THE INTER-RELATIONSHIP OF FOLK, TRADITIONAL AND WESTERN MEDICINE WITHIN AN ASIAN COMMUNITY IN BRITAIN

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Abstract—A community-based interview study of Asians and a questionnaire study of health professionals were performed to ascertain the role of traditional medicine in the context of health care within the Asian community.

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 its use comprises a significant health threat.

Opportunities for further research and a prediction of the future of Asian medicine in Britain is presented.

NOMENCLATURE

DEFINITION OF TERMS—as applied in this study

Asian The term is restricted to persons and culture of the Indian Subcontinent.

Asian Traditional Medicine The term includes both Asian folk and indigenous systems of medicine.

Bhai Bhaadi This is a cultural concept and represents a 'cold disorder with excess production of mucus' (a full description is in preparation).

'Hot/Cold' The humoral concept that ill-health may result from an imbalance of 'hot' and 'cold'. Illnesses, food and medications are ascribed 'hot' and 'cold' properties. 'Hot' and 'cold' is not directly related to temperature but reflects a poorly-defined subjective sensation.

Asian healer Refers to vaidyas and hakims who are practitioners of Ayurveda and Unani-Tibb respectively, the principle Asian traditional systems of medicine.

Nazar The literal translation of this Punjabi word is vision. The disorder given this name is similar to the concept of the 'evil eye'.

Taveez Holy words from the Koran, often incorporated into an amulet, used for various purposes including healing.

INTRODUCTION

Traditional systems of medicine contribute significantly to the medical needs of 80% of the world's population [1]. The expansion of Western medicine is limited not only by financial and manpower restraints but also by a preference in some societies for traditional care, particularly for cultural and chronic disease [2,3]. Lay medical beliefs and remedies, upon which self-care is based, are allied to the prevailing professional system of medicine. Clearly, to provide effective care all health workers need an understanding of both lay and professional forms of traditional care available within the communities they serve.

Within the Indian Subcontinent there is a rich tradition of lay medicine based on foods, herbs, physical techniques such as yoga, magic and religion [4]. Humoral views of food, illness and health including the 'hot/cold' concept are widely held [5,6] and are central to both Ayurveda and Unani-Tibb, the principle traditional medical systems. While Ayurveda is indigenous to India and has a unique and ancient body of theory [7], Unani-Tibb derives from Greek medicine and evolved in Persia [8]. Both lay a heavy emphasis on the disturbance and rectification of the 'hot/cold' equilibrium. Their materia medica is based on herbs, minerals and dietary manipulation but also borrows freely from the drugs and techniques of western medicine [9]. Traditional medicine enjoys public and government support and practitioners of Ayurveda and Unani-Tibb outnumber their counterparts in Western medicine [10].

Residents of Britain who originate from the Indian Subcontinent (subsequently referred to as Asians) now comprise 2% of the population and yet little is known of their health beliefs and practices [11]. The anecdotal observations of experienced practitioners [12] are insufficient (though sometimes perceptive) while most national studies have too few Asians to allow meaningful comment. Aslam [13] and co-workers have studied the use of Asian medicine by Asians in the Bradford area and have highlighted the use of Asian healers [13], the morbidity caused by toxic metal based Asian proprietary medications (usually imported from the Indian sub-continent) [14], and the deleterious effects of belief in the 'hot/cold' concept on compliance with physicians.
advice and therapy [15]. Their results and views have been widely publicized [16,17]. Johnson et al. [18] report that Asians in the West Midlands did not perceive traditional medicine to be superior to 'conventional' medicine.

This study was performed in a community setting in Glasgow, the major industrial city of Scotland where an estimated 11,000 Asians (1.3% of the city's population) reside. The National Health Service in Glasgow enjoys a level of funding greater than most areas of Britain and provides access to a range of free facilities including child clinics, general practice (family practice) and hospital care. As the census in Britain notes only place of birth but omits questions on ethnicity/race, official data on the demographic and socio-economic characteristics of the Asian population are limited. Luthra [19] analysed data from several sources and reported that the 7000 persons originating in Pakistan came from the Mirpur and Punjab regions while the 4000 from India came mainly from the Punjab. Gujaratis, Bengalis and Kenyan Asians were few in number. He estimated that Muslims outnumbered non-Muslims by a factor of 2:1. Two distinct communities in inner city areas characterised by the availability of inexpensive housing stock were identifiable in the North and South of the city.

