



XIAN WEN JIN, MD, PhD

Department of General Internal Medicine,
The Cleveland Clinic

JACQUELYN SLOMKA, PhD, RN

Department of Bioethics, The Cleveland Clinic

CAROL E. BLIXEN, PhD, RN

Department of General Internal Medicine,
The Cleveland Clinic

Cultural and clinical issues in the care of Asian patients

ABSTRACT

Special problems of Asian patients have considerable impact on diagnosis and treatment, and the number of persons of Asian ancestry seen in primary care in the United States is increasing. Knowledge of how to provide optimal care despite language barriers, low socioeconomic status, different health beliefs and practices, and medical issues unique to this heterogeneous group is crucial to competent health care.

KEY POINTS

Several diseases are more common in Asians than in the general population: lactose intolerance, hepatitis B, nasopharyngeal carcinoma, and tuberculosis.

In traditional Chinese culture, if a person feels well, there is no need to see a doctor. Also, because blood is considered as nonrenewable vital energy, patients may resist having blood tests to check such things as cholesterol and glucose levels.

Toxicity or side effects of ginseng such as central nervous system stimulation and increased blood pressure have been reported. Excessive amounts of ginseng may cause headache, insomnia, and palpitations. Ginseng may decrease the diuretic effect of furosemide, causing an adverse reaction in patients with congestive heart failure.

Fourteen percent of US Asian families live below the poverty line, compared with 11.5% of Caucasian families.

CHALLENGES COMMONLY ENCOUNTERED with Asian patients include language barriers, low socioeconomic status, traditional health beliefs and practices, and epidemiologic issues.

This article presents three case studies that illustrate how these problems can affect the health care of Asian patients, and describes ways to deal with them constructively. We also discuss what diseases are more common and what conditions have unique clinical aspects in this population.

Asians: The fastest-growing minority

Asians and Pacific Islanders are the fastest growing ethnic minorities in the United States, and are predicted to number more than 17 million by 2010.¹ This heterogeneous population is from many cultures and speaks many languages—the 1990 US Census identified 25 distinct Asian ethnic groups (TABLE 1).² Due to space limits, this article focuses on cultures more populous in the United States: East Asian (China, Japan, Korea) and Southeast Asian (Vietnam, Cambodia, Thailand), but recognizes that cultures differ widely within and among these countries.

A caveat: The observations in this article about each ethnic group are generalizations, which may or may not apply to specific patients.

A positive approach to patients from other cultures requires openness to differences and willingness to accommodate their issues in their overall care. Rather than viewing these differences as something to be overcome or simplistically “respected,” culture becomes meaningful to health care when it is analyzed and interpreted within the individual patient’s social and historical situation.³



■ CASE 1 LANGUAGE DIFFICULTIES

A previously healthy 48-year-old Chinese woman presented to the emergency department with the chief complaint of “passing out.” She speaks some English, but not fluently. A translator was not available in the emergency department, and the record noted simply that “the patient suddenly fainted at home while in the kitchen and experienced loss of consciousness for 1 to 2 minutes.”

The initial workup included a complete blood count, chemistry panel, urine toxic substance screen, and an electrocardiogram. Her potassium level was 3.2 mmol/L (normal range 3.5–5.0), but the rest of the laboratory results were normal.

The patient was admitted to a step-down unit for observation and was sent home the next day with 48-hour Holter monitoring.

The day after discharge she was seen in the outpatient department by her primary care physician, who shared her ethnic background and spoke her native language. At this time she was found to have orthostatic hypotension and was dizzy when she stood up, but her Holter monitoring results were unremarkable.

The physician then obtained a complete history of her present illness. The patient related that 1 week earlier she noted a productive cough with yellow sputum, fever, and decreased appetite. On the morning of that day, she took a hot shower, went to the kitchen, and sat down for breakfast. When she stood up suddenly, she felt light-headed and almost fainted. She did not lose consciousness, nor did her husband witness any seizure activity. She stated that she lay down immediately and felt better.

