

Cross-Cultural Tuberculosis Manual

*Cultural Influences on TB-related Beliefs and Practices of
Filipinos, Vietnamese, Chinese and Koreans*

Draft: October 1998
Introduction to the Manual
Chapters 1, 2, 3 & 4

A manual to assist health providers to improve communication about tuberculosis with patients from the Philippines, Vietnam, China and Korea

Cross-Cultural Tuberculosis Manual

Developed by
Kalihi-Palama Health Center
Association of Asian and Pacific Community Health Organizations
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This manual was developed with direction and guidance from the Advisory Panels on Filipino, Vietnamese, Chinese and Korean Cultures, convened in Honolulu, Hawaii 1996-1998.

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Introduction

Tuberculosis: A Biopsychosocial Perspective

Perhaps more so than with any other disease, TB has historically been recognized to be a societal problem. The most common cause of death in the U.S. and Western Europe in the nineteenth century, it remains the most common cause of death by an infectious disease among adults worldwide (WHO, 1996). Because of its infectiousness, in the U.S., TB has fallen under the purview of public health authorities, particularly state departments of health. Patients with TB, however, can present anywhere within the health care system.

A biopsychosocial perspective on tuberculosis encourages a focus not simply on the infectious mycobacterium, but also on the distribution of TB in our society, how people think about TB, what it means for people to have TB, and how best to enlist people who have TB to be treated.

This manual addresses these concerns in regards to cultural beliefs, attitudes, and practices in four cultures: Filipino, Korean, Vietnamese, and Chinese. People in each of these ethnic groups range from the recent immigrant with a limited command of English to the fourth or fifth generation Asian-American. Obviously, such people will differ in the degree to which they subscribe to traditional culture. Thus, while this manual seeks to provide general characteristics about cultural beliefs regarding TB, the health provider will need to assess each patient's beliefs individually.

National Trends in Tuberculosis

From 1953 to 1984, the number of cases of TB in the U.S. decreased yearly, by approximately 5% per year since the 1950s and 6 to 7% per year in the early 1980s. Between 1985 to 1992, however, the number of cases increased by 20%. Compared to the trend in the early 1980s, the actual number of cases exceeded the expected number by

some 39,000 during the period 1985 to 1991. Much of this rise has been attributed to the number of cases of TB among people with HIV infection. The immigration of persons from countries where TB is prevalent is another major factor. Fortunately, from 1993 to 1997, the incidence of tuberculosis has declined (American Thoracic Society, 1993, Centers for Disease Control and Prevention, 1998, Sato and Rodenberger, 1996).

Over two-thirds of the cases of TB in the U.S. occur in non-white minorities and immigrants. In comparison with non-Hispanic whites, the risk of TB is five times greater among Hispanics, Native Americans, and Alaskan Natives, eight times greater among African-Americans, and *ten times greater among Asians and Pacific Islanders* (American Thoracic Society, 1993). Asians and Pacific Islanders accounted for 17.9% of the reported TB cases in 1996. Over one-third (36.1%) of all cases of TB occur in foreign-born persons. Within the foreign-born group, the countries of origin with the largest numbers are Mexico (23.2%), Philippines (13.6%), Vietnam (11.1%), People's Republic of China (5.1%), Haiti (3.9%), India (5.3%), and Republic of Korea (3.6%) (Centers for Disease Control and Prevention, 1997). These numbers account for this manual's concern with Filipino, Vietnamese, Chinese, and Korean cultures.

Who is this Manual for?

This manual is for health workers (including nurses, physicians, clinic receptionists, and outreach workers) who work with people at risk for TB and who desire a better understanding of how their patients think about TB.

Why is it Important to Understand What TB Means to People?

An inherent difficulty in TB control is the long duration of therapy. This makes it all the more important to develop good patient-provider relationships. Two elements which comprise a successful relationship are mutual understanding and mutual trust. The purpose of this manual is to foster understanding of the patient perspective. We hope that from mutual understanding will flow mutual trust and improved patient care.

Another inherent difficulty is that the pool of TB-infected persons is much larger than the pool of persons with TB disease. Much of TB disease is reactivation TB in persons who were infected in the past, sometimes even decades ago. If high risk infected people are given preventive therapy, the number of new cases of active TB can be reduced. However, finding and treating infected people who feel well is a daunting task. The distinction between TB infection and TB disease is often difficult for even the TB worker to understand. This makes it doubly difficult to explain the concept to the patient.

What does it Mean to have Tuberculosis?

Although it is possible for anyone to contract TB, TB most often strikes those in lower socioeconomic groups: residents of the inner cities, minorities, recent immigrants from developing countries, migrant workers, the homeless. Further, people with HIV/AIDS are

susceptible. In our society, the diagnosis of TB is stigmatizing. In fact, TB is stigmatizing in perhaps every culture in which it is known. [Though Sontag (1977) notes that in nineteenth century European aristocratic society, the thin and sickly appearance of the consumptive was believed to be glamorous.] Consequently, people with TB often face social isolation. People have lost their employment, housing, and social networks.

Therefore, patients who have TB prefer that it not be known to others. TB workers investigating cases must take care to maintain confidentiality. This may involve measures such as not utilizing vehicles with health department markings, and meeting patients in sites other than the TB clinic or the patient's home, such as in parks, restaurants, or other "neutral" settings.

Persons who seek to immigrate to the U.S. must submit evidence (a chest x-ray) that they do not have active, infectious tuberculosis. Those with chest x-ray evidence of TB but who are sputum negative are allowed to enter the U.S., and are followed by health department staff after entry. The evaluations take place in the countries of origin and the quality of the procedures is quite variable. There are even reports of an underground trade in normal chest x-rays (Iseman & Stark, 1995). Case-finding and treatment of TB among immigrants is therefore complicated by fears of being deported, as well as concerns that the possibility of other family members immigrating would be compromised (Wong, 1993). This is another potential source of distrust of the provider by the patient.

Such concerns are easily understood in light of the fact that TB falls within the purview of government institutions such as immigration and state departments of health. If health care workers are required to deny care and report those of questionable status to immigration authorities (as required by Proposition 187 in California), patients with TB may become even more suspicious of health providers. Although the implementation of Proposition 187 has been blocked, the perception that patients will place themselves at risk of deportation leads to delay in seeking health care. As patients with TB delay seeking services, the public health is endangered (Ziv & Lo, 1995).

See Table 1 for additional reasons why immigrants and foreign-born persons might not seek or accept TB treatment.

Why Should We Study How Different Cultures View TB?

Every person grows up with an understanding of how the world works. Much of this understanding is learned during childhood. Some of the rules (or means) by which we understand the world are written rules, but many of the rules are unwritten. We can view culture as consisting of these rules of meaning. People who come from cultures different from ours have different rules (or means) by which they interpret the world.

To be culturally sensitive is to recognize that people who come from different cultures might think in a different way than we do. Their understanding and approach to a problem might be completely different from ours.

As our society becomes more multicultural, we must move beyond being simply culturally sensitive. Increasingly, we must become culturally competent. To be culturally competent is to be aware of how others think. To be aware of how others understanding and approach to a problem may be different allows us to work more effectively with them (Wong 1994).

How Can Health Providers Assess Patient Perceptions about TB?

While this manual seeks to outline cultural beliefs regarding TB, the health provider must keep in mind that the individual patient has an individual set of beliefs that derives not only from his or her culture, but also relates to his or her age, education, income, length of residency in the U.S., and geographic area of origin (urban or rural). Thus we recommend, "*Don't assume; Assess.*"

Drawing upon Kleinman, Eisenberg, and Good's questions for eliciting patient health beliefs (1978), the Centers for Disease Control and Prevention (CDC) (1994) suggests a series of exploratory questions for assessing patient perceptions about TB:

1. What do you think causes TB?
2. What problems will your illness cause you?
3. Why do you think you got sick when you did?
4. What does TB do to your body?
5. How severe do you feel your illness is?
6. What treatment do you think you should receive for TB?
7. What are the most important results you hope to receive from this treatment?
8. What are the main problems your illness has caused for you?
9. What do you fear about your illness?
10. How do your family members or close friends feel about your TB?

How Information on Cultural Conceptions of TB was Gathered

This report is based on the results of focus groups conducted to examine knowledge, attitudes, and practices regarding tuberculosis. Eighteen groups of Asian and Pacific Islanders at nine community health centers nationwide were brought together as part of a research project conducted by the Association of Asian and Pacific Community Health Organizations (AAPCHO) and funded by the Centers for Disease Control (CDC). The groups were conducted by staff of the member community health centers of AAPCHO (Magana and Lee, 1994). The questions used in the focus groups (Caballero, 1994) were adapted from those in the above section, "Assessing Patient Perceptions about TB."

This focus group data was then reviewed and the results were interpreted by Cultural Advisory Panels convened by the Kalihi-Palama Health Center in Honolulu during 1996, 1997 and 1998.

Manual Content and Format

The manual begins with tables that summarize health-related cultural issues common to four cultural groups. Table 1 lists key cultural issues and suggested provider responses. Table 2 lists examples of "Culturally Competent Communication" issues and strategies for health providers. Table 3 lists recommendations for improving TB Care from the cultural advisory panel from all 4 cultural groups. The manual then devotes a chapter to each of four cultural groups: Filipinos, Vietnamese, Chinese and Koreans. Each chapter discusses relevant cultural beliefs and practices, as well as barriers to TB diagnosis and treatment. Also included are suggestions of how health care providers can help to overcome cultural barriers and facilitate effective TB prevention, casefinding and treatment.

Reasons for non-adherence: Why a person might not want to take TB medications (CDC 1994. *Improving Patient Adherence to TB Treatment*)

- Immigrants and refugees may fear that having TB disease or infection will make them subject to legal action, such as deportation, so they may give the appearance of being adherent by picking up refills (although they may not take the medicines).
- Many foreign-born persons have histories of BCG inoculation and believe they cannot develop TB.
- Persons vulnerable to TB may have other life demands that are of higher priority to them than preventing or curing TB.
- Many people think of public health as part of the "system" that they have come to mistrust; some may believe that public health interventions will actually cause disease or attempt to hurt a group of people because of their race.
- Some patients who use alcohol or drugs fear the side effects that may result from their taking TB medications while taking other substances.
- Having TB carries a stigma for many people and may lead to shame, fear of social rejection, or fear of the loss of a job.
- Attending a treatment center for TB may mean taking time off from work or other essential competing activities.
- Many patients are afraid that TB drugs will cause dangerous side effects and lead to illness or costly medical interventions.

- Some groups may not believe that health care providers can correctly diagnose or treat TB and that the drugs (and dosages) prescribed are ineffective or inappropriate for members of their racial or national group.
- Many groups have strong cultural beliefs about health and treatment that may compete with the prescribed regimen for TB.

Cross-Cultural Issues in Tuberculosis Care

Table 1: Summary of Key Cultural Issues and Provider Response

| Issue | Provider Assessment | Provider Action | Desired Outcome |
|--|--|---|---|
| LANGUAGE & COMMUNICATION | <p><i>What language or dialect do you speak at home?</i></p> <p><i>How long have you lived in the U.S.?</i></p> | <ul style="list-style-type: none"> *Use trained interpreters *Use appropriate gestures & voice tone *Learn greetings in patient's language *Greet elders with respect *Professional dress by health workers *Establish rapport first *Attentive, unhurried listening *Ask patient to repeat back what health provider has said *Orient to U.S. health system | <p>Improved provider-patient relationship</p> <p>Accurate information re: medical history, health status and adherence to treatment</p> |
| FEAR OF DEPORTATION & IMMIGRATION BARRIERS FOR FAMILY | <p><i>What worries do you have about your illness?</i></p> <p><i>Are you worried about immigration problems because you have TB?</i></p> | <ul style="list-style-type: none"> *Clarify deportation & immigration laws re: TB *Assure confidentiality *Introduce yourself to avoid confusion with INS workers. *Offer alternative treatment sites | <p>Increase in Trust</p> <p>Accurate information</p> <p>Better acceptance of and adherence to treatment</p> |
| SOCIAL STIGMA OF TUBERCULOSIS | <p><i>How do you feel about TB?</i></p> <p><i>How does your family feel about your TB?</i></p> <p><i>Your co-workers?</i></p> | <ul style="list-style-type: none"> *Educate re: TB transmission & TB treatment effectiveness *Assure confidentiality *Offer alternative treatment sites *Offer information to family, employers, landlords, others *Community education re: TB | <p>Patient motivated to accept and adhere to treatment</p> <p>Greater social support for patient during treatment</p> |

| | | | |
|--|--|--|---|
| <p>USE OF CULTURAL TREATMENTS</p> | <p><i>Some of my patients also go to a traditional (Filipino, Vietnamese, Chinese, or Korean) healer. Is this true for you?</i></p> <p><i>Do these treatments help you? How?</i></p> | <p>*Indicate tolerance for cultural treatment in general *Encourage combining Western medical and cultural healing *Look for ways to incorporate cultural beliefs in treatment plan *Prepare patients for side effects of medicines</p> | <p>Provider understands patient treatment needs</p> <p>Provider is aware of whole treatment picture</p> <p>Treatment is effective</p> |
|--|--|--|---|

Table 2: Culturally Competent Communication

To avoid unintentional insult and communicate respect, it is important for health providers to learn appropriate cultural "etiquette." This section includes some examples of appropriate "etiquette" for communicating with Filipino, Vietnamese, Chinese and Korean patients. It is not, however, intended as a complete listing. Health providers are encouraged to seek out the cultural experts in their own organizations and communities.

Language

- Determine the patient's preferred language/dialect during intake: *"What language or dialect do you speak at home?"*
- Use trained Interpreters (See Attachment on *Working with Interpreters*)
- Avoid using family members to interpret especially children.
- Talk directly to the patient when using an interpreter.

Greetings & Correct Form of Address

"Give respect, especially for the elderly. If it's an elderly Ilocano patient and I am younger, I give respect by addressing them as Tata or Nana" Filipino Advisory Panel, Honolulu.