Though relations with the host population are harmonious, with minimal overt racial tension, Asians remain a close knit and socially segregated group. Muslims, Hindus and Sikhs share entertainment, shopping and business facilities and pool resources at times of adversity. However intimate social contact, particularly intermarriage, is limited. The community is characterized by its trading endeavours with Asian food and clothes shops being prominent. Most Asian foods, dried spices and herbs are widely available but Asian medications are not. The community is geographically but not culturally or socially homogeneous but is perceived as such by the native population.

This study aimed to examine the application of traditional health beliefs and remedies and relate this to the health care provided by the health services.

METHODS

The Asian community study

A group general practice with 5 white doctors caring for 9000 patients was chosen as the source of the sample in view of its high proportion of Asian patients (> 10%). The practice's two geographical locations are situated in the South of the city in areas where there is socio-economic heterogeneity as characterized by a wide variation in the type and cost of housing. The register of patients yielded 413 Asian names of persons exceeding 18 years of age. These were stratified into Muslim (285) and non-Muslim (128) groups and 50 names selected randomly from each group. Of these 100 persons, 22 could not be traced. 6 were abroad, 3 were not Asians, 3 refused and 1 was deceased. Thus the 65 interviews which took place represent 96% of those contacted. The religious grouping was found to have been correctly predicted for 61 of the 65 persons on the basis of name.

Interviews, conducted in the homes of interviewees, were based on a questionnaire with 55 stem questions. All questions were open-ended and discussion invited. Interviews were conducted by the researcher who is fluent in Punjabi (the preferred tongue of most interviewees) and familiar with Hindi and Urdu. There was no language difficulty.

Consultation data was extracted from the medical records of 60 of the 65 persons by one of the general practitioners.

Data suitable for numerical analysis was coded and analysed with the Statistical Package for the Social Sciences (SPSS) computer program. Spearmann's correlation was used as most data were non-parametric. Further details regarding methods and manipulation of the data are given where appropriate.

The health professional's study

Fifty-seven general practitioners and 15 attached health visitors from all 20 general practices in the vicinity were offered a self-completion questionnaire with 17 stem questions regarding the use of traditional medicine by their Asian patients. Of the 33 (58%) general practitioners who responded 3 had no Asian patients on their list. Ten health visitors (67%) replied giving an overall response of 60%. No reminders were sent as scrutiny of returned answers revealed a predominantly negative response.

RESULTS

Characteristics of the study population

Of the 30 men and 35 women interviewed, 54 were married. Their median age was 31 years (mean 34.9) and the range 19–70 years. The religious groups were Moslems (30), Sikhs (19), Hindus (13), Christians (2) and an atheist. Only 6 persons had been born in the United Kingdom, the others in the Indian Subcontinent. The family origin of all the group was the North West of the Indian sub-continent, and most were from the Punjab. The median duration of residence of the 59 migrants was 17 years with a range of 1–32 years. Twelve persons perceived themselves as having difficulty in communication with their general practitioner due to poor knowledge of English. In view of changes of occupation following migration and socioeconomic heterogeneity within occupational groups (3 shopkeepers hold university degrees) social class categorization was considered inappropriate. The occupational categories were: 26 shopkeepers; 14 manual workers; 4 unskilled non-manual workers; 7 professional/semi-professional workers and 3 students. Data on husband's occupation was not requested from 11 women (only 3 women were working). Husband's occupation is given for the others.

With few exceptions women dressed in traditional costume and showed the traditional diffidence in their approach to the male researcher, most requesting the presence of chaperones, usually family members. Nevertheless, women were keen to air their views. In contrast most men were dressed in Western clothes and were forthcoming and mutual trust was rapidly established.
Knowledge and uses of Asian traditional remedies

Awareness of traditional Asian medicine was the norm with a few persons exhibiting extensive knowledge and application of its concepts and remedies. Only 1 person (an 18 year-old single girl living apart from her family) was unaware of the existence of Asian medicine.

One hundred and twelve health remedies were discussed by respondents. These are categorized in Table 1. It is notable that 54 (48%) of these remedies, particularly those which are culinary ingredients, are readily available in the home or local food stores. Of the 18 commercially prepared substances, 13 were for gastro-intestinal problems. One was a powder which had been effective for extensive vitiligo, a condition refractory to Western treatment. Most of these proprietary substances were imported from the Indian sub-continent.

