY SERVICES/ (3600)
6 3 and 5 (13)
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9 comm$ pharm$.mp. [mp=title, abstract, registry number word, mesh subject heading] (1231)
10 pharmac$.mp. [mp=title, abstract, registry number word, mesh subject heading] (231867)
11 9 and 10 (1230)
12 1 or 8 (56969)
13 11 and 12 (3)
14 from 13 keep 1-2 (2)
Search Strategy:

1. `exp Ethnic Groups/ (56757)`
2. `asian$.mp. [mp=title, abstract, registry number word, mesh subject heading] (10245)`
3. `1 or 2 (64027)`
4. `exp PHARMACY/ (2743)`
5. `PHARMACY/ or exp COMMUNITY PHARMACY SERVICES/ (3600)`
6. `3 and 5 (13)`
7. `limit 6 to english language (13)`
8. `south asian.mp. [mp=title, abstract, registry number word, mesh subject heading] (278)`
9. `comm$ pharm$.mp. [mp=title, abstract, registry number word, mesh subject heading] (1231)`
10. `pharmac$.mp. [mp=title, abstract, registry number word, mesh subject heading] (231867)`
11. `9 and 10 (1230)`
12. `1 or 8 (56969)`
13. `11 and 12 (3)`
14. `from 13 keep 1-2 (2)`
15. `from 13 keep 1-2 (2)`
16. `exp "Referral and Consultation"/ (31275)`
17. `minor ailment$.mp. [mp=title, abstract, registry number word, mesh subject heading] (68)`
18. `limit 17 to english language (59)`
19. `from 18 keep 6, 13, 20, 46, 51, 54... (7)`
14  8 and 11 (75)
15  from 14 keep 4-5, 12 (3)
16  from 14 keep 4-5 (2)
17  limit 14 to english language (63)
18  from 17 keep 4, 9, 11-12, 19, 23, 31... (9)
19  from 17 keep 23 (1)
20  exp Ethnic Groups/ (56757)
21  south asian$.mp. [mp=title, abstract, registry number word, mesh subject heading] (346)
22  21 or "22".mp. [mp=title, abstract, registry number word, mesh subject heading] (200258)
23  exp Cultural Diversity/ or exp Culture/ or exp Cultural Characteristics/ or exp Cross-Cultural Comparison/ (93212)
24  cultur$ sensitiv$.mp. [mp=title, abstract, registry number word, mesh subject heading] (1597)
25  23 or 24 (94261)
26  exp PHARMACY/ or exp COMMUNITY PHARMACY SERVICES/ or exp EDUCATION, PHARMACY/ or exp EDUCATION, PHARMACY, CONTINUING/ or exp EDUCATION, PHARMACY, GRADUATE/ or exp LEGISLATION, PHARMACY/ (6752)
27  comm$ phamac$.mp. [mp=title, abstract, registry number word, mesh subject heading] (1230)
28  26 or 27 (7597)
29  22 and 25 and 28 (0)
30  25 and 28 (80)
31  14 or 30 (155)
32  14 or 26 (6823)
33  31 and 32 (144)
34  33 not 30 (75)
35  limit 34 to english language (63)
36  22 and 28 (37)
37  limit 36 to english language (36)
38  from 37 keep 8, 13, 16-17, 24 (5)
39  from 38 keep 1-5 (5)

Ovid Technologies, Inc. Email Service
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Search for: from 17 [limit 14 to english language] keep 4,9,11-12,19,23,31,41,51
Citations: 1-9

Database: Medline <1966 to Present>
Search Strategy:
--------------------------------------------------------------------------------
1  exp Cultural Sensitivity/ or exp Asians/ (0)
2  south asia$.mp. [mp=title, abstract, registry number word, mesh subject heading] (520)
3  1 or 2 (520)
4  cultural sensitiv$.mp. [mp=title, abstract, registry number word, mesh subject heading] (162)
5  3 or 4 (682)
6  exp "Pharmacy and Pharmacology"/ (0)
7  pharmac$.mp. [mp=title, abstract, registry number word, mesh subject heading] (231867)
8  6 or 7 (231867)
9  ailments.mp. (970)
10  minor ailment$.mp. [mp=title, abstract, registry number word, mesh subject heading] (68)
11  9 or 10 (974)
12  5 and 8 and 11 (0)
13  5 and 8 (9)
14  8 and 11 (75)
15  from 14 keep 4-5, 12 (3)
16  from 14 keep 4-5 (2)
17  limit 14 to english language (63)
18  from 17 keep 4, 9, 11-12, 19, 23, 31... (9)

***************************
APPENDIX 4

Phase 1

Letter of invitation (adapted for GP and pharmacist interviews)

Doctors interview documents
Questionnaire
Topic guide
Detailed topic guide (for moderator training purposes and reference)

Pharmacist interview documents
Questionnaire
Detailed topic guide (for moderator training purposes and reference)

Phase 2

Focus groups
Patient information leaflet
Consent form
Demographic data collection forms
Topic guide
Demographic details of focus groups
FACTORS INFLUENCING THE USE OF COMMUNITY PHARMACY SERVICES BY SOUTH ASIAN ETHNIC MINORITIES
PHASE 1 (PHARMACIST INTERVIEWS)

MAIN QUESTIONS (to be used with topic guide)

Q1. Can you tell me the percentage of S Asian ethnic minority clients in your area who use your pharmacy.

Q1.1 What particular information would you find pertinent to have on the computer?

Q2. In your opinion, are there any cultural beliefs or attitudes you may have come across that can influence health and health beliefs in this particular population?

Q3. What are your views on the use of complementary or alternative medicines and alternative practitioners by this particular population?

Q4. Have you received any formal training on awareness of cultural issues affecting ethnic minority health?

Q5. How do you communicate with patients who do not speak English (or another unfamiliar Asian language)

Q6. Do you tend to counsel all your patients or clients? If answer is NO how do you prioritise which patients/clients to counsel?

Q7. Research indicates that this particular population consults a GP as a first port of call (particularly for minor ailments) and I would like to have your thoughts on this. What might be the reasons for this?

Q7.1 A lot of pilot studies are being done with pharmacists actually working alongside GPs and other staff within the doctor’s surgery. Do you think that the concept of pharmacy triage would be accepted by (a) this particular population and (b) by the GPs themselves?

Q7.2 If cost barriers were removed, would these patients come to the pharmacist before going to the GP?

Q8. Are there any particular areas of health promotion your pharmacy targets to this population? What methods are used?

Q9. I would like your views on the recent Government initiatives ‘Pharmacy in the New NHS: implementing the future’. What initiatives, if any, do you think would be of benefit to this particular population?

Q9.1 What barriers, if any (other than those discussed) would you perceive for the provision of such services
FACTORS INFLUENCING THE USE OF COMMUNITY PHARMACY SERVICES BY SOUTH ASIAN ETHNIC MINORITIES
PHASE 1 (DOCTOR’S INTERVIEWS)

1. INTERVIEWEE DETAILS AND PRACTICE DEMOGRAPHICS (to be filled in by the interviewee prior to the interview)

1.1 PRACTICE NAME AND ADDRESS

1.2 NAME OF DOCTOR INTERVIEWED 1.3 SEX M/F

1.4 LENGTH OF TIME IN GENERAL PRACTICE

☐ 1-5 yrs  ○ 6-10yrs  ○ 11-15yrs  ○ >15yrs

1.5 Please tick ANY of the following that best describes your ethnic background and religion (if you are from a South Asian ethnic minority background)

<table>
<thead>
<tr>
<th>BACKGROUND</th>
<th>RELIGION</th>
</tr>
</thead>
<tbody>
<tr>
<td>INDIAN</td>
<td>HINDU</td>
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<td>PAKISTANI</td>
<td>SIKH</td>
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<td>BENGALI</td>
<td>MOSLEM</td>
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<tr>
<td>INDO-CARIBBEAN</td>
<td>SIKH</td>
</tr>
<tr>
<td>MALAYSIAN (OR SE ASIAN)</td>
<td>OTHER (PLEASE STATE)</td>
</tr>
</tbody>
</table>

1.6 Do you speak a South Asian language? Y/N (If Y go to 1.7. If N go to 1.8)

1.7 If YES, please indicate which one(s)

☐ HINDI
☐ GUJERATI
☐ PUNJABI
☐ URDU
☐ BENGALI
☐ TAMIL
☐ ARABIC

1.8 Please indicate the following:

1.8.1 The number of male doctors within the practice
Of these the number from S Asian ethnic minority background ............

1.8.2 The number of female doctors within the practice
Of these the number from S Asian ethnic minority background ............

1.8.3 The number of other practice staff from S Asian ethnic minority background ....

THIS INFORMATION WILL BE TREATED AS CONFIDENTIAL AND WILL ONLY BE USED FOR RESEARCH PURPOSES. NO DATA WILL BE DISCLOSED WITHOUT PRIOR CONSENT.
Dear Dr xxxxxxxxx

Medicines and health information to the S Asian ethnic minorities: the role of pharmacists.
Phase 1: Overcoming barriers—A GPs perspective

Thank you for agreeing to be interviewed as part of my research project. I am writing to confirm the following:

Interview date:
Time:
Venue:

The interview will be of a semi-structured format and will be tape-recorded for transcribing. I can assure you that no part of this interview will be publicised or used without prior permission from yourself. The information will only be used as anonymised data as part of the final research report.