"Everyone has a title in front of their name, partly for endearing and partly for respect; like auntie, uncle, older sister, older brother." Vietnamese Advisory Panel, Honolulu.

"Some western doctors call their patients by their first name to break down barriers. However, with Korean patients, never address them in that way. Call them by their full name." Korean Advisory Panel, Honolulu.

- Greet the patient warmly and respectfully. Even if the words are not understood, the caring and respect will be "heard". A smile and a slight bow of the head conveys a respectful greeting.

- It is helpful to learn to say greetings in the patient's preferred language/dialect; get training in correct pronunciation and correct form of address (see below).

Elderly persons are highly respected in Filipino, Vietnamese, Chinese, and Korean culture. It is therefore inappropriate and disrespectful to address an elderly Asian patient by first name. (Vance 1995). Use "Mr.", "Miss" or "Mrs." Chinese advisors suggest using "Miss", if a woman's marriage status is unknown.

- For Filipinos who speak Ilocano, a greeting that connotes both respect and affection is "Tata" (for men) and "Nana" (for women). For example, to an elderly woman, one might say "Kumusta, Nana?" (How are you?). For Tagalog speakers, one would say "Kumusta po" when addressing elderly men and women. *Po* connotes respect similar to the English "Sir" and "Madam" (Guthrie & Jacobs, 1976 as cited in Giger 1995).
- For elderly Vietnamese, a respectful greeting is "Chao Bac" (pronounced "chow bok?"), accompanied by a slight bow of the head.

Body Language: Gestures, Touch, and Eye Contact

"Non-verbal signals are very important to Filipinos. Actions and affect speak louder than words" Filipino Advisory Panel, Honolulu.

"An elderly Vietnamese woman complained that she did not like a certain clinic because a nurse there patted her on the back" Vietnamese Advisory Panel, Honolulu.

Common Western gestures and other body language can have unintended meanings in another culture and can hurt communication efforts before a word has been spoken.

If you are gesturing to an Asian patient to come in your direction, do not use the usual American motion (with palm turned *up*, moving one or all of the fingers toward yourself). This motion is associated with calling a dog in the Philippines, Vietnam, China, and Korea and may be highly insulting to the patient. A more acceptable gesture is to motion with the palm and fingers pointing *downward or sideways*, fingers bending towards you.

- For Vietnamese and Korean patients, it is respectful to make a slight bow, and motion toward the desired direction (as if saying, "After you...").

- Crossing two fingers connotes a wish for good luck in the US, but in Vietnamese culture, it is a vulgar way of saying intercourse or vulva.
- For Vietnamese, Chinese, Filipino and Korean patients, touching a child on the head is acceptable, but not an adult. “*Don’t ever touch the head—they think you’re degrading them*” Filipino Cultural Advisory Panel, Honolulu.
- For Vietnamese, Chinese, and Korean patients, avoid body contact, even as simple as a pat on the back, especially male to female, except as needed for an exam.
- Vietnamese and Korean patients may be uncomfortable with a health provider who moves or fidgets while listening or talking (such as a shaking foot or leg). This may signify the provider is “*not stable*”, or nervous when s/he should appear calm. In addition, to a Korean patient, this motion can represent bad luck and or chase away wealth.
- Before beginning a standard (Western biomedical) exam, prepare the patient by explaining what you need to do and why, so s/he is not startled by unexpected or unfamiliar procedures. This is especially important when a complete physical is needed for a woman patient.
- Some Filipino, Vietnamese, and Korean patients will avoid eye contact with the provider, out of respect. This should not necessarily be interpreted as lack of interest, embarrassment, or disagreement.
- A smile should not necessarily be interpreted as a sign of happiness or agreement. A Chinese patient who is embarrassed or does not understand instructions is more likely to smile than to frown.

Tone of Voice

When speaking with a patient whose English is limited or one who speaks softly, some health care workers will raise their voices and speak loudly.

- Speaking in a loud or abrupt tone of voice may be heard by a Filipino patient as reprimanding, rude, immature or lacking finesse (Giger, 1995). When calling the patient's name, the voice intonation should go higher as the name is said, “*as though calling someone in an endearing manner*” Filipino Cultural Advisory Panel, Honolulu.

Pronunciation & Order of Names

A story is told about a clerk at a busy TB clinic who called a name repeatedly, with no response from the patients in the waiting room. Later that morning, a Filipina woman approached the desk asking when the doctor would see her. It was then discovered that this was the missing woman whose name the clerk thought she had called. The clerk had so mis-pronounced the woman's name that it was unrecognizable to her, and, as a result, she had patiently waited three hours for her appointment!

Filipino Advisory Panel, Honolulu.

- To avoid confusion and communicate respect, all clinic staff should learn basic rules for correct pronunciation of names from unfamiliar languages, and/or ask for assistance from bi-lingual staff or community agencies.
- The Chinese, Vietnamese, and Korean system of name order is different from the Western order of given family name. Instead of the Western order of first, middle and last name, the Chinese and Vietnamese system is as follows: last name, generation name, and first name. Names are sometimes mistakenly changed during the immigration process causing confusion for recent immigrants as well as health providers. As a result, family members are often listed with similar names. Providers are advised to ask patients, “*Is this your correct name?*” and “*What name would you prefer I call you by?*”
- A distinctive characteristic of the Korean language is that there are 5 common last names (Locke, 1992). What may look to Westerners as a middle name, is actually part of their first name. For example, a patient listed as Park, Bong Sook: their first name is Bong Sook and last name is Park. No middle name exists. It is considered insulting to a Korean patient to not greet the person by their full name. To avoid confusion and communicate respect, call the patient by their full name, starting with Mr. or Mrs. For example, Park, Bong Sook, one would address the patient and say, “Mrs. Bong Sook Park”.

Professional appearance of health care workers

A story is told about a registered nurse at a community health clinic who dressed in a relatively informal style. Upon seeing her a Filipina woman anxiously questioned a Filipina medical assistant: "Is she my doctor?" Filipino Advisory Panel, Honolulu.

- It is important that the health care provider and staff have a neat and professional appearance. An informal or immodest style of dress or grooming by a provider may be taken as a sign of disrespect by some immigrant patients, possibly interpreted as an indication that the clinic views the patient as "low-class".

REFERENCES

- American Thoracic Society. (1993). Control of Tuberculosis in the United States. American Review of Respiratory Disease, 146, pp. 1623-1633.
- Caballero, J. (1994). TB project focus group protocol and questions. Unpublished manuscript.
- Centers for Disease Control and Prevention. (1994). Improving Patient Adherence to Tuberculosis Treatment. Atlanta, GA: U.S. Department of Health and Human Services.
- Centers for Disease Control and Prevention. (1997). Reported Tuberculosis in the United States, 1996. Atlanta, GA: U.S. Department of Health and Human Services.
- Centers for Disease Control and Prevention. (1998). Tuberculosis Morbidity---United States, 1997. Morbidity and Mortality Report, 47, pp. 253-257.
- Iseman, M.D. & Stark, J. (1995). Immigrants and tuberculosis control. The New England Journal of Medicine, 322, pp. 1094-1095.
- Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. Annals of Internal Medicine, 88, pp. 251-258.
- Magana, M. and Lee, E. (1994, September) "Health education and outreach" Workshop at Targeting TB in Asian Pacific Islander Communities. Oakland, CA.
- Palafox, N. (1996, September). Filipinos. Presentation at Faculty Development Workshop, University of Hawaii Department of Family Practice and Community Health, Mililani, HI.
- Sato, A. & Rodenberger, W. (1996). Tuberculosis in Hawai'i: A Five-year review. Hawaii Department of Health Communicable Disease Report, pp. 4-5.
- World Health Organization Global Tuberculosis Programme (1996). WHO Report on Tuberculosis Epidemic 1996. http://www.who.int/gtb/publications/tbrep_96/execsum.htm
- Wong, W. (1994, September). Demystifying cultural competence in TB control: A Framework for service delivery. Paper presented at Targeting TB in Asian Pacific Islander Communities, Oakland, CA.
- Ziv, T. A. & Lo, B. (1995). Denial of care to illegal immigrants: Proposition 187 in California. New England Journal of Medicine, 332, pp.1095-1098.

Chapter 1. TB and Filipino Culture

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Filipinos in the U.S.

The Philippines was a colony of the U.S. from the close of the Spanish-American War in 1898 until 1946, after the end of World War II. Filipinos have been in the U.S. in large numbers since they were recruited to be sugar cane workers in Hawaii during the period 1906-1946. A second wave of immigration followed large numbers of Filipinos joining the U.S. Navy from the 1920s to the 1970s. Since 1965, with the liberalization of immigration policies, many Filipino professionals have come to the U.S. In addition, family reunification policies have allowed earlier immigrants to apply for entry for their families. Currently the number of immigrants from the Philippines is second only to the number from Mexico (Espiritu, 1996).

More than eighty dialects are spoken in the Philippines. The official languages of the Philippines are Tagalog, English, and Spanish. The largest number of Filipinos in the U.S. come from the Tagalog-speaking regions of Luzon (the largest island), the Ilocano-speaking region of Northern Luzon, and the many Visayan-speaking central islands. The per capita income of Filipinos in the U.S. is \$13,616. The poverty rate is 6.4% compared with 13.0% for the general population (U.S. Department of Commerce, Bureau of Census, 1993, cited in Vance, 1995).

In addition to language, Filipinos in the U.S. vary considerably with regard to length of residence in the U.S., degree of acculturation to American society, age at immigration, level of education and socioeconomic status. The values, characteristics and beliefs described in this chapter, while potentially relevant to all Filipinos, are more likely to apply to post-1965 immigrant Filipinos.

Relevant Characteristics of Filipino Culture

Interpersonal relationships

"How you talk to them is very important, especially the elderly. Do not rush through the visit, or end it abruptly" Cultural Advisory Panel, Honolulu¹.

"The more traditional Filipino patients think, 'I feel respect for this doctor and he really cares, so I'll follow his treatments'" Cultural Advisory Panel, Honolulu.

¹ The Cultural Advisory Panel (also referred to as "Cultural Advisors") refers to the *Advisory Panel on TB and Filipino Culture* convened in 1996 in Honolulu to review and interpret AAPCHO-sponsored Filipino Focus group data. This panel was a multi-disciplinary committee of Filipino and non-Filipino health and immigrant services providers, representing both public and private sectors. It was convened by the Kalihi-Palama Health Center, a community health center located in Honolulu, Hawai'i.

Interpersonal relationships are valued highly in Filipino culture. Communicating respect and caring is critical to effective TB care, especially with the elderly and with culturally traditional patients. Respect is communicated by using appropriate gestures and voice tone, correct form of address and pronunciation of names, as well as by professional dress and appearance. (See Table 2: *Culturally Competent Communication*).

Caring may be communicated through careful listening, politeness, warmth in greeting, and an unhurried manner. American culture and American health care providers place a high value on time, whereas in Filipino culture the quality of the relationship is primary. The hurried health provider with 15 minutes budgeted per patient may be seen as uncaring and may miss hearing information or concerns critical to effective TB treatment. It is important to establish (and re-establish) rapport *before* launching into questions about compliance to treatment. The health care worker may find that rapport is enhanced by first talking about safe topics such as the weather or family (Vance 1995).

Recommendations from Cultural Advisors:

- Relationships

Ask "*How are you?*" or "*How is your family?*"

Prepare patients for the medical system's norms regarding time as part of an intake, assessment, and relationship-building process by another member of health care team (such as interpreter, community health worker, nurse): "*The doctor is going to be quick, because there are many people to see her, but you are important and she wants to be sure we take care of your concerns today. That's why she asked me to talk with you first.*"

Family and Social Networks

"Filipinos listen to family, friends or any intimate person. Everything travels by word of mouth...Some patients come to our clinic because Mrs. So-and-So came here & she got well" Cultural Advisory Panel, Honolulu.

Filipinos are family-oriented. For Filipinos, the extended family is the source of one's personal identity, the source of emotional and material support, and the focus of one's primary duty and commitment (Okamura & Agbayani 1991). More so than other ethnic groups, sibling relationships are very close. When asked who they would first tell about their pregnancy, Filipino women in Manila listed their sisters first. Husbands were listed third (Lantican & Corona, 1989, cited in Vance, 1995).

Recommendations from Cultural Advisors

- Include family members in TB therapy planning and decision-making.
- Include testimonials from peers in patient and community education.

Other cultural characteristics & communication with health providers

"They are very respectful, but give them importance" Filipino TB outreach worker, Honolulu.

"Out of their hospitality, if they offer you something take it or they will be slighted" Filipino TB outreach worker, Honolulu.

"They will seem to agree, nod and say "Yes, Doctor" even if they don't agree or understand because they don't want to offend, they are giving respect to you" Cultural Advisory Panel, Honolulu.

The importance of understanding four other cultural characteristics of Filipinos is noted by Ponce (1980): *amor propio*, *hiya*, *utang na loob*, and *pakikisama* (in the Tagalog language). *Amor propio* can be seen as self-esteem, pride, or sensitivity to personal affront. *Hiya*, shame or embarrassment, arises from improper behavior and serves to maintain social controls. *Utang na loob* is a debt that must be repaid for favors done. *Pakikisama* is getting along harmoniously, or following the lead of another. These characteristics derive their significance from the "core" value of *kapwa* ("shared identity") according to Enriquez (1990). The Philippine Senate in 1988 commissioned a study which identified the following strengths of the Filipino character: *Pakikipagkapwa* ("regard for the dignity and being of others" Enriquez, 1978), family orientation, joy and humor, flexibility, adaptability, creativity, hard work and industry, faith and religiosity, and ability to survive (Ramos-Shahani, 1988, as cited in Okamura & Agbayani 1991).