Knowledge and use of eight substances, known to be in common use as health remedies on the Indian sub-continent, are outlined in Table 2. Khushtay (a medicinal herb) was used by eight people of whom two self-treated diabetes mellitus with it as had two close relatives of respondents.

Ginger, turmeric and garlic (condiments of the everyday diet) were frequently used for their medicinal value in the manner discussed below. Asafoetida (a spice noted for its carminative properties) was infrequently used either as a condiment or as a health remedy. The products of the nim tree (which is known as ‘the home doctor’ in India) were popular in India and Pakistan, but lack of fresh ingredients apparently restricts their use in Britain.

Each person was given a ‘knowledge’ score for knowing of a medicinal value of a remedy and a ‘use’ score for having used the remedy. The mean scores were 3.1 and 1.2 respectively. There was a statistically significant association between age and knowledge scores ($R_s = 0.35, P = 0.01$) and age and use scores ($R_s = 0.23, P = 0.03$). This supported the observation that those most knowledgeable regarding Asian medicine were the middle-aged and elderly.

The use of traditional remedies was explored by asking questions regarding the past management of 9 common health problems. Answers regarding children were accepted, but where a particular problem had not occurred the question was considered inapplicable. Information regarding the use of ‘over the counter’ drugs and visiting the doctor was collected only when offered spontaneously but the use of traditional remedies was explored by direct questioning.

Table 2 outlines the responses. Asian remedies contribute substantially to the care of abdominal discomfort, toothache, earache and diarrhoea. However 25% had never used such a remedy for these problems, while only 8% had treated 4 or more of these 9 problems with Asian remedies. The mean number of conditions treated by Asian remedies was 1.64. This was overshadowed by both ‘over the counter’ remedies (mean = 2.32 conditions) and seeking professional advice (mean = 2.77).

The use of Asian remedies for acute illness occurring in the 2 weeks preceding interview and chronic illness was explored. Of 20 acute illnesses only 1 was treated with an Asian remedy. Of 28 chronic problems 1 was treated with an Asian remedy alone and 4 with both Asian remedies and western medicines.

The mode of application of commonly used Asian remedies

There was a high degree of agreement regarding the spectrum of activity and mode of administration

*ATM = Asian traditional medicines.

Table 1. Categories of ATM's* identified by interviewees

<table>
<thead>
<tr>
<th>Type of substance</th>
<th>Number identified</th>
<th>Number which are home ingredients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spices, herbs</td>
<td>62</td>
<td>39</td>
</tr>
<tr>
<td>Nirm (Indian Lilac)</td>
<td>25</td>
<td>55</td>
</tr>
<tr>
<td>Khushtay</td>
<td>49</td>
<td>51</td>
</tr>
<tr>
<td>Warak</td>
<td>37</td>
<td>60</td>
</tr>
<tr>
<td>Karkila</td>
<td>25</td>
<td>63</td>
</tr>
<tr>
<td>Ginger</td>
<td>12</td>
<td>63</td>
</tr>
<tr>
<td>Turmeric</td>
<td>32</td>
<td>52</td>
</tr>
<tr>
<td>Garlic</td>
<td>29</td>
<td>58</td>
</tr>
<tr>
<td>Asafoetida</td>
<td>42</td>
<td>51</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
<td>54</td>
</tr>
</tbody>
</table>

*ATM = Asian traditional medicines.

Table 2. Knowledge and use of ATM's

<table>
<thead>
<tr>
<th>Substance</th>
<th>% With no knowledge of medicinal use</th>
<th>% With knowledge of medicinal use</th>
<th>% With experience of medicinal use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Khushtay</td>
<td>49</td>
<td>51</td>
<td>0</td>
</tr>
<tr>
<td>Warak</td>
<td>37</td>
<td>60</td>
<td>1.5</td>
</tr>
<tr>
<td>Karkila</td>
<td>25</td>
<td>63</td>
<td>12</td>
</tr>
<tr>
<td>Ginger</td>
<td>12</td>
<td>63</td>
<td>25</td>
</tr>
<tr>
<td>Turmeric</td>
<td>32</td>
<td>52</td>
<td>15</td>
</tr>
<tr>
<td>Garlic</td>
<td>29</td>
<td>58</td>
<td>12</td>
</tr>
<tr>
<td>Asafoetida</td>
<td>42</td>
<td>51</td>
<td>8</td>
</tr>
<tr>
<td>Nirm (Indian Lilac)</td>
<td>25</td>
<td>55</td>
<td>20*</td>
</tr>
</tbody>
</table>