From this conversation, the primary care physician concluded that the patient probably had had a recent respiratory tract infection associated with dehydration resulting from poor oral intake, and most likely had orthostatic hypotension at the time of her symptoms due to vasodilatation brought on by the hot shower. The patient was treated with antibiotics for bronchitis and intravenous fluids for dehydration during the office visit. She recovered completely.

TABLE 1

Asian ethnic groups in the United States

Asian

Asian Indian	Japanese
Bangladeshi	Korean
Burmese	Laotian
Cambodian	Malaysian
Chinese	Okinawan
Filipino	Pakistani
Guamanian	Samoan
Hawaiian	Sri Lankan
Hmong	Thai
Indonesian	Vietnamese

Pacific Islanders

Fijian
Northern Mariana Islander
Palauan
Tahitian
Tongan

Discussion

In this patient, language difficulties resulted in an inaccurate initial diagnosis and suboptimal treatment. Only after she spoke to her physician who shared her language did she receive the correct diagnosis and satisfactory treatment.

The conversation between patient and primary care physician is probably the most fundamental part of medical practice. Many Asian-born patients have some difficulty with English, and medicalese is even more difficult to speak and understand than everyday English language. As a result, making appointments, registering, nurse triage, and following instructions may present considerable difficulties. Studies showed that Vietnamese men who could not speak English well were less likely to obtain stool hemoccult tests,⁴ and Chinese patients who could not speak English well were less likely to obtain serum cholesterol screening.⁵ Language barriers can also lead to unnecessary diagnostic testing.

Patients may interpret symptoms within a framework that does not correspond with the physician's meaning.⁶ For example, a Chinese woman may attribute her symptoms of hyperthyroidism to yin-yang imbalance. This misunderstanding may lead the physician along a

24-hour
telephone
interpreting is
available at
1-800-874-9426

circuitous and sometimes inaccurate diagnostic path.

How to deal with language barriers

Professional interpreters are rarely available in health care. As a result, patients and physicians rely on their own language skill, family or friends, or ad hoc interpreters (bilingual strangers from the waiting room or employees).

All of these approaches may be suboptimal. Most physicians in the United States are probably not sufficiently bilingual to practice medicine in a language other than English. Family, friends, and ad hoc interpreters may add, omit, substitute, or edit while translating. Their services are also problematic in terms of patient confidentiality.

Finding an interpreter. Good interpreter services are possible despite these problems. Interpreters can be hired locally, as the Asian community generally consists of persons with a spectrum of language skills. Physicians and nurses who are fluent in an Asian language also generally make excellent interpreters because of their familiarity with the language and with the cultural dimensions of the patient's illness.

Other interventions. A few simple interventions can also be very helpful for Asian patients with limited English proficiency.

- *Bilingual signs* can be very effective in helping patients making appointments, filling prescriptions, and obtaining laboratory tests.
- A *bilingual list* of common phrases, medical terms, and questions is helpful to both staff and patients.
- A *24-hour telephone interpreter service*, the AT&T Language Line, is available in all major languages at 1-800-874-9426.^{7,8} There is a charge of \$4.50 per minute on a credit card or less for an account with AT&T.

■ CASE 2 LOW SOCIOECONOMIC STATUS

A 76-year-old Chinese man with hypertension, diabetes mellitus, and a history of stroke, who speaks no English, was admitted to the hospital for upper gastrointestinal bleeding and was diagnosed with duodenal ulcer. After

discharge, he was followed by his neurologist and primary care physician.

His physician noted that the patient's functional status was poor and that he had fallen many times. He was often without help at home because his children were involved in running a small family business and his wife had many medical problems and was unable to care for him adequately.

When the physician discussed obtaining home health services, the family initially was reluctant to have a nonfamily member caring for their parent. They believed they could not afford such services and were suspicious of relying on state agencies for help. The physician contacted the hospital's social services department, which found the patient and his family eligible for certain state-funded social services and persuaded them to accept home care.