I would also be grateful if you could fill in the enclosed questionnaire prior to the interview and hand it to me when I come to conduct the interview.

Background: I am investigating the role of pharmacists in providing drug and health information to the S Asian ethnic minorities in Leicestershire. Previous research indicates that for this role to be effective, certain barriers (e.g., cultural, communication, etc.) have to be understood and possibly overcome. In the first instance, I will be conducting interviews with GPs, pharmacists, and several focus groups of patients from different S Asian ethnic minority backgrounds. This data will then be analysed and the findings used as data to research a second intervention phase of this project.

The project is being funded by the Medicines Information Centre, LRI. The steering group that is guiding me comprises of the following members:

Dr Nicola Seare (research manager, UHL Trust): 1st supervisor
Dr A Farooqi (East Leicester Medical Practice)
Dr M Johnston (Research associate, Mary Seacole School of Nursing)
Dr David Upton (Centre for Pharmacy Practice Research, DMU)
Mr Peter Golightly (Director, Trent Medicines Information Centre, LRI)

Please do not hesitate any of the above or myself if you have any queries regarding the project or if you require further clarification.
DOCTORS INTERVIEWS

THE FOLLOWING QUESTIONS MUST BE ASKED AND FURTHER EXPLORED USING THE TOPIC GUIDE.

Q1. I’d like you to give me an overall picture of the ethnic minority patient population of the practice.

   Q1.a What information would be of benefit?

Q2. Are there any predominant reasons or patterns for ethnic minority consultations?

Q3. I would like to find out a little bit about how you communicate with these patients, particularly those that have difficulty in speaking English.

Q4. Previous research in this field suggests that cultural influences may affect how this population perceives good health and health promotion. Can I ask you your view on this subject?

Q5. Have you received any formal training on awareness of cultural issues affecting ethnic minority health?

Q6. I would like to have your views on what cultural beliefs you think in particular affect the health in this particular population, particularly patients compliance/concordance to taking medicines.

Q7. I would like to ask about methods of health promotion used for this population in your practice. What methods are used in your practice?

Q8. Can I ask you for your opinions on the services currently provided by community pharmacists to members of this population and the potential ‘extended’ roles?
FACTORS INFLUENCING THE USE OF COMMUNITY PHARMACY SERVICES BY SOUTH ASIAN ETHNIC MINORITIES
PHASE 1 (PHARMACIST INTERVIEWS)

1.1 PHARMACY NAME AND ADDRESS

1.2 NAME OF PHARMACIST INTERVIEWED

1.3 SEX  M / F

1.4 CURRENT EMPLOYMENT

- Employed by a multiple
- Employed by an independent
- Proprietor pharmacist
- Locum (self employed) pharmacist

1.5 LENGTH OF TIME IN PHARMACY PRACTICE

- 1-5 yrs
- 6-10 yrs
- 11-15 yrs
- >15 yrs

1.6 Please tick ANY of the following that best describes your ethnic background and religion
(if you are from a South Asian ethnic minority background)

<table>
<thead>
<tr>
<th>BACKGROUND</th>
<th>RELIGION</th>
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</thead>
<tbody>
<tr>
<td>INDIAN</td>
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<td>MOSLEM</td>
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<tr>
<td>INDO-CARIBBEAN</td>
<td>SIKH</td>
</tr>
<tr>
<td>MALAYSIAN (OR SE ASIAN)</td>
<td>OTHER (PLEASE STATE)</td>
</tr>
</tbody>
</table>

1.7 Do you speak a South Asian language?  Y/N  (If Y go to 1.8.  If N go to 1.9)

1.8 If YES, please indicate which one(s)

- HINDI
- GUJERATI
- PUNJABI
- URDU
- BENGALI
- TAMIL
- ARABIC
FOCUS GROUP DISCUSSION WITH MEMBERS OF THE PUBLIC

To investigate and establish methods to promote the role of the community pharmacist to members of the South Asian ethnic minorities in Leicestershire

Date:

Discussion group no:

No of people present:

No of males:

No of females:

Ethnic background:

Interviewers:

Language used to conduct discussion:

Venue:

Time started:     Time finished:

LAYOUT OF SEATING PLAN
PATIENT CONSENT FORM

To investigate and establish methods to promote the role of the community pharmacist to members of the South Asian ethnic minorities in Leicestershire

Principal Investigator: Neena Lakhani, MRPharmS, Research Pharmacist

Academic Supervisor: Professor Mark Johnson, De Montfort University

This form should be read in conjunction with the Patient Information Leaflet

I agree to take part in the above study as described in the Patient Information Sheet.

I understand that I may withdraw from the study at any time without justifying my decision and without affecting my normal care and medical management.

I understand that all the information I provide will be treated as confidential.

I understand medical research is covered for mishaps in the same way as for patients undergoing treatment in the NHS i.e. compensation is only available if negligence occurs.

I understand that the focus groups will be audio-recorded, and should I wish a copy of the tape or transcript will be made available to me.

I have read the patient information leaflet on the above study and have had the opportunity to discuss the details with Neena Lakhani and ask any questions.

Signature of patient ..........................................................

Date......................................

(Name in BLOCK LETTERS) ............................................................................................... 

I confirm I have explained the nature of the study, as detailed in the Patient Information Sheet, in terms which in my judgement are suited to the understanding of the patient.

Signature of Investigator  ..................................................

Date......................................

(Name in BLOCK LETTERS) ............................................................................................... 

PATIENT INFORMATION LEAFLET

Investigating and establishing methods to promote the role of the community pharmacist to members of the South Asian ethnic minorities in Leicestershire

Principal Investigators: Professor Mark Johnson  
Professor of Ethnicity and Diversity, De Montfort University  
Neena Lakhani  
Research Pharmacist

You may contact: Neena Lakhani  
Research office  
Leicester General Hospital  
Gwendolen Road  
Leicester  
Tel: 0116 2588183  
Fax: 0116 258 4226  
Email: neena222@hotmail.com

You are invited to participate in this research project. Please take your time to read this patient information leaflet and discuss it with your family. Please do not hesitate to ask Neena Lakhani (at the telephone number and address above) if you need to know more about the project and / or to make the information given below more clear.

1. **What is the purpose of the study?**

We would like to explore the views and attitudes of South Asian ethnic minority patients to the services provided by community pharmacists in Leicester.

We hope that the results of this study will help identify any cultural sensitivities and/or specific health care needs of this population.

The information collected in this study will be used to improve existing services and develop any new services by community pharmacies to meet the specific needs of the South Asian ethnic minority patients.

2. **What will be involved if I decide to take part in the study?**

You will be invited to take part in a group discussion on selected topics around community pharmacy services and any cultural issues that affect the health care of the South Asian community. It is hoped that the discussion will last for 1-2 hours.
The principal investigator (Neena Lakhani), who speaks English and Gujarati, will facilitate the discussion. She will also have an assistant (who speaks English, Hindi and Punjabi) to help her in the discussion.

Groups will be conducted separately for males and females.

The group discussion will be recorded on an audiotape (i.e. via a tape recorder). The contents will be transcribed and used as a basis for the study analysis. A copy of the audiotape or the transcription (the written version) will be made available should you request it.

3. Will information I provide for the study be confidential (i.e. private)?

Any information for the study obtained will be dealt with in the usual degree of confidentiality under the Data Protection Act (a government law). This means that the information you give is anonymous (your name will not be mentioned anywhere) and the information will not be given to any third party. It will only be used for research purposes.

You will not be identified by name in any documents relating to the study.

4. What if I am harmed by the study?

It is very unlikely in this particular study. However, any medical research is covered for anything that goes wrong in the same way as for patients undergoing treatment in the NHS i.e. if there is negligence in the way you have received treatment then you can be compensated.

5. Will I receive out of pocket expenses for taking part in the study?

The group discussions will be conducted in a venue to be determined in the near future. We hope that this will be in a meeting room in a neighbourhood centre or similar, near the area where you live.

You will be re-imbursed your travelling expenses (upto a maximum of £5), at standard public transport rates.

6. What happens if I do not wish to participate in this study or wish to withdraw from the study?

If you do not wish to participate in this study or if you wish to withdraw you may do so at any time before, during or after the study.
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<thead>
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<th>Resp No. and post-code</th>
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<th>Marital status (Married, Single, Divorced, Widowed)</th>
<th>Number of household members</th>
<th>Languages spoken (S), understood (U) and read (R) inc. English (please indicate main spoken language with a *)</th>
<th>Country of birth</th>
<th>Length of residence in UK</th>
<th>No of visits to pilgrimage/homeland in last 5 years</th>
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<td>Adults</td>
<td>Children (&lt;12 yrs)</td>
<td>Language S U R</td>
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<td>Data collection form</td>
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<td>Number of household members</td>
<td>Languages spoken (please indicate main spoken languages with a *)</td>
<td>Country of birth</td>
<td>Length of residence in UK (yrs)</td>
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<td>Number of household members</td>
<td>Languages spoken (please indicate main spoken languages with a *)</td>
<td>Country of birth</td>
<td>Length of residence in UK (yrs)</td>
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* preferred spoken language
FOCUS GROUP 3  PUNJABI FEMALE  
MODERATOR:  DAVINDER NAGRA  
RESEARCHER:  NEENA LAKHANI  
Interview conducted in Punjabi

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- Participants did not know their exact age
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- All participants did not wish to personal details except what is stated above
FOCUS GROUP 6  MOSLEM MALE  
MODERATOR:  DAVINDER NAGRA  
RESEARCHER:  NEENA LAKHANI  
Interview conducted in English and Gujerati

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* Manager of the centre  
All participants did not wish to personal details except what is stated above
Appendix 5
Case vignettes
Appendix 5

Examples of reflexive diary entries illustrating ‘vignettes’ of two GP settings

(Phase 1)

Illustrative case note diary entry: Vignette 1

Field notes and Diary for interview with GP5 (South Asian)

Location: surgery in Highfields.