*All in India or Pakistan.
of most remedies. A decoction of fennel seed (sonf) prepared in water, milk or tea was considered efficacious for gastrointestinal problems (30 persons) and for respiratory infection (4 persons). Instances when this remedy had proved superior to 'the doctor’s medicine' were numerous and were recounted with enthusiasm. The leaf of the nim tree and turmeric (haldi) were used as antiseptics and applied as poultices to cuts, bruises and infections. When ingested both were said to be 'internal antiseptics' (turmeric was recommended as such in the post-partum period) while the bark of the nim tree was chewed for oral hygiene and to brush teeth.

Oils (particularly almond and mustard) were used for massage for such conditions as fatigue, muscular pain, abdominal pain and in one instance each, muscular paralysis and mental retardation. Direct instillation of warmed oil is common practice in the home treatment of earache. Traditionally, cow’s or a child’s urine is used in the same way but this seems to be rare now. Whole cloves, placed over the site of toothache, were used by 22 persons, most of whom reported symptomatic relief. Cloves may also be used alone, or in combination with cardammons and fennel for gastrointestinal problems.

Most remedies were ascribed a narrow spectrum of actions but three exceptions were garlic, ginger and karela. They were considered ‘hot’ substances and were used to prevent or treat ‘cold’ diseases. Thus ginger was cited as useful (in ranking order of frequency) for ‘bhai bhadi’, arthritic and bone pain, respiratory infection, gastrointestinal problems, asthma, circulatory problems and several other conditions. Garlic was ascribed similar actions. Karela was cited for diabetes mellitus, bhai bhadi, as a ‘hot’ substance, blood purification, skin infection and for other conditions.

Table 3. Responses to health problems

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>% Of people showing each type of response*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Take ATM or OTC</td>
</tr>
<tr>
<td>Common cold</td>
<td>11 12 35 14</td>
</tr>
<tr>
<td>Cough</td>
<td>6 12 45 25</td>
</tr>
<tr>
<td>Earache</td>
<td>18 12 8 37</td>
</tr>
<tr>
<td>Sore eyes</td>
<td>7 2 5 31</td>
</tr>
<tr>
<td>Abdominal discomfort</td>
<td>34 16 25 14</td>
</tr>
<tr>
<td>Constipation</td>
<td>8 0 25 15</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>14 0 25 40</td>
</tr>
<tr>
<td>Toothache</td>
<td>25 9 20 31</td>
</tr>
<tr>
<td>Fatigue</td>
<td>0 2 6 3</td>
</tr>
</tbody>
</table>

*The figures do not add up to 100% as some people do nothing and others cannot recall having had such a problem.

**OTC = over the counter.

Attitudes towards Asian medicine and the Asian healer

As indicated in Table 4, few people prefer traditional medicine to Western medicine, though opinion is divided regarding safety. Several persons emphasized that herb based Asian medicines are safe but metal based ones are not, especially when they are poorly prepared. Supporters of Asian medicine cited the antiquity of its knowledge base, the fact that most of its drugs are natural substances and the rarity of overdose. It was frequently argued that Asian medicines get to the root of the problem while Western medicines merely suppress symptoms. This philosophy may explain the popularity of homeopathy (the theory of homeopathy emphasizes attacking the root of the disease) in India. Indeed, though not quantified, support for homeopathy was found to be high and several respondents had consulted local homeopaths on a regular basis or possessed homeopathic remedies.

Arguments against Asian medicine were more vociferous and numerous and included the following; there is a lack of fresh ingredients to prepare effective remedies; reliable advice is difficult to obtain; ‘quacks’ produce and distribute ineffective or harmful remedies; children dislike the smell and taste of Asian remedies; Asian remedies may be against the law; Asian remedies are inconvenient to prepare for the busy person; Asian remedies work too slowly; Asian remedies are inactive in the British climate; Asian remedies simply do not work. Paradoxically some persons who rejected Asian remedies outright were utilizing the principles of Asian medicine. Thus one person who declared—‘I am completely against the use of Asian medicines in Britain’—took ginger for his asthma and karela for diabetes. A mother who knew numerous recipes lamented that as her children were unwilling to learn her methods (though they used her remedies when in need) her secrets would die with her.

