Essays and Commentaries

Culture, Language, and Health Literacy: Communicating About Health With Asians and Pacific Islanders

Giang T. Nguyen, MD, MPH; Marjorie A. Bowman, MD, MPA

The Asian and Pacific Islander (API) population in the United States is ethnically and linguistically diverse. American API patients in the most disadvantaged subgroups (limited English proficient, low income, low literate, etc) are at risk for having unmet communication needs. Medical education programs and primary care physicians need to address issues of culture, language, and health literacy when they communicate with these patients so that appropriate questions are asked, and accurate information is exchanged between patients and their providers.

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There are 7 million speakers of Asian/Pacific Islander (API) languages in the United States,[1] and a large number of them are immigrants. Many of these Americans do not speak English (61% of Vietnamese, 51% of Chinese, and 24% of Filipinos in the United States do not speak English) and, therefore, are limited in their access to health information.[2] Among languages spoken by Americans who speak English "not well" or "not at all," Chinese is second only to Spanish.[3]

For API immigrants with limited English proficiency and limited education, poor health literacy can present great challenges in accessing health care and health information. Using data from the National Adult Literacy Survey, Rudd and colleagues established a Health Activities Literacy Scale (HALS), with scores ranging from 0 (worst) to 500 (best). For US-born whites, the average HALS score was 286. In contrast, the average score was 254 for foreign-born Europeans and only 228 for foreign-born Asians. Foreign-born Asians with less than high school education had an even lower score—179; in contrast, the mean score at this educational level was 232 for US-born adults (all races) and 206 for Blacks (US- and foreign-born combined).[4]

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From the Department of Family Medicine and Community Health, University of Pennsylvania.

Implications of the Article by Wu et al

As noted by Wu and colleagues in their article published in this issue,[5] Chinese American patients in a sample of low-income immigrants with limited English proficiency frequently turn to Traditional Chinese Medicine (TCM) for most of their health concerns, with nearly 100% reporting TCM use in the previous year. These patients often treat themselves without the guidance of either a Western physician or a TCM provider (self-medication with herbal products was reported by 93%). Given the potential for drug interactions and/or inappropriate treatments, the lack of communication between patients and providers regarding this issue is an important one. While most physicians say they routinely ask about use of traditional medicine treatments, patients report that they are rarely asked about this, even in this sample of adults who attended Chinese-specific health clinics with a large number of ethnic Chinese physicians on staff. Thus, even if physicians are asking about CAM use, the lack of patient recall suggests that these discussions do not have a high degree of salience for the patients.

Many Asian patients combine conventional Western therapies with complementary and alternative medicine (CAM) in the management of their chronic conditions. For example, a study of patients with hypertension in India revealed that 64% used CAM therapies (predominantly Ayurveda). However, more than half eventually became dissatisfied with their CAM treatments and added conventional

Western therapies. Meanwhile, only 5% of CAM users discussed this with their providers.[6] It is likely that an active dialogue between patients and providers about CAM use could facilitate patient decision-making about therapeutic options.

CAM usage patterns appear to vary among racial/ethnic groups. For example, in a California Health Interview Survey subset of 9,187 adults, use of acupuncture, TCM, and green tea was most commonly associated with Asian Americans. Meanwhile, massage and osteopathic medicine were most often used by whites, and garlic pills and having "others pray for you" were common to African Americans. Asians with limited English proficiency are more likely than other Asians to report using CAM.[7] Physician understanding of CAM usage patterns can help providers discuss the topic more efficiently with their patients by asking the right questions regarding CAM modalities used.

The Role of Medical Education

If we are to expect physicians to speak with patients about CAM therapies, then we must ensure that physicians are trained to understand the range of CAM treatments, their efficacy (or lack thereof), implications within the context of mainstream Western medicine, and how best to access reliable information about new treatments that become available. In a random sample of California physicians, 61% did not feel sufficiently knowledgeable about CAM, and 81% desired more education about the topic,[8] but much of this may be because there is little data available to them. Some models of CAM education within conventional medical training programs do exist.[9-11] For example, an urban children's hospital created an interdisciplinary center for holistic pediatric research and education. By integrating this center into an academic medical center, CAM education was provided through didactic sessions, workshops, self-learning modules, and clinical care.[9] In a smaller model, a family medicine residency program created a CAM curriculum focusing specifically on herbal medicine, TCM, homeopathy, and complementary nutrition. This program demonstrated that after receiving the education, providers were more selective in their recommendations of CAM to their patients.[10]

The Wu et al article showed that communication about CAM was suboptimal even in a clinic with a large number of ethnic Chinese providers (who are likely to have a greater understanding of TCM than the average physician). This suggests that physician knowledge about CAM may not be enough; doctors also need to be trained about how best to discuss CAM with their patients and integrate the discussion efficiently in health care.

Moreover, educational programs should focus on effective communication skills in an increasingly multilingual and multicultural society in which patients frequently have limited English language literacy skills. Examples are the need for education about cultural competency and effective use of medical interpreters. Use of interpreters has been demonstrated to improve health disparities for both Hispanic and API patients compared to non-Hispanic whites.[12] Researchers have also explored ways of assessing how well medical learners communicate with English-speaking patients,[13] but little has been done regarding communication with non-English-proficient patients, whether in English or through interpreters. A recent review of medical student curricula showed that few medical schools include substantial discussion of language in their cultural competency curricula,[14] although it is difficult to ascertain exactly how much attention is enough, especially within the time constraints of most medical school curricula.

Medical students and primary care residents also need to learn about how best to convey messages (both verbal and written) to patients with low literacy.[15,16] Moreover, educating patients about how to communicate effectively with their providers is an area that deserves further attention.[15]

In addition, physicians need to understand the way in which their patients approach health. This type of cultural competency is difficult to teach, particularly because fear of overgeneralization and stereotyping[17] may lead educators to avoid substantive discussions altogether. As clinicians, we find that the frequently recommended approach of using open-ended questions is helpful, but providers need to have enough background information to ask intelligent questions when speaking with patients and know when to follow through with more specific questions. In our experience, medical students and residents often complain that lectures in cultural competency rarely go beyond making the global statement that providers need to learn more about the communities they serve. Poorly designed cultural competency curricula may work against these goals,[18] and this is an area that deserves further investigation. At the same time, the task of assessing whether learners (or their instructors) are culturally "competent" remains a challenge.[19]

Conclusions and Recommendations

The API population in the United States is heterogeneous and growing.[20,21] As we move to the future in this diverse environment, primary care providers will need to pay particular attention to the way in which we communicate with API patients with respect to health literacy, language access, and culturally appropriate history-taking. Without such concerted efforts from the health care community, the health communication needs of this disadvantaged group of Americans will continue to be unmet.

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Corresponding Author: Address correspondence to Dr Nguyen, University of Pennsylvania, Department of Family Medicine and Community Health, 3400 Spruce Street, 2 Gates Building, HUP, Philadelphia, PA 19104. nguyeng@uphs.upenn.edu.

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