Discussion

Contrary to the stereotype that US Asians are a homogeneous, high-achieving, "model minority," they are actually bimodal in their socioeconomic status: 14% of US Asian families live below the poverty line (compared with 11.5% of Caucasian families).⁹ The Asian population demonstrates the same social, cultural, and economic vulnerability as other minority groups in this country.

Socioeconomic status has a large impact on the health care of patients in general, and Asian patients are no exception. Impoverished Asian immigrants usually have low-income jobs with long working hours and no health benefits. Consequently, they often do not seek medical care, especially for disease prevention, unless they have symptoms.

A study in California⁵ revealed that 23% of uninsured Chinese people over age 40 never had their blood pressure checked, compared with only 6% of insured Chinese people. Poverty has also been associated with failure to have a screening mammogram.⁵ Furthermore, these patients are usually reluctant to seek medical attention, even when they have symptoms, because of potential loss of work time and inability to pay doctors' fees. Even Asian patients who are native-born may lack knowledge about how the health care system functions or harbor stereotypes about state assistance that prevent them from

Reassure
Asian
immigrants
that you
do not work
for the INS



FIGURE 1. Ecchymosis produced by coin-rubbing, a traditional Asian healing technique.

obtaining adequate care.

An unknown number of Asian immigrants resides in the United States illegally. This subgroup is even more vulnerable and may refuse to seek medical help for fear of being reported to federal authorities and deported.

How to deal with socioeconomic barriers

Socioeconomic barriers are more complex than language barriers, with several issues that need to be recognized.

- Some Asian patients with low socioeco-

omic status may have the cultural belief that seeking public assistance is shameful.

- It is important to reassure Asian immigrant patients that doctors and other health-care workers do not work for the Immigration and Naturalization Service and will not report their immigration status. This may reduce noncompliance with treatment for tuberculosis or sexually transmitted diseases.
- Involving social workers in making patients aware of available social services is often helpful.
- On the other hand, do not assume that all Asian immigrants are poor or that they have been receiving suboptimal medical service in their native countries—this group is very heterogeneous.

■ CASE 3

HEALTH BELIEFS AND PRACTICES

A 40-year-old Cambodian woman, who immigrated to the United States at age 10, presented to the primary care department with a 3-day history of nausea, vomiting, watery diarrhea, intermittent epigastric abdominal pain, fever, and muscle aches.

On examination, she was febrile and had orthostatic hypotension and mild epigastric tenderness; otherwise, her abdominal exam was normal. However, she was found to have ecchymosis on her back (FIGURE 1). Since the distribution was symmetrical and linear, the resident first suspected it was due to spousal abuse. Upon questioning, the patient reported that she had treated her symptoms with a traditional healing technique known as “coin rubbing.” The basis of this technique is a belief that ecchymosis induced by rubbing the skin with an object such as a coin will remove toxins that cause illness and will relieve congestion, thus allowing for regulation of blood and energy.

Discussion

Physicians should ask patients about their use of traditional treatments and herbal medications while taking the history of the present illness. Some Asian patients resort to Western medicine only if traditional healing fails; others use both traditional and Western medicine, or only Western medicine.



Asian patients who hold culturally rooted health beliefs and practices may not seek out preventive screening, diagnostic testing, and treatment. In traditional Chinese culture, if a person feels well, there is no need to see a doctor. Also, since blood is considered a non renewable vital energy for the body, patients may not seek preventive care and may resist having blood tests to check such things as cholesterol and glucose levels.⁶

Cultural beliefs about cancer may be a barrier to cancer screening when patients believe that cancer cannot be treated successfully and fear rejection by the community if cancer is diagnosed, as shown in a study of cancer screening in Cambodian women.¹⁰

Traditional treatments. Traditional Eastern Asian treatments include acupuncture, skin scraping, rubbing the skin with an object such as a coin, cupping (local suction created by placing a heated cup on the skin to open skin pores), and herbal medicine.