Communication between Filipino patients and health care providers may be affected by the value placed upon respect and obedience to authority, and by *Pakikisama*, (the desire to get along harmoniously with others at all costs). (Ponce 1980; Baysa, Cabrera, Camilon & Torres, 1980; Palafox, 1996; Vance, 1995). Some Filipinos will express verbal agreement even though they are not truly in agreement, or they may not have even understood the question. Thus, in response to questions about whether they are taking their TB medications, Filipino patients may answer, "Yes, Nurse," or, "Yes, Doctor," in order to seem friendly, agreeable and respectful.

Recommendations from Cultural Advisors:

- Questions and Communication

If the patient asks no questions, then a "Yes" probably means "No". The reticence to ask questions can be reduced by "listening attentively, and unhurriedly to what the patient is saying" (Harwood, 1981). An interpreter on the Panel suggests asking the patient to repeat back what the health provider or interpreter has said "so we

can be sure we have understood each other". A physician adds that if he senses communication is not occurring, he may ask the interpreter's opinion: "What's the problem here?".

Recommendations from Cultural Advisors, continued:

- Communication

Health providers should monitor their own non-verbal behaviors as well as those of the patient, being sensitive to physical and emotional discomfort or concerns of the patient (Kozier et al, 1993 as cited in Giger, 1995).

Listen for euphemism and metaphors which may convey messages with minimum risk of offense

- Take time to explain

Health providers simply need to "take the time to explain", emphasize those who work most closely with immigrants. First (and sometimes, second) generation immigrant patients will often need to be scheduled for longer than usual appointments. Extra time may be needed for translation, for discussion and clarification of biomedical concepts, for explanation of the diagnosis, for negotiation of the treatment regimen, and for socializing the patient to the health care delivery system of this country. (Harwood, 1981). This is most effectively and economically accomplished by health care teams that include physicians, nurses, and bi-lingual health workers.

TB diagnosis and treatment in the Philippines

"We don't know over there in the Philippines if someone actually has TB, or if they are cured. We can only go by what we see: high shoulders, skinny, coughing, there is no way of knowing for sure. Over there we only see it when it's critical. There is only one doctor for a small town and medicines are very expensive...so many don't get treatment for TB...or they may divide the medicine for one week to last two weeks." Cultural Advisory Panel, Honolulu.

A story was told of an 18 month old PPD+ child whose parents were recent immigrants from the Philippines. The TB clinic physician recommended a chest X-ray, but the mother wanted to wait till the child was two years old, fearing the x-rays would harm the child, possibly resulting in sterility and cancer. Cultural Advisory Panel, Honolulu.

"If you drink a cup of milk, you'll get a negative chest x-ray; if you drink vinegar it will cause the x-ray to be blurry." Cultural Advisory Panel, Honolulu.

The cost of medical care and medications, and the relative unavailability of services in rural areas are barriers to obtaining TB diagnosis and treatment in the Philippines. Outside of Manila and other major cities, it is unusual for those who are not health workers to receive chest x-rays and other definitive diagnosis of tuberculosis. For many Filipinos newly immigrated to the US, a chest x-ray is a new procedure. As a result of this lack of familiarity, some consider them harmful. In addition, it is believed by some that the results of a chest x-ray can be affected by diet.

In the Philippines, TB medications (INH and rifampin) are sold in some pharmacies, labeled as *"vitamins for the lungs"*, and are used for short duration for non-TB related illnesses of adults, or to strengthen the lungs of children (Nichter, 1995). This, in turn, may contribute to drug resistance and delay effective treatment for both TB and acute respiratory illness. Because of the stigma associated with TB, some clinicians in the Philippines use the term *weak lungs* "when talking to patients testing positive for TB without the telltale sign of coughing up blood" (Nichter, 1995).

TB patients, especially those who feel better after several months of treatment, may be inclined to share medication with other family members for other respiratory conditions. The linking of TB to respiratory tract infections may lead some patients to expect that TB medications will prevent episodes of respiratory infections. When such episodes occur the TB patient may fear a relapse, lose faith in the treatment and/or seek additional unnecessary treatments. (Nichter, 1995). *See TB Beliefs on p.27 for more on weak lungs concept.*

Recommendations from Cultural Advisors:

- X-rays
Providers should be aware that Filipino patients may have learned about TB in the context of a different health care system, and assess and educate accordingly. They should not assume patients understand the need for and safety of basic tests and procedures. An interpreter explains X-rays to patients this way: *"Our eyes cannot see inside the body, so the x-ray helps us see inside the lungs by taking a picture of them"*
- "Weak Lungs"
While the illness concept of *weak lungs* may be limited to immigrants from certain regions of the Philippines (Oriental Mindoro), health providers should be alert to the possible influence of this concept on a

patient's expectations of treatment and his or her use of health services.

Immigration and Deportation

"They don't believe they have TB because they passed the immigration process. This is the Number 1 reason given for not adhering to treatment. They say, 'If I have TB, why would the U.S. allow me to immigrate?'" Cultural Advisory Panel, Honolulu.

As described in the Introduction to the Manual (p.10), persons who seek to immigrate to the U.S. must submit evidence that they are not infectious before they are allowed to enter the country. This consists of a chest x-ray and negative sputum smear results. Those with chest x-ray evidence of TB but who are sputum negative are allowed to enter, but are followed after entry. Since the diagnostic tests take place in the country of origin, the quality of the procedures is quite variable, and there are even reports of an underground trade in normal chest x-rays. As illustrated by the quote above, some Filipino immigrants may not fully understand the immigration process and the distinction made between active TB disease and TB infection. Case finding and treatment is further complicated by fears of being deported, and concerns that the immigration of other family members will be affected.

Recommendations from Cultural Advisors:

- **Confidentiality and Trust**

Assure patient and family of confidentiality. Offer flexibility in location of treatment (e.g. park, restaurant, patient's home). If doing home visit or outreach, introduce yourself as a health worker, to avoid confusion with immigration authorities. Do not use cars with government markings for home visits; use unmarked vehicles to assure greater confidentiality.

To counter mistrust of government agencies, partnerships should be developed with non-governmental agencies (such as community based clinics and organizations).

Educate sponsors of immigrants regarding TB transmission, diagnosis and treatment.

Tuberculosis-related Beliefs and Practices of Filipinos in the U.S.

The following section describes some beliefs and practices regarding tuberculosis which may be found in Filipino communities in the US. It is based upon (1) The transcripts from two Ilocano focus groups held in Hawai'i, and two Tagalog focus groups held in California, and (2) Questionnaires completed by bilingual TB outreach workers from the State of Hawaii Department of Health Tuberculosis Program, and (3) Interpretation of the data by the *Advisory Panel on TB and Filipino Culture* convened in Honolulu in 1996.

Causes of TB

"The first and number one cause of TB is overwork, second is alcoholic, third is heavy smoking and fourth is if you do not eat the right foods" Ilocano focus group, Honolulu

"I think the cause of TB is a certain microbe" Tagalog focus group, San Diego.

"I heard that it is a poor man's disease...either their food is not sufficient or nutritional. Their environmental condition, dirty house, could trigger the bacteria to become active" Tagalog focus group, Los Angeles.

In Filipino culture, tuberculosis is believed to be caused by multiple factors. Some participants in the Ilocano and Tagalog TB focus groups mentioned the germ theory of tuberculosis, but other causes were mentioned also, including:

- * Unsanitary conditions, * Poverty, * Overwork, *Wearing wet clothing,
- * Cigarettes and alcohol, *Poor nutrition, *Worries about family problems,
- * Inherited within the family, and * Contagion, including: Sharing eating utensils, Touching a person with TB, and Airborne spread.

Cultural Advisory Panel members who were born in the Philippines added other causes of TB they had heard: * Washing and ironing too much, and *Becoming pregnant too often (every year).

This view of multiple causes of TB may result from common sense observations of events and conditions that seem to precede the onset of active TB in a community of people. This view is actually consistent with the modern day understanding of TB wherein TB microbes, risk factors (such as contact with an infectious person, environmental conditions), and the susceptibility (immune system) of the host/patient, all play a role in the onset of active TB disease.

Symptoms and Progression of Tuberculosis

"TB starts up after coughing for a long period of time, and one does not seek medical advice or by inhaling polluted surroundings" Ilocano focus group, Honolulu.

"...you always feel exhausted because you feel weak and tired all the time" Ilocano focus group, Honolulu.

"TB makes you suffer before it kills you" Ilocano focus group, Honolulu.

"If you have a cough and you don't treat it right away, it might become something more serious, such as TB" Tagalog focus group, Los Angeles.

Focus group participants identified primary symptoms of TB as coughing, spitting up blood, and weight loss. The body is thought to shrink, so the shoulders appear high. The disturbance of sleep is another prominent feature.

In the Philippines, most believe that the body becomes dry; because phlegm cannot be produced, blood is coughed out. Some believe, however, that in severe TB, the lungs are filled with water.

Tuberculosis is not clearly differentiated from other respiratory conditions in the popular health belief system. Thus, it is thought that colds and bronchitis, especially if left untreated, can become tuberculosis. Tuberculosis, on the other hand, can develop into asthma. The term *"weak lungs"* is used, at least in some parts of the Philippines (Nichter, 1995) to refer to a broad range of respiratory problems, including TB. "While some people equate *weak lungs* with TB, many others think of *weak lungs* as a condition which may develop into TB over time." (Nichter, 1995). "*Weak lungs*", however, are seen as being less serious than TB per se and generally not thought to be contagious (For more on *weak lungs*, see also TB Diagnosis & Treatment in the Philippines on p.24)

Contagion and Social Stigma

"Your family members don't come around you because they feel you are dirty and they are afraid to be infected from you. They don't want to talk to you...because they don't want to inhale the same air as you" Ilocano focus group, Honolulu.

"Having TB is so lonely" Tagalog focus group, San Diego.

"I have an Auntie in the Philippines with TB, she cannot join a group, she is isolated, dishes are separated..." Cultural Advisory Panel, Honolulu.

"TB is something so dreadful to the eyes of their society that they will always try to hide their frailty" Filipino TB Outreach Worker, Honolulu.

The focus group participants viewed TB as highly contagious: it could be contracted by passing a sufferer on the street or by engaging in casual conversation. TB could be contacted by sharing eating utensils, telephones, or beds. To prevent spread, the clothes of a sufferer have to be boiled. Even the smell from an open coffin of a victim of TB was thought to produce the disease.

This belief in the extreme contagiousness of TB results in efforts to unnecessarily isolate and stigmatize TB victims. Thought to be dirty and dangerous, they may be avoided by even family and spouse. Spouses may refuse to have sexual relations and may even seek a

new partner. This stigmatization can have serious consequences, with TB victims losing housing, employment and social networks, even when under treatment and no longer contagious. In a culture that values harmonious interpersonal and family relationships, this social stigma causes persons with TB and their families much suffering and sadness. Feelings of shame, and the desire to avoid the consequences described above, lead some to deny their illness, attempt to hide it, and/or to not seek medical attention.

"They are afraid to be known, especially to their landlords, because if they are required to come to the TB clinic, the other residents blame the TB patient. I have some patients that need to leave their rented rooms. I explained that they are being treated and no longer contagious to the landlords and even the immediate relatives of new immigrants, still they cannot accept the explanations" Cultural Advisory Panel, Honolulu.

While some TB patients are indeed highly contagious, in most cases household contact of many months duration is required for transmission. Because ultraviolet light kills mycobacteria, outdoor transmission is rare. TB is not spread by contact with objects handled by a person with the disease (Daniel, 1994).

Focus group participants mentioned that a positive effect of TB treatment was that the person is no longer infectious to others. This person is no longer stigmatized and is able to live and enjoy life. The community as a whole is made happy by the cure. Further, immigration to the US becomes possible for some.

Recommendations from Cultural Advisors:

- Educate re: TB transmission
Educate the patient, his/her family, and others in the patient's social network (e.g.: employer, landlord) regarding the transmission of TB and appropriate precautions, including the phase of treatment when the patient is no longer infectious to others.
- Address shame
A Filipina TB outreach worker addresses shame by saying, *"If I have TB, it is not me that is contagious, it is that I have a contagious disease...there is nothing wrong with who I am"*
- Assure patient of confidentiality
Offer alternatives to the TB clinic for medication re-fills, such as the patient's home or "neutral" sites (for example, a park or restaurant). Use unmarked vehicles for home visits, rather than state or county health department cars.
- Emphasize positive social consequences of treatment
Motivate patient to complete treatment with information about treatment effectiveness and the expected results: TB victim need no

longer feel ashamed or outcast, family and community will be made happy by the cure, immigration or deportation concerns will be allayed.

Treatment Beliefs

Consistent with the belief that TB is caused by various factors, focus group participants believe that there are multiple factors involved in the healing of the TB sufferer and his/her disease:

Changes in environment and exposures

- *Going to the home province to circulate fresh air through the lungs
- *Good sanitation at home *Cleaner work environments *Stop smoking

Correcting imbalances of the body

- *Exercise *Avoiding problems and worries, having a positive outlook
- *Eating a balanced diet, gaining more weight *Getting enough rest
- *Discipline and sacrifice *Not bathing when one is tired or sweating

Seeing a physician and taking medicines is considered to be the most effective treatment, a necessary component of any treatment program. However, other forms of treatment are also considered effective, in and of themselves, or combined with prescribed TB medications.

Recommendations of Cultural Advisors:

- Enlist patient beliefs regarding healing

Many of the beliefs listed above are consistent with the current Western understanding of factors that can strengthen the functioning of a patient's immune system. Make use of a patient's belief that there are multiple factors involved in the healing of TB. Ask: "*What do you think will help you to get well?*" or "*While these medicines are doing their job, what else could help your body become strong again?*"

Traditional healing

An *albularyo* (traditional healers used throughout the Philippines and in the US as well) may be consulted for herbal and other treatments. A *spiritista* (faith healer) may be consulted for healing with prayer and holy oil. Herbal treatments mentioned by focus group participants included eucalyptus, the seeds of a certain Chinese plant, and red guava leaf (red guava leaf may be used only in Hawaii). Other measures mentioned were drinking the blood of a pure black dog, drinking Carnation milk, and drinking large quantities of water --all consistent with the belief that tuberculosis is a "dry" disease. Specific dietary measures mentioned included avoiding salty foods, avoiding sweet foods, and avoiding crabs and shrimp.

