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## Short Report

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# A focus group study of older Chinese people with CVD patients in the North West of the UK

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## Abstract

**Background:** Cardiovascular disease (CVD) is the leading cause of death for Chinese migrants around the world. Chinese CVD patients rely heavily on their native Chinese language, cultural values and beliefs, which adds challenges for the healthcare providers to offer primary health-care services with standard protocol. The inappropriate treatment could lead to life loss, mistrust in doctor-patient relationship and heavy burden for healthcare funding. **Methods:** 28 participants were included for focus group study with the grounded theory methodology. **Results:** There is considerable misunderstanding among the Chinese community about the role of primary care doctors in the treatment of cardiovascular disease resulting in the variable use of primary care services. **Conclusion:** Chinese CVD patients or identified risk factors for CVD arguably need closer management, culturally sensitive advice, support and robust follow-up compared to the general population. Doctors and nurses should enhance their practice and give them confidence in their interaction with Chinese patients on the basis of how they think and behave in relation to help seeking.

## Background

The Chinese ethnic population (mainly from China, Taiwan, and Hong Kong) is a sizeable visible minority in the UK, representing 0.7% of the UK total population in 2011, and was estimated about 400 thousand by 2015. It is known that the numbers of Chinese people permanently resident in the UK is significantly underestimated (Algan *et al.*, 2010), and they are an ageing population (White, 2011; Office for National Statistics, 2017).

As a minority group, the various Chinese populations in many parts of the world are known to rely heavily on their native Chinese language, cultural values and beliefs (Lei, 2017). Though “superdiversity” has been emerging in many urban areas due to decline of illegal immigrants and increasing of the international students’ settlements (Nathan, 2011; Sepulveda *et al.*, 2011), a large number of people, especially the elders, instinctively tend to live a close social life within identified areas and districts, often labelled as “Chinatowns” (Orum & Li, 2019).

Abundant literature suggested that Chinese immigrants are known to have an independent and unique cultural outlook which influences almost every aspect of their life (Lei, 2017; Ang, 2020). They are described as bearing hardships without seeking help or financial support and that they often fail to take and use government assistance, including healthcare services (Lai & Chau, 2007). The Chinese community in the UK are also known to be hard working in academy, less active in physical activities (Pang, 2021), concerned to earn their own independent living, which explains why they are one of the highest-income ethnic minority groups in the UK (ONS, 2018). These characteristics of the community have been reported in many countries in the world (Huang & Spurgeon, 2006; Jin *et al.*, 2017).

A small number of qualitative studies have shown that older immigrant Chinese people fail to use primary or community health care services (Liu *et al.* 2015; Zhang *et al.*, 2020). Instead, it was found that Chinese people report a high rate of, and preference for using Accident & Emergency (A&E) services for most general health concerns, but the reason why requires further investigation (Liu *et al.*, 2015; Jin *et al.*, 2017; Zhang *et al.*, 2020).

Currently, cardiovascular disease (CVD) is the leading cause of death for Chinese migrants in the UK as well as elsewhere in the world (Gong & Zhao, 2016; Jin *et al.*, 2017; Zhang *et al.*, 2020). Possible reasons were indicated, including income and education gaps in different groups (Boykin *et al.*, 2011) and lack of regular exercises (Jose *et al.*, 2014), which enhances the importance of early detection, robust management and continued support for CVD patients as a means to prevent the onset of long term, disabling chronic conditions (Evandrou *et al.*, 2016; Kypridemos *et al.*, 2016; 2018).