Herbal remedies. In addition to using Western medicine, Asian patients may use traditional herbal remedies, some of which contain pharmacologically active substances that can have adverse effects as well as interact with prescription drugs.

Ginseng, for example, is believed to help the body build resistance to stress, improve immunity, and enhance sexual function. However, toxicity or side effects such as central nervous system stimulation and a rise in blood pressure have been reported.¹¹ Patients taking excessive amounts of ginseng may present with headache, insomnia, and palpitations. Also, ginseng may decrease the diuretic effect of furosemide, causing an adverse reaction in patients with congestive heart failure.¹²

Mo-ehr. Another traditional remedy the physician may encounter is *mo-ehr* (black tree fungus). This medication is used to enhance circulation and may have anticoagulation effects. It can cause bleeding in patients taking warfarin.¹³

How to deal with health belief barriers

The issue of culturally related health beliefs is even more complex because of the heterogeneity of the ethnic and cultural backgrounds of Asian immigrants. It is virtually impossible for US physicians to understand

the culturally related health beliefs of each distinct group of Asian patients.

In our practice, we have observed that a person's education, socioeconomic status, level of acculturation, and religious background may not be accurate predictors of the influence of culturally related health care beliefs and practices.

A simple and very helpful approach in overcoming cross-cultural barriers is to ask the patient for his or her perception of the illness. This approach avoids assumptions of the patient's ethnic heritage and level of acculturation, and acknowledges the differences between his or her culture and the biomedical culture.¹⁴

■ DISEASES THAT ARE MORE COMMON IN ASIANS

Lactose intolerance

Lactose intolerance is found in as many as 75% to 100% of Chinese, Japanese, and Korean people.¹⁵

Treatment considerations. On the basis of a careful history that rules out other common diseases, a lactose-free diet could be tried before starting an extensive diagnostic workup for many Asian patients who present with watery diarrhea.

Hepatitis B

Hepatitis B is much more common in Asians than in the general US population, occurring in about 8% to 22% of Asians vs only 0.2% to 0.9% in the US population.² Consequently, primary hepatocellular cancer among Asians is not as rare as in the US general population.

Treatment considerations. In evaluating an Asian patient with a hepatic lesion or new onset of cirrhosis, an alpha-fetoprotein measurement and magnetic resonance imaging scan of the liver should be included.

Nasopharyngeal carcinoma

Nasopharyngeal carcinoma is rare in the general population but remarkably common in Cantonese Chinese, presumably because of a high incidence of Epstein-Barr virus infection in the region.¹⁶

Treatment considerations. An otolaryngology referral is essential in evaluating a

Ask patients if they use traditional treatments and herbs

Chinese patient with epistaxis or cervical adenopathy to rule out a nasopharyngeal lesion.

Tuberculosis

Tuberculosis is more common in Asian Americans than in other ethnic groups. Most cases in foreign-born Asians develop within the first 2 years after arrival in the United States.¹⁷

Many countries in Asia still use bacille Calmette-Guérin (BCG) vaccination as part of their tuberculosis control program, especially for infants. This vaccine was initially derived from a strain of *Mycobacterium bovis* and was attenuated through years of serial passage in culture.¹⁸ BCG immunization may cause a positive reaction to the tuberculin skin test.

In our practice, this phenomenon complicates clinical decision-making about prophylactic therapy for BCG-vaccinated Asian patients who have a positive skin test result. There is no reliable method of distinguishing tuberculin reactions caused by BCG from those caused by natural infection.

According to the Centers for Disease Control and Prevention, a positive reaction to tuberculin skin testing in a person with a history of BCG vaccination is more likely due to tuberculosis infection if any of the following are true:

- The induration is large
- The person was vaccinated a long time ago
- The person recently came into contact with a person with tuberculosis
- There is a family history of tuberculosis
- The person comes from an area where tuberculosis is common
- Chest x-ray findings show evidence of previous tuberculosis.