Some people believe the use of any traditional healing must be exclusive:

"There is a superstitious belief that it has to be one way of treatment, that you can get worse if you combine both" Cultural Advisory Panel, Honolulu.

"If it is an albulario, it must be an albulario" Ilocano focus group, Honolulu.

Cultural Advisory Panel members believe that most Filipinos in the U.S. who use traditional treatments will do so in conjunction with prescribed medical treatment.

Recommendations from Cultural Advisors:

- Assess cultural healing practices

Ask about patients' use of traditional cultural health practices.

for example: "Some of my patients also go to an albulario or healer. Is this true for you?"

Indicate tolerance for cultural healing, or at least stay neutral. Avoid invalidating traditional health practices, at least initially, in order to generate accurate information and honest communication. A story may elicit responses:

"When I was a little girl in the Philippines during W.W.II, I got sick with malaria and they gave me medicine made from leaves and bark of a tree and it tasted bitter.. quinine is bitter in the same way. Many modern medicines are refinements of crude herbal medicines. When I tell this story," says a Filipina physician, "then people say 'Ah, you understand', and I hear all the traditional medicines".

- Seek opportunities to integrate Western and cultural healing

Encourage patient to combine (non-harmful) cultural healing with Western TB treatments. Enhance trust and cooperation by working with patient beliefs. In the Philippines it is not uncommon for a physician to incorporate certain aspects of the folk medicine belief system, such as the theory of hot and cold, as part of a treatment plan (Hart et al. 1965, as cited in Giger 1995)

For example:

* If patient views TB as a "dry" disease, provider might recommend drinking extra water.

* If patient believes in the hot/cold concept of health and illness, and they say their illness or side effects are "hot", ask *"what did your grandma tell you to do when you feel 'hot'?"* and, if appropriate, combine with Western approaches to alleviate side effects

- Side effects

Concept of negative side effects from medication may be new. Prepare patients for possible side effects and encourage him/her to communicate with health

provider about any that may occur. *"I tell the patients: 'All medicines have side effects, even Tylenol'*

REFERENCES

- Agustin, G. (1994, September). Tuberculosis focus group: The Ilocano focus group. Unpublished transcript of focus group session. Honolulu, HI.
- Baysa, E., Cabrera, E., Camilon, F., Torres, M. (1980). The Pilipinos. In N. Palafox & A. Warren (Eds.) Cross-cultural caring: A Handbook for health care professionals in Hawaii. Honolulu, HI: Transcultural Health Care Forum.
- Caballero, J (1996). Focus group ethnicity/language and discussion topic themes and quotes. Unpublished manuscript.
- Daniel, T. (1994). Tuberculosis. In Isselbacher, et al. (Eds.), Harrison's Principles of Internal Medicine. New York: McGraw-Hill.
- Dubos, R. (1980). Man Adapting. New Haven: Yale University Press.
- Espiritu, Y.L. (1996). Colonial oppression, labor importation, and group formation: Filipinos in the United States. Ethnic and Racial Studies, 19, pp. 29-47.
- Giger, J.N. & Davidhizar, R.E. (Eds) Transcultural nursing: Assessment and Intervention. St. Louis, Mo: Mosby.
- Harwood, A. (Ed). (1981). Ethnicity and Medical Care. Cambridge, MA: Harvard University Press.
- Mayer, Marvin. (1980). A Look at Filipino Lifestyles. Dallas: SIL Museum of Anthropology.
- Nichter, M. (1994). Illness semantics and international health: the Weak lungs/TB complex in the Philippines. Social Science and Medicine, 38, pp.649-663.
- Nuqui, J., Lazo, G., & Magana, M. (1994, July). Operation Samahan tuberculosis focus group--Pilipino senior citizens. Unpublished transcript of focus group session. Mira Mesa, CA.
- Okamura, J. & Agbayani, A. (1991). Filipino Americans. In Mokuau, N. (Ed) Handbook of Social Services for Asian and Pacific Islanders. Westport, CT: Greenwood.
- Palfax, N. (1996, September). Filipinos. Presentation at Faculty Development Workshop, University of Hawaii Department of Family Practice and Community Health, Mililani, HI.
- Ponce, D. (1980). Introduction: the Philippine background. In J.F. McDermott, W.S. Tseng, & T.W. Maretzki (Eds.) People and Cultures of Hawaii: a Psychocultural profile. Honolulu, HI: John A. Burns School of Medicine and University of Hawaii Press.
- Rivera, C. (1994, August). Tuberculosis focus group. Unpublished transcript of focus group session. Los Angeles, CA.
- Tagata-Mindo, M. (1994, October). Kalihi-Palama Health Center Ilocano focus group on tuberculosis. Unpublished manuscript of World War II Filipino Veterans focus group session.

Vance, A. R. (1995). Filipino Americans. In Giger, J. N. & Davidhizar, R. E. (Eds.) Transcultural nursing: Assessment and intervention. St. Louis, MO: Mosby.

Chapter 2. TB and Vietnamese Culture

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Vietnamese in the U.S.

"Although it may not be agreed with scientifically, the Vietnamese people have been taught that the history of Vietnam is 4000 years old." Cultural Advisory Panel, Honolulu.²

"We were taught a patriotic song that says that Vietnam was under Chinese rule for 1000 years and 100 years under the French." Cultural Advisory Panel, Honolulu.

Vietnam has a long history spanning thousands of years, and a rich culture that survived many years of occupation by foreign powers. Chinese rule lasted approximately 1000 years. France colonized Vietnam from the mid-19th century until 1954. The Geneva accords of that year divided the country into the Communist North and the non-communist South. In 1975, following the Vietnam-U.S. war, the country was unified under the Socialist Republic of Vietnam.

There have been three waves of immigrants from Vietnam to the U.S. The first wave, which started to arrive in 1975, were largely urban, highly educated professionals and military officers with ties to the U.S. The second wave, arriving in 1979 and 1980, was a more diverse group. Originating from the rural areas of the country, many in this group had less formal education and exposure to Western Culture than their counterparts from the previous wave. Many were "boat people," who had left Vietnam under difficult circumstances and had spent extended periods of time in refugee camps (Hoang & Erickson, 1985; Stauffer, 1995). Also included in this wave were ethnic Chinese who were being persecuted by the government in Vietnam. The third wave, arriving after 1986, were mainly political prisoners, persons seeking reunification with family members from abroad, and Amerasians (Pocket Guide for Medical Interpretation, AAPCHO 1996).

² Cultural Advisory Panel (also referred to as "Cultural Advisors") refers to the Advisory Panel on TB and Vietnamese Culture convened in 1997 in Honolulu to review and interpret findings from AAPCHO-sponsored Vietnamese TB focus groups. This panel was a multidisciplinary committee of Vietnamese and non-Vietnamese health and immigrant service providers, representing both public and private sectors. It was convened by the Kalihi Palama Health Center, a community health center located in Honolulu, Hawai'i.

The adjustment of Vietnamese in the U.S. varies considerably depending on their level of education, knowledge of English and their status upon entry into this country (Immigrant vs. Refugee). Immigrants are described as being more prepared for Western culture, whereas refugees are more likely to have experienced displacement, persecution, loss and post traumatic stress disorder, all of which have made their adjustment to life in the U.S. more difficult (Cultural Advisory Panel, Honolulu).

Relevant Characteristics of Vietnamese Culture

Interpersonal relationships

"It is particularly impolite to answer no to someone older or of higher status to oneself." Cultural Advisory Panel, Honolulu.

Proper restraint and a dignified manner are paramount in the interpersonal interactions with Vietnamese. Some Vietnamese do not make eye contact with their health care providers out of deference to their superior position. They are therefore often seen by Western health providers as unassuming and uncomplaining, or alternately, as ignoring the health provider. Harmony in interpersonal relationships is also highly valued by Vietnamese. Thus, many Vietnamese patients will nod in acceptance or answer in the affirmative, even if they do not actually agree, or they have not understood the question. In the Vietnamese language there is an expression, "da khong" (South), "thua khong" (North) which translates literally as "yes, no" but means "I'm afraid not" or "I'm sorry to say no". This is reflective of the importance placed on avoiding conflict in interactions with others (Hoang and Erickson, 1985; Muecke, 1983).

Relationship with Health Providers

"Even if they don't agree, they say yes doctor, yes doctor, for respect. It is not lying. It is our way from growing up" Cultural Advisory Panel, Honolulu.

Vietnamese patients may be accustomed to a paternalistic relationship with health providers and may adopt a passive role, asking no questions and waiting to be told what to do. Such a patient may be puzzled if the doctor offers choices, perhaps responding "You are the doctor, you tell me". If the patient does not agree with the advice, or doesn't like the treatment, he is most likely to express it via non-compliant behavior.

In Vietnam there is no family doctor system, and many Vietnamese patients are accustomed to "hopping" from one health practitioner to another. *"It is not uncommon for someone to see several doctors in a day, all by word-of-mouth reputation. There is no loyalty to one doctor. If they go to the hospital, they cannot ask for their doctor to be called like in the US. They just see whoever is there."* (Cultural Advisory Panel).

However, a Vietnamese internist adds that *"Once they trust you, you are supposed to be able to handle any problem. If I refer someone to, say, an OB-GYN, then she may say: 'Why can't you do this for me?' and I lose her trust."*

Family and Social networks

"Word-of-mouth information affects a lot of medical decisions." Cultural Advisory Panel, Honolulu..

"They often come to me with the decision about their diagnosis and treatment already made: "Oh, my friend said that so and so got this and that" Physician, Cultural Advisory Panel, Honolulu.

Vietnamese people identify themselves as members of extended families and a larger community. Three generations will often live together in a household. Medical decisions are often made by the elder in the family. Thus, starting off by addressing elder family members accompanying a patient demonstrates proper respect for elders (Muecke, 1983). The loss and separation of family members engendered by the war and refugee status has been a source of great pain for many. In the U.S., female family members are often able to find employment more easily than the males. English-speaking children often serve as interpreters for their parents. These factors lead to a reversal of traditional roles, which can create conflicts (Gold, 1992).

Medical decisions are often based upon the advice of family, neighbors, friends, or *"anyone except themselves alone"* (Cultural Advisory Panel).

Recommendations from Cultural Advisors:

- Respectful Greetings

"A respectful greeting, with conscientious behavior during the examination would be helpful". A slight bow of the head conveys a respectful greeting. Begin by greeting/addressing elder family members accompanying the patient

- Include family members

"At the TB clinic, Vietnamese families often come together for the visit, sometimes due to transportation, but also because the patient wants their opinion and help with language. Even if there is an interpreter, it helps to have the family in the room to repeat instructions when the patient goes home"

- Assess who helps patient make health decisions

Providers may need to assess patient's decision-making process: "Who else have you talked to about this health problem? Is there someone else you need to talk with before you decide to do this? Would you like to bring them to the next visit?"

- Questions and Patient Education

Patient reticence to ask questions of providers can be reduced by "listening attentively and unhurriedly to what the patient is saying." (Harwood, 1981). If no questions are asked, the provider may need to anticipate issues that may be of concern to the patient, and address them (e.g.: beliefs about side effects of medication, blood tests or x-rays weakening the body, etc.). *"Persistent education and an open line of communication"* helps build trust. An interpreter suggests

asking the patient to repeat back what the health provider or interpreter has said "so we can be sure we have understood each other".

- Take extra time to explain

Health providers simply need to "take the time to explain". Recent immigrants, especially, will often need to be scheduled for longer than usual appointments. Extra time may be needed for translation, discussion and clarification of biomedical concepts, explanation of the diagnosis, negotiation of the treatment regimen, and socializing the patient to the health care delivery system of this country (Harwood, 1981). This is most effectively and economically accomplished by health care teams that include physicians, nurses, and bilingual health workers.

Recommendations from Cultural Advisors, continued:

- Written materials and Compliance

"In Vietnam, illiteracy is rampant", says a Vietnamese physician, "patients who are illiterate, or minimally literate, put much faith in written words, and this fact can be used to increase compliance. Health care providers can supply written instructions, even to illiterate patients, in addition to verbal instructions (to convey importance)".

An internist says: "You have to follow-up. I tell them to bring in the bottle and I count the pills."

Concepts of Health and Illness drawn from Chinese Medicine

Popular Vietnamese conceptions of health and illness incorporate many aspects of Chinese medicine (see Chpt. 3: *TB & Chinese Culture*). Particularly prevalent is the concept of "hot" and "cold". The Chinese medical meaning of "hot" and "cold" does not correspond to physical temperature. (For example, ice is considered to be "hot"). Rather, they are related to the opposing forces of *yin* and *yang* or, in Vietnamese language, *am* and *duong*. *Am* (*Yin*), the female, negative force, is associated with darkness, softness and cold. *Duong* (*Yang*), the male, positive force, is associated with light, strength and heat. The proper balance of *am* and *duong* is believed to be necessary for proper health.

Illness is a sign that the body is out of balance. If a person has symptoms such as a sore throat, dry lips, frequent thirst, difficulty sleeping, fast pulse, or dark color urine, then the body is considered to be overheated or "hot" (*duong*). If a person feels weak, chilly with slow pulse, or his urine is clear and colorless, then the body is in a "cold" condition (*am*). Traditional Chinese treatment of illness often consists of foods and herbal medicines believed to restore the balance of body and mind. All food, drink, herbs and medicines fall

somewhere on the continuum of "hot" to "cold". Thus, if the body symptoms are "hot", they should be treated with foods or medicines that are "cold" (*mat* in Vietnamese), such as leafy vegetables, fruit, or "cooling soups" (Wu 1980). Likewise, if the symptoms are "cold" they should be treated with foods or medicines that are "hot" (*nong* in Vietnamese), such as meat and poultry. These symptoms and treatments are considered "commonsense", familiar to most lay persons raised with this tradition (similar to the perhaps more familiar cultural practice of giving chicken soup to someone with "a cold"). A doctor of traditional Chinese medicine would be called on to diagnose and treat signs and conditions that are too complicated for the lay person to learn. (Wu, 1980; Cultural Advisory Panel).