No Asian healer was identified in Glasgow but 2 persons had consulted one in England and another had taken relatives. By contrast 13/57 persons who had returned to India consulted traditional healers while there. Consultations with hakims were generally for chronic problems and rarely resulted in cure or subjective improvement, the majority relating that their symptoms had deteriorated or remained the same. Nevertheless, the Asian healer was held in high
estee although this faith was tempered by the knowledge that unqualified persons pose as 'hakims and vaidyas', that they often rely upon Western medicine and the fact that their medications, especially khushtay, may be toxic. The following remarks reflect the basis of this faith.

“The Asian healer listens very carefully while doctors here do not. Doctors often give weak medicines which you have already tried.”

“I feel that doctors are not always paying attention and sometimes I wish I did not come, especially as the medicine they give often does not work”.

The ability to communicate in a way acceptable to the patient and to induce faith in the therapy offered seems central to the success of the Asian healer.

The ‘hot/cold’ concept

The role of the ‘hot/cold’ concept (garam and thanda are the equivalent Punjabi words) in relation to diet, medications and nutrition in pregnancy was explored. Eighteen persons had no understanding of the ‘hot/cold’ concept of food and most of the other 47 had rudimentary knowledge. Nine persons recalled treating health problems with dietary alterations. These included increasing ‘cold’ spogel seeds to control epistaxis, increasing ‘hot’ foods such as ginger, garlic and eggs for joint pains and reducing ‘hot’ foods in general for pimples.

Ten persons noted that Western medicines are ‘hot’ (several persons commented that Asian medicines are also ‘hot’) and described their subjective sensations. These included a hot and sweaty feeling, palpitations, dizziness, an ill-defined change in consciousness and abdominal discomfort. One person gave vitamins to her children for their warmth giving properties. Many respondents, including those who did not find Western medicines ‘hot’, readily admitted poor compliance with prescribed therapy. Stopping treatment when symptoms subside seemed to be a common response. The prevalence of and reasons for non-compliance need systematic study.

The proposal that ‘hot’ foods are to be avoided in pregnancy was widely rejected as untrue and many respondents took pains to emphasize that in Asian culture the pregnant woman gets preference for all foods both during pregnancy and for at least 21 days after birth. However 10 persons were in some agreement and elaborated on this idea, stating that abortion is a risk of such foods as prawns, dried fruit, lentils, eggs and goats legs but only if eaten in quantity. Milk, cheese, meat and antenatal iron and vitamin supplements were not considered sufficiently ‘hot’ to cause abortion. The views are summarized by the following quotation.

“Avoid very ‘hot’ foods such as dried fruit. Even my grandmother would not have avoided either milk or meat”.

Nazar and taveez—magico religious concepts

Enquiry regarding nazar and taveez allowed insight into the place of magic and religion in the health concepts of Asians. The majority (43/65) dismissed nazar as a superstition, 6 were unsure, while 16 accepted this concept as reality. Of the latter group 2 had experienced minor illnesses resulting from nazar, while another, an insulin dependent diabetic, felt that nazar had played some part in her problems. The gaze of a loving or malevolent person is considered the common and important cause of nazar but eating in the presence of a stranger is another. Illness resulting from nazar usually affects children who develop crying, restlessness and loss of appetite. The illness may be severe but is usually self-limiting. Nazar was said to be prevented by reducing one’s pride, avoiding public display of possessions (including children), blackening the child’s face and by wearing a taveez. Rituals described for the treatment of nazar included the following:

Burn chili peppers in the presence of the child, This also serves for diagnosis as if the child has nazar the normal pungent smell is absent.

Pass a red hot iron rod over the child.

Reflect the child’s face in a dish of oil then throw the oil away.

