Ethnicity, Health and Health Care
Understanding Diversity, Tackling Disadvantage

Edited by

Waqar I. U. Ahmad and Hannah Bradby
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Introduction

Sociologists of health and illness explore the role of social, cultural and economic divisions in the experience of health and illness, with class, age, gender, sexuality, impairment and, increasingly, race, culture and ethnicity being crucial dimensions of analysis. Divisions of various orders are a given feature of industrial societies and the arrival of migrants, travellers or scholars from outside provides further dimensions to understand and manage. In the British Isles, and particularly England, with a longstanding, stable Anglo-Saxon population, and a national character imbued with a colonial past, minority ethnic identity has particular meaning. The post-World War II mass migration was met, in Britain, with ambivalence and hostility coupled, simultaneously, with assumptions that the white privileged position would persist and yet immigrants would assimilate to the British way of life.

This chapter is not aimed at providing an overview of literature and debates on ethnicity and health. Such overviews are available elsewhere (Smaje 1995, Davey Smith et al. 2000b). Our aim is to locate ethnicity and health in an appropriate context by considering how conceptual and policy apparatus has developed over recent decades. We therefore start with a discussion of how ‘race’ and ‘ethnicity’ have been conceptualised, articulated and employed historically and across cultures. The management of ethnic diversity is a key policy concern for most industrialised countries. We discuss the key trends and developments in the history of ethnicity and health in Britain. This leads to a discussion of how sociologists of health have responded to an increasingly ethnically diverse Britain, with an interest in both the positive developments and the areas that have been neglected. Finally, we introduce the papers selected for this Monograph which make distinctive contributions to the literature by extending some of the debates introduced in this opening chapter.

Locating ethnicity, culture and ‘race’

Like ‘community’, ‘ethnicity’ is an over-employed term, sometimes used with such imprecision that it risks losing its analytical value. Isajiw (1974) identified over 70 elements in defining ethnicity in US and Canadian literature between 1945 and 1971, of which ancestry, culture, language, ‘race’ and religion were most prominent. Others emphasise ‘ethnicity’ as an identification articulated through negotiating boundary and social processes, requiring both self-affirmation but also others’ acceptance of such claims. Ethnicity is thus a dynamic concept, characterised by its relationship to forms of heritage (national, linguistic, cultural), notions of belonging and external recognition of such claims, but also by its malleability, flexibility and situationality. Contemporary notions of ‘ethnicity’ conceptualise it as a marker of identity, a vehicle for community mobilisation and a possible indicator of disadvantage, discrimination or privilege. How notions of ethnic identity play in time and space may vary. For example, in Pakistan, ethnic relations take on a regional and linguistic
flavour – inter-ethnic conflicts in the country continue to be termed ‘lissani’ (language) conflicts. Canada gives French- and English-speaking people secure status as ‘founding peoples’, with French and English defined as ‘official’ languages. Indigenous ‘First Nationals’, enjoy a variety of legal protections, and yet remain economically and socially marginal in Canadian society. Similarly, in the US and Australia, being indigenous to a land equates with a socioeconomic status even worse than many of the recently arrived minorities. In most countries ethnic minority status, often deriving from having migrated from elsewhere, goes hand in hand with social, economic and health disadvantage.

Ethnic identity can be powerfully related to access to resources such that the formation, maintenance and transformation of ethnic relations is crucial to wellbeing. The transformation of inter-ethnic group relations sometimes occurs through extreme violence: the slaughter of Tutsies by Hutus in Rwanda; of Bosnian Muslims by their neighbours; the apparently un-ending war between Tamil Tigers and the Sinhalese dominated government in Sri Lanka, to give a few recent examples. Referring to conflicts in East Asia, Mackerras (2003) argues that ethnic conflict may have replaced ideological conflict since the end of the cold war. While he may be overstating the case, it is clear that ethnic identity cannot be ignored in any meaningful contemporary analysis of relations between groups as well as between nations.