Reception manned by mainly S Asian ethnic minority ladies. Practice manager is white

Surgery has one female GP (white) and 3 male GPs of Hindu origin.

According to the GP and Practice manager, 95% of the patients are from South Asian ethnic minorities background, though no specific information was captured on the practice computers.

Languages spoken by practice staff: English, Gujerati, Hindi and Punjabi.

Leaflets: many displayed but in haphazard order. Whilst I was waiting to see the doctor, I did not see anybody picking up any leaflets or reading any of the posters. Many leaflets were strewn on the floor and in and around the waste bins in the reception.

Patients varied from parents with children to the elderly. The reception area was full despite it being near closing. Some heated arguments observed with receptionist about prescriptions and appointments. A television screen was in waiting area but not displaying anything. The practice employed a female nurse of South Asian origin. Receptionists were invited into consulting rooms to interpret or be chaperones.

Interview lasted for about an hour and towards the end of the interview he was in a hurry to leave. GP 5 was very polite and courteous but nevertheless did not want to go into too much depth about his practices. Despite having a good relationship with the PCT prescribing advisor (a pharmacist), his attitude seemed to be quite non-committed when it came to the discussion of pharmacists taking new roles and admitted he did not know much about their training or what role they could play in alleviating the pressures on GP services.

Patients insisted on making appointments with him rather than the other GPs and it appeared he was very popular with his patients. His receptionists acknowledged this.
Illustrative case note diary entry: Vignette 2

Field notes and Diary for interview with GP1 (European)

Location: surgery in Highfields, Leicester.

Reception manned by mainly white receptionists on the day of interview. Practice manager is South Asian.

Surgery has doctors from both white and South Asian backgrounds with some female GPs. Patients are from both South Asian ethnic minorities, white Caucasian and a few from African origin.

Languages spoken: English, Gujerati, Hindi and Punjabi: not obvious to me whether any staff spoke these as the receptionists spoke in English. Medical centre was open plan, bright and airy with many visually aided posters and electronic notice boards.

Leaflets: many displayed and well laid out. Whilst I was waiting to see the doctor, I did not see anybody picking up any leaflets or reading any of the posters.

Patients varied from parents with children to the elderly.

GP1 did his consultations in English. He was very positive about practice pharmacists as he had the experience of having a prescribing advisor looking at his repeat prescription services. But this was a relatively new role and he did not elude further into the benefits of a pharmacy service as this was new to him.

Interview lasted for about an hour. GP1 was very amiable. His attitude seemed positive when it came to the discussion of Pharmacists taking new roles and admitted he did not know much about their training or what role they could play in alleviating the pressures on GP services.

I also had the opportunity to meet the Senior partner of the practice who was very interested in the outcome of this project. He was very positive about prescribing advisors (PCT pharmacists) and the role they could play, but again did not know much community pharmacists could help alleviate the pressure on GP services. He did confirm that he wanted to see more South Asian patients coming to him about their chronic disease management than minor ailments.
Examples of reflexive diary entries illustrating ‘vignettes’ of two pharmacy settings (Phase 1)

**Illustrative diary entry: Case Vignette 3: Pharmacist**

Field notes and diary for interview with Pharmacist 3 (locum pharmacist)

**Location:** Independent Pharmacy on Belgrave Road

Pharmacy was small, but bright and airy. There was a private office at the back. The pharmacy was open plan with a medicines counter and a retail area selling Schools sandals, toiletries, some cosmetics and bins of ‘special offer goods’. There was a rack where leaflets were displayed but was haphazard and some leaflets out of the reach of patients. The interviewer could not see any leaflets in other languages. There was no special consultation area where patients could speak without being overheard unless taken to the dispensary or the office.

The interview was interrupted several times due to dispensing, professional checks and counter prescribing. The dispenser had gone to lunch and the pharmacy was staffed by a counter assistant.

The interview was timed for about an hour but took longer. The thought process was constantly disrupted and the interviewer had to remind Pharmacist 3 of what had been said and what the current train of thought was to be focused on.

Pharmacist 3 is a very experienced locum pharmacist and has worked extensively in the areas of Belgrave and Highfields in Leicester, as well as Loughborough. She speaks Gujarati and Hindi and feels it is vital to have knowledge of Gujarati if working in Belgrave as most of her patients and clients speak Gujarati. She feels that her patients ‘trust’ her and her counter staff if they speak in Gujarati. The younger clients speak English but she has a fair clientele of elderly patients who need extra time to be explained about their medicines.

There were hardly any sales of counter products and Pharmacist 3 says counter sales are fairly low in this area. People mainly come in for prescriptions.

The relationship with the GP only goes as far as prescription queries. Although enthusiastic about new pharmacy services, she is unenthusiastic about the remuneration and the relationship with the GPs who she says do not make any attempt to treat her as something more than a shopkeeper and a dispenser of medicines. She seems fed up of trying and is now performing a job that remunerates her well. Her patients also perceive her as a dispenser and she says, without extra staff investment, she cannot spend the time she wants with her patients and do a health advisory role. Observing the few people who came into the shop, the interviewer confirmed that the advice was given in Gujarati and English about medicines dispensed and only when asked by the patient or representative.
Illustrative diary entry: Case vignette 4: Pharmacist

Field notes and diary for interview Pharmacist 1 (manager Leicester City Centre)

Location: Pharmacy in Gallowtree Gate (large multiple)

A large city centre store where the pharmacy was bright and airy. The pharmacy was open plan with a big medicines counter. The retail area was a large open place space with a large superstore type of feel. There was a good counter area with a good range of P and GSL medicines.

Leaflets were displayed around the pharmacy area and also at many points on the GSL shelves in the retail area. All were within reach of patients and clients. The interviewer could not see any leaflets in other languages. There was no special consultation area where patients could speak without being overheard unless taken to the dispensary. There was a small area in front of the dispensary where patients could wait for their medicines. Pharmacist 1 gave the interview away from the dispensary and there was another pharmacist on duty.

The pharmacy is well staffed and duties are well delegated. The staff included members who could speak Gujerati but did not work there on a regular basis. Pharmacist 1 worked at the pharmacy on a shift basis and the pharmacy is normally open from 8.00am to 10.00pm. The pharmacy was manned by counter assistants all fluent in English.

Pharmacist 1 is a very experienced pharmacist and has worked extensively in and around Leicester and also in the hospital sector. She speaks English and her clientele is mainly City Centre shoppers and office workers. Most South Asian clientele speak English. However, she does struggle when it comes to dealing with representatives of the patients, who normally come and pick up prescriptions for their elderly relatives. She does try and get the message across but talking via relatives can prove difficult when they have to speak to the patients themselves. There were good sales of counter products and Pharmacist 1 says counter sales are fairly good in this area. She does admit that South Asian clients come in mainly for prescriptions and are often buying things on behalf of their relatives and children. She admits she does not have any ‘loyal’ patients and that her patients vary everyday due to their location. She has not come across any problems with South Asians who take herbal remedies. She does have knowledge of the standard complementary therapies (herbal, aromatherapy and homeopathy) which she sells in her store. The relationship with the GP is building up slowly although it is one to solve prescription queries and supply of medicines. The GPs are from all over Leicester due to the clientele of the store.
Examples of reflexive diary entries illustrating ‘vignettes’ of a focus group setting (Phase 2)

**Illusttrative diary entry: focus group observations of the principal investigator**

**Focus groups 5 and 6** (Moslem groups)

**General field observations**
Language used: Gujerati and English. Participants also spoke Kacchhi and Gujerati and fellow participants ‘interpreted’ for those more comfortable speaking in Kacchhi.

This forum, where a common ‘daily’ language is used to conduct discussions and for participants to feel comfortable with the moderators is vital. At the beginning, some of the older women in the group found it difficult to open up and proved initially very difficult to communicate with, but these participants observed the behaviour and body language of the moderators carefully before they participated.

A meal was provided for all participants and this was very well received. The catering was organised by the community centre (halal etc respected) and in itself the meal was very simple. It gave a chance for the moderators and participants to open up, and after the meal all participants wanted more of these ‘discussions’ and welcomed any initiatives that could provide them with relevant information.

The manager of the community centre also informed the moderators that the feedback was very positive.