Awareness of the health giving power of taveez (and other forms of amulet) was high but only 6 persons, all Muslim, had experience of their use. Faith in God, irrespective of religion, by both recipient and prescriber, was emphasized as a prerequisite of success in the use of the taveez. The dispensation of taveez’s by ‘quacks’ for large amounts of money was widely recognized and condemned and such amulets considered to be ineffective. The taveez had been used for nazar, convulsions, nightmares, failure to thrive, chronic pain and prevention of ill-health in pregnancy. Five of 6 users claimed to have benefited from this technique. One woman prepared taveez and had ‘prescribed’ them for several women, particularly for infertility. She claimed a high success rate.

Asian health concepts and remedies—the relationship to general practice

Asian remedies were used before, with and after Western medicine yet respondents rarely divulged this information to their doctors and seemed to consider this matter as quite separate from health service care. Only 1 person could recall discussing Asian medicine in a consultation, an instance when he sought and obtained permission to consult an Asian healer while visiting India. A woman who had required prolonged treatment following side-effects after taking an Asian healer’s therapy omitted to inform her general practitioner of the cause of her illness. She explained that the healer was a member of the local community whom she did not want to be troubled by the law. Fear of disapproval and a belief that Western doctors were neither knowledgable nor interested in Asian medicine seemed to be the overriding factors in this lack of communication. The latter fear was largely confirmed by the health professional’s survey.

Only 3 of 40 health professionals could recall ever eliciting information about Asian remedies from their patients, but 8 could recall instances when patients had broached the subject. No health professional had ever encountered an illness attributable to Asian medications. Overall, knowledge regarding Asian medicine was extremely low and health practitioners were
unaware of the use of Asian health remedies by their patients. Nevertheless, 50% of the group indicated that Asian remedies should be encouraged unless shown to be harmful, 20% stated that they should be discouraged while the others had no view. The tolerant attitude of the practitioner may be conditioned by their experience of 'home remedies' used by their native Scottish patients as indicated by the following statement:

"The indigenous population uses many remedies which they are reluctant to divulge to their doctors. Chemist shops and supermarkets do a great trade and old fashioned remedies are still on the go. The Asian community is, I am sure, very similar".

No correlation between either knowledge or use of Asian medicine and overall general practice consultation rates was demonstrable ($R_s = 0.01$ and $R_s = 0.00$ respectively).

**DISCUSSION**

Within the Glasgow Asian community, and in particular among older persons, awareness of Asian health concepts, remedies and healers is high. Application of this knowledge, however, is on a modest, though not insignificant, scale. In the absence of local Asian healers, unavailability of local proprietary Asian medicines, lack of some fresh herbs and establishment disapproval, barriers to Asian medicine are considerable compared to the 'free' National Health Service. Home remedies, particularly those employing culinary ingredients, are perceived by most people as convenient, safe, inexpensive and effective and remain popular in the self-care of common illnesses. This accords with observations of Indians in India [4] but contrasts with British people for whom food and herbs comprised a mere 5% of self-medication [22] and who have a basic distrust of 'home' remedies [23]. Self-medication may be supplementary [24] or a substitute [22] to general practice consultation depending on the population studied. For this community, general practice consultation rates were unaffected by knowledge or utilisation of Asian health remedies. It appears that these remedies are an alternative to 'over the counter' drugs for acute self limiting illnesses and supplementary to professional consultation for chronic problems.

The use of Asian medicine does not comprise a major health hazard within this community. Use of toxic Asian remedies such as khusthay and warak [14] is rare while hakims are rarely consulted in Britain. Only one instance of side-effects attributable to Asian remedies was recalled by the 65 Asians while the health professionals had never encountered such a problem. Nevertheless, awareness by health workers of a potential hazard needs to be high. Karela (bitter-gourd) has been reported to interfere with their experience of 'home remedies' used by their native Scottish patients as indicated by the following statement:

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substances [31, 32] and has usually supported the traditional usage.

Asian medicine is likely to decline in view of diminishing interest among the young, a halt in migration of Asians, increasing familiarity with 'over the counter' drugs and the adverse publicity that some Asian remedies receive. Nevertheless traditional views are durable (though application of them may not be) and will remain in the "social stock of knowledge" [33] of Asians for many generations. However, in view of increasing barriers to care such as waiting lists, appointments systems and limited prescribing for self-limiting illness [34] and the revival of "alternative systems" of care [35] it is conceivable that the use of Asian medicine may endure. As such, health workers caring for Asians need to gain awareness of Asian medicine and develop understanding of its application by their patients.

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