Treatment considerations. An Asian immigrant who comes from a country where tuberculosis is common and who has a positive PPD (purified protein derivative) skin test should definitely have a chest roentgenogram done to rule out active pulmonary tuberculosis infection. The patient should then be evaluated for isoniazid preventive therapy after active disease has been ruled out.^{19,20}

■ CONDITIONS WITH UNIQUE ASPECTS

Sensitivity to beta-blockers

Chinese patients may have increased sensitivity to beta-blockers.²¹

Treatment considerations. In clinical practice, these patients may require only a very low dosage of a beta-blocker to treat hypertension while avoiding side effects such as bradycardia, bronchoconstriction, and sexual dysfunction.

Mental health problems may be masked

Mental health problems among Asian patients may be masked by a negative cultural attitude that prevents many Asians from seeking professional care. The nature of these problems in Asian immigrants is strongly affected by several factors, including the circumstances that motivated them to leave their countries, the expectation for starting a new life in the United States, and the adjustment experience they have had here.²

Refugees forced to leave their native country because of war or political persecution may bring with them memories of torture and atrocities, and may suffer post-traumatic stress disorder and intrusive, frightening thoughts. Sleep disturbances, therefore, are common.²² These patients are relatively easy to identify and treat for their psychological disorders.

Treatment considerations. The primary care physician, in assessing for psychological disorders, should inquire about the circumstances surrounding the patient's decision to come to the United States, with the understanding that it may be difficult or impossible for the person to recall painful memories.

Depression may be difficult to recognize

In contrast to other psychological factors mentioned above, major depression in immigrants facing culture shock, separation from family, language barriers, and unsatisfactory employment is much more difficult to recognize. This immigrant group tends to include professionals with fewer language barriers and higher education levels, who are usually perceived as successful by the wider society.

BCG vaccine may cause positive TB skin tests

Women's Health

.....

Special Edition

An 80-page compilation of 15 selected articles from the *Cleveland Clinic Journal of Medicine*.

Supplies are limited. To obtain your copy send check for \$16.00 payable to:

Cleveland Clinic Journal of Medicine
9500 Euclid Avenue NA32
Cleveland, OH 44195
Email: ccjm@ccf.org Fax: 216-444-9385

Send to:

NAME

ADDRESS

CITY

STATE

ZIP

CLEVELAND
CLINIC
JOURNAL OF
MEDICINE

WOMEN'S HEALTH

JIN AND COLLEAGUES

Treatment considerations. Frequently, these patients present to primary care settings with multiple physical complaints. Multiple visits may be required to establish the diagnosis of depression and involve the patient in a treatment alliance.

■ GENERAL RECOMMENDATIONS

In caring for individual patients, avoid cultural stereotyping by carefully interviewing and assessing each patient and analyzing the patient's context: ie, his or her relationship with other family members and with health care providers, or his or her social situation in the country of origin and in the United States.

In many ways, caring for the Asian patient is no different than caring for any other patient in terms of diagnosing the disease, eliciting the patient's ideas about his or her illness, and negotiating a treatment plan. When a patient differs from the physician in culture, religion, or socioeconomic status, however, miscommunication can occur.

In dealing with patients from other backgrounds, the following recommendations may be useful:

- Do not make assumptions about the patient's ethnic heritage and level of acculturation. When in doubt, ask the patient about his or her comfort with a particular plan.
- Acknowledge differences in culture. Recall that biomedicine is also a "culture," with its own premises that may not be congruent with those of the patient.¹⁴
- Use a translator when possible if language difficulties exist.
- Take a careful history, which should include the patient's social situation and history, use of herbal medicines, use of alternative therapies, and how health care decisions are made in the family. Take care to assess stressors the patient may be experiencing at home or at work.
- Learn about your patient's culture through library research, just as you might research an unfamiliar medical issue. Do so with the understanding that your patient may or may not fit the generalities provided in the literature. ■