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<td><strong>General field observations</strong></td>
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</tr>
<tr>
<td>This forum, where a common ‘daily’ language is used to conduct discussions and for participants to feel comfortable with the moderators is vital. At the beginning, some of the older women in the group found it difficult to open up and proved initially very difficult to communicate with, but these participants observed the behaviour and body language of the moderators carefully before they participated.</td>
</tr>
<tr>
<td>A meal was provided for all participants and this was very well received. The catering was organised by the community centre (halal etc respected) and in itself the meal was very simple. It gave a chance for the moderators and participants to open up, and after the meal all participants wanted more of these ‘discussions’ and welcomed any initiatives that could provide them with relevant information.</td>
</tr>
<tr>
<td>The manager of the community centre also informed the moderators that the feedback was very positive.</td>
</tr>
</tbody>
</table>
APPENDIX 6
Proposal for a major intervention study (Phase 3)
APPENDIX 6

Proposal for a major intervention study

It was envisaged that the findings of this study would be used to inform a more substantive study. The proposal for a randomised clinical trial is outlined below. The principal investigator of this study worked with a team of researchers from the University Hospitals of Leicester in the preparation of this study. Funding was sought from the The National Institute for Health Research Service Delivery and Organisation (NIHR SDO) programme and the application for this was submitted in April 2004.

A clinical trial comparing a community pharmacy based minor ailment service to one provided through a GP practice

Aims: To compare the acceptability, outcome and costs of community pharmacists and general practice care of minor illness in a multicultural city population.

Objectives:
(i) Determine the proportion of people with minor illness who present to primary care and who will accept care from a community pharmacist by their ethnicity;
(ii) Compare the process, health and participant orientated outcomes of pharmacist and general practice care;
(iii) Compare the costs of each type of care;
(iv) Determine how representative people who accept randomisation are of those who seek care from community pharmacies and general practices

Study type: Parallel RCT with participant preference arms.

Context: The study will take place in the Eastern Leicester PCT, a primary care trust with a population of 180,000 of whom approximately 34% are considered to be of South Asian origin.

Methods: A sample of people who present to primary care with minor illness will be invited to participate in a RCT of usual care of minor illness by general practices or care from community pharmacists. Those who decline randomisation will be invited to participate in a descriptive study of people who chose each type of care. All participants will have a brief baseline interview at which a follow up will be arranged in for 5 to 7 days time and given a
study pack with trial diary and questionnaires. They will then receive the care they were randomised to or choose. At follow up interview, the initial questionnaires and study diary will be reviewed, repeat study measures administered and, if symptoms have not resolved, participants encourage to continue their dairies until 14 days and return them. This will be prompted by telephone. A quota sample will drawn from each arm and interviewed to increase understanding of their choices.

**Outcome measures.**

(i) The proportion of participants who accept pharmacy care by age, sex, ethnicity and diagnosis.

(ii) Process and outcome of care: Patient satisfaction and quality of life, symptom duration, amounts and types of medications prescribed/administered/purchased, referrals to practices (in the pharmacy arm) and other services, reconsultation rates. Preferences for pharmacy or practice care will be explored using qualitative interviews with a quota sample of participants.

(iii) Costs: contacts with practice staff and pharmacy staff, prescription and over the counter medications, repeat visits to any staff and referrals, patient borne costs. EuroQol (EQ-5D) and a modified CSQ will be used for the economic/satisfaction evaluation. Patient satisfaction will be used to inform a cost-effectiveness analysis.

**Analysis:** For the randomised control trial interview and diary data will be compared between the two treatment groups using appropriate parametric and non-parametric methods controlling for differences at baseline. Patients who chose each type of care will be compared using similar methods.
Proposal for a randomised clinical trial comparing a pharmacist led minor ailments service with a general practice led service

Service User request for care of minor illness

Invitation to participate in study

Accepts

Randomisation

NO, wants pharmacist care

YES

NO, wants GP care

Pharmacy care

Practice care

Consent, symptom/cost diary, provisional appointment for interview

PHARMACY CARE
Anonymised Age, Sex, Ethnicity and Presentation from 'study tickets'

PRACTICE CARE
Anonymised Age, Sex, Ethnicity, Presentation from consulting practitioners

Interview at 3 – 7 days

Diary returned at 14 days (telephone prompt)

Reconsultation rate and service utilisation within 28 days abstracted from notes

Key:

Patient preference arm

RCT
Appendix 7
Executive report for Phase 1 scoping study
To investigate the role of the community pharmacist as a health advisor to members of the South Asian ethnic minorities in Leicestershire.

Neena Lakhani
Research Pharmacist
Medicines Information Centre
Leicester General Hospital
UHL

EXECUTIVE REPORT

Draft only (academic report)
To investigate the role of the community pharmacist as a health advisor to members of the South Asian ethnic minorities in Leicestershire.

EXECUTIVE REPORT

INTRODUCTION

Research has been undertaken looking at the medicine and health information needs of the ethnic minority populations, particularly in the South Asian community. To date, the evidence suggests that communication between members of the public and health professionals can and should be improved. An editorial in the British Medical Journal (1) suggests that the NHS needs to provide accessible interpreting services for all health care personnel. It comments on the fact that health authorities lack knowledge about the languages spoken in their districts and of the extent of the need for interpreter services. This can also have implications for the recently introduced NHS Direct.

It has been suggested that primary care groups should consider a pro-active pharmacy input since their emphasis will be on local communities, improving services, increasing the quality of care and tackling health inequalities more effectively. (2,3).

Jesson et al (4) concluded that pharmacy services are not utilised effectively by the South Asian ethnic population because of both communication problems and how the pharmacist’s role is perceived by this particular population. It has also been emphasized that it is not only communication needs that are important for pharmacists working with the South Asian ethnic minorities. The overall understanding of the cultural issues surrounding the use of both conventional and traditional Asian medicines as well as other cultural sensitivities and practices (e.g. the Fast of Ramadan) play an important part in this population.

In recent years there have been moves by the government and pharmaceutical bodies to promote the role of the pharmacist in treating minor ailments. (2) This should contribute to a reduction of the drug budget for the NHS and also allow General Practitioners (GP) time to deal with more serious cases. GPs have been encouraged to liase with pharmacists on this issue. There have been mixed reactions to the role of the pharmacist treating minor ailments; some bodies have felt that pharmacists perform poorly when advising patients on minor ailments, whilst others have felt that the range of minor ailments that a pharmacist can treat should be expanded.

Local health education and health promotion initiatives in Leicestershire, for example ‘Project Dil’, have been shown to have positive interim outcomes. (7) However, many such initiatives do not utilise the skills of the local community pharmacist.

Leicester has a South Asian ethnic minority population of 25%. In Eastern Leicester PCT, the total population is 180,000 of which over 35% is of South Asian origin. These statistics and current local health strategies highlight a further need for research aimed at meeting the health care needs for this population. For community pharmacists to have an appreciable role in providing an information service for these people, it is important to have an understanding of these issues, particularly at local level, as well as being aware of various risk factors for different diseases states in this particular population.
RESEARCH AIMS

This project aims to explore the following areas:

- The perception of the current pharmacy services by members of the local South Asian ethnic population and local GPs
- The GPs and pharmacists’ knowledge of cultural sensitivities (if any) relating to the use of medicines by the local South Asian ethnic population.
- Identify barriers and incentives for the ‘new’ extended community pharmacy services from local GPs, community pharmacies and members of the local South Asian ethnic minority population

The research project is executed in three phases.

**Phase 1** (time span 18 months commenced Nov 2000) uses qualitative research methodology to explore the views of five local General Practitioners and five community pharmacists. **This report concentrates on Phase 1 of the project.**

**Phase 2** (research underway) involves the using focus groups of members of the South Asian ethnic minority to explore further themes that evolve from Phase 1.

**Phase 3** (to be executed) will build on the results of Phase 1 and 2 to undertake an evaluation of the role of the community pharmacist as a health advisor, with particular emphasis to the management of minor ailments.

PHASE 1

AIMS

- To investigate the views of local GPs and pharmacists of their perception of pharmaceutical advice and services
- To explore methods used for the provision of information/advice relating to the use of medicines, particularly for minor ailments.
- Cultural influences relating to the use of medicines in general will also be investigated.

OUTCOMES

Analysis of the data should highlight/identify the knowledge of cultural beliefs that influence a GP consultation process and the role of the pharmacist in addressing patient education and patient information needs of members of the South Asian ethnic minorities.

METHODOLOGY

Advice and help from a steering group of research associates was obtained to formulate appropriate topic guides for the interviews. The group comprised of 6-7 research active personnel from organizations interested in the research topic.
Ten semi-structured interviews were conducted with individuals comprising of the following participants. The sample was identified by members of the steering committee using similar demographic and epidemiological population characteristics of the Belgrave (mainly Hindu) and Highfields (Mainly Moslem and Sikh) areas of Leicester.

6 GPs (ethnic and non-ethnic origin)
5 Community pharmacists (ethnic and non-ethnic origin)

The topics investigated were highlighted in a separate topic guide that was produced after a critical evaluation of the literature. The topic guides are included in the appendix.

An introductory letter was sent to all participants prior to the interview to explain the nature of the study and to assure participants of the confidentiality of results.
Once consent had been obtained for the interview, a short questionnaire was sent to each participant prior to the interview to obtain basic demographics of their practice, their background and other areas relevant to the research aims. The questionnaire also provided the researcher pertinent data to probe for relevant information on the areas covered in the topic guide for the interviews.

The interviews were conducted at the time and place of the participants’ choosing. In the case of the GPs this was at the place of work. Two pharmacists were interviewed away from their place of work and the other three at the work premises. All interviews were conducted in English by the researcher and took on average 1-1.5 hours each.

All the interviews were tape-recorded. External transcribers were used and this enabled to reduce bias in the analysis of the transcriptions.