Historically, the pseudoscientific notion of ‘race’, supported by both science and Christianity, created hierarchies of people and justified slavery, bonded labour and colonialism. Science and the Church decreed such oppression to be in the best interests of the colonised and the enslaved. Colonising and enslaving people has been justified both as a means of civilising slaves and of saving their souls. The contention that slavery and colonisation benefit the slaves and colonised has also been used to oppose the abolition of slavery in the American South and to prevent colonised countries from gaining the right to self-rule. This is illustrated by the following paraphrasing of the fears expressed by the white elite about the abolition of slavery in the United States:

Enlarged freedom, too often ending in licence, excessive use of stimulants, excitement of emotions, already unduly developed [could lead to insanity. The black people] are removed from much of the mental excitement to which the free population . . . is necessarily exposed in the daily routine of life, not to mention the liability of the latter to the influence of the agitating novelties of religion, the intensity of political discussion . . . They were taught from infancy obedience and self control . . . The cause of insanity and other diseases with them now, from which they were exempted in slavery, is the removal of all healthful restraints that formerly surrounded them (Littlewood and Lipsedge 1989: 37–8).

Medicine was a strong ally in giving racist systems of thought a scientific gloss. Entirely rational actions, such as running away from a slave master or disrupting the slave system, were medicalised with the invention of new diagnoses, respectively *d rapetomania* (an ‘irrational’ desire of slaves to run away from their masters), and *Dysaesthesia Aethiopica* (or rascality) (Littlewood and Lipsedge 1989). While freedom from slavery was opposed in the American South, on the grounds of threats to the mental wellbeing of the enslaved, decolonisation too was deemed dangerous to the natives. In Egypt, for example, Lord Cromer opposed independence on the basis that Egyptian society possessed insufficient democratic maturity and was guilty of the poor treatment of women. Simultaneously, and with no sense of irony, he stopped an indigenous Egyptian movement for women’s education as disruptive and counter-productive and, in Britain, staunchly opposed the Suffragette movement (Ahmed 1992).
While hierarchical, immutable categories of ‘race’ are no longer explicitly used to differentiate between groups, many features of racial thinking have permeated concepts of ethnicity and culture. Culture is often referred to as if it possessed primordial, innate and immutable features which manifest as properties of specific ethnic groups. However, the desire to attribute particular characteristics to other groups, and to denigrate those characteristics is not unique to Western societies. Growing up in rural Pakistan, WA ‘knew’ that the service castes such as ‘mirasis’ were inappropriately jovial, assured to be a sign of mental immaturity, the ‘jolahas’ were inherently cowardly and could not be trusted in times of danger, and the ‘musallies’ were dull, fit only for menial labour. The ‘mirasis’ were story-tellers and musicians and the ‘jolahas’ were weavers. Both groups were often better educated than the ‘zamindars’ (land-lord farmers) and skilled in their occupations. But this did nothing to challenge their institutionalised oppression at the hands of the dominant ‘zamindars’ to whom they provided a variety of routine and life-cycle-related services in exchange for land for their houses, fodder for their animals and a share of the harvest.

Culture as a presumed primordial feature allows the same justification of unique and immutable nature of particular groups that ‘race’ allowed previously. ‘Ethnicity’ and ‘culture’ take on ‘social meanings and importance when physical and cultural traits are paired with social attributes, such as intellectual, moral or behavioural characteristics’ (Li 1999: 7). Barker, in an influential book, argued that cultural or ‘new’ racism offered justification for hostility towards ‘others’ by locating such hostility in our ‘nature’ and downplaying the role of politics and economy:

Nations, on this view, are not built out of politics, or economics, but of human nature. It is our biology, our instinct, to defend our way of life, traditions and customs against outsiders, not because they are inferior, but because they are part of different cultures (1981: 23).

Li (1999) notes that:

This line of reasoning puts disadvantaged groups in an even more disadvantaged position since their culture becomes the source of their misfortunes. Thus, the economic problems of First Nations [indigenous Canadians] is often seen as caused by Native people’s own ineptitudes and cultural inadequacies (1999: 4).

Using culture and ethnicity as an explanation of inequality between groups distorts perceptions of how ethnic relations, and the related inequities of power are produced. Defined by those in power, the disadvantage of minority ethnic groups too often continues to be seen as ‘caused’ by their diseased genetic and dysfunctional cultural inheritance. Notions of biology and culture mingle in a messy but complementary mortar, cementing inferiority of some, while conveniently absolving powerful groups and states from responsibility. Such thinking has seriously influenced definitions of health and care needs of minority ethnic groups in Britain, and elsewhere.