The Influence of French Medicine

"They believe in French medicine because the French were the first to bring Western medicine in the 17th century and life improved after that." Cultural Advisory Panel, Honolulu.

The Western medicine practiced in Vietnam has many roots in the period of French influence. There is a greater emphasis on clinical diagnosis than on laboratory methods (though financial constraints also limit the extent to which technology is utilized). Empirical treatment for suspected conditions with a "shotgun" approach utilizing a variety of medications is a common practice. Many medications available only by prescription in the U.S., including antibiotics, are available over the counter in Vietnam (Hoang & Erickson, 1985).

Injectable medications are considered to be more potent than oral medications. Vietnamese patients often ask to have injections or intravenous medications, even when an oral medication serves the purpose (Cultural Advisory Panel).

Many Vietnamese from the educated socioeconomic strata maintain a continued trust in French medicine. There continues to be brand loyalty to medications from France, e.g. to *Cortan*, a cold medication, and *914*, an injectable antibiotic. In Vietnam, the TB medication rifampin is often called by its French brand name, *Rimifon*.

Vietnamese Perceptions of Western Medicine

"Many Vietnamese are not used to Western Medicine. If the medicine has bad effects, they don't want to complain, they just stop taking it, or decide the doctor isn't good." Cultural Advisory Panel, Honolulu

"In Vietnam, the health care practitioners ask 1,2 or 3 questions, that's all. After seeing an American doctor, Vietnamese patients say to me: 'I thought this is a free country. Why do they question me more than the communists?'. One lady in her 50's at first answered the questions, then stood up and left." Cultural Advisory Panel, Honolulu.

Traditional Chinese and Vietnamese medicine does not emphasize the taking of patient history. For many Vietnamese, the physical examination or "laying on of hands" is all that is necessary for diagnosis and treatment (Fassano, Hayes, & Wilson, 1986). Thus, the questions commonly posed by Western practitioners may seem irrelevant (e.g., fertility

history, the cause of death of family members) or unfamiliar (e.g. allergy, name of medications) (Muecke, 1983).

Many Vietnamese patients maintain their beliefs in the Chinese medical system. They maintain that Eastern medicines may take longer to be effective, but that they are more appropriate for the bodies of Asian people. Many Vietnamese maintain "a deep-seated distrust" of Western medications, which are thought to cause a variety of side effects. Such patients may be quick to blame any new symptoms on their (Western) medications.

Within the Vietnamese medical system many Western medicines are believed to be "hot". Many Vietnamese patients are thus reluctant to take medications on a regular basis, fearing that they would make their bodies too "hot". Within this medical system, this "side effect" of medications could be counterbalanced by consuming a variety of green herbs and vegetables, fruit and soups that are considered to be "cold". Although water is considered "cold", many Vietnamese are not in the habit of drinking much water, perhaps due to prior experience with unclean water. (Stauffer 1995; Cultural Advisory Panel)

In addition to classifying Western medications as "hot", Vietnamese also believe that Western medicines are too strong, and the dosages of medications prescribed for Westerners are excessive for the Asian body. Thus, some Vietnamese patients routinely decrease medication dosages on their own, often by cutting pills and taking only a portion. (Cultural Advisory Panel; Stauffer, 1995).

Recommendations from Cultural Advisors:

- Western medical exam:
Offer a brief description of and reasons for the examination process for those with limited experience of Western medicine. A Community Health Worker explains to patients before the exam: *"I am sorry, the doctor needs to ask some deep questions. It is not nosy, in America it is routine to ask these questions. I know it is hard, but doctor needs to know."*
- Side effects of medication:
The concept of medication side effects may be new and should be explained. Providers can indicate that because these medicines work so well at killing the TB germs, they may also have side effects, and this is normal. A community health worker says: *"The medicine might be too strong for you or it might be too weak, and if it is, you must talk with us after you've taken the medicines, so that we can make it right for you."*
- Medication dosage:
A health worker addresses the belief that Western medication doses are too strong for small Vietnamese, saying *"In Vietnam, they never take your weight. Over here,*

they always take your weight, so we can be sure we have the right dose of medicine for you". A Vietnamese TB physician explains that decreasing the dose is dangerous and doesn't work; with a smaller dose, you can still get the same side effects, but you get no benefits.

- Refusing antibiotics

"Many Vietnamese believe that antibiotics ("tru sinh") cause bones to rot ("muc xương"), and will refuse antibiotics", says a Vietnamese physician. "They are more likely to take antibiotics if the health provider calls it "Thuoc chua benh", meaning "medicine to cure illness"

Recommendations from Cultural Advisors, continued:

- Concept of "hot" and "cold":

"If they believe in hot and cold, encourage them to eat more fruit and vegetables when they are taking the TB medications". A TB outreach worker adds: "We tell them to drink a lot of water, 8 cups a day. The TB medicine is hot, makes the mouth dry, they feel better after drinking water."

Tuberculosis-Related Beliefs and Practices of Vietnamese in the U.S.

The following section describes beliefs and practices relating to tuberculosis among Vietnamese residing in the U.S. It is based primarily upon (1) the transcripts of three Vietnamese focus groups held in California in 1994, and (2) interpretation of this data by the *Advisory Panel on TB and Vietnamese Culture*, convened in Honolulu in 1997.

Causes of TB

"Everyone has germs that cause TB itself in the body, but TB will be developed whenever people does not have enough strength or lack of nutrition, or does not maintain personal hygiene." Vietnamese Focus Group, Gardena.

Vietnamese believe tuberculosis to be caused by a variety of factors. Some members of the focus groups mentioned the germ theory of disease, but many other causative factors were mentioned. Among these were the following:

- *Malnutrition, *Overwork, *Excess stress, *Alcohol, *Cigarettes,
- *Poor hygiene, *Unsanitary neighborhoods, *Polluted environments,
- *Heredity, *Exposing the chest to cold, *Supernatural causes.

Cultural Advisory Panel members also noted that many believe tuberculosis is caused by humidity or by dusty environments.

Regarding the germ theory, some participants noted that TB develops when the body is weakened by factors such as those listed above. Such a view is consistent with modern biomedical views on the cause of tuberculosis.

It was also stated that "everybody" has the TB germ, perhaps reflecting the high prevalence of TB infection in Vietnam. Given this experience, patients from Vietnam may not consider a positive PPD as a matter for concern, and extra time may need to be taken to explain the unfamiliar concept of TB preventive therapy. Some patients may believe that the BCG vaccination, commonly used in Vietnam, will protect them from TB infection (Carey et al, 1997).

Symptoms and Progression of TB

"...TB destroys body, coughing a lot, skinny, no energy, and then died" Vietnamese Focus Group, Oakland.

Focus group participants identified the medically recognized symptoms of TB, as follows:

*Coughing, *Weight loss, *Fever, *Fatigue

They also noted that people with TB experience:

*Bloody vomit, *Muscle aches and pains, *Difficulty sleeping, *Depression,
*Suffering and death

A physician in the Cultural Advisory Panel noted that patients often associate middle and/or upper back pain with TB.

While some focus group participants maintained that TB is a silent disease which can't be detected early, others maintained that it can be found early, and that the mild stages of TB can be treated. Similarly, a survey of recent Vietnamese refugees found that while most respondents understood that TB disease is not inevitable following infection, a minority of those respondents (29%) incorrectly thought that the development of disease inevitability followed infection. "Such a belief could lead to a view that chemoprophylaxis is useless" (Carey et al., 1997)

Focus group comments indicate that tuberculosis is not clearly differentiated from other respiratory conditions in the popular health belief system. Thus, it is believed that TB can become cancer, that TB can cause other "lung diseases." It is also believed that the person with TB easily develops colds and flu.

Contagion and Social Stigma

"Some will hide that they have TB because people will say 'don't play with those children, family has TB" Cultural Advisory Panel, Honolulu.

"Isolation is like death" Cultural Advisory Panel, Honolulu.

The focus group participants viewed TB as a contagious illness that it can be spread by

- *Coughing, sneezing, spitting
- *From mother to child during pregnancy
- *Sharing eating utensils, blankets, bed sheets, towels

Focus group participants indicated ways to prevent the spread of the illness: “*Separate active TB, severe cases, to cure and prevent spread.*” and “*Don’t get too close or use their things.*”

This belief that TB is extremely contagious leads to isolation of the sufferers of TB and their families. In Vietnam, “*TB in the family is social humiliation, jeopardizing marriage contracts and work*”. There are stories told about Vietnamese families in the US where planned marriages were called off due to a family history of TB (Cultural Advisory Panel). In the U.S., TB is seen as having “highly adverse social consequences”, including job loss, deportation, family and community stigmatization (Carey et al., 1997).

Significant stress and mental anguish can result from the stigma associated with TB and the resulting isolation of TB sufferers and their families. Vietnamese patients are most likely to express these stresses somatically, often as fatigue or body aches. Since fatigue and body aches are also potentially symptoms of TB disease, or side effects from medication, health practitioners may not have an easy time sorting through cause and effect.

The Western concept of psychiatric illness is different from that of Vietnamese culture and medicine. Severe mental illness is recognized, although families will rarely send a mentally ill relative to an institution, “*preferring to hide him at home*” (Cultural Advisory Panel). The concept of an apparently functional person suffering from mild or moderate psychiatric illness, however, is not familiar. Thus, a suggestion to seek counseling is equivalent to labeling a Vietnamese patient as “crazy”.

Health practitioners who attempt to label symptoms as psychiatric and refer the patient out for therapy, especially on the first visit, are likely to be met with anger and/or non-compliance. They are advised to focus initial efforts on agreed-upon symptoms and problems, to build a relationship with the patient over several visits (“*just get them talking*”), gradually provide education regarding therapy, and then attempt a referral for behavioral therapy (Cultural Advisory Panel).

Beliefs Regarding TB Diagnosis and Treatment

“*In Vietnam, before, TB can’t be cured. It will take Western medicine to cure TB*” Cultural Advisory Panel, Honolulu.

“*One who has TB needs to follow not only the doctors direction but also take care of him or herself.*” Vietnamese focus group, Los Angeles.

Consistent with the belief that TB is caused by various factors, focus group participants and advisory panel members believed that there are multiple factors involved in healing the sufferer of TB.

Changes in the environment and exposures

- *Change the living environment: avoid areas with mildew and mold
- *Change the weather conditions: living near the ocean is beneficial

Correcting imbalances in the body

- *Improve personal nutrition, hygiene, and health habits

Western medicine, combined with the health-promoting behaviors listed above, is generally believed to be the best treatment for TB (AAPCHO TB focus groups, Cultural Advisory Panel, Carey et al., 1997). Focus group participants expressed doubt that traditional or herbal medicines, acupuncture, or praying would cure TB. Cultural Advisory Panel members stated that while many Vietnamese believe certain illnesses are best treated with either Chinese medicine or Vietnamese treatments (such as "coining" or "cupping"), that most believe Western medicine is needed to cure TB. Carey et al. found all respondents listed a Western physician as the most appropriate person to consult for TB treatment.

There may, however, be Vietnamese patients who believe in the efficacy of Eastern treatments, and may choose to utilize them in addition to biomedical treatment. Some may even choose to resort to such methods exclusively. It may be difficult to get Vietnamese patients to go along with particular aspects of the biomedical approach to TB. Many Vietnamese believe that exposure to X-rays kills their blood cells and makes them tired or turns their skin yellow. In Vietnam, nurses will often advise their patients to eat meat and eggs to compensate for the effects of X-rays. Traditionally, it is believed that the body has a finite amount of blood, and that withdrawing blood causes an irreversible decrease. This makes many Vietnamese patients very reluctant to consent to drawing blood. Some mention the number of bowls of rice needed to make up for the effects of drawing blood.

Recommendations from Cultural Advisors:

- TB infection
Address possible patient assumption that "everybody" has TB germs in the body, and, for those under 35, take time to explain the significance of a positive PPD and the rationale for preventive therapy. A Vietnamese TB physician says recent immigrants are "*really shocked*" when he tells them that most U.S.-born Vietnamese have negative TB tests: "*They always have a moment of silence. They*

realize that having a positive TB test has nothing to do with being Vietnamese", and that it is something that can be prevented or changed.

- Blood tests & X-rays

It may be helpful to educate patients that the body constantly makes new blood cells. If a patient seems concerned about harmful effects of x-rays or blood tests, stress may be alleviated by asking: *What have you found that helps strengthen your body when it feels weak?* If the response is something non-harmful, such as eating a "cold" food, or eating extra meat, encourage them to do a bit more of this strengthening activity, *"even though the x-ray/blood test is quite safe and should not cause any problem."*

Recommendations from Cultural Advisors, continued:

- Psychosomatic illness

An internist advises: "If I tell a Vietnamese patient: 'You may be depressed', they will say 'What are you talking about?'. If I say this, especially on the first visit, they get angry, they think I am saying they are lying. In dealing with psychosomatic cases, let them somatize, get them talking, consider them a "future referral" and after a couple months slowly, slowly introduce the concept of psychiatric care".

REFERENCES

- Association of Asian Pacific Community Health Organizations (1996). Vietnamese: Pocket Guide for Medical Interpretation. Oakland, CA
- Caballero, J. (1996). Focus group ethnicity /language and discussion topic themes and quotes. Unpublished manuscript, AAPCHO.
- Carey, J.W., Oxtoby, M.J., Nguyen, L.P., Huynh, V., Morgan, M., Jeffery, M. (1997) Tuberculosis Beliefs Among Recent Vietnamese Refugees in New York State. Public Health Reports, 112, 66-72.
- Fassano, M.B., Hayes, J., & Wilson, R. (1986). Traditional beliefs and use of health care services by Vietnamese and Laotian refugees. Texas Medicine, 82, 33-36.