The interviews were analyzed by the research pharmacist using ‘grounded theory’ (Glaser and Strauss) analysis techniques. The interviews were also independently analyzed by two research associates to ensure neutrality and validity of the results.
Each transcript was separately coded to enable the researcher to build appropriate ‘themes’ from the results.
AN OVERVIEW OF THE MAIN RESULTS

A more detailed report on results of the interviews may be obtained from the researcher. The overview presented highlights the main pertinent findings of the research.

The results of the questionnaire and interview analysis are presented separately for doctors and pharmacists. Data resulting from the analysis of the interviews are accompanied by examples of ‘quotes’ or ‘verbatim’.

Respondent profile (from questionnaire analysis)

*General Practitioners*

No. interviewed: 6 (One interview was conducted with two GPs)

<table>
<thead>
<tr>
<th>GP code (*)</th>
<th>Location of practices</th>
<th>Length of time in general practice</th>
<th>Ethnic origin (and religion if from South Asian background)</th>
<th>Spoken S Asian language</th>
<th>% S Asian ethnic minority patient pop.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1(M)</td>
<td>Highfields</td>
<td>6-10 yrs</td>
<td>European</td>
<td>None</td>
<td>25%</td>
</tr>
<tr>
<td>2(F)</td>
<td>Loughborough</td>
<td>6-10yrs</td>
<td>European</td>
<td>None</td>
<td>6%</td>
</tr>
<tr>
<td>3(M)</td>
<td>Belgrave</td>
<td>&gt;15 yrs</td>
<td>South Asian (Hindu)</td>
<td>Hindi, Gujerati, Urdu, Arabic and Telegu</td>
<td>70%</td>
</tr>
<tr>
<td>4(M) 4a(F)</td>
<td>Highfields</td>
<td>&gt;15 yrs</td>
<td>South Asian (Moslem)</td>
<td>Hindi, Punjabi, Urdu</td>
<td>90%</td>
</tr>
<tr>
<td>5(M)</td>
<td>Belgrave and Highfields</td>
<td>11-16yrs</td>
<td>South Asian (Hindu)</td>
<td>Hindi, Punjabi, Gujerati</td>
<td>80%</td>
</tr>
</tbody>
</table>

*M = male  
*F = female

All practices except for respondent 6 had partners of whom at least one GP spoke a South Asian language. All practices except for respondent 2 had at least one member of staff that spoke at least one South Asian language. Of the practices of the male GP participants, all except respondent 3 (who was single-handed) had at least one female GP within the practice.
INTERVIEW OBJECTIVES

- to explore the views of local GPs of their perception of the role of a community pharmacist
- to investigate whether GPs and community pharmacists were aware of cultural beliefs of the South Asian ethnic minorities that influence (a) the consultation process and (b) the use of medicines
- to determine if there were any difficulties in communication with this population and methods of how these were overcome
- to determine the personal views of local community pharmacists of their professional role in meeting the needs of the local population
- to explore any incentives and barriers community pharmacists perceive in providing effective services to the local population

Analysis of GPs interviews – an overview

THEME 1. PERCEPTION OF COMMUNITY PHARMACY SERVICES

Some of the GPs interviewed perceived pharmacists to be ‘shopkeepers’ and ‘dispenser of medicines’. There appeared to be limited knowledge regarding the vocational training the pharmacist has undergone and the extended services they could provide.

‘Basically they all provide a standard service i.e. dishing out the medicine that we have prescribed but there is no more than that.’ (GP 5)

‘Although we work closely with our pharmacist and chemist next door its seen as a sort of commercial thing and there has been barriers with doctors colluding with specific pharmacists so that stops you forming a real genuine team’ (GP 2)

‘I think a pharmacist should always be a pharmacy not selling newspapers and chocolates’ (GP 3)

Many GPs commented cautiously on initiatives such as ‘pharmacy triage’.

‘How would the pharmacist perceive that? Wouldn’t that undermine your role in the sense you are just doing triaging but your prime role is to dispense medication as well.’ (GP 5)

THEME 2. FACTORS THAT CONTRIBUTE TO GP CONSULTATION PATTERNS BY SOUTH ASIAN ETHNIC MINORITY PATIENTS

GPs felt that members of this population consulted for ‘multiple’ problems and were ‘poorer’ historians compared to Caucasian patients and did not discuss ‘stigmatized’ conditions until probed. GPs also highlighted that members of this population consulted less frequently for chronic conditions and those that did consult GPs came for advice on minor ailments. Financial (expectation of free prescriptions) and social (re-assurance) ‘reasons’ or ‘barriers’ were important in the consultation process.

‘I think part of it is to do with the payment of prescriptions because of our a lot of our Asian patients are on repeat prescriptions so it is advantageous to come to the doctors to get the prescription even if it is Sudafed, so they are not going to go to the pharmacist because they would have to pay.’ (GP 2)
’They will sit on their illness, they will say as soon as I am in England I will go and see my doctor I will have a free consultation and a free treatment. This is the greatest misuse of the health service.’ (GP 4)

’I don’t think they necessarily consult more with their minor ailments but the consultations they do make are more likely to be for minor ailments because they won’t necessarily come in for the more chronic diseases.’ (GP 2)

’Asians tend to find it difficult to present that way, they don’t open up, you have to literally dig, and they are very poor historians. You are not just dealing with your normal English patients and therefore communication is not a problem. They much better historians and their more specific to the point and do not present multiple problems, all these things you see with Asian patients, they put emphasis on the wrong things when the real problem is somewhere else’ (GP 5)

’It’s just their perception (of illness) and acceptance of what is wrong that seems to be the difference’ (GP 1)

**Cultural sensitivities**

Of the 6 GPs interviewed, four were from South Asian backgrounds and relied on their own knowledge of cultural issues affecting the health of this population. GPs differed in their perceptions of practical implications of the use of alternative medicines and practitioners by this population.

’If you give them something if its not quite agreeable with their religious beliefs then they won’t comply with the medicines’ . (GP 5)

’I haven’t found it a big problem…. As I can say that there seem to be let out clauses if you like that enables them to take certain things’ (GP 1)

’I don’t think they do actually (tell Dr about taking other medications) That can be quite frustrating because you don’t know quite what they’re doing outside of conventional medicine. (GP3)

’The problem arises when they go to a traditional herbalist hakims, and the potions and mixtures that they give them you don’t know what’s in them and whether that will interact with the medicines I have given them and that could be a possibility and that is always a problem.’ (GP 5)

**THEME 3. OVERCOMING COMMUNICATION BARRIERS**

Only one of the GPs interviewed knew of the availability of interpreter services and all GPs expressed concerns in using interpreter services. Family members and practice staff were often used for translation purposes.

’I know that I am not providing the same service that I would with somebody who I could converse with myself, it is more difficult, and you are almost sort of doing damage limitation and it is not as full a service as you would do otherwise.’ (GP 2)

One GP highlighted that perhaps the issue of a prescription is one of the ways to overcome a communication barrier.

’I think some of the time we are guilty of giving people a prescription because we assume that they want a prescription and I think some of the south Asian patients, if there is a language problem and you can’t really explain it is easier to give them a prescription because then you feel that you have made them happy even if that wouldn’t necessarily be what you would do with a coca ion patient that you could explain things to.’ (GP 2)

Information leaflets were not pro-actively used in a consultation and many GPs did not have access to translated material. Four GPs did not think that leaflets were read. (see below)
Concerns were raised about the level of information in the leaflets as many members of this population could not read or write their own language let alone English.

**THEME 4. RAISING AWARENESS, EDUCATION AND TRAINING**

There was no computer entry of the patient’s ethnic status on the GPs patient records although it was thought to be beneficial.

‘We have not at the moment got a system where we routinely get a history of the cultural background of these patients. But I think this is important to get it right in terms of this information. It would be helpful to have this information so that we can help to plan better things like health promotion activities’. (GP 1)

None of the GPs had any formal training on cultural issues. They welcomed the idea of practical approaches in improving patient care in this population.

Some GPs also suggested that methods other than leaflets could be explored.

‘The vast majority basically use leaflets like a play method for their kids to do it and tear pieces out of it and things like that.’ (GP 5)
Respondent profile

Community pharmacists

No. Interviewed: 5

<table>
<thead>
<tr>
<th>Resp. No (*)</th>
<th>Pharmacy location</th>
<th>Nature of employment (M=multiple) (P=proprietor) (L=locum)</th>
<th>Length of time in pharmacy practice</th>
<th>Background (and religion) if from S Asian origin</th>
<th>S Asian language spoken</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (F)</td>
<td>City Centre</td>
<td>M</td>
<td>11-15 yrs</td>
<td>European</td>
<td>None</td>
</tr>
<tr>
<td>2 (F)</td>
<td>City Centre</td>
<td>M</td>
<td>11-15 yrs</td>
<td>European</td>
<td>None</td>
</tr>
<tr>
<td>3 (F)</td>
<td>Belgrave and Loughborough</td>
<td>L</td>
<td>6-10 yrs</td>
<td>Indian (Hindu)</td>
<td>Hindi, Punjabi, Gujarati, Urdu</td>
</tr>
<tr>
<td>4 (F)</td>
<td>Highfields</td>
<td>P</td>
<td>&gt;15 yrs</td>
<td>Indian (Hindu)</td>
<td>Hindi, Gujarati</td>
</tr>
<tr>
<td>5 (M)</td>
<td>Belgrave and Loughborough</td>
<td>P</td>
<td>&gt;15 yrs</td>
<td>Indian (Hindu)</td>
<td>Hindi, Gujarati</td>
</tr>
</tbody>
</table>

*M= male  
*F= female

Analysis of pharmacists interviews – an overview

THEME 1. THE COMMUNITY PHARMACISTS’ AWARENESS OF CULTURAL BELIEFS/ATTITUDES OF THE SOUTH ASIAN POPULATION

Three of the community pharmacists were from South Asian background and relied on their own knowledge of cultural issues. However, there was disparity whether awareness of these issues (apart from language barriers) could affect their role in promoting initiatives such as ‘medicines management’. All the pharmacists were aware of the dietary habits/restrictions of certain patients. None of the pharmacists proactively asked patients about the use of alternative/complimentary medicines and alternative practitioners.