**Ethnic diversity and its management in Britain**

The presence of ‘blacks’ and ‘coloureds’ in the UK is not new. Given Britain’s central involvement in the slave trade, its role as a major colonial power, and the size, reach and labour needs of its navy, this is not surprising. There were such sizeable numbers of non-White
people in Britain in the 16th century as to worry Queen Elizabeth I that they were consuming welfare rightfully belonging to her loyal and deserving (White) subjects. She ordered a mass expulsion of such people from her land. These themes of whiteness being linked to belonging, citizenship and entitlement to welfare relief have remained common features in relation to minority ethnic life in Britain ever since: access to health and other services remains intrinsically linked to claims of citizenship, with health and social care professionals increasingly required by the state to act as a second (often reluctant) line of immigration control. Britain’s ports had settlements of non-white sailors and merchants before, and since, the 16th century, while high society has long included the odd ‘coloured’ nabob. In the early 20th century British Universities and Inns of Court had the elite from the colonies being trained as the transitional or buffer classes between the natives and the white master class, and increasing numbers of both workers and students were arriving from the colonies as the century progressed. It is perhaps ironic that the death of British imperialism in South Asia was plotted by some of these visitors, with the chief architects of Indian and Pakistani independence – Iqbal, Gandhi, Nehru and Jinnah – all students or legal pupils in London, Oxford or Cambridge in the early 1900s.

Mass migration of people from the ex-colonies, however, is a relatively recent phenomenon. The need to rebuild Britain following World War II, the demands of an expanding economy, and the development of the welfare state required labour on a scale that could not be provided locally. The arrival of the Empire Windrush in 1946 from the Caribbean, to Tilbury in Essex, carrying some 500 men and women migrants, remains the iconic symbol of the start of mass colonial immigration to Britain. Migration, with its heyday in the 1960s, followed relatively predictable patterns, dictated by the needs of local and regional industries and driven by networks and patronage more than by direct recruitment in the ex-colonies. This period of economic expansion meant that in spite of blatant racist discrimination – in employment, health, housing and other services – new arrivals could secure initial employment and move jobs easily.

The needs of the local economy and patronage of fellow villagers or family explained the patterns of settlement of different minority ethnic groups more than other factors. Caribbeans settled in large numbers in London and were employed on public transport and in hospitals. Their settlement patterns demonstrate the importance of identities associated with particular islands, with Jamaicans, St Lucians and so on settling in small enclaves alongside friends and kinfolk of the same island. Indians too arrived in large numbers in the 1960s. A diverse community, their settlement patterns were more scattered than Caribbeans in terms of residential location and the industries in which they gained employment. The so-called ‘East African Asians’ entered Britain in the 1970s. Predominantly a business community, and British passport holders, they sought resettlement in Britain following expulsions from Uganda, Kenya and Tanzania. Pakistanis, a more homogenous group dominated by those with backgrounds as small-scale land-owning farmers, were recruited to provide semi-skilled labour in the steel industry in the Midlands and the textile industry in the northern belt running between Manchester in the west, through the Pennine towns, to Bradford and Leeds in the east. The Chinese arrived in various phases, opting predominantly to settle into family-run restaurant and take-away businesses, and remain highly dispersed with ‘Chinatowns’ in London and Manchester acting as cultural and community hubs. Bangladeshis arrived after the other major groups in the late 1970s when employment opportunities and immigration opportunities were increasingly restricted. This had an impact on their ability to accumulate capital and to be joined by their families. Family formation and unification followed in the next couple of decades and for many, remains an unfinished business.
This story of migration to and settlement in Britain in the second half of the 20th century has shown that the fortunes of certain communities have been inextricably tied to certain industries and regions – decline in these industries has had a disproportionate impact on some minorities, while having little or no effect on others. For example, the heavy concentration of migrants from Pakistan in the textile industry and the relative homogeneity of their skills meant that large numbers suffered from the rapid decline in the regional textile industry. Communities with greater internal diversity, which settled in a number of different regions and industries, such as migrants from India, were better able to respond to changes in the fortunes of particular industries. Equally, cities and regions with diverse industrial bases fared better in both cushioning partial industrial decline and in reinventing themselves through growth in new industries. Settlement patterns have had an impact on the availability of cultural resources and support networks, for instance social and cultural isolation is a key issue for the highly dispersed Chinese community, whereas Bangladeshis in East London, Indians in Leicester or Pakistanis in Bradford do not face this problem. However, the advantages of areas where minorities are highly concentrated have to be considered alongside the disadvantages.