■ REFERENCES

1. Yu ES, Liu WT. U.S. National health data on Asian Americans and Pacific Islanders: a research agenda for the 1990's. *Am J Public Health* 1992; 82:1645–1652.
2. Chen A, Ng P, Sam P, et al. Special health problems of Asians and Pacific islanders. In: Matzen R, editor. *Clinical preventive medicine*. St. Louis: Mosby-Yearbook; 1993:739–761.
3. Hern HE Jr., Koenig BA, Moore LJ, Marshall PA. The difference that culture can make in end-of-life decision making. *Camb Q Healthc Ethics* 1998; 7:27–40.
4. Behavioral risk factor survey of Vietnamese—California, 1991. *MMWR* 1992; 41(5):69–72.
5. Behavioral risk factor survey of Chinese—California, 1989. *MMWR* 1992; 41(16):266–270.
6. Spector RE. *Cultural diversity in health and illness*, 2nd ed. New York: Appleton-Century-Crofts, 1985.
7. Woloshin S, Bickell NA, Schwartz LM, Gany F, Welch G. Language barriers in medicine in the United States. *JAMA* 1995; 273:724–728.
8. Putsch R. Cross-cultural communication. The special case of interpreters in health care. *JAMA* 1985; 254:3344–3348.
9. Francese P. America at mid-decade. *Am Demographic* 1995; 17(2):2–31.
10. Kelly AW, Fores Chacori M, Wollan PC, et al. A program to increase breast and cervical cancer screening for Cambodian women in a Midwestern community. *Mayo Clin Proc* 1996; 71:437–444.
11. Hammond TG, Whitworth JA. Adverse reactions to ginseng [letter]. *Med J Aust* 1981; 1:492.
12. Becker BN, Greene J, Evanson J, Chidsey G, Stone WJ. Ginseng-induced diuretic resistance [letter]. *JAMA* 1996; 276:606–607.
13. Fitzgerald F, Ainsworth M, Bach H, et al. Cross-cultural medicine. Medical knowledge self-assessment program 10. Philadelphia: American College of Physicians, 1995:140–142.
14. Kleinman A, Eisenberg L, Good B. Culture, illness and care: clinical lessons from anthropologic and cross-cultural research. *Ann Intern Med* 1978; 88:251–258.
15. Flatz G. The genetic polymorphism of intestinal lactase activity in adult humans. In: Scriver C, editor. *The metabolic basis of inherited disease*, 6th ed. New York: McGraw-Hill, 2001:1651–1666.
16. Raab-Traub N, Hood R, Yang CS, Henry B 2nd, Pagano JS. Epstein-Barr virus transcription in nasopharyngeal carcinoma. *J Virol* 1983; 48:580–590.
17. *Tuberculosis statistics in the United States, 1987*. Atlanta: USDHHS Technical Information Service, CDC, 1989.
18. Luelmo F. BCG vaccination. *Am Rev Respir Dis* 1982; 125:(3 part 2):70–72.
19. Greenberg PD, Lax KG, Schechter CB. Tuberculosis in house staff: a decision analysis comparing the tuberculin screening strategy with the BCG vaccination. *Am Rev Respir Dis* 1991; 143:490–495.
20. Snider DE. Bacille Calmette-Guérin vaccinations and tuberculin skin tests. *JAMA* 1985; 253:3438–3439.
21. Wood AJ, Ahou HH. Ethnic differences in drug disposition and responsiveness. *Clin Pharmacokinet* 1991; 20:350–373.
22. Lin EH, Ihle LJ, Tazuma L. Depression among Vietnamese refugees in a primary care clinic. *Am J Med* 1985; 78:41–44.

ADDRESS: Xian Wen Jin, MD, PhD, Department of Internal Medicine, S70, The Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, OH 44195.