Gold, S. J. (1992). Mental health and illness in Vietnamese refugees. Western Journal of Medicine, 157, 290-294.

Hoang, G. and Erickson, R. (1985). Cultural barriers to effective medical care among Indochinese patients. Annual Review of Medicine, 36, 229-239.

Muecke, M.A. (1983). Caring for Southeast Asian refugee patients in the USA. American Journal of Public Health, 73, 431-438.

Stauffer, R.Y. (1995). Vietnamese Americans. In J. N. Giger and R.E. Davidhizar, (Eds.) Transcultural nursing: Assessment and intervention. St. Louis, MO: Mosby, pp. 441-474.

Wu, D.Y.H. (1980). East West Perspectives. The East West Center Magazine, Vol 1, No.2, 27-30.

Chapter 3. TB and Chinese Culture

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Chinese in the U.S.

Chinese began to arrive in the U.S. mainland in large numbers during the 1840s. Between the 1850s and 1882 more than 300,000 Chinese emigrated to the U.S. They largely came from Guangdong (Canton) Province, which was undergoing social upheaval during this period. These immigrants were mostly indentured laborers in occupations such as farming, mining, and railroad building. Approximately fifty thousand arrived in Hawaii during this period to work as field laborers. An economic recession in the U.S. in the 1870s led to scapegoating of Chinese workers. On occasion, this led to Chinese being subjected to mob violence. The Exclusion Act of 1882 ended the immigration of Chinese and forbade them from becoming naturalized citizens.

As the Exclusion Act did not apply to students, Chinese continued to arrive in the U.S. to study. After the Communist takeover of China in 1949, large numbers of students were unable to return. The Immigration Act of 1965 removed quotas and allowed immigration on the basis of national needs for skilled workers as well as on the basis of family reunification. The recent immigrants have come from mostly urban areas and originated from both a working class and professional class in comparison to the earlier group. Roughly, sixty percent of the immigrants, settled in the two states, California and New York (Takaki, 1989). Persecution in Vietnam has led to an out-migration of ethnic Chinese, many of whom have come to the U.S.

While the dominant dialect in Chinatowns across the U.S. had been Cantonese, with Toisan dialect second, recent immigrants speak a variety of dialects, including Mandarin, Fujian, and Hakka.

Tremendous diversity exists within the Chinese community. Chinese in the U.S. have immigrated to the U.S. from Mainland China, Hong Kong, Taiwan, Macau, as well as

Indo-China. Some cultural differences exist among the individuals coming from these various regions, for example, many believe that Chinese from Hong Kong are the most Westernized. In some respects, however, they may be more traditional because Hong Kong did not undergo the upheavals of the Cultural Revolution in China (Cultural Advisory Panel). In addition to geographic diversity, length of residence in the U.S. varies greatly, ranging from the descendants of the earliest immigrants to recent arrivals. Consequently, acculturation to American life varies greatly. Some Chinese in the U.S. are familiar with only the English language and others only with Chinese, while still others are bilingual or trilingual (speaking Chinese, Vietnamese and English). Some grew up in the security of the American middle class while others experienced major psychological and physical traumas before fleeing their homelands in Asia (Uba, 1994). Education levels also vary greatly. The information and advice in the chapter is more likely to apply to Chinese persons who are elderly, have less formal education, and/or who have more recently immigrated to the U.S.

Relevant Characteristics of Chinese Culture

Interpersonal relationships

“Age is important in Chinese culture. It is difficult for a younger person to inform an older person about a serious illness or disease” ---Cultural Advisory Panel³

“Rain falls from the sky, not from the ground” ---Chinese saying regarding importance of age vs. youth

Traditional Chinese culture, based upon Confucianism, emphasizes filial piety (respect for one’s parents and ancestors). In the customary family, age, sex, and generational status are the primary determinants of role behavior (Locke, 1992). Thus, respect for elders is highly important, and individuals are mindful of their respective positions within the family. Siblings are referred to as “older sister,” “younger brother,” etc.

Similarly, in the larger social sphere, Confucianism emphasizes a structured order. Each individual knows his or her place within the social order, and thus, harmony is maintained. Outward expressions of individual needs, emotions, or opinions are considered to represent a lack of self-control and are discouraged. Consequently, from the point of view of American culture, Chinese are often seen as quiet and reserved.

In the health care setting, doctors and nurses are respected as authority figures. As a result, some Chinese patients may not feel comfortable asking questions, even if they don’t understand or agree. Young health providers, however, may not be believed or taken seriously by an elderly or first generation immigrant Chinese patient. There is a

³ The Cultural Advisory Panel (also referred to as "Cultural Advisors") refers to the Advisory Panel on TB and Chinese Culture, convened in 1997 in Honolulu to review and interpret findings from AAPCHO-sponsored Chinese TB focus groups. This panel was a multidisciplinary committee of Chinese and non-Chinese health and immigrant service providers, representing both public and private sectors. It was convened by the Kalihi-Palama Health Center, a community health center located in Honolulu, Hawai'i.

...

saying that is reflective of the Chinese patient's perception of the young nurse or doctor:
“ *I ate more salt than you ate rice.*”

A health provider's credentials may be less important to some Chinese patients than a trusting relationship. “They are very sensitive to an unstable or mistrusting relationship with health care givers.” (Shih, 1996). Chinese patients might prefer a doctor whom they know, "even if the doctor was incompetent," over a doctor with whom they feel uncomfortable. (Cultural Advisory Panel).

Recommendations from Cultural Advisors

- Questions and Compliance

To accurately assess the needs of a Chinese patient, doctors may need to ask more questions. The patient may not actively offer information unless asked. Take the time to develop a trusting relationship with the patient. *"When two people are talking, the one who does not understand gets embarrassed. A smile and nodding 'yes, yes' may mean they don't understand and/or are embarrassed. Talk to them long enough to know their command of English and level of understanding. Ask them to repeat back what you have said to them 'so we can be sure we understand each other'".*

- Age and Advice

A person of the same generation, or of an older generation, should inform a patient that he or she has a serious disease, such as tuberculosis. *"A Chinese person might beat around the bush if he had to tell his father or mother: 'you have TB'. (If family members are translating) ask an older person, an uncle or an auntie, to tell the elder."* Avoid using younger people to encourage older people to take medication. *"A young person with an education may be able to consult with their parents because many worked hard for their children's education, however they may not be able to give advice to grandparents."* A Chinese medical student says, *"My grandmother will not listen to me."*

Pair a young health provider with a mature interpreter.

- See also: Table 2: "Etiquette" for Greetings and Correct Form of Address.

Chinese Medicine: History and Concepts of *qi*, *yin* & *yang*, *hot* & *cold*

“Great emphasis is placed on maintaining balance. Elements of that balance include activity, sleep, schedule, flow of chi, and diet according to seasons.” ---Cultural Advisory Panel

“Focus on correct foods more than on medicine.” ---Cultural Advisory Panel

Traditional Chinese medicine is a system of knowledge, philosophy, and practices distinct from Western biomedicine. The traditional texts of Chinese medicine date back to antiquity. The most famous are the *Shang Han Lun* (A Treatise on Exogenous Febrile Diseases), the *Ben Cao Jing* (Canon of Materia Medica), which were written around the first century A.D., and the *Huang Ti Nei Ching* (The Yellow Emperor’s Canon of Internal Medicine), which is said to have been written around 700 B.C. (Gould-Martin and Ngin, 1981).

A widely utilized concept in Chinese medicine is *qi*, or the life force. Disease is thought to be caused by interruptions in the flow of *qi*. Modalities such as acupuncture restore the flow of *qi*.

Another widely utilized concept is that of *yin* and *yang*, the two life forces, with opposite and complementary characteristics. *Yin* is female, dark, cold, wet. *Yang* is male, light, hot, and dry. Various bodily conditions and diseases possess a *yin* or *yang* quality. A person must be in balance with these two forces otherwise illness will occur. (Wu, 1979). Interventions are undertaken in order to restore balance. Thus, for a “cold” condition, an individual may take “hot” foods or herbal concoctions.

Within this traditional medicine system, there is no clear distinction between food and medicine. (Wu, 1979). Depending on the symptoms of the illness or disease, a combination of herbal medicines and foods are used to restore the health of the individual. For example, if an individual has a cold, a common treatment would be to fry gingerroot and place it in hot water to make tea.

As practiced today Chinese medicine is a heterogeneous system. In general, there is an emphasis on maintaining balance in one’s life in order to prevent illness. Practitioners in Chinatown clinics utilize a variety of modalities: from herbs to acupuncture. Some make diagnoses by feeling the patient’s pulse and examining the patient’s facial features. At the popular level, people modify their diet to address various bodily conditions.

Chinese Perceptions of Western Medicine

“Most Chinese, even those from Hong Kong [considered to be the most Western], are concerned about the side effects of Western medications.” ---Cultural Advisory Panel

“No medicine is the best medicine.” ---Physician, Cultural Advisory Panel

“When health care providers draw too much blood, they [Chinese] are very concerned...believe too much blood loss will weaken the body. In Chinese medicine, the blood is regarded as the most important element of life” --- Cultural Advisory Panel

“In Hong Kong, if you don’t come home with medicine, you do not have a good doctor. Hong Kong doctors are very smart because they give vitamin pills in all different colors. When Hong Kong people compare American and Chinese doctors, they say, ‘No wonder it takes a long time for Americans to get better.’” ---Cultural Advisory Panel

Western medicine is viewed by many Chinese as effective for symptoms of diseases and acute care. Chinese medicine is considered better for the causes of disease and chronic care (Cultural Advisory Panel). Some Chinese patients like antibiotics because they are “fast”, but some “*take it three days at the most and then save the rest for others, such as the children*” (Cultural Advisory Panel). Still others feel antibiotics and other Western medications weaken them and will not take them at all.

Many Chinese believe that Western medicines are either too "hot" or too "cold" and can weaken the body. Some Chinese utilize traditional medicines in order to counteract the side effects of Western medications (Cultural Advisory Panel). As a result, it is believed that consuming foods that are either "hot" or "cold" in nature, depending on the medicine, can counteract the effect of the medicine. For example, some Chinese feel that antibiotics can harm the body. In order to counteract the effects, the common person would know that taking herbal tea, watercress soup, chicken soup, or gingerroot with tea are all helpful in balancing the system.

Also viewed with suspicion by some Chinese is the taking of X-rays and the drawing of blood samples. It is believed that these procedures kill or harm red blood cells and thus weaken the body (Cultural Advisory Panel).

Many Chinese people expect a prescription when they visit a doctor and are often disappointed if they do not receive medication (Cultural Advisory Panel). Prescriptions are freely passed around among family members and friends, who urge those with similar symptoms to utilize the same remedies (Gould-Martin and Ng, 1981). Some say that, “*If it (medicine) is good for you then it is good for me.*” (Cultural Advisory Panel). In Mainland China, many Chinese ask for more medicine than necessary in order to save the medicine for later when a family member or friend becomes sick (Cultural Advisory Panel). In Vietnam, the ethnic Chinese often view medicines that are locally made and/or provided for free to be not quite as good. Many feel that medications that are imported are better (Cultural Advisory Panel).

Some Chinese patients may not accept a TB diagnosis from an American doctor. “*They think I feel fine, I can work, how can I have TB? This is just a Western standard diagnosis of TB. My doctor in China never told me I had TB*” (Cultural Advisory Panel)

Recommendations from Cultural Advisors:

- Address common beliefs

Chinese patients may not express their reservations regarding medications, X-rays and blood tests, so practitioners should either ask patients if they have concerns, or address concerns the patient may have ("*Some of my patients say they fear that blood tests weaken the body...*"). "*Explain to the patient that x-rays are not harmful, that the risk is greater if you don't take the x-ray exam than if you do. Tell them also that blood cells can build back up.*"

- Consider Western and Eastern approaches:
In some cases, trying to "explain away" a deeply held belief is ineffective. Providers can also encourage the patient to combine the Western treatment with non-harmful Chinese treatments that the patient believes will strengthen him/her.

Tuberculosis-Related Beliefs and Practices of Chinese in the U.S.

The following section describes beliefs and practices regarding tuberculosis among Chinese residing in the U.S. It is based upon (1) the transcripts of five Chinese focus groups held in Boston, Los Angeles, New York, and San Francisco, and (2) interpretation of this data by the Advisory Panel on TB and Chinese Culture, convened in Honolulu in 1997.

Causes of TB

"TB bacteria are in the patient's lungs, and if that patient coughs a lot, he can pass the TB bacteria through coughing, sneezing, and from spitting." Chinese Focus Group, San Francisco

"The causes of TB include heredity, malnutrition, environment, pollution, and the most important cause is smoking, because it is most direct." Chinese Focus Group, Los Angeles

"Smoking definitely has something to do with TB. My father-in-law was a heavy smoker and he died of TB. It is because of the accumulated chemicals in the lungs. They will destroy the lung tissue." Chinese Focus Group, San Francisco

"Because we work very hard, especially people who work in the garment factory, and live in crowded environments, the chances of getting TB infection are high." Chinese Focus Group, New York

"By avoiding working excessively and having nutritious food and soup, especially soup, one could prevent being infected and getting the disease." Chinese Focus Group, New York

"Being too hot and dry inside is damaging to one's lungs." Chinese Focus Group, San Francisco

Chinese in the U.S. believe tuberculosis to be caused by a variety of factors. Some participants in the focus groups mentioned the germ theory of disease, and many noted the contagiousness of TB. Thus, participants thought that TB could be caused by

* contact with someone with TB, * contact with airborne particles coughed up by people with TB, and * contact with household utensils used by such people.

Many other causative factors were mentioned. Among these were the following:

* heredity, * crowded places, * pollution, * dust/dirt, * smoking, * excessive alcohol consumption, * hard work, * stress, * “hot” foods, * body “dryness”

The last two are related to the concept of *yin and yang*, as outlined on pp. 47-48: *Chinese Medicine: History and Concepts of qi, yin & yang, & hot & cold*.