At the time of the 2001 Census, ethnic minorities constituted 7.9 per cent of Britain’s population (or 4.6 million people). They are concentrated in the major urban areas, with 45 per cent in London alone. Their age profile is younger compared to the White population and 50 per cent of Britain’s people of Indian, Pakistani, Bangladeshi, Black Caribbean and Black African origin are now British born. While there is greater diversity within minority populations than between them, overall (with some exceptions), minority ethnic groups do worse than their White fellow citizens in health, employment, earnings, education and housing.

Ethnic concentration has received attention by academics, policy makers and politicians. The British state has benefited from the emerging ethnic enclaves in Britain from the 1960s onwards in that concentration in particular neighbourhoods enabled the establishment of voluntary-sector provision of welfare services within and for these minority communities (Rex 1991). Concentration has allowed the development of community networks, economic activity, community resources, reaffirmation of positive self-identity and resources for its maintenance. Migrants and minorities (re)create structures and institutions which allow the maintenance and reproduction of cherished cultural and religious values. Religious and community institutions as well as established systems of mutual support took rapid root in these communities in British towns and cities. Werbner (1990) notes the importance of family and community networks in the establishment and success of minority ethnic businesses. Such concentration potentially acts as a buffer against prejudice and racism, provides role models, accords status to individuals for skills or knowledge not acknowledged outside the community, offers social and moral support, and provides resources for the recreation of community. But all this happens at a price, including in terms of health.

Ethnic strife and street disturbances in the 1980s and more recently in 2001, brought attention to the ‘problem’ of such concentration, referred to negatively as ‘segregation’. The Chairman of the Commission for Racial Equality, the official watchdog in this field, in a much hyped, but ill-informed speech warned the nation that Britain was ‘sleepwalking to segregation’ – he painted a picture of US style segregated ghettos and no-go areas (Philips 2005). The picture of ‘parallel’ universes, un-integrated young minority ethnic people and of a cultural rift between generations that he painted also emerges in a plethora of official reports into the 2001 street disturbances. The evidence suggests, however, a different, more complex picture in which deprivation and oppression as well as contestations over identity and territory play a significant role. Amin (2002) identifies four main reasons for street
fighting and disturbances: the increasing activity by the far right and often violent, British National Party in areas of Pakistani and Bangladeshi concentration; prolonged heavy-handed policing targeted against Asian youth, combined with little if any protection against racist activity; inflammatory media reporting of Asian-led crime and violence; and young Asians’ anger over political marginalisation and paternalism of their leaders. Amin notes that by the 1990s, the new generation of British-born-and-bred young South Asians in the northern towns, was unwilling to accept the second-class status endured by their elders. The street violence by South Asian young people was thus a claim to Britishness and their way of defending their streets from racists, almost exclusively from outside of their areas.

The exceptionally punitive sentencing meted out to the South Asian young people involved in, what they regarded as, the defence of their streets from racist British National Party and racist police, confirmed for many that the police and the judiciary were there to control their communities without offering them protection.

While a high concentration of minority ethnic communities in specific areas may have been over-played as a cause of street disturbances, or as a harbinger of an ethnically segregated Britain, it merits attention for other reasons. The areas where disturbances have occurred suffer multiple deprivation: over two-thirds of minority ethnic people in Britain live in the 88 most deprived local authority districts, compared to 40 per cent of the general population (NRU 2004). The problems that afflict these districts therefore have a disproportionate effect on minority ethnic groups. Around one third of all British children live in poverty – defined as having family income below 60 per cent of the national average – compared to 74 per cent of Pakistani and Bangladeshi children and 63 per cent of Black Caribbean children. Such blatant and significant inequalities matter. Housing, public amenities, health and welfare services, employment opportunities and, perhaps most importantly, aspirations and expectations may all be poor in these areas. Primary care services, especially dental health provision, in such areas are extremely poor and since primary care acts as a conduit to secondary care, this neglect diminishes prospects for appropriate and timely secondary care.