THEME 2. COMMUNICATION PROCESSES AND PATTERNS

Three pharmacists could speak at least one South Asian language. All pharmacists relied on having at least one member of staff from a South Asian background to help with communication problems. Official interpreter services were not used.

All respondents highlighted that professional communication between the pharmacist and the local GPs needs to be improved. Having no access to medical records was also cited as a barrier. Respondent no. 5 highlighted that because of the lack of appropriate communication their appeared to be ‘confusion’ in patients about the role of the pharmacist or ‘mixed messages’ about who to consult.

‘It’s a major barrier between the GPs here and our population in this area and the communication from the GP to pharmacist. The patients sometimes appear confused.’ (Pharmacist 5)
It was acknowledged that leaflets were a useful means of communication if used pro-actively at the time of consultation and could give more weight to a verbal explanation.

**THEME 3. PERCEPTION AND CONCERNS OF COMMUNITY PHARMACISTS OF THEIR PROFESSIONAL ROLES**

All respondents considered patient counselling to be part of their current role. All the respondents highlighted how they would prioritise patients for counselling, as all patients were not routinely counselled. Consultation for minor ailments did not feature as a significant entity.

‘Possibly because they self treat with traditional remedies although I don’t know that this is the case or possibly because they don’t particularly believe in treating things like minor ailments’ (Pharmacist 1)

No differences were perceived between the respondents about their role in this area between ethnic minority patients and the normal Caucasian patient population except for the time factor for patients who could not read or write English.

All interviewees cautiously commented the ‘new and extended’ roles of pharmacists. Remuneration and lack of time were cited as two important barriers to the provision of this service.

Three respondents worked in premises, which had separate consultation areas for patients. The two respondents who did not have such areas were located in the city centre. All respondents commented that having such areas would be beneficial to all populations and encourage frequent contact.

‘I think it would change the whole dynamics of the pharmacy’ (Pharmacist 1).

The pharmacists’ role was better perceived in the younger, more educated members of the population. All respondents commented that GPs had to be a willing party if any new initiatives were to be tried. It is suggested that the pharmacist’s role to be promoted positively similar to that of a nurse within the practice (i.e. time saving) for services such as blood pressure and glucose monitoring.

There was concern about the ‘commercial collusion’ aspect of the service and that the expectation of a prescription by the patient was a still barrier to doing appropriate ‘triage’ services. Patient Group Direction and proper referral systems needed to be in place if such a system could work as there was thoughts of the service being ‘abused’ if it was ‘free’ e.g. the removal of cost barriers of OTC medication.

Most respondents were in favour of offering additional services although two respondents said they would be cautious about performing them without adequate training. Time was also considered to be important and the concept of ‘sole pharmacist’ mechanics had to be revised.

**THEME 4. THE COMMUNITY PHARMACIST AS A HEALTH ADVISOR**

None of the pharmacists had received any formal training on cultural issues affecting the health of this population. All welcomed the idea of training on practical aspects in this area. Information provision on travel health in addition to the well-known areas such as diabetes and CHD were also suggested useful and where a positive, pro-active contribution to patient education could be delivered in a community setting.
None of the respondents were actively involved in local health promotion and awareness campaigns (e.g. Project Dil.). Patient information leaflets were not actively used at time of consultation and health promotion leaflets were available (in English) for passive uptake by clients. None of the pharmacies displayed any translated material. Concerns were raised about the usefulness of translated leaflets, as there was doubt if the leaflets were actually read by the patients. The uptake of displayed patient information and health promotion leaflets was not evaluated in any of the pharmacists interviewed.

’Some of them (the patients) actually look at them and take them. A lot of them are binned, but the educated people say they read them. Otherwise children use them as scrap paper’ (Pharmacist 4)

’I don’t know how many people of the whole population go round reading patient information leaflets. The language in them is sometimes difficult anyway and even if you are well versed with the language sometimes people don’t understand what is trying to be said in them anyway, and so if you are from a population and your understanding of written English is poor then I doubt that you would even try to read that. Obviously that is only a problem with the part of the population which isn’t well versed in written English and of course that isn’t all. But it is an issue more than it would be with a coca ion population.’ (Pharmacist 1)

Respondents raised doubt as to whether the screening of videos was a practical solution in a community pharmacy setting. The uptake of videos, which could be bought or loaned, relied on personal viewing preference, interest in the topic and cost.

All respondents commented on the fact that their role was not promoted adequately, especially by GPs. All the respondents also highlighted that most GPs were not aware of the current role of the pharmacist apart from the supply of medicines.

’We are still not perceived to be complete professionals in our field.’ (Pharmacist 3)

’Sometimes I think it is a perception of our role which is the problem rather than whether they go to the GP or whether they go to the pharmacist. I think the GP is seen as the font of all knowledge if you like and the pharmacist is seen as the person who dispenses the medicines, I think sometimes that is a problem.’ (Pharmacist 1)

’I also think the doctors do not do enough to persuade people to come to us because we are perceived to be making profits on whatever we sell. I think the message they give to their patients is that they get better, more expensive things on the prescription.’ (Pharmacist 3)

**DEFICIENCIES IN RESEARCH DESIGN**

The researcher recognizes that there are a number of deficiencies in the research design that could have been minimized if different approaches had been used. The limitations are highlighted below.

An interview with the pharmacists at their workplace was particularly difficult when they were the sole pharmacist on duty. Interruptions in the interview process hindered a train of thought and clarity and the respondent had to be reminded on several occasions about the topic discussed. This could have contributed to the disparity in the responses obtained during the pharmacist interviews. The research process would have been more beneficial if the pharmacists were interviewed at a time outside of their working hours.
DISCUSSION

It must be emphasized that the findings of this study cannot be generalized because of the very nature of qualitative research.

However, the picture that emerges from these findings reveals several areas that need to be further explored and sensitively addressed for appropriate health care provision to members of this particular local population.

The themes generated from the data correlate well to the issues discussed in the literature. It is intended that these themes will be used to explore practical issues for future research and not just reflect theoretical hypotheses cited in the literature.

Exploring and improving communication methods to members of the South Asian ethnic minority patients

All the GPs and community pharmacists interviewed were aware of local interpreter services but some were weary about how to use them effectively in the consultation process. It was interesting to note that uptake of interpreter services was not considered to be important by both professions. Literature (NHS recommendations) highlights this to be a suitable method of improving communication to members of the population whose first language is not English.

It is interesting to note that one GP respondent eluded that a prescription may be the only way to communicate with the patient.

GPs also eluded to the fact that they used family members to aid the interpretation/translation process. The use of family members was considered to be more as a re-assurance for the patients as well as being patient advocates. Literature also highlights the pitfalls and benefits of using family members or patient advocates for this purpose in a consultation process.

Informing and educating members of the South Asian ethnic minorities on health matters

Leaflets used for health promotion and information were not appropriately used. The availability of translated leaflets, or indeed their usefulness as a health promotion exercise is debatable. The reliance of passive uptake of leaflets for members of this particular population is low. There was cautious comment by both professions on the use and availability of the usual audio-visual methods (videos etc) and should be used together with other alternatives rather than a sole method. The use of local media (radio and TV) may be appropriate but need to be sustained to be effective. This has tremendous resource implications. Pictograms have been suggested in the literature as an alternative method and should be explored. Providing information over the telephone was not explored in detail in this research and needs to be separately investigated. ‘Language line’ services have been locally set up and the outcomes of this method of service provision need to be evaluated.
Addressing barriers to the services provided by community pharmacists

The variable responses from the pharmacist and GP respondents in particular highlights that more interviews on areas of current perceptions of community pharmacy services and ‘extended roles of pharmacists’. The GPs interviewed both directly and indirectly highlighted the image of the community pharmacist being a ‘shopkeeper’. This lack of knowledge and perhaps ‘misinterpretation’ of the community pharmacists role appears to be an important factor in the message given to patients from GPs for under-utilizing the community pharmacist as a health advisor rather than shopkeeper and dispenser of medicines.

It is vital for communication between GPs and pharmacists to improve for any initiatives involving GPs and community pharmacists to be executed. There needs to be an effective method for improving collaboration and trust between the two professions, particularly at local level. Literature has already highlighted initiatives in other parts of the country where this collaboration has been successful, but, when probed in the interviews, the GPs were not aware of this and cautiously commented on the topic.