Symptoms and the natural history of TB

“If the TB condition worsens, the patient may change to lung cancer.” Chinese Focus Group, Los Angeles

Focus group participants identified symptoms of TB that are also recognized in biomedicine:

*cough, particularly cough productive of blood, * difficulty breathing,
*weakness & fatigue, * fever, * loss of appetite, and * weight loss.

They noted that people with TB therefore become thin and pale. Some participants identified “cold-like” symptoms as occurring in TB. A large number of participants identified damage to the lungs and lung cancer as consequences of TB. The most dire consequence identified was, of course, death.

Implications for function and social stigma

“Many Chinese do not want to tell others they have TB because they [immigrants] share living quarters with their relatives.” Cultural Advisory Panel, Honolulu

“People tend to keep away from people with TB because they do not want to contract TB.”
Chinese Focus Group, Boston

“When I think about eating out, I feel bad about the possibility of spreading the disease to other people.” Chinese Focus Group, Los Angeles

“When someone starts to perform poorly because of ailing health, he may get fired. Eventually, he becomes financially disadvantaged, and that will affect other people in the family.” Chinese Focus Group, San Francisco

“TB brings psychological pressure to myself and other people. Like myself, I have to take care of my daughter. If I don’t feel good, I feel very frustrated.” Chinese Focus Group, Los Angeles.

Much concern was expressed about being unable to function normally due to the contagiousness of TB. As a result, those with TB are feared by the community and socially isolated. The thin and pale appearance of the person with TB is considered unattractive. Since those with TB can become physically unable to work, losing one's employment is a common concern. Many Chinese believe that some are blessed with good fortune and others suffer from misfortune. As might be expected, those with TB are considered to be unlucky.

Beliefs Regarding TB Diagnosis and Treatment

“Traditionally, Chinese never mentioned tuberculosis because they view that the disease is incurable.” Cultural Advisory Panel, Honolulu.

“People in general are much more relaxed about TB now. We know that there is a cure available. If I know someone who has TB, I will tell him to see a doctor right away.” Chinese Focus Group, San Francisco.

“In the Chinese medicine, the doctors will prescribe medicine that has a tonic effect to the lungs. Something that can maintain the vitality of the lungs and preserve the lung's functions.” Chinese Focus Group, San Francisco.

“The doctor prescribes TB medications and some Chinese patients flush it down the toilet after three months because the medication increases the cold element [shan in Cantonese] Cultural Advisory Panel, Honolulu.

“Western medicine is more effective treatment . . . combined with some Chinese herbs and foods that can help bring down the “hotness” inside one's system. I think that will be the ideal treatment.” Chinese Focus Group, San Francisco.

Consistent with the belief that TB is caused by various factors, focus group participants and advisory panel members believed that there are multiple factors involved in healing the patient with TB. Almost all focus group participants believed that TB can be cured with “modern” medicines. A significant number of participants believed in the utility of traditional Chinese methods as well. Many believed that modern and traditional methods can be utilized together. The belief that Western medicines cause imbalances in the body's system for health (as described on p. 48-49: *Chinese Perceptions of Western Medicine*), may cause some patients to discontinue TB treatment or preventive therapy.

Focus group participants recommended other modalities, including changes in ones personal habits. As overwork is thought to cause TB, obtaining sufficient rest and “taking

it easy” are considered to be beneficial. Maintaining an optimistic attitude was also thought to be important by some.

“One should rest to treat TB.” Chinese Focus Group, Boston.

“I think the mental state of the patient is important in determining the length of treating the disease. If someone is mentally prepared, he will be more ready to accept treatment and listen to the doctors.” Chinese Focus Group, San Francisco.

Recommendations from Cultural Advisors:

- Combine Western and Eastern healing
The most effective approach with Chinese patients may be to explain the importance of TB medications while supporting the need to strengthen and balance the body *“while the medicine fights the TB germs.”* If they are concerned about the side effects (or in the Chinese system: imbalance, too much hot or cold element), ask them, *“What do you do to strengthen your body?”*
- Complete course of medication
Stress the importance of completing the medication. A Community Health Worker explains: *“Now the germ is in your body. You killed some, but not all. Later on they will wake up. You need to take all the medicine to complete killing the germs”.*
- Explain reason for dosage
Health care providers should explain clearly the reason for the prescribed dosage to the patient. *“They think that if they take more[medication], they will get better faster”.*
- Monitor medication adherence
The use of a pillbox for the patient’s medications is recommended: *“Medicine bottles with childproof caps are difficult to open for the elderly. Many transfer their medicines to other bottles. Ask them to return with the bottle (to the next exam) to monitor their adherence to the regimen.”*
- Inquire about the patient's true age

When prescribing medications where age is critical, such as for TB preventive therapy, practitioners should consider that the age listed on the medical records of some Chinese patients may be inaccurate (by as much as 10 years in some cases). In Vietnam, many Chinese changed their age in order to avoid being drafted into the armed forces. Others altered their age in order to attend high school and receive an education in the United States. Many Chinese who left Mainland China after the Communist takeover in 1949 and went to Hong Kong, fabricated their age in order to obtain a job. Providers may need to stress the importance of knowing the patient's true age to be sure the medication is good for him/her.

REFERENCES

- Chang, K. (1995). Chinese Americans. In J. N. Giger and R. E. Davidhizar, (Eds.), Transcultural nursing: Assessment and intervention. St. Louis, MO: Mosby, pp. 395-414.
- Char, W. F., W-S. Tseng, K-Y. Lum, and J. Hsu. (1980). The Chinese. In J. F. McDermott, W-S. Tseng, and T. W. Maretzki, (Eds.), People and cultures of Hawaii: A Psychocultural profile. Honolulu, HI: University of Hawaii Press, pp. 53-72.
- Gao, G. (1996). Cross-cultural considerations in health care delivery: Chinese viewpoints. Maryland Medical Journal, 45, 231-234.
- Gould-Martin, K. and C. Ngin. (1981). Chinese Americans. In A. Harwood, (Ed.), Ethnicity and medical care. Cambridge, MA: Harvard University Press, pp. 130-171.
- Hesketh, T. and W. X. Zhu. (1997). Health in China: From Mao to market reform. British Medical Journal, 314.
- Huang, K. (1991). Chinese Americans. In N. Mokuau, (Ed.), Handbook of social services for Asian and Pacific Islanders. New York: Greenwood Press.
- Kunz, K., C. Lam, K. Siu, and D. Young. (1980). The Chinese. In N. Palafox and A. Warren, (Eds.), Cross-cultural caring: A Handbook for health care professionals in Hawaii. Honolulu, HI: Transcultural Health Care Forum, pp. 25-47.
- Locke, D.C. (1992). Increasing Multicultural Understanding. Newbury Park, CA: Sage Publications, Inc., pp. 81-95.
- Shih, F-J. (1996). Concepts related to Chinese patients' perceptions of health, illness and person: Issues of conceptual clarity. Accident and Emergency Nursing, 4, 208-215.
- Takaki, R. (1989). Strangers From Different Shores: History of Asian Americans. Boston, MA: Little Brown Company.
- Uba, L. (1994). Asian Americans: Personality Patterns, Identity, and Mental Health. New York, NY: The Guilford Press.

Wu, D.Y-H. (1979). East-West Perspectives. The East-West Center Magazine.
Honolulu. Vol.1, No.2.

Chapter 4. TB and Korean Culture

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Koreans in the U.S.

Korea, referred to by many as the “Land of the Morning Calm”, is a country rich in history and culture. Situated between China and Japan, Korea has suffered a long history of oppression due to its geographical and political location. China strongly influenced Korea for centuries. In 1910, Japan annexed Korea for the next 36 years. As a result of the Korean War (1949-1953), the country was divided at the 38th parallel demilitarized zone into North and South Korea.

There were three waves of immigration from Korea to the U.S. Driven by political turmoil, social upheaval, and poor conditions brought upon by famine and drought, the first wave of immigrants arrived in the U.S., mainly in Hawaii, between 1898-1905 to work as laborers on the sugar and pineapple plantations. Mostly coming from the farming and the working classes, these immigrants were sojourners who intended to stay only temporarily in the U.S. The second wave of Korean immigrants entered the U.S. between 1945-1964. This group consisted of the brides of U.S. military servicemen, children orphaned during the Korean war and students who came to the U.S. to continue their education (AAPCHO,1996 & Pang, 1985). Following the 1965 Immigration and Nationalization Act, the third and largest wave of Koreans arrived in the U.S., mainly as family units. This group is highly educated and skilled compared to the two previous waves. Many occupy positions in skilled labor and professional services with a majority holding managerial positions (Harvey et al, 1985).

The official language of both North and South Korea is Hangul. Several dialects exist within this language; however, most are able to understand each other without much difficulty.

Assimilation of Koreans into U.S. culture has been very challenging. Although many are well educated, some have had trouble practicing their professions, primarily due to language barriers and to racial and job discrimination (Takaki,1994). Thus, many have turned to self-employment such as becoming owners of restaurants or mom-and-pop grocery stores.

Relevant Characteristics of Korean Culture

Interpersonal Relationships

Interpersonal relationships are highly valued in Korean culture. Centering around strict social hierarchical relationships, emphasis is placed on filial piety and strict role differences with a generally subservient position of women (Pang, 1980). Governed by Confucian principles that focuses on maintaining social order, Koreans are very conscious of their relationships with others. Children are expected to show respect and follow the guidance of their elders.

Some Koreans have difficulty making eye or physical contact in the public realm and are in that sense a “non-contact” cultural group (Earp, 1995). Due to the hierarchical nature in interpersonal relationships, Koreans generally do not make direct eye contact with someone of a higher social status. It is considered inappropriate, for example, for a patient to make direct eye contact with a doctor who is socially esteemed. To do so is to show disrespect and disregard of social propriety.

Evidence of the hierarchical nature of Korean society is also shown through its language (Locke,1992 & Earp, 1995). An elaborate honorific system reflects the nature of Korean society. Different verb endings and word forms are utilized by the speaker depending on the degree of familiarity and/or intimacy and the rank or position of the individual. Younger individuals or those of lesser rank or status are expected to give respect towards their elders and persons of higher position or stature.

Family and Social Network

The Korean family is the major focal point of the culture. Males are highly regarded in Korean families. In health care settings, families should be consulted in the care of family member. “As the primary social unit, family members must be included in the plan of care, if culturally appropriate care is to be rendered” (Earp, 1995).

The church is a primary social organization in the Korean culture. Church activities provide stress relief from conflicts faced in everyday situations and energy to cope with problems encountered during the week (Chang et al, 1997). Through this relationship

with the church, Koreans are able to share their experiences with others and learn ways to adapt into U.S. culture.

Relationship with Health Providers

“In Korea, many patients see three or four doctors at a time.” --- Cultural Advisory Panel⁴

“The reason why Koreans switch and go to different doctors is because the doctors didn’t treat them with respect, they were very abrupt, and not culturally sensitive. They were rushed and the doctors didn’t take their time.” --- Cultural Advisory Panel.

“A story was told of a Grandpa who was sick and the grandchild was told that he had Hepatitis B. The grandchild understood 100% but didn’t want to scare the Grandpa and so he didn’t tell.”--- Cultural Advisory Panel.

“At a dental office, an elderly patient refused to have a young, female dentist pull a tooth out because the dentist looked too young. But a Community Health Worker explained how old she was and she had it done.” ---Cultural Advisory Panel.

Physicians are well respected and highly regarded in the Korean culture. It is customary for Korean patients to call their doctor “Sir Dr. or Madam Dr.” to extend their respect. Korean patients may not be accustomed to being offered alternative choices in reference to the care that they receive from their doctor. *“In Korea, the doctor’s position is to give instruction. If they do not provide direction, they appear not to be confident, especially if the doctor is young. Some may even ask, ‘Is he really a doctor?’* (Cultural Advisory Panel).

In Korea, a family doctor system does not exist. Many Korean patients are used to “hopping” from one doctor to another. Consequently, long term compliance is difficult to sustain; *“It is hard to follow up, especially when patients don’t like the diagnosis”* (Cultural Advisory Panel). However, when a doctor takes the time to establish a trusting relationship with the patient, Korean patients tend to be loyal to that doctor and will seek out his/her services as long as the trusting relationship is maintained. If there is a diagnosis that the patient is not comfortable with, many Koreans will seek out other doctors to get a second and many times a third opinion.

Building trust between Korean patients and their health providers is a critical issue. Koreans are accustomed to taking responsibility for their own health (Pang, 1985). Many are used to educating themselves on the particular disease they possess. *“In the past, many doctors in Korea were not very truthful. Some doctors used to give medicine to their patients all grounded up”* (Cultural Advisory Panel). As a result, many patients did not know what kind of medicine they were receiving and some patients could have even

⁴ The Cultural Advisory Panel (also referred to as “Cultural Advisors) refers to the Advisory Panel on TB and Korean Culture, convened in 1998 in Honolulu to review and interpret findings from AAPCHO-sponsored Korean TB focus group. This panel was a multidisciplinary committee of Korean and non-Korean health and immigrant service providers, representing both public and private sectors. It was convened by the Kalihi-Palama Health center, a community health center located in Honolulu, Hawaii.

received vitamins. Consequently, developing trust with a physician is a new experience when Koreans immigrate to the U.S.

Communication between Korean patients and health care providers may be strained due to the language barrier. Some patients may bring in a trusted family member or friend to interpret for the patient. When possible, avoid using family members to translate for the patient. *“It is not favorable to use a family member when translating because it can cause miscommunication”* (Cultural Advisory Panel).

Among the elderly patients, young health providers may be at a disadvantage and not be taken seriously. *“Koreans may not accept what they say, especially if they don’t speak the language”* (Cultural Advisory Panel). Some Koreans may even be hesitant to accept care from a young, female provider. In the past, there were few Korean providers that were female. Thus, among the elderly, *“Some think the male doctor is better”* (Cultural Advisory Panel).