Furthermore, if, as is sometimes the case, White parents living in deprived areas are more successful in placing their children in better-performing and predominantly White schools outside the area, the local schools can become almost exclusively non-White. This process represents a severe reduction of the opportunity for routine, everyday, mundane, and yet vital, inter-ethnic dialogue, and permits apathy or even hostility to develop between sections of communities whose interests and problems are often the same (Amin 2002). Social solidarity may therefore be damaged alongside the life chances of both the majority and the minority communities. We discuss the culture of ‘special provision’ and ‘anti-racist’ approaches below.

Ethnicity, health and care

Early interest in minority ethnic health came from public health and tropical medicine specialists with an initial focus on protecting the British population from diseases which could be imported by immigrants. This was followed by an interest in the exotic and peculiar, and above all that which was ‘different’ from the British ‘norm’. The focus on diseases and conditions peculiar to minorities was unfortunate in that it had the effect of ignoring both the health issues that concerned the communities themselves and the diseases which afflicted the largest numbers of people in these communities. Instead, and not surprisingly, the focus reflected the prevalent racial and cultural stereotypes and fears, from
deficient parenting in relation to child health, restrictive cultures and their impact on nutritional deficiency among South Asians, low pain thresholds and proneness to addiction to pain killers among African Caribbean sickle cell sufferers, to dangerous and irresponsible behaviour on the part of Muslim consanguineous parents ‘causing havoc’ of death and disability among their off-spring.

The focus on deficient minority culture turns conditions without any necessary connection to a given culture into ‘ethnic’ conditions, with assumed racial or cultural features. Conditions thus become racialised, with ethnic or cultural features over-emphasised to the extent that the commonly understood aetiological or prognostic factors are ignored and new solutions invented, aimed at changing the presumed deficient cultures of the communities concerned. The victims are thus blamed for their own ills, as illustrated in the following two examples. First, vitamin D deficiency in children was endemic in the poor British population of the mid-20th century. Pictures of bow-legged children adorned basic clinical medicine text books of the period. Eradication owed much to better outdoor facilities for children and, in particular, the fortification of margarine with vitamin D and the universal free availability of milk in schools. When rickets appeared in South Asians in the 1970s, after it had largely disappeared in the majority population, it was re-cast as an exotic disease (Donovan 1984). Now termed ‘Asian rickets’, its cause was located in deficient South Asian diets and codes of gender and dress. It was also assumed that South Asian skins were too pigmented to convert northern hemisphere sunlight into vitamin D and that modest clothing further hampered the process. It was suggested that ‘the long-term answer to Asian rickets probably lies in health education and a change towards the Western diet and lifestyle’ (Goel et al. 1981: 405). Remarkably, for some considerable time, the solution that worked for the white population – fortification of a staple diet with vitamin D – was considered inappropriate on the pretext that such fortification of South Asian staple diets (ghee or chapatti flour) may lead to vitamin D toxicity. Why toxicity was not an issue in the case of fortification of margarine was never discussed.

Secondly, a more recent fascination in Britain has concerned consanguinity, the practice of marriage between blood relatives. Marriage between first cousins has been quite acceptable in Britain, and among the well-known cases of cousin marriages was Charles Darwin’s marriage to Emma Wedgwood, with whom he had 10 children. Cousin marriage is a common and favoured pattern of family formation in Britain among South Asian Muslims and remains normal in many parts of the world. In current day Britain, first cousin marriage has become highly stigmatised, even bordering on incest, such that the true prevalence among the ethnic majority is likely to be underestimated. The presumed ill effects of consanguineous marriage among South Asians have been indicated as ‘explaining’ a variety of ills, from bleeding disorders, to heightened rates of physical impairment and deafness. For certain recessively inherited genetic conditions such as thalassaemia, marriages within a family group with a particular genotype will undoubtedly increase the chance of the two partners having the condition or being carriers, and will increase the statistical probability of passing on the genes and/or the condition to offspring. In relation to South Asian, especially Pakistani, parents, there is a marked tendency on the part of health professionals to blame consanguinity for a child’s ills, irrespective of the known mechanisms of causation and often without clinicians confirming whether or not parents are in fact blood relatives. South Asian parents of thalassaemic children were regularly told that the child’s condition had been ‘caused’ by parental consanguinity and yet in several cases, parents were not in a consanguineous marriage and were puzzled by this information (Ahmad et al. 2000). Some parents did not make the link between consanguinity ‘causing’ thalassaemia and the genetic transmission of the condition, so the attribution of cause did not inform further