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**Table 1.** Demographic information of participants by gender

Gender (6 focus groups, <i>n</i> , %)	Male (10, 35.71%)	Female (18, 64.29%)
Age (mean = 70.05)	72.25	68.83
Place of birth ( <i>n</i> , %)	Mainland China (4, 40%) Hong Kong (6, 60%)	Mainland China (7, 38.89%) Hong Kong (9, 50%) Taiwan (2, 11.11%)
Family Status ( <i>n</i> , %)	Nuclear Family (4, 40%) Extended Family (2, 20%) Childless Family (1, 10%) Other (3, 30%)	Nuclear Family (8, 44.44%) Extended Family (4, 22.22%) Childless Family (1, 5.56%) Other (5, 27.78%)
First Language ( <i>n</i> , %)	Cantonese (10, 100%)	Cantonese (13, 72.22%) Mandarin (5, 27.78%)

## Methods

This study adopted a pragmatic, qualitative methodology using focus group interviews. This study aim was to develop an understanding of the concerns of older Chinese people with CVD including their management of health-seeking events with primary care services.

### Sample selection and recruitment

We recruited Chinese people (self-defined by the elder and not in acute treatment) aged 60 years old or over who were living within the local community of a “Chinatown” in the North West of England who self-identified as being previously diagnosed with CVD (angina, stroke, peripheral vascular disease) or having a significant risk factors for CVD such as hypertension or high cholesterol. Some of the participants were under the care of registered primary care doctor (General Practitioner, GP) and some used an alternative primary care facility for people who were not registered with an identified local GP, which was staffed by two GPs who were of Chinese origin.

### Data collection

Data were collected using established focus groups practice (Barbour & Morgan, 2017). The topics covered in the focus group discussions were their understanding of their CVD or CVD risk factors; health-related help-seeking behaviours and the facilitators and barriers to help seeking in primary care or through their GP. The participants chose the language for the interview or focus group discussion from Mandarin, Cantonese or English. Two researchers were present during the focus group discussions which were held in a private room in a local community centre.

### Data analysis

Data analysis was conducted by two researchers independently and then collectively to establish rigour in the analysis process. A modified form of the process recommended by grounded theory was used (Glaser & Holton, 2007) instead of other versions by different sociologists (Corbin & Strauss, 1990). Member checking with the project reference group (local Chinese community members) was used to establish the trustworthiness of the data analysis process, the emerging codes, constructed themes and the final results.

## Results

(Table 1) All the participants compared the primary care services they had accessed to medical services available in China, Taiwan or

Hong Kong. In making this comparison participants reported that their GP were not experts in CVD, so their expectation of treatment was low, which explains why they reported limited expectations of their consultations with them. They viewed primary care doctors as being only for prescriptions, regular brief check-ups, and referral for appointments for out-patient services for CVD problems. Group members talked as follows when asked about the GP:

(G1P3) But my GP only got the right to write a letter to the specialist. But GP also cannot tell (from the examinations) ... he could not trace the result;

Participants perceived the lack of action, assessment, advice, and treatment from the GP as a source of concern suggesting that GPs have only a minor role to play in CVD management:

(G1P5) The GP can only do those minor treatments. This is the regulations in the UK;

(G1P6) I don't know why I'm not asking GP (about my concerns), but I feel I can't get answers from them;

What is more, limited services and language barriers could confound the encounter and lead participants to think that the GPs have a negative attitude towards the Chinese community, as stated by one of the participants and agreed with by others in the focus group discussion:

(G3P3) I told him I could not take that tablets, he deliberately prescribed that tablets to me. I told him the tablet made me very dizzy, I could not take it. He deliberately prescribed that one to me. He is a western doctor; I don't think he understand us (Chinese);

According to the participants, the “big hospital” in the UK was the preferred place of treatment for them, which usually meant A&E or in-patient services. It was suggested that when their symptoms are not so clearly developed, they perceived that the barriers at their GP would prevent them from getting adequate hospital services in a timely manner and therefore, in their view, result in sub optimal care. The following narrative outlines the social processes that participants engaged in when making a choice to access hospital services:

(G1P4) Problem is not serious, so they (GP) did not make you appointment of the big hospital for you;

There is a perceived mismatch between their concerns and treatment in primary care and hospital is thought to be the best option:

(G1P6) They only treat the big problems in hospital;