Recommendations from Cultural Advisors:

- Communicate Respect:
When establishing trusting relationships, the manner in which the provider communicates is very important. As an advisory member stated, *“Treat with respect and not in an inferior manner. Be sensitive to the culture.”* Basic courtesy, sincerely exhibited, is a good faith gesture that overcomes traditional Korean mores (Earp,1995).
- Use trained interpreters:
Use trained interpreters to facilitate communication between provider and patient. If possible, when translating topics to the elderly, use an older interpreter rather than a younger one. Avoid using children as interpreters for the patient. Children should not be used as translators because it may cause conflict and create a reversal in parent-child relationships (Earp,1995).
- Utilize a humble approach:
When interacting with Korean patients, health providers should be aware of both their verbal and non-verbal behaviors. Carefully listen and respect what the patient has to say, so that it does not appear as if one is talking down or telling them what to do. For example, when caring for an elderly patient, a physician says: *“You bring many years of experience of living a long time and knowing your body and illness. I’m*

sure that you know best, however, this is what may happen if you do not take the medicine.” This fills the need to be an authority figure at the same time utilize a humble approach towards the patient.

- Advice for Young Health Providers:
Inform the elderly patient of your background and experience and/ or pair with an older community health worker. Address this issue directly. For example, one can share the length of experience in the field by saying, *“I’ve been working here at this clinic for more than 10 years.”* This establishes credibility and provides comfort for the elderly patient.
- Provide written materials
Give written materials to the patient to reinforce instruction even if these are only available in English. A Korean physician says, *“It is good to give written materials even if it is in English because the patient can read the materials many times. Many Koreans feel more comfortable reading in English, then listening to spoken English. Even the most well educated person can have difficulty understanding a native English speaker.”*

Korean Medicine: History and Concepts of Oriental Medicine, Ki, um (yin) & yang

Traditional Korean medicine has been strongly influenced by many aspects of Chinese medicine; yet, Koreans have maintained their own system of medicine. One of the most famous and influential traditional text, Ho Chun’s *Tongui pogam* (Precious Mirror of Eastern Medicine, 1631) contains over 4000 prescriptions for over 1000 symptoms. (Jae, 1996).

Health is viewed as a balance between the many elements that make up a person, the organic and inorganic, the mind and the body (Pang, 1980). Imbalance of aforementioned factors is viewed as the basic nature of disease. Another widely utilized health illness theory is that of *eum* and *yang*, based upon Yin and Yang concepts of Chinese medicine.

Eum (pronounced *um*) is water, female, dark, and shade. *Yang* is fire, male, light, and bright. Disturbance of this balanced relationship results in illness.

Oriental medicine incorporates a variety of therapeutics that are used for health promotion and disease prevention such as herbal medicine, acupuncture, and moxibustion. Diagnoses are made through the inspection by the eye, auscultation, pulse feeling and inquiry to trace the causes and the progress of a disease (AKOM, 1996).

Another concept used in Oriental Medicine is *Ki*. The concept of *Ki* is considered the very essence of life energy.

Korean Perceptions of Western Medicine

“Many Koreans believe TB medicine is too strong for Koreans. They believe that the medication dose is for Caucasians that are much bigger than Koreans. So they cut the dose in half.” --- TB outreach worker, Cultural Advisory Panel.

“When comparing Western doctor’s medication, they will question and have more doubts. With herbalist’s medicine, they won’t question and will pay and take it on pure faith.” --- Cultural Advisory Panel.

“Whatever side effects they may have, they’ll attribute it to the medicine.” --- Cultural Advisory Panel.

The Western medical system has been in place in Korea for over 100 years. Many Koreans are familiar with the system and at times utilize both Eastern and Western approaches. However, *“If they see a regular Western doctor and cannot find the source of illness, they lose faith. Acupuncturists will provide hope to the patient”* (Cultural Advisory Panel). When it comes to TB, however, Western medicine is considered best; most Koreans are *“knowledgeable and there is no confusion about TB.”* Some Koreans, however, will take herbal medication *“as a tonic” (bouyag)* to increase *Ki*.

Korean patients also have more faith in injectable medications and believe it to be more effective than oral medications. *“Some TB patients would rather have a shot. They believe that it is faster than medicine taken orally”* (Cultural Advisory Panel).

Many Western prescription drugs are readily available without prescription in Korea. As a result, some Koreans may feel uneasy with the Western method of obtaining drugs and other medicines (Chang et al, 1997). *“Koreans can buy any kind of medicine without prescription. They explain their symptoms and say they need this medicine, without taking into consideration the amount of milligrams...”* (Cultural Advisory Panel).

Some Korean patients may be reluctant about having their blood drawn. Elderly Korean patients, especially, since blood is considered to be life and removing blood from the body is considered to be the same as removing *Ki* (Earp, 1995). Others may be apprehensive as well because the needles used in the past in Korea were non-disposable. They may be concerned about contracting other diseases such as hepatitis; thus, further worsening their condition.

Recommendations from Cultural Advisors:

- **Medication Dosage:**
Address the possible patient concern that Western medications are too strong for Korean patients. Take the time to explain the importance of the medication and following the recommended dosage at a fixed time. A TB outreach worker says, *“Take this medicine everyday. This is the doctor’s order. The dose is right for you.*

It is good for your age and weight. It is very important for you to take it everyday. The best time is one hour after dinner, before bed to avoid stomach problems.”

- **Blood Tests:**

Assure the patient that new, clean, disposable needles are used to draw blood. Inform the patient that the amount of blood that is taken is very small and the amount of time it takes to “replace” is minimal. If the patient is still concerned, offer suggestions of what can be done to replace the blood. A panel member suggests, *“After you have had your blood drawn, have one small piece of chicken and nothing bad will happen.”* This is to suggest to the patient that the amount of blood lost has little effect on the body.

- **Monitoring Medication:**

A physician says, *“Ask the patient what medications they are taking and ask them to bring the bottle of medications. This is very important to ask.”* Since prescribed medicines are accessible within the Korean community, it is necessary to inquire about other possible medicines they are taking concurrently. Stress the possible side effects of using different medicines. Tell them, *“Mixing medications can be harmful.”*

Recommendations from Cultural Advisors, continued:

- **Side Effects of Medication:**

Inform the patient ahead of time of both the benefits of the medication (eg. urinate less) and possible side effects of the medication.

Tuberculosis-Related Beliefs and Practices of Koreans in the U.S.

The following section describes some beliefs and practices regarding tuberculosis among Koreans residing in the U.S. It is based upon (1) the transcript of one focus group held in Los Angeles and one personal interview with a Korean TB patient and (2) interpretation of this information by the *Advisory Panel on TB and Korean Culture*, convened in Honolulu in 1998.

Causes of TB

“When your parents have TB, the children get it genetically.” Korean Focus Group, Los Angeles.

“When your cold symptoms get worse.” Korean Focus Group, Los Angeles.

“Most Koreans know that TB is caused by germs, however, older people have different theories regarding the causes of TB.” Cultural Advisory Panel, Honolulu.

Focus Group participants believe that tuberculosis is caused by several factors. Some participants believe that it is caused by the germ theory of tuberculosis, while others indicated that it was caused by the following factors:

* heredity, * unhealthy life style, * cigarettes, * alcohol, * result of common cold, *contact with a carrier of TB, * sharing things with the carrier, *environmental conditions: places that are dusty, poor environment etc.

Symptoms and Natural History of TB

“Your lungs gets detrimentally damaged...therefore your respiratory system gets damaged too and the worst someone can die from it. But usually you get very weak and can therefore contract many diseases.” Korean Focus Group, Los Angeles.

Focus group participants identified the following symptoms of TB:

cough up blood, * weakness, *the ability to contract many diseases, *death

Implications for Function and Social Stigma

“I feel ashamed to have TB, since TB is contagious, I think other Koreans will not feel comfortable with me around them.” Korean Focus Group, Los Angeles

“I don’t know about completely being cured, but at the worst case, you are put into quarantine.” Korean Focus Group, Los Angeles

“I think I would want to avoid sharing things with the carrier.” Korean Focus Group, Los Angeles

“Many believe that TB is a poor person’s disease.” Cultural Advisory Panel, Honolulu.

Focus group participants perceived TB as highly contagious and spread through:

* physical contact with carrier, *sharing things with the carrier (such as spoons, chopsticks, rice bowls and towels)

In addition, the stigma associated with having TB included:

*feelings of shame, * social consequences: such as being viewed as poor, interference in relationships, * being placed in quarantine, * having cautious behavior towards those who are infected

Many Koreans deny having TB because of the social stigma associated with the disease. In the past, TB patients were quarantined at a hospital located near the city of Masan, at

the southern peninsula of Korea. Consequently, many fear isolation and confinement when diagnosed with TB. (Cultural Advisory Panel).

Recommendations from Cultural Advisors:

- To Alleviate Social Stigma:
Explain the nature of TB and how it is transmitted. Tell them, “*Don’t feel embarrassed. TB bacteria is very prevalent. Anyone can catch this disease. Just follow the patient plan and TB can be cured.*”

Beliefs Regarding Diagnosis and Treatment

“Since traditional medicine is to help you stay healthy, I think it can prevent your body to contract it by making it healthy. But maybe it can’t cure the TB that’s already in the body.” Korean Focus Group, Los Angeles.

“I don’t believe traditional treatment can cure TB. TB treatment has to work to kill the TB germ. I think the western medicine is good for killing germs but the Chinese medicine is only preventive medicine, it’s not to be used to cure something that has gone bad already.” Korean Focus Group, Los Angeles.

“Ninety-five to ninety-seven percent of Koreans are PPD+. Many believe that positive PPD is normal for Koreans. In Korea, the Head nurse says that ‘if you take the BCG, you never need to worry about the TB organism.’” ---Cultural Advisory Panel.

Consistent with the belief that TB is caused by several factors, focus group participants believed that there are multiple methods of treating those with TB:

- * taking medicine and living a healthy lifestyle, *consulting traditional healers,
- * patient initiative to cure oneself, * injection

Many Korean immigrants are PPD+. In Korea, immunization is a governmental requirement in the schools and many have received the BCG immunization (Pang, 1985 & Cultural Advisory Panel). They attribute being PPD+ to the BCG immunization and believe they are protected. As a result, many Koreans do not think of TB as a serious problem, nor do they consider a positive TB skin test a matter of concern. “*New immigrants to the US are never worried about TB.*” (Cultural Advisory Panel).

Recommendations from Cultural Advisors:

- TB infection:
Address the belief that everyone is PPD+. For those under 35, stress the importance of the medication and explain the reasons behind preventative therapy, for example: “

You might get TB in the future. BCG doesn't cure or protect you from TB. (BCG only provides a small amount of protection for a short period of time and that it is useful in preventing small children with TB from developing very serious forms of TB. Unfortunately, there is no vaccine which can assure we will never develop TB throughout our lifetime. (L. Zackin, personal communication, September 15, 1998). You have the TB germ. We have to give you preventative medicine to kill the germs in your body. Take the preventative medicine and you'll only have a very small chance of having active TB."

- **Monitor Adherence to Drug Regimen:**

Compliance to drug regimen amongst Korean patients should be monitored because of a tendency to not take prescribed medication when no obvious symptoms exist (Earp, 1995). *'As long as they show symptoms, than there is no problem taking the medicine. If they don't show symptoms, it will be difficult for them to comply with the medication.* (Cultural Advisory Panel).

- **Take the time to explain:**

Explain the seriousness of TB and the reason behind the need to stay on the medications for six to nine months. For a patient who is hesitant to comply with the medication regimen because they feel well, a TB outreach worker says, *"Can you see your lungs? Don't wait till you feel bad, sooner is better."*

Recommendations from Cultural Advisors, continued:

- **Use Visual Aids:**

Color pictures can be very useful to explain what happens when TB is in the body. Describing TB in tangible and measurable terms will make TB much easier for the patient to understand.

- **Patient compliance:**

Assess the education level and the knowledge of TB of the patient. For those who are familiar with the nature of TB, concentrate on the advantages of taking preventative medicine. A panel member says, *"Focus on the benefits of taking the medication. Provide brochures and inform in detail of what may occur."* For those patients who may be unfamiliar with TB, be brief. Focus on the consequences of not taking the medication. Tell them, *"I'm sure you know best, however, this is what may happen if you do not take the medicine."* Share with the patient true stories of patients who did not comply with the medication in order to demonstrate the possible outcome of non-compliance.

REFERENCES

- Alphen, A. and A. Aris. (1996). Oriental medicine: an illustrated guide to the Asian arts of healing. Boston, MA: Shambhala pp.217-229.
- Association of Asian Pacific Community Health Organizations (1996). Korean: Pocket Guide for Medical Interpretation. Oakland, CA
- Chang, N.J. and B.T. (1997). Caring for Korean-American Community. The South Carolina Nurse. 4(2): 7-8.
- Eap, J.B. (1995). Korean Americans. In J.N. Giger and R.E. Davidhizar, Transcultural nursing: Assesment and intervention. St. Louis, MO: Mosby, pp. 555-572.
- Kim-Harvey, Y.S. and S.H. Chung. (1980). The Koreans. In J.F. McDermott, W.S. Tseng, & T.W. Marezki (Eds.) People and Cultures of Hawaii: a Psychocultural profile. Honolulu, HI: John A. Burns School of Medicine and University of Hawaii Press.
- Locke, D.C. (1992). Increasing Multicultural Understanding. Newbury Park, CA: Sage Publications, Inc., pp.113-126.
- Miller, J.K. (1990). Use of traditional Korean health care by Korean immigrants to the United States. Sociology and Social Research, 75(1), 38-48.
- Pang, C. (1980). The Koreans. In N. Palafox and A. Warren, (Eds.), Cross-cultural caring: A Handbook for health care professionals in Hawaii. Honolulu, HI: Transcultural Health Care Forum, pp. 121-137.
- Takaki, R. (1994). From the Land of Morning Calm: The Koreans in America. New York, N.Y.: Chelsea House Publishers.

Internet: Association of Korean Oriental Medicine (AKOM)
<http://www.koma.or.kr/foreigner.html>