The research highlights that members of this population need to be better informed about appropriate use of NHS services apart from the financial ‘free’ provision of services. The expectation of a prescription because it is ‘free’ needs to be addressed both in its socio-economic as well as cultural context. Although the socio-economic factors pertinent to this population were not probed for or explored in depth, cost was highlighted as a barrier to the appropriate use of community pharmacy services. For example, community pharmacists welcomed the idea of a ‘cost barrier’ being removed for the provision of simple over-the-counter (OTC) remedies for people who are entitled to free prescriptions. However, some community pharmacists also eluded that other complex social factors such as gaining the GPs confidence and patients’ trust was just as important to address.

Community pharmacists also highlighted that the extra services they are expected to provide in the new NHS reforms cannot be done without appropriate remuneration, recognition, time and further training. The concept of ‘pharmacy triage’ was explored in the interviews and cautiously commented on both by GPs and community pharmacists. The GPs suggested that they needed re-assurance of the pharmacists’ vocational training and gain trust in the services they provide.

Both GPs and community pharmacists acknowledged that the role of the community pharmacist was not appropriately promoted to members of the local South Asian population and all welcomed the idea of appropriate promotion to this population.

Raising awareness of pertinent cultural patterns to GPs and community pharmacists

The research has highlighted that amongst the respondents who were from a European background, that there was a lack of awareness of the knowledge of pertinent cultural issues around the health of South Asian ethnic minorities. Language and communication have been highlighted above.

It is evident that South Asian ethnic minority members consult for ‘multiple’ problems and are very poor historians, particularly for ‘stigmatized’ and chronic conditions. This can take more time on a GP consultation and can also be important in teasing out pertinent points for
counselling by community pharmacists. It is also proposed that this presentation of predominantly somatic symptoms has led to the notion that this particular population consults the GP mainly for minor ailments and more chronic conditions are overlooked.
RECOMMENDATIONS

- Existing interpreter and advocacy services need to be made more accessible to GPs and community pharmacists who need them.

- The issue of prescriptions at the end of a consultation as a method of communication is inappropriate and needs to be addressed.

- The use of patient advocates needs to be further explored as an alternative to interpreter services.

- Leaflets could be a useful way of communicating with patients provided it was actively (rather than passively) and appropriately used in the consultation process.

- It is recommended to think of different, simpler and more effective methods (e.g. pictograms, media advertising) for health education and promotion. The use of telephone help-lines needs to be investigated.

- The barriers and incentives to appropriate utilization of community pharmacy services could be further explored; for example by using qualitative methodologies such as focus groups, with groups of health professionals and members of the local South Asian communities.

- The community pharmacists’ role as a provider of health advice needs to be appropriately and sensitively promoted to GPs and other health professionals and members of the South Asian ethnic minorities.

- Members of the South Asian ethnic minorities need to be specifically informed of the role of the NHS and appropriate use of NHS services.

- Appropriate communication methods need to be established between community pharmacists and GPs to improve patient care.

- Any new ‘extended’ services to the local population will need to be effectively monitored and economically validated to ensure that it is not inappropriately utilized.

- A practical training programme or aide-memoir to raise awareness on clinically significant consequences of pertinent cultural habits and activities of patients of South Asian ethnic minorities could lead to a better consultation.

- It would be useful for GPs and community pharmacists to record ethnic and religious background of patients so that this data is available to them at time of consultation.
CONCLUSION

This report highlights further areas of research to gain insight of a local community with complex health care needs.

Ethics approval has been obtained from Phase 2 of this project and will commence in February 2002.

A feasibility study (5,6) to explore the transfer of the management of minor ailments from general medical practice to community pharmacy has recently been completed in Sefton, Merseyside. The study transferred 38% of minor ailment presentations to a community pharmacy, significantly reducing the GP minor ailment workload in the GP practice. There was no impact on the GPs total workload with ‘released’ consultations being taken up with other patients but not minor ailments. Some of the conditions were easier to transfer to the community pharmacy than others, with the majority of patients with head lice and vaginal thrush transferring and patients with earache, cough and upper respiratory tract infection preferring to consult a GP. Interviews with patients suggest that the community pharmacy referral was used when patients had a clear understanding of their illness and its treatment.

By introducing this way of delivering care, this study will determine whether, how, and to what degree a reconfiguration of services can result in better management of demand for GP services by the indigenous members of the local population. In addition, it will explore and investigate any additional needs for members of the South Asian ethnic minority population in Leicester.

A major grant has been applied for from the NHS Service Delivery and Organisation (SDO) National Research and Development programme for Phase 3 of this project, which aims to evaluate the community pharmacists role in the management of minor ailments. This research will be in collaboration with the Eastern Leicester PCT, Department of General Practice, UHL, CPPR and the Mary Seacole Research Centre.
ACKNOWLEDGEMENTS

I would like to thank the following people for their invaluable moral support and guidance throughout Phase 1 of this project

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Research Manager
UHL

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Leicester

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Leicester

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Project ‘Dil’ Research Assistant
Leicester

Invaluable thanks to all GPs and community pharmacists who participated and Harpel Ghattoraya for transcribing the interviews.

Finally a big thank you to Becky, Lottie, Stephanie, Sharon, Georgina, Aimee, Glen in the research office LGH
REFERENCES

5. Hassell K. Diverted traffic: GP workload can be cut…. Health Services Journal (2000); 22-3 (Jan 6th)
APPENDIX 8

Further statistics on BME population in the East Midlands
Appendix 8

Further statistics on BME population in the East Midlands

The East Midlands Public Health Observatory (EMPHO) is one of nine regional Public Health Observatories funded by the Department of Health in England. They reported that there is a very high percentage of black and minority ethnic groups in the City of Leicester with more than 1/3rd of the population in a BME group. Leicester City Primary Care Trust (PCT) has some of the most deprived areas and some of the worst health in the whole of Britain. The PCT states that it works to improve the city's health and be respectful and sensitive to the city's many cultural differences.

Census findings relating to the health of South Asians in the East Midlands, including the following self reported statements for South Asian respondents:

- Pakistani and Bangladeshi men and women were most likely to report their health as 'not good'.
- Pakistani and Bangladeshi men and women and Indian women had the highest rates of long-term illness or disability.

The following tables illustrate that a significant proportion of South Asians report long term illness or disability which restricts their daily activities.
Percentage of people in the East Midlands rating their health as “not good”: data from Census 2001 (EMPHO (2005b)).

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age-standardised proportion</td>
<td>Age-standardised proportion</td>
</tr>
<tr>
<td>White British</td>
<td>8.4%</td>
<td>9.6%</td>
</tr>
<tr>
<td>White Irish</td>
<td>10.8%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Other White</td>
<td>8.6%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Mixed</td>
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<td>12.0%</td>
</tr>
<tr>
<td>Indian</td>
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<td>15.7%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>12.6%</td>
<td>19.0%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>12.6%</td>
<td>16.3%</td>
</tr>
<tr>
<td>Other Asian</td>
<td>9.5%</td>
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</tr>
<tr>
<td>Black Caribbean</td>
<td>11.6%</td>
<td>15.6%</td>
</tr>
<tr>
<td>Black African</td>
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<td>11.5%</td>
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<tr>
<td>Other Black</td>
<td>9.8%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Chinese</td>
<td>5.0%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Any other ethnic group</td>
<td>6.5%</td>
<td>7.9%</td>
</tr>
<tr>
<td>All ethnic groups</td>
<td>8.5%</td>
<td>9.8%</td>
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</tbody>
</table>
Percentage of people in the East Midlands reporting long-term illness or disability which restricts daily activities: data from Census 2001 (EMPHO, 2005b)

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age-standardised proportion</td>
<td>Age-standardised proportion</td>
</tr>
<tr>
<td>White British</td>
<td>17.5%</td>
<td>19.1%</td>
</tr>
<tr>
<td>White Irish</td>
<td>20.2%</td>
<td>20.4%</td>
</tr>
<tr>
<td>Other White</td>
<td>16.3%</td>
<td>18.2%</td>
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<tr>
<td></td>
<td>18.4%</td>
<td>21.3%</td>
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<tr>
<td>Indian</td>
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<td>25.8%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>22.7%</td>
<td>28.3%</td>
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<tr>
<td>Bangladeshi</td>
<td>24.2%</td>
<td>25.6%</td>
</tr>
<tr>
<td>Other Asian</td>
<td>18.7%</td>
<td>23.4%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>20.8%</td>
<td>24.7%</td>
</tr>
<tr>
<td>Black African</td>
<td>16.7%</td>
<td>21.1%</td>
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<tr>
<td>Other Black</td>
<td>19.7%</td>
<td>22.0%</td>
</tr>
<tr>
<td>Chinese</td>
<td>10.8%</td>
<td>14.6%</td>
</tr>
<tr>
<td>Any other ethnic group</td>
<td>13.1%</td>
<td>15.1%</td>
</tr>
<tr>
<td>All ethnic groups</td>
<td>17.5%</td>
<td>19.3%</td>
</tr>
</tbody>
</table>

Note: Proportions are direct age standardised (using four broad age bands) using the entire East Midlands population at Census 2001 as the reference population.
APPENDIX 9

Additional literature sources
Major websites for information on ethnicity and diversity since 2004

The NHS choices website has been created since 2004 and the site provides information on health and the NHS in other languages, including South Asian languages. [http://www.nhs.uk/Pages/HomePage.aspx](http://www.nhs.uk/Pages/HomePage.aspx) (accessed Jan 2008)

Since 2005, the NHS Evidence-Ethnicity and health library has been introduced to include evidence based resources in this field. The library can be accessed on-line [http://www.library.nhs.uk/ethnicity/](http://www.library.nhs.uk/ethnicity/) accessed June 2008).

Since this PhD study commenced, websites for the Runneymede foundation [http://www.runnymedetrust.org/](http://www.runnymedetrust.org/) accessed Jan 2010 and the Joseph Rowntree foundation [http://www.jrf.org.uk/about-us](http://www.jrf.org.uk/about-us) accessed Jan 2010) have also been updated to streamline access to the grey literature on health inequalities and diversity.

In addition, another specific internet portal has also been created by the charity The South Asian Health Foundation (SAHF [http://www.sahf.org.uk/](http://www.sahf.org.uk/)) accessed Jan 2009. This is an invaluable resource for patient information, reviews and articles, particularly for ‘grey’ literature and local initiatives relating to South Asian health. Information sources for the South Asian community are also available in different languages. The publications repository includes those which may be of particular interest to community pharmacy.
APPENDIX 10

Themes and Categories used for the Reconfirmation exercise 2008 (Phase 2 Chapter 6)

‘Knowledge’ and its associated findings

‘Professionalism’ and its associated findings

‘Communication’ and its associated findings
### APPENDIX 10

‘KNOWLEDGE’ and its associated findings

<table>
<thead>
<tr>
<th>GPs</th>
<th>Pharmacists</th>
<th>South Asians</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowledge of population characteristics</strong>&lt;br&gt;IT systems: ethnicity data not captured&lt;br&gt;Limited Knowledge of ethnic population demographics</td>
<td><strong>Knowledge of population characteristics</strong>&lt;br&gt;IT systems: ethnicity data not captured&lt;br&gt;Limited Knowledge of ethnic population demographics</td>
<td>Not explored</td>
</tr>
<tr>
<td><strong>General knowledge of service provision</strong>&lt;br&gt;Limited awareness of pharmacists education and training&lt;br&gt;Knowledge of new pharmacy services (e.g. minor ailment schemes)&lt;br&gt;South Asian’s knowledge and expectations of the NHS</td>
<td><strong>General knowledge of service provision</strong>&lt;br&gt;Knowledge of new pharmacy services (e.g. minor ailment schemes)</td>
<td><strong>General knowledge of service provision</strong>&lt;br&gt;Limited awareness of pharmacists education and training&lt;br&gt;Knowledge of new pharmacy services (e.g. minor ailment schemes)</td>
</tr>
<tr>
<td>Telephone help lines (NHS Direct)&lt;br&gt;Limited knowledge of local education and health promotion initiatives</td>
<td>Telephone help lines (NHS Direct)&lt;br&gt;Limited knowledge of local education and health promotion initiatives</td>
<td>Telephone help lines (NHS Direct)&lt;br&gt;Limited knowledge of local education and health promotion initiatives&lt;br&gt;No use of IT to enhance knowledge of health issues</td>
</tr>
<tr>
<td><strong>Knowledge of consultation patterns and health needs</strong>&lt;br&gt;Knowledge of major health issues&lt;br&gt;Knowledge of health inequalities&lt;br&gt;Minor ailments&lt;br&gt;Expectation of medicine on a prescription&lt;br&gt;Mental Health consultations</td>
<td><strong>Knowledge of consultation patterns and health needs</strong>&lt;br&gt;No access to patient clinical record&lt;br&gt;Knowledge of major health issues&lt;br&gt;Knowledge of health inequalities&lt;br&gt;Minor ailments&lt;br&gt;Expectation of a prescription medicine&lt;br&gt;Mental Health consultations</td>
<td><strong>Knowledge of consultation patterns and health needs</strong>&lt;br&gt;No access to patient clinical record by community pharmacist&lt;br&gt;Knowledge of major health issues&lt;br&gt;Knowledge of health inequalities&lt;br&gt;Minor ailments&lt;br&gt;Limited knowledge of ‘pharmacy only’ medicines on prescription&lt;br&gt;Benefits of prescription medicines&lt;br&gt;Mental health/stigmatised conditions</td>
</tr>
<tr>
<td><strong>Knowledge of specific cultural influences on medicines concordance and health beliefs</strong>&lt;br&gt;Minimal training/knowledge of cultural beliefs and attitudes&lt;br&gt;Fasting and dietary beliefs&lt;br&gt;Alternative practices medication&lt;br&gt;Complementary therapies&lt;br&gt;Male/female cultural issues</td>
<td><strong>Knowledge of specific cultural influences on medicines concordance and health beliefs</strong>&lt;br&gt;Minimal training/knowledge of cultural beliefs and attitudes&lt;br&gt;Fasting and dietary beliefs&lt;br&gt;Alternative practices and medication&lt;br&gt;Complementary therapies&lt;br&gt;Male/female cultural issues&lt;br&gt;Travel health</td>
<td><strong>Knowledge of specific cultural influences on medicines concordance and health beliefs</strong>&lt;br&gt;Endorsement by local leaders (Moslem community)&lt;br&gt;Fasting and dietary beliefs&lt;br&gt;Alternative practices and medication&lt;br&gt;Complementary therapies&lt;br&gt;Male/female cultural issues&lt;br&gt;Travel Health&lt;br&gt;Other influences&lt;br&gt;Diet and Lifestyles&lt;br&gt;‘Hot and cold’ medicines&lt;br&gt;Fate (karma, belief in God curing all)</td>
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**PROFESSIONALISM, THE ‘PROFESSIONAL IMAGE’ and its associated findings**

<table>
<thead>
<tr>
<th>GPs</th>
<th>Community Pharmacists</th>
<th>South Asians</th>
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<tr>
<td><strong>Professional image: current perceptions</strong></td>
<td><strong>Professional image: current perceptions</strong></td>
<td><strong>Professional image: current perceptions</strong></td>
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<tr>
<td>The shopkeeper image of the pharmacist</td>
<td>The shopkeeper image</td>
<td>The ‘shopkeeper’ image of the pharmacist</td>
</tr>
<tr>
<td></td>
<td>The dispenser role</td>
<td>The dispenser role</td>
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<tr>
<td></td>
<td>Health advisor role</td>
<td>Acknowledgement of health advisory role for children</td>
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<tr>
<td></td>
<td>Lack of ability to diagnose</td>
<td>GPs ability to diagnose</td>
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<td></td>
<td>Attitude of GP receptionists</td>
<td>Attitude of GP receptionists</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GP competence</td>
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<td><strong>Improvement in professional image</strong></td>
<td><strong>Improvement of professional image of the pharmacist and GP</strong></td>
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<td>Recognition of extended roles</td>
<td>Professional development for extended roles</td>
<td>Promotion and recognition of new /extended NHS services</td>
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<td>Private consultation areas</td>
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<td>Co-location with GP surgery (pharmacy triage)</td>
<td>Access to medical records</td>
<td>Access to medical records</td>
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<td></td>
<td>Co-location with GP surgery (pharmacy triage)</td>
<td>Co-location with GP surgery (pharmacy triage)</td>
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<td>Changes in remuneration for current and extended duties</td>
<td>Time for consultation by GPs and pharmacists</td>
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<td>Time to provide extended services</td>
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<td></td>
<td>Improvement in collaboration and communication with GPs</td>
<td>Promotion of the pharmacist as a health care professional</td>
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<td>Promotion of the pharmacist’s professional role</td>
<td>Promotion of the pharmacist’s professional role</td>
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<td><strong>Access to pharmacists</strong></td>
<td><strong>Access to GPs</strong></td>
<td><strong>Access to GPs and pharmacists</strong></td>
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<td>GP appointment systems</td>
<td>GP appointments</td>
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<td>Telephone</td>
<td>Telephone</td>
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<td>Preferred access to local community pharmacies</td>
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<td><strong>Trust</strong></td>
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<td>Time for consultation</td>
<td>Lack of ability to ‘diagnose’ and examination</td>
<td>Less time spent by GPs in consultation</td>
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<td>Issue of prescription</td>
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<td>Lack of privacy and confidentiality</td>
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<td>Race issues</td>
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### COMMUNICATION and its associated findings

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<th>Community Pharmacists</th>
<th>South Asians</th>
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<td>Use of independent interpreters and/or translators: none</td>
<td>Use of independent interpreters and/or translators: rare</td>
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<td>Use of family members for interpretation/translation: common</td>
<td>Use of family members for interpretation/translation: common</td>
<td>Use of family members: preferential</td>
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<td>Use of practice staff for communication</td>
<td>Use of pharmacy staff for communication</td>
<td>GP receptionists</td>
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<td></td>
<td>Telephone help lines for communication: rarely used</td>
<td>Telephone help lines for communication: not known to be available</td>
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<td>Limited use of leaflets for health promotion/education</td>
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<td>Leaflets and posters: display for passive uptake</td>
<td>Videos, media</td>
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<td>Translated leaflets: used rarely</td>
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<td>Local initiatives commented on</td>
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<td>Limited counselling by GP</td>
<td>Counselling by pharmacists only for important issues</td>
<td>Counter assistant or pharmacist</td>
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<td>Labels (including those in different languages)</td>
<td>Counselling by pharmacists only when asked</td>
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<td></td>
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<td>Gestures</td>
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