A consequence of this was that many of the participants did not report minor symptoms to their GP. The following excerpt outlines

how symptoms can be left developing to a serious point until the participant expected a referral or urgent treatment:

(G3P3) Just like my heart was beating very fast, I went to see the doctor, but the doctor ignored me. I checked my blood pressure, 190; heart rate ninety or more sometimes... but the doctor did not say anything... he just ignored me;

For this participant, it would inevitably result in contact with emergency services when the tachycardia occurs again. Given the lack of engagement and satisfaction with the NHS system, participants reported that they developed their own ways to cope with their health-related problems. A common process would be that they would spend a considerable amount of time searching for information from social networks and the media, about any way to improve their “healthy status” and help with symptoms such as dizziness or even mild chest pain. Some of these strategies were reported to have seemingly “good” evidence:

(G1P3) But some people told me, “you have palpitation, don’t drink coffee” then I give up this habit and started drinking tea;

Some relied on TCM formulations such as health restoring teas in favour of prescribed medication:

(G1P1) Some people got better after drinking it (Wu long Tea). I tried myself and it is good. Sometimes I don’t take the diabetic tablet that doctor prescribed for me, I just take Wu long Tea, and I am all right. A lot of newspapers reported the advantages of drinking it, saying it’s good for diabetics.

The informal “evidence” from newspapers, which may be advertising products rather than prompting evidence-based health messages were referred as sources of information:

(G1P4) Cranberries juicy is good for your heart and newspaper said every woman should drink this;

Participants were keenly interested in supplementing the lack of information and treatment with informal sources of health advice and information.

(G3P4) (Researcher asked what kind of Chinese herbs do you use for soup normally?) It depends on what kind of illness... But if we sit together, we can research on this topic and use it as method to get information, and then we need to turn to the doctor to get the diagnosis;

The implication here means the participants would use these approaches to cope with their symptoms before they contact their GP or hospital services.

## Discussion

There is an ageing Chinese population in the UK (and in other countries such as the USA, Canada, Australia) who are increasingly likely to develop long-term CVD associated with the ageing process (Liu *et al.*, 2015; Jin *et al.*, 2017; Zhang *et al.*, 2020). The data presented in this study have highlighted some of the barriers to access for treatment, which will have resonance for many countries.

Participants in this study inevitably compared the services they accessed for CVD treatment to those available in their original country and found them insufficient. They reported having low expectations of primary care services and preferred to cope with symptoms themselves or to use secondary care or emergency services. All of which mean that they often dealt with symptoms until they became unmanageable or unbearable. The participants used informal sources of information and sought support from other Chinese people rather than health care professionals.

Problems with health literacy, communication and mismatched expectations were reported in this study.

Similar findings have been found in the USA (Tsoh *et al.*, 2016) and Australia (Zhang *et al.*, 2020) in relation to CVD. But to the best of our knowledge, findings were different in the UK, where the primary care system is different to other countries. The cost to the healthcare system of this is clearly evident, due to the “inappropriate” use of expensive and intensive emergency or secondary care treatment when primary care management could prevent potential and actual healthcare problems related to CVD.

The implications of these data for primary care services are that Chinese people with CVD or identified risk factors for CVD arguably need closer management, culturally sensitive advice, support, and robust follow-up. Understanding general health needs and experiences with health service utilisation by community groups can be used to enhance cost-effective service delivery planning. On the other hand, doctors and nurses can use the findings of this study to enhance their practice and give them confidence in their interaction with Chinese patients on the basis of how they think and behave in relation to help seeking.

Although this is a small-scale study, we believe we have captured the perceptions and some social processes of a group of Chinese people who have seldom been approached about this subject in the UK. Further studies investigating culturally sensitive and health literacy approaches may help to overcome the barriers to appropriate access to primary care services.

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**Authors’ contribution.** SS and ZL designed the study and collected the data. ZS and SS analysed the data and drafted the manuscript. ZL supervised the whole process and edited the manuscript.

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**Conflicts of interest